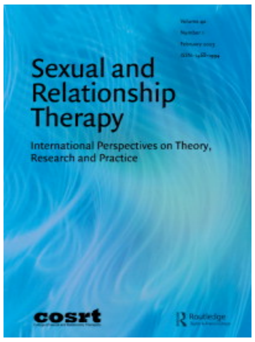

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“No one has ever asked me and I’m grateful that you have” men’s experiences of their partner’s female sexual pain

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ABSTRACT

Female sexual pain (FSP) occurs within a relational context, yet little is known about partners’ experiences. We explored 26 men’s understandings and experiences of FSP within their different-sex relationships, using an online qualitative survey and semi-structured interviews. Nine of the 25 men who completed the survey were also interviewed, and one man shared his experience via interview only. We report our reflexive thematic analysis which resulted in the following themes: 1. *Pain is a communication of a problem: It could be a problem in me* captured how men made sense of FSP; 2. *On the outside - Where potency is problematic* illustrated men’s experiences of being marginalised, and the ways in which this shaped their sense of power and agency within the medical setting and their relationship; 3. *Downplaying suffering: My experience doesn’t matter… and yet* described men’s view of their own distress, though complex and significant, as less worthy of attention compared to their partner’s; and 4. *Hegemonic heterosexuality and the individual man* illustrated how men resisted dominant cultural notions of men’s sexuality to various extents, and oriented towards an ‘intimacy imperative’. The implications of our findings are discussed in relation to the help-seeking context for men and couples.

LAY SUMMARY

In this study we explore how men understand their female partner’s sexual pain during intercourse - how they make sense of it, are impacted by it, and their responses to this complex condition. Partnered sex is an interpersonal experience and these findings have important implications for expanding and enhancing treatment approaches.

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Sexual pain; partner experiences; (hetero)sex; men’s sexuality; thematic analysis

Introduction

Globally between 8 - 21% of women are estimated to experience genito-pelvic pain during penile-vaginal intercourse (PVI) (Sorensen et al., 2018). The mechanisms

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through which pain during PVI arises - and persists - are complex and may involve interdependent organic, psychological, social, cultural and relational factors (Zarski et al., 2021). Despite such factors seemingly indicating that female sexual pain (FSP) be best understood within a biopsychosocial framework, this has not been the case. Instead, it is biomedical paradigms that have largely been privileged in contemporary understandings, with pain reduction being the dominant focus of treatment interventions (Farrell & Cacchioni, 2012; Shallcross et al., 2018). A focus on pain mitigation has generated important clinical enquiry and treatment options for a condition which has often been (mis)treated as though the pain was 'all in her head' - arguably a legacy of early psychoanalytic notions in which FSP was understood as hysteria (Grace, 2000; Kleinplatz, 2005; Tiefer, 2005). However, in the context of different-sex relationships, most women seek treatment not only for the pain, but for their difficulty or inability to have 'normal' sex with their male partner. Further, a focus on pain reduction risks neglecting women's sexuality and broader experience (Payne, 2005). Biomedical approaches to FSP have therefore been criticised for attending to the parts of the woman that may require 'fixing', focussing on disease rather than people, and artificially removing sexual pain from the cultural, social and gender-based paradigms in which it is inevitably experienced (Kleinplatz, 2005; Tiefer et al., 2002). Furthermore, the medical framework problematically uses an exclusively individualised approach to FSP that locates the 'difficulty' within the individual woman. As with any sexual difficulty, FSP potentially influences women *and* their partner's, alongside 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 women's partners are included in FSP research (Al-Abbadey et al., 2016;; Bergeron et al., 2014; Connor et al., 2008; Jodoin et al., 2008; Rosen et al., 2013; Rowland & Kolba, 2017). Although there is a growing body of quantitative research which has involved men both as 'pain partners' (examining men's role in mediating women's pain experience, e.g. Rosen et al., 2010, 2012), and as 'sexual partners' (examining measures such as sexual satisfaction and sexual function, e.g. Rancourt et al., 2017; Rosen et al., 2015, 2017; Smith & Pukall, 2014), there is a dearth of qualitative research in this area. Qualitative research that has centred the voices of women who experience FSP has illuminated many potentially distressing aspects of their entire experience (beyond physical pain), which meaningfully informs wider treatment attention (Braksmajer, 2017; Shallcross et al., 2018). However, as men's voices are mostly absent in the FSP literature, any equivalent understanding of men's experiences is distinctly lacking. The following outline of existing qualitative research involving women is therefore necessarily drawn on, due to the minimal focus on men's experiences, alongside the limited wider qualitative sex research involving men to contextualise potential areas of enquiry into men's experiences.

Is the pain real? Making sense of FSP

Central to women's experience is a quest to have their pain legitimised (Tosh & Carson, 2016). Within the medical context, women do not always feel their illness claims are believed by practitioners, particularly when attempts to find physical causes of the pain fail (Braksmajer, 2017; Tosh & Carson, 2016; Toye et al., 2014). Women have often (perhaps inadvertently) been exposed to suggestions of being ‘crazy’, ‘neurotic’ and ‘frigid’ by doctors and other medical professionals (Kaler, 2006; Marriott & Thompson, 2008; Sadownik et al., 2012). Their struggles to have their pain sanctioned as ‘real’ within the healthcare system may also be played out within their relationships with their partners (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. Conner et al. (2008) explored couples’ experiences in the context of vulvar pain and discussed how learning about the disorder (specifically vulvar vestibulitis syndrome) helped men recognise that their partners were not rejecting them personally (Conner et al., 2008). This suggests that men may draw on various notions of what sexual pain represents (and for these men it was rejection). The way in which FSP is understood has implications not only for clinical practice and research attention, but also for how women and their partners respond (Binik et al., 2002). However, due to a distinct lack of focus on partners within qualitative research, in either the social sciences or medical literature, little is known about how men make sense of FSP - and whether they too may question the legitimacy of their partner’s pain.

Sexuality is social

Feminist qualitative research has emphasised the role of social factors in shaping women’s experiences of FSP, in particular the influence of dominant social discourses of heterosexuality (Ayling & Ussher, 2007; Johnston, 2013; Kaler, 2006; Marriott & Thompson, 2008; McCann, 2015; Stelko, 2015; Svedhem et al., 2013). For example, the ‘coital imperative’ positions PVI as ‘real sex’ and the obvious, normal, inevitable result of all (hetero)sexual encounters (Kaler, 2006; McPhillips et al., 2001; Stelko, 2015). Women excluded from its praxis due to FSP 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 (hetero)sexual identities (Ayling & Ussher, 2007, p. 298; Kaler, 2006, p. 50). Sadownik et al. (2016) interviewed men about how FSP impacted them. The results mirrored their earlier study with women (Sadownik et al., 2012), whereby these men associated FSP with psychological and sexual distress, as well as reporting that there were communication challenges and strains on the relationship. Interestingly they discussed how some men took up a position of ‘inadequate lover’, mirroring women’s narratives in earlier studies (e.g. Ayling & Ussher, 2007). The authors noted that the impact of the ‘coital imperative’ had not been considered from men’s perspectives, and recommended that researchers explore the potential influence of dominant discourses of masculinity and men’s sexuality on their experience of FSP (Sadownik et al., 2016). Also evident in women’s accounts has been a sense for some that FSP might threaten the security of their relationship, particularly if they perceive that their partner is not sexually satisfied (Hinchliff et al., 2012). Women have described tolerating pain and continuing to engage in PVI in order to maintain value as a partner and avoid the threat of their partner seeking ‘problem-free’ sex elsewhere (Ayling & Ussher, 2007; Elmerstig et al., 2008). However, little is known about how men respond to FSP and whether, for them, difficulty with PVI poses a threat to the relationship.

Men's experiences of endometriosis

Due to the minimal research specifically on men's experience of their partner's FSP alone, we turn now to the somewhat related body of qualitative research exploring men's perspectives as partners of women with endometriosis (see, Ameratunga et al., 2017; Culley et al., 2017; Facchin et al., 2020; Fernandez et al., 2006; Hudson et al., 2015). Endometriosis involves symptoms such as chronic pelvic pain, fatigue and infertility in addition to painful sex, consequently impairing women's functioning in many domains, including finances and career choices (Facchin et al., 2020; Hudson et al., 2015). Due to this broad symptomology, men may respond differently to endometriosis compared to other presentations of FSP such as provoked vulvodynia in which the pain is specifically aggravated through sexual interaction. Nevertheless, this research has illuminated important aspects of men's overall experience, such as being marginalised in endometriosis care and largely being ignored by health care providers (Facchin et al., 2020). Some men commented that endometriosis research interviews were the first time they had been asked to speak about their experiences, further evidencing the tendency for partners to be overlooked (Culley et al., 2017). Men have also described prioritising their partner's wellbeing over their own, yet at the same time have expressed a significant impact of endometriosis on themselves and an absence of any support (Culley et al., 2017; Hudson et al., 2015). This illustrates the importance of giving men a voice to more fully understand the different ways in which they are impacted by FSP, which in turn can inform optimal treatment options for both individuals and the couple.

Method

Research design

Qualitative research is particularly suited to exploring previously under researched topics and allows the potential to gather meaningful responses about participants' lives and experiences (Willig, 2022). Initially, online qualitative surveys using *Qualtrics* were chosen due to their potential advantages. Qualitative surveys allow the collection of participants' perceptions, understandings and experiences as questions are open ended, and can be answered in their own words (Opperman et al., 2014). Online surveys are also viewed as being ideally suited to exploring sensitive topics due to the felt anonymity offered to participants (Braun et al., 2020; Braun & Clarke, 2013). Finally, online surveys offer an efficient way of collecting data from a geographically dispersed sample (Braun & Clarke, 2013; Terry & Braun, 2016) providing a "wide-angled lens" of perspectives, sense making and experiences (Braun et al., 2017; 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. Furthermore, given the sensitivity of the topic, participants could potentially be hard to find' and geographical reach was therefore deemed necessary. Survey development was informed by the literature on women's experiences of FSP and the primary researcher's own clinical experience. Survey questions were therefore designed to explore how men made sense of FSP (e.g. *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);* how FSP had impacted them as an individual and their sexual and broader relationship (e.g. *In what ways has your partner's pain influenced your sex life*?); and how they had responded to and navigated their partner's sexual pain, including their experience of help seeking (e.g. *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?*). Ethical approval was granted by the university's Faculty Research Ethics Committee (HAS.18.07.208).

During the early stages of data collection, it became evident that few people were participating. Furthermore, opportunities to probe participants and explore meanings, complexities and ambiguities were being missed (Opperman et al., 2014). We considered it possible that the anonymity and invisibility of the researcher in this online environment may have been perceived by some participants as more threatening than comforting, and that researcher visibility and accountability may be required (Liamputtong, 2007). Therefore, a semi-structured interview schedule was developed based on the survey questions. Following ethical approval, participants were given the option to participate anonymously *via* the survey, and/or *via* a qualitative interview where they could interact with the researcher in person. The telephone and online video (e.g. Skype) are considered to be viable alternatives to the in-person interview with similar advantages (Hanna, 2012), and men were therefore given all three options. The survey became a tool for data collection and recruitment, with participants invited to leave their contact details if they were willing to take part in an interview. Interview schedules were then tailored to each participant based on their written survey responses.

Participants

To be eligible participants were required to be a man, over the age of 18 years, resident in the UK and having been in a relationship with a woman experiencing FSP. The relationship could be current or in the past, but their partner must have experienced pain for six months or more, either during PVI, or that prevented PVI. A formal diagnosis of their partner's pain was not required. This ensured 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 developed as the research progressed and was eventually extensive, due to initial difficulties and ongoing challenges in successfully recruiting. Strategies included posting on social media platforms of relevant organisations by the moderators (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 alongside 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*.

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 ($M = 44.6$, $SD = 18.1$), and were predominantly middle class ($n = 7$) and white ($n = 9$). Interviews were between 48 and 119 min long ($M = 75.5$, $SD = 22.2$). 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 ($M = 15.9$, $SD = 15.61$).

Procedure

Before consenting to participate in the study via a consent form, men were directed to an online information sheet that fully informed them of what participation involved; how their data would be stored and 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 compliance. Interviews were transcribed verbatim and analysed as one data corpus along with the survey responses. A reflexive 6-phase approach to thematic analysis (TA) was used to analyse the data and interpret patterns of meaning (themes; Braun & Clarke, 2013; Braun & Clarke, 2006; Clarke & Braun, 2018; Terry & Hayfield, 2021). In reflexive TA, the analysis is understood to be informed by the researcher through a rigorous coding and theme development process, with researcher subjectivity and interpretation being embraced (Terry et al., 2017). The first author is a clinical sexologist and counselling psychologist. The second author is a social psychologist with particular interests in sex and sexuality and the third author is a counselling psychologist.

Data were 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). The six phases of thematic analysis were used to guide analysis focusing on the experiences of participants as well as some critical interrogation of the meanings with the wider social context. An inductive approach was taken where the starting point was the data, rather than analysis being driven by a specific theory. All researchers familiarised themselves with the data, during which they read the survey and interview responses repeatedly and made notes about what stood out in the data. The first author then moved to independently coding the survey and interview responses. During this phase they ensured all data were read closely and carefully in order to 'tag' parts of it with a label or code. Codes were both at semantic level (close to the data) and latent (requiring making sense of and interpreting responses beyond the surface level). Two rounds of coding were undertaken on the complete data set. The codes for each participant were listed and a 'remove the data' test performed to check the codes clearly 'evoked' the data without having to read the data segments (Braun et al., 2016). The codes for the entire data set were then brought together to complete this phase which resulted in an extensive set of codes that captured the meanings interpreted from the data. We then engaged in developing initial themes. The second and third authors worked with the first author as a research team to discuss, review and develop the themes. The relationship between themes, their interconnections and boundaries were explored and revised (Braun et al., 2016). These themes were then defined and named before a report of them was written, drawing on extracts from surveys and interviews. In this paper we report four key themes. Data extracts of P1-10 are from participants who were interviewed and P11 upwards are from men who participated in the survey only. Due to the sensitivity of the topic, potential identifiers such as age of the participant have not been given.

Results

Pain is a communication of a problem: it could be a problem in me

The first theme captures the ways in which men made sense of their partner's pain. Men's talk of their own 'pain theories' constructed their partner's pain as a communication of sorts, either signalling 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 understood FSP as purely a physical pain condition appeared to have access to an organic explanation at its onset.

In the space between their partner's pain emerging and receiving an 'authoritative' medical explanation, many men considered 'something in them' as a potential candidate to account for their partner's pain. P3 described his sense making ahead of his partner's 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." Similarly, P10 said:

> [T]he 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 how genuine the pain was but engaged instead with *what* the pain may be 'signalling'. These men seemingly understood their partner's pain as signalling them 'not wanting to have sex' which was attributed to their own unattractiveness.

Some men, like P4, toyed with various theories of their partners' pain as they tried to locate the problem: "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' appeared to have access to a definitive physical explanation. For example, P8 understood sexual pain to have a physical cause as a result of 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 offers an explanatory framework and medical professionals may then contribute significantly to how women and their partners define the reality of the situation (Bell, 2016; Jutel, 2009). For many men 'pre' and 'post' diagnosis eras were evident in their talk. 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) to the woman's body. The journey to diagnosis can however take months or even years (Feldhaus-Dahir, 2011). P1 gave an account of months of self-questioning and the relief (for him and his partner) 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.

However, a medical explanation did not necessarily relieve all men of their self-doubt and questioning of what the cause of the pain might be. P17 wrote, "it seems it's down to menopause, but I don't think she has ever fancied me."

This theme has illustrated how men who did not initially have access to an unequivocable physical cause, seemingly drew on notions of pain communicating a problem, hypothesised as probably within them, until a diagnosis was established. On the whole, they appeared to then join the men who had conceptualised FSP as having an obvious physical cause from its onset and understood it to be a problem located within the woman.

On the outside - where potency is problematic

This theme demonstrates how men's accounts captured their sense of being on the outside of the FSP experience, a position which left them feeling insignificant and marginalised. Men appeared to understand themselves as lacking agency and took up more passive positions relative to that of their partner. They expressed concerns that their partners might experience them as too 'pushy' or coercive were they to try to take an active role in navigating the experience of FSP. This occurred not only in the medical context, but also more broadly within their couple relationships.

In medical settings, the woman's body was the focus which seemingly served to embed a dichotomy whereby women's status as patient and men as the 'non-patient' was firmly established. Many men who went into the consultation with their partner described their sense of being invisible or actively excluded by medical professionals: "it was like I was over there in the shadows; well, I was on the side there" (P6). Similarly, P2 stated "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." Several other men gave accounts in which, for them, the notion of 'attending appointments' meant they sat in the car or the waiting room implying they understood they were not expected (or possibly entitled) to even be in the room and remained outside the door.

Furthermore, some men described being ‘kept on the outside’ of the medical appointment experience by their partner. 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.” P5 also spoke about his exclusion and illustrated a tension that appeared to exist for several of these men between respecting their partner’s right to privacy, and understanding that they were then placed on the outside of the privacy boundary: “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.”

Relegation to an outside position appeared to shape men’s sense of power and agency as many seemingly experienced a lack of potency and appeared to take up more passive positions within the partnership. Due to their patient status, women appeared to take control of decisions around whether and which treatment or treatments were pursued. P3 spoke of his wife’s agency as she rejected the prescribed treatment and his contrasting lack of agency and despondency: “it just added to the kind of hopelessness.” Several men understood their partner to govern not only treatment decisions but *conversations* about treatments and FSP in general. Men seemed to want to have conversations around various aspects of the FSP experience, but implied that instigating a dialogue risked agitating their partner. They spoke of “periods of egg-shells, you know sort of tip-toeing” (P6) and how 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.” As they ‘tiptoed’, ‘left it’ and ‘shut up’, men appeared cautious and ineffective in their attempts to engage women in conversation with talk reported to be shut down by their partner’s irritation.

Men’s loss of potency 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 these data was of men being passive in contrast to women, who were described as agentic initiators. For example, P9 said, “I usually wait for her to say to be honest these days,” whilst P10 commented that “I don’t want to receive a ‘no’ so I wait for her to initiate things.” For some men, seeking to be sexually active and initiating such activity was problematised as it seemed to be understood as almost a form of abuse, due to their partner’s pain only being present during - or exacerbated by - sexual activity. P10 said, “it’s also like maybe she is looking at me as a perpetrator,” and 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.” It appeared that these men were cautious of not only causing pain, but also of being understood more broadly as abusive. P18 wrote:

> It is quite upsetting to feel that you may have hurt your partner/caused physical discomfort when you would not dream of doing anything to hurt them. There is so much in the media about men mistreating women and it feels like I am almost part of the problem.

Interestingly, some men reported that within their relationships, women did not disclose their pain or downplayed its significance. Several men spoke about not knowing about pain in the early stages (referring either to their relationship or the pain’s appearance) and gave accounts of their partner “eventually admitting that she was in pain" (P22). Evident in some men's talk was a need to be vigilant to the possibility of pain being 'present but concealed' and the distress this caused them as written by P22:

> 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.

Similarly, 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 a relief from this only if he can be certain she will declare the pain and not feel coerced to continue.

These accounts then, do not align with the masculine hegemonic of men always being sexually assertive (Hammond & van Hooff, 2020). Instead, these participants struggled with the notion of becoming a perpetrator of pain, with some highly cautious of any potential dominance over women. This appeared to result in them positioning themselves more passively, and as attentive to any potential harming of their partner. Diminished agency and movement towards inactivity was not confined to sexual relations; it extended into other areas of their relationship, with many men also struggling to pursue conversations with their partner and influence or be a part of engagement in medical treatment.

Downplaying suffering: my experience doesn't matter… and yet

This theme captures men's ambivalence around whether their own distress and suffering was worthy of attention. Although they did not perceive themselves as suffering in the same way their partners did, there were many ways in which men experienced their own emotional and psychological pain. However, they downplayed their own suffering on the basis that it was not as significant as their partner's. 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'.

Men frequently expressed a sense that it was selfish to even speak about their own distress, as captured succinctly by P6, "to be self-indulgent, it's fucking hard sometimes." Many participants employed various strategies to interrupt talk of their own experience during the interviews. They did so by redirecting attention back to their partner, as illustrated by P7, who in response to being asked specifically how it was for *him* said, "it's quite challenging, its' quite sad," and promptly returned to talking about his partner "because she gets up into her head …." Other strategies involved emotions being 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 that their experience was not entitled to such attention and/or that this was a challenging topic to discuss.

When men in the current study did speak directly of their own suffering, they gave accounts of significant distress. Frustration was a feature of most of these men's emotional responses. P22 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" suggesting, as many men did, the frustration arose from their partner's suffering not being alleviated. Men also spoke about sadness not only around the loss of the act of PVI, but also of the lack of spontaneity and playfulness in their sexual relationship, "it [sex] was always strategized (…) it was too controlled and careful" (P16); the loss of 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 self-confidence, the security of the relationship, and their partner's well-being. For example, P1 spoke of how he questioned not only his attractiveness but his sense of self more broadly: "it started affecting my work life (…) there were things that I wouldn't say because I was second guessing, I'd be quiet and reserved and not quite myself" and P3 said, "I did all of a sudden feel really insecure in our relationship" as he spoke about the disconnection within the couple. P6 illustrated his ongoing worry about the impact of the distress his partner was experiencing: "the pain doesn't go away, and nor does the threat," referring to his wife having said she couldn't cope much longer and his understanding that persistent chronic pain can lead to suicidality.

Several men talked about a sense of shame which seemed to be premised on the basis of their own sexual desire continuing to be present.

> 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. (P3)

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," echoed by P8 "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." Their interpretation of the situation seemed to suggest that their partner's loss of sex (due to pain) should equate to their own loss of desire and therefore pursuing masturbation somehow made them 'bad'.

Apparent in these accounts was the considerable distress which men can experience, yet the dominant story was that these men largely remained silent about their own suffering. Men did however talk about their difficulties when prompted to speak in the research context. Several men such as P8 expressed their appreciation: "no one has ever asked me and I'm grateful that you have" indicating opportunities to break this silence may indeed be welcomed.

Hegemonic heterosexuality and the individual man

Attending specifically to the sexual relationship, these men's accounts 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 discourses and engaged with multiple versions of heterosexuality (McCabe et al., 2010). Despite this, many of these men positioned *their partner* as making sense of their relationship through the lens of dominant notions of heterosex.

Men gave varied accounts of how important sex (of any kind) was within their relationship, but 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. Some men appeared to privilege PVI, yet 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, 1984; 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 - hence PVI was both centred and decentred within the complexities of his account.

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

> [U]sually, 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)

> [B]eing 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 men's narratives, they orientated 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 of 'penis-in-vagina')if intercourse was eliminated. Most men's talk demonstrated an 'intimacy imperative', in which intimacy was conceptualised as either sitting alongside the coital imperative and conventional understandings of sex; or intimacy was viewed 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."

Further demonstrating a departure from hegemonic heterosexuality, a few men spoke about how removing PVI from the couple's sexual repertoire might even offer 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. They were reported to understand PVI to be ‘what men wanted’: “I don’t see us as having a difficulty, although she would I think!” (P23). This seemed to place men in a position where they were ‘not believed’ and were struggling to provide assurance: “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 did not have acces to sex within the relationships, then they would feel they had the right to pursue and obtain it elsewhere. For example, P7’s partner suggested an open relationship, though “it couldn’t suit her less.” 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.

It appears that in this study, within several couples, women’s experience of FSP was understood by participants to be more strongly shaped by social discourse than men’s were, and women found it difficult to believe that deviation from the social dictate was not problematic for the individual man.

Discussion

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. The first theme addressed men’s sense making of FSP and illustrated how men who did not initially have access to an unequivocable organic cause seemingly drew on notions that pain could be a communication of something other than a physical problem. For these men it offered the potential to signal that something was wrong in them, leaving either themselves or the sex as undesirable, until this could be ‘ruled out’ by a medical diagnosis. This echoes other findings when men who partner women with FSP have been described as taking up a position of ‘inadequate lover’, and only understanding that they were not being personally rejected when they learned about vulvar pain (Connor et al., 2008; Sadownik et al., 2016). There has been division among academics and clinicians regarding how to conceptualise and classify FSP (Cabello-Santamaría et al., 2015), in particular whether FSP be understood and treated as a ‘sexual dysfunction’ or a ‘pain condition’ (Kleinplatz, 2018). Addressing this issue ahead of the release of the fifth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), Binik and colleagues asked the question ‘is the pain sexual or is the sex painful?’ (Binik et al., 1999), which prompted twenty-one papers to be written by interdisciplinary commentators in response (see Peer Commentaries on Binik, 2005). The accounts of men’s sense making in this study suggests they too can engage with different notions of how FSP is understood. During the ‘pre-diagnosis era’ (and in the absence of an obvious biological explanation) men seemingly contemplated the notion of ‘the pain is sexual’ which potentially represented a lack of their desirability. This sense making was largely replaced by the notion of ‘the sex is painful’ post-diagnosis, which appeared to relieve men of self-questioning as they then understood pain to be predominantly biological and definitely situated in their partner.

The understanding of FSP that is offered by a diagnosis potentially shaped many aspects of men's experiences as illustrated in the second theme. Within the medical community, the difficulty is located within the woman, and treatments largely target the physical pain experience (Shallcross et al., 2018). Locating the problem in this way excludes men entirely from the formulation. The dominant story for men was of them being unseen and ignored within the medical environment as they were cast in secondary non-patient roles. This parallels accounts of men's experiences in the context of pregnancy, where men are also involved and invested in the issue that brings a couple into the medical system, but where women have the biological claim to patient status. 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' (Facchin et al., 2020) have been reported, similarly reflecting men's sense of being marginalised and pushed aside.

In the current study, the positioning of men as very much in a non-patient role appeared to further shape men's responses in several ways. Evident in men's accounts was a sense of impotence and loss of agency. Within the medical context, this was expressed as powerlessness to influence their partner's engagement with treatment. However, men's marginalisation also appeared to play out within the sexual and relational dynamic more broadly. Many men spoke of not initiating sex and instead described their partners as the ones who held the role of initiator (e.g. "I wait for her to initiate"). It is not known if these men's partners were motivated to be sexual through their own sexual interest or were 'permitting' sex which they believed was desired by men and functioned therefore as gatekeepers. As gatekeepers of sex, women sometimes 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 portrayed a picture where they were not in a position to initiate sex even when they desired it (despite normative notions of men being initiators—see Hayfield & Clarke, 2012). For several men, their narratives indicated concern around how any action and initiative may be experienced by their partners as perpetrating. Men have previously expressed their difficulty with potentially 'causing' harm, as pain may only be experienced or exacerbated during sexual activity (Sadownik et al., 2016). Many men in the current study also specifically expressed concern over hurting their partner, but also appeared to more broadly speak to an uneasiness around issues of power, abuse and coercion. The dominant picture was one where men were guarded against being active and agentic (not only sexually but also in initiating conversations, making suggestions around pursuing treatment and finding solutions) and presented instead as cautious, tentative, and deeply caring of any discomfort their partner may experience. These accounts suggest contradictory responses by men to those that may be anticipated by their partners as women 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.

In addition to shaping potency and agency, men's marginalisation also potentially influenced their ambivalence around whether their own distress and suffering was worthy of attention, as reported in the third theme. Men's accounts clearly illustrated the negative impact of FSP on *them* as well as their partners, yet men appeared to understand their own experience to be insignificant compared to their partner's, and themselves selfish if they attended to it, which resulted in men remaining largely silent about their own psychological and emotional pain. These findings align with research involving men as partners of women with endometriosis, men's experience of miscarriage and men as partners of women who have been sexually assaulted, which have all reported men similarly downplaying their own emotional distress and giving precedence to their partner's suffering despite experiencing significant distress themselves (Connop & Petrak, 2004; Culley et al., 2017; van Wijk et al., 2014; Williams et al., 2020). It is possible that men's minimisation of their distress and unwillingness to speak freely about their own experience may reflect, in part, efforts to uphold cultural expectations of masculinity due to the importance placed on 'appearing strong' and remaining stoic (Culley et al. 2017). However, it can also be considered that locating the problem in the woman's body (which is itself problematic), and positioning the woman as the patient appeared to render men and their distress insignificant and not entitled to be voiced. The research setting appeared to offer men an opportunity to speak about their experience, and 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. 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 some men spoke specifically about the shame they felt around masturbation and their own sexual interest continuing to be present, which has not previously been reported.

Turning now to the potential disruption to PVI and the sexual encounter that FSP may pose, men gave diverse accounts of their responses. Men did not appear to strictly 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. These men's accounts therefore appeared to be predominantly at odds with accounts of traditional masculine sexuality, and many of the narratives echoed the 'counter stories' that some men have told in men's sexuality research in different contexts (Potts et al., 2006). For example in the context of cancer, whilst many men have been described as positioning the erection and PVI as central to masculine sexuality, some men have resisted the coital imperative and positioned non-coital practices as better, enjoyable and satisfying (Gilbert et al., 2013; Ussher et al., 2013). Similarly, research on men's sexuality in later life has also described erectile changes, for some men, as offering an opportunity to explore alternative sexual practices that were not constrained to penile performance and penetrative sex (Potts et al., 2006); and the aging process potentially involved a movement from young biologically driven, PVI focussed, objectifying sexuality, to a mature sexuality involving sensuality and intimacy (Sandberg, 2013; Terry & Braun, 2009). The men in the current study also appeared to be intimacy orientated and draw on more than traditional notions of (hetero)sexuality. It is important to note that although these men were viewed within the context of FSP, they were also men in long-term relationships (with the exception of 2) and this social location has been proposed to be the site where men are more likely to challenge traditional discourses of heterosexuality and masculinity (Holland et al., 1998; Mooney-Somers & Ussher, 2010; Terry & Braun, 2009, 2011). Interestingly many women who partnered the men in this study appeared to draw on more 'fixed' and traditional social discourses of masculine sexuality despite also being in a long-term relationship. In men's accounts, their partner responses to PVI being difficult or impossible echoed what women have been reported to have said in interview studies, regarding 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). Dominant heterosexual discourses have been proposed to be powerful for women with FSP regardless of their relation context (Ayling & Ussher, 2007). 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 things they really wanted were intimacy and connection, either within the sexual and.or broader relationship. Dominant discourses of men's sexuality seemingly had less authority over the individual man than their partners may have believed.

Implications and recommendations

These findings have important implications regarding how men and the couple can potentially be better supported. The patient and 'non-patient' dichotomy potentially shaped how men responded within and beyond the medical setting. They appeared, for the most part, to experience themselves as marginalised, lacking in agency, and uncertain if their own distress was worthy of attention. In order to soften this division, it has previously 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, it is important to note that encouraging men to attend appointments is not without complications as this may violate women's own need for privacy, and problematise deviation from the norm (of men attending; Draper & Ives, 2013) - women may, for example, feel a coercive pressure to invite men, or escalate tension within the couple if they chose to prevent men from joining them. Therefore, this needs to be sensitively approached by professionals. The purpose of including men does nevertheless needs to be more fully considered. In the sexual pain literature, recommendations to include men have largely aimed to involve them in supporting women and their treatment. As an example, Caruso and Monaco (2019, p. 17) suggested "partners can be instructed in assisting in mindfulness or distraction to cope with the pain." The current study has clearly shown that men are deeply impacted by FSP and have their own intra and interpersonal difficulties, indicating the potential need for men themselves to also be offered receive support. However, as men also downplayed their distress and appeared ambivalent around their entitlement to talk about their own experience, practitioners in a medical setting (e.g. GP'S, gynaecologists, physiotherapists) can serve an important role in normalising the need for men's psychosocial support and render it acceptable and even expected. Men can however meaningfully be included in the therapy setting and attention given in full to their own experience.

Turning to the implications of the findings of this study for talking therapy, in alignment with the qualitative research into women's experience of FSP, many facets of men's entire experience were illustrated, that offer potential areas to explore in therapy. Importantly, the therapeutic setting provides a space for men to give voice to their experiences, when they may have otherwise felt invisible and silenced. Specific attention could be directed towards potential marginalisation and problematic dynamics within the relationship, such as difficulties with initiations of conversations or sexual approaches. This study also illustrated how some men can experience a sense of inadequacy or unattractiveness if they understood FSP to be a communication of 'something wrong in them'. This suggests that exploring men's meaning-making around the possible causes of FSP and how this impacted them may also be helpful.

Addressing now sex and sexuality within the couple, an important finding was that men's accounts contradicted taken-for-granted assumptions about men's sexuality, as the majority of men upheld an 'intimacy imperative' rather than a 'coital imperative'. This finding 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 of these 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. McCabe et al. (2010) theorised that sexual scripts at the cultural level *inform* but do not *dictate* the formation of individual and relational scripts. Both members of the couple may therefore benefit from exploring their own understandings at these different levels (e.g. what are my own expectations, what is expected within our relationship, what is expected within our culture?), and the assumptions that are made about their partner's notions of sex (e.g. what do you think your partner expects?). 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. Finally, 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), yet men in this study expressed discomfort around being a perpetrator of pain, and were seemingly vigilant to (unwanted) concealment of pain. It therefore seems essential to address how physical discomfort is communicated; expectations and acceptability of declining PVI when pain is present; and experimentation with pain free sexual practices and non-sexual sources of intimacy within the couple.

Limitations

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. Whilst this mirrors the demographic details of participants in the qualitative research of women's experiences of FSP (for a systematic review, see Shallcross et al., 2018), the findings and conclusions are limited by this. Our understandings of men of colour and from different socio-economic backgrounds are considerably lacking. 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, hencedespite extensive recruitment efforts to involve men more broadly, men who may experience the breakdown of relationships due to FSP have not been represented here.

Future research

Broader scale research is now required to explore the experiences of heterosexual men from different social andcultural backgrounds. As we only involved heterosexual men, including the experiences of bisexual men, and lesbian women who partner women with FSP, would broaden our knowledge 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.

As men in this study 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, yet it is not known how their partner responded if they were aware of their partner's practices. Related to this, men's experiences of shame when masturbating in the context of FSP may be interesting in itself to explore further, as to our knowledge this has not previously been reported.

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. Finally, this study 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 own psychosocial functioning.

Conclusion

There is a clear 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. We have foregrounded men's experiences due to them being integral to the entire FSP experience yet invisible through a biomedical lens. 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, an expanded notion of men's sexuality that may help to allay women's fears and support successful navigation of this complex condition. This study has highlighted the importance of including men (both in research and in practice) and expanding upon biomedically informed treatments by giving priority to contextual factors and locating FSP within individuals' relational and social world.

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