

PAIN

A Comparison of Approach and Avoidance Sexual Goals in Couples With Vulvodynia and Community Controls



Justin P. Dubé, BSc,¹ Sophie Bergeron, PhD,² Amy Muise, PhD,³ Emily A. Impett, PhD,⁴ and Natalie O. Rosen, PhD^{1,5}

ABSTRACT

Background: Provoked vestibulodynia (PVD) is a prevalent form of vulvodynia that interferes with the sexual and relational functioning of affected couples. Approach and avoidance sexual goals are associated with the sexual and relationship well-being of women with PVD and their partners. However, whether sexual goals differ in couples coping with PVD compared with community couples is unknown.

Aims: To compare the approach and avoidance sexual goals of women with PVD and their partners with a control sample of community women and their partners to build on an established motivational model and to compare the sexual goals of women with PVD with those of their partners.

Methods: Women diagnosed with PVD and their partners (n = 161) and control couples (n = 172) completed measures of approach and avoidance sexual goals.

Outcome: Approach and Avoidance Sexual Goals Questionnaire.

Results: Women with PVD reported lower approach and higher avoidance sexual goals than control women, whereas partners of women with PVD did not differ from control partners in their sexual goals. Women with PVD also reported lower approach and higher avoidance sexual goals compared with their partners, whereas there were no differences between partners in the control sample.

Clinical Implications: Given that avoidance sexual goals have been linked to negative sexual and relational outcomes, clinicians could strive to help couples with PVD become aware of their sexual motives, with the aim of weakening avoidance sexual goals and bolstering approach sexual goals.

Strengths and Limitations: This is the first study to empirically document differences in sexual goals between couples affected by PVD and community couples. Limitations include the study's correlational design, differences in demographic characteristics between samples, and the homogeneity of participants' sexual orientation.

Conclusions: Findings suggest that the sexual goals of women affected by PVD differ from those of community women and from their partners and support sexual goals as targets for psychological interventions to help couples coping with PVD. **Dubé JP, Bergeron S, Muise A, et al. A Comparison of Approach and Avoidance Sexual Goals in Couples With Vulvodynia and Community Controls. J Sex Med 2017;14:1412–1420.**

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Key Words: Provoked Vestibulodynia; Vulvodynia; Couples; Sexual Motivation; Sexual Goals

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¹Department of Psychology and Neuroscience, Life Sciences Centre, Dalhousie University, Halifax, NS, Canada;

²Department of Psychology, Université de Montréal, Montréal, QC, Canada;

³Department of Psychology, York University, Toronto, ON, Canada;

⁴Department of Psychology, University of Toronto, Mississauga, ON, Canada;

⁵Department of Obstetrics and Gynaecology, IWK Health Centre, Halifax, NS, Canada

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INTRODUCTION

Provoked vestibulodynia (PVD), a subtype of vulvodynia characterized by acute pain in the vulvar vestibule, is the most frequent cause of pain during intercourse in premenopausal women.¹ Although the precise etiology is unknown, multiple biological, psychological, and interpersonal factors contribute to the development and maintenance of PVD.² PVD is associated with psychological and sexual impairments for affected women and their romantic partners, such as increased psychological distress and decreased sexual function and satisfaction (see Bergeron et al² for a review). Sexual motivation is emerging

as a key factor that is relevant to women with vulvovaginal pain, prompting recommendations that it be targeted in psychological interventions to help women adapt to the condition.^{3–5} Although sexual goals, defined as the outcomes that people pursue when engaging in sex, are associated with the sexual and relational functioning of women with PVD and their partners,^{5,6} whether sexual goals differ for couples affected by PVD compared with community couples is unknown. Because PVD renders sexual intercourse painful and affected women report many relationship fears and guilt as a result,⁷ they might tend to engage in intercourse primarily to avoid negative consequences (avoidance goals) compared with women without pain who might engage in intercourse most often to pursue positive outcomes (approach goals). Determining the presence and nature of such differences could help account for the sexual impairments that are commonly observed in couples affected by PVD and could support sexual goals as targets of interventions to help these women and their partners. The present study compared the sexual goals of couples affected by PVD with those of community control couples and compared the sexual goals of women with PVD with those of their male partners.

People's desires to approach pleasure and avoid pain are well established in theories of motivation.^{8,9} Such theories distinguish between independent systems of approach (or attainment) and avoidance (or inhibition), which are activated when individuals adopt self-regulatory actions focused on attaining success and averting failure, respectively.^{10–12} The approach-avoidance distinction, when applied to sexuality, posits that people might engage in sex to attain positive outcomes, such as to show love for a partner (ie, an approach sexual goal), and to avoid negative outcomes, such as their partner's disappointment (ie, an avoidance sexual goal)^{5,13} (see review by Impett et al¹⁴). Sexual goals have been further delineated in their focus on the self (eg, to feel good about one's self) vs the partner (eg, to experience pleasure with a partner).¹⁵ Although conceptualized as independent systems, it is possible to simultaneously hold approach and avoidance goals for sex.^{14,16} For instance, one might pursue sex to achieve intimacy and to avert discord with a partner. Indeed, although some studies have found a positive correlation between approach and avoidance sexual goals,^{5,17} others have found no significant association.¹³ Importantly, sexual goals have distinct associations with sexual and relationship outcomes; approach sexual goals are associated with enhanced sexual desire and relationship and sexual satisfaction (while controlling for avoidance goals), and avoidance goals are associated with lower desire and satisfaction (while controlling for approach goals).^{5,13,17}

Although other types of goals, such as task persistence and pain avoidance, have been shown to affect a person's ability to manage pain,^{18,19} the role of goals in vulvovaginal pain has only recently received empirical attention. An epidemiologic study found that, despite their pain, more than 90% of affected women engaged in intercourse in the preceding 6 months.²⁰ In a qualitative study, Elmerstig et al⁴ found that women with pain

during sexual intercourse reported engaging in intercourse to achieve intimacy with, and to avoid abandonment by, their partners, suggesting that approach and avoidance sexual goals—and particularly those that were partner-focused—affected women's decisions to persist with painful intercourse. Further, Rosen et al⁵ found that in a sample of women with PVD and their partners, women's higher approach sexual goals were associated with their higher relationship and sexual satisfaction, whereas women's higher avoidance sexual goals were associated with women's lower sexual and relationship satisfaction, more depressive symptoms, and lower relationship satisfaction for their partners.

Although no studies have directly compared the level of sexual goals in women affected by PVD with those of unaffected women, Brauer et al³ found that, compared with controls, women who experienced pain during intercourse (ie, they did not have a specific diagnosis) reported persisting with sex for fewer reasons that involved pleasure (conceptually aligned with approach sexual goals) and for more reasons that included a sense of obligation or to avoid losing a romantic partner (conceptually aligned with avoidance sexual goals). Further, couples affected by PVD have reported lower sexual rewards and higher sexual costs compared with control couples.²¹ Fears of partner loss or disappointment and feeling obliged to meet partners' sexual needs also have figured prominently into the sexual goals of women with vulvovaginal pain in qualitative studies.^{4,7} Together, these findings suggest that partner-focused sexual goals might be especially relevant for women with PVD, and that they might endorse lower approach sexual goals and higher avoidance sexual goals compared with control women. Because partners of women with PVD also are negatively affected by the pain²² and romantic partners tend to adopt similar goals (see Laurin²³ for a review of goal contagion research), partners of women with PVD might report lower approach and higher avoidance sexual goals compared with partners of control women. Moreover, although research with community couples typically finds no sex differences in sexual goals,¹³ in the context of PVD, in which women bear the burden of pain, it is plausible that women might endorse higher avoidance sexual goals and lower approach goals than their partners. Uncovering differences in sexual goals will provide insight into an important motivational factor that could help account for the negative sexual and relational consequences observed in couples struggling with this condition. An enhanced understanding of how the sexual goals of couples affected by PVD differ from control couples also could support sexual goals as targets for interventions to improve sexual and relational functioning in couples coping with PVD.

AIMS

The aim of this study was to compare the sexual goals of women with PVD and their partners with those of a control group of community women and their partners. This study also sought to determine whether there were differences in sexual

Table 1. Sample characteristics

	PVD (n = 161)	Controls (n = 172)	P value*
Age (y), mean (SD)			
Women	26.53 (5.60)	35.27 (9.21)	<.001
Partners	28.26 (7.00)	37.83 (10.61)	<.001
Combined annual income, n (%)			<.001
\$0–39,999	62 (38.50)	23 (13.40)	
\$40,000–59,999	28 (17.40)	35 (20.34)	
>\$60,000	71 (44.10)	114 (66.30)	
Relationship type, n (%)			<.001
Live apart	33 (20.50)	11 (6.40)	
Cohabitate	71 (44.10)	26 (15.10)	
Married	35 (21.7)	123 (71.50)	
Other	22 (13.70)	12 (7.00)	
Relationship duration (y), mean (SD)	4.76 (3.55)	12.37 (8.74)	<.001

PVD = provoked vestibulodynia.

*By Student t-test or χ^2 test.

goals between women with PVD and their partners. We predicted that women with PVD would have lower approach sexual goals and higher avoidance sexual goals compared with control women. The same pattern was expected when comparing partners of women with PVD with control partners: women with PVD would have lower approach sexual goals and higher avoidance sexual goals compared with their partners. Consistent with prior research,^{13,17} we expected no differences between control women and their partners in approach or avoidance sexual goals.

METHODS

Participants and Procedure

The studies were approved by the authors' institutional research ethics boards. The PVD and control couples were drawn from samples who participated in larger studies examining interpersonal factors in couples coping with PVD and community couples, respectively.^{5,17} Data for the present study were drawn from the baseline assessment sessions only. Participant and couple characteristics are presented in Table 1.

PVD Sample

Women with PVD and their partners were recruited from two cities (Halifax and Montreal). Couples were recruited from poster, print, and online advertisements (n = 209; 63%), through participation in previous studies in the authors' laboratories (n = 43; 13%), physician referral (n = 53; 16%), and word of mouth (n = 27; 8%). Women with PVD were first screened for eligibility with a structured telephone interview conducted by a research assistant. Participants were eligible if they experienced pain during intercourse that was subjectively distressing, occurred on at least 80% of intercourse attempts, lasted for at least 6 months, and was limited to activities involving pressure to the vestibule. Women had to be 18 to 45 years old and premenopausal, and partners had to be older than

18 years. Couples must have had at least four in-person contacts per week, been together for at least 3 months, and have engaged in sexual activity at least once per month during the previous 3 months. Sexual activity was defined broadly and included non-penetrative activities. Women attended a gynecologic examination for diagnosis by a standardized cotton-swab test,²⁴ which included a minimum average pain rating of 4 on a scale of 0 (no pain) to 10 (worst pain ever) in at least one location of the vestibule during the gynecologic examination. Women were excluded if they had an active vulvovaginal infection previously diagnosed by a physician, self-reported infection, or pregnancy. Of the 332 women who were eligible after initial screening, 223 women and their partners agreed to participate. However, 62 couples were excluded after initial screening, resulting in a final sample of 161 couples (see Figure 1 for details). Of the participating couples, 159 were in a mixed-sex relationship and 2 were in a same-sex relationship. Further descriptive characteristics of the study sample (eg, level of sexual satisfaction, sexual function, mood, and relationship satisfaction) can be found in prior publications.^{5,6} Women and their partners attended a laboratory-based session where they provided informed consent and independently completed the study measures. Women were compensated \$30 (\$10 for their initial visit and \$20 for the gynecologic examination) and partners were compensated \$10.

Control Sample

Control couples were from a convenience sample that was recruited at the Ontario Science Center in Toronto, Canada. To be eligible, participants were required to be English-speaking couples older than 18 years who were in a relationship for at least 3 years and were married or living together. Eligible couples provided informed consent and were invited to complete a survey independently from each other about aspects of their relationship, including their approach and avoidance sexual goals. Of the 212 community couples who began the survey, 40 provided incomplete data, resulting in a final sample of 172 couples.

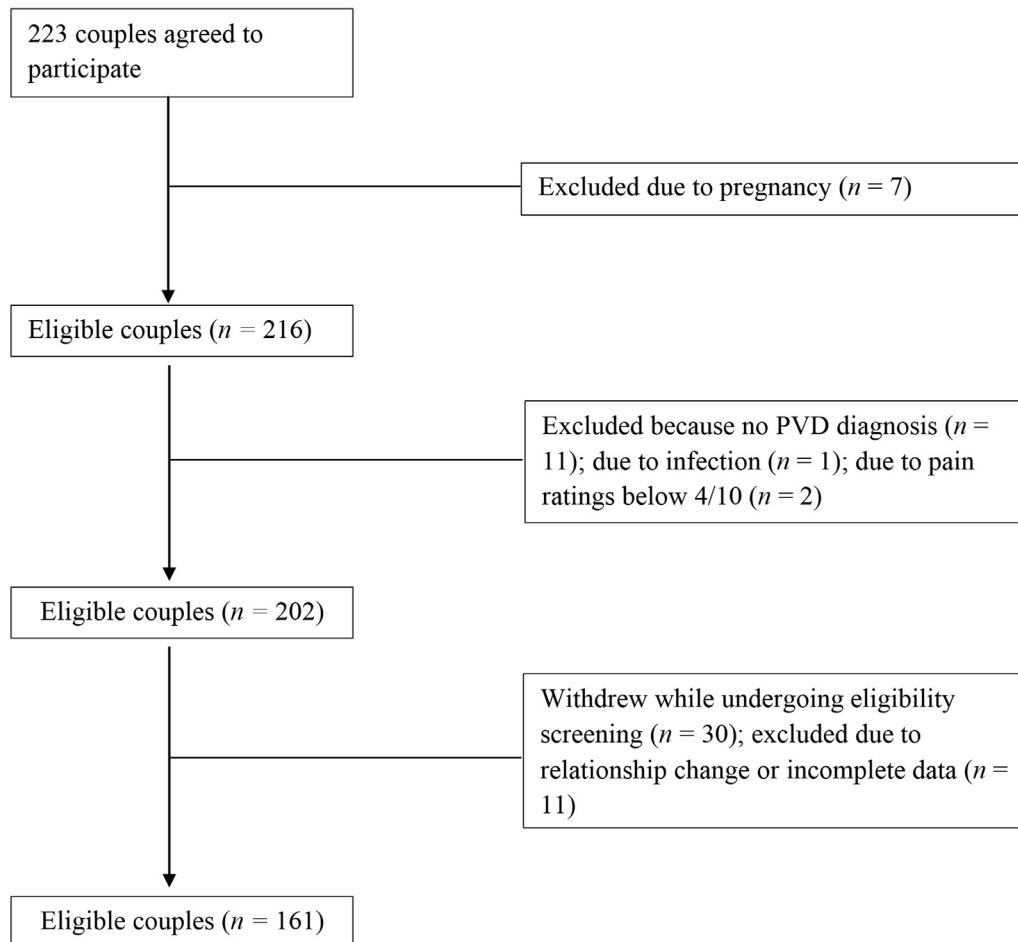


Figure 1. Flowchart of PVD couples excluded from the study. PVD = provoked vestibulodynia.

Couples who participated in the study were awarded a small gift for their time (eg, a pen or notebook with a university logo). All couples were in mixed-sex relationships.

Measures

Sexual Goals

Interpersonal sexual goals were measured using 10 items previously used in research on sexual motivation.^{5,25,26} Only items reflecting partner-focused goals influencing the decision to engage in sex—as used in prior research^{5,6,27}—were retained (Table 2). Participants indicated the importance of five approach sexual goal items in motivating their decision to have sex with their partner (eg, “to promote intimacy in my relationship” and “to experience pleasure with my partner”) and five avoidance goal items (eg, “to prevent my partner from becoming upset” and “to prevent my partner from falling out of love with me”). Items were rated on a seven-point scale (1 = not at all important to 7 = extremely important). Items for approach and avoidance sexual goals were averaged; higher averages for each subscale indicated a greater tendency to be motivated by that sexual goal. Previous research supports the reliability and validity of this measure.^{13,17} An approach sexual goal item (“to please my

partner”) was removed to improve the internal consistency of the measure for women with PVD. An exploratory factor analysis using principle axis factoring and a ProMax rotation showed that this item did not load onto the approach subscale as expected for the women with PVD (factor loading = 0.11) or partners of women with PVD (factor loading = 0.38). Conceptually, this item differs from other approach sexual goals by focusing more on the individual pleasure of the partner rather than on the shared pleasure of the couple as the motive for pursuing sex, which could explain why it failed to properly load with the other approach sexual goal items. All other items loaded onto the approach and avoidance sexual goals subscales, as expected, for women with PVD and their partners. For approach sexual goals, the Cronbach α values were 0.79 for women and 0.81 for partners in the PVD sample and 0.77 for women and 0.73 for partners in the control sample. For avoidance sexual goals, the Cronbach α values were 0.88 for women and 0.90 for partners in the PVD sample and 0.86 for women and 0.86 for partners in the control sample.

Data Analysis

Statistical analyses were conducted with SPSS 23.0 (SPSS, Inc, Chicago, IL, USA). We used a 2 (sex) by 2 (group) mixed

Table 2. Items assessing approach and avoidance sexual goals*

Approach sexual goals	Avoidance sexual goals
To please my partner.†	To prevent my partner from falling out of love with me.
To promote intimacy in my relationship.	To prevent my partner from losing interest in me.
To express love for my partner.	To avoid having to decline my partner’s request.
To experience pleasure with my partner.	To prevent my partner from becoming upset.
To add excitement to my relationship.	To avoid conflict in my relationship.

*Participants were asked to rate the importance of the items as to why they typically engage in sex with their partner (1 = not at all important to 7 = extremely important).

†Item was removed for analysis because of low internal consistency and poor factor loading for women with provoked vestibulodynia.

multivariate analysis of variance with sex as a within-subjects factor to compare the groups, followed by univariate analyses of variance and mean comparisons (t-tests) for any observed group effects. Effect size estimates were made using partial eta squared (η_p^2). The χ^2 tests were used to measure differences in the categorical demographic variables between the two groups, including relationship type and annual income bracket. Student t-tests were used to compare age and relationship duration between groups. Data reduction for demographic variables, such as combined annual income and relationship type, involved combining response options among couples and binning the results into categories. For example, participants selected their annual income from among 11 income brackets (eg, 1 = \$0–9,999; 2 = \$10,000–19,999; ...; 11 = >\$100,000). Then, incomes were combined among partners and put into the following three annual income brackets: \$0 to \$39,999, \$40,000 to \$59,999, and higher than \$60,000. A similar procedure was used for relationship type, which was treated as nominal categorical data. Then, χ^2 tests were used to compare these variables between the PVD and control samples. When significant differences were observed, these variables were controlled for in the analyses.

RESULTS

Women with PVD were significantly younger than control women ($t_{331} = 10.54, P < .001$), and partners of women with PVD were significantly younger than control partners ($t_{331} = 9.77, P < .001$). The PVD sample had been in a relationship for a shorter period ($t_{331} = 10.53, P < .001$), was less likely to be married ($\chi^2 [3, n = 333] = 83.56, P < .001$), and more likely to report an annual income below \$40,000.00 ($\chi^2 [2,$

$n = 333] = 28.33, P < .001$) compared with the control sample (Table 1). Therefore, age, relationship length, relationship type, and level of income were controlled for in the analyses. The means and SDs for approach and avoidance sexual goals are presented separately for the PVD and control samples in Table 3.

There was a significant multivariate effect for group ($F_{2, 325} = 14.23, P < .001, \eta_p^2 = 0.08$) and for the group-by-sex interaction ($F_{2, 325} = 8.82, P < .001, \eta_p^2 = 0.05$). The main effects for sex ($F_{2, 325} = 0.10, P = .91, \eta_p^2 = 0.00$), women’s age ($F_{2, 325} = 0.15, P = .86, \eta_p^2 = 0.00$), partners’ age ($F_{2, 325} = 0.31, P = .73, \eta_p^2 = 0.00$), relationship length ($F_{2, 325} = 0.54, P = .59, \eta_p^2 = 0.00$), relationship type ($F_{2, 325} = 0.54, P = .59, \eta_p^2 = 0.00$), and income level ($F_{2, 325} = 0.41, P = .66, \eta_p^2 = 0.00$) were not significant, and there were no significant interactions between sex and age, relationship length, relationship type, or income level.

Results of the follow-up analysis of variance for the group effect showed that, overall, couples affected by PVD endorsed lower approach sexual goals ($F_{1, 328} = 21.75, P < .001, \eta_p^2 = 0.07$) and higher avoidance sexual goals ($F_{1, 328} = 4.59, P < .05, \eta_p^2 = 0.01$) compared with control couples (Table 3). These effects are considered moderate and small, respectively.²⁸ The follow-up analysis of variance for the sex-by-group interaction effect was significant for approach sexual goals ($F_{1, 328} = 13.01, P < .001, \eta_p^2 = 0.04$) and avoidance sexual goals ($F_{1, 328} = 5.65, P < .05, \eta_p^2 = 0.02$), with effects within the small to medium range²⁸ (Table 4). Pairwise mean comparisons showed that women with PVD reported lower approach sexual goals compared with control women ($t_{331} = 5.91, P < .001, Cohen d = 0.65$) and with their partners ($t_{320} = 4.25, P < .001, Cohen d = 0.48$) and higher avoidance sexual goals compared

Table 3. Mean and SD for approach and avoidance sexual goals for couples affected by PVD and pain-free control couples*

Variable	Group	Mean	SD	F	η_p^2
Approach	PVD	5.79	0.77	21.75†	0.07
	Control	6.12	0.61		
Avoidance	PVD	3.63	1.34	4.59†	0.01
	Control	3.32	1.20		

PVD = provoked vestibulodynia.

*N = 161 couples with PVD and 172 control couples. Approach and avoidance sexual goal scores had a possible range of 1 to 7.

† $P < .05$; ‡ $P < .001$.

Table 4. Mean and SD, follow-up ANOVAs, and simple effects analysis for approach and avoidance sexual goals in women affected by PVD and their partners and control couples*

Variable/group	Women		Partners		Follow-up ANOVA	
	Mean	SD	Mean	SD	F	η_p^2
Approach						
PVD	5.50 _{ab}	1.12	5.98 _a	0.95	13.01 [†]	0.04
Control	6.21 _b	1.11	6.10	0.94		
Avoidance						
PVD	3.98 _{de}	1.84	3.31 _d	1.85	5.65 [†]	0.02
Control	3.29 _e	1.82	3.30	1.84		

ANOVA = analyses of variance; PVD = provoked vestibulodynia.

*For the outcome variables, means with the same subscript indicate a significant difference of $P < .05$ (161 couples with PVD and 172 control couples).

[†] $P < .05$; [‡] $P < .001$

with control women ($t_{331} = 3.44$, $P < .001$, Cohen $d = 0.38$) and with their partners ($t_{320} = 3.44$, $P < .01$, Cohen $d = 0.36$). According to Cohen,²⁹ effects sizes are considered large at 0.80, moderate at 0.50, and small at 0.20. No significant differences in approach and avoidance sexual goals were found between partners of women with PVD and control partners or between control women and control partners. In sum, women with PVD reported lower approach sexual goals and higher avoidance sexual goals compared with control women and their partners.

DISCUSSION

Using an established motivational model,^{8,9} the present study compared the approach and avoidance sexual goals of couples affected by PVD with those of community control couples. Overall, couples affected by PVD reported lower approach and higher avoidance sexual goals compared with control couples. However, at closer examination, only women with PVD (and not their partners) reported lower approach and higher avoidance sexual goals compared with controls. Further, women with PVD reported lower approach and higher avoidance sexual goals compared with their partners. Findings are consistent with interpersonal conceptualizations of pain^{30,31} and underscore sexual motivation as an important interpersonal factor that differs between couples with PVD and community control couples. As such, sexual motivation should be considered in biopsychosocial conceptualizations and treatment of this condition.

In support of our hypothesis, women with PVD reported higher avoidance sexual goals than control women. These results are in line with those of Brauer et al³ who found that women experiencing pain during intercourse reported more avoidance motives for intercourse, such as to prevent the loss of their partner or feeling pressured to have sex with their partner, than women without this pain. Compared with controls, women with PVD might be more motivated by avoidance sexual goals because of the experience of pain. Qualitative studies have found that women who experience pain during intercourse report feelings of shame and guilt.³² Correspondingly, women with PVD have

reported emotional distress and damage to their relationship because of the pain.³³ Together, these findings suggest that the experience of PVD-related pain might contribute to increased relational strain, possibly accounting for the observed differences, such that women with PVD are more likely to engage in sex to avoid further stress, conflict, or guilt. Further, women with PVD might be more attuned to negative interpersonal or pain-related cues than control couples,³⁴ which also could contribute to stronger avoidance sexual goals.

In line with Rosen et al,⁶ avoidance sexual goals were higher for women with PVD than for their partners, likely because it is the woman with PVD who ultimately experiences the pain and suffers more extensive consequences. Indeed, although couples affected by PVD have reported more sexual costs (ie, physical or mental effort, pain, or negative affect as a result of a sexual exchange with a partner) compared with unaffected couples, women with PVD reported even higher sexual costs than their partners.²¹ In contrast, no differences in approach and avoidance sexual goals were found between partners of women with PVD and partners of control women, suggesting that PVD is not significantly associated with partners' motives for having sex. An opposite picture might emerge when examining avoidance sexual goals for *not* initiating sex. That is, although both partners in couples affected by PVD might avoid initiating sex because of the pain, partners of women with PVD might experience a greater burden related to fears of being rejected or causing pain to their partner.³⁵ Thus, partners of women with PVD might report higher avoidance goals for *not* engaging in sex compared with women with PVD. Couples' sexual goals for *not* engaging in sex and the implications of these goals are understudied and should be explored in future research.

Although overall couples affected by PVD reported lower approach sexual goals compared with control couples, only the approach sexual goals of women with PVD were significantly lower than those of control women. Women with PVD also had significantly lower approach goals than their partners. This is likely due to the fact that it is the woman with PVD who must endure the pain and not her partner. However, approach sexual

goals were still moderately high in women with PVD and were higher than their avoidance goals (approach sexual goals, mean = 5.50; avoidance sexual goals, mean = 3.98, on a seven-point scale), suggesting that despite the presence of pain, women with PVD might still pursue sex in pursuit of approach goals. This result is consistent with other PVD research that has found that certain aspects of the relationship are less affected by the pain problem. For example, Rosen et al²¹ found that women with PVD and their male partners evaluated their sexual relationship as highly rewarding (ie, pleasurable and positive) and to the same extent as control couples. It follows that perceiving a high level of sexual rewards could help women with PVD stay motivated to pursue sex for intimacy and connectedness, even in the presence of pain. There are many negative sexual, psychological, and relational consequences associated with PVD.³⁶ Thus, it is notable that although women with PVD are struggling with a distressing condition, they can still appreciate, and seek out, positive aspects of their sexual relationship. However, the study methods might have precluded the participation of more distressed couples and biased the PVD sample toward those in which women were predisposed to be more approach oriented in their sexual relationships.

The present study empirically documented differences in sexual goals between couples affected by PVD and community couples. Finding that the sexual goals of both members of the couple with PVD differed from controls, although ultimately it was the women with PVD whose goals were significantly different, further elucidates the scope of the impact of PVD on intimate relationships and supports the movement toward relationship-oriented designs in PVD research and treatment.^{37,38} Some limitations should be acknowledged. First, the correlational design of the study limits confidence that the results were due to a causal link between PVD and sexual motivation. Second, despite efforts to select a control sample similar to the PVD sample, there remained significant differences in age, relationship length, relationship type, and income level, which were controlled for in the analyses. There might have been differences in other variables that were not assessed in the present study. Third, the comparison group was recruited in the context of a study focusing on interpersonal factors in community couples, which precluded a systematic screening for vulvovaginal pain. Given that the lifetime prevalence estimates of PVD ranges from 7% to 8% in reproductive-age women,¹ some women in the comparison sample also might have had PVD. Fourth, although similar to prior samples,³⁹ the samples were composed primarily of Caucasian couples in mixed-sex relationships, which could limit the external validity of the present findings.

In conclusion, results are in line with previous research recommending sexual goals as targets for psychological interventions to help couples cope with PVD.⁵ Recent findings suggest that sexual motivation is dynamic and potentially open to intervention. For example, in community couples, increasing the salience of approach sexual goals improved sexual satisfaction.²⁷

Motivational interventions also have shown promise in relieving pain and coping in chronic pain populations.^{40,41} With this in mind, clinicians could strive to help couples with PVD become aware of their sexual motives, with the aim of bolstering approach sexual goals and weakening avoidance sexual goals. The size of the effects observed in the present study suggests that interventions targeting sexual goals could be maximally beneficial when used in combination with other empirically supported targets (eg, cognitive biases, intimacy^{42–44}) and in the context of cognitive-behavioral or acceptance-based treatments. Nevertheless, couples who can shift their focus toward approach sexual goals and away from avoidance sexual goals might adjust better to PVD and experience fewer consequences as a result.

Corresponding Author: Natalie O. Rosen, PhD, Department of Psychology and Neuroscience, Dalhousie University, 1355 Oxford Street, PO Box 15000, Halifax, NS B3H 4R2, Canada. Tel: 902-494-4044; fax: 902-494-6585; E-mail: nrosen@dal.ca

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STATEMENT OF AUTHORSHIP

Category 1

(a) Conception and Design

Justin P. Dubé; Sophie Bergeron; Amy Muise; Emily A. Impett; Natalie O. Rosen

(b) Acquisition of Data

Sophie Bergeron; Amy Muise; Natalie O. Rosen

(c) Analysis and Interpretation of Data

Justin P. Dubé; Natalie O. Rosen

Category 2

(a) Drafting the Article

Justin P. Dubé; Natalie O. Rosen

(b) Revising It for Intellectual Content

Justin P. Dubé; Sophie Bergeron; Amy Muise; Emily A. Impett; Natalie O. Rosen

Category 3

(a) Final Approval of the Completed Article

Justin P. Dubé; Sophie Bergeron; Amy Muise; Emily A. Impett; Natalie O. Rosen

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