Exploring Men’s Experiences of Their Female Partner’s Sexual Pain: A Qualitative Thematic Analysis Study

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Contents

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Abstract

Aims

Female sexual pain occurs within a relational context, yet little is known about partners' experiences This study adds to the very small literature exploring men's experience of sexual pain within a different-sex relationship. I aimed to give voice to men and explore their sense making and responses to female sexual pain; their views on how it has impacted them, their sexual relationship and the relationship more broadly; and their own experience of help seeking.

Method

A qualitative survey and in-depth semi-structured interviews were used to explore men's experiences and understandings of their partner's sexual pain. A total of 26 men took part; 25 completed the survey, 9 men went on to be interviewed and one man shared his experience via interview only. The data was analysed using reflexive thematic analysis to identify themes across the data.

Findings

Thematic analysis resulted in 5 themes. The first, 'Pain Is a Communication, It Could Be a Problem in Me' captured how men made sense of female sexual pain. 'Men Are Not the Patients, Women Are' illustrated men's invisibility within the medical setting and 'Men's Loss of Agency, Impotence to Act, and Inactivity' described men's responses within both the medical setting and the relationship. In the fourth theme, it was evident that men viewed their own distress, though complex and significant, as less worthy of attention compared to their partner's, as reported in 'Downplaying Suffering: My Experience Doesn't Matter… And Yet'. The final theme 'Hegemonic Heterosexuality and The Individual Man' described how men engaged with multiple versions of masculinity and accessed individual scripts that differed, to varying extents, from dominant cultural scripts: predominantly, men sought intimacy.

Conclusions

Female sexual pain is not just a woman's matter. There are many dimensions to men's experiences

which impact their own psychosocial functioning and how the couple adapt and respond. The findings implicated that men need to be meaningfully included in the help seeking process as their own suffering has been neglected. Through their exclusion, taken for granted assumptions about men’s sexuality are left unexamined and positive adaptation opportunities are overlooked. Counselling psychologists, through their emphasis on phenomenology and contextualising experience, are ideally positioned to provide therapeutic support to men and the couple to helpfully explore their entire sexual pain experience.

Introduction

The most frequently searched term on Google that accompanies the phrase ‘during sex’ is ‘pain’ (Stephens-Davodowitz, 2017). Globally between 8-21% of women are estimated to experience pain during penile-vaginal intercourse (medically termed dyspareunia; Sorensen et al., 2018), although under-reporting by women and poor recognition by clinicians has made assessing prevalence challenging (Simonelli et al., 2014). Contemporary approaches to understanding and treating sexual pain privilege biomedical frameworks (Farrell & Cacchioni, 2012). The medical model places the ‘problem’ within the woman and takes an exclusively individual approach to sexual difficulties, attending to the parts of the woman which may require ‘fixing’ (Tiefer et al., 2002). However, penile-vaginal intercourse (PVI), and therefore pain during PVI, is an interpersonal experience and occurs within a partnership (Davis & Reissing, 2007). As with any sexual difficulty, sexual pain potentially influences both partners’ sexuality alongside the nature of the sexual and broader relationship that both members of the couple share (Potts et al., 2003). In recognition of the relational context of sexual pain, it has frequently been recommended that partners are included in research, yet to date, their voices remain largely absent in the sexual pain literature (Al-Abbadey et al., 2015; Bergeron et al., 2014; Connor et al., 2008; Jodoin et al., 2008; Rosen et al., 2013; Rowland & Kolba, 2017). A better understanding of partners’ experiences could contribute to more effective treatment for both members of the couple and expand treatment approaches beyond those only involving the woman and removal of her symptoms. This study therefore aims to explore men’s experiences of women’s pain during PVI in the context of different-sex relationships.

Counselling psychology centres phenomenological enquiry but does not exclude positivist perspectives (James, 2018). Counselling psychologists therefore have an understanding of diagnosis and the medical context; *and* engage with subjectivity and the individual’s unique experience (British Psychological Association, 2019). I have organised the literature review in line with our attention to ‘both’. I begin with an overview of sexual pain within a medical model framework and draw on quantitative studies. I then move to what is missing or ignored within this framework. I discuss qualitative research which privileges the subjective experience, and the critical feminist literature which broadens the conceptualisation and potential treatment of sexual pain. Within this structure, the broad literature on women's sexual pain is first discussed as this contextualises and informs research into men's experiences. Woven through the multiple dimensions and perspectives of sexual pain, that centres women themselves, are indications of potential areas of enquiry into men's experiences. Arriving finally at men, I review the very limited research relating to pain during PVI which has involved partners, and broader literature on masculinity and men's sexuality.

The literature I review is plagued with multiple terminologies as sexual pain falls under both psychiatric and medical classification systems (Cabello-Santamaría et al., 2015). The mechanisms through which sexual pain arises and persists are complex: physical (e.g., inflammation, hormonal and neurological changes) and psychological (e.g., fear of intimacy, relationship distress and negative sexual attitudes) factors potentially contribute independently and in combination (Simonelli et al., 2014). Various disciplines such as gynaecology, psychology, sexology, and physiotherapy are therefore involved in sexual pain research and treatment. Confusion around nosology and terminology is understandably common in the health sciences, particularly when multiple disciplines are involved (Van Lankveld et al., 2010). In this paper, I therefore mostly use a commonly referenced umbrella term 'female sexual pain' (FSP) to encompass all of the various diagnoses and conditions which relate to the experience of painful PVI. The exception is when I refer to specific studies in which case the authors' terminology is used (e.g., dyspareunia, vaginismus, genito-pelvic pain/penetration disorder, vulvodynia etc). I have provided brief definitions of these terms in Table 1 below to assist with reading and a more detailed explanation of different classifications and nosology in Appendix A.

As already mentioned, the structure of the review is informed by counselling psychology, as a discipline, drawing on both medical and phenomenological models. I therefore begin by situating the exploration of FSP within counselling psychology and illustrate how it is ideally positioned to address sexual issues and in particular FSP.

Table 1

Diagnoses and Descriptions of Various Conditions Associated With Female Sexual Pain

Diagnosis	Description
Chronic pelvic pain (CPP)	chronic and persistent pain, perceived in structures related to the pelvis
Dyspareunia	recurrent or persistent genital pain associated with sexual intercourse
Endometriosis	a disease in which tissue that normally grows inside the uterus grows outside
Genito-pelvic pain/penetration disorder (GPPD)	a DSM-5 classification that has merged dyspareunia and vaginismus
Lichen sclerosus	an inflammatory condition that creates patchy white skin
Provoked vestibulodynia (PVD)	a subtype of vulvodynia referring to pain in the vestibule (the entrance of the vagina) when the area is touched
Vaginal atrophy	thinning drying and inflammation of the vaginal wall
Vaginismus	a recurrent or persistent involuntary spasm of the outer third of the vagina that interferes with intercourse
Vulvodynia	vulvar pain without known aetiology

Counselling Psychology and Female Sexual Pain Research

The medical model conceptualises sexuality as an essential pan-human biology. Sexual experience is categorised as either ‘normal’ or ‘abnormal’ and the cause of sexual dysfunction is assumed to be either organic or psychogenic (Kleinplatz, 2004). The medical model’s view of sexuality has been extensively criticised for its biological reductionism and focus on diseases rather than people (Tiefer, 1991). Treatments ‘fix’ parts in disrepair and the person or couple are largely ignored as the subjective, interpersonal and social aspects of the sexual experience are overlooked (Kleinplatz, 2004). The assumptions embedded in the medical model around sex and sexuality have been challenged by critical feminists. They have advocated that greater attention is given to the social influences that create different experiences and meanings of sex to compensate for the failures of the medical model (Tiefer, 1991).

The medical model has heavily influenced psychology's traditional lens on sexuality via the use of the American Psychiatric Association's diagnostic system of sexuality disorders as documented in their *Diagnostic and Statistical Manual of Mental Disorders* (DSM; Syme et al., 2012). Counselling psychology has in part developed in response to the limitations of the medical model, which dominates in the sister professions clinical psychology and psychiatry (Bolton, 2020). Counselling psychology draws upon and aims to develop phenomenological models of practice and enquiry (Bury & Strauss, 2006) and attention is given to the individual's subjective experience as it "unfolds in their interaction with the physical, social, cultural and spiritual dimensions of living" (Jones Nielsen & Nicholas, 2016, p. 11). This ideally equips counselling psychologists to locate sexual difficulties within the context of individual's lives, relationships and wider social environments; and also understand different experiences and meanings of sex. They can attend to what has been identified as the failures of the medical model, regarding its view of sex and sexuality, and also appreciate its potential gains.

Engagement with both phenomenological and medical models is of particular importance when conceptualising and treating FSP. Leonore Tiefer, widely acknowledged as one of the most public critics of the DSM and the medical model of sexuality, clarified that her criticism focussed on universalised notions of desire, arousal and orgasm and not on sexual pain. She described how her immersion in the feminist literature had attuned her to the "disgraceful history of neglect and mishandling of women's complaints of pelvic pain" (Tiefer, 2005, p. 50). She therefore acknowledged the merits of conceptualising FSP within a medical framework as it generated important clinical enquiry and treatment options for a poorly understood and poorly managed condition (Tiefer, 2005). As FSP has a 'pain' and a 'sexual' component, it has therefore largely been recognised as a unique case among sexual difficulties due to its obvious relationship to biomedicine's expertise in gynaecological and physical pain conditions (Farrell & Cacchioni, 2012).

Having established counselling psychology's 'good fit' with FSP research and practice, I now turn to a review of the sexual pain literature beginning with how FSP has been understood and treated within the medical model.

Conceptualising Female Sexual Pain Within the Medical Model

The way in which FSP is conceptualised has implications for clinical practice, research attention, how health organisations address the problem and importantly "how women and their partners react to pain" (Binik et al., 2002, p. 428). Scholarly understandings of FSP, as with sexual difficulties in general, have oscillated between organic, psychological and social theories depending on the era (Cacchioni & Tiefer, 2012). I have therefore provided a historical account of the understandings of sexual pain (and to some extent how it has been treated) to illustrate how contemporary conceptualisations within the medical model have been shaped over time. Throughout the account, references to psychiatric diagnostic classifications of sexual pain are intertwined with sexual difficulties in general, to locate FSP within its broader context. Psychiatric and medical conceptualisations also interweave due to FSP having both a 'pain' and a 'sexual' component. As the understanding of FSP evolves, it is evident that medicine gains growing authority over how sexual difficulties are viewed. By the end of the account, it is apparent the pain component of FSP is foregrounded and sexual pain falls under the dominion of biomedicine. This has important implications for men who, as sexual partners, are potentially removed from the formulation and treatment of FSP.

From Freud to Masters and Johnson

Historically during the 18th and 19th centuries many 'diseases of women' were diagnosed as hysterias. Pelvic pain without any physical evidence of disease was described as 'hysterical mimicry' and physicians were warned "you will damage your own reputation, for you will never cure her; she will have the pain as long as she pleases" (Herman, 1898, as cited in Grace 2000, p. 32). In the late

1800's Freud became famous for treating hysteria believing it to be caused by unresolved trauma (often child sex abuse and typically incest). A crucial target of treatment became uncovering and dealing with the emotions that were denied expression (Kleinplatz, 2018). Dyspareunia (painful PVI) was largely considered to be a hysterical symptom for most of the 20th century under the influence of the psychoanalytic movement and made its first appearance (along with impotence) in the second edition of the DSM (American Psychiatric Association, 1968). Categorised under psychophysiological disorders, the pain or physical symptom was assessed as being caused by 'emotional factors' (Moser, 2005). However, the middle of the 20th century saw ground-breaking research on the physiology of the sexual response by William Masters and Virginia Johnson. In 1966 they published a paper describing a 'human sexual response cycle' (HSRC; Masters & Johnson, 1966), and three years later a follow-up text titled *Human Sexual Inadequacy* (Masters & Johnson, 1970). In doing so they offered a template for a 'normal' sexual response and new understandings of sexual difficulties as 'abnormal' deviations from the HSRC (Kleinplatz, 2018). They believed the aetiology of all dysfunctions was 10% organic and 90% psychogenic. Sexual functioning was conceptualised as being like any other bodily function (e.g., respiration and urination). Psychosocial factors, such as sex-negative expectations and 'performance anxiety', were viewed as interrupting 'normal' biological functioning. They revolutionised the model of treatment, including that of sexual pain, by replacing the prevailing psychodynamic approach with brief behaviourally based treatment involving the couple and not just the individual. Their model for treating vaginismus (an involuntary spasm of the vagina which causes PVI to be painful) was considered to be the "prototype illustration" of their approach (see Kleinplatz 2018, pp. 36-38 for a full description). The DSM-III was released in 1980 and psychoanalytic language and diagnostic groupings of the first two editions were removed as the goal of the editors of the DSM was to become empirically based and atheoretical (Kleinplatz, 2018). For the first time, all sexual problems were separated from non-sexual problems and grouped together under a 'psychosexual dysfunctions' section (American Psychiatric Association, 1980). This 'arbitrary' decision is largely viewed as being influenced by the work of Masters and Johnson around that time

(Segraves et al., 2007; Tiefer, 2006). Dyspareunia was included as a psychosexual dysfunction (as 'functional dyspareunia' and later in the DSM-III-R, revised to 'dyspareunia') and grouped with vaginismus as 'sexual pain disorders' under 'sexual dysfunctions' (American Psychiatric Association, 1987). As noted by Binik (2005) sexual pain was not linked to any stage of the sexual response cycle and there was no explanation offered for the sexual pain disorder grouping or its listing under sexual dysfunctions.

The Turn to Pharmaceuticals and the Biomedical Model: Medicalisation and 'The New View'

There were no significant changes to the diagnoses of women's sexual problems in the DSM-IV (American Psychiatric Association, 1994). There was however a significant surge in the 'medicalisation of sex' in the 1990s due to the introduction of Viagra (i.e. sildenafil citrate) and understandings of sexual difficulties changed dramatically (Cacchioni & Tiefer, 2012; Kleinplatz, 2018). The term medicalisation refers to a "process of defining a condition, problem, or life event in medical terms" and typically involves using a biomedical intervention to treat the problem (Braksmajer, 2017, p. 1). Prior to the mid 1990's, erectile difficulties, the same as sexual pain, were more commonly attributed to psychological causes (Potts, 2002). However, ahead of the release of Viagra, the Pfizer marketing department worked hard to change the discourse around 'impotence' and rebranded it as a more medical 'erectile dysfunction' (ED) condition. Importantly it promoted ED as being 90% organic and 10% psychogenic. This represented a complete turn-around in how sexual difficulties were understood (Kleinplatz, 2018). The incessant media publicity promoted sexual difficulties as physical/biomedical problems to the public (Tiefer & Giami, 2002). The introduction of medication to prescribe for ED meant medical professionals also had less incentive to refer patients to talking therapies. In the US this coincided with sex clinics opening in major cities offering biomedical interventions for a variety of sexual difficulties (Tiefer, 2012). The outstanding financial success of Viagra prompted a growth in the 'business' of treating all sexual dysfunctions. New sexual medicine groups such as the International Society for Sexual Medicine (ISSM) and the International Society for Women's Sexual Health (ISWSH), primarily populated by urologists and gynaecologists respectively, were formed. Sexual dysfunctions in general, which had typically been treated by sex therapists attending to intrapsychic, interpersonal, and psychosocial dimensions of sexual difficulties, now fell under the care of sexual medicine practitioners who focused on organic pathology (Kleinplatz, 2018). The goal of treatment, heavily supported by the research of pharmaceutical companies, became to 'fix' the body part of the person in whom the dysfunction resides (Tiefer et al., 2002). This also in effect removed the partner from the treatment setting: sex therapy which had often involved the couple was largely replaced by sexual medicine which focussed on the individual body.

A backlash against this biological reductionism and the growing medicalisation of sexuality occurred with a prominent New View Campaign launched by an interdisciplinary group of feminist sexologists (Kleinplatz, 2018). One component of the campaign targeted highlighting the weakness of the prevailing medical model and its nomenclature and offered a social constructionist view of sexuality in its place (Tiefer, 2006). The New View emphasised that sexuality is socially contextualised and is a matter of culture and individual diversity, rather than an essential pan-human biology. They also argued that the overall medicalisation of sex was driven by the social construction of heteronormative sex (Potts, 2002; Tiefer, 1994). In order to enact hegemonic heterosexuality, barriers to sexual functioning such as 'soft penises' and in the case of sexual pain 'closed vaginas' had become treatment targets so that 'normal' (penetrative) sex could resume (Kleinplatz, 2012). They argued that the consumption of products, procedures and drugs that may improve sex and cure pain was being driven by a demand for sexual 'normalcy' (Conrad & Leiter, 2004; Tiefer, 2004). Alongside promoting a social constructionist perspective as an alternative to the medical model, they stressed the central role of qualitative studies to better understand the broad range of lived sexual experiences and the ways in which these experiences are made meaningful (Tiefer, 2006). I review the qualitative literature generated by feminist scholars later (see 'Sex is Social' and 'The Pain of Abnormality in Women') and continue here with the final era of the 'conceptualisation' story which turns now purely to FSP.

Is the Sex Painful or the Pain Sexual?

An interest in painful sex focussed on the 'pain' aspect of FSP had also been growing in medical fields outside of psychiatry and sexual dysfunctions. In 1975 The International Society for the Study of Vulvar Disease (ISSVD) had been formed and the 1980s had seen a growth in research into genital disease, in particular 'vulvodynia' referring to the presence of vulva pain in the absence of a known cause (Farrell & Cacchioni, 2012). Painful PVI was and continues to be recognised as the most common and troubling complaint of women with vulvodynia (Mitchell et al., 2017). Ahead of the release of the fifth edition of the DSM, the chronic genital pain research was drawn on by Binik and colleagues in a series of papers proposing dyspareunia be reconceptualised as a 'urogenital pain disorder' as the ISSVD already did (Binik, 2005, 2010a, 2010b; Binik et al., 1999, 2002) They asked the question 'is the pain sexual or is the sex painful?'. They highlighted that as sexual pain disorders were the only pain problem (in the then DSM-IV) that appeared outside of 'pain disorders', FSP was conceived as a special type of pain and different to other types of pain, i.e., there were two types of pain in the world, sexual and non-sexual. They disagreed with this view and proposed that vaginismus and dyspareunia be conceptualised as genital pain disorders that naturally interfere with PVI (and other insertion/penetration activities such as tampon use and gynaecological examinations). Binik's proposal triggered a lively debate with twenty-one papers focussing on this question alone (Peer Commentaries on Binik, 2005). In their questioning of why vaginismus and dyspareunia were singled out amongst pain syndromes, Binik and colleagues were also disputing whether sexual pain should be classified as a sexual-mental disorder and potentially stigmatised (Kleinplatz, 2018). This issue was taken up by some commentators as they argued that a sexual dysfunction classification relied on a conceptualisation of women's pain that emerged in an era of medicine influenced by Freudian notions of genital pain (as discussed above). Classifying sexual pain as a 'pain condition' was therefore understood to be a movement away from ascribing it as a manifestation of psychological disturbance or characterological dysfunction (Kaler, 2005). Kleinplatz (2005) argued the 'pain' aspect of FSP at the beginning of the 21st century had been overlooked noting that when no organic cause was readily identifiable, the woman was often (mis)treated as though the pain was all in her head. On the other hand, in support of keeping sexual pain classified as a sexual dysfunction, Payne (2005) argued that most women seek treatment not because of the pain per se, but due to an inability to have PVI: an act so valued in society that it is the correction of their sense of sexual inadequacy that is sought. Classifying their pain as a pain disorder, she argued, risked denying women's true experience and would result in medical professionals treating the pain and women's sexuality being neglected. Although not discussed in this commentary, neglecting women's sexuality (by focussing on pain) also potentially extends the exclusion of men from the formulation. Men, as partners, are not included in the classification of FSP as a sexual dysfunction in the DSM but have an invisible presence within heterosex. Conceptualising FSP as a pain condition potentially removes men entirely.

Binik light heartedly described the debate as 'team pain' against 'team sex' (Binik, 2005) and for the DSM-5, team sex appeared to win as sexual pain disorders remained listed in the sexual dysfunction category. What did change was dyspareunia and vaginismus were collapsed to a single diagnostic entity 'genito-pelvic pain/penetration disorder'(GPPD) due to overlapping symptomatology (American Psychiatric Association, 2013; see Appendix A for a description of GPPD). Interestingly, although 'team sex' seemingly won the DSM classification debate, 'team pain' has heavily dominated contemporary treatment approaches. This shift to conceptualising and treating FSP as a pain condition may be explained by the push from pharmaceutical companies to offer pain alleviation 'magic bullets' (Tiefer & Giami, 2002). However, medicalisation has an 'it's not all in your head' mantra (Tiefer, 1994); the turn towards pain mitigation treatments may therefore also have been supported by practitioners and researchers who were keen to avoid early psychoanalytic perspectives and their legacy of notions of hysteria (Grace, 2000). I later discuss the research which has addressed how women themselves understand FSP and why exploring men's sense making is important, but now turn attention to treatment interventions and the foregrounding of FSP as a pain condition.

Treatment of Female Sexual Pain

Around the time of Binik and colleagues' bid to classify FSP as a pain disorder, 26 treatment options had been identified for vulvodynia that aimed to reduce pain (Ayling & Ussher, 2007). In more recent treatment reviews, the authors have also stated that the goal of most interventions for FSP is pain reduction (Farrell & Cacchioni, 2012; Shallcross et al., 2018). Multidisciplinary approaches to treatment (that target pain) are currently recommended (Kleinplatz, 2018).

Medical Treatments

Following is a very brief summary of treatments that focus on organic elements (for detailed reviews, see Caruso & Monaco, 2019; Sorensen et al., 2018). Interventions aimed at mitigating pain vary according to potential causes, and treatments may be pharmacological, physical or surgical. Examples of pharmacological treatments are local anaesthetics (e.g. topical lidocaine), anti-inflammatory agents (e.g., corticosteroids), Botox, hormonal treatment (e.g. topical oestrogen if vaginal atrophy is evident) and systemic medications (e.g. tricyclic antidepressants which are known to reduce peripheral nerve sensitisation; see Loflin et al., 2019 for a review of pharmacological treatments).

Physiotherapists utilise pelvic floor exercises; biofeedback (which targets gains in control over bodily processes such as muscle contraction); internal and external pelvic massage; and trigger point work (downregulating hyperirritable spots) to desensitise painful areas and reduce involuntary muscle tension (Farrell & Cacchioni, 2012). Vaginal dilators (candle-like objects that come in varying widths inserted into the vagina to stretch the pelvic floor muscles and allow the woman to get used to the sensation of penetration) may also be used as a physical therapy modality although the instruction of their use has also fallen under sex therapy approaches. Vaginal dilators may be incorporated into behavioural therapy and guided by sex therapists or talk therapists more broadly (see Bergeron et al., 2018).

Surgical treatments, viewed as a last resort intervention, also obviously depend on the specific disorder and may involve options such as vestibulectomy (involving excision of areas of vulval tenderness) or lysis of pelvic adhesions (involving destruction of scar tissue; Sorensen et al., 2018)

Psychological Treatments

Treatment approaches used by psychologists for FSP have also prioritised mitigation of the pain experience. Cognitive behaviour therapy (CBT) is considered to be the most popular therapeutic modality (Dunkley & Brotto, 2016; Flanagan et al., 2015; Rosen et al., 2019; Sorensen et al., 2018). CBT treatments that have been found to be efficacious in the treatment of chronic pain (anywhere in the body) have been applied to FSP. The 'fear and avoidance model' typically provides the theoretical underpinnings of the CBT approach to pain (Flanagan et al., 2015). Fearful cognitive and emotional responses to pain are viewed as generating avoidance of activities that cause pain. Behavioural avoidance diminishes opportunities to test expectations of anticipated pain; this, in turn, exacerbates fear, leaving the individual caught in a fear-avoidance cycle (Flanagan et al., 2015). Therefore, CBT typically focuses on psychoeducation, challenging maladaptive pain related cognitions and avoidance, and introducing adaptive coping behavioural interventions that are relevant to pain (Dunkley & Brotto, 2016; Rosen et al., 2019). Pain mitigation interventions under the CBT umbrella have also been expanded to include mindfulness exercises which have been found to be effective in the treatment of a variety of chronic pain conditions (Brotto et al., 2013, 2015; Dunkley & Brotto, 2016; Veehof et al., 2016).

Involving Men in the Psychological Treatment of Female Sexual Pain

Viewing FSP as a decontextualised pain condition seemingly removes men from the treatment picture although research of the CBT model of pain has actually involved them. Chronic pain research identified that the asymptomatic partner's response styles can potentially become a source of pain maintenance or exacerbation (Davis & Reissing, 2007). Men were therefore construed as 'pain partners' rather than 'sexual partners' in the application of the chronic pain (anywhere in the body) framework to FSP. For example, in a series of quantitative studies, the effect of men's negative (demonstrations of hostility and frustration), solicitous (providing attention and sympathy), and facilitative (encouraging adaptive coping) responses on women's perception of pain were investigated (Rosen et al., 2010, 2012, 2013). The authors interpreted the results within a CBT model of pain and proposed that, in contrast to facilitative responses, greater solicitous and negative partner responses positively reinforced pain behaviours (such as avoidance and maladaptive appraisal of pain) which lead to greater pain and impairment for the woman (Rosen et al., 2013). CBT approaches (and the medical approaches outlined above) have been criticised for helping women conform to heteronormative sexual expectations by focussing on the restoration of PVI (Farrell & Cacchioni, 2012). Additionally, through primarily targeting pain mitigation (to make penetration possible) an exploration of why pain or distress around penetration exists is largely ignored (Tosh & Carson, 2016). Practitioners, therefore, risk encouraging women to cope with the pain to restore PVI. Furthermore, encouraging partners to provide 'facilitative responses' when women communicate their pain potentially teaches men to ignore signs that women may not be enjoying the sexual experience or do not want to participate (Tosh & Carson, 2016). In the more recent literature, these criticisms have to an extent been addressed. The involvement of men in the later research expanded beyond investigating their role in modulating women's pain in recognition of them also being 'sexual partners'. Relationship factors which potentially impact a couple's sexuality outcomes were also incorporated (e.g., Rosen et al., 2015, 2017). This led to the development and empirical investigation of a CBT programme for couples targeting reduction of pain *and* improvement of sexual function and satisfaction (Corsini-Munt et al., 2014). This programme is described as borrowing strategies from CBT pain management programmes and integrating them with interventions aimed at improving connection; expanding the sexual repertoire beyond intercourse; and facilitating experiences of desire and arousal for both parties (Bergeron et al., 2018). Evident here is an important move towards de-centring PVI and challenging the assumptions of heterosex. However, practitioners must consider the earlier criticisms of CBT approaches and, prior to any pain mitigation treatment, address in full women's understandings of why the pain may be present (including potential penetration distress); establish whether PVI is indeed wanted; and communicate that not participating in PVI is a legitimate option. Alternative modes of intimacy for the couple who do not wish to work towards pain free PVI can be explored; traditional approaches involving desensitisation, dilation techniques and CBT may be incorporated for those who do (Farrell & Cacchioni, 2012).

As this research involving men and couples has aimed to illuminate social, relational and psychological aspects of FSP rather than solely focussing on the pain dimension, it can be viewed as a positive movement towards integrating ‘team pain’ with ‘team sex’. However it has been further criticised for presenting sexual pain and related phenomena in a way that resembles reductionist biomedical accounts of bodily processes as emotional and relational experiences are quantified and presented as “fractured statistical constructs” (Farrell & Cacchioni, 2012, p. 330). I now therefore turn attention to the qualitative research which centres the voices and lived experience of women with FSP. In addition to illustrating dimensions of FSP not attended to in the pain literature, this body of literature also emphasises the role of social factors in women’s experiences as argued by the New View and informs potential areas of enquiry about men’s experiences.

Just Women’s Fear of Pain?

Qualitative research has illuminated many aspects of the entire FSP experience that has largely been neglected, through the focus on pain mitigation, within a medical model framework. For example, women themselves have attributed their own experience of vaginismus to be due to a fear of pain *and* fear of vaginal penetration (Ward & Ogden, 1994). A number of quantitative studies from a physiotherapy perspective identified increased pelvic floor tension and muscular guarding reactions in women with FSP (e.g., Reissing et al., 2013). These muscular responses were explained as a protective mechanism against vaginal penetration which was expected to be painful and also which was not *wanted*. Whilst the involuntary spasm may indeed be underpinned by the fear of pain, foregrounding pain in research and practice has ignored the negative associations of penetration that may be defended against in the tensing and guarding response of the pelvic floor. For decades gynaecology textbooks have indicated the diagnosis of vaginismus can be made by just looking at the external genitalia during an examination as they resemble a woman's pursed lips saying 'no' (Kleinplatz, 2018). Ward and Ogden (1994) included a qualitative component in their study in which vaginismus sufferers wrote in their own words about causality. Descriptions were given of vaginismus being a 'defense against letting people inside', 'a means to avoid disintegration', 'a way to take control'; and sex in general was described as 'disgusting', 'animal like', and 'something that nice girls don't do'. This highlights how dimensions of FSP sit outside the limits of a 'pain paradigm' and how for some women the pain may indeed be sexual. These women appear to talk about vaginismus as a defense of sorts, yet there is very little research on FSP which is psychodynamically informed. Early psychoanalytic theory understood vaginismus as a conversion or hysterical symptom of a woman's unconscious wish to frustrate the man's sexual desire in revenge for her own 'castration'. Treatment based on this theory had poor results and was therefore not made available (Jeng, 2004). However, the Institute of Psychosexual Medicine in the UK, primarily a teaching organisation founded by a psychoanalyst, aims to develop a psychodynamically informed understanding amongst doctors and allied health professionals of connections between the mind and the body in sexual difficulties (Brough & Denman, 2019). They draw on notions of psychosomatic illness being a hidden unconscious communication and a 'story in need of a listener', rather than 'illness which is not real' or a 'hysterical' symptom (Goldbeck-Wood, 2019). Redirecting attention back to psychodynamic perspectives may therefore expand effective treatment options for some women with FSP, in particular for women who may not want or fear penetration (see Cowan & Frodsham, 2015; Lee et al., 2018). However, due to the 'hysteria' legacy of early psychoanalytic understandings, women's accounts of sexual pain have historically been viewed as untrustworthy and women having frequently been told 'it's all in the head'(Grace & MacBride-Stewart, 2007; Tosh & Carson, 2016). It is therefore essential for women to understand the vaginal spasm as a protective and productive response in which fear and anxiety is expressed physiologically and is not representative of psychological instability (Jeng, 2004). Practitioners are encouraged to explore and understand the 'no' and as already highlighted in reference to CBT approaches, fully explore gendered norms of sexuality, social pressures of heteronormativity and to offer alternatives to PVI as legitimate and valued options.

Is the Pain Real? Women's Help Seeking Experience

Women's experience of FSP is also shaped by their interaction with the medical system which they may turn to for help. The body of research addressing how women experience the help seeking process also illuminates aspects of men's experiences which warrant further attention. Within Western cultures, individuals have become consumers of medicine increasingly approaching practitioners with requests for diagnosis and treatments of their bodily symptoms, and therefore medicalising their own distress (Bell & Figert, 2012; Braksmajer, 2017). However, approximately only half of women with chronic vulvovaginal pain formally seek help from a medical practitioner (Reed et al., 2012). Of women who do, many describe seeing multiple professionals whom they view as having very little knowledge about genital and sexual pain (Buchan et al., 2007; Marriott & Thompson, 2008; Sadownik et al., 2012). Women have reported seeing an average of five physicians before being given a diagnosis, and between 40-50% never receive one (Harlow & Stewart, 2003; Nguyen et al., 2012). Little is known however about the experiences of men whose partner is encountering these challenges and how involved they may or may not be in this process.

Central to women's experience of engaging with medical professionals is a quest to have their pain legitimised (Tosh & Carson, 2016). Women do not always feel their illness claims are believed, in particular when attempts to find physical causes of the pain fail (Braksmajer, 2017; Tosh & Carson, 2016; Toye et al., 2014). Grace and MacBride-Stewart (2007) noted that eliminating the word 'hysteria' from medicine and the DSM does not eliminate the phenomenon. Indeed women have reported feeling dismissed by health care professionals and have often been exposed to suggestions of being 'crazy', 'neurotic', and 'frigid' (Kaler, 2006; Marriott & Thompson, 2008; Sadownik et al., 2012). The potential for pain (not) being taken seriously may be gendered as suggested by a rare study of chronic pelvic pain (CPP) which both men and women can experience. Toye et al. (2014) noted that men do not appear to struggle to have their illness claims acknowledged, and their experience of pain is not discredited in the way that it is for women. Furthermore, the difficulty women encounter establishing a diagnosis and accessing appropriate treatment can lead to long term ‘doctor shopping’ which risks attracting the unfortunate diagnosis of a ‘psychosomatic’ illness (Graziottin et al., 2001). In this context psychosomatic refers to bodily symptoms being misattributed as symptoms of disease which triggers the seeking of medical treatment that is not necessitated. This label problematically positions the woman as generating the problem (Graziottin et al., 2001). It is therefore evident that an important feature of women’s sexual pain experience is the struggle they may endure to have their pain sanctioned as ‘real’ (Al-Abbadey et al., 2106; Bergeron et al 2014; Farrell & Cacchioni, 2012; Pacik, 2014).

Women with sexual pain are therefore eager to receive a diagnosis as it lends legitimacy to their claims (Tosh & Carson, 2016). That said, women appear to favour a particular explanation for their pain. A general acceptance of the medical model framework is widespread amongst the ‘lay’ public, in particular the dualist concept of the problem lies either in the mind or in the body (Grace & MacBride-Stewart, 2007). Women have been found to resist psychological explanations and have preferred pain to have a physical explanation (Braksmajer, 2017; Marriott & Thompson, 2008). Some women have described feeling more hopeful if the pain is physical in origin due to a possibility of it being ‘removed’ via a medical intervention (Braksmajer, 2017), whilst others have perceived a ‘core aspect of themselves is wrong’ when pain is attributed to a psychological cause (Marriott & Thompson, 2008). Women may therefore be understandably elated when they are able to successfully get a biomedical diagnosis and help for their pain management, particularly if they have had their pain experience dismissed as being ‘in their heads’ (Cacchioni & Wolkowitz, 2011).

Women’s privileging of physical over psychological explanations and their pursuit of medical legitimacy may also take place in a wider context and they may seek validation from others in their social world, in particular their partner (Braksmajer, 2017). In a recent interview study with women who were self/medically diagnosed with vulvodynia, or experienced painful PVI, several women believed a biomedical diagnosis led to empowerment in declining sexual activity which they otherwise viewed to be an obligation. The author concluded that women may use validation from the medical profession to evidence their illness when their accounts of their own subjective experience need fortifying (Braksmajer, 2017). However, due to a distinct lack of focus on partners, it is not known how men make sense of women's sexual pain symptoms; whether they consider pain to be legitimate; and what expectations they may have around sexual activity in the presence of pain. Men (interviewed with their partner) have voiced that learning more about vulvar pain disorders had helped them recognise their partner was not rejecting them personally (Connor et al., 2008). This suggests that men may draw on different notions of what sexual pain represents (for these men rejection). If explanations of pain cannot be anchored in a specific physical condition, there is scope for men to develop their own theories around either the cause of pain or the potential disruption to PVI. Women's struggle to have their pain sanctioned as 'real' within the healthcare system may therefore also be played out within the relationship with their partner if, for example, pain is misunderstood to be a deliberate alibi for avoiding sexual activity (Graziottin et al., 2001).

I have highlighted some dimensions of the FSP experience and potential sources of distress for women not accounted for within the medical model. I now complete the overview of women's experiences of FSP, revealed by the qualitative literature, by turning attention to sexuality and sexual pain through a social constructionist lens. Feminist scholars have argued that medical approaches to sexuality and sexual problems overlook the ways in which sexual experiences are made meaningful through social and cultural discourses (Frith, 2013). To avoid repetition, I first outline dominant social discourses that shape both men and women's sexuality. I then focus on the influence of dominant discourses of femininity and heterosexuality on women's experiences of FSP, to complete the overview of women's experiences, before turning attention specifically to men.

Sexuality is Social

Social discourses of heterosexuality create normative versions of sex and obligations for both men and women, and make clear distinctions between what constitutes male and female sexuality (Farvid & Braun, 2006; Frith, 2013; Gavey et al., 1999). Simon and Gagnon (1969) introduced the concept of ‘sexual scripts’ and theorised that sexuality and sexual behaviour are social processes. Their original theory has since been further developed; however, the central notion of script theory is the idea that sexuality is learned from culturally available messages. Scripts define what ‘counts’ as sex, how to recognise a sexual situation and set guidelines for appropriate behaviours, emotions and cognitions relating to sexual experiences (Farvid & Braun, 2006; Frith & Kitzinger, 2001; Rose & Frieze, 1993). Normative gender expectations of boys and girls during childhood forms the foundation for separate sexual scripts for men and women in adulthood. These scripts typically prescribe that men and women take on differing roles in sex that are largely oppositional yet complementary (McCabe et al., 2010; Simon & Gagnon, 2003; Wiederman, 2005). According to the theory, these culturally available scripts can be adapted and internalised by the individual as an ‘intrapsychic’ script and also modified in interpersonal contexts thus producing three ‘levels’ of scripts (Gagnon, 1990; Simon & Gagnon, 2003).

Examples of discourses that are particularly relevant to FSP are the ‘male sexual drive’ and ‘the coital imperative’ (Braun et al., 2003; Gavey et al., 1999; Hollway, 1984; Jackson, 1984; Potts, 2002). In the male sexual drive discourse, identified by Hollway (1984), male sexuality is constructed as a biological ‘need’ for sex that must be sated. Women are responsible for satisfying this need and it is understood to be prioritised over their own pleasure. The coital imperative encapsulates the premise that PVI is fundamental to heterosex (Gavey et al., 1999), is a crucial feature of sex and the ‘logical conclusion’ of a sexual interaction (Braun et al., 2003). PVI is positioned as the central objective of sexual interaction and non-penetrative activities are viewed as secondary to ‘real’ sex (Potts, 2002). Men are positioned within the coital imperative discourse as unequivocally desiring penetrative sex (Braun et al., 2003). Women are more ambiguously positioned as not *necessarily* having a coital imperative themselves (although they may) but they are subject to it through sexual relations with men (Braun et al., 2003).

Conventionally, men’s sexuality is constructed as being physically orientated and driven by a biological imperative (Sakaluk et al., 2014). Men are expected to always be prepared for sex, and take charge of when, what and how it is performed (Carlson & Soller, 2019; Wiederman, 2005). In contrast, women are expected to have a strong emotional and relationship-centric view of sexuality (McCabe et al., 2010) and act as ‘gatekeepers’ by assembling a boundary that men are required to overcome, therefore, delaying sexual activity until emotional intimacy is established (Dworkin & O’Sullivan, 2005). Men and women’s sexualities are therefore often constructed as dichotomous, with men having an active desire, seeking out and initiating sex and women’s desire is represented as being passive and orientated towards being “loved and cherished” (Braun et al., 2003, p. 238; Hayfield & Clarke, 2012).

The Pain of Abnormality for Women

The powerful influence of dominant social discourses of femininity and heterosexuality on women’s experiences of sexual pain has been addressed in a growing body of feminist qualitative studies. This research has given voice to the lived experience and the meaning of living with FSP (Ayling & Ussher, 2007; Johnston, 2013; Kaler, 2006; Marriott & Thompson, 2008; McCann, 2015; Stelko, 2015; Svedhem et al., 2013). These studies have illustrated the intricate connection of PVI with gender norms, sexual norms and sexual identity; and the distress for women who are excluded from its praxis. For example, in an IPA study of women’s experience of living with vulvodynia, the participants reported that the central issue was not the pain per se, but the effect of sexual pain on their sense of femininity, and the consequential loss of their sexual identity (Marriott & Thompson, 2008). Kaler (2006) reported that women diagnosed with vulvodynia described themselves as ‘effectively genderless’, ‘not a real woman’ or a ‘fake woman’. Similarly, Ayling and Ussher (2007) reported that participants with vulvodynia described themselves as ‘inadequate sexual partners’, ‘inadequate women’ and ‘not normal’. They emphasised, “a woman’s experience of vulvodynia might be understood as emerging within her simultaneous negotiation of dominant discourses of femininity and heterosexuality” (Ayling & Ussher, 2007, p. 296). Participants in their study continued to have intercourse despite it being painful, describing motivations such as wanting to maintain value as a partner, to remain intimate, and to be ‘normal’. An interview study of young Swedish women also revealed that they continued to engage in PVI even though it was experienced as painful (Elmerstig et al., 2008). These young women described tolerating the pain as necessary: to conform to an image of how an ideal woman behaves and to avoid the threat of their boyfriends finding other partners who could offer problem-free sex. Evident in women's accounts of living with FSP is a sense, for some, that their relationships are at risk if their partner is not sexually satisfied (Hinchliff et al., 2012). Kaler (2006, p. 64) described women as perceiving either consciously or unconsciously "a loss of currency" (sex) due to difficulties with PVI. Women have reported experiencing shame even when they had supportive partners, suggesting discourses of heteronormative sex continue to influence women's sense of normality regardless of the material context of an accepting partner (Ayling & Ussher, 2007). Women are clearly deeply impacted by their understanding of how sexual pain may affect their relationship; however, little is known about men's perspectives and whether FSP, for them, also threatens the relationship.

This body of feminist qualitative research firmly evidences that the distress of FSP may be located in the transgression of heterosexual dictates and anxiety about normality. Kleinplatz (2012) proposed that rather than offering medical treatments, clients needed to be offered ways of contextualising their desire to be normal and dialogue around how social discourse shapes women's lives and their sexuality. It is likely the same could helpfully be offered to men.

Qualitative Research and Men's Experiences of Female Sexual Pain

The literature on women's experiences evidences important dimensions of potential distress for women beyond the physical pain experience. It has highlighted the potential for women to struggle to have their pain legitimised; to fear penetration or being sexual; and to experience anxiety around abnormality. This suggests that many dimensions of men's experiences have yet to be addressed as, to date, there has seemingly been only one entirely qualitative study in which men's experiences of FSP has been explored. Sadownik et al. (2016) interviewed 16 male partners of women with dyspareunia secondary to provoked vestibulodynia (PVD, a subset of vulvodynia referring to pain in the vestibule on contact) about the impact of PVD on themselves (and the impact of an intervention programme on their partners). They identified 5 main themes which they noted were similar to their earlier findings with women (Sadownik et al., 2012): psychological distress, sexual distress, relationship strain, communication challenges and growth opportunities. Of particular interest was the authors' discussion of some men being vulnerable to taking up a position as an 'inadequate lover', similar to the positioning of women previously discussed (Ayling & Ussher, 2007). The authors noted, "the impact of the coital imperative has not been considered from the perspective of male partners and would be an interesting future course" (Sadownik et al., 2016, p. 538). The authors recommended that research attention is given to the potential influence of dominant discourses of masculinity and men's sexuality on their experiences of FSP. I now therefore turn attention to the literature on masculinity and men's sexuality that may be relevant to the understanding of men's experiences of FSP, and later address aspects of men's experiences beyond the sexual.

Masculinity and Men's Sexuality

Traditional Notions of Masculinity and Men's Sexuality

Hegemonic masculinity refers to dominant forms of masculinity that society views as defining what a man is (Shumka et al., 2017). Certain attributes are taken as given: physical strength or resilience, emotional stoicism, independence, ability to provide, unlimited (hetero)sexual desire, potency and assertiveness, and appropriate displays of aggression (Allen, 2003; Lamb et al., 2018; Mooney-Somers & Ussher, 2010; Shumka et al., 2017). However, Connell and Messerschmidt (2005) have criticised the treatment of masculinity as an 'assemblage of traits', and described masculinity instead as involving a wide range of ideologies, behaviours, embodiments, practices, and relationships. Nevertheless, hegemonic constructions of masculinity are arguably enmeshed with masculine sexuality and heterosex (Robertson & Monaghan, 2012).

Social discourses around the male sexual drive and the coital imperative have already been discussed above. In addition, masculine sexual scripts equate sex with phallocentric sexual performance focused on achieving erection, penetration and demonstrating sexual stamina (Masters et al., 2013). The essence of men's role in heterosexual relationships is therefore viewed as being an ability to maintain an erection and perform sustained coital sex (Tiefer, 1994). By living up to this ideal, men are realising their cultural ideal of masculinity (West & Zimmerman, 1987). In addition to the male sexual drive discourse, in which male sexuality is constructed as a biological 'need', the penis is also represented as having a 'mind of its own' and extrinsic to self, portraying male sexuality as not only a drive but also as uncontrollable (Kilmartin, 1999). Boys learn early in life that 'manhood is tied to their penis' (Zilbergeld, 1992). Difficulty or impossibility of engaging in PVI, due to FSP, may therefore potentially prevent men from taking up the role in which they are cast (Shefer & Ruiters, 1998).

Contemporary Notions of Masculinity and Men's Sexuality

There is a growing body of evidence that indicates men's understanding and experiencing of their sexuality is not solely bound to these conventional notions of penile performance and penetrative sex. Men evidently invest in more diverse, contemporary, and 'relationship-orientated' forms of masculinities (Potts et al., 2003). For example, Gilbert et al. (2013) explored the experience of changes to sexuality for men with different types of cancer. They noted that many men in their study positioned an erection as central to sexuality and drew upon a range of medicalised resources to restore their hegemonic masculinity and phallocentric sexuality. However, they also described accounts of men who had accepted the changes in their sexuality, prompting the authors to note the dynamic nature of masculine sexuality, and the need to recognise that men do not necessarily passively conform to hegemonic masculinity. Men with cancer have been found to resist the coital imperative and actively renegotiate sexual activities to include non-coital practices which are positioned as better, enjoyable and satisfying (Ussher et al., 2013).

Another source of 'counter stories' to the hegemonic is the literature on men's sexuality in later life. For example, Potts et al., (2006) presented the perspectives of mid-to-late life heterosexual men in New Zealand who spoke about their personal stories of erectile difficulties, Viagra use and their viewpoints of sexuality over their life course. The authors summarised how the experience of ageing and erectile changes had, for some men, given them an opportunity to explore alternative sexual practices that were not constrained to penile performance and penetrative sex. Men in this group told ‘progressive’ stories about adapting to, enjoying, and even preferring sexual experiences that were very different to the practices of their youth. Similarly, Sandberg (2013) interviewed Swedish men in later life and described how they distanced themselves from the ‘fiery urges’ of their youth and orientated towards the ‘freedom of intimacy’. Their earlier sexuality was discussed as being egoistic, driven by sexual urges and primarily focussed on penetrative sex. Their sexuality in later life was discussed as being ‘something more’ than a narrow focus on PVI, which instead involved an expansion of their sexual experiences to incorporate sensuality and intimacy, and they described themselves as better and more considerate lovers. This changing of men’s sexuality over time was also described by Terry and Braun (2009) who examined how heterosexual men in New Zealand constructed their identities. They proposed two different constructs of men’s sexual self that of ‘immature’ and ‘mature’. The former was described as involving a narrow focus on penetrative sex; treating women as sexual objects; and positioning sex as essential proof of masculinity, as ordained by other boys and men. The ‘mature self’ considered sex to be important as it served to produce intimacy in the relationship. Sex therefore functioned as a way to bring them and their partners closer together, and as a way of expressing emotional connection physically. The men in their study were of varying ages (average age was 37) and the transcendence from immature to mature was not linked to an ageing (of the body) process, rather a ‘past self’ and ‘present self’ in the context of now being in a long-term relationship.

Research outside of the context of long term different-sex relationships has also highlighted difference and diversity in ‘what it is to be a man’ in a sexual context. The recent literature on men who purchase sex (see Birch et al., 2017; Hammond & van Hooff, 2020; Sanders, 2008; Shumka et al., 2017) has also described complex and varied motivations for paying for sex. Some men’s accounts reflected traditional notions of hegemonic masculinity: they described satisfying their biological needs and urges, and exercising their masculine power, authority and entitlement over women. Others expressed a need for intimacy, emotional closeness, female friendship and talked of caring for and protecting sex workers. In general, the authors concluded that men engage with multiple versions of masculinity and that the sex work research indicates the importance of expanding the construction of masculinities to include being affectionate, caring, loving and seeking intimacy.

These various bodies of research, in which men engage with multiple versions of masculinity, suggests that a focus or assumption of hegemonic masculinity is misguided. Connell (2005) made a distinction between hegemonic and 'ordinary' masculinities: hegemonic masculinity exists as an ideal, and something men (may have once) aspired to, whereas ordinary masculinity is likely to be a more inclusive and egalitarian form of masculinity. Sanberg (2013) argued that discourses of gender equality have also been central to shaping contemporary masculinity. The rise of gender equality since the mid-20th century has been mirrored in greater egalitarianism within sexual relationships (Carlson & Soller, 2019). Sex has been democratised via open communication and mutual sexual empowerment. Women are positioned as equally active as men in sexual decision making, and able to advocate for their own psychological and physical pleasure within the sexual encounter. Carlson and Soller (2019) proposed that whilst traditional gender norms in Western society emphasise men's control and dominance in sexual decision making, egalitarian minded couples are more likely to resist these conventions. As such, contemporary notions of 'idealised' masculinity are therefore equated with being caring, egalitarian and democratic (Sandberg, 2013).

It is important to emphasise the literature I have reviewed to illustrate traditional and contemporary notions of masculinity and men's sexuality (and the earlier literature regarding women's sexuality and experiences of FSP) is grounded in Western understandings and notions of gender and heterosexuality. However, whom one is permitted to have sex with, in what ways, and for what purpose is governed by the implicit and explicit rules and regulations of a particular social and cultural system (Parker, 2009). In Western culture, sexuality is typically viewed as a source of pleasure and an expression of love and intimacy within a relationship. In traditional and faith-based cultures such as Arab-Muslim societies, sexuality is associated with reproduction (Heinemann et al., 2016). There is little place for sensuality and pleasure as penetration and conception are central to the sexual relationship (Zgueb et al., 2019). Inevitably, sexuality and sexual difficulties are experienced differently within non-Western cultures. For example, FSP in traditional Arab-Muslim cultures has predominantly been addressed in the literature in the context of 'unconsummated marriages' (e.g., Farnam et al., 2014; Lema, 2014; Yasan et al., 2009; Zgueb et al., 2019) itself illustrative of the importance given to PVI. Vaginismus (which renders penetration impossible) may be considered a family problem potentially threatening the reputation and perpetuation of the family name. Conventions such as displaying blood-stained linen, or the expectation of (the man's) family members to receive confirmation the marriage has been consummated can lead to a loss of social status for women unable to participate in PVI (Yasan et al., 2009). Within some families, permissive and passive attitudes towards women being beaten by their husband for being unable to have PVI, may exist (Karrouri, 2017). Understanding sex and sexuality as contextualised within relationships and wider social environments (rather than a pan-human biology) speaks to the impossibility of separating meanings and experiences from an individual's (and couple's) social and cultural environment. The account of 'sexuality is social' I have given, and the outlining of 'traditional' and 'contemporary' notions of masculinity, men's sexuality and heterosexuality is contextualised within Western culture and has drawn on research involving mostly White middle-class participants. Looking specifically at FSP, there is an absence of research on men's (and women's) experiences within non-Western cultures; on men (and women) from traditional cultures living within Western societies; and on the intersection of other social factors such as class (in any culture). It can therefore be hypothesised that the meanings of sex; notions of gender identity; and the expectations and obligations of masculinity (and femininity) and relationships vary according to social and cultural context. This also infers that men's understandings and responses to FSP are likely to be socially and culturally bound and need to be considered within the specific context. I return now to FSP within the Western context.

Masculinity, Men's Sexuality and Female Sexual Pain

I have presented both conventional notions of masculinity and heterosex, and 'counter stories' which describe men drawing on more than these traditional notions in various contexts; however, little is known about how men respond to potential difficulties in the sexual encounter due to their partner's pain**.** There is a small body of qualitative and semi-qualitative research exploring partners' experiences of endometriosis (see Ameratunga et al., 2017; Culley et al., 2017; Facchin et al., 2020; Fernandez et al., 2006; Hudson et al., 2015)**.** Endometriosis is a chronic gynaecological condition that has chronic pelvic pain, fatigue, severe menstrual pain, heavy menstrual bleeding, infertility and pain during or after sex as common symptoms**.** Culley et al. (2017) addressed the influence of cultural expectations of masculinity such as being strong, stoical and unemotional on their ability to discuss their feelings with their partner, family or friends, but did not specifically explore how notions of masculinity or men's sexuality may have shaped men's responses to the disruption of sexual activity. They did however generate a theme 'sex and intimacy' which described men either taking up a position of the lack of sex being unproblematic, or one in which it would be unreasonable not to accept it. It is important to note that in addition to painful PVI, endometriosis also involves broad symptomatology, as described above, which may prioritise women's health in a different way to other presentations of women's sexual pain. The research on men's experiences of endometriosis has therefore typically addressed sexuality as one dimension among many (e.g., household income, working lives, social lives) typical of chronic illness investigations. Further insight into how heteronormative ideology may influence men's experience of PVI difficulty is therefore needed to better inform therapeutic practice which moves beyond medical interventions and pain mitigation (Kleinplatz, 2012).

There's More to Men's Experience of FSP Than Potential Difficulties in the Sexual Encounter

As with the qualitative research on women's experiences there are likely several dimensions to men's experience that have started to be explored and warrant further attention. Returning to the study by Sadownik et al. (2016) on men's experience of vulvodynia, the authors noted, somewhat surprisingly, a small number of men reported a *positive* impact of vulvodynia on themselves and their relationship (for example, through feeling they matured individually and a sense of becoming closer as a couple through team building efforts). This highlights the importance of not relying on dominant discourse when considering men's realities and opens up the possibility for positive outcomes; and the importance of the wider relationship beyond the sexual aspect. Other studies have also shown that a sexual pain disorder does not necessarily negatively impact the relationship or sexual satisfaction (Connor et al., 2008; Rosen et al., 2013; Smith & Pukall, 2014; Ward & Ogden, 1994). Exploring how women could have such different experiences of FSP (in their study of GPPD), Svedhem et al. (2013) reported the attitude of the woman's partner was considered central to how FSP was adapted to. This speaks again to the importance of further understanding how men experience FSP, and how this understanding may guide the development of therapeutic work that could potentially help couples successfully navigate the challenges of FSP.

The research involving partners of women with endometriosis has also indicated other dimensions of men's experience of FSP that warrant further exploration. For example, men have commented that the interview was the first time they had been asked to speak about their experiences (Culley et al., 2017). Men have described a tendency to prioritise their partner's wellbeing over their own needs, and an understanding of the focus being on women amongst health care providers (Culley et al., 2017; Hudson et al., 2015). However, they also expressed a significant impact of endometriosis on themselves and highlighted an absence of any support. It is therefore important to give men a voice and have further knowledge of men's experiences of FSP to potentially have a better understanding of the different ways in which men are impacted, and an indication of what support men may need as individuals, in addition to treating the couple.

Aims

It is clear the evidence base that can inform FSP treatment and practice is relatively solid for women but is distinctly limited for men. The aim of this study is therefore to explore the ways in which men make sense of and respond to women's sexual pain within a different-sex relationship. The following research questions will be considered:

- What are the different ways in which men make sense of their partner's pain?
- What is the meaning for men of difficulty or impossibility of engaging in penile-vaginal intercourse?
- How is sexual pain responded to in terms of adaptation and negotiation of the sexual relationship, the partner relationship more broadly, and the impact on men individually?

This Research, Sexuality and Me

The approach I take, in terms of the methodology of this research, is a fully qualitative one dubbed by Kidder and Fine (1987) as a 'Big Q' orientation. This embraces a research philosophy that emphasises "researcher subjectivity as a resource", "the importance of reflexivity" and the "situated and contextual nature of meaning" (Clarke & Braun, 2018, p. 107). Ahead of discussing my methodology and having reviewed the FSP literature, I now situate myself in this research and in particular lay out my own view of sexuality and understanding of FSP.

I position myself as having a 'sex-positive' attitude that orientates towards 'sexual health'. Here I draw heavily on the ideal presented in the World Health Organisation's (2006) definition of sexual health:

> a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence.

Sex positivity emphasises the right for people to make choices regarding their bodies and whether they participate in or abstain from a multitude of intimate relationship configurations and sexual behaviours (Burnes et al., 2017). I therefore celebrate sex and sexuality as being inherently diverse and varied and consider all types of relational and sexual connection to be valuable, provided they are safe and consensual. I am a cisgender woman and identify as heterosexual. I am in a long-term monogamous relationship with a cisgender heterosexual man. I would describe our relationship as egalitarian. Situating myself more broadly, I self-describe as White and middle class. My nationality is British, but I have lived in Hong Kong for most of my adult life (25 years) and identify therefore as a 'Hong Kong expat'.

I have not personally experienced FSP, but I do have experience of working with women and their partners who suffer from this. I qualified as a clinical sexologist/sex therapist several years ahead of training as a counselling psychologist and starting this research. The context and content of my previous work inform my current researcher subjectivity and therefore needs to be described. I worked in a private medical practice in a highly medicalised environment. However, the juxtaposition of Eastern and Western cultures in Hong Kong evokes an imperative to attend to the social context of the client. Notions of sexuality and sexual practices, in particular, were evidently shaped by strikingly different cultures. This medicalised *and* socially sensitive environment has shaped my own conceptualisation and stance in working with, and now researching, sexual difficulties. I understand sexuality to be subjective and contextual and for it to be erroneous to treat any sexual difficulty without considering all dimensions of the individual's experience. Here I take up a position informed by the feminist literature that places sexual difficulties within the context of cultural ideologies around sex and gender. However, sexuality is multifaceted and includes an interplay between biological, psychological and social factors. I therefore also consider the biological to be an integral part of sexuality and in particular, sexual pain. In practice, the biological is not treated by psychologists and we more appropriately address psychological, interpersonal and sociocultural factors (Caruso & Monaco, 2019). The biological forms part of my thinking and formulation particularly in the case of FSP due to the importance of pain mitigation for women. A critical discussion of biomedical models and the term medicalisation does not for me imply a 'rejection of medicine' (Garry, 2001). Rather, my view is that the biomedical model fails to fully explain and effectively treat sexual difficulties in general, and FSP more specifically, which leads me to a ‘both/and’ position. I can appreciate the benefits of medicalisation to alleviate suffering and, at the same time, attend to the psychosocial factors which create different experiences and meanings of sex. It is an expanded framework that can hold the benefits (and losses) of medicalisation *and* the highly contextual and subjective nature of sexuality. Within this framework I view women’s sexual pain as a lived embodied physiological experience that is simultaneously shaped by social norms, the relationship in which it occurs and intrapersonal factors.

The medical practice in Hong Kong was also the site in which the motivation for this research was spawned. I worked with a man who presented with many psychosocial difficulties. His wife suffered from lifelong vaginismus and they had never been able to have PVI over the 20 years of their marriage. His wife did not want to attend therapy and I therefore worked with him individually. The man was my client, not the woman or the couple. I had a rare insight into the lived experience of a man who partnered a woman with FSP and listened for many months to accounts of his own pain. I therefore bring my experience of working with him into the current research for which his experience was its genesis.

Methodology

In this section, I introduce the methodology used in the study. I first state my theoretical position and then outline the rationale for my initial choice to use an online survey, ethical considerations and the procedures involved. The recruitment channels and methods of data collection changed as the project evolved. I therefore describe my insights from the earlier stages which informed a decision to include interviews, and then outline the ethical considerations and their procedure. The overall approach to recruitment is briefly summarised and the resulting participants described, before discussing the rationale for the data analysis and the method involved.

Theoretical Position

A critical realist framework was adopted (Bhaskar, 1989). Critical realism is a philosophical approach that was developed in response to the limitations of naïve realism and of relativism which sit at opposite ends of an imaginary scale. At one end, realism assumes there is one reality that is knowable and 'out there', and at the other, relativism argues there are multiple versions of reality that are socially constructed (Braun & Clarke, 2013, p. 27). Situated between these two positions, critical realism affirms the existence of a pursuable reality that is experienced by individuals, whilst acknowledging that representations of this reality are characterised and mediated by culture, language and political interests (Bhaskar, 1989). Therefore, this is both an ontological and epistemological standpoint and "facilitates reconciliation of both the material and discursive aspects of experience" (Ussher, 1999, p. 45). With regards to exploring sexual pain, critical realism was selected by me as a researcher for the potential it holds to recognise the materiality of the body and aspects of experience (such as pain and negotiation of sex), while conceptualising this materiality as always being mediated by discourse, culture and social practices (Ayling & Usher, 2007). This allows the biological, psychological, social, and relational aspects of the sexual pain experience to be addressed in a non-reductionist way (Farrell & Cacchioni, 2012). It also enables subjective experience to be treated as legitimate, whereby lay knowledge is positioned as equal to expert (Hinchliff et al., 2012).

Data Collection

Online Qualitative Survey Rationale

At the beginning of the project, I decided to use an online qualitative survey as the method of data collection due to several potential advantages in relation to my topic. While quantitative surveys have more typically been used in sex research, qualitative surveys allow the collection of rich detailed data of participants' perceptions, understandings and experience as questions are open ended, and can be answered in their own words (Opperman et al., 2013). Advocates argue that they enable researchers to capture the "nuances, contradictions and ambiguities of the participants' experience" and allow for participants to identify their own key issues (Frith & Gleeson, 2008 p. 253). Online surveys are also viewed as being ideally suited to exploring sensitive topics due to the felt privacy and anonymity offered to participants (Braun & Clarke, 2013; Braun et al., 2020). Online qualitative studies have already been used to explore sensitive topics such as orgasm and sexual pleasure (Opperman et al., 2013), and pubic hair removal (Braun et al., 2013). Opperman et al. (2013) proposed the anonymity of the survey may have encouraged a broader range of people to participate than if volunteering for a face-to-face interview.

The felt anonymity granted by the online environment may also aid in reducing the tendency for participants to provide socially desirable responses and favourably self-present, to some extent (Moore et al., 1997; Braun et al., 2020). I prioritised optimising the potential for men to speak freely and disclose 'unpleasant' opinions and experiences when considering my method. I also viewed the online environment as preferable to in-person interviews due to the potential challenges of a woman interviewing men, and the risk of receiving not only socially desirable responses, but responses assumed to be desirable for a woman to hear. Taken together, it was hoped that an online research method would mean that participants would not have to be answerable to a researcher in person, which could promote honest and open responses.

Finally, online surveys offer a quick and efficient way of collecting data from a large and geographically dispersed sample (Braun & Clarke, 2013; Terry & Braun, 2016). A "wide-angled lens", which potentially captures a diversity of perspectives, sense making and experiences, is particularly useful when researching an under-explored area (Braun et al., 2017; Braun et al., 2020, p. 3). Hearing a range of voices was considered preferable in this study given both the heterogeneous nature of FSP, and the extremely limited inclusion of male partners in qualitative research to date. Optimising geographical reach was also deemed necessary due to difficulties in recruiting men. For example, in an interview study of men who partnered women with vulvodynia, the authors noted a low response rate of men invited to participate compared to women in a parallel study (Sadownik et al., 2017). Likewise, in a study exploring the experiences of male partners of women who have been sexually assaulted, the researchers included women to speak about their own sense of their partner's experience due to the difficulties they encountered in involving men (Connop & Petrak, 2004). In summary, an online qualitative survey was chosen as the method of data collection as it potentially offered a ‘wider net’ with which to reach men and an anonymous environment for them to tell their own stories about a sensitive and under-researched topic.

Ethical Considerations for the Online Survey

Ethical approval for this study using an online qualitative survey was granted by the University of the West of England Faculty Research Ethics Committee (UWE, FREC). The survey was conducted using *Qualtrics* software which is recognized by UWE as a secure way to gather and store data. Before starting the survey, participants were directed to an online information sheet that fully informed them of what participation involved; how data would be used; their rights as voluntary participants; key information about the study; where they could seek more information or support on the topic; and data protection requirements that were complied with throughout the study (Appendix B). Participants were then required to provide informed consent before they were able to continue with the survey (Appendix C). Participants were asked to choose a pseudonym to ensure their anonymity on *Qualtrics* and any saved documents. Although men were fully informed ahead of deciding to participate, there was a small chance that writing about their experiences of their partner’s pain in the survey may be distressing to them. Support resources were therefore listed again at the end of the survey.

Survey Development

The survey was developed using *Qualtrics* software. Demographic questions have traditionally been positioned at the end of surveys, however, there is evidence that collecting demographic data at the beginning can ease participants into the process and result in more completions (Braun & Clarke, 2013; Terry & Braun, 2017). As sexual pain is a sensitive topic, the demographics were placed at the beginning of the survey in the hope of factual questions facilitating flow into more in-depth and intimate questions. A small section of questions concerning the relationship and their partner (e.g., length and status of the relationship, type of pain/diagnosis; Appendix D) then segued into the open-ended questions. The survey topics were informed by the many dimensions of women’s entire experience illustrated in the literature on FSP, and also by my own clinical experience of working with this issue. The questions were therefore broadly designed to encourage men to give accounts of how they had made sense of pain during sex; how FSP had impacted them, their sexual relationship and the relationship in general; and how they had responded to and navigated their partner's sexual pain, including their experience of help-seeking. The questions were drafted, reviewed with my supervisors, and then revised to ensure they were presented in a logical order; would optimise detailed responses; encourage men to talk about all aspects of their experience which were important to them; and were open enough for unanticipated topics to be covered. Despite their advantages, one potential restriction of surveys lies in the inability of the researcher to probe participants and extend questions (Frith & Gleeson, 2008). To try to counter this, prompts, clarifications, brief explanations and invitations to give examples were included in the questions to promote engagement. Additionally, participants were told at the beginning of the survey 'I am interested in everything you have to say so please answer as fully as possible' and 'You can navigate forward and back during this section if you want to add more to your responses', to encourage detailed responses. When the survey 'went live' I piloted the first 6 participant responses by including a section at the end for men to give feedback about their experience of completing the survey. I then reviewed their feedback and their survey responses and made minor changes to the wording. The final survey questions are listed in Appendix E.

Insights From the Early Stages of Data Collection Using the Online Survey

Initially, I aimed for 100 participants in line with guidance for postgraduate studies (see Braun & Clarke, 2013). However, as a result of the research project registration process, the Faculty Research Degrees Committee (FRDC) proposed aiming for a more conservative sample of 60 responses, due to the anticipated difficulty of recruiting men and the sensitive topic. A range of recruitment strategies was used initially and expanded on as the study developed (these are summarised later in the section on 'Recruitment' and more fully in Appendix J). Nevertheless, a relatively small number of completed survey responses in the early stages of data collection threatened the viability of the study. I made a further adjustment to the survey to improve potential engagement as the survey was being accessed but not completed. The demographic questions were moved to the end of the survey but the questions about the relationship and their partner's diagnosis were left at the beginning. It was hoped this rearrangement would allow participants to still be eased into the open-ended questions (by the questions about the relationship and their partner) but lessen the risk of them becoming fatigued during the demanding open-ended questions (by repositioning demographic questions after them, rather than ahead). Also, from my experience of the recruitment process, it became apparent that the anonymity of the online environment may, for some, function as a barrier to participation. For example, in response to calls to participate in research on 'genital esteem' posted on Mumsnet, one woman expressed her concern that it 'could be a perv' pretending to do research. Researcher visibility and accountability have been proposed to be a requirement for marginalised groups to get involved in research (Liamputtong, 2007). It was possible therefore that my own anonymity and invisibility as the researcher may have been experienced by some as more threatening than comforting in the online environment.

Further consideration also needed to be given to the lack of opportunity to probe participants (Braun & Clarke, 2013). This potential limitation of surveys had been acknowledged and discussed with my examiners during stage one of my progression. Despite design attempts to overcome this, there was clearly a lack of depth to several men's written responses in the early surveys completed. I therefore considered including some face-to-face interviews as they enable researchers to probe participants and explore further meanings, complexities and ambiguities within participants' responses (Opperman et al., 2013). However, I also needed to take into account the sensitive nature of men's disclosures and how men may experience interacting with me in an interview setting. I had several years of clinical interviewing experience around sexual difficulties and had worked extensively with men. I felt equipped to conduct interviews ethically and sensitively but also had to consider the potential influence of my gender when interacting with men and how this may influence their responses. As already described, there was a concern around men giving responses that were desirable for a woman to hear. However, in a study of the influence of researcher gender in interviews with men, it was noted that participants framed their responses differently with a male and female interviewer, but nevertheless optimised their social desirability in either context (Williams & Heikes, 1993). The authors concluded that researchers should be sensitive to *how* respondents may take into account the gendered context, rather than consider whether providing socially desirable responses happens more or less in same-sex or different-sex pairings. Yong (2001) addressed interviewing men on sensitive issues. She noted that they discussed unconventional sexual encounters and extramarital sex with her, illustrating that men can disclose 'undesirable' aspects of their experience with women. Furthermore, the literature on different gender dynamics presented some potential advantages of being a woman when interviewing men. For example, Arendell (1997) suggested that being a woman had encouraged the depth of emotion and detail in her interviews with divorced men. Men had given accounts of not speaking to other men about their feelings or experience due to their belief they would be more critical of expressions of emotional distress. Taking this literature together with my own experience of speaking with men about sexual issues within a clinical context, I decided to introduce semi-structured interviews to the data collection method in response to the limitations that were surfacing by using solely an online survey.

Ethical Considerations for Interviews

An amendment to add interviews as a data collection method was approved by UWE FREC. As it was essential to consider participant comfort and privacy during the disclosure of sensitive material, men were given a choice for the setting of their interview. The telephone and online video (e.g., Skype) are considered to be viable alternatives to the in-person interview (Hanna, 2012) and men were therefore given all three options. To mitigate the risk of harm to myself as a woman working alone, a therapy room within a staffed clinic in either London or Bristol was presented as a possibility for an in-person interview, but no participants chose this option. It was also important to acknowledge the potential for the interview process to be sexualised as erotic thoughts and emotions can emerge in response to the narration of sexual material (Grenz, 2005). Due to the sexual agenda of the interview, I chose to use either an online video, telephone or clinical environment for interviews. I considered these settings balanced the need for participant privacy and my personal safety and also provided a contained professional space to explore sensitive sexualised material. Furthermore, research that protrudes into private and deeply personal experience can also be potentially distressing (Lee, 1993). For example, in an interview with men exploring their sexual health help seeking decision-making, Walls et al. (2010) described some men expressing feeling vulnerable, uncertain and embarrassed during discussion of sexually transmitted infection. It was therefore essential to be sensitive to the potential for unleashing deep-seated emotions; remain attuned to potential distress and address it as it emerged; and negotiate consent to continue and reinforce participants' right to withdraw (Walls et al., 2010). In the interview setting, professional experience can be drawn on to aid attunement and response to men's distress. As I had also read extensively about the topic of sexual pain, I considered myself able to interview participants, prioritise their wellbeing, and manage potential distress appropriately. Although I considered that potential health and safety risks to myself as the researcher were minimal, if conducting the interviews (or reading survey responses) was found to be distressing, support from my supervisor (Zoe Thomas) who is an experienced practitioner psychologist (HCPC) would have been provided.

Interview participants were e-mailed a further information sheet that fully informed them of what participation involved, data management, their right to withdraw and a reminder of support resources (Appendix F). They were also directed back to the online information sheet used for the survey for detailed information about the study (Appendix B). As not all participants were recruited via the survey, a separate 'participant information' sheet was developed (Appendix G) alongside a privacy notice (Appendix H) and the demographic, partner diagnosis and relationship information questions used in the survey (Appendix D). All participants were required to provide informed consent before they arranged the interview (Appendix I). The interviews were audio recorded and transcribed. The transcriptions were anonymised by removing any details that could identify the participant and changing all names. Once the transcription was completed and reflective notes were made, the audio recordings were deleted.

Functions of the Online Survey as Interviews Were Added

The function of the survey extended beyond data collection when interviews were added as a method of data collection. Firstly, it served as one of the various recruitment tools for interviews as I added a response box (to leave an e-mail address) for men who wished to be contacted about being interviewed. Secondly, the survey also served as a familiarisation tool for men ahead of the interview. For many men, engagement with this research project would possibly be their first opportunity to discuss their experiences and it was anticipated that articulating this in conversation may be challenging (Walls et al., 2010). Researchers have been cautioned to consider how well suited semi-structured interviews are to exploring topics that participants find difficult to speak about (Affleck et al., 2013). However, completing the survey ahead of the interview allowed men to reflect on the topic and have an initial experience of telling their story. Men recruited directly to interviews were therefore encouraged to visit the survey prior to the interview.

Further, utilising two methods of data collection functioned as a way to offer men an option. They could tell their story textually online and completely anonymously and/or interact with me in an interview. Both data collection options allowed men to speak about what was important to them in their own words, and the addition of interviews allowed me to gather richer and more detailed responses.

Interview Procedure

As already mentioned, men were given the option of a telephone, video or (if their location permitted) an in-person interview. I used the survey questions as a guide to creating the interview schedule because when men did complete the survey, these questions seemed to be working well. The responses of interviewees who had already completed the survey were reviewed and interesting points to probe were noted, allowing me to also develop a more individualised schedule. The guide was used as a loose prompt to allow men to describe the aspects of their experience that were important to them within a conversational flow. Towards the end of the interview, I referred to the schedule to ensure all relevant domains had been addressed. I kept a reflective diary throughout the process attending to impressions and noticings from the interviews. The interviews were audio-taped and transcribed verbatim with hesitations and speech repetitions included (Terry & Braun, 2009).

Recruitment

Purposive criterion sampling, where UK participants were recruited on the basis of having experience of being in a relationship with a woman suffering from FSP, was utilised (e.g., Cresswell & Plano Clark, 2011). The relationship could be current or in the past. A formal diagnosis of a sexual pain disorder was not required in order to include partners of women who may not have sought treatment; women who had sought treatment but had not been given a diagnosis; and women given a diagnosis that they did not agree with. This supports a position that lay knowledge is equal to expert knowledge and honours the subjective experience of the woman experiencing pain during PVI (Hinchliff et al., 2012).

The recruitment process was extensive and protracted and is documented in detail in Appendix J. A brief outline is provided here. There were two major branches to my recruitment channels: ‘indirect’ and ‘direct’ communication with potential participants. The indirect branch largely involved: 1) accessing potential participants using social media platforms of various organisations and the charity Vulval Pain Society’s (VPS) online newsletter; and 2) connecting to participants through practitioners working in the field of FSP, using newsletter postings on the College of Sex and Relationship Therapists (COSRT); delivering flyers that could be handed on by practitioners to men or their partners; and e-mailing relevant parties with online material and links. In response to the difficulties of recruitment and the potential importance of improving researcher visibility and accountability, I added a second ‘direct’ branch that put me ‘in person’ with potential participants (and also professionals who work in the field). I attended two conferences and exhibited my ‘call for participation’ using a pull up banner and leaflets (Appendix J, Figures J6 and J7). The first conference was organised by the VPS and was attended by vulval pain sufferers, their partners and multidisciplinary practitioners. The second conference was organised by the British Society for Sexual Medicine and was attended by multidisciplinary professionals only.

The final number of participants for the survey was only 25, despite actively recruiting between April and October 2019. Of the 25 survey respondents, 9 went on to be interviewed. One more interviewee, who I had met at a conference, did not complete the survey.

Participants

A total of 26 men took part in the study. Ten men were interviewed (as noted above, 9 of whom also completed the survey). These men ranged in age from 23-68 (*M* = 44.6, *SD* = 18.1), were predominantly middle class (n = 7) and white (n = 9). Sixteen men completed the survey (but did not go on to be interviewed). These men were aged 22-84 years (*M* =46.4, *SD* = 19.3), all described themselves as white and were predominantly middle class (n = 11). The length of relationships for all participants ranged from 6 months to 60 years (*M* = 15.9, *SD* = 15.6; see Appendix K for full demographic data). Men were partnered with women who were at various stages of acquiring a diagnosis for their pain (e.g., no medical investigations, investigations were currently being undertaken, and a diagnosis had been received) and had a variety of diagnoses and presentations (e.g., vulvodynia, vaginal atrophy, lichen sclerosus, vaginismus, menopause and post-surgery; see Appendix L). Only 2 men who participated in the survey were no longer in the relationship and neither of these men elected to be interviewed. The research therefore predominantly captures the experiences of white middle class men who are currently in a long-term relationship with women who suffer from FSP.

Data Analysis

Ahead of data analysis it was necessary to consider the significance of having collected data via interviews and an online survey. There is a substantial literature within the social sciences which illustrates the potential for the gender and ethnicity of the researcher and the researched to shape the responses of participants to varying extents across different methods of data collection (see

White et al., 2018). The act of interviewing and being interviewed has been described as performative with gender intrinsically built into this act (Holmgren, 2011). The literature on gendered relationships in interviews has described a range of influences of gender from little difference to men tending to emphasise discourses of gender equality (more than women) when interviewed by a woman (White et al., 2018). However, in my own study the research topic and the interview environment can easily be understood as gendered: I am a woman and interviewed men about men's understandings and responses to women's sexual pain. My gender within the interview setting is therefore likely highly salient.

Turning then to consider the prominence of gender within the online survey environment. There is a growing literature attending to researcher identity in the online environment. For example, when the name of the researcher has been manipulated, respondents under a female researcher condition were found to be more likely to express beliefs supportive of women's equality (White et al., 2018). This evidences the potential for participants to possibly understand the online environment also as an 'interaction' of sorts. The literature exploring the impact of gender (and other researcher participant dimensions such as ethnicity) has been based on quantitative online surveys. To date, qualitative online surveys are relatively underutilised and the saliency of gender in this context has apparently not yet been given attention (Braun et al., 2020). I therefore offer some speculative considerations. In my own study, questions in the online survey were intentionally phrased to remind the reader of my presence and personhood as a researcher to facilitate men talking about their experiences in a more personal and intimate manner (for example: "Please could you tell me; "I am interested in everything you have to say"; "You do not need to give names but do tell me about …"). Some men added comments such as 'thank you for doing this research', intimating a sense of interacting and talking with me as the researcher. When considering participants' awareness of my gender as the person they were 'telling to', men would have known from reading the participant information that I am a woman. Furthermore, due to the multiple recruitment channels I used, there were likely several cues regarding my gender as I had purposely made myself 'visible' as a researcher out of concerns that my anonymity was negatively impacting men's participation (for example, I had linked the survey to my professional website and Twitter campaigns gave access to a profile photo). I had also personally interacted with at least one of the men who participated in only the survey at a conference. Although my gender in the online survey setting is unlikely to have the same prominence as within the interview setting, I nevertheless considered it to be present.

In my initial readings all of the data I was also able to make general comparisons between the survey and interview data. Looking at the survey and interview data for men who participated in both, it appeared that survey responses of men who went on to be interviewed were different in ways to be expected (greater depth and nuance in the interview). In the interviews, men elaborated on their experience they had shared in the survey and did not seem to give accounts of a different experience. Similarly, men who told their story via 'survey only' appeared to tell a broadly similar array and type of story to men who engaged in both. I had also chosen to use thematic analysis (TA) which is a flexible method of cross case data analysis that can be used for a wide range of data types (Braun & Clarke, 2013; Terry et al., 2017). It has been advocated that surveys and interviews can be used together within TA, particularly if qualitative data is understood to be accounts collected from participants and that these accounts are always situated and shaped by the telling environment (Braun et al., 2020). I therefore conceptualised the survey and interview data as being comparable as both methods offered an opportunity for men to tell their stories in their own words on the same broad topics; but the two different environments potentially foregrounded my own gender to varying extents which could shape the telling of men's accounts. Consequently, I analysed the survey and interview responses as one data corpus. For men who had participated in both the survey and the interview, all of their data was treated as 'a collection of data' for that individual, i.e., everything the individual said about the topic.

As already stated, I used TA as a method of cross data analysis as it can be used for a wide range of data types to identify themes and interpret patterns across the data set. It can also be used for a wide range of research questions including experiences (Braun & Clarke, 2013; Terry et al., 2017). Interpretive phenomenological analysis (IPA) also offers a cross-case approach to data analysis and is widely used in counselling and psychotherapy research. However IPA specifies the use of a small, homogeneous sample (Braun & Clarke, 2020). I had intentionally involved a diverse group of men in terms of them partnering women with various presentations of FSP as previous qualitative studies had only included men who partnered women with a specific diagnosis (Connor et al., 2008; Sadownik et al., 2016). Women with sexual pain have varying presentations, frequently do not seek help, may not receive a diagnosis, are misdiagnosed, or it may take years to establish an accurate diagnosis (Harlow & Stewart, 2003; Mitchell et al., 2017; Nguyen et al., 2012; Reed et al., 2012; Simonelli et al., 2014). Due to men’s experiences being vastly under-explored I aimed to broaden the exploration by including men who partnered women who experience FSP without limiting inclusion to a particular diagnosis. The intended heterogeneity of my sample therefore precluded the use of IPA. Furthermore, although the sample size of the interview data was suitable for IPA, including the survey data (although small) rendered the sample size inappropriate. The survey data was deemed important to include as it offered valuable insights into men’s experience and extended the diversity of voices.

There are a variety of approaches to TA that can be divided into two broad categories: ‘small q’ TA founded on notions of accuracy and reliability in positivist research; and ‘Big Q approaches located within a qualitative research paradigm (Terry et al., 2017). A reflexive approach firmly positioned within the latter and developed by Braun and Clarke (Braun & Clarke, 2006; 2013; Clarke & Braun, 2018) was applied in this analysis. In reflexive TA, the analysis is seen as something created by the researcher and coding and theme development are embraced as subjective and interpretative processes (Terry et al., 2017). TA has no inbuilt theoretical assumptions and can be flexibly applied to produce either a data-driven or theory-driven analysis. It is recommended therefore that theoretical assumptions are clearly specified (Braun & Clarke, 2006). The data was read within a critical realist framework in which participants’ responses were treated as real for them but theorised to be intertwined with socially available meaning (Bhaskar, 1989; Braun et al., 2013). I considered reflexively what assumptions I was bringing to the reading of the data (see Appendix M) and carried out a largely inductive analysis.

The first phase of Braun and Clarke's six phases, familiarisation, initially involved reading the survey responses alongside conducting and personally transcribing all interviews. I then printed out and read all of the data twice and made casual observational notes around patterns and quirks before starting the coding process. The second phase, generating codes, involved deeper immersion into the data. Each piece of the data that had relevance to the research questions was 'tagged' with a code. I coded at both the semantic and latent level, e.g., both descriptively (such as 'masturbation feels like cheating') and interpretively (such as 're-thinking of self'). I also coded broadly, incorporating as many potential codes as possible, and exhaustively allowing a data extract to have unlimited numbers of codes (see Appendix N for an example of coding). I utilised a 'remove the data' test for the codes, checking the codes clearly 'evoked' the data without having to read the data segment (Braun et al., 2016). Alongside tagging the data on the printed transcript, I wrote a code on a 'post-it' and placed these on the wall in front of me as a reminder of existing codes (Appendix O, Figure O1). On the first coding round of the data set I analysed interviews 1 through 10 in order. Potential candidate themes were noted at this point. On the second coding round I analysed 6 through 10, and then 1 through 5, so that the early interviews benefitted from the growingly nuanced coding process and the revised and refined codes. I then moved to coding the survey responses of all participants. After 2 rounds of coding, I compiled the codes for each participant. This allowed me to again do the 'remove the data' test and check each individual participant's experiences had been captured by the codes (see Appendix P for a sample of one participant's codes). It also enabled me to look at coding across all of the men as I was interested in patterns across the data set. Phase 3 involved identifying candidate themes, by clustering codes around a meaning they all shared, or a 'central organising concept'. The 'post-its' were removed from the wall and arranged on separate pages, each page loosely representing a candidate theme (Appendix Q,

Figure Q1). A couple of pages were used for codes that did not fit into the candidate themes. I then returned to the whole data set and re-read each transcript to check that the themes represented the participants' experiences. I collated relevant data extracts that represented different layers of the candidate theme. The codes that did not fit into the candidate themes were reviewed for their importance and relevance to the research questions. The codes were rearranged into different clusters and new candidate themes developed. In phase four, reviewing themes, the relationship between themes, their interconnections and boundaries were explored and revised (Braun et al., 2016). As themes were reviewed, the 'post-its' were rearranged until I felt the candidate themes gave a coherent account of participants' experiences across the data. The selected data extracts were also checked to ensure they evidenced the different layers of the theme. In phase five, defining and naming themes, I wrote a theme summary to identify the essence of the theme and clarify what each theme was and was not. I also compiled the relevant data extracts and gave the theme a title (see Appendix R for an example of a theme summary). The final phase 'producing the report' involved providing an analytic narrative of all the themes. This is presented in the next section 'Results and Discussion' where I have merged the report with an interpretation in light of known literature. Participants are represented by the letter 'P' and a number to differentiate how they participated. P1-P!0 are interview participants; P11 upwards completed the survey only. I have included a very small amount of information about the participants to give a general picture, however, as some men had not informed their partner they were participating, this information has been kept to a minimum to protect their anonymity. I have represented their age within a 10-year band (i.e., 26 years old is referred to as '20's') and given their relationship status. All partners' names have been changed. When presenting extracts from interviews in the report, I have omitted word repetitions and speech hesitations (i.e., all terms such as 'um', 'err' 'ah). Also, I have used three dots to represent a pause, and three dots in parentheses (…) to indicate a portion of speech has been cut. All extracts from surveys are included as they were written.

Results and Discussion

I developed five themes in the analysis: ‘Pain Is a Communication, It Could Be a Problem in Me’; ‘Men Are Not the Patients, Women Are’; ‘Men’s Loss of Agency, Impotence to Act, and Inactivity’; Downplaying Suffering: My Experience Doesn’t Matter… And Yet; and Hegemonic Heterosexuality and The Individual Man. I outline and discuss each theme in turn.

1. Pain Is a Communication, It Could Be a Problem in Me

The first theme captures how men make sense of their partner’s pain. Men’s talk of their own ‘theories’ constructed pain as a communication with pain signalling either a ‘physical problem in their partner’s body’ or ‘a problem elsewhere, probably within them’. For many men, the possibility that pain is a signal of a problem within themselves existed until it could be ‘ruled out’ by a medical diagnosis. Men who immediately understood FSP as purely a physical pain condition had access to an organic explanation at its onset.

In the space between the pain emerging and receiving an ‘authoritative’ medical explanation, many men considered ‘something in them’ as a potential candidate to account for the pain. P1 (20’s, partnered) described his sense making ahead of a diagnosis: “I started thinking maybe it’s something that I’ve done, so then I started thinking it’s me, that I’m not attractive enough”. P3 (30’s, married) echoed the potential location of the ‘problem’ lying within him: “partly I couldn’t rule out that it was just that she didn’t want to have sex with me anymore, that she didn’t find me attractive anymore”. These accounts show how men drew on the notion of their partner’s pain being a communication of ‘something about them’, rather than arising from a specific organic cause in the body. They did not explicitly question whether the pain is fabricated, and their partner is creating an alibi to avoid sexual activity; nor did they talk about an understanding of pain being potentially psychosomatic and arising from, or influenced by, their partner’s mind and emotions. Instead, pain appeared to be understood as an announcement, either conscious or unconscious, and men engaged with sense making around *what* the pain may be ‘signalling’. Apparent in P1 and P3’s accounts is they understood their partner’s expression of pain as being linked to her ‘not wanting’ to have sex, which they feared was explained by their unattractiveness. This echoes the findings from other studies in which men who partner women with FSP have been described as taking up a position of 'inadequate lover', and how learning more about vulvar pain had helped them understand they were not personally being rejected (Connor et al., 2008; Sadownik et al., 2016). Men in this study were specifically asked how they made sense of their partner's pain experience and were prompted to talk about all of the different ways in which they 'explained' the pain, and how this may have changed over time. P1 (20's, partnered) and P3 (30's, married) had toyed with their own (un)desirability, as described, *and* had considered other potential (physical) candidates. P1 talked about physical options he'd considered: "maybe it's thrush, maybe she's dehydrated, maybe she's like eaten something". P3 spoke about a surgical procedure his wife had and how this may have played a part: "It's major surgery, not in the same area but, you know, in a close area, so you maybe kind of wonder if there has been some maybe nerve damage or something". P4 (60's, married) also drew on various possibilities as he narrated his own wonderings: "Is it a psychological issue? Is it a physical issue? Is it me? Is it the relationship?". He implied here that along with considering pain to have a physical explanation, he also understood FSP to be a potential communication of something being wrong, locating the problem not solely within himself, but also possibly in his wife's mental state or their relationship. P10 (30's, married) however, firmly explained the problem as being within himself and, unlike other men, did not talk at any point about physical candidates:

> the first thing that comes into my mind, when we have sex and she is experiencing pain, is like, oh maybe she's not attracted to me, she doesn't want to have sex with me, she has less desire, or no desire for me.

It is worth noting that P10 was the only man interviewed who also did not talk about his wife having medical investigations. He described himself as having a sexual difficulty which he attributed to his own psychosocial issues and therefore appeared to not apply a medical framework to his understanding of sexual difficulties.

These accounts of men’s sense making suggest that partners, as well as academics and clinicians may engage in the conceptual interrogation of whether ‘the sex is painful, or the pain is sexual’ (Binik et al., 2002; Peer Commentaries on Binik, 2005). Some men appeared to draw on the notion of FSP being an unspoken communication of a ‘no’ (Kleinplatz, 2018) and a declaration of either the sex, or men themselves, not being desirable (the pain is sexual). The only men who did not engage with these types of narratives were those who could access a definitive physical origin to the onset of pain. For example, P8 (60’s, married) anchored his understanding in a physical cause having witnessed the likely candidate himself. He said, “she had something like a cyst on one of her lips, labia is it? (…) she had me have a look at it and I said yes there’s something there and so she had that cut out, that was in hospital”, with the mentioning of the hospital seemingly lending further authority to the physical nature of the complaint. P2 (40’s, married) stated, “my wife started to go through the change roughly 2 years ago. She was put on HRT and then taken off (…) that’s what I put it down to, when she started going through the change”. For these men, it appears they understood the pain to be a physical/medical condition and therefore ‘the sex is painful’. P17 (50’s, married) however was given a biomedical explanation by his partner but nevertheless held onto his own understanding: “it seems it’s down to menopause, but I don’t think she has ever fancied me”, illustrating the potential persistence for some men to view FSP as a communication of something in them being the problem. The majority of men who were without an obvious physical explanation from the onset, held the possibility that the ‘pain is sexual’ until the pain was sanctioned as having an organic cause, or at least identified as a recognisable ‘medical problem’.

A diagnosis typically provides an explanatory framework with medical professionals then defining the reality of the situation (Bell, 2016; Jutel, 2009). The journey to diagnosis can nevertheless take several months and even years, and many men described ‘pre’ and ‘post’ diagnosis eras. The dominant picture was one where receiving a diagnosis appeared to free men from the burden of it potentially being ‘about them’ as the pain is adjudicated to be real, identifiable and biomedical. P1 (20’s, partnered) described months of angst in which he questioned his adequacy and attractiveness as his partner was repeatedly told by several practitioners “there is nothing wrong with you”. In the following extract, the duration of his (and his partner’s) suffering and the instantaneous relief from the self-questioning that a diagnosis brought is highlighted:

> we were only there for about 10 minutes and bear in mind this has been a year and a half (…) she had an examination and 2 seconds later we got the diagnosis of vulvodynia and “I’m referring you to the pain clinic”, it was like sorry?... it’s an actual THING?... it was like a penny drop moment, both of us burst into tears.

Interestingly the diagnosis ‘vulvodynia’ refers to ‘unexplained pain’ so offers little in terms of an ‘explanatory framework’, yet for P1 the pain had seemingly been authenticated and classified in medical terms as being physical and therefore conceptualised as an ‘actual thing’. P6 (60’s, married) had also considered himself to be a viable candidate ‘pre-diagnosis’ saying, “I was worried I couldn’t be the man that she wanted me to be … I was worried that I was boring”. Later in the interview he talked about receiving a diagnosis: “at least there was something other than me that was equally the issue, yes so, we could focus on that”, seemingly welcoming a redirection of attention away from him (and his potential inadequacy) onto something else outside of him.

Constructing FSP as a medical condition relocates the problem to being in the woman’s body and puts the woman (and not the man) under scrutiny. This may function to relieve the man of self-blame as the notion of ‘the pain is sexual’ shifts to being conceptualised as ‘the sex is painful’ and falls under the remit of medical management. Women who experience sexual pain have also been found to prefer biomedical explanations (Braksmajer, 2017), as this potentially allows the troubled body to be disconnected from the real essential self (Kaler, 2006). Likewise, it has been proposed that through their own medicalisation of infertility, men could understand it as an ‘objective’ ailment to treat, rather than a subjective part of their identity (Bell, 2016). Identification of an organic cause for men in this study may similarly disconnect their selves (and their potential defectiveness) from their partner’s troubled body.

It is also possible that men prefer to focus on biomedical explanations as it allows access to an objective world of medical science with predictable and structured processes and procedures. Draper (2002) noted the value attached by some men to technical, objective and scientific knowledge due to it being a more familiar 'masculine' discourse. This was articulated by P9 (60's, married), "I've always found the whole medical thing very interesting anyway, it appeals to my logical nature"; and an attractive precision of the biomedical world was suggested by P7 (20's, partnered) when he encouraged his partner "try to find out *exactly* [emphasis added] what it is" in reference to her seeking medical help. Several men appeared to have an awareness of non-biological factors being in play: either explicitly referencing their partner's mood or emotional state mediating the pain experience; or inferring this via references to 'calmer' times. For example, "the only time we had any sort of success (…) was out on a holiday" (P5 [20's, partnered]), "we're going to try to have penetrative sex when we're in a place where we are not stressed" (P1 [20's, partnered]). However, they mostly focussed on the biological aspects of their partner's pain (once they had a biomedical explanation). Attending to the physical dimension may permit some men to ignore the complex and less chartered territory of understanding FSP as being influenced by psychological, relational and social factors; and the formidable task therefore of 'fixing it'. The biomedical model, on the other hand, is appealingly set out to offer a potential cure, once a clear cause is identified. Women who suffer from FSP have also described feeling more hopeful about the pain being 'removed' by a medical intervention, which also contributes to their favouring physical explanations of pain (Marriott & Thompson, 2008). Although workable solutions to FSP remained elusive for many couples, and most men gave accounts of their frustrations about the problem not being 'fixed', many clung to the idea that the solution lay in biomedicine and that eventually they would have access to it. P2 (40's, married) captured his investment in biomedicine when he described listening to a radio programme about other people's experiences of treatment for FSP: "it gave me a bit of hope really, there are people out there getting help, so maybe one day we'll get it".

In this theme I have illustrated how men who do not initially have access to an unequivocable physical cause, seemingly draw on notions of pain communicating a problem ‘mostly within them’, until a diagnosis is established. They appear to then join the men who conceptualised FSP as having an obvious physical cause from its onset and focus on biomedicine’s potential to mitigate or remove the pain. The appeal of the medical framework, whether due to potentially offering a predictable diagnosis and treatment structure, or allaying men of their fears of their unattractiveness, appears to capture their attention and other influences of FSP become overlooked.

2. Men Are Not the Patients, Women Are

Closely linked to and possibly a consequence of the first theme, the second theme captures men’s accounts of being on the outside of the FSP experience, in particular with reference to help seeking. In emphasising the physical aspects of FSP, most couples enter into the medical system. Men do not have a biological claim to patient status as medicine focuses on the woman’s body; however, the man therefore becomes the ‘non-patient’, a position which left these men feeling insignificant and marginalised.

Men who were involved in the help seeking process described their sense of being invisible in their encounters with medical professionals. This was illustrated by P6 (60’s married): “it was like I was over there in the shadows; well, I was on the side there”. P2 (40’s, married) also described his invisibility and an active exclusion from the encounter:

> So, the second time with the consultant I went with her, but I felt like I was being looked through, the doctor, he was just speaking to my wife all of the time and I was actually trying to get words in.

P8 (60’s, married) seemed to understand not being spoken to as ‘expected’ saying “that sort of goes with it really,” and was content to be a witness to the proceedings. He did however protest at being separated from his wife and excluded physically from a part of the consultation saying, “well I don’t know why they took her into another room to examine her when I have seen her in intimate detail many many times”. These were examples of men who were in the consultation room with their partner. For many men ‘attending appointments with their partner’ was interpreted as meaning driving them there or sitting in the waiting area. This suggests they understood they were not expected, or possibly even entitled, to be part of the ‘appointment’ experience, and ‘being with’ their partners in the car or in the building was as close to the experience as they should get.

Men’s accounts of being on the outside of the medical experience echoes the findings of a substantial body of literature on men’s experience of their partner’s pregnancy. In this context men are also not recognised (by the medical system) as a patient, but nevertheless are highly involved in the issue that brings their partner to a medical appointment. Early writings identified an obvious marginalising of men with Shapiro (1987, p. 38) noting that even though men are encouraged to participate, they are “simultaneously given to understand, in a multitude of ways, that they are outsiders”. More recent qualitative researchers have generated themes such as ‘men as bystanders’ (Locock & Alexander, 2006) and ‘feeling side-lined’ (Fenwick et al., 2012) which captured similar accounts in which men express being ignored, invisible and pushed aside during interactions with professionals at antenatal visits. Similarly, themes titled ‘secondary status in comparison with the female partner’, and ‘marginalisation in endometriosis care’ were generated in reviews of men’s experience of pregnancy loss and endometriosis respectively (Facchin et al., 2020; Williams et al., 2020). It therefore appears this study evidences another situation in which men report a sense of exclusion and lack of consideration for their own experience, despite being highly involved in the issue for which their partner is receiving care.

In the current study many men notably shifted from using the shared pronoun ‘we’ to using ‘she’ when talking about engagement with the medical system. Appointments belonged to their partner as demonstrated by P5 (20’s, partnered) when he said, “we were just trying to find answers, it got a little more distressing along the way when Sam obviously wasn’t getting the answers and things like that and I think she stopped going after the third GP visit”. Excluded by medical professionals, many men appeared to take up supportive positions typically aimed at ‘being there’ for their partner as she experienced her frustrations with the medical system. These notions were exemplified in P5's (20's, partnered) account: "she wasn't getting the help she wanted, again its quite frustrating but I'm just there to provide support", highlighting both the clear sense of his own role and his outsider position, as it is his partner (and not the couple) who wasn't getting the necessary help. Some men appeared to want to offer protection by attempting to mitigate their partner's frustration. P7 (20's, partnered) said,

> I wanted to go just because of what I said about her being passed around different GP's and sort of medical professionals and never getting to the right appointment, so I wanted to go, just so that she didn't have to do all of that really.

P7 stopped short of saying whether he managed to impose himself into the system but seemed to describe an intention to put himself into the experience, notably not as a patient but as a minder of how she was moved around. P9 (60's, married) drew on his own illness experience and demonstrated a clear understanding that his wife was the patient this time:

> I mean she was mainly talking to Mary [his wife] which is what I would expect, but I'm fairly certain I piped up a couple of questions. We also knew, because of [their experience with his illness] there is another person there. My wife always has a list and I'll look at the list and say ah yeah we need to ask this, so I saw my role as a support role.

He emphasised his efforts to speak, yet the questions he 'piped up' were seemingly from his wife's list which he 'prompted from the wings'. Men may be diminished within the medical setting and respond to this by creating new roles (Draper, 2003). Locock and Alexander (2006) proposed that men take up roles as supporters and protectors to maintain the hegemonic conception of masculinity. Men (and those around them) may view these roles as valuable to their identity and they may function as an attempt to resist marginalisation.

Men's narratives indicated varied responses to being excluded that ranged from resentment to acceptance; the experience of being on the outside of interactions with medical professionals was however consistent across this data. Some men also gave accounts of being kept on the outside not by medical professionals, but by their partners. P3 (30's married) explained why he was not present at his wife's medical appointments:

> I'd argue that it was more my wife's decision … I did offer to go to the GP with her, and she didn't want me to. Now, you could argue that I could have pushed harder, and I didn't, and I'm not entirely sure … it's not like I felt I should be there, I wanted to respect her decision.

In this extract P3 clearly articulates his wife's preference to attend alone and then grapples with his own sense of wanting to go, and whether he was indeed entitled to do so. Ultimately, he settled on the notion that he probably shouldn't be there and deferred to his wife's decision to exclude him. P6 (60's, married) also acknowledged his wife's preference to attend alone and his 'complete' acceptance of her choice, but interrupts his account and reflects on of his actual experience:

> and quite often Sally wanted to go on her own anyway which I completely accept … As I say 'completely accept' … I think … because of the hesitation that doesn't ring true, I'm trying to analyse this as we are talking (…) I suppose there is a small percentage of being left out, yeah and not being party to the full story, I suppose that's the niggle there.

As P6 questions the completeness of his acceptance, he starts to unveil his sense of being on the outside and seemingly minimises his experience of this to being just a 'niggle'. This may reflect an understanding that he is not obviously entitled to inclusion and therefore keeps his feelings of exclusion to a 'small percentage'. Several men's accounts suggested a tension between respecting their partner's right to privacy, and a realisation that they are the ones who the 'privacy' protected from knowing. P5 (20's, partnered) said,

> she wanted to go in by herself just because of the sensitive nature of it, it's a very private matter to her and she felt like she wanted to go in there on her own when they checked her out, she didn't want me there for whatever reason, it's not something I haven't seen before but it's obviously a very private matter for her.

His repeat of ‘very private matter for/to her’ appeared to emphasise the impossibility of him being party to her experience, and the ‘for whatever reason’ suggested he did not necessarily share this perspective.

As men’s partners were not involved in this study it is not possible to speak to whether women’s exclusion of men is deliberate or even consciously considered. Women may unintentionally cast men in the role of outsider and non-patient in response to medicine casting women as the solo and individualised patient. It is also possible, as suggested by Bell (2016), that as medicine excludes men, men may voluntarily take up the ‘opportunity’ of an outsider position. In reference to men and infertility, she proposed that the historical stereotyping of infertility as a woman’s issue has caused men to overlook the ways in which they can be involved in the treatment process. She proposed that if medicine focuses on women and removes men from the scene, then men will remove themselves as well. This may serve to distance men further from their own sense of responsibility (for infertility) and reappoint any blame from him to her. This may similarly happen in FSP. An outsider position may further relieve men of the angst they experienced when considering that sexual pain may have been their responsibility due to a perceived deficit in themselves.

The understanding that women are the patients and men are not can endure beyond the medical encounter and framework. P1 (20’s, partnered) shared his experience of eventually being referred (as a couple) to a psychosexual therapist after many encounters with medical professionals. He recounted his partner’s response to him finally being asked how he was feeling: “she was horrendously offended that I was asked!”. I asked P7 (20’s, partnered) if he would consider therapy if his distress worsened, to which he responded, “yeah I think so, yeah I think my girlfriend would be quite supportive as well, I think she’d encourage it”, implying an understanding that he was not necessarily the patient (this is his girlfriend’s position), and he would seek her ‘approval’ before adopting this position himself.

In the context of FSP, it therefore appears that women are positioned centre stage by health care professionals, men and women themselves; and men form the supporting cast. Regardless of whether these positions are taken up voluntarily or intentionally/unintentionally assigned, men's experience is understood as secondary to women's, and side-lined as a consequence.

3. Men's Loss of Agency, Impotence to Act, and Inactivity

Framing of sexual pain as purely a physical problem situates the problem within the woman. As the woman takes ownership of the problem men's agency seemingly becomes thwarted. Men appeared to experience themselves as impotent to act effectively and expressed caution should they be experienced as too active, 'pushy' or coercive. Their ineffectiveness was experienced in the medical context and also more broadly in their interpersonal interactions with their partner.

In the medical context P3 (30's, married) spoke about the consequence for him of being excluded from appointments and his compromised sense of efficacy: "I don't really know what's going on, so it's hard to really support my wife in that sense, or to talk through options or whatever because I just don't know". For P3 his loss of agency was described as being rooted in not having an informed understanding of sexual pain: only his wife had been privy to this through attending the appointment. As the pain is located in their own body, women seemingly appeared to take control of the decisions around whether treatment is pursued, and which treatments will be taken up within the medical system. P2 (40's, married) described his attempt to engage in seeking medical solutions without effect:

> I'd just talk to her and say what can we do about this and she'd just say, 'well they've told me there is nothing wrong so what can I do about it' and if I try to push it any further, it seems to get, you know, she seems to get a bit angry, so I just leave it.

P3's (30's, married) narrative also highlighted his wife's agency regarding treatment choices and his corresponding inertness as he talked about her rejecting the suggested treatment: "it just added to the kind of hopelessness, (…) if that is the standard you know like prescriptive model or whatever and she didn't want to take it, well where would we go from there".

Medical treatments for FSP are frequently ineffective or unworkable, and fail to alleviate women's pain (Al-Abbadey et al., 2015). Many men described a sense of powerlessness in response to their partners continued suffering. Despite having invested hope of a ‘cure’ in seeking expert help, many men expressed distress around not being able to solve the problem themselves. P5 (20’s partnered) described his struggle: “the biggest thing for me is I can’t help her, there isn’t anything I can do that is going to make her feel better, I can’t do anything that is going to take the pain away”, and P6 (60’s, married) similarly said, “I don’t know what to do about it, it’s a real, the hardest thing of all, I can’t fix it”.

In addition to not being able to influence either whether medical solutions were pursued, or their partner’s pain was alleviated, men also described a loss of agency within their relationship. Men spoke of “periods of eggshells, you know sort of tip-toeing” (P6 [60’s, married]) and “the elephant in the room” (P1 [20’s, partnered]) in describing their tentativeness about, and avoidance of, talking about sexual pain. Their reluctance to talk seemed to be due to a sense their partner did not welcome conversations and pursuing them therefore felt ‘pushy’ and risked provocation. As described earlier, P2 (40’s married) attempted to talk about ‘what they may do’, but his enquiry was met with an angry response which prompted him to “leave it” and retreat. P6 (60’s, married) described his own withdrawal from conversations: “sometimes it’s good to shut up, you know, just not dig a deeper hole”, implying, as other men frequently did, that conversations were better avoided as they led to conflict and further distress. Men are often understood to be focussed on solutions, and women have been found to resist having conversations with men due to their frustrations around the style of men’s communications describing it as ‘overly focussed on logic and problem solving’ (Schuth et al., 1994). Women may also resist engaging in dialogue because of the difficult emotions they experience in doing so. In the sexual pain literature, women have communicated the difficulty they have faced in talking to their partners, healthcare providers and peers due to the shame they experience (Shallcross et al., 2018). Women may not welcome conversations for many reasons, but nevertheless many men in this study communicated their own sense of ineffectiveness in pursuing conversations about the FSP experience in general.

Men’s loss of agency also appeared to manifest within sexual encounters. Conventional discourses of heterosexuality position men as the initiators of sexual activity and women as the recipients of male desire (Allen, 2003; Hollway, 1984). However, the dominant account within the data was of men being passive and women were described as active and agentic initiators. P9 (60’s, married) clearly illustrated his movement from active towards passive since the onset of FSP: “I usually wait for her to say to be honest these days”. P10 (30’s, married) also described his inactivity and offered an explanation: “I don’t want to receive a ‘no’, so I wait for her to initiate things”. In P6’s (60’s, married) account he declared his wife to be the initiator: “it’s only when Sally was, is, feeling up to it, you know, … she is the instigator”, but introduces the notion that sex happens when his wife is feeling able/well enough to engage. What is not known is whether Sally and other women, are motivated to be sexual through their own desire in the conventional understanding of the initiating/receiving dyad or are ‘permitting’ sex which they know is desired by their partner. As part of the interview conversation, I often asked how sex was initiated and through my own talk had presented the concept of initiation. It is therefore possible that men understood themselves to no longer be the initiators and appointed women in this position (somebody had to be in that position as I had introduced the concept) when women were more accurately functioning as gatekeepers to men’s access to sex. As gatekeepers of sex, women decide when sex is given and when it is withheld in response to what they perceive as men’s need for sex (Hayfield & Clarke, 2012). Nevertheless, many men appeared to have an understanding that their option to initiate had seemingly been removed. P8 (60’s, married) stated that he has “always been the initiator” and unlike most of the other men, continued to be, even with the onset of FSP. However, the following extract illustrates his wife’s control of decisions around when sex happens and the conditions under which his initiation was permissible:

> she is, I want to say only prepared to offer it once a week, but those are the wrong words as well, she would rather it is kept to a Sunday morning and I can tell from her sort of reaction if I suggest it more often.

For some men being active in initiation was problematised as it risked them being experienced as abusive and perpetrating. P18 (40’s, partnered) drew on his social environment in writing about his discomfort around approaching his partner sexually: “there is so much in the media about men mistreating women and it feels like I am almost part of the problem despite having no intention to be cruel or belittling to women in any way”. P4 (60’s, married) said, “her previous partner was quite difficult (…) I wouldn’t quite put it as abuse (…), I guess my fear was of being tarred with the same brush”. This concern of being experienced as abusive was also expressed by a small number of men who expressed either knowing, or having a sense, that their partner had been sexually abused. They appeared particularly cautious and worked to ensure they did not pressure their partner and be experienced as an offender themselves. P10 (30’s, married) said, “it’s also like maybe she is looking at me as a perpetrator, like a rapist, you know”. Partners of women who have experienced sexual violence have described being forced to consider potentially coercive aspects of heterosexual practice (Connop & Petrak, 2004). The presence of pain during sex seemingly brought some men to examine their own actions in a similar way. FSP is a unique pain condition in that for many women, pain is either only experienced or exacerbated during sexual activity. In heterosex this means it is the man who triggers the pain and men have previously expressed their fear of causing pain (Sadownik et al., 2016). In this study many men also spoke to this: “from a man’s point of view you are causing it” (P4 [60’s, married]). In response to the survey question ‘what has been the most difficult part of your experience?’ two men wrote, “her discomfort and the feeling that I have caused it in some way” (P13 [30’s, partnered]), and “not wanting to do something that hurts my wife whilst getting pleasure” (P22 [60’s, married]). Many men expressed their concerns about causing their partner pain yet continued to engage in sexual activity, despite pain being present. None of these men offered an explanation. Women, however, have spoken about their motivations for continuing to have intercourse despite it being painful. They have described wanting to maintain value as a partner and avoid the threat of their partner finding other women who could offer problem free sex (Ayling & Ussher, 2007; Elmerstig et al., 2008). From the data in this study, it is apparent that in some relationships, women did not disclose their pain or downplayed its significance. Several men spoke about not knowing about the pain in the early stages (either of their relationship or of the pain's appearance) and gave accounts of their partner "eventually admitting that she was in pain" (P22 [60's, married]). P14 (20's, partnered) identified "the feeling of hurting her and her not telling me" as the most difficult part of his experience, highlighting the distress this caused him and also the notion that women may continue to withhold information about their pain. P4 (60's, married) also talked about his wife minimising her pain: "you don't want to think that the outcome of making love with someone is going to leave them with some sort of pain, however they dismiss it and say it doesn't matter". He went on to talk about his own sense of wanting to know and needing to ask if she is in pain, explaining "that is for my own reassurance". If women hold knowledge of the pain and keep it from their partner, men are left impotent to act effectively. The appropriate response, of say redirecting the interaction towards pain free activities, is not considered if pain is concealed. For some men, a loss of potency during the sexual encounter was evident in their talk as they seemingly remained vigilant to the possibility of pain being present. P22 (60's, married) wrote, "She obviously tries to hide the pain, but of course this does not help as it is clearly too much and because I struggle to keep an erection as soon as I realise this", emphasising his bodily response on 'discovering' the pain. P23 (60's, partnered) wrote, "I am much more at ease having sex when I'm confident she will say when she wants to stop", implying the presence of anxiety in his sexual experience, and the relief from this if he could be certain she was not feeling coerced to continue. These accounts suggest contradictory responses in men to those that may be anticipated by women as they have described a fear of hostility in their partner if they refuse sex due to pain (Donaldson & Meana, 2011). It is however essential that these men's responses are not considered to be representative of all men's responses.

Most of the men in this study did not, or could not, align with the masculine hegemonic of being sexually assertive (Hammond & van Hooff, 2020). Many struggled with the notion of being the perpetrator of pain and some were highly cautious of a potential dominance over women. Men's loss of agency and thwarted ability was not confined to the sexual relationship; it extended into other areas of their relationship, with many men also struggling to pursue conversations with their partner and influence engagement in medical treatment.

4. Downplaying Suffering: My Experience Doesn't Matter… And Yet

This theme captures men's ambivalence around whether their own distress and suffering is worthy of attention. Although they may not suffer in the same way their partners do, there are many ways in which men experience their own emotional and psychological pain. In this theme I illustrate men's downplaying of their own suffering on the basis that it is not as significant as their partner's distress; their reluctance to voice their experience; and the considerable impact of FSP on men.

Men appeared to measure their own distress and compare it to their partner's as captured in the following accounts:

> I find it impossible to talk about, I guess like I am to you, in terms of certain aspects being difficult for me, do you know what I mean? I don't want to do the 'poor me' thing because Ann would say, well I don't think she would really but well, 'poor me I've got vulvodynia and it's a thousand times worse for me'. (P8 [60's, married])

> I felt like my issues were nothing in comparison to what she is going through and imagine, if I feel like my self-esteem is lacking, I can't imagine what she is feeling like. (P1 [20's partnered])

When men spoke about their own experience, they frequently expressed a sense that it was selfish to even speak about their own distress. P3 (30's, married) paused his response to my question about the most difficult aspect of FSP to acknowledge this: "I think the most difficult thing, and I guess I'm sad that it's going to be something about myself" and finished his answer with, "so those were the two main difficulties, they were both about myself!". P6 (60's, married) succinctly captured his sense that attention should not be on his own difficult experience "to be self-indulgent, it's fucking hard sometimes”. Many men who were interviewed employed various strategies to interrupt talk of their own distress and suffering. Some men redirected attention away from their own experience to talk about their partner as illustrated by P7 (20’s, partnered). His narrative was largely about his partner’s experience and I asked him directly how it was for him. He talked briefly about his own feelings saying, “it’s quite challenging, its’ quite sad”, and promptly returned to talking about his partner “because she gets up into her head …”. Others seemingly found ways to talk about their emotions without attention being directly on themselves. Emotions were depersonalised “there’s anger, there’s guilt”, or given to others “for some people it could be really quite a big thing”. It was apparent in the way men talked that their own experiences were difficult to foreground, suggesting an ambivalence over whether their experience was entitled to such attention. This echoes findings in other areas of research such as miscarriage and sexual assault. In these contexts, men also seem to downplay their own emotional distress and give precedence to their partner’s suffering, despite being traumatised themselves (Connop & Petrak, 2004; van Wijk et al., 2014; Williams et al., 2020). It is possible that men’s unwillingness to speak freely about their own experience may reflect, in part, efforts to maintain a sense of masculinity. Partner coping responses characterised by silence, rationality and emotional detachment/containment have been explained as being in line with what is expected of them as men (Williams et al., 2020). Similarly, men’s reluctance to talk about their feelings in the context of endometriosis was suggested by the authors to be due to the importance placed on ‘appearing strong’ and remaining stoic: this served to uphold cultural expectations of masculinity (Culley et al. 2017).

When men in the current study did however speak of their own suffering, they gave accounts of significant distress involving their pain which centred around their partners suffering; sadness around loss; different anxieties; and shame about their own sexuality. Frustration characterised many men’s emotional responses, particularly in relation to medicine’s inability to relieve their partner’s suffering and the pain for them of witnessing this. P24 (70’s +, married) illustrated this writing, “She has lived with pain on and off since the original intervention and I have felt angry and frustrated that she has suffered years of pain”, and went on to identify “the feeling of helplessness in not being able to help her,” as the most difficult aspect of his experience. Many men spoke of their frustration and helplessness when, in the face of medicine having failed them, they themselves attempt (but fail) to relieve their partner of their suffering. P5’s (20’s, partnered) account exemplified this:

> I can be there for her, but it’s, I can’t do anything. It’s like the GP story, it’s like I’ve got the diagnosis, but I can’t do anything, there is nothing in that moment that I can possibly do to make her feel better.

P9 (60’s, married) gave an emotional account of how he felt when he found out his wife’s pain condition could not be treated: “I felt sad … it was something we had lost”, communicating, as several men did, sadness around the loss of something special. The loss was more than the act of PVI. Men talked of a loss of spontaneity and playfulness in the sexual relationship, “it all sort of choreographed naturally (…) whereas now there had to be almost an instruction list” (P6 [60’s, married]); the loss of their partner as they had known her, “she has changed so much” (P19 [60’s, married]); and the loss of a future they had planned,

> We are both retired now, and I had hoped that things would almost go back to, you know, the children have left home and have grown up, and I hoped it would get back to what our sex life was when we were just the two of us (P8 [60’s, married]).

P18 (40’s, partnered) wrote candidly about his own biographical interruption when, now at 40 years old, he described the ‘stunting’ effect of vaginismus:

> in the last year or so, as I get older, it is causing me a lot of concern as I fear we will never be able to have children (…) when you cannot take part in a usual element of adult life [referring to PVI] you can feel like a pathetic child or teenager- especially when there is the worry of not being able to potentially have kids as that could be seen as a rite of passage/important part of life I feel may never happen.

He appeared to write about both his loss of manhood in describing himself as a “pathetic child”, and his potential loss of entry into fatherhood.

Men also expressed various anxieties. P1 (20’s, partnered) appeared to experience a rethinking of self as he spoke about a decline in self-esteem in the sexual relationship which had spread to a deterioration in his confidence at work. He also spoke about the enduring effect of his self-questioning and the constraints on his sense of self, captured in his statement “I am obviously not the person I know I am”. P17 (50’s, married) also spoke about his own sense of inadequacy. He had understood his partner’s sexual pain to be due to his own lack of attractiveness and wrote very succinctly “I feel bad about myself and feel that I am failing her”. P6 (60’s, married) talked about his anxiety around potential consequences of his wife’s experience of pain. He spoke about a woman he knew of who had ended her own life, and the concern he had for his wife when she says, “I’m not sure I can put up with this much longer”. His wife has persistent vulval pain (not only provoked by sex) and he illustrated the pervasiveness of his fear by saying “the pain doesn’t go away, and nor does the threat”. P3 (30’s, married) appeared to experience anxiety around an attachment threat as he described a period of disconnection from his wife, saying “I did all of a sudden feel really insecure in our relationship”.

Although men’s psychological and emotional responses were varied, men’s accounts nevertheless clearly illustrated the negative impact of FSP on them. Sadownik et al., (2016) also described men’s distress in their study of partners of women who suffered from PVD. Similarly, they noted men’s sense of loss, despair, frustration, anxiety and low self -esteem. However, in the current study several men also talked about their sense of shame which seemed to emerge from their own sexual desire continuing to be present. P3 (30’s, married) spoke of his own confusing experience:

> I just felt like ashamed by the kind of way I felt for my wife, which is kind of ridiculous in the sense that you shouldn’t feel ashamed of wanting to be intimate with your loved one, but that’s how I felt.

Whilst P3 described his ‘badness’ in feeling desire, several men experienced shame when they acted on desire and masturbated. P1 (20’s, partnered) said “I would secretly masturbate, and I almost felt ashamed at the time because, you know, because it felt wrong because, almost like I’m cheating on her”. Similarly, P8 (60’s, married) said,

> I feel a little bit ashamed; I feel a little bit dirty. I’m not proud of myself for doing it and I’m not sure why… you know, I put something on the computer to get myself going, but let’s not go down that route, you know, I feel a bit ashamed of myself for that.

None of the men offered an explanation for masturbating despite it causing them shame, which may imply they understood their motivation to be biologically driven and that I also understood this. However, their experience of shame for acting on this urge was nevertheless evident in the apparent discomfort they experienced talking about it. P8 for example, clearly communicated this topic was not suited to further probing when he said, “let’s not go down that route”.

Apparent in these accounts is the considerable distress which men may experience. However, a tension existed for men: on the one hand, they understood their own experience to be worthy of attention due to the extent of their struggle, and on the other hand, understood their own experience to be insignificant compared to their partner’s, and themselves selfish if they attend to it. The dominant story however was that men had been largely silent about their own distress. Culley et al. (2017), in their study of men’s experience of endometriosis, reported that for most men, participation in the research was the first time they had been asked about their experience and the impact of endometriosis on them. Several men in this study also reported that they had not previously been asked and voiced an appreciation of having their experience recognised. As expressed by P8 (60’s, married), “no one has ever asked me and I’m grateful that you have”. This ambivalence for men around the significance of their own experience manifested in their reflections on the notion of receiving support. P1 (20’s, partnered) said, “I would have loved someone to have come up to me and said right your girlfriend has been diagnosed with this and you are being referred to counselling, and you’re both being referred to counselling”. P1’s account suggested that whilst he would have openly welcomed support, it was not his place to ask for it, preferring instead for a professional to ‘come up to him’ and offer it. The ‘prescription’ of partner support may serve to legitimise men’s claim to their distress. P3 (30’s, married) gave a similar account in which he too recognised the value of psychotherapeutic help for himself, but implied a preference for it to be offered by professionals, rather than sought for himself:

> even when support kind of did kick in in theory for my wife, there wasn’t kind of any inclusivity for the partner, and I know I could have gone, I guess I could have got counselling if I had explained I was very depressed about this to my GP, but there was just no inclusivity at all.

For some men their own support seemed like something they had never considered but would welcome, as illustrated by P8 (60’s, married): “it would be lovely if there was some … I had never thought about that, just in an old-fashioned sort of way (…) I think my frustrations were up to me to solve”. P8 alluded to traditional gender expectations of men to appear stoic, self-reliant and able to manage their own emotions. P7 (20’s, partnered) drew directly on these gendered prescriptions: “I’m quite a typical man in that respect, I think with this issue, I’m quite happy keeping it to myself”. Despite recognition of painful emotions within themselves, the outward control of these emotions has been described as a mechanism in which the public appearance of manliness is maintained (Williams et al., 2020). Adhering to traditional notions of masculinity, in addition to questioning their entitlement to attention, may offer explanations of why men may not seek professional support. However, it is also important to note that men seemingly did not look to their partners for support either. Men’s reluctance to speak to their partner about their experience is potentially founded in protecting their partner (who is already experiencing intense distress) from further burden (Culley et al., 2017). Some of the men in this study who spoke about feeling unable to have conversations with their partners, were asked what they would like to be able to talk about with them. They all spoke about their desire for their partner to understand their own experiences. This suggests that men may want their own perspectives or distress to be acknowledged by their partner but are reticent to 'bring it up'. Again, as women were not involved in this study, it is not possible to establish whether women do not attend to their partner's experiences as they are not aware of men's distress, or whether they too feel men's distress is not entitled to attention.

Men's reluctance to speak about their own distress to their partner, and to me as a researcher, has been highlighted in this theme. Largely, men viewed women's distress as taking precedence and therefore was in greater need of attention, yet gentle probing unveiled multiple ways in which men may suffer. Although men cannot experience FSP in the same way as women, they nevertheless have their own painful experiences.

5. Hegemonic Heterosexuality and The Individual Man

The final theme captures how men resisted traditional discourses of heterosex to various extents within their own relationship, in the context of FSP. Men's talk about the meaning of sex generally, and the importance of PVI more specifically, generated contrasting and diverse accounts of male sexuality. Most men privileged intimacy within their relationship, but many expressed their partner more strongly upheld dominant notions of heterosex.

Men's narratives consistently indicated that sexual interaction was understood to be a necessity within their partnered relationship. Although their accounts showed variety in how important sex (of any kind) was within their relationship, it was generally considered to fortify the relationship. P4 (60's, married) described his view: "I think sex is like the mortar in a brick wall", suggesting sex is 'the glue' that holds the elements of the relationship together, whereas P6 (60's, married) said, "if it's a relationship that is just based on sex it is pretty shallow", seemingly indicating that sex can't be the only foundation, but his use of 'just' suggests sex is there in the foundational mix. Men who were interviewed were specifically asked about the importance of PVI within the sexual relationship, and they also spoke about this as we talked more generally. Most men who only responded to the survey, though not directly asked, referenced explicitly and implicitly the importance to them of PVI. None of these men appeared to consider coitus as an 'absolute' imperative in their own notions of sex. The men who appeared to privilege PVI upheld and simultaneously challenged traditional notions of PVI being essential to the sexual encounter. P2's (40's, married) account was representative of these men's talk: "the most difficult? … just not being able to have proper sex really, that's the most difficult for me, yeah", clearly authenticating the coital imperative in positioning PVI as the defining, real or 'proper' sexual act (Jackson, 1986; Potts, 2002). However, he then went on to talk about his relationship which currently did not involve PVI:

> I think we still have a sex life, it's not as though its closed and that's it, you know, we'll wake up one morning and we, you know, from both of us kind of thing and it is enjoyable and it's a release and it says yeah you know she still loves me, and I still love her.

Here P2 appeared to expand his notion of sex to also involve non-coital activities and constructs coitus-free interaction as a 'sex life'. P8 (60's, married) recognised his own talk of sex held contradictions and spoke explicitly about his difficulty to establish a clear view of the centrality of PVI. Initially he responded promptly to my question of its importance saying, "yes penetrative sex is important to me … being able to orgasm inside her, it feels like the proper way to do it", drawing strongly on traditional notions of heterosex. Shortly after, he wavers in his conviction when speaking about the impact of not having PVI on his relationship: "I think our marriage in many respects is no different really… I strongly believe our marriage is just as strong … perhaps you could say from what I've said it's not important, we are having intimate moments". To finally settle his own debate, he drew on the gravitas of legal definitions regarding marriage and infidelity to support PVI's privilege: "that's the act of being unfaithful, having penetrative sex isn't it, so I think penetrative sex is an important thing, it's an important thing full stop!".

P4 (60's, married) on the other hand spoke about a varying importance of PVI depending on the relationship and his partner saying, "with my current wife it's different, I enjoy it more than with anybody else, and with other people I could take it or leave it". P23 (60's, partnered) wrote about an unexpected shift in the importance of PVI for him: "I suppose I have been surprised by how easy it has been for me to get used to not having penetrative sex. Although our physical interaction is more limited, I don't feel that sex has become more routine - and I am somewhat surprised by that."

In stark contrast to the men who seemed to privilege PVI (to an extent), P9, P7 and P3's talk of sex resisted the coital imperative and conceptualised sex as involving many different possibilities, with PVI being of no particular importance:

> Usually, it's a nice bit of groping and to be honest if it just carried on as a nice bit of groping and we stopped after that, I would be quite happy. (P9 [60's, married])
>
> I wouldn't miss many aspects of penetrative sex, maybe like the intimacy of it … like face to face … but yeah, other than that, it wouldn't make much of a difference to me. (P7 [20's, partnered])
>
> sex to me, of course there are different aspects to it, but being together and close and like hugging and kissing, like to me, that's as important as anything else. Of course, I like penetrative sex and I like whatever but, you know, it's not just that alone … no, certainly not. (P3 [30's, married]).

In these narratives, men orientate away from intercourse-focussed sexuality and towards an intimacy-focussed sexuality as exemplified by P7, who would be robbed of an opportunity to be 'face-to-face', not 'penis-in-vagina,' if intercourse was eliminated. Most men's talk demonstrated an 'intimacy imperative', conceptualising intimacy either as sitting alongside the coital imperative and conventional understandings of sex; or viewing intimacy as being central, privileged and coveted. They spoke of sex bringing them closer to their partner or it being a means of expressing emotional connection, as said by P10 (30's, married), "it's more like about connection, yeah I think being more, I think sex is a good way to connect with someone else". For many men physical intimacy was not only experienced in the sexual encounter, but in the relationship more broadly. They referenced the importance of kissing, cuddling and caressing in their everyday interactions suggesting these men conceptualised sexuality as requiring intimacy, but intimacy could be experienced without sex. P21 (20's, married) exemplified this when he wrote about the impact of FSP on the relationship: "a relationship is a lot more than sex and we are incredibly intimate on a day to day basis (hugging, kissing etc). I feel fortunate that we have that closeness".

These men’s accounts are predominantly at odds with accounts of traditional masculine sexuality. In their talk, many decentred PVI emphasising equally acts of kissing, cuddling and a ‘nice bit of groping’, and sought intimacy, connection and closeness over the simple pursuit of releasing their ‘biological’ urges. Their narratives echo the ‘progressive stories’ that men have told in the aging and sexuality research in which sex takes on a new meaning and men orientate towards intimacy (Potts et al., 2006; Sandberg, 2013). Sanberg (2013) explained this turn towards intimacy as an ‘adaptation to the changes that men’s aging bodies underwent’, and Potts et al. (2006) proposed the experience of aging and erectile changes offers an ‘opportunity to experiment with alternative practices’. However, this reorientation towards intimacy was seen in men in this study across various ages and not as a result of their own bodily changes. It is therefore possible that this shift in sexuality occurs not only as an adaptation to deficits of the aging body, but as a process of a ‘maturing’ sexuality (Terry & Braun, 2009). Several researchers have proposed the social location of the long-term relationship is the site where men are more likely to challenge traditional discourses of heterosexuality and masculinity and express a mature sexuality (Holland et al., 1998; Mooney-Somers & Ussher, 2010; Terry & Braun, 2009, 2011). The ‘progressive stories’ of the men in this study may therefore be attributed to them all being in long-term relationships.

A few men spoke about how removing PVI from the couple’s sexual repertoire offered them relief of sorts from the conventional expectations of sex. These accounts illustrated other ways in which dominant notions of heterosexuality are not upheld. For these men they typically resisted the sexually confident and ‘always ready for sex’ discourse and spoke about the pressures they experienced in the sexual arena. P6 (60’s, married) spoke about his sense of the onus being on him to provide the pleasure in coitus and how removing the option of PVI seemingly allowed him to share the performance burden: “I think there is a pressure on blokes to make sure their partner is satisfied, having something that isn’t all down to you is quite a bit of relief”. Similarly, P20 (30’s, partnered) wrote, “as a man who sometimes struggles to reach orgasm during PIV sex, it has resulted in a sexual environment which encourages other forms of sexual interaction", apparently welcoming the opportunity to explore a sexuality that is not bound by the coital imperative.

Men in this study appeared to access individual scripts that differed from the dominant cultural scripts and engaged with multiple versions of heterosexuality. McCabe et al. (2010) theorised that sexual scripts at the cultural level inform but do not dictate the formation of individual and relational scripts. Interestingly, the regulatory power of hegemonic discourses (or social sexual scripts) was strongly represented in men's accounts of how they considered their *partner* responded to difficulties with PVI. Many women (in men's accounts) appeared to draw on traditional 'fixed' social discourses of masculine sexuality. This seemed to position men as 'not believed' and struggling to provide reassurance:

> I don't see us as having a difficulty, although she would I think! (P23 [60's, partnered])

> It makes her depressed and anxious and then this causes her to want to end the relationship. I always reassure her but don't know what more I can do. (P17 [50's, married])

> I cannot be sure that she doesn't feel blame even though I try and assure her. (P22 [60's, married])

Women, in men's stories, appeared to hold the belief that if men were refused sex, they would feel they had the right to pursue and obtain it elsewhere:

> We were discussing the problem and I said, 'listen I'll never leave you' and she said, 'you must have thought about it' and I said, 'I haven't!', It hadn't occurred to me that if this isn't happening then I need to find it elsewhere, I've never ever thought like that ever. (P2 [40's, married])
>
> she has even suggested like an open relationship and stuff like that, and I know for a fact that couldn't suit her less! She would not be comfortable with me seeing other people and I do not want to anyway. (P7 [20's, partnered])

P7 also voiced struggling to reassure his partner saying that his words didn't seem to have any effect, but how he hoped his actions of staying did, therefore. This disparity between men's actual response, and the response their partner anticipates them to have; the offer by women for men to pursue sex elsewhere; and the challenge for men to assure their partner that FSP does not threaten the relationship, is captured by P11 (30's, single) when he wrote,

> Although I had no issue with not having penetrative sex, my partner did not believe me and would regularly accuse me of resenting her because of it. She would also encourage me to find someone else to sleep with on the basis that it was unfair on me that we could not have penetrative sex because of her. I did not take her up on this offer as I loved her and did not want to hurt her. Over time however it became less of an issue as my partner began to accept that penetrative sex was not a deal breaker for me, and I did truly love her.

Men's accounts of their partner's responses echo what women themselves have said about their concerns about their 'ability to attract and keep a man' and their loss of currency if unable to perform coitus (Ayling & Ussher, 2007; Kaler, 2006). Women have reported experiences of shame even when their partner is supportive. Ayling and Usher (2007) suggested this contradiction could be explained by dominant heterosexual discourses having a powerful influence regardless of the material context of the relationship. It appears that in this study, within several couples, women's experiences of FSP may have been more strongly shaped by social discourse than men's were, and women found it difficult to believe deviation from the social dictate was not problematic for the individual man. One of the two men involved in the study who were no longer in the relationship they spoke about, wrote about the impact of his ex-girlfriend's own distress on their relationship:

> Personally, I found it created an additional concern and burden for me as I was always seeking not to upset my partner (…) it was not something that bothered me directly however, as I was content just to be in a relationship with my partner. (P11 [30's, single])

In his narrative he implies that the ‘deal breaker’ was the tension in the relationship caused by his partner’s continued experience of shame around not being able to offer PVI, despite it genuinely not being of significance to him.

This theme has illustrated how men responded in various ways to sexual pain and resisted, to differing degrees, traditional notions of heterosex. FSP potentially interferes with PVI and heterosexual practices yet men engaged with multiple versions of heterosexuality and consistently privileged intimacy within their relationship. Dominant discourses of men’s sexuality seemingly had less authority over the individual man than their partners may believe.

Conclusions, Implications and Recommendations

Conclusions

This research offers insights into the way a small group of heterosexual men, living in the UK, understood and responded to their partner’s sexual pain. Men’s narratives, in the main, reflected an understanding of FSP that is upheld by the medical community which locates the difficulty within the woman and focuses on treatments that target the physical pain experience (Shallcross et al., 2018). However, ahead of a diagnosis, some men drew on the notion that pain was a communication of something other than a physical problem; it signalled something was wrong in them, leaving either themselves or the sex as undesirable. Receiving a diagnosis appeared to relocate the problem from possibly being about them (and their partner not wanting to be sexual with them), to definitively being in their partner’s body. The diagnosis, or an unequivocal physical explanation, seemingly allowed men to understand FSP within a medical framework which views the body as a machine that can readily be fixed (Tiefer, 1994). Men’s experiences were then shaped by the medical system they entered as they were cast in the secondary, non-patient role. The dominant story for men was of them being unseen and ignored within the medical environment. Men largely took up supportive positions, but also evident in their accounts was a sense of impotence as they felt powerless to alleviate their partner’s distress or influence their partner’s engagement with treatment. Taken together this illustrates how the understanding of FSP that is upheld by the medical community can shape how lay people conceptualise and respond to the condition (Bell, 2016).

In addition to exploring men's sense making and their experience of the help seeking process, I also explored their views on how FSP had impacted them personally, the sexual relationship, and the relationship more broadly. Men's accounts gave an insight into the many ways in which they were negatively impacted by FSP: loosely organised around erosion of self-esteem, a sense of loss, various anxieties and shame. However, dominant in their stories was an ambivalence around whether their distress was worthy of attention. The affirmation of the problem being located in the woman's body (which is itself problematic) appeared to render them and their distress insignificant. Most men were not asked by professionals or their partner about their own experience, which seemed to leave them further questioning whether they were entitled to voice their own suffering.

The impotence and loss of agency which men experienced in the medical context, also manifested within the sexual and relational dynamic. Many men spoke of no longer initiating sex, and conversations around sex and sexual pain were viewed as difficult to pursue and were often avoided. For several men their narratives indicated concern around how any action and initiative may be experienced by their partners as perpetrating. Conversations risked burdening their partner with emotional distress, and sexual initiations likely led also to physical pain. However, when talking about the potential disruption to PVI and the sexual encounter that FSP may pose, men gave diverse accounts of their responses. Men did not uphold the imperative status of coitus. Some oscillated between complying with traditional notions of heterosex and resisting them; others conceptualised sex as involving a variety of possibilities and gave no importance to PVI. Contrary to the belief held by women with FSP that 'the one thing that men really want is sex' (Shallcross et al., 2018), for the majority of men in this study, the one thing they really wanted was intimacy and connection, either in the sexual or broader relationship. Many men did not feel their partner believed their 'intimacy-imperative' suggesting that, although FSP is not just a 'woman's matter', within some couples, the interruption to PVI was perceived as mattering more to women than to men.

Implications and Recommendations

Including Men

In line with other qualitative research that explores the experiences of men conventionally viewed as being in a secondary role to their partner (e.g., pregnancy, pregnancy loss, endometriosis, sexual assault), men in this study were largely marginalised throughout the help seeking process, despite their own psychosocial functioning being significantly impacted by FSP. In order to include men, it has been recommended that all treatment providers (e.g., doctors, therapists, physiotherapists) invite both members of the couple to attend medical appointments and therapy (Sadownik et al., 2016). In general, men may feel more meaningfully included by being invited to appointments, and by health care providers improving their interactions with them once there (by for example, addressing men by name and actively engaging them in the dialogue). However, encouraging men to attend appointments is not without complications. If the norm becomes for men to attend, then deviation from this norm may be problematic (Draper & Ives, 2013). As an example, women may feel a coercive pressure to invite men and potentially violate their own need for privacy; on the other hand, if women choose not to include men, this may generate tension within the couple. Many men in this study reported their partner chose to attend alone, and largely voiced acceptance of this out of respect for their partner's right to privacy. They also held the view that it was 'to be expected' that they weren't there. What is not known is how men would respond to being 'officially' included and then excluded by their partner. However, Draper and Ives (2013), in their examination of ethical considerations of including partners (in pregnancy care), concluded that men's interest in attending appointments, and their involvement in any decision-making regarding treatment, is ultimately trumped by the woman's preference as it is the woman's body which is acted upon.

It is also important to consider the function of including men and to question what inclusion really means. Men have been recognised as playing a valuable role in supporting women in the traumatic experiences of pregnancy loss (Williams et al., 2020) and sexual assault (Connop & Petrak, 2004). Including men has therefore been advocated to ensure men take up this role and do it well. This view has been criticised: the partner should be considered as more than just a potential supporter, as men themselves have support needs that warrant attention (Locock & Alexander, 2006). Recommendations to 'invite' partners therefore needs to be more fully considered. In the sexual pain literature, recommendations to include men in treatment have largely aimed to involve them in the mitigation of their partner's pain experience. For example, Caruso and Monaco (2019, p. 17) suggested "partners can be instructed in assisting in mindfulness or distraction to cope with the pain" exemplifying the recruitment of men into support roles. The current study, however, has clearly shown that men have their own story, and have their own intra and interpersonal difficulties which would likely benefit from support services. Medical services that are designed for men to attend *with* their partner inevitably constrain men's voicing of their own experiences (Draper & Ives, 2013). It therefore seems pertinent to acknowledge that the consultation room, in a medical setting, is not the space to attend in full to the man's experiences. Nevertheless, it can be the place where men are first signalled that their experience may require attention. Most men in this study were ambivalent about their entitlement to talk about their own feelings. Practitioners in a medical setting (GP'S, gynaecologists, physiotherapists), though not positioned to attend to the man's experiences, can serve an important role in normalising the need for men's psychosocial support, and render it as acceptable and even expected.

What Might Support for Men Look Like?

Men in this study gave various responses to wanting support and what that support may look like. Men themselves proposed receiving written educational information from professionals through to being offered counselling, both for themselves and with their partner. This suggests men's preferences for support are varied and individualised. Support groups were also suggested by some men, highlighting a potential need for networking with other men who share their experience. Although it was not the case in this study, in the context of miscarriage, men have clearly expressed a preference for online services which covered a range of engagement options, from accessing information, to participating in an online community support group (Miller et al., 2019). Men in this study did not automatically feel entitled to support; therefore, it is possible that services led or introduced by professionals may be more readily accessed. The participants in Sadownik et al.'s (2016) study suggested adding partner-specific sessions into the in-person support programme already established for women. This may offer a way of integrating men with other men, with women, and with professionals.

Additionally, some men may wish to access either individual or couple’s therapy, and I turn attention now to what may be helpful to address in the talk therapy setting, in particular within the context of counselling psychology.

Therapeutic Support and Counselling Psychology

Ahead of discussing the implications of these findings to the therapeutic work of counselling psychology, it is first necessary to consider the issue of counselling psychologists addressing sexual issues. Clients who disclose sexual issues are often informed their difficulties require a referral to a specialist therapist or sex therapy service (Pukall, 2009). Sexuality is a universal human experience, and an important dimension of overall psychological health and quality of life (Bancroft, 2009), yet training in sexual issues on doctoral training programmes for psychologists in the UK has long been argued to be insufficient (Hill, 2013). Sex and sexuality are therefore typically viewed as special areas of practice, as opposed to a general competency common to all psychologists (Cruz et al., 2017). However, there is a compelling argument that the ‘therapy’ part of ‘sex therapy’ is not distinct from other types of psychotherapies (Binik & Meana, 2009; Pukall, 2009). What sets it apart is that it ‘deals with sex’. As proposed by Pukall (2009), a separate ‘other’ category has likely been created out of general discomfort, for both practitioners and clients, around talking about anything sex related. Being a good ‘sex therapist’ can therefore involve being a good therapist overall *and* being comfortable with addressing sexual issues (Pukall, 2009). I take up the position that sex therapy is not distinct from other psychotherapies, and I view sexual issues as akin to any other facet of human existence that a client may find distressing enough to seek help for. I further contend that counselling psychologists in particular are well positioned to apply their therapeutic skills to sexual difficulties. As already discussed, the medical model approach to sexuality has been extensively criticised for its view of sexuality being a matter of an essential pan-human biology; it's production of binary 'normal' and 'abnormal' distinctions of sexual functioning; and neglecting that sexuality is socially contextualised and therefore a matter of culture and individual diversity (Kleinplatz 2012, 2018; Tiefer et al., 2002). The following priorities of counselling psychology positions the discipline as ideally suited to address these potential shortfalls and failings of the medical model: 1) an explicit use of phenomenological and hermeneutic inquiry distinguishes it from other applied psychologies (Jones Nielsen & Nicholas, 2016); 2) an expectation of counselling psychologists to recognise social contexts and value the individual's experience as it unfolds in the social and cultural dimension of living (BPS 2005; Jones Nielsen & Nicholas, 2016); and 3) counselling psychology, with its grounding in humanistic psychology, emphasises an escape from notions of diagnosis and deficit, and a movement towards embracing diversity and fulfilment (Bury & Strauss, 2006). Therefore, in addressing the implications of this study's findings to therapeutic work, I first illustrate how counselling psychology's emphasis on phenomenological models of inquiry can apply to effective practice when working with FSP. I then offer a counselling psychology approach to working with a sexual difficulty, by contextualising the individual's experience within their social environment.

Rather than splitting the client into diagnostic categories, counselling psychology focuses on the full extent of their experience (Elliott & Williams, 2003). As with the qualitative research into women's experience of FSP, this study has identified many facets of men's entire experience which may create distress and could require attention in the therapeutic setting. For example, this study illustrated the potential for men to make sense of FSP as being a communication about something being wrong within them (without an unequivocal physical cause to eliminate this option). It may take several months or even years to establish a diagnosis, and many men described self-esteem deficits, a rethinking of self and enduring self-doubt during this time and beyond. This suggests an exploration of how men may have made sense of their partner's pain, and their response to this sense making, could form an important part of the work. Men also gave accounts of varied, but distressing, emotional responses to FSP being present in their lives. These warrant attention in the same way any other painful emotions are brought to therapy. Men also described their sense of being marginalised, invisible and silenced in the medical encounter. The therapeutic setting provides a space to give voice to their experiences. Their sense of disempowerment also manifested, for some men, within the relationship and led to a reluctance to initiate either conversations or sex. This suggests consideration could be given to how they experienced themselves within the relationship generally and the sexual relationship more specifically, helping men to understand their distress before, if helpful, exploring how to bring about desired change.

Focussing on the entire FSP experience, it is evident that many aspects are only loosely related or are indeed separate from 'dealing with sex' which brings into question whether men (and women, and the couple) benefit from referral to a specialist sex therapy practitioner or service. I now however turn attention to 'dealing with sex' and offer a counselling psychology approach to addressing the findings from this study. Conventional sex therapy has been strongly influenced by Masters and Johnson's (1966, 1970) model of a 'normal' sexual response and their brief behaviourally based treatments (Kleinplatz, 2018). Traditional sex therapy therefore commonly uses CBT techniques to mitigate the woman's pain experience. This approach been criticised for its focus on removing barriers such as closed or painful vaginas to enable normal penetrative sex to resume, without regard for the meaning of the sexual encounter (Kleinplatz, 2012). In a paper encouraging counselling psychologists to integrate topics of sex and sexuality into their clinical practice, Cruz et al. (2017) recommended that, as a minimum, practicing psychologists should be aware of empirically supported treatments for common sexual concerns, and familiarise themselves with commonly used behaviour therapy interventions. Whilst this may helpfully orientate counselling psychologists toward the medical model and mainstream perspectives, I would argue that counselling psychologists are well equipped to ‘do more’. Their foothold in phenomenology, meaning making and contextualising the human experience, positions them to explore the meaning of the sexual encounter, the shaping of sexuality through interactions in the world and the power of social discourse to inform expectations of gender and sex. Essentially this involves attending to ‘everything else sexual’ that the medical model neglects.

With this in mind, the findings of the study have illustrated many lines of inquiry that could be opened up in therapy. As FSP affects the nature of the sexual relationship which both members of the couple share, much of the work on sex and sexuality is better suited to working with both members of the partnership. A very important finding was that men’s accounts contradicted taken for granted assumptions about men’s sexuality, with the majority of men upholding an intimacy imperative. This may potentially liberate some women from their fear that sexual pain, and the interruption of PVI, threatens their value as a partner and the security of their relationship (Ayling & Ussher, 2007). However, as many men gave accounts of their partner not always believing their assertions, this suggests that both members of the couple may benefit from exploring their own understandings of the expectations of heterosex; how their understandings may have been influenced by social narratives; how their individual sexual scripts may differ from cultural level scripts; and the assumptions they may have held about their partner’s notions of sex. The couple can then be encouraged to renegotiate, construct and define for themselves their own notions of sex, masculinity, femininity, practices they may choose to include and relational aspirations.

Another important finding that can be applied to the couple’s work involves the discomfort that many men expressed around being a perpetrator of pain. Women have been found to continue to have sex despite experiencing pain, due to concerns of a potential loss in their sexual ‘currency’ (Elmerstig et al., 2008; Hinchliff et al., 2012). It therefore seems essential to address how physical discomfort is communicated; expectations and acceptability of ‘refusals’ when pain is present; and experimentation with pain free sexual practices and non-sexual sources of intimacy.

Finally, in order to enable these conversations, difficulties in communication likely need addressing. Men appeared to be largely avoidant of having conversations due to the tensions and conflicts they caused. Normalising the inherent difficulties of having conversations, for both parties, and exploring effective ways to communicate, may help mitigate men's sense of ineffectiveness in bringing up and pursuing conversations and bring their voice into the dialogue.

This study has evidently illuminated many facets of men's experience which may meaningfully be explored in therapy, and I have offered some ways in which phenomenological enquiry, as used in this research, can also be applied in practice. This therapeutic approach centres the whole person and the couple experiencing a sexual difficulty. It expands upon biomedically informed treatments by giving priority to contextual factors and locating FSP within individuals' relational and social world.

Broader Implications for Understanding Men's Sexuality

This study also adds to the growing literature which has illustrated that men engage with multiple versions of masculinity and (hetero)sexuality and further supports the assumption of a monolithic masculine sexuality as misguided. As with other research into men's sexuality throughout life and in later life (Potts et al., 2006; Sandberg, 2013; Terry & Braun, 2009); in the context of cancer (Gilbert et al., 2013; Ussher et al., 2013); and for men who purchase sex (Birch et al., 2017; Hammond & van Hooff, 2020; Sanders, 2008; Shumka et al., 2017), the men in this study, in the context of FSP, resisted traditional notions of masculinity and heterosex to varying extents and their 'counter-stories' drew on expanded and diverse notions of sexuality which coveted intimacy and emotional connection. Unfortunately, it has been noted that these alternative experiences, which disrupt normative constructions of male (hetero)sexuality and masculinity, are seldom acknowledged and even more rarely presented as positive or desirable (Potts et al., 2006). More problematically alternative experiences may be pathologized with heterosexual males who prefer or need non-PVI experiences being treated as sexually disabled and requiring intervention (Diorio, 2016).

There appears to be a pressing need to make different constructions of men's sexuality and (hetero)sex more widely available in order for individuals to interpret their own sexuality positively (DeLuzio Chasin, 2011). There are nevertheless multiple ways in which traditional and restricted notions of gender and (hetero)sexuality are produced and reinforced. The media, for example, plays a major role in shaping ideals and expectations of (hetero)sex (Du Plessis, 2015). Articles offering 'sex advice' to women in magazines such as *Intimacy*, *Cleo* and *Cosmo*, have been found to represent narrow ideas of sex, sexuality and gender relations which are phallocentric and privilege PVI (Du Plessis, 2015; Farvid & Braun, 2006). Men have been constructed as desiring sex all of the time and as being potential cheaters; men's fidelity is ensured by women providing 'great sex' (Farvid & Braun, 2006). This construction of male sexuality was echoed in the current study through some men's accounts of their partner offering 'open' relationships and alternative access to problem free sex which these men did not want. Men also talked of not being believed for their own disruption of the hegemonic. All forms of media can therefore be encouraged to include diverse and broader notions of men's sexuality (and heterosexuality) that are representative of 'counter-stories' and men's own experiences.

Sexuality education has also contributed to the perpetuation of traditional gender roles and, in particular, has upheld the coital imperative in (hetero)sex through its focus on avoidance of teenage pregnancy (Allen, 2004; Hayfield & Clarke, 2012). More recent education programmes have encouraged fostering attitudes and values which promote mutually respectful and consensual partnerships; and have included addressing diversity of sexual orientations (see for example World Health Organisation, 2017). Although this can be viewed as a progressive move towards disrupting oppressive power dynamics within heterosex and the centrality of heterosexuality itself, it is also important to note how heterosexuals continue to be (mis)treated as a homogeneous group. Acceptance of diverse sexual preferences among LGBTQ sexualities is increasingly evident, however all heterosexuals are assumed to desire PVI as their ultimate sexual objective (Beasley et al., 2012). Diorio (2016) noted that heterosexuals who prefer non-coital activities constitute an invisible minority who cannot ‘come out’ because there is no such identity. There is a need therefore within sexuality education to also challenge normative understandings and diversity within heterosexuality.

Although media and education have a broad reaching influence on how men’s sexuality and heterosex is constructed, it is also necessary to consider our own involvement as counselling psychologists, either in practice or in research in perpetuating restricted and narrow notions of men’s sexuality and heterosex in general. Shah-Beckley et al., (2020), for example, found that therapists were just as likely to draw on heteronormative discourses as non-therapists in a story completion study, emphasising the need for critical understandings of sexuality to be integrated into therapist training. Researchers also need to consider the types of questions they ask and to ensure participants are given space to report attitudes, feelings and behaviours which do not conform with gender stereotypes and hegemonic notions of (hetero)sexuality (McCabe et al., 2010). Furthermore, researchers need to be encouraged to examine their own assumptions, beliefs and attitudes which they bring to the research process. I laid out my own assumptions which had been heavily influenced by the feminist literature (see Appendix M for my reflexive process). Scholarship on masculinity and sexuality within this literature has provided more negative than positive accounts (Terry & Braun, 2009). However, as the literature relating to men’s experience of FSP was very small I had to draw on ‘other’ research exploring men with ED and men who pay for sex, for example, to provide an overview of men’s sexuality. It was here that I found accounts which disrupted hegemonic notions and I was mindful of them throughout the research process. That said, I question whether I would have immersed myself in the men’s sexuality literature to the same extent if my own research involved women; would I have looked beyond accounts of women’s experiences and scholarship relating to women’s sexuality to consider men? The potential to uphold and perpetuate the taken for granted assumptions about men’s sexuality in the feminist literature (and through also being situated myself within the dominant social discourses of (hetero)sex) is obvious without access to alternative understandings. The diversity of men’s sexuality (and heterosexuality) therefore requires greater acknowledgement in research, education, and the media to provide such counter rhetoric.

Strengths, Limitations and Future Research

Strengths and Limitations

There are several strengths of this study. Firstly, to my knowledge, it is the only qualitative study to date, in the UK, that has specifically explored men's experience of sexual pain. Within the UK, Culley et al. (2017) conducted a qualitative study of men's experiences of endometriosis, and addressed sexuality and intimacy within the context of endometriosis being a chronic illness. They therefore addressed broader domains such as household income, working lives and planning to have children, however, pain during the sexual encounter was the focus of the current study. Two other qualitative studies, specifically addressing partners' experiences of FSP, were conducted in Canada (Sadownik et al., 2016) and the USA (Connor et al., 2008). The former study involved interviewing men whose partner had been diagnosed with vulvodynia and was participating in a multidisciplinary treatment programme. Men's partners were a homogeneous group of vulvodynia sufferers and, as they were all in the same treatment programme, they were also geographically restricted. In the latter study, men were recruited through more varied channels, but their partners required a very specific diagnosis which was a subset of vulvodynia. As men's experience of FSP is vastly understudied, it was my intention to explore patterns across a diverse group of men who shared the experience of their partner having pain during PVI, irrespective of their partner's diagnosis. The men in this study came from a range of networks and geographical locations within the UK, rather than through one particular service. Also, men in this study were partners of women with various diagnoses and manifestations of FSP (e.g., vulvodynia, vaginismus, menopause, lichen sclerosus, labiaplasty), women who had not yet established a diagnosis, and women who were not seeking help. The men in this study also had a broad range of ages, which further added to the strength in variation.

My chosen methodology reflected my interest in looking for commonality in a diverse group of men with experience of a heterogeneous phenomenon, as TA develops themes across cases. Braun and Clarke (2013) have however highlighted a potential weakness of TA in that the 'voice' of the individual can get lost, as the focus on patterns across the data prevents attention being given to the continuity and contradictions within an individual account. I endeavoured to highlight contradictions within men's accounts and also across the data set to capture the nuances of men's experiences. Nevertheless, there may be further important aspects of men's experiences that may be unique to particular FSP conditions, or groups of men, that were not captured in this analysis. Researchers who want to explore the voices of the individual participant in more depth, may therefore find that an IPA study of homogenous groups could yield rich findings, and further inform our understanding of men's experiences of FSP.

A further strength of this study lies in the richness of the data. Although men appeared uncertain about their entitlement to voice their own story, FSP was clearly an important topic to them, and many men gave in depth accounts of their own experiences. Whilst the data collection methods evolved according to the needs of the project, the eventual arrangement may have facilitated this. The final design offered these men an option to tell their story either via an anonymous online platform or via an interview, enabling them to choose what felt more comfortable. Also, through using the survey as a recruitment tool for interviews, men were given an opportunity to think about their experiences and communicate them in writing, ahead of a conversation with me. This design arrangement may have been well suited to both engaging men and encouraging them to speak openly about a sensitive and personal topic. From a researcher perspective, reading men's survey responses ahead of the interview enabled 'points of interest' to be noted and personalised prompts to be easily accessed.

Despite collecting rich data from this group of men, a limitation of this study lies in it offering insight into the experiences of men who are White, mostly middle class, English speaking, and who have access to health services. This mirrors the demographic details of participants in the qualitative research of women's experiences of FSP (see the systematic review Shallcross et al., 2018). However, the findings and conclusions cannot be assumed to transfer to other groups of men differing in culture, ethnicity, socioeconomic status and healthcare access. A further limitation is that all of the relationships were long term, and only two men in the study were no longer in the relationship they spoke about. The findings therefore likely represent men who have been able to adapt to their partner's pain. Despite extensive recruitment efforts to involve men more broadly, men who may experience the breakdown of relationships, due to FSP, have not been represented here. It may well be that men who prioritise the importance of PVI and consider it an imperative have not had their voices heard.

Furthermore, men's accounts of de-centring the importance of PVI and privileging intimacy may have been partly shaped by the research environment. Firstly, in considering the influence of my own gender, it is possible that men presented narratives deemed more acceptable for me as a woman to hear. I am also of a similar demographic to their partners (White and middle class) which may also have influenced how they communicated their story with me. Furthermore, it has been noted that men who volunteer to participate in sexuality research, and talk seriously about sex, may not adhere rigidly to traditional masculine practice, and possess more flexibility in their sense of sexual self (Allen, 2003). This may inform the variance in how they engaged with traditional masculinities and discourses of heterosexual sex and sexuality. Men who are willing to take part in research may therefore be different to those who are unwilling, or unable, to participate. It is also possible that the research environment offered men a unique space that differs from their daily life environment. The privacy and anonymity of the research setting has been theorised to allow men to speak about their experience without detrimentally impacting their masculine identity (Allen, 2003). It may well be that how men have talked about themselves in the research setting was influenced by the research setting itself.

Future Research

Broader scale research is now required to further explore the experiences of heterosexual men from different ethnic and cultural backgrounds. As I only involved heterosexual men, including the experiences of bisexual men and lesbian women who partner women with FSP would widen the research further. The current study did not only yield interesting insights into men's responses within the sexual relationship but also, for example, how they understood FSP and their experience of help seeking. This again would be interesting to explore in different cultures and partner dyads. Also, exploring the experiences of men who have left relationships because of an interruption to PVI, or men who are in very new or casual sexual relationships with women with FSP, would likely provide further valuable insights.

There were many aspects of men's accounts of their partner's response which were spoken about speculatively, and men seemed to understand that women may have different perspectives to theirs. It would be interesting to explore how both individuals within the same couple understand and respond to FSP, and the ways in which they overlap and diverge. An example of this could be views on masturbation in the context of FSP, as several men gave accounts of solo sex evoking shame; however, it is not known how women responded. Additionally, men's experiences of shame when masturbating may be interesting in itself to explore further.

Women's experience of sexual pain is highly diverse: it may be one aspect of a broader condition such as endometriosis or menopause; intermittent, acquired or life-long; or may be experienced during arousal without physical contact. It could therefore be valuable to explore men's experiences of the various conditions more specifically that sit under the FSP umbrella. For example, men's experiences of lifelong vaginismus which has prevented any form of penetration may differ from experiences of pain that is site specific or intermittent.

Finally, this study also highlighted that men may have their own support needs. Further research is required to better understand what type of support is the most acceptable and feasible, as men's needs likely differ from women's (Miller et al., 2019). This may also inform the support needs of men in other contexts such as menopause and pregnancy where men's experience is traditionally viewed as secondary to women's, but which has a significant impact on their psychosocial functioning.

Final Conclusions

There is an obvious benefit for women's sexual pain to be recognised, investigated and treated medically, yet there are many dimensions to the FSP experience that are not attended to within this framework. Female sexual pain occurs within the context of a relationship and I have foregrounded men's experiences due to them being integral to the entire FSP experience. Men themselves appeared drawn to the biomedical lens, yet simultaneously experienced themselves backgrounded within this view. Bringing them into focus, men were impacted in many ways by how they were (un)seen within the medical framework: they downplayed their own suffering and were ambivalent around whether their distress was worthy of attention. This positioning of men as insignificant compared to their partner (by medical professionals and men themselves), potentially influenced men's loss of agency and sense of impotence, both within the medical context, the sexual relationship and the relationship more broadly. However, through centring men's voices, it was also evident men coveted intimacy within their relationship which contradicts frequently taken for granted assumptions about men's sexuality. Many men reported not being believed by their partner, and women have previously reported being anxious about their own sexual adequacy and the security of the relationship (Ayling & Ussher, 2007). This further highlights the importance of including men, both in research and in practice, as their own views of 'what matters' can expand restricted notions of men's sexuality, help to allay women's fears and support successful navigation of this complex condition.

The aim of this research was to offer some data on a topic about which little is known. Whilst there are many more areas to investigate in this highly under-researched area, this study has demonstrated the limitations of solely viewing FSP through a biomedical lens, and the importance of a more nuanced understanding which also takes into account psychological, relational and social influences on the entire sexual pain experience. Additionally, through exploring men's experiences of FSP, this study also adds to the growing research which illustrates how men may engage with diverse, contemporary and relationship orientated forms of sexuality, interrupting traditional notions of heterosexuality.

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Appendices

Contents

Appendix A

Relevant Terminology and Classification of Female Sexual Pain

Women who experience painful PVI may be diagnosed with various conditions which fall under both psychiatric and medical classification systems.

Psychiatric Classification

Sexual pain falls under psychiatric classification when medical causes have been excluded and either psychological causes are presumed, or it is assessed that psychological processes are involved in the maintenance of pain (Flanagan et al., 2015). In the fourth edition of the Diagnostic and Statistical Manual of Mental Health Disorders (DSM-IV, American Psychiatric Association, 2000, p.554) there were two discrete diagnoses relating to female sexual pain:

i) Dyspareunia: recurrent or persistent genital pain associated with sexual intercourse.

ii) Vaginismus***:*** a recurrent or persistent involuntary spasm of the outer third of the vagina that interferes with intercourse.

In the fifth (and current) edition of the DSM, dyspareunia and vaginismus were merged due to overlapping symptomology and are now fall under '*Genito-pelvic pain/penetration disorder'* (GPPD; American Psychiatric Association, 2013 p. 437). GPPD is described as including one or more of the following four symptom dimensions:

i) difficulties with vaginal penetration during intercourse.

ii) vulvovaginal or pelvic pain during vaginal intercourse or penetration attempts.

iii) fear or anxiety about vulvovaginal or pelvic pain in anticipation of, during, or as a result of vaginal penetration.

iv) tensing or tightening of the pelvic floor muscles during attempted vaginal penetration

Medical Classifications

The experience of painful PVI also falls under medical classification systems typically defined by the area of the body or organ affected by pain (Al-Abbadey et al., 2106). Pain can occur outside of and at the entrance of the vagina (vulva), and deep in the vaginal canal or in the pelvis (Sorensen et al., 2018)..

Vulvovaginal Diagnoses

The International Society for the Study of Vulvovaginal Diseases (ISSVD) terminology has been used for over a decade by gynaecologists, dermatologists, vulvar pain specialists and researchers as a guide to diagnosing vulva pain (Bornstein et al., 2016). There are two overarching categories:

i) ‘vulvar pain caused by a specific disorder’ when a *clearly identifiable underlying cause is present* (e.g., an infection; inflammation; neurologic; trauma such as female genital cutting; iatrogenic; and hormone deficiency). Examples of known conditions are therefore herpes, lichen sclerosus, genitourinary syndrome of menopause,

ii) ‘vulvodynia’ referring to the presence of vulva pain in the *absence of known aetiology*

Although vulvodynia is a condition classified by the area of the body affected by pain, painful PVI is recognised as the most common and troubling complaint of women with vulvodynia (Mitchell et al., 2017). Various sub-types of vulvodynia such as ‘provoked vestibulodynia’ (PVD) are characterised by the specific site of pain (e.g., vestibule) and when the pain occurs (e.g., provoked by contact; Rosen et al., 2012).

Diagnoses of Deeper/Pelvic Areas

There are two diagnoses that appear in the sexual pian literature which related to deeper areas of the pelvis : ‘chronic pelvic pain’ (CPP) defined as ‘chronic and persistent pain, perceived in structures related to the pelvis’ (Engeler et al., 2019) and ‘endometriosis’ referring to a disease in which tissue that normally grows inside of the uterus grows outside of it (World Health Organisation, 2004).

Appendix B

Participant Information on Qualtrics

Information for Participants

Who are the researchers and what is the research about?

Thank you for your interest in this research. My name is Debbie Lovell and I am a psychology postgraduate student in the Department of Health and Social Sciences, University of the West of England, Bristol. I am completing this research for my Professional Doctorate in Counselling Psychology dissertation project. My research is supervised by Dr Nikki Hayfield and Dr Zoe Thomas (see the end of this Participant Information section for their contact details).

Pain during sexual intercourse has only received research attention in the last two decades. Most of this research has focused on women. Whilst understanding women's experiences is hugely important, sex is an interpersonal experience and much less is known about the experience of women's partners. The aim of this research is to better understand how men make sense of and respond to their partner's sexual pain and to increase our knowledge of how men view pain during sexual intercourse influencing the sexual relationship and the relationship in general. This can in turn inform therapeutic practice for both individuals and the couple and enhance support for anyone seeking help.

What does participation involve?

You are invited to complete an online qualitative survey (where you write the answers to questions in your own words, rather than ticking boxes). It will take around 30 minutes depending on how quickly you type and how much you want to write. There are no right answers – I am interested in the range of opinions, thoughts and experiences that people have. It would be very helpful for my research if you could provide detailed answers.

Before you complete the survey questions, you will first be asked to respond to some questions concerning your eligibility and consent to participate. Following the survey questions, there will be a section of demographic questions for you to answer (some of these will be tick box questions). This is for me to gain a sense of who is taking part in the research. Before submitting the survey, you will be invited to request more information about taking part in an interview should you be interested. You are under no obligation to take part in either the survey or an interview.

Who can participate?

Men over the age of 18, who are resident in the UK, and have been in a relationship with a woman suffering from pain during sexual intercourse or that prevents sexual intercourse. The relationship may be current or in the past. The pain must have been present for 6 months or more.

How will the data be used?

The responses you provide to the demographic and survey questions will be used for my Professional Doctorate in Counselling Psychology research project. All data will be anonymised (i.e., any information that can identify you will be removed). This means extracts from your survey responses may be quoted in my dissertation and in any publications and presentations arising from the research, but I will make sure that you will remain anonymous and will not include any identifying information. The demographic data for all of the participants will be compiled into a table and included in my dissertation and in any publications or presentations arising from the research but not in a way that any participant can be identified individually.

The information you provide will be treated confidentially and all personally identifiable details will be stored separately from the data. I will be the only person that will see the data in its entirety (i.e. your responses and your personal details). My supervisors will only have access to the data once it has been anonymised and external examiners may also request to see the anonymised data. The data will not be transferred to any other institutions. I aim to publish the study after submitting my dissertation and therefore all data will be deleted after the final output is accepted for publication. You will be offered the option of being sent a summary of findings. If you would like to receive this, you will be asked for your e-mail address. Your e-mail address will be treated as confidential information and stored on a password protected file separate from your responses to the survey question. Your e-mail address will only be used to contact you with the summary of findings and not for any other purpose. Once the summary has been sent out, your e-mail address will be deleted.

The personal information collected in this research project (e.g., online using the Qualtrics survey software, during an interview) will be processed by the University (data controller) in accordance with the terms and conditions of the 2018 Data Protection Act. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on this participant information sheet. You have a number of rights in relation to your personal data. For data protection queries, please write to the Data Protection Officer, UWE Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, or dataprotection@uwe.ac.uk

What are the benefits of taking part?

Participants in research report that they find it interesting and useful to have the opportunity to participate in a research project on issues that matter to them and that inform social and psychological understanding.

What if you change your mind and want to withdraw from the research?

If you decide you want to withdraw from the research, please contact me via email Deborah2.Lovell@live.uwe.ac.uk quoting the pseudonym (fictitious name) you will be asked to choose for yourself before completing the survey. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my dissertation. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data and at the latest by December 2019 when my data analysis will commence. I'd like to emphasise that participation in this research is voluntary and all information provided is anonymous where possible.

Are there any risks involved?

I don't anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. I hope this is not the case for you, but nonetheless, for this reason I have provided information about some of the different resources which are available to you:

The Vulval Pain Society (VPS) provides information to vulval pain sufferers and their partners and have a list of regional support groups in the UK. Please see http://www.vulvalpainsociety.org/vps/index.php/vulval-pain-support-groups/support-groups

The Vaginismus Network offer resources for women suffering from vaginismus and their partners, follow this link https://www.thevaginismusnetwork.com

The Pelvic Pain Support Network (PPSN) https://www.pelvicpain.org.uk provides information, support, advocacy, a community blog and links to specialist expertise

The College of Sexual and Relationship Therapists (COSRT) https://www.cosrt.org.uk have a listing for therapists that specialise in relationship and sexual issues

Relate http://www.relate.org.uk/ provide counselling services specific to relationships.

The Institute of Psychosexual Medicine https://www.ipm.org.uk/ have a list of doctors with specialist training in working with sexual difficulties

General counselling support can be accessed at ***Mind*** https://www.mind.org.uk/information-support or ***The British Association of Counsellors and Psychotherapists (BACP)*** http://www.bacp.co.uk/ can help you find an accredited counsellor or therapist in your area.

The British Association of Sex and Marital Therapy http://www.basmt.org.uk/ provides extensive information and helpful advice on relationship and sexual difficulties

If you have any questions about this research please contact me or my research supervisors: Deborah Lovell Email: Deborah2.Lovell@live.uwe.ac.uk; Dr Nikki Hayfield Email: Nikki2.Hayfield@uwe.ac.uk; Dr Zoe Thomas Email: Zoe2.Thomas@uwe.ac.uk ; Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY.

Appendix C

Consent Form on Qualtrics

UWE Bristol | University of the West of England

Consent Form

Before we begin, I would like to emphasise that:

- your participation is entirely voluntary
- you are free to refuse to answer any question
- you are free to withdraw at any time (within the limits specified on the information sheet)

In order to participate it is essential that you agree with all of the following statements and consent to take part:

- I have read and understood the information sheet
- I am participating in this research on a voluntary basis
- I consent to anonymised extracts from my responses being used in the dissertation report, conference presentations and journal articles
- I am either currently or was previously in a relationship with a woman experiencing pain during sexual intercourse or that prevented intercourse. The pain has been present for 6 months or more
- I am over 18 years of age and based in the UK

By ticking this box, I confirm that I agree with all of these statements and consent to take part

☐

Appendix D

Demographic and Relationship Questionnaire for the Survey and Interviews

Demographics

In order for me to learn about the range of people taking part in this research, I would be grateful if you could answer the following questions (they are either tick box or one- or two-word responses).

1. How old are you?

2. How would you best describe your employment situation?

   Full time employment ☐

   Part-time employment ☐

   Looking for employment ☐

   Not employed and NOT looking for employment ☐

   Student ☐

   Unable to work ☐

   Other ☐ Please describe

3. If you work, what is your occupation?

4. How would you describe your social class?

   Upper class ☐

   Upper middle class ☐

   Lower middle class ☐

   Working class ☐

   Lower class ☐

   No class ☐

   Other ☐ Please describe

5. How would you describe your racial/ethnic background? (e.g., White, Black, White Jewish, Asian Muslim)

6. Do you have or are you studying towards any of the following qualifications?

   GCSE/O levels ☐

   AS/A levels ☐

   Bachelors/undergraduate degrees ☐

   Post graduate degree (Masters or equivalent) ☐

   Doctoral degree (PhD, DPhil etc) ☐

   HND/Professional Qualification ☐

   BTEC/Vocational Qualification ☐

   Other ☐ Please describe:

7. Do you consider yourself to be disabled?

   Yes ☐
   No ☐
   If ‘yes’ please describe your disability if you are happy to share this

8. What is your relationship status?

   Single ☐

   Partnered ☐

   Married/Civil Partnership ☐

   Separated ☐

   Divorced/Civil Partnership Dissolved ☐

   Other ☐ Please describe:

9. Do you have children?

   Yes ☐
   No ☐

Nature of the relationship and your partner's pain

I would also like to ask some brief questions about your relationship with your partner and your partner's pain:

1. Is your relationship with a partner experiencing pain during sexual intercourse current?

   Yes ☐

   No ☐

2. How long have you been in this relationship? (If the relationship is in the past, you may want to simply give approximate dates e.g., June 2015 - Sep 2017)

3. Which of the following best describes the investigation of your partner's pain?

- The cause of pain has not been medically investigated ☐
- Investigations are ongoing ☐
- Investigations were undertaken but no cause was identified ☐
- A diagnosis has been given but it has a 'poor fit' and does not seem to explain the pain ☐
- A specific diagnosis has been given such as 'vulvodynia', 'provoked vestibulodynia'(PVD), genito-pelvic pain/penetration disorder (GPPD) or 'vaginismus' that does not link the pain to a specific medical cause ☐

  Please state the diagnosis if you know it:
- The pain is linked to a known medical/physical condition e.g., a result of surgery, endometriosis, injury ☐

  Please describe the medical/physical condition:

- Other ☐ Please describe:

Appendix E

Survey Questions on Qualtrics

The following questions were included in the survey:

1. Please could you tell me how you initially became aware of your partner’s pain during sexual intercourse? Please write as much as you are comfortable with about what happened.
2. In this question I’d like to ask you how your partner’s pain has influenced your sex life and your relationship in general. This may have changed over time, so do please write about this. I have included two different sections but please write under one section if this seems more appropriate:
    a. In what ways has your partner’s pain influenced your **sex life**?
    b. In what ways has your partner’s pain affected your **relationship in general**?
3. In what ways has difficulty with sexual intercourse affected you as an individual?
4. It is common for women to report experiencing pain during sex for months or years before an explanation or accurate diagnosis of the pain is received. During this time individuals typically have their own thoughts about what may account for the pain. How have **you** made sense of your partner's pain? This may have changed over time so please describe all of the thoughts you may have had about this.
5. Please can you describe everything you have tried in order to address and manage the experience of pain during sexual intercourse.
6. Lots of people report that it is difficult to talk about pain during sexual intercourse and its impact (although I recognise this may not be your experience). I have 2 questions to ask about this:
    a. Have there been aspects of sex and sexual pain that you have found to be difficult or impossible to talk about? If so please describe and discuss these here
    b. What have you been able to talk about regarding sex and sexual pain?
7. If you personally have sought help from professionals or joined your partner when they visited professionals, can you tell me who you consulted with and what this experience was like for you? (You do not need to give names but do tell me if they were a nurse, GP, gynaecologist, sex therapist, psychologist, counsellor etc.)
8. Are there points when you would have appreciated more support as the partner of a woman who experiences sexual pain? If so, please discuss what support would have been helpful or discuss what support you think other men might find useful.
9. What has been the most difficult part of **your** experience of your partner’s pain during sexual intercourse?

10. Have there been any positives, in your relationship or life, due to your experience of your partner’s pain during sexual intercourse? Could you please talk about these?
11. Is there anything else you would like to say about your experience, or the topic of women's sexual pain, that I have not asked you about? If so, please use this section to tell me more.

Appendix F

Interview Participant Information (Following the Survey)

Interview Participant information

Thank you very much for completing my online survey regarding your experience of your partner's pain during sexual intercourse. The next stage of my research involves inviting you to be interviewed to talk more about your responses.

This information sheet is designed to give you an overview of what taking part in an interview will involve. As with the survey, your data will be processed in a way that complies with the General Data Protection Act, and you can see the original information sheet at the following link if you want to recap on any of this or other details:

https://tinyurl.com/mensexperiencesofsexualpain

What do interviews involve?

Interviews can be conducted either via video call (*Skype* or *FaceTime)*; a telephone call; or if you live in either Bristol or London, there is the possibility of a face-to-face interview at a limited number of venues. Research interviews typically last between 45 and 90 minutes although it may take less time, depending on how much you want to say. The questions for the interview are based on the survey questions that you have already answered. As with the survey, you don't have to answer any questions that you do not want to.

On the day of the interview, I will ask you to read and sign a consent form (either on-line, or in-person depending on how the interview is conducted), I will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have. You will be given another opportunity to ask questions at the end of the interview. The interview will be audio recorded and I will transcribe (type-up) the interview.

How will the data be handled?

As with the survey, I will remove any information that may identify you or anyone else you speak about in the interview from the data. Once the transcription is complete, the audio recording will be deleted. The transcription will be stored on a password protected file and linked only with your pseudonym.

I will treat your email address as confidential information and store it in a password protected file after I have separated it from your data (so that any personally identifiable details are kept separately from the data). Once you have participated in an interview, I will only use your email address to contact you with the summary of findings (if you request this) and not for any other purpose. Once I have sent this to you, I will delete your email address.

I have also attached a Privacy Notice to inform you how the University of the West of England, Bristol (UWE) collects, manages and uses your personal data before, during and after you participate in this study.

What if you change your mind and decide to withdraw from the research?

If you decide you want to withdraw from the research please contact me via email Deborah2.Lovell@live.uwe.ac.uk quoting the pseudonym (fictitious name) you have chosen for yourself. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my dissertation. Therefore, if you decided to withdraw, this will need to be within one month of the interview.

Are there any risks involved?

I don't anticipate any particular risks to you with participating in this research. However, this is a personal and potentially sensitive topic, and this means that there is a risk that this might raise uncomfortable and distressing issues for you. Please consider carefully whether or not you want to discuss the topics that you mentioned in your survey responses with me in an interview before you agree to participate. If you need them then I have provided information again about some of the different resources that are available to you:

- ***The Vulval Pain Society (VPS)*** provides information to vulval pain sufferers and their partners and have a list of regional support groups in the UK. Please see http://www.vulvalpainsociety.org/vps/index.php/vulval-pain-support-groups/support-groups
- ***The Vaginismus Network*** offer resources for women suffering from vaginismus and their partners, follow this link https://www.thevaginismusnetwork.com
- ***The Pelvic Pain Support Network (PPSN***) https://www.pelvicpain.org.uk provides information, support, advocacy, a community blog and links to specialist expertise

- ***The College of Sexual and Relationship Therapists (COSRT)*** https://www.cosrt.org.uk have a listing for therapists that specialise in relationship and sexual issues.
- ***Relate*** http://www.relate.org.uk/ provide counselling services specific to relationships.
- ***The Institute of Psychosexual Medicine*** https://www.ipm.org.uk/ have a list of doctors with specialist training in working with sexual difficulties
- General counselling support can be accessed at ***Mind*** https://www.mind.org.uk/information-support or ***The British Association of Counsellors and Psychotherapists (BACP)*** http://www.bacp.co.uk/ can help you find an accredited counsellor or therapist in your area.
- ***The British Association of Sex and Marital Therapy*** http://www.basmt.org.uk/ provides extensive information and helpful advice on relationship and sexual difficulties

Next steps

If you are interested in taking part in an interview, please respond to this e-mail and let me know whether you would prefer to be interviewed via a video call on Skype/FaceTime, a telephone call, or (if you live or work in either Bristol or London) an in-person interview. I will then contact you to establish a suitable date and time (and if you decide on face to face, we will need to discuss what options are available for where to meet).

Appendix G

Information for Interviews (for Participants Who Did Not Participate in the Survey)

UWE Bristol | University of the West of England

Information for Interview Participants

Who are the researchers and what is the research about?

Thank you for your interest in this research. My name is Debbie Lovell I am completing this research for my Professional Doctorate in Counselling Psychology at the Department of Health and Social Sciences, University of the West of England, Bristol. My research is supervised by Dr Nikki Hayfield and Dr Zoe Thomas (see the end of this Participant Information section for their contact details).

Pain during sexual intercourse has only received research attention in the last two decades. Most of this research has focussed on women. Whilst understanding women's experiences is hugely important, sex is an interpersonal experience and much less is known about the experience of women's partners. The aim of this research is to better understand how men make sense of and respond to their partner's sexual pain and to increase our knowledge of how men view pain during sexual intercourse influencing the sexual relationship and the relationship in general. This can in turn inform therapeutic practice for both individuals and the couple and enhance support for anyone seeking help.

What does participation in an interview involve?

Men can participate by responding to an online survey or by being interviewed by me (or both). Interviews can be conducted either via video call (*Skype* or *FaceTime)*; a telephone call; or if you live in either Bristol or London, there is the possibility of a face-to-face interview at a limited number of venues. Research interviews typically last between 45 and 90 minutes although it may take less time, depending on how much you want to say. The questions for the interview are based on the open-ended questions in the online survey questions. You can find the online survey on https://tinyurl.com/mensexperiencesofsexualpain if you would like to familiarise yourself ahead of the interview. Prior to the interview I will ask for some demographic information in order to learn more about the range of people taking part in this research (if you have completed the on-line survey, I will already have this). You do not have to answer any questions that you do not want to.

On the day of the interview, I will ask you to read and sign a consent form (either on-line, or in-person depending on how the interview is conducted), I will discuss what is going to happen in the interview and you will be given an opportunity to ask any questions that you might have. You will be given another opportunity to ask questions at the end of the interview. The interview will be audio recorded and I will transcribe (type-up) the interview. The transcript is then anonymised, and the recording is deleted.

Who can participate?

Men over the age of 18, who are resident in the UK, and have been in a relationship with a woman suffering from pain during sexual intercourse or that prevents sexual intercourse. The relationship may be current or in the past. The pain must have been present for 6 months or more.

How will the data be used?

The responses you provide to the demographic and interview questions will be used for my Professional Doctorate in Counselling Psychology research project. All data will be anonymised (i.e., any information that can identify you will be removed). This means extracts from your interview responses may be quoted in my dissertation and in any publications and presentations arising from the research, but I will make sure that you will remain anonymous and will not include any identifying information. The demographic data for all of the participants will be compiled into a table and included in my dissertation and in any publications or presentations arising from the research but not in a way that any participant can be identified individually.

The information you provide will be treated confidentially and all personally identifiable details will be stored separately from the data. I will be the only person that will see the data in its entirety (i.e. your responses and your personal details). My supervisors will only have access to the data once it has been anonymised and external examiners may also request to see the anonymised data. The data will not be transferred to any other institutions. I aim to publish the study after submitting my dissertation and therefore all data will be deleted after the final output is accepted for publication. You have given me your e-mail address in order to be contacted about being interviewed. Your e-mail address is treated as confidential information and stored on a password protected file separate from your interview data. You will be offered the option of being sent a summary of findings. If you would like to receive this, your e-mail address will be deleted once the summary has been sent out. Your e-mail address will only be used to contact you with the summary of findings and not for any other purpose. If you do not wish to receive a summary, your e-mail address will be deleted after the interview.

The personal information collected in this research project (e.g., online using the Qualtrics survey software or during an interview) will be processed by the University (data controller) in accordance with the terms and conditions of the 2018 Data Protection Act. We will hold your data securely and not make it available to any third party unless permitted or required to do so by law. Your personal information will be used/processed as described on this participant information sheet. You have a number of rights in relation to your personal data. Please see the Privacy Notice for further information. For data protection queries, please write to the Data Protection Officer, UWE Frenchay Campus, Coldharbour Lane, Bristol, BS16 1QY, or dataprotection@uwe.ac.uk

What are the benefits of taking part?

Participants in research report that they find it interesting and useful to have the opportunity to participate in a research project on issues that matter to them and that inform social and psychological understanding.

What if you change your mind and want to withdraw from the research?

If you decide you want to withdraw from the research, please contact me via email Deborah2.Lovell@live.uwe.ac.uk. Please note that there are certain points beyond which it will be impossible to withdraw from the research – for instance, when I have submitted my dissertation. Therefore, I strongly encourage you to contact me within a month of participation if you wish to withdraw your data and at the latest by December 2019 when my data analysis will commence. I'd like to emphasise that participation in this research is voluntary and all information provided is anonymous where possible.

Are there any risks involved?

I don't anticipate any particular risks to you with participating in this research; however, there is always the potential for research participation to raise uncomfortable and distressing issues. I hope this is not the case for you, but nonetheless, for this reason I have provided information about some of the different resources which are available to you:

- ***The Vulval Pain Society (VPS)*** provides information to vulval pain sufferers and their partners and have a list of regional support groups in the UK. Please see http://www.vulvalpainsociety.org/vps/index.php/vulval-pain-support-groups/support-groups
- ***The Vaginismus Network*** offer resources for women suffering from vaginismus and their partners, follow this link https://www.thevaginismusnetwork.com
- ***The Pelvic Pain Support Network (PPSN)*** https://www.pelvicpain.org.uk provides information, support, advocacy, a community blog and links to specialist expertise
- ***The College of Sexual and Relationship Therapists (COSRT)*** https://www.cosrt.org.uk have a listing for therapists that specialise in relationship and sexual issues.
- ***Relate*** http://www.relate.org.uk/ provide counselling services specific to relationships.
- ***The Institute of Psychosexual Medicine*** https://www.ipm.org.uk/ have a list of doctors with specialist training in working with sexual difficulties
- General counselling support can be accessed at ***Mind*** https://www.mind.org.uk/information-support or ***The British Association of Counsellors and Psychotherapists (BACP)*** http://www.bacp.co.uk/ can help you find an accredited counsellor or therapist in your area.
- ***The British Association of Sex and Marital Therapy*** http://www.basmt.org.uk/ provides extensive information and helpful advice on relationship and sexual difficulties

If you have any questions about this research, please contact me or my research supervisors: Deborah Lovell Email: Deborah2.Lovell@live.uwe.ac.uk; Dr Nikki Hayfield Email: Nikki2.Hayfield@uwe.ac.uk; Dr Zoe Thomas Email: Zoe2.Thomas@uwe.ac.uk ; Department of Health and Social Sciences, Frenchay Campus, Coldharbour Lane, Bristol BS16 1QY.

Appendix H

Privacy Notice for All Interview Participants

Privacy Notice

Purpose of the Privacy Notice

This privacy notice explains how the University of the West of England, Bristol (UWE) collects, manages and uses your personal data before, during and after you participate in the "Men's experience of their partner's sexual pain" study. 'Personal data' means any information relating to an identified or identifiable natural person (the data subject). An 'identifiable natural person' is one who can be identified, directly or indirectly, including by reference to an identifier such as a name, an identification number, location data, an online identifier, or to one or more factors specific to the physical, physiological, genetic, mental, economic, cultural or social identity of that natural person. This privacy notice adheres to the General Data Protection Regulation (GDPR) principle of transparency. This means it gives information about:

- How and why your data will be used for the research;
- What your rights are under GDPR; and
- How to contact UWE and the project lead in relation to questions, concerns or exercising your rights regarding the use of your personal data.

This Privacy Notice should be read in conjunction with the Participant Information Sheet and Consent Form provided to you before you agree to take part in the research.

Why are we processing your personal data?

UWE undertakes research under its public function to provide research for the benefit of society. As a data controller we are committed to protecting the privacy and security of your personal data in accordance with the (EU) 2016/679 the General Data Protection Regulation (GDPR), the Data Protection Act 2018 (or any successor legislation) and any other legislation directly relating to privacy laws that apply (together "the Data Protection Legislation"). General information on Data Protection law is available from the Information Commissioner's Office (https://ico.org.uk/).

How do we use your personal data?

We use your personal data for research with appropriate safeguards in place on the lawful bases of fulfilling tasks in the public interest, and for archiving purposes in the public interest, for scientific or historical research purposes. We will always tell you about the information we wish to collect from you and how we will use it. We will not use your personal data for automated decision making about you or for profiling purposes.

Our research is governed by robust policies and procedures and, where human participants are involved, is subject to ethical approval from either UWE's Faculty or University Research Ethics Committees. This research has been approved by the Faculty Research Ethics Committee; reference number HAS.18.07.208. They can be contacted on researchethics@uwe.ac.uk for any queries, comments or complaints The research team adhere to the **Ethical guidelines of the British Educational Research Association (and/or the principles of the Declaration of Helsinki, 2013) and the principles of the General Data Protection Regulation (GDPR).**

For more information about UWE's research ethics approval process please see our Research Ethics webpages at:

https://www1.uwe.ac.uk/research/researchethics

What data do we collect?

The data we collect will vary from project to project. Researchers will only collect data that is essential for their project. The specific categories of personal data processed are described in the Participant Information Sheet provided to you with this Privacy Notice.

Who do we share your data with?

We will only share your personal data in accordance with the attached Participant Information Sheet and your Consent.

How do we keep your data secure?

We take a robust approach to protecting your information with secure electronic and physical storage areas for research data with controlled access. If you are participating in a particularly sensitive project UWE puts into place additional layers of security. UWE has Cyber Essentials information security certification.

Alongside these technical measures there are comprehensive and effective policies and processes in place to ensure that users and administrators of information are aware of their obligations and responsibilities for the data they have access to. By default, people are only granted access to the information they require to perform their duties. Mandatory data protection and information security training is provided to staff and expert advice available if needed.

How long do we keep your data for?

Your personal data will only be retained for as long as is necessary to fulfil the cited purpose of the research. The length of time we keep your personal data will depend on several factors including the significance of the data, funder requirements, and the nature of the study. Specific details are provided in the attached Participant Information Sheet. Anonymised data that falls outside the scope of data protection legislation as it contains no identifying or identifiable information may be stored in UWE's research data archive or another carefully selected appropriate data archive.

Your Rights and how to exercise them

Under the Data Protection legislation, you have the following qualified rights:

(1) The right to access your personal data held by or on behalf of the University;
(2) The right to rectification if the information is inaccurate or incomplete;
(3) The right to restrict processing and/or erasure of your personal data;
(4) The right to data portability;
(5) The right to object to processing;
(6) The right to object to automated decision making and profiling;
(7) The right to complain to the Information Commissioner's Office (ICO).

Please note, however, that some of these rights do not apply when the data is being used for research purposes if appropriate safeguards have been put in place.

We will always respond to concerns or queries you may have. If you wish to exercise your rights or have any other general data protection queries, please contact UWE's Data Protection Officer (dataprotection@uwe.ac.uk).

If you have any complaints or queries relating to the research in which you are taking part please contact either the research project lead, whose details are in the attached Participant Information Sheet, UWE's Research Ethics Committees (research.ethics@uwe.ac.uk) or UWE's research governance manager (Ros.Rouse@uwe.ac.uk)

v.1: This Privacy Notice was issued in April 2019 and will be subject to regular review/update.

Appendix I

Interview Consent Form

UWE Bristol | University of the West of England

Interview Consent Form

Thank you for agreeing to take part in an interview for my research on men's experiences of their partner's sexual pain. I would like to emphasise that:

- Your participation is entirely voluntary
- You are free to refuse to answer any question
- You are free to withdraw at any time (within the limits specified on the information sheet).

In order to participate it is essential that you agree with all of the following statements and consent to take part:

I have read and understood the 'Information for Interview Participants' and the 'Privacy Notice' ☐

I am participating in this research on a voluntary basis ☐

I consent to anonymised extracts from my responses being used in the dissertation report, conference presentations and journal articles ☐

I am currently or was previously in a relationship with a woman experiencing pain during sexual intercourse or that prevented intercourse. The pain has been present for 6 months or more ☐

I am over 18 years of age and based in the UK ☐

By ticking this box, I confirm that I consent to take part ☐

If handing over a hard copy of this form, please sign to confirm your consent to participate in the research:

____(Signed)

____ (Printed)

_______________ (Date)

This research has been approved by the Health and Applied Sciences Faculty Research Ethics Committee (FREC) ref: HAS.18.07.208.

Appendix J

Recruitment Process

There were two major branches to my recruitment channels which I labelled ‘indirect’ and ‘direct’ connection with potential participants. The first branch ‘indirect’ was the initial branch and incorporated what may be deemed to be very typical recruitment routes when targeting a large and geographically dispersed sample: ‘others’ are called upon to disseminate ‘calls to participate’. The second ‘direct’ branch involved connecting ‘in-person’ with potential participants and was added in response to challenges and insights as the recruitment process evolved. Initial recruitment targeted participants for the online survey only, however, when interviews were added as a method of data collection, all artwork and copy was amended to reflect this. The recruitment channels remained unchanged. In the following outline I am therefore referring to efforts to access men for the study in general.

Indirect Connection With Potential Participants

In this branch I involved organisations who provide support services for women with FSP and other therapists who work with sexual difficulties.

Recruitment Through Organisations

I contacted organisations that hosted relevant websites which may be accessed by men or had communication channels with women experiencing FSP who could potentially pass on information to their partners. The response was varied, and I will therefore focus on the organisations who engaged with promoting my research. ‘Vaginismus Awareness’ is a website for vaginismus sufferers hosted by Sh! Women’s erotic emporium, a ‘sex shop’ in London founded and run by women, for women. They e-mailed information about my research to women on their list of vaginismus sufferers. They also connected me with the Vaginismus Network who are a support group run by women with vaginismus. They distributed flyers at their peer support events (see Figure J1 for a sample flyer).

Figure J1

An Example of a One-Page Flyer

Participants needed for research

Painful Sex?

Approximately 1 in 10 women experience pain during sex. Whilst understanding women's experiences of this is hugely important, sex is an interpersonal experience and much less is known about the experiences of women's partners.

A new study aims to better understand how men, in heterosexual relationships, make sense of and respond to their partner's pain and difficulty with sexual intercourse. It is hoped this research will inform how to better support both individuals and the couple.

There are 2 ways for men to participate:

Via an anonymous online survey
https://tinyurl.com/mensexperiencesofsexualpain

Or

Via a confidential interview
with the researcher
Please contact
Deborah2.Lovell@live.uwe.ac.uk

UWE Bristol | University of the West of England

This research has been approved by the UWE Faculty Research Ethics Committee reference number HAS 18. 07. 208.

Note. A one-page flyer allowed for hard copies to be mailed out and also to be e-mailed as an attachment which could be forwarded to potential participants. Flyer produced by Oldroyd Publishing Group Ltd.

The Vulval Pain Society (VPS) is a UK registered charity which supports vulval pain sufferers. They posted a detailed 'call to participate' on their homepage and also on a 'current research' section on their site (see Figure J2). The VPS provide support for a broad range of vulval pain conditions and in addition to hosting a website, also run local support groups and a national conference. The in-person support groups are for women only, but at the time of recruitment a link to a Facebook support group for partners was posted on their website, and they actively encourage partners to attend their conferences (see Direct Communication With Potential Participants and Related Professionals).

Figure J2

The Vulval Pain Society's Website Posting

University of the West of England (Bristol, England, UK)

Subject: Men's experience of their partner's pain during sexual intercourse

Contact: Debbie Lovell at Deborah2Lovell@live.uwe.ac.uk

Details and requirements: Pain during sexual intercourse has only received research attention in the
decades. Within heterosexual relationships, most of this research has focused on women. Whilst un
women's experiences is hugely important, sex is an interpersonal experience and much less is know
experience of women's partners. The aims of this study therefore are to better understand a) how m
of and respond to their partner's sexual pain, and b) how men view possible difficulties with sexual i
influencing their sexual relationship, their relationship in general and themselves individually.

Participation in this study involves responding to an anonymous online survey. In order to capture th
varied experiences that men may have, questions are answered in respondents' own words rather t
from a fixed choice of answers. The survey takes about 30 minutes to complete depending on how
and confidentiality of all data will be rigorously maintained. At the end of the survey, participants will
request more information about a potential follow up interview, in order to talk more about their resp
to participate in the study, men must be over the age of 18, resident in the UK and have been in a re
woman suffering from pain during sexual intercourse (or pain that prevented intercourse). The relati
current or in the past. The pain must have been present for 6 months or more.

The research will be used to better inform therapeutic practice for both individuals and the couple ar
support for anyone seeking help.

Website: The survey can be directly accessed through the following links:

https://tinyurl.com/mensexperiencesofsexualpain

or

https://uwe.eu.qualtrics.com/jfe/form/SV_7R4WqXlJcWtGXRP

Alternatively, you can use a smartphone to scan the QR code below.

(Correct as at 3 July 2019)

Connecting to Participants Through Practitioners

I also e-mailed information about my research to individual therapists specialising in sexual and relationship difficulties who are listed on the College of Sex and Relationship Therapy (COSRT) directory. The response rate from therapists was very low and some voiced ethical concerns around inviting their clients to participate in research. I therefore contacted the CEO and the Head of Standards at COSRT to discuss this. They did not consider therapists passing on information about research to clients violated their ethical standards and encouraged me to pursue it. COSRT posted recruitment information in their newsletter to professionals which seemingly served to endorse therapist involvement. Whilst discussing ethical considerations of therapists involving clients in research, it is also important to note that I was working with couples on sexual pain difficulties in private practice. I considered involving my own clients in this research could potentially compromise our therapeutic work as I would have a dual relationship of therapist and researcher with the man and a dimension to the relationship which excluded the woman. There was also a concern of whether clients would feel their participation to be voluntary or obligatory if the researcher is their therapist. I therefore chose to involve therapists in a manner that involved simply ‘passing on’ information (flyers, links etc.) which directed men directly to the survey or myself and did not involve the therapist again. This pathway was designed to mitigate the risk of men feeling their participation was ‘expected’ by their therapist.

This branch also involved contacting other professionals such as physiotherapists and gynaecologists who worked with FSP. In an attempt to specifically target practitioners with a particular interest in this topic, I searched online for individuals who had spoken at a conference, been involved in training, had written about the topic, or spoken on radio programmes. There was a small response from this group, and I mailed flyers to them for handing out to potential participants (if men attended appointments) or to women to pass on to their partners. I also e-mailed a digital flyer which they could forward to clients/patients.

Insights From the Initial Recruitment Process and Consequent Adjustments

Most of these channels relied on women to engage their partners, apart from websites which men may access directly. The number of men recruited was very low and I needed to ‘cast different nets’ to access this hard-to-reach population. I therefore submitted an application to UWE FREC to amend the original recruitment routes I had proposed. I broadened them to involve more organisations and include more interfaces such as social media, personal websites and conferences. On approval I launched a Twitter campaign by making connections with ‘influencers’ to retweet calls to participate. I could then target men in general through various men’s groups (e.g., Inside Man; Male Positive Media; Men and Boys Coalition; Men and Boys Initiative) and speak directly to them (see Figure J3).

Figure J3

Sample of Artwork for the Twitter Campaign Targeting Men

Academic Research Study

MEN'S EXPERIENCE OF THEIR PARTNER'S PAIN DURING SEXUAL INTERCOURSE

This research will be used to better inform therapeutic practice for both the individual and the couple

Artwork adapted from a photo by Ana Francisconi on Pexels

I also developed different artwork and copy for groups such as Pelvic Roar Physiotherapy and Menopause Café who were more likely followed by women for them to potentially involve their partners (see Figure J4). Furthermore, I involved professional organisations such as the Centre for Psychosexual Health and individual practitioners who may have either men, women or couples as followers.

Figure J4

Sample of Artwork for the Twitter Campaign Targeting Women to Involve Their Partners

ARE YOU SUFFERING FROM PAIN DURING SEX?

WE NEED YOUR PARTNER FOR ACADEMIC RESEARCH

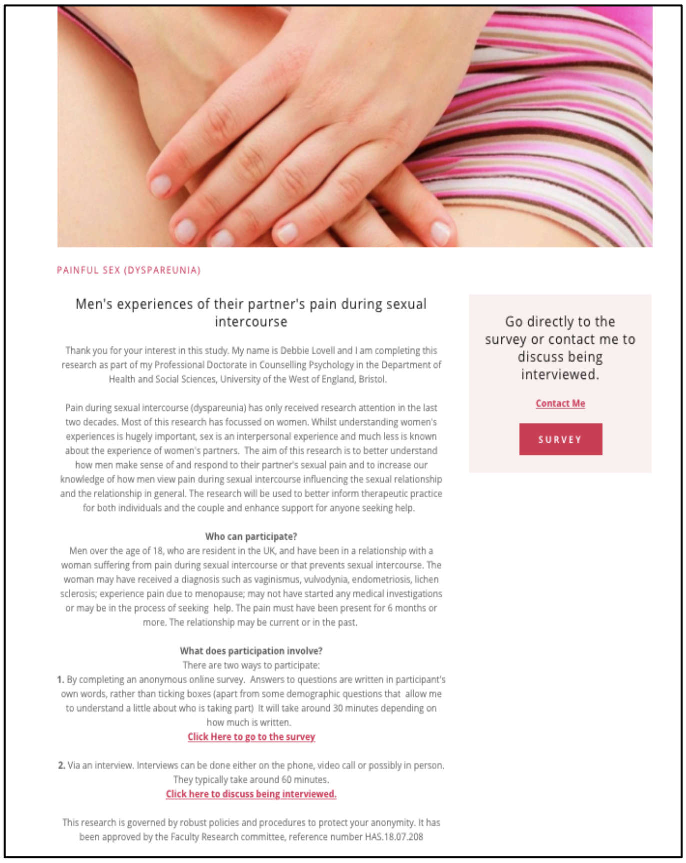
This research will be used to better inform therapeutic practice for both the individual and the couple

Artwork adapted from a photo on Pexels

There was an increase in visits to the online survey in response to this campaign, however, engagement with the survey remained low. Embedded in all Twitter postings was a link to the survey. The first interface with the survey involved a necessary but long section on ‘Participant Information’ which I considered may serve as a barrier to engagement. I therefore included a page on my own professional website which introduced the research in a briefer way and linked the Twitter campaign to this page (see Figure J5). Potential participants were given the option to then go to the Qualtrics survey via a link or contact me directly at my University of the West of England e-mail address if they were considering being interviewed.

Figure J5

The Research Posting on My Own Website debbielovell.com



PAINFUL SEX (DYSPAREUNIA)

Men's experiences of their partner's pain during sexual intercourse

Thank you for your interest in this study. My name is Debbie Lovell and I am completing this research as part of my Professional Doctorate in Counselling Psychology in the Department of Health and Social Sciences, University of the West of England, Bristol.

Pain during sexual intercourse (dyspareunia) has only received research attention in the last two decades. Most of this research has focussed on women. Whilst understanding women's experiences is hugely important, sex is an interpersonal experience and much less is known about the experience of women's partners. The aim of this research is to better understand how men make sense of and respond to their partner's sexual pain and to increase our knowledge of how men view pain during sexual intercourse influencing the sexual relationship and the relationship in general. The research will be used to better inform therapeutic practice for both individuals and the couple and enhance support for anyone seeking help.

Who can participate?
Men over the age of 18, who are resident in the UK, and have been in a relationship with a woman suffering from pain during sexual intercourse or that prevents sexual intercourse. The woman may have received a diagnosis such as vaginismus, vulvodynia, endometriosis, lichen sclerosis; experience pain due to menopause; may not have started any medical investigations or may be in the process of seeking help. The pain must have been present for 6 months or more. The relationship may be current or in the past.

What does participation involve?
There are two ways to participate:
1. By completing an anonymous online survey. Answers to questions are written in participant's own words, rather than ticking boxes (apart from some demographic questions that allow me to understand a little about who is taking part) It will take around 30 minutes depending on how much is written.
Click Here to go to the survey

2. Via an interview. Interviews can be done either on the phone, video call or possibly in person. They typically take around 60 minutes.
Click here to discuss being interviewed.

This research is governed by robust policies and procedures to protect your anonymity. It has been approved by the Faculty Research committee, reference number HAS.18.07.208

Go directly to the survey or contact me to discuss being interviewed.

Image used on the website adapted from photo by Voyagerix on iStock

I also considered that my own anonymity to participants may be problematic. I had read members of the public’s responses to appeals to participate in research on a website ‘Mumsnet’.

One woman expressed her concern about not knowing who was behind a study on genital esteem and had written about the possibility of a 'perv' collecting their stories. My anonymity was also seemingly emerging as a problem for other professionals who I was attempting to engage in passing on information about my research. For example, I received a response from a professional who candidly said they would not be able to help "as I don't know you". I had relocated to the UK at the start of this research and therefore had a very limited professional network. To counter being 'unknown' to both participants and professionals, I developed the second major branch of recruitment which involved me being 'in-person'.

Direct Communication With Potential Participants and Related Professionals

In an effort to improve researcher visibility and accountability I negotiated attending two conferences as a delegate whilst displaying a 'call to participate' in the exhibition area. I 'exhibited' a pull-up banner (Figure J6); was able to speak to attendees about my research; and hand out

Figure J6

The 'Call to Participate' Pull Up Banner

Introduction
Sexual pain is an interpersonal experience. In the context of heterosexual relationships, there is a solid body of evidence addressing women's own experience but little is known about their partner. **This study aims to explore men's lived experience of women's sexual pain.** A better understanding of men's experience can inform effective treatment for both individuals and the couple.

How is the data collected?
Two qualitative methods of data collection are being used: an online survey and semi-structured interviews. Both allow for men to identify their own key issues and for rich detailed data to be collected as questions are open ended and answered in men's own words. Surveys are ideally suited to exploring sensitive topics due to the privacy and anonymity offered. They also enable a wide-angle view as more men can be reached. Interviews allow for more in-depth exploration of men's experiences and perspectives.

Who can participate?
Men must be aged 18 or over, resident in the UK, and have experience of being in a relationship with a woman who experiences pain during sexual intercourse or that makes intercourse impossible. The relationship can be current or in the past.

How will the data analysed?
Thematic analysis (TA) will be used to analyse the data. TA is a systematic method of identifying themes and interpreting patterns across the data set and is particularly suited to under-researched areas.

Researcher:
Debbie Lovell

Supervisors:
Dr Nikki Hayfield
Dr Zoe Thomas

Participants needed for current research:

Men's experience of Women's sexual pain

UWE Bristol
University of the West of England

Banner produced by Oldroyd Publishing Group Ltd.

professionally printed foldable leaflets (Figure J7). The latter could accommodate more information about the study than the single page flyer I was previously using. The first conference was organised by the Vulval Pain Society and was attended by vulval pain sufferers, their partners and multidisciplinary practitioners. I was given time between conference presentations to talk about my research on stage. Several men approached me to discuss my research and many professionals collected leaflets to take back to their practice sites. The second conference was organised by the British Society for Sexual Medicine and was attended by multidisciplinary professionals only. Again, several delegates took leaflets away with them.

Figure J7

The Foldable Flyer

Participants Needed

Men's experience of Women's sexual pain

UWE Bristol University of the West of England

Why this research?

The bulk of research on women's sexual pain has focused on the reduction of pain. However research that has given voice to women's lived experiences has identified other central areas of distress. Women have spoken, for example, about a struggle to have their pain legitimised and their sense of 'not being a real woman' when sex* becomes difficult or impossible. This body of research on women's experiences has illuminated key areas to address in the help seeking process.

Painful sex is also an interpersonal experience and therefore there have been many calls to include partners in research. However, in the context of heterosex, little is known about men's perspectives and responses to women's sexual pain. A better understanding of men's experience can further inform more effective treatment for both individuals and the couple.

How is this research being conducted?

There are two methods of data collection: an anonymous on-line survey and interviews. Both allow for men to identify their own key issues and for rich detailed data to be gathered as questions are open ended and answered in men's own words. Online surveys allow complete anonymity and are ideally suited to exploring sensitive topics (a pseudonym/fictitious name is used). Depending on how much men write, the survey typically takes around 30 minutes to complete. Interviews allow for even more in-depth exploration of men's experiences and are conducted by the researcher either via telephone, video-call or in-person. Interviews typically take around 60 minutes (again depending on how much men want to say).

All participants are given detailed information about what participation involves and the robust procedures that are in place to protect anonymity and confidentiality before consenting to participate. This is a requirement of all academic research.

Who can participate?

Men need to be aged 18 or over, resident in the UK, and have experience of being in a relationship with a woman who experiences pain during sexual intercourse or that makes intercourse impossible. The pain must have been present for 6 months or more and the relationship can be current or in the past.

* 'sex' and 'sexual' refers to penile-vaginal intercourse. This is used for ease of reading and does not represent a view that 'sex' is in any way limited to penile-vaginal intercourse.

How to get involved

- Men can access the anonymous online survey directly using the following link

https://tinyurl.com/mensexperiencesofsexualpain
or QR code.

At the end of the survey there is an option to be contacted about potentially being interviewed

- Men can also contact the researcher directly on Deborah2.Lovell@live.uwe.ac.uk if interested in being interviewed.

Note. This flyer used for handing out at conferences and mailed to potential recruiters to hand out but was nor suitable for e-mailing. Flyer produced by Oldroyd Publishing Group Ltd.

Professionals appeared to be very interested in my research when I engaged with them in-person. I therefore considered how I could potentially develop a relationship or be experienced as more 'known' or 'visible' with the professionals I had been trying to engage via e-mail. I recontacted them with an invitation to connect on Linked-In which allowed a viewing of my profile photo and biographical information. If they connected with me, I then e-mailed them with information about my research. Compared with e-mail, the response rate from allied professionals was noticeably higher through this channel.

Evaluation and Reflection of the Entire Recruitment Process

Recruitment efforts by the end of the process looked vastly different to how I had initially conceptualised them. It therefore seems worthwhile to review the entire process with a view to evaluating the effectiveness of the different recruitment routes and also offering insights into how the experience of this process may have shaped my analysis.

There is no simple answer to the question ‘which recruitment channels were effective?’ I did not ask men how they had found out about the research on the survey and in hindsight it would have been a useful question to incorporate. I am however able to offer information on the men I interviewed. Two men came from the VPS conference. There were only 5 partners who attended the conference, four of whom came to speak with me. Of these four, three volunteered to be interviewed and one said he would fill in the survey. The third man who had expressed an interest in being interviewed was not able to and he completed the survey instead. Another participant came indirectly from the conference as he explained that his wife was part of a support group and he thought someone else in the group had attended a conference and passed on information. Four men had accessed the VPS website, two came via professionals (talk therapists) and one couldn’t recall exactly saying he had ‘seen it somewhere’. The recruitment routes were therefore varied and likely speaks to the necessity of using multiple methods of communication. My own sense was legitimising the research through association with ‘credible’ and ‘trustworthy’ organisations and professionals resulted in better engagement, though this was not always the case. There may also have been an additive effect of two or more channels which influenced men to participate. For example, the men who came to the conference may have read about my research on the VPS website, seen the banner, read the leaflets and had a conversation with me. It is also worth noting the potential for the opposite to happen, with men hearing about the research third party (as in the interviewee whose wife is part of a group) or ‘reading it somewhere’. Using multiple routes and adapting and responding to potential obstacles as they emerge may be critical to accessing hard-to-reach participants.

The difficulties I encountered may be due to sexual issues being intrinsically uncomfortable to talk about, or men being difficult to recruit (Connop & Petrak, 2004; Sadownik et al., 2016). However, I felt these men were particularly difficult to access due to them being ‘outsiders’ in the FSP experience. The organisations who provided support for sufferers of FSP largely focussed on women. Health professionals (apart from talk therapists who may work with the couple) attend to the woman. A gynaecologist who I spoke with at a conference illustrated men’s exclusion when she said, “goodness we don’t even think about them”. I was therefore relying heavily on women to pass on information and possibly encourage their partners to participate. Women themselves can act as gatekeepers and seemingly took up varied stances. A couple of women who I met at the VPS conference spoke of how they would ‘get their partners to join in’. On the other hand, one man who had completed the survey and voiced his interest in being interviewed, later e-mailed to say his wife did not want him to speak with me. A sense of men being on the outside of the help seeking process and their experience being secondary to women’s emerged in the recruitment process. Familiarisation with the data is the first stage of thematic analysis; arguably I was immersed in aspects of men’s stories during this phase of the project. My experience of recruitment likely shaped my development of ‘Men Are Not the Patients, Women Are’ and ‘Downplaying Suffering: My Experience Doesn’t Matter…And Yet’ themes.

Appendix K

Demographic Information for All Participants

Descriptor	Number of Participants
Age	
20-29	7
30-39	6
40-49	2
50-59	2
60-69	8
70+	1
Employment	
Full-time	17
Part-time	3
Looking	1
Retired	5
Social Class	
Middle	20
Working	4
Did not respond	2
Education level	
N/A	2
GCSE	2
A level	3
BTEC/HND	4
Undergraduate degree	6
Post-graduate degree	8
Doctoral degree	1
Self-described race/ethnicity	
White	24
Arab	1
No response	1
Relationship status	
Single (and relationship discussed is past)	2
Partnered	11
Married	13
Length of relationship	
6 months to 1 year	2
1-5 years	6
6-10 years	5
11-15 years	3
16-20 years	3
21-25 years	1
26 -30 years	1
30 year +	5

Appendix L

Partner's Diagnosis or Stage of Investigation Information

Partner's diagnosis/medical explanation or stage of investigation (in men's own words if known)	Number
Vulvodynia	5
Lichen sclerosus	4
Vaginismus	2
Menopause (or vaginal atrophy due to menopause)	2
Provoked vestibulodynia (PVD)	2
Polyps	1
Consequence of labiaplasty	1
Consequence of prolapse repair after hysterectomy	1
Osteoporosis and chronic pelvic pain	1
Investigations have been made but no diagnosis given	1
Investigations are ongoing	2
No investigations have been made	3
Diagnosis is known to partner but not to him	1

Appendix M

Reflexivity Ahead of Data Analysis

The role of the researcher in knowledge production is at the heart of reflexive TA (Braun and Clarke 2019). Themes in reflexive TA are actively created by the researcher through reflective engagement with data and reflexive engagement with the analytic process. I have offered my reflections on the recruitment process which largely shaped my own understanding of men's position within the help seeking process ahead of data analysis (see Appendix J 'Evaluation and Reflection of the Entire Recruitment Process' p. 149). Here I lay out the assumptions I held about masculinity and men's sexuality which needed to be interrogated as I engaged with the data.

Through my own immersion in the critical feminist literature relating to FSP, I had read about predominantly problematic constructions of heterosex and accounts of women considering themselves to be inadequate lovers; viewing FSP as threatening the security of their relationships; and women continuing to have PVI despite it being painful in order to secure their relationship. Based on this literature I anticipated that some men would, to varying extents, talk about their frustrations around not having access to PVI, potentially disclose 'affairs' and in some way 'blame' their partner for an inadequacy they viewed as residing in her. I had also read a very separate literature on men's sexuality in which the hegemonic construction was resisted by some men. In literature relating to erectile dysfunction, aging, cancer and procurement of sex, some men were giving accounts of sex and sexuality which differed from notions seemingly drawn on in women's experiences of FSP. I also had my own experience of relationships with men in my social world and had encountered men in my clinical work which disrupted traditional notions of masculinity and men's sexuality. These together provided a small catalogue of 'other possibilities' to look for and be open to; nevertheless, I considered them to be 'counter' and disruptive, not as 'normative' and expected against the weight of the more robustly acknowledged notions of men's sexuality.

I had also read feminist literature which explored power dynamics in interviews, in particular when women interview men (e.g., Vogel, 2019). Accounts of the ways in which men assert their dominance and undermine the position of the researcher alongside strategies to manage power dynamics are frequently cited (Holmgren, 2011). The nature of my research required that I invite men to talk explicitly about their sexuality and sexual experiences. Going into the interviews, I held an assumption that some men may engage in sexist or misogynistic talk. I also expected that some men would engage in ‘compensatory practices’ to express their masculinity or dominance to me. The men I interviewed however were notably respectful (my noticing likely due to this contradicting my expectation that I would experience, at some points, ‘assertion’ by these men). Some men appeared to respect my interview schedule by suggesting I didn’t let them ‘waffle on’ about irrelevant topics, and checking it was ‘ok to talk about this now’ when entering into a different topic from which I had asked about. One participant ‘checked in’ regularly “is it ok to talk about this?” when talking about specific sexual acts such as masturbation, seemingly concerned he may harm me with his talk. In addition to men being respectful and considerate of me as a researcher, there was also an absence of sexist or misogynistic talk. There were very few obvious instances in which men engaged in compensatory practices to assert their masculinity and dominance. One participant told me, “I have a big penis” (in offering his sense making about his partner’s pain). I startled, not because it was disturbing to me or viewed as a form of ‘grandstanding’, but because of the striking contrast of this declaration to his otherwise self-questioning and self-denigrating narrative. My experience of interviewing men therefore contrasted accounts I had read in the feminist literature. Holmgren (2011, p.365) noted “the social category of men at times seems almost stereotypically constructed” as she reflected on her own experience of interviewing men. She too spoke of how much is written about power dynamics in cross gender interviews and her own contrary sense of ‘having fun’ and not encountering any overt sexism or feeling threatened.

Alternative accounts of men’s sexuality and masculinity are more rarely acknowledged (Potts et al., 2006) and their absence challenges the (novice) researcher to assert claims which may disrupt the hegemonic. This speaks to the importance of continued reflection and reflexivity throughout the research process. Through identifying my own assumptions, they could be interrogated to see whether they hold, and used as prompts to notice features in the data that may otherwise have been overlooked. Additionally, reflection throughout the whole research process (immersion in a varied literature, recruitment and data collection) potentially led to a better understanding of men’s experiences which I could more accurately represent as I interacted with the data.

Appendix N

Sample of Transcript Coding

This is a sample of coding for lines 72-90 of transcript for P1. All coding is in italics. Some text is assigned more than one code indicated by a backslash.

DL: How were you making sense of this when this was happening?

P1: Yeah well I'm a very logical person (*sense making can be logical or illogical*) emm I don't want to be too general and say that many men are (*logic is masculine*) but I'm very black and white so I was you know, initially (*there are different stages to sense making/ sense making changes*) it was I'm sure it's something she's eaten (*the problem is in her/this is his own explanation*) or we thought a lot that it was thrush (*problem is in her/a shared explanation)* emm that it was something that we could buy some medicine across the counter for *(medicine can fix this/shared pronoun*), that sort of thing. So, my kinda thinking is very logical. It must be *this,* if it's not *that* it must be *this* you know, I was trying to find a box to sort of put it in *(pronoun shift/FSP has a logical explanation/ ruling out, eliminating/ FSP has one explanation)* , if that makes sense, emm yeah so from that kind of very trying to work out , it seems very confusing now *(perspective changes over time)* but there was kind of like weeks when we weren't really talking about it *(FSP story has chapters / active becomes inactive*) it was kind of like this big elephant in the room for quite a long time *(FSP is a taboo subject/conversations are difficult/conversations are avoided)…* I would say a good, from the first sign of symptoms to getting a diagnosis was like, the best part of a year or maybe like 9 months, or something like that (*the journey is long /pre-diagnosis is an era/ a diagnosis changes sense making/ diagnosis is a landmark*) and they were quite difficult (*FSP is difficult/FSP story has chapters).*

Appendix O

Creating and Noting Codes

Figure O1

'Post–It's on the Wall as Codes Are Created

Appendix P

Codes for One Participant

Below are codes for Participant 1 at the end of two rounds of coding. They have been roughly clustered and codes with identical meanings collapsed into one.

Sense making varies (within the individual)
Sense making is logical and illogical
Physical come to mind first; possibilities are many
Intermittent pain confuses the sense making
Logic is masculine
A ‘logical’ explanation must be found
Non bio explanations are illogical
Considering non-bio possibilities is hysteria/ridiculous (in men)
Psychological underpinnings cannot be ‘seen’/confirmed
Reassurance is not possible (that it’s not him)
Irrational cannot be spoken about
The problem is me
I am not enough
I must fix me
Compulsive changing of self through exercise
Her pain may be an excuse
Problem is in her, me, us (relocating the problem)
Pronouns shift
Self-esteem erodes
Re-thinking self in other domains
Erosion of self cannot be contained
Self-concept is altered
I am inadequate and need to hide
Wounding is enduring
Personhood is thwarted
Doctors accused him of infidelity
‘Problem is in him’
He is the problem until a test can exonerate him
Partner is re-thinking him
Her difficulties are worsened by stress (the problem is in her)
Hindsight can see she anticipated pain
Real time and retrospective awareness are different

A diagnosis is a quest
FSP is an actual ‘thing’
Relief of a diagnosis
Relief of the cause being biomed
A biomed explanation allows the couple to come together to solve
A biomed explanation signals safety for him
Exoneration allows ‘stepping up’
Regaining agency through ‘heroic’ supporting
Agency through care work
Biomed explanation mitigates blaming
Psychological explanations invite blaming

Biomed solutions redirect attention back to her (and away from the problem being in man)
A diagnosis without a solution brings more despair
Effort is focussed on the pursuit of a fix
Finding answers is a quest
Medicine can fix this
Biomedical solutions are logical
Sexual difficulties are biomedical
Logical/biomed thinking provides an anchor in the chaos
Difficult emotions are fled from via problem solving
Contesting masculinity, men can cry
Illness quest narrative
Problem solving can be frantic
Medical interventions that mitigate pain and allow PVI are pursued

FSP starts to influence the relational dynamic
FSP doesn't fit the biography of the couple
On the outside we are perfect, on the inside we are broken
Couple biography is interrupted
FSP interrupts life/relationship trajectory
Sweet has soured
Re-thinking her
Reconstructing who they are

Distance is created by approaches being blocked
He is increasingly shut out (conversations, touch)
Inactivity/passivity inevitable part of being rejected/pushed aside
Absence of agency, impotence
Masculine 'active' script cannot apply
His hard work goes unrewarded
He is pushed aside
He is on the outside/ shut out
Partner also keeps his experience on the outside (not just med profession)
Partner is offended he is asked (about his feelings in therapy)
Own process never processed
His pain is concealed from the partner
Attention on the woman's pain leaves his neglected
My experience doesn't matter
My pain is irrelevant
Attention on man's pain feels odd
Stoicism is masculine
Intense emotional experience is bottled up
I am not normal (if not having PVI)
Re-thinking self
Own experience has been ignored/neglected
I don't have the right to speak
My partner is not interested in my experience
Her pain is greater than mine
My pain is not as great and yet I have enormous pain
I am in pain and I cannot speak about it
It is not manly to speak about own vulnerability
Men talk about fixing not feeling

Nothing is certain, (self, her, causes)
Solid becomes uncertain
Nothing is known
Secure base has gone
Nothing can be known or trusted
Re-thinking of self, relationship and future
Questioning/reconstructing who they are and how the future is imagined
Vulnerability cannot be spoken about, anger can
Not being able to fix is frustrating
Helplessness
Perpetrator of pain
Nothing I do is right
His role is to bottle up his own emotions

Sex has an obvious end goal
Sexual frequency is a measure of success
Sex becomes an endeavour
Sex happens on special occasions
Special occasion sex increases success pressure
Low frequency of sex increases pressure to succeed on the sexual occasions
Original prizing of PVI has changed (via therapy)
PVI is the ultimate destination
Foreplay is a lesser experience
PVI is the standard
Virility expressed (to researcher)
Sex without PVI is good enough
Sexual repertoires can be expanded
PVI is banned to allow exploration
Sex needs a stress-free environment
Perspective of sex needs to be expanded to allow for possibilities
Intimacy is craved for

Partner assembles a wall
The wall is impenetrable
Sexual urges are inevitably present
Masturbation needs to be kept secret
Desire needs to be hidden
Masturbation feels like cheating
Masturbation is at least something I can do
Masturbation causes further isolation
Masturbation creates further disconnect
Masturbation is agency
Self-satisfaction creates more disconnect
The secret is the problem
Shame reduced by sharing with partner
Masturbation sanctioned by partner

When pain first emerges, it can be spoken about within the couple
FSP cannot be spoken about
FSP is an ‘elephant in the room’
FSP is a taboo subject
Diagnosis makes some talk possible (once the cause is physical)
Talking leads to conflict
Emotions cannot be safely contained
Men don’t talk about sex in this way
FSP is an intimate problem and therefore held secret
No one understands unless they have lived experience
If friends can’t fix no point in talking
Talking has been cathartic (in therapy)

In the medical setting, the woman is the patient
In therapy both are ‘patients’
Therapy facilitates sense making
Therapy shifts perspectives
Therapy gives attention to what has been neglected
Therapy allows talk of own pain
Non-masculine self-reflection requires justification
Effective talking can only happen in therapy
Therapy provides a safe place to talk

Compassion is essential in medical encounter
Medics can solve the problem
Drs don’t know enough about FSP
Hope in the medical system can be quickly lost
Nobody knows enough about FSP
GP’s are violating
GP’s cause more pain (than him)
Splitting in experience of medics
I am not as bad (as GPS’)
Situational powerlessness in medical setting
Finding agency through requesting a referral
Individuals do background work to take suggestions to the doctor
Drs need to be pressed to act
Unnecessary suffering caused by medics not knowing enough
Enacting masculinity through controlled aggression

Navigation requires a commitment to the relationship
Women are anxious about the stability of the relationship
The choice to stay in relationship lies with the man
FSP can be navigated if united
Unhelpful cycles need to be interrupted
Curiosity and exploration are only possible when tensions have been resolved
Vigilance to pain remains
Resolution requires a structured programme
Repair requires work
Breaking up is understandable (for others)
Communication is key to navigation
Emotions can have logical explanations

Peer support is suggested
Men’s experience needs to be legitimised
Support needs to be offered at point of diagnosis
Diagnosis is a gateway to treatment for men
Professionals need to offer treatment; men can’t ask for it
Professional can legitimise men’s experiences as worthy of treatment
Men are on the outside of support groups

FSP threatens the relationship (discourse on forums which he understands but resists)
Relationships are measured against social norms
FSP is outside of ‘normal experience’
FSP is isolating
Relationships have a ‘normal’
Normality does not need an explanation
Other people don’t have these problems
Own experience normalised through forums

Appendix Q

Codes Become Candidate Themes

Figure Q1

Codes Arranged in Potential Themes

Note. Several codes are listed on each ‘post it’ as they represent a cluster of similar meaning

Appendix R

A Theme Summary With Data Extracts

Following is a theme summary for the first theme with examples of data extracts to be used in the report

Pain Is a Communication, It Could Be a Problem in Me

This theme captures how men make sense of their partner's pain (it's a communication: 'physical problem in their partner's body' or 'a problem elsewhere probably within them'; the role of a diagnosis and the appeal of the biomedical framework.

During the period between the pain arising and getting a diagnosis, many men drew on various potential candidates to explain the pain, without an unequivocal physical candidate, men described considering pain communicated a problem in them:

> P1: "I started thinking maybe it's something that I've done, so then I started thinking it's me, that I'm not attractive enough"
>
> P3: "partly I couldn't rule out that it was just that she didn't want to have sex with me anymore, that she didn't find me attractive anymore
>
> P10 "the first thing that comes into my mind, when we have sex and she is experiencing pain, was like, oh maybe she's not attracted to me, she doesn't want to have sex with me, she has less desire, or no desire for me"

Most of these men considered pain to be a communication of both a physical problem and a problem in themselves (or other locations), it varied:

> P1: "maybe it's thrush, maybe she's dehydrated, maybe she's like eaten something"
>
> P3: "it's major surgery, not in the same area but you know in a close area, so you maybe kind of wonder if there has been some maybe nerve damage or something"
>
> P4: "Is it a psychological issue? Is it a physical issue? Is it me? Is it the relationship?"

The only men spared from considering it might be 'about them' were those whose partner had an obvious and confirmed physical cause:

> P8: "she had something like a cyst on one of her lips, labia is it? (…) she had me have a look at it and I said yes there's something there and so she had that cut out, that was in hospital";
>
> P2: "my wife started to go through the change roughly 2 years ago. She was put on HRT and then taken off (…) that's what I put it down to, when she started going through the change".

A diagnosis ‘ruled out’ that it is ‘not them’ and brought relief:

> P1: “we were only there for about 10 minutes and bear in mind this has been a year and a half (…) she had an examination and 2 seconds later we got the diagnosis of vulvodynia and “I’m referring you to the pain clinic”, it was like sorry.... it’s an actual THING?... it was like a penny drop moment, both of us burst into tears”
>
> P6: “I was worried I couldn’t be the man that she wanted me to be … I was worried that I was boring” and later as a possible biomed explanation emerges
>
> “at least there was something other than me that was equally the issue, yes so we could focus on that”

And yet not for all

> S17 “it seems it’s down to menopause, but I don’t think she has ever fancied me”

The appeal of biomedical explanations: psychological explanations are ‘messy’; biomedical framework is logical and precise

> P9: “I’ve always found the whole medical thing very interesting anyway, it appeals to my logical nature”
>
> P7: “try to find out exactly what it is”

The biomedical framework is given full attention despite other factors such as stress being at play

> P5: “the only time we had any sort of success (…) was out on holiday”
>
> P1: “we’re going to try to have penetrative sex when we’re in a place where we are not stressed”

Appendix S

Article

Word Count = 6,033

Exploring Men's Experiences of Their Female Partner's Sexual Pain: A Qualitative Thematic Analysis Study

Debbie Lovell, Nikki Hayfield, Zoe Thomas

Abstract

Female sexual pain occurs within a relational context, yet little is known about partners' experiences. We explored 26 men's understandings and experiences of sexual pain within a different-sex relationship using an online qualitative survey and semi-structured interviews. Thematic analysis resulted in five themes. Men largely understood sexual pain within a biomedical framework, but could also understand it to communicate something about them and their desirability. Men described being the 'non-patient' within the medical context which also impacted how they viewed themselves within the relationship. Despite their own complex psychosocial difficulties, they remained largely silent and viewed their partner's distress as more worthy of attention. Men also reported a reluctance to be sexual initiators and perpetrators of pain; and resisted traditional notions of men's sexuality to various extents, orienting instead towards an 'intimacy imperative'. The implications of our findings in the help-seeking context for men and the couple are discussed.

Keywords: sexual pain, partner experiences, (hetero)sex, sexuality research, thematic analysis

Introduction

A woman experiencing pain during penile-vaginal intercourse (PVI) is potentially burdened with both a pain condition and a sexual difficulty. Biomedical frameworks have been privileged in understanding female sexual pain (FSP) and multidisciplinary treatment has prioritised pain mitigation and largely neglected the sexual component (Farrell & Cacchioni, 2012; Shallcross et al., 2018). The medical model's approach to FSP has been criticised for situating the problem within the woman, taking an exclusively individual approach to sexual difficulties, and artificially removing sexual pain from the cultural, social and gender-based paradigms in which it is inevitably experienced (Tiefer et al., 2002). As with any sexual difficulty, FSP potentially influences both partners' sexuality, and the nature of the sexual and broader relationship that both members of the couple share (Potts et al., 2003). In recognition of the relational context of FSP, it has frequently been recommended that partners are included in research, but to date their voices are mostly absent in the FSP literature (Al-Abbadey et al., 2015; Bergeron et al., 2014; Connor et al., 2008; Jodoin et al., 2008; Rosen et al., 2013; Rowland & Kolba, 2017).

Qualitative research which has centred the voices of women with FSP has illuminated many dimensions to the entire lived experience beyond physical pain, and informs potential areas of enquiry about men's experiences. For example, within the medical context women do not always feel their illness claims are believed, in particular when attempts to find physical causes of the pain fail (Braksmajer, 2017; Tosh & Carson, 2016; Toye et al., 2014). Women's struggle to have their pain sanctioned as 'real' within the healthcare system may also be played out within the relationship with their partner. Some women, for example, described feeling empowered to decline sexual activity once their pain has been medically legitimised, but otherwise viewed sex to be an obligation (Braksmajer, 2017). If explanations of pain are not anchored in a specific physical condition (as is often the case in FSP) there is scope for men to develop their own theories around the cause of pain and/or disruption to PVI. Men have reported that learning about vulvar pain disorders helped them recognise their partners were not rejecting them personally (Connor et al., 2008), suggesting men may draw on different notions of what sexual pain represents (for these men rejection). However due to a distinct lack of focus on partners, little is known about how men make sense of FSP; whether they question the legitimacy of pain; and what expectations they may have around sexual activity when pain is present.

Feminist qualitative research has emphasised the role of social factors, in particular the influence of dominant social discourses of heterosexuality on women's experience of FSP (Ayling &

Ussher, 2007; Johnston, 2013; Kaler, 2006; Marriott & Thompson, 2008; McCann, 2015; Stelko, 2015; Svedhem et al., 2013). For example, the ‘coital imperative’ defines PVI as ‘real sex’ and the obvious, normal, inevitable result of a (hetero)sexual encounter (Kaler, 2006; McPhillips et al., 2001; Stelko, 2015). Women have described themselves as ‘inadequate sexual partners’, ‘effectively genderless’, and ‘not a real woman’ illustrating the intricate connection of PVI with gender norms, sexual norms and sexual identity, and the distress for women who may be excluded from its praxis (Ayling & Ussher, 2007; Kaler, 2006). Also evident in women’s accounts is a sense for some that FSP threatens the security of their relationship if their partner is not sexually satisfied (Hinchliff et al., 2012). Women have described tolerating pain and continuing to engage in PVI to maintain value as a partner (Ayling & Ussher, 2007; Elmerstig et al., 2008). However, little is known about how men respond to FSP and whether for them it threatens the relationship. Sadownik et al. (2016) interviewed men about the impact of FSP on themselves. They reported themes similar to those of their earlier study with women (‘psychological distress’, ‘sexual distress’, ‘relationship strain’, ‘communication challenges’ and ‘growth opportunities’; Sadownik et al., 2012) and interestingly discussed some men being vulnerable to taking up a position as an ‘inadequate lover’, akin to the positioning of women in earlier studies (e.g., Ayling & Ussher, 2007). They noted the impact of the ‘coital imperative’ had not been considered from men’s perspective, and recommended research attention be given to the potential influence of dominant discourses of masculinity and men’s sexuality on their experience of FSP (Sadownik et al., 2016).

Furthermore , qualitative research exploring partner’s experiences of endometriosis has illuminated other aspects of men’s entire experience that warrant further attention (see Ameratunga et al., 2017; Culley et al., 2017; Facchin et al., 2020; Fernandez et al., 2006; Hudson et al., 2015). Men have described prioritising their partner’s wellbeing over their own needs, yet also have expressed being significantly impacted themselves but without support (Culley et al., 2017; Hudson et al., 2015). Endometriosis involves broad symptomology which may lead to men responding differently to other presentations of FSP, but nevertheless this research illustrates the importance of giving men a voice and extending knowledge of men's experiences of FSP.

The Study

Participants were recruited on the basis of them being men over the age of 18 years, resident in the UK and with experience of being in a relationship with a woman suffering from FSP. The relationship could be current or in the past and it was required their partner experienced pain during, or that prevented PVI, for six months or more. A formal diagnosis was not required to ensure the inclusion of partners of women who may not have sought treatment; not been given a diagnosis; or had a diagnosis that they did not agree with.

The recruitment process was extensive utilising varied channels including social media platforms of relevant organisations (e.g., Centre for Psychosexual Health; Vaginismus Network); a post on the Vulval Pain Society's (VPS) website; forwarding flyers to practitioners working in the field and newsletter postings from the College of Sex and Relationship Therapists (COSRT); and exhibiting a 'call to participate' at two conferences organised by the VPS and the British Society for Sexual Medicine.

Men were given the option to participate either via an anonymous online qualitative survey and/or an interview by telephone, online video (e.g., Skype), or, if feasible, in-person in a clinical setting (in a therapy room). Survey questions were designed to explore how men made sense of FSP; how FSP had impacted their sexual and broader relationship; and how they had responded to and navigated their partner's sexual pain, including their experience of help seeking. The semi-structured interview schedule was based on the survey questions. As men who completed the survey could elect to be interviewed, men's survey responses were reviewed ahead of the interview and interesting areas to probe were noted. Demographic, pain presentation and relationship information were also gathered.

A total of 26 men took part in the study. Ten men were interviewed (8 online via *Skype* video call, 2 via telephone), of whom 9 also completed the survey. These men ranged in age from 23-68 years (*M* = 44.6, *SD* = 18.1), were predominantly middle class (n = 7) and White (n = 9). Interviews were between 48 and 119 minutes long. Sixteen men aged 22-84 years (*M* =46.4, *SD* = 19.3) completed the survey only, of whom 11 were middle class and all were white. The participants were partnered with women at various stages of help seeking with different diagnoses/presentations (e.g., vulvodynia, vaginal atrophy, lichen sclerosus, vaginismus, and post-surgery). Only 2 men who participated in the survey were no longer in the relationship. The length of relationships ranged from 0.5-60 years (*M* = 15.9, *SD* = 15.61)

Interviews were transcribed verbatim and analysed as one data corpus with the survey responses. A reflexive 6-phase approach to thematic analysis (TA) developed by Braun and Clarke was applied to identify and interpret patterns across the data set (Braun & Clarke, 2006; 2013; Clarke & Braun, 2018). Five themes were developed and to protect participants anonymity, no potential identifiers have been used in the report. P1-10 are interviewees and P11 upwards participated in the survey only.

Results and Discussion

1. Pain Is a Communication, It Could Be a Problem in Me

In the space between the pain emerging and an 'authoritative' medical explanation, men's talk of their sense making constructed pain as a communication. FSP either signalled a 'physical problem in their partner's body' or 'a problem elsewhere, likely something in them'. For many men, the possibility of a problem within themselves existed until it could be 'ruled out' by a medical diagnosis.

P3 described his sense making ahead of a diagnosis: "partly I couldn't rule out that it was just that she didn't want to have sex with me anymore, that she didn't find me attractive anymore". P10 said:

> the first thing that comes into my mind, when we have sex and she is experiencing pain, is like, oh maybe she's not attracted to me, she doesn't want to have sex with me, she has less desire, or no desire for me.

These accounts show how men can draw on the notion of their partner's pain being a communication of 'something about them'. They did not explicitly question whether the pain was fabricated, engaging instead with *what* the pain may be 'signalling'. These men seemingly understood their partner's pain signalled 'not wanting to have sex' which was explained by their unattractiveness. This echoes other findings when men who partner women with FSP have taken up a position of 'inadequate lover', and have understood they were not personally being rejected through learning about vulvar pain (Connor et al., 2008; Sadownik et al., 2016).

Many men, like P4, toyed with various candidates: "Is it a psychological issue? Is it a physical issue? Is it me? Is it the relationship?". The only men who did not engage with notions of 'a problem elsewhere' could access a definitive physical explanation. For example, P8 understood sexual pain to have a physical cause having witnessed and confirmed the likely candidate himself: "she had something like a cyst on one of her lips, labia is it? (…) she had me have a look at it and I said yes there's something there".

A diagnosis typically provides an explanatory framework and medical professionals then define the reality of the situation (Bell, 2016; Jutel, 2009). However, the journey to diagnosis can take months and even years, and for many men 'pre' and 'post' diagnosis eras were evident in their talk. P1 spoke about the relief from months of self-questioning that a diagnosis brought:

> She had an examination and 2 seconds later we got the diagnosis of vulvodynia and 'I'm referring you to the pain clinic', it was like sorry?... it's an actual THING?... it was like a penny drop moment, both of us burst into tears.

In P6's pre-diagnosis account he said, "I was worried I couldn't be the man that she wanted me to be … I was worried that I was boring", and on establishing a diagnosis said, "at least there was something other than me that was equally the issue, yes so we could focus on that". A biomedical diagnosis appeared to adjudicate FSP to be real, identifiable and biological, and consequently redirected attention away from men (and their potential inadequacy) and placed the woman's body (and not the man) under scrutiny. A medical explanation did not however relieve all men of their self-questioning. P17 wrote, “it seems it’s down to menopause, but I don’t think she has ever fancied me”.

Academics and clinicians have debated whether ‘the sex is painful’, or ‘the pain is sexual ‘in conceptualising and classifying FSP (Binik et al., 2002; Peer Commentaries on Binik, 2005). These accounts of men’s sense making suggest they engage in a similar interrogation with the majority of men, who could not access an unequivocal physical explanation from its onset, considering the possibility that ‘the pain is sexual’. Once authenticated as an ‘actual thing’ and sanctioned as a ‘medical problem’, men appeared relieved of self-blame and understood FSP to be a pain condition (the sex is painful).

2. Men Are Not the Patients, Women Are

Closely linked to and possibly a consequence of the first theme, the second theme captures men’s accounts of being on the outside of the FSP experience, in particular with reference to help seeking. As medicine focusses on the woman’s body, their partner becomes the patient and men the ‘non-patient’, a position which leaves them feeling insignificant and marginalised.

Many of the men who were involved in their partner’s help seeking process described their sense of being invisible or actively excluded during their encounters with medical professionals: “it was like I was over there in the shadows; well, I was on the side there” (P6). Similarly, “I felt like I was being looked through, the doctor, he was just speaking to my wife all of the time and I was actually trying to get words in” (P2). These are examples of men who were in the consultation room with their partner. Several men gave accounts of ‘attending appointments’ which implied they were not expected or possibly entitled to be part of the ‘appointment’ experience as ‘attending’ for them meant being in the car or in the waiting room.

Men’s accounts of being on the outside of the medical experience echoes the findings on men’s experience of their partner’s pregnancy, another context in which men are involved and invested in the issue that brings a couple into the medical system. Themes such as ‘men as bystanders’ (Locock & Alexander, 2006); ‘feeling side-lined’ (Fenwick et al., 2012); and ‘secondary status in comparison with the female partner'(Facchini et al., 2020) similarly reflected men's sense of being ignored, invisible and pushed aside.

Some men gave accounts of also being kept on the outside by their partners. For example, P3 explained his absence at an appointment: "I'd argue that it was more my wife's decision …I did offer to go to the GP with her, and she didn't want me to". A tension appeared to exist between wanting to respect their partner's right to privacy, and understanding they were the ones then excluded. P5 said, "she didn't want me there for whatever reason, it's not something I haven't seen before but it's obviously a very private matter for her".

In the context of infertility Bell (2016) suggested that if medicine focuses on women, men may also remove themselves as this distances men from their own sense of responsibility and reappoints any 'blame' from him to her. An outsider position for men in the context of FSP may similarly relieve them of the angst they experienced when considering the problem may have been 'in them'. Nevertheless, it appears that women are positioned centre stage by health care professionals and possibly men and women themselves. Men's experiences are understood as secondary to women's and side-lined as a consequence.

3. Men's Loss of Agency, Impotence to Act, and Inactivity

Framing of FSP as a physical problem situates the difficulty within the woman. Women appear to take ownership of the problem and as a result, men lose agency, struggle to act effectively and become 'inactive'. This occurs not only within the medical context but also more broadly within the couple relationship.

As pain is located in their own body, women seemingly appear to take control of decisions around whether treatment and which treatment is pursued. P3 spoke of his wife's agency and his corresponding despondency as she rejects the prescribed treatment: "it just added to the kind of hopelessness, (…) if she didn't want to take it, well where would we go from there". Several men appeared to understand their partner also governed conversations about treatments, solutions and FSP in general. Men spoke of "periods of egg-shells, you know sort of tip-toeing" (P6) and "the elephant in the room" (P1). P2's attempt to talk about 'what they may do' was met with an angry response which prompted him to 'leave it'. P6 said, "sometimes it's good to shut up, you know, just not dig a deeper hole", implying, as other men frequently did, that conversations are better avoided as they risked further agitating their partner. Men are often understood to be focussed on solutions and women have been found to resist having conversations due to their frustrations around men being 'overly focussed on logic and problem solving' (Schuth et al., 1994). However, as they 'tiptoed', 'left it' and 'shut up', men appeared impotent to engage women effectively in conversation and talk of solutions largely eluded them.

Men's loss of agency and impotence to act effectively also manifested within sexual encounters. Despite conventional discourses of heterosexuality positioning men as initiators of sexual activity and women as the recipients of male desire (Allen, 2003; Hollway, 1984), the dominant account within the data was of men being passive and women were described as active and agentic initiators: "I usually wait for her to say to be honest these days" (P9); "I don't want to receive a 'no' so I wait for her to initiate things" (P10). It is not known if these men's partners are motivated to be sexual through their own desire in the conventional understanding of the initiating/receiving dyad or are 'permitting' sex which they believe is desired by men. As gatekeepers of sex, women decide when sex is given and when it is withheld in response to what they perceive as men's need for sex (Hayfield & Clarke, 2012). Regardless of women's motivations, men appeared to have an understanding that their option to initiate had seemingly been removed.

For some men being initiators and active was problematised as they expressed concern about being experienced as coercive, abusive or perpetrating. A small number of men knew or had a sense that their partner had been sexually abused. P10 said, "maybe she is looking at me as a perpetrator, like a rapist, you know", and these men appeared particularly cautious and worked to ensure they did not pressure their partner or be experienced as an offender themselves. FSP is a unique pain condition in that for many women, pain is either only experienced or exacerbated during sexual activity and many men expressed their discomfort around being a 'perpetrator of pain'. For example, in response to a question about the most difficult part of their experience, P13 wrote, "her discomfort and the feeling that I have caused it in some way", and P22 wrote, "not wanting to do something that hurts my wife whilst getting pleasure". From the data in this study, it was apparent that in some relationships, women did not disclose their pain or downplayed its significance. Several men spoke about not knowing about pain in the early stages (either of their relationship or of the pain's appearance) and gave accounts of their partner "eventually admitting that she was in pain" (P22). If women hold knowledge of the pain and keep it from their partner, men's ability to act effectively, by for example redirecting the interaction towards pain free activities, is thwarted. For some men, a loss of potency during the sexual encounter was evident in their talk as they seemingly remained vigilant to the possibility of pain being present but concealed. P22 wrote,

> She obviously tries to hide the pain, but of course this does not help as it is clearly too much and because I struggle to keep an erection as soon as I realise this.

P23 wrote, "I am much more at ease having sex when I'm confident she will say when she wants to stop", implying the presence of anxiety in his sexual experience and the relief from this if he can be certain she is not feeling coerced to continue. These accounts suggest contradictory responses in men to those that may be anticipated by women: women have described a fear of hostility in their partner if they refuse sex due to pain (Donaldson & Meana, 2011).

4. Downplaying Suffering: My Experience Doesn't Matter… And Yet

This theme captures men's ambivalence around whether their own distress and suffering is worthy of attention. Although they may not suffer in the same way their partners do, there are many ways in which men experience their own emotional and psychological pain. Men downplayed their own suffering on the basis that it was not as significant as their partner's suffering. P8, for example, spoke of this:

> I find it impossible to talk about, I guess like I am to you, in terms of certain aspects being difficult for me, do you know what I mean? I don't want to do the 'poor me' thing because

> Ann would say, well I don’t think she would really but well, ‘poor me I’ve got vulvodynia and it’s a thousand times worse for me’.

Captured succinctly by P6, “to be self-indulgent, it’s fucking hard sometimes”, men frequently expressed a sense that it was selfish to even speak about their own distress. Many men who were interviewed employed various strategies to interrupt talk of their own experience. Men redirected attention back to their partner; emotions were depersonalised, “there’s anger, there’s guilt”; or given to others, “for some people it could be really quite a big thing”. Their own experience appeared difficult to foreground in their own talk suggesting an ambivalence over whether their experience was entitled to such attention. This echoes findings in other research on miscarriage and sexual assault where men also seem to downplay their own emotional distress and give precedence to their partner’s suffering despite being traumatised themselves (Connop & Petrak, 2004; van Wijk et al., 2014; Williams et al., 2020).

When men in the current study did speak of their own suffering, they gave accounts of significant distress. Frustration characterised most men’s emotional responses. P22, for example, wrote, “She has lived with pain on and off since the original intervention and I have felt angry and frustrated that she has suffered years of pain”. Several men spoke about sadness and loss, not simply of the act of PVI, but spontaneity and playfulness in their sexual relationship, “it all sort of choreographed naturally (…) whereas now there had to be almost an instruction list” (P6), “it was always strategized (…) it was too controlled and careful” (P16)“; their partner as they had known her, “she has changed so much” (P19); and the loss of a future they had imagined, “the children have left home and have grown up, and I hoped it would get back to what our sex life was when we were just the two of us” (P8). Men also expressed various anxieties around their sense of self, a threat of disconnection within the couple, and their partner’s well-being. For example, P3 said, “I did all of a sudden feel really insecure in our relationship”. P6 talked about knowing of a woman who had ended her life and his own wife sometimes saying she couldn’t put up with it much longer: “the pain doesn’t go away, and nor does the threat”.

Although men's psychological and emotional responses were varied, men's accounts nevertheless clearly illustrated the negative impact of FSP on them. This echoes the findings of Sadownik et al., (2016) who noted men's sense of loss, despair, frustration, anxiety and low self - esteem in their study of men's experience of provoked vestibulodynia. However, in the current study several men also talked about their sense of shame which seemed to emerge from their own sexual desire continuing to be present. P3 spoke of his own confusing experience:

> I just felt like ashamed by the kind of way I felt for my wife which is kind of ridiculous in the sense that you shouldn't feel ashamed of wanting to be intimate with your loved one, but that's how I felt.

Several men experienced shame when they masturbated. P1, for example, said, "I would secretly masturbate, and I almost felt ashamed at the time because, you know, because it felt wrong because, almost like I'm cheating on her.

Apparent in these accounts is the considerable distress which men can experience. The dominant story however was that men have remained largely silent about their own suffering. Partner's silence and emotional containment has been explained as being what is expected of them as men (Williams et al., 2020). However, P8 said, "no one has ever asked me and I'm grateful that you have". In accord with the partners in Culley et al.'s (2017) research of endometriosis, and other men in this study, his involvement in research seemed to be a welcomed opportunity to break this silence.

5. Hegemonic Heterosexuality and The Individual Man

Attending specifically to the sexual relationship, men resisted traditional discourses of heterosex to various extents within their own relationship in the context of FSP. They appeared to access individual scripts that differed from dominant cultural scripts and engaged with multiple versions of heterosexuality (McCabe et al., 2010).

Men's narratives consistently indicated that sexual interaction was understood to be a necessity within their partnered relationship. Although their accounts showed variety in how important sex (of any kind) was within their relationship, it was generally considered to fortify the relationship as, for example, described by P4: “I think sex is like the mortar in a brick wall”. None of these men however appeared to consider coitus as an ‘absolute’ imperative in their own notions of sex. The men who appeared to privilege PVI upheld and simultaneously challenged traditional notions of PVI being essential to the sexual encounter. P2’s account was representative of these men’s talk: “the most difficult? … just not being able to have proper sex really”, clearly authenticating the coital imperative in positioning PVI as the defining, real or ‘proper’ sexual act (Jackson, 1986; Potts, 2002). However, he then went on to talk about his sexual relationship which did not include PVI and constructed non-coital activity as “a sex life” that was enjoyable and allowed them to communicate their love for each other.

In stark contrast to the men who seemed to privilege PVI (to an extent), P9, P7 and P3’s talk of sex resisted the coital imperative and conceptualised sex as involving many different possibilities with PVI being of no particular importance:

> usually, it’s a nice bit of groping and to be honest if it just carried on as a nice bit of groping and we stopped after that, I would be quite happy. (P9)

> I wouldn’t miss many aspects of penetrative sex, maybe like the intimacy of it…like face to face…but yeah other than that it wouldn’t make much of a difference to me. (P7)

> being together and close and like hugging and kissing like to me, that’s as important as anything else. Of course, I like penetrative sex and I like whatever but, you know, it’s not just that alone…no, certainly not. (P3)

In these narratives, men orientate away from intercourse-focussed sexuality and towards an intimacy-focussed sexuality as exemplified by P7 who would be robbed of an opportunity to be ‘face-to-face’, not ‘penis-in-vagina’ if intercourse was eliminated. Most men’s talk demonstrated an ‘intimacy imperative’, conceptualising intimacy either as sitting alongside the coital imperative and conventional understandings of sex; or viewing intimacy as being central, privileged and coveted.

They spoke of sex bringing them closer to their partner, or as said by P10, “it’s more like about connection”.

These men’s accounts were predominantly at odds with accounts of traditional masculine sexuality. Their narratives echo the ‘progressive stories’ that men have told in the aging and sexuality research in which sex takes on a new meaning (Potts et al., 2006; Sandberg, 2013). The long-term relationship has been proposed to be the site where men are more likely to challenge traditional discourses of heterosexuality and masculinity and express a ‘mature’ sexuality (Holland et al., 1998; Mooney-Somers & Ussher, 2010; Terry & Braun, 2009, 2011).

A few men spoke about how removing PVI from the couple’s sexual repertoire offered them relief of sorts from the conventional expectations of sex. P20 for example wrote, “as a man who sometimes struggles to reach orgasm during PIV sex, it has resulted in a sexual environment which encourages other forms of sexual interaction”, apparently welcoming, as some other men did, the opportunity to explore a sexuality that is not bound by the coital imperative and the performance burden they may experience.

Interestingly, although men engaged with multiple versions of heterosexuality, their partners (in men’s accounts) appeared to draw on traditional ‘fixed’ social discourses of masculine sexuality. This seemed to position men as ‘not believed’ and struggling to provide assurance: “I don’t see us as having a difficulty, although she would I think!” (P23); “it makes her depressed and anxious and then this causes her to want to end the relationship. I always reassure her but don’t know what more I can do” (P17); “Although I had no issue with not having penetrative sex, my partner did not believe me and would regularly accuse me of resenting her because of it (P11). Women, in men’s stories, appeared to hold the belief that if men were refused sex, they would feel they had the right to pursue and obtain it elsewhere, like P7’s partner who suggested an open relationship. Men themselves described a very different perspective as illustrated by P2:

> I said listen I'll never leave you and she said you must have thought about it and I said I haven't! It hadn't occurred to me that if this isn't happening then I need to find it elsewhere, I've never ever thought like that ever.

Men's accounts of their partners' responses echo what women themselves have said about their concerns about their 'ability to attract and keep a man' and their loss of currency if unable to perform coitus (Ayling & Ussher, 2007; Kaler, 2006). It appears that in this study, within several couples, women's experience of FSP was more strongly shaped by social discourse than men's were, and women found it difficult to believe deviation from the social dictate was not problematic for the individual man.

Conclusions

This research offers insights into the way a small group of heterosexual men living in the UK understood and responded to their partner's sexual pain. Men's narratives, in the main, reflected an understanding of FSP that is upheld by the medical community which locates the difficulty within the woman (Shallcross et al., 2018). However, some men drew on the notion that pain communicated 'a problem in them', until a diagnosis ruled this out allowing men to then understand FSP within a medical framework. Men's experiences were shaped by the medical system they entered as they were cast in the non-patient role, largely unseen, ignored and powerless to influence their partner's treatment or alleviate her distress.

Men gave accounts of varied but significant distress involving pain which centered around their partner's suffering; sadness around loss; different anxieties; and shame about their own sexuality. However, viewing their own suffering as insignificant compared to their partner's, men largely remained silent about their own experience.

Men's loss of agency in the medical context, also manifested within the sexual and relational dynamic. For many men action and initiative was problematised through a concern of being experienced as a perpetrator. Conversations risked burdening their partner with emotional distress and sexual initiations risked physical pain with both therefore mostly avoided. However, men gave diverse accounts of their responses to the potential disruption that FSP may pose within the sexual encounter. Some oscillated between complying with traditional notions of heterosex and resisting them, whilst others firmly conceptualised sex in broader terms. Contrary to the belief held by women that 'the one thing that men really want is sex' (Shallcross et al., 2018), for the majority of men in this study, the one thing they really wanted was intimacy. Many men did not feel their partner believed their 'intimacy-imperative' suggesting that although FSP is not just a 'woman's matter', within some couples, the interruption to PVI may matter more to women than to men.

These findings have many implications regarding potential support for men and also the couple. Men were largely marginalised throughout the help seeking process despite their own psychosocial functioning being significantly impacted by FSP. It has previously been recommended that all treatment providers (e.g., doctors, physiotherapists, psychologists) invite both members of the couple to attend appointments (Sadownik et al., 2016). In general men may experience better inclusion by being invited to appointments and through health care providers improving their interactions with them once there. Nevertheless, it is also important to consider the function of including men. For example, in the context of psychotherapy, Caruso and Monaco (2019, p17) suggested, "partners can be instructed in assisting in mindfulness or distraction to cope with the pain", seemingly involving men in mitigation of their partner's pain experience. The current study, however, has clearly shown that men have their own intra and interpersonal difficulties which would likely benefit from support services. Practitioners in a medical setting (e.g., GP'S, gynaecologists, physiotherapists) are not positioned to attend in full to the man's experience (as talking therapists are) but can nevertheless serve an important role in normalising the need for men's psychosocial support and render it as acceptable and even expected.

Considering then the talking therapy setting. A very important finding was that men's accounts contradicted taken for granted assumptions about men's sexuality. Men's apparent intimacy imperative may liberate some women from their fears of FSP threatening their value as a partner (Ayling & Ussher, 2007), yet many men gave accounts of 'not being believed'. Both members of the couple may therefore benefit from exploring their own understandings of the expectations of heterosex; how these have been influenced by social narratives; ‘individual’ and ‘cultural’ level sexual scripts disparities; and assumptions of their partner’s notions of sex. The couple can then be encouraged to renegotiate, construct and define for themselves their own notions of sex, masculinity, femininity, practices they may choose to include and relational aspirations. Similarly, as many men expressed concern around their partner concealing pain, communication of physical discomfort, expectations and acceptability of ‘refusals’; and experimentation with pain free sexual practices and non-sexual sources of intimacy within the couple require attention.

There are several limitations to this study. Firstly, it offers insight into the experience of men who are predominantly White, mostly middle class, English speaking, and who have access to health services. The findings and conclusions cannot therefore be assumed to transfer to other groups of men differing in culture, ethnicity, socioeconomic status and healthcare access. Furthermore, all of the relationships were long-term and apart from two, were current. These findings therefore likely represent men who have adapted to FSP and men who have experienced relationship breakdown or considered PVI an imperative have not had their voices heard. Further research exploring the experiences of heterosexual men from different ethnic and cultural backgrounds; bisexual men and lesbian women who partner women with FSP; men who have left relationships due to FSP; and men in new or casual sexual relationships with women with FSP is required. Finally, men in this study were partners of women with various diagnoses and manifestations of FSP. There may be important aspects of men’s experiences that may be unique to particular FSP conditions suggesting further study of homogenous groups may better inform our understanding of men’s experience of FSP.

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