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"If Sex Hurts, Am I Still a Woman?" The Subjective Experience of Vulvodynia in Hetero-Sexual Women

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Abstract Vulvodynia has recently been recognized as a significant health problem among women, with a considerable proportion experiencing psychological distress and sexual dysfunction for many years. This study used a material-discursive framework and a qualitative methodology to investigate women's subjective experience of vulvodynia within the context of a hetero-sexual relationship, and their negotiation of coitus, commonly associated with vulvar pain. Seven women, who had experienced vulvodynia between 2 and 10 years, took part in in-depth interviews. Thematic decomposition drawing on a Foucauldian framework for interpretation identified that six of the seven women took up subject positions of "inadequate woman" and "inadequate partner," positioning themselves as failures for experiencing pain during coitus, which they interpreted as affecting their ability to satisfy their partners sexually, resulting in feelings of shame, guilt, and a decreased desire for sexual contact. This was interpreted in relation to dominant discourses of femininity and hetero-sexuality, which conflate a woman's sexuality with her need to be romantically attached to a man, position men as having a driven need for sex, and uphold coitus as the organizing feature of hetero-sex. Only one woman positioned herself as an "adequate woman/partner," associated with having renegotiated the coital imperative and the male sex drive discourse within her relationship. These positions, along with women's agentic attempts to resist them, were discussed in relation to their impact on hetero-sexual women's negotiation of vulvodynia. Implications for future research and vulvodynia treatment regimes are also raised.

Keywords Vulvodynia · Femininity · Hetero-sexuality · Positioning theory

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Introduction

> The impact of vulvodynia has been far greater than physical pain. Over time, my feelings of inadequacy have grown: I felt inadequate as a wife, inadequate as a woman. I began to resent my body and the fact that it was "faulty." Feelings of ugliness grew also. [Cherie].

Cherie wrote these words as part of her own personal "story of vulvodynia" before she had knowledge of this study. During her interview for this study, Cherie said vulvodynia impacted her on an "emotional, physical, and spiritual level" and that she hoped she could help other women to "avoid some of the stuff I put myself through, about all the shame stuff, [that] something was wrong with me, and the secrecy and not allowing myself to acknowledge the hugeness of it and if you could avoid some of that battle it would be a lot easier." Unfortunately, Cherie's experience of vulvodynia is not unique.

The International Society for the Study of Vulvovaginal Disease has recently defined vulvodynia as "vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder" (Haefner et al., 2005, p. 41). Some women report vulvar pain commencing with first attempts at tampon insertion while other women report pain-free, enjoyable sexual intercourse for many years prior

to onset (Reed, Advincula, Fonde, Gorenflo, & Haefner, 2003). A population based study specifically designed to assess vulvar pain reported that 16% of women had suffered from chronic vulvar pain at some time in their life (Harlow & Stewart, 2003). When this figure was further limited to women who had no history of other pelvic disorders and those who specifically reported pain associated with sexual intercourse, the rate remained high at 10%. Despite affecting one in ten women, vulvodynia remains relatively unrecognized and misunderstood by many general practitioners and gynecologists, resulting in symptoms being misdiagnosed and mismanaged for many years (Gates, 2000; Pagano, 1999; Reed, 2004).

Research efforts examining the etiology and treatment of vulvodynia have, so far, produced varied and sometimes conflicting conclusions. Difficulties begin with the complexities of a firm diagnosis. While gynecological examinations should exclude any known, treatable causes of vulvar pain before a woman is classified as having vulvodynia, this often presents a serious challenge to physicians due to the presence of numerous urogenital and dermatological conditions that frequently co-occur (Binik, 2003; Graziottin & Brotto, 2004; Haefner et al., 2005). Biophysiological studies suggest there are numerous factors that may contribute to vulvodynia. A variety of urogenital infections and skin irritations of the vulvar may cause nerves in this area to become hypersensitive and, over time, a neurological "pain loop" may develop (Jones, 2000; Reid, 2003; Ridley, 1996). Psychosocial etiological pathways, such as personality characteristics, psychopathology, history of sexual abuse, and sexual and relationship adjustment have also been suggested; however, the correlational and cross-sectional nature of this research has resulted in debate as to whether these are causal factors or consequences of vulvodynia (Gates, 2000; Jantos & White, 1997; Masheb, Brondolo, & Kerns, 2002; Meana, Binik, Khalife, & Cohen, 1998; Reed et al., 2000; Wojnarowska, Mayor, Simkin, & Day, 1997).

Current research into the psychosocial effects of living with vulvodynia suggests many women suffer psychological distress, with reports of high rates of depression, anxiety, and decreased sexual satisfaction (Gates, 2000; Jantos & White, 1997; Masheb et al., 2002; Meana, Binik, Khalife, & Cohen, 1997a; Sackett, Gates, Heckman-Stone, Kobus, & Galask, 2001; Stewart, Reicher, Gerulath, & Boydell, 1994; Wojnarowska et al., 1997), lower levels of relationship adjustment (Meana et al., 1997a; Sackett et al., 2001), physical and emotional limitations (Masheb et al., 2002; Sackett et al., 2001), and decrements in self-esteem (Katz, 1996).

A number of researchers and clinicians have called for vulvodynia to be reclassified as a chronic pain syndrome in an attempt to move beyond the current bio-physiological emphasis (Bergeron, Binik, Khalife, & Pagidas, 1997; Binik, Meana, Berkley, & Khalife, 1999; Meana, Binik, Khalife, & Cohen, 1997b; Pukall, Payne, Binik, & Khalife, 2003; Turk & Okifuji, 2002). Binik (2005) argued that dyspareunia meets all the criteria in the DSM-IV for pain disorder and that, significantly, the pain experienced by many women with vulvodynia is similar to the characteristics of other pain syndromes and is not unique to sexual intercourse, as it also occurs during a variety of other activities, such as tampon insertion, bicycle riding or wearing tight jeans. In response, Graziottin (2005) argued that the current classification of dyspareunia as a "sexual pain disorder" helpfully encompasses both the chronic pain experienced by women and the impact of that pain on their sexual health. There were 19 nineteen additional responses to Binik's (2005) article, indicative of the breadth of debate around, and the growing interest in, chronic vulvar pain and its treatment.

Despite this ongoing debate, vulvodynia treatment remains primarily biomedically focused, with attention focused on muscle hypertonicity in the vulvar which often makes penetrative vaginal-penis sex extremely painful and the neurological pain loop that develops over time (Graziottin & Brotto, 2004; Reid, 2003). Unfortunately, a strong biomedical focus encourages treatment regimes that "fix the woman" for pain free coitus and views any decrements in psychological or relational functioning as individual pathology rather than as an understandable reaction to chronic vulvar pain (Nicolson, 1993). At least 26 treatment options have been developed aimed at reducing the pain associated with vulvodynia, despite the absence of any large clinical trials evaluating their benefit (Binik, 2003; Edwards, 2003; Green, Christmas, Goldmeier, Byrne, & Kocsis, 2001; Stewart, 2003).

In a qualitative study that examined women's subjective experience of vulvar pain, Katz (1996) reported that women spoke of isolation, feelings of sexual inadequacy and loss of femininity, guilt, shame, loss of self, and diminished confidence. Such experiences cannot be encapsulated within a narrow biomedical model. In contrast, a recent study by Kaler (2006), based on the experiences of women who live with chronic vulvar pain, examined the ways in which women's experience of such pain intersected with dominant discourses of hetero-sexuality and gender. In other areas of women's health, researchers have also shown how material symptoms are mediated by relational and discursive factors in conditions such as postnatal depression (Mauthner, 1999; Nicolson, 1998), premenstrual syndrome (Ussher, 2004), sexual dysfunction (Tiefer, 1994), and menopause (Hunter & O'Dea, 1997). This work draws on Foucault's (1972) post-structuralist deconstruction of knowledge and power, which highlights how sociohistorical forces and, in particular, the discursive and material practices located within particular sociohistorical contexts, constrain and govern behavior.

From this perspective, a hetero-sexual woman's experience of vulvodynia might be understood to emerge within her simultaneous negotiation of dominant discourses of femininity and hetero-sexuality, which conflate a woman's sexuality with her need to be romantically attached to a man (Potts, 2002) and uphold coitus as the organizing feature of hetero-sex (Nicolson & Burr, 2003; Potts, 2002), motivating women to engage in painful coitus due to their desire to maintain some status as a "desirable woman" or a "caring hetero-sexual partner." Conversely, the consequences of transgressing dominant discourses and social norms may lead to significant emotional or relational distress. While Kaler's (2006) study focused on what the experience of vulvar pain has to say about the "enmeshment of gender, (hetero)sexuality and bodily practices," it places less emphasis on the implications of these enmeshments for research and clinical interventions in relation to vulvodynia. A theoretical understanding of why women continue to subjugate their own needs to the perceived needs of their partner's, despite the physical and psychological trauma that results from painful coitus (Graziottin & Brotto, 2004), could helpfully inform vulvodynia treatment regimes. However, to date, no effort has been made to investigate the "psychologic symptomology" of women with vulvodynia from a discursive perspective. This was the aim of the current study.

The current study adopted both a material-discursive approach (Ussher, 1997), embedded within a critical realist epistemology (Bhaskar, 1989) and a qualitative methodology, to investigate how a woman's experience of material factors associated with vulvodynia, such as pain and the negotiation of sex, were constructed and experienced within the context of broader discourses of gender and sexuality. Critical realism has been recently positioned as a way forward for research examining health in a sociocultural context (Williams, 2003), and is an epistemological standpoint which recognizes the materiality of the body, and other aspects of experience, but conceptualizes this materiality as always mediated by discourse, by culture, language and social or political practices (Bhaskar, 1989). Critical realists accept the legitimacy of subjective experience, and the utilization of a variety of methodologies, both qualitative and quantitative, without the findings of one being privileged above the other (Sayer, 2000), thus allowing the findings of qualitative research to be integrated into existing knowledge about vulvodynia collected through standardized quantitative measures. Within this framework, positioning theory was used to interpret the data. As outlined by Davies and Harré (1990) in their seminal paper:

> Positioning as we will use it is the discursive process whereby selves are located in conversations as observably and subjectively coherent participants in jointly produced story lines. There can be interactive positioning in which what one person says positions another. And there can be reflexive positioning in which one positions oneself. However, it would be a mistake to assume that, in either case, positioning is necessarily intentional. One lives one's life in terms of one's ongoingly produced self, whoever might be responsible for its production. (p. 48)

Given that difficulties with coitus are central both to treatment regimes and women's self-reports of vulvodynia, the research questions were:

1. What subject positions do hetero-sexual women with vulvodynia take up in relation to their sexuality when coital sex is limited or painful?
2. In what ways do these subject positions impact upon women's negotiation of material and discursive aspects of vulvodynia within a hetero-sexual relationship?

Method

Participants

Seven Anglo-Australian women aged between 18 and 41 years (M age = 27) participated in the study. In accordance with established protocols in qualitative research, sampling was discontinued when information redundancy was reached, and no additional information was forthcoming (Miles & Huberman, 1994). All women reported having vulvodynia symptoms for longer than 12 months, a medical diagnosis of vulvodynia for longer than 6 months, and a current or recent hetero-sexual relationship for longer than nine months. No differentiation was made on the basis of whether the participant had unprovoked or provoked vulvodynia (continuous pain, versus pain following contact) as it was expected that women would share a similar experience of pain during coitus, even if those with unprovoked vulvodynia also experienced pain independent of coitus. Exclusion criteria included any gynecological surgery in the previous two years unrelated to vulvodynia and any diagnosed chronic pain conditions unrelated to vulvodynia. Only one woman was excluded from the study as her age exceeded the upper age limit set at 41 years to avoid confounding of menopausal or peri-menopausal symptoms.

Six of the women were currently partnered of which four were co-habitating. One woman, Katherine, had recently been in a relationship. Five of the seven women were tertiary educated. Three women (Anna, Katherine, and Nina) had experienced vulvodynia symptoms for 2–5 years and the remainder had experienced symptoms for 5–10 years.

Procedure

A total of 47 information letters detailing the study were disseminated through a vulvar pain clinic in Sydney which specializes in the psychophysiological monitoring of chronic vulvar pain. Women attending the clinic received the letters in a sealed envelope at the end of their consultation. Five information letters were emailed to women on the mailing list of the Sydney based vulvodynia support group. Only one of the women interviewed, Cherie, had attended this small support group. Full ethics approval was received for the study.

One pilot interview was conducted to assess the suitability of the interview questions. The interviews were semi-structured and conducted as a dialogue between two women, the interviewer and the participant. Four questions were used as a guide to ensure each area of interest was addressed during the interview: (1) Please tell me about your experience of living with vulvodynia. (2) Has living with vulvodynia affected how you see yourself as a woman? (3) Has living with vulvodynia affected how you see yourself as a "sexual being"? (4) Has living with vulvodynia affected your relationship with your partner? The aim of the interview was to encourage "open, detailed and reflexive discussion" (Gavey & McPhillips, 1999, p. 355). While the interviewer honored the primacy of the women's experiences, initial reflections were shared during the interview and women were invited to reflect more deeply about their experiences (Gavey & McPhillips, 1999).

Interviews were conducted face-to-face by the first author. They were audiotaped and lasted between 60 and 100 min. Before commencing the interview, women signed a consent form and completed a brief demographic questionnaire asking about age, current relationship status, diagnosis, and duration of vulvodynia symptoms. At the close of the interview, all women were given contact information for the Sydney vulvodynia support group, "Group V," and the contact number of their closest Women's Health Centre where they could access free counseling.

Women were asked to choose a pseudonym which was then used to ensure anonymity on their transcript and in any published material. Partner's and children's names were also replaced by pseudonyms during transcription. Apart from these amendments, interviews were transcribed by the interviewer verbatim. Women received a printed copy of their own transcript. One participant, Cherie, gave the interviewer a copy of her written "story of vulvodynia" (prepared for a public testimonial prior to knowledge of this study and given to the interviewer after her face-to-face interview). This participant's written story was consistent with the information shared in her interview; therefore, it was included in the data analysis as part of her experience of vulvodynia.

Data analysis

Thematic deconstruction was used as a method of analysis, interpreted though the use of a Foucauldian post-structuralist framework (Willig, 2004), which examined the subject positions women with vulvodynia take up in regard to their hetero-sexuality, and how these subject positions impacted on their negotiation of both material and discursive aspects of vulvodynia. This analysis was based on the premise that there is an ongoing dynamic relationship between the subject positions individuals take up, the practices they engage in, and what they think or feel, i.e. their subjectivity (Davies & Harre, 1999; Willig, 2004). After transcription, interview transcripts and Cherie's prewritten story were read and re-read a number of times by the interviewer to identify overall themes, which were then discussed between the researchers. Themes were then grouped together, and then checked for emerging patterns, for variability and consistency across participants, and for the function and effects of specific themes. After further discussion between the researchers, and within a broader research group, these themes were then clustered into a coding frame that depicted the main subject positions evident in the women's stories. The interviewer then used QSR NVivo software, to code and index the main themes throughout the transcripts.

Reflexivity

Reflexivity is the act of reflecting on the role the researcher plays through their own "personal, political and intellectual autobiographies...in creating, interpreting and theorising data" (McKay, Ryan, & Sumsion, 2003, p. 52). Reflexivity was a critical factor in this research due to the experience of the interviewer, who is also an Anglo-Celtic Australian woman, negotiating a hetero-sexual relationship while living with vulvodynia. This experience meant that the interviewer was very much "in"s the research from an insider perspective (Humphreys, 2005). In contrast, the second author had no personal experience of vulvodynia and, in addition, while she has a prior history of hetero-sexuality, she is now in a lesbian relationship. The authors intentionally used this insider–outsider contrast to enhance the research design and analysis by reflecting on how each author's individual material-discursive history constrained or enhanced their interpretation of the data, allowing for the many taken for granted assumptions associated with hetero-sex and vulvodynia to be explored and challenged at a reflexive level.

At the stage of data collection, the authors decided to make known to the participants the interviewer's experience of vulvodynia, in order to be able to provide an honest answer if participants questioned the interviewer about this

issue, and because it may have become apparent during the discussion. A declaration at the outset therefore ensured consistency across interviews. However, the authors were keenly aware of the potential for this disclosure to limit the richness of participant's explanations due to an assumption of shared knowledge. The interviewer therefore adopted a position of unknowing questioner, informing her participants that "women's experiences of vulvodynia are not all the same, and thus I don't assume that my experience of vulvodynia is the same as yours. The purpose of this interview is to examine *your* experience of living with vulvodynia."

Results

Participants identified a range of emotional issues associated with vulvodynia, including anger, embarrassment, fear, grief, confusion, and self-surveillance. However, the predominant themes which emerged associated with the subject positions women adopt in relation to their sexuality were those of "inadequate sexual partner" and "inadequate woman." Only one woman, Sophia, positioned herself as an "adequate woman/sexual partner." Most women also reported experiences of "resisting the inadequate woman/sexual partner" position. The reported experiences of women who identified as having unprovoked vulvodynia were similar to those who identified as having provoked vulvodynia. (The woman who positioned herself as "adequate" and half of the women who positioned themselves as "inadequate" reported having provoked vulvodynia). The following analysis focused on how the four main subject positions—"inadequate sexual partner," "inadequate woman," "adequate woman/sexual partner," and "resisting the inadequate woman/sexual partner"—were constituted by dominant discourses of femininity and hetero-sexuality and how these positions impacted on the women's lived experience of vulvodynia in the context of their hetero-sexual relationships.

Inadequate sexual partner

The subject position of "inadequate sexual partner" was associated with adherence to the "male sex drive" discourse, which defines man's "need" for coitus as a biological drive which his female partner must accommodate (Hollway, 1989; Nicolson & Burr, 2003; Potts, 2002). Anna, Katherine, Cherie, Charlotte, and Nina referred to themselves as "not normal," "worthless," "useless," "broken," and "dysfunctional" because they positioned themselves as being unable to satisfy the perceived sexual needs of their partner.

> Charlotte: I still count periods of time between having sex and you know...I'm still very aware of how much can he take...you're letting him down and *why* would you stay with someone who's inadequate in some way.
>
> Anna: ...I was just so like, there's no point in being with you, there's no point because I can't fulfil my role as I said, there's things you want, there's things I want to give you and I can't do that, and then there's a lot of pressure, he's a male and he's very, he's 23, he wants to get it all out of his system and he just can't (laugh), he goes "I'm missing out, look I should be having more sex than this at 23" and I'm like (quiet voice) "I know you should."

Other women took up the position of "inadequate partner" even when they said their male partners were "incredibly supportive." For example, while Cherie reported feeling "inadequate as a partner [and] as a woman," she also said there was never any pressure for coitus from her partner: "He's amazing, like he's been totally understanding, he's never put any pressure on me to do anything, he's allowed me to set the tone of our relationship".

The women discussed all acts of physical intimacy in relation to the "coital imperative" (McPhillips, Braun, & Gavey, 2001; Potts, 2002), which posits that "real sex" equals coitus: penetration of the vagina by the penis. Charlotte commented that "it's very difficult not to feel stress about it, you know, going and having other intimate acts without kind of having the crescendo." She went on to say:

> Charlotte: ...what I think I would need is for him to say, "under no circumstances for the next six months am I going in there, I don't even want penetration, that's all. I'm not going to attempt, I'm not going to expect it, and it's banned, absolutely banned." Maybe that would be, I think that would give me some sort of relief. Maybe that's what I should do (laugh).
>
> Kathryn: Can you do that?
>
> Charlotte: Yeah, again, I think it's going back to believing that, you know, they still really want it and you'll disappoint them in some way.

Similarly, Nina appeared to struggle to find a way of conceiving of sex beyond coitus when questioned about how she might reshape her sexual relationship with her partner:

> Why should I bother because we're not going to be able to have intercourse which is just going to be a disappointment for him and for me so why would I bother...and I don't want to seem like I'm leading him on.

As was typical of the women interviewed, Nina reported that not participating in intercourse, irrespective of her own or her partner's desires, was associated with considerable guilt: "I feel guilty and I feel bad because I'm not able to keep going." Cherie explained her experience of inade-

quacy by articulating the difference between guilt and shame:

> You just feel like, sure there's something wrong with me as opposed to I've done something wrong, which I would define "guilt" as I've done something, and "shame" as I am wrong.

Cherie's reports of her "shame," despite her husband's "total understanding and support," highlight the significant influence of discourses on thoughts and behavior, regardless of material context (Willig, 2004).

All of the women positioned their experience of vulvodynia as being shaped by pressure that they perceived to exist within their current relational context. All of the women reported attempting sexual intercourse at times, despite the resulting pain, however, they also reported imagining a context where they could avoid this situation. Anna had entertained the idea of being single: "It would *just* be me, I don't have to sexually answer to anything"; Katherine said that "when I'm not in a relationship I can just ignore it"; and Jackie said "you would be better off to be a lesbian having this." These reports suggest that it is pressure, or perceived pressure, for coitus within hetero-sexual relationships, due to a desire to be 'normal', or to achieve sexual pleasure, which is a critical factor in hetero-sexual women's experiences of vulvodynia.

Inadequate woman

The inextricable linking of femininity with dominant discourses of hetero-sexuality was evidenced in the women's accounts of vulvodynia. Confirming Kaler's (2006) report that women with vulvodynia characterized themselves as "not a real woman," Charlotte reported that she perceived her identity as a woman to be directly linked to her ability to attract and keep a man, drawing connections between her experience of vulvodynia and that of a woman whose face has been burnt:

> I was able to chop and change men and be really good at it, it just opened loads of doors... and to have that side of you suddenly, well it wasn't suddenly taken away um, it's kind of like having a pretty face and being in a burns accident or a fire or something, so that you lose a big part of yourself that you *relied* on for, you know, choices.

Discourses of femininity which position the "good" woman as sexually passive or receptive, as well as caring and nurturing in relation to men (Ussher, 1997), were also utilized by women to privilege their partner's need for coitus over their own need for, or right to, pain-free sex.

> Nina: ...when I first had the bleeding and everything I wouldn't say anything because I didn't want to make him feel bad and sort of go, you know, I have to stop, I can't, I have to stop now because it's painful. I just put up with it.

All women talked of the physical and emotional consequences that resulted from participation in painful coitus: "yep, straight away burning itching raw...this isn't worth it and it'd still be in the same state four days later" [Jackie]; "I bled incredibly, it was really traumatic" [Cherie]; "on a couple of occasions, I'd have anxiety attacks...I'd start panicking" [Nina]; "I didn't say it hurt but I was just really resenting it and thinking in my mind, this must be what it feels like to be raped" [Katherine]; "it's the first thing I think of with any sort of intimate act, is it may lead up to, it's oh my god, it's going to hurt" [Charlotte].

Despite these reports of pain, all women, except Anna, positioned their current partner as more supportive and understanding than they imagined other men might be: "If anything was to happen sort of thing, I don't think I could meet another guy. I don't think that many men would understand it" [Jackie]; "if it had been my ex-boyfriend, he probably would have broken up with me" [Nina].

Younger women who positioned themselves as "inadequate" were aware of the growing liberal permissive discourse identified by Hollway (1989). However, compared to the popular representations of permissive women as adventurous, skillful, and eager for sex (Hollway, 1989; Potts, 2002), the younger women reported feeling immature, inexperienced, and constrained by the material limits of their vulvar pain:

> Just in the media, it's like women's desires are portrayed as so much wanting intercourse just as if that's the normal thing to do and like the easy thing to do, like it's really easy...you just feel a bit, not embarrassed but, yeah I guess embarrassed, cause it's expected that everyone is 23 and doing whatever you want, whereas I can't really [Katherine].

Thus, while the liberal permissive discourse may appear to bring greater freedom for women in hetero-sexual relationships, it does not appear to challenge the "coital imperative".

Adequate woman/sexual partner

In contrast, one interviewee, Sophia, did not position herself as either an inadequate woman or an inadequate sexual partner. Through the adoption of an egalitarian relational discourse which did not privilege one partner's needs or concerns over the others, Sophia reported that, as a couple, she and her partner were able to dismiss the "coital imperative" and experiment with other sexual practices:

> I guess at one stage I was, okay, I just won't start anything because then I feel bad if I don't go towards

penetrative sex. He said, "gosh, I don't care, you're allowed to give my bum a squeeze and you know (laugh), and give me a grope and all those things and I'm not going to expect you to launch on top of me."

Kathryn: And you believed him?

Sophia: I did (laugh), so, um, yeah that took a bit of time to get used to...so it's just a case of this is where I'm standing, and if he initiated something I'd just let him know, he'd go, "yeah, that's fine, we just won't do that," so we figured that there were lots of other options out there.

Sophia said her initial "bad" feelings about not being able to participate in coitus were dispelled through their open communication and she now reports feeling "confident and happy in the bedroom," despite her inability to engage regularly in coital sex.

Resisting the positioning of "inadequate woman/sexual partner"

While "inadequacy" was prominent in the women's talk, there were also many accounts of resistance. After talking about her "massive guilt," Anna corrected the interviewer in the following extract, indicating she was not totally accepting of the "male sexual drive" discourse which positioned her as an inadequate sexual partner:

Anna: ...he'll say it outright you know well I'm not getting enough and it's like then this massive guilt.

Kathryn: And yet, I mean it's a contradiction for you and him because although he's not getting enough...

Anna: Or what *he* feels he should have.

A further example of resistance was evident in Anna's account of attempting to accommodate her partner's need for coitus by negotiating a non-monogamous relationship, thus retaining her status as a hetero-sexual partner without having to endure pain during coital sex:

I got to such a point where I've gone well, just be here with me, and you go and sleep with someone else, release it and then I'm here you know, everything'll stay the same...I'll just be here to, you know, to fill it in.

Through emphasizing her caring, nurturing nature, where she'll "just be there...to fill in," Anna is attempting to reconstruct the position of woman and resist the conflation of woman with "inadequate sexual partner".

Similarly, Charlotte had also begun to critically reflect on the positions she took up, emphasizing her caring qualities as a "new woman":

Charlotte: ...but again, that's a confidence thing, you know, go back, are you fully developed as the new woman or are you really that good without your sexuality, are you *really* that good?

Kathryn: What is a new woman?

Charlotte: Well, just, well more of a balance, more of a companion, more of a support mechanism, more of the other *things.*

Knowledge of less traditional discourses of sexuality, such as feminist or egalitarian discourses, also opened up discursive spaces where women could question the position of "inadequate woman," as can be seen in the following example:

Um... well, I've always been quite feminist I guess, so I don't think of a woman's role as just being, you know, sexual in a relationship, so I also sort of was thinking well, you know, if my boyfriend was thinking he wasn't having enough sex then I was, one of my reactions in my head was sort of like, well you're lucky you get it all (laugh) kind of like, don't expect anything, but I also did think I should be able to do this at another point, on the other hand. So I was thinking both things. I wasn't just thinking one or the other [Katherine].

Katherine's talk reflect the poststructuralist concept of a "non-unitary subject," one where a plurality of possible, and often contradictory, subject positions renders dominant discourses unstable (Gavey, 1989).

Discussion

This thematic analysis of hetero-sexual women's subjective experience of vulvodynia found that most women took up positions of "inadequate woman" and "inadequate sexual partner" when they were unable to regularly engage in coitus. The women used dominant discursive constructions of "successful" hetero-sex (Potts, 2002) as reference points for their experience, centering on the "coital imperative" equating sex with penetration of the vagina by the penis. Discourses of femininity which position the "good" woman as sexually passive or receptive, as well as caring and nurturing in relation to men (Ussher, 1997), were also utilized by women in this study to privilege their partner's need for coitus over their own need for, or right to, pain-free sex. The women's reports were symbolic of the self-renunciation encouraged by discourses of femininity which place the responsibility for the man's physical and emotional needs on the woman (O'Grady, 2005). The women's subjectivity was thus constrained by discourses of hetero-sexuality and femininity, which position woman as an object of a man's desire, the means for satisfaction of his sexual drive and the reproductive imperative, as well as being a passive, acquiescent partner. Thus, women strug-

gled to see themselves as "adequate" even when they could have coitus occasionally, and even when they had negotiated a non-coital relationship that they reported to be satisfying to themselves and their partner.

Previous inconsistencies in vulvodynia research can be re-examined in light of this analysis, which suggests that the influence of intra- and interpersonal factors may be dependent upon the subject position a woman adopts. For example, women who adopt an "adequate woman/sexual partner" subject position may be more likely to engage in pain-free non-coital sex, and experience it as pleasurable, intimate, and emotionally satisfying. In contrast, women who adopt an "inadequate woman/sexual partner" position may see the same non-coital acts as a reminder of their inability to satisfy their partner sexually, resulting in feelings of guilt, shame, and a decreased desire for sexual contact. Thus, any research that attempts to account for inconsistencies in correlations between dyspareunia and coitus, wherein women experience pain on coitus, but still engage in the act (Meana et al., 1997a; Reed et al., 2003), must take into account the discursive constructions of hetero-sexuality and femininity. As this research study has shown, the decision to engage in coitus was not solely influenced by the potential for physical pain, or by one's psychological status, but by multiple factors, such as the desire to maintain intimacy, to achieve sexual pleasure, the embodied expectations of femininity, and the need to maintain status as a valued hetero-sexual partner. These are also explanatory factors in broader analyses of why any woman or man engages in sex that is unwanted, uncomfortable, or painful (Gavey, 2005), and thus the findings of this study have broader implications beyond the experience of vulvodynia.

Taking up a subject position is never a once and for all act. Women in this study were reflexive and creative, both in their struggle to conform to, and resist, dominant discourses of sexuality (Haug, 1999). Women were engaged in a dynamic, ongoing negotiation between adequacy and inadequacy and between the materiality of pain and the meanings of femininity and sexuality within a specific relational context. This process, however, was bound by the women's discursive economy, which inextricably links femininity and hetero-sexuality to create few, if any, positive positions for women that do not conflate a woman's sexuality with her need to be romantically attached to a man (Ussher, 1997). These discourses also exclude any positive positions for hetero-sexual women who cannot, or who choose not to, participate in coitus regularly. Non-coital sex is considered as peripheral to real sex: as foreplay, after play, or immature play, or as safe sex–but never as real sex (Tiefer, 1994). Women who choose non-coital sex risk punitive consequences, such as the derogatory labels of "frigid" or "prick tease," or a diagnosis of sexual dysfunction (Nicolson, 1993).

When a woman perceives she cannot fulfill normative (or desired) functions of hetero-sexuality, she may judge herself as "inadequate" through a process of reflexive self-positioning (Moghaddam, 1999). This process takes place at an intrapersonal level, identified by Foucault (1977) as an internalized self-policing whereby individuals constantly appraise their performance against cultural ideals. Falling short of these ideals can lead to feelings of inferiority and inadequacy (O'Grady, 2005), as was the experience of most women in this study. The adoption of an "inadequate" position means accepting a position of inferiority, being "less than" what one believes one should be, which Kaufman (1993) calls shame. Shame is highly disempowering and can result in self-silencing and isolation (Seu, 1995). Combined with the taboo associated with female genitalia and the discussion of sexual practices, this can act to constrain women from seeking professional help for their symptoms, or from communicating honestly with partners and experimenting with alternative forms of intimacy. Silenced by shame, and a fear of physical pain, women may choose indirect methods of avoiding sexual contact which are open to misinterpretation by their partner and which leave deeply felt emotions unexpressed. As self-silencing has also been associated with depression (Jack, 1991), this may provide partial explanation for the fact that some women with vulvodynia struggle with depression, and in extreme cases, suicidal ideation (Jones, 2004; Kaschak, 1992; Kaufman, 1993). A deconstruction of the primacy of coitus to a hetero-sexual relationship, however, may greatly facilitate a woman's ability to negotiate intimate spaces that are free of the physical and psychological pain they have come to associate with painful coitus. The one woman in this study who viewed herself as adequate had, through a process of open communication with her partner, reconstructed a positive (hetero)sexual relationship that accommodated her inability to engage in coitus regularly. When women perceive their positions as a hetero-sexual partner to be precarious, they may engage in self-silencing of the pain they experience, both physically and psychologically, from coitus.

Despite the negative consequences of taking up positions of inadequacy, most women in this study reported sustaining strong relationships with their current partner. The reasons for this are not clear from the current study, but indicate that there are other sustaining features of a hetero-sexual relationship that were not accessed by the interview questions used here. It may indicate a willingness in male partners to renegotiate coital sex, suggesting that men may not position their female partner as an "inadequate woman" or "inadequate sexual partner" when she cannot engage regularly in coital sex. In a recent study that asked men and women if they could imagine a hetero-sexual relationship without coitus, almost half of the participants said they

could (McPhillips et al., 2001), and many hetero-sexual relationships do endure despite mismatches between partners' desires for sexual activities (Mooney Somers, 2005). Thus, the women interviewed in the present study may have been inaccurate in their perception of their partner's need for coitus, suggesting that, in practice, the "coital imperative" may not be so imperative after all. Including the partners of women with vulvodynia in future research would clarify this issue.

The accounts analyzed here were not presented as being representative of all women's experiences of vulvodynia. This analysis was a snapshot of a dynamic process, used in this context to gain insight into the influence of discursive factors in the subjective and bodily experience of vulvodynia. However, given the rich data produced by this qualitative analysis of vulvodynia, it is clear that further investigation is warranted. Future research should endeavor to broaden the sample to include women who are not presenting for professional help for vulvodynia, as well as those in different relational contexts, and with different lengths of symptom duration, as well as the experience of partners, thus enabling researchers to compare and contrast the material and discursive forces at play in different contexts, and give a clearer picture of the negotiation of symptoms over time.

This article has examined vulvodynia from a material-discursive standpoint, arguing that the discursive construction of gender and sexuality, and the subject positions women adopt in relation to these discourses, need to be considered in any analysis of the etiology and treatment of distress associated with this disorder. Subject positions offer ways of being and behaving (Willig, 2004); therefore, they have real implications for the negotiation of the material aspects of vulvodynia: factors which have previously been conceptualized in a reductionist manner in cross-sectional questionnaire based studies framed within a positivist epistemological standpoint.

The aim of this material-discursive analysis has not been to disembody vulvodynia, but rather to acknowledge that a woman experiences vulvodynia both physically and subjectively (Stoppard, 1998) and to highlight the difficulty of reducing the emergent experience to unitary etiological factors. While medical assessment is imperative and an accurate diagnosis often brings significant relief to women, individualized biomedical treatment alone does not address the full impact of vulvar pain on a woman's life. Vulvodynia is being continuously constructed in the lived experience of each woman, the outcome of reciprocal interactions between material (pain, relational context, diagnosis, and treatment) and discursive (gender, sexuality, relationship, and medical) factors. A material-discursive framework, which is capable of engaging all of these factors, is imperative for the implementation of a multi-factorial approach to vulvodynia that could significantly improve women's subjective experience of this disorder and intersect positively with interventions. This approach would acknowledge the materiality of the embodied experience of vulvodynia, as well as the psychological experience of women, and the discursive context in which sexuality and femininity are constructed and experienced.

A multi-factorial approach to interventions could include a radical deconstruction of the embodied discourses of femininity and hetero-sexuality to challenge current thoughts and practice, which may have a significant impact on the practices women engage in as well as their subjective experience of vulvodynia (Gavey & McPhillips, 1999). A simple direction to abstain from coitus during treatment may be more efficacious if accompanied by an intervention such as narrative therapy aimed at deconstructing those discourses that have come to automatically guide women's and men's subjectivity and practice (Gavey & McPhillips, 1999). This deconstruction can draw on subtle inconsistencies in the meaning of coitus, womanhood, and the transmission of intimacy, to open up discursive spaces for critical reflection (Gavey et al., 1999). When coitus can be seen as no longer critical to intimacy, hetero-sexual women and men are more likely to be able to maintain an active engagement in exploring alternative practices of sexual pleasure which will contribute to a sustained intimacy and closeness from which they can draw considerable support. Women who can position themselves as "adequate" and who are also positioned as such by their male partner may thus no longer feel impelled to engage in painful coitus or experience thoughts of self-recrimination for their normative failings, thus minimizing experiences of anxiety, fear, resentment, guilt, shame, and isolation, and the positioning of both the body and self as "faulty."

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