The importance of interpersonal context when conceptualizing sexual pain after female genital cutting

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August 2019

Archives of Sexual Behavior

doi: 10.1007/s10508-019-01523-x

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In their Target Article, Connor, Brady, Chaisson, Mohamed, and Robinson (2019) make a compelling case for the timeliness and relevance of a conceptual model to guide research and clinical management of sexual pain[1] in women who have experienced female genital cutting (FGC). They draw parallels between the experiences of women with FGC and women with other types of sexual pain (e.g., vulvodynia or chronic vulvar pain) to support their model, while also underscoring the unique features of the FGC context. For example, feelings of being stigmatized and other communication difficulties with health care providers are common barriers for women reporting other types of genital and pelvic pain (Nguyen, Turner, Rydell, Maclehose, & Harlow, 2013), but these experiences may be heightened among women who have undergone FGC given the widely held negative judgement toward this practice in Western cultures. In their model, Connor et al. have smoothly integrated four well-known (to the pain community) and empirically supported models of pain and applied them to women who have pain during sexual intercourse as a result of FGC. In so doing, they have avoided a common pitfall in chronic pain, which is to emphasize distress and maladaptive coping, and instead they acknowledge the heterogeneity of women's responses, such that some women who have experienced FGC may demonstrate healthy adaptation.

I was, however, struck by one glaring omission in Connor et al.'s (2019) conceptual model, which is essential for understanding the maintenance of any type of sexual pain and associated consequences for women and their romantic partners—that is, the interpersonal context (Rosen & Bergeron, 2018). In relation to pain during sexual activities, the interpersonal

[1] To be consistent with Connor et al.'s terminology, I am using the term "sexual pain" to refer to pain during sexual activity experienced by women who have undergone FGC. However, as argued by Binik (2010); Binik et al.,(2002) and reflected in the Fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association, 2013), the pain is not inherently sexual but rather it is located in the genital and pelvic region and commonly triggered by penetrative sexual activities. The pain can be provoked in both sexual and non-sexual contexts. Thus, the terms genito-pelvic pain and/or pain during intercourse/sexual activity are typically preferable.

context refers to the processes that occur between members of a couple that shape how the couple co-manages the pain and their sexual relationship. An interpersonal conceptualization of sexual pain acknowledges that each member of the couple brings unique thoughts, feelings, and behaviors to painful sexual interactions and their subsequent coping such that each person is affected by, and affects, the pain and couples' sexuality. Also embedded within an interpersonal framework and potentially relevant to women's pain and couples' sexual adjustment when women have undergone FGC are the gender roles and norms within the couple and their culture.

I'd like to share an anecdote to illustrate the importance of considering the intimate relationship, gender, and culture in relation to genital pain. In 2018, I spent a 6-month sabbatical at the Stellenbosch Institute for Advanced Study in South Africa. I gave a seminar on my vulvodynia research to a group of approximately 20 international academics. The mostly male audience included researchers from Ghana, Sudan, and Nigeria (three countries where FGC is practiced) among other Middle Eastern, European, and North American countries. One of the first questions I received at the end of my talk was from a researcher from Ghana. He asked me why I assumed that women having pain during sex was necessarily negative and unwanted. He explained that, in his culture, women experiencing pain during sex meant that the man was "doing the right thing". In other words, more expression of pain by a woman denoted better sex. During the post-seminar reception, I spoke to several other men who endorsed this culturally-accepted position. I asked them to imagine the reverse scenario whereby men having pain during sex was considered to be acceptable and an indicator of good sex. They laughed and said that this scenario "would never happen." To their credit—and recall that these were highly educated academics—they acknowledged this gender inequity, but also encouraged me to see how a central assumption of my research was inconsistent with their cultural experience.

This anecdote—though not specific to FGC—illustrates that culturally-based and gendered expectations can have serious implications for both the conceptualization and potential treatment of pain during sexual activity. Although limited, there is evidence of differences in sexual pain intensity based on ethnicity (Nguyen, Reese, & Harlow, 2015); however, no studies have compared pain during sexual intercourse related to FGC to other types of sexual pain. In Western samples, trait identification according to masculine/feminine stereotypes has been linked to pain tolerance, intensity, and unpleasantness such that greater feminine identification relates to poorer outcomes (Racine et al., 2012). Connor et al. (2019) posit that women who have undergone FGC and who are less acculturated may be more likely to fall into the "eustress endurance" quadrant of their model due to culturally-motivated beliefs such as being more communal and considering marital sex a duty. Presumably, there are also gendered undertones to these beliefs, but the influence of gender roles and expectations is not made explicit in Connor et al.'s model.

The anecdote also underscores that focusing on only the woman's perceptions and experience of sexual pain neglects the fact that two people are typically involved in the painful sexual activity and both experience consequences related to the pain. Indeed, male partners of women with sexual pain report lower sexual satisfaction, poorer sexual communication, and more erectile difficulties compared to partners of women without this pain (Pazmany, Bergeron, Verhaeghe, Van Oudenhove, & Enzlin, 2014; Rosen, Santos-Iglesias, & Byers, 2017; Smith & Pukall, 2014). They also report negative emotions including anger, frustration, and guilt, and negative relationship implications (Sadownik, Smith, Hui, & Brotto, 2017). Although impacts for the partners of women who have undergone FGC may be unknown, like the other parallels drawn by Connor et al. (2019) it is reasonable to assume that there may be some negative

repercussions for partners' sexual and intimate relationships. Connor et al. (2019) acknowledge that partners can be a source of positive support (e.g., willingness to adapt sexual behaviors) and that good communication between partners can promote a resiliency response. However, the role of partners' own responses to the pain and dynamic interactions between members of the couple as influencing women's pain, and the couples' relationship and sexuality are largely absent.

A key strength of Connor et al.'s (2019) model is their use of chronic pain theories to inform their conceptualization of women's sexual pain following FGC. Indeed, there is extensive evidence to support that the biopsychosocial processes involved in other chronic pain conditions are also relevant to sexual pain (Bergeron, Rosen, & Morin, 2011; Pukall et al., 2016; Rosen & Bergeron, 2018). Based on decades of pain research, clinicians and researchers alike endorse the important contribution of social/interpersonal factors in the development and maintenance of pain and its consequences (Cano & Williams, 2010; Edmond & Keefe, 2015; Gatchel, Peng, Perters, Fuchs, & Turk, 2007; Hadjistavropoulos et al., 2011; Krahé, Springer, Weinman, & Fotopoulou, 2013), including sexual pain (Bergeron et al., 2011; Rosen & Bergeron, 2018; Rosen, Rancourt, Corsini-Munt, & Bergeron, 2014). In fact, the interpersonal context of sexual pain is perhaps even more salient given that the intimate partner is often involved in provoking the pain via penetration, is present to witness the pain, and experiences consequences to their own sexual lives (Rosen & Bergeron, 2018).

Recently, Bergeron and I proposed the *Interpersonal Emotion Regulation Model* of sexual dysfunction, based on over 10 years of research establishing interpersonal factors as central to more or less adaptive adjustment to recurrent pain during sexual activity (Rosen & Bergeron, 2018), which may also be relevant to sexual pain related to FGC. In our model, interpersonal factors acting at both a distal level (i.e., overarching relational experiences,

contexts or styles such as attachment and intimacy) and a proximal level (i.e., interactions before, during, or immediately following painful sexual activity, such as partner responses to the pain) influence couples' emotion regulation of pain-related stimuli, with consequences for women's pain and couples' sexual, relational, and psychological adjustment. We review evidence of interpersonal factors that contribute to more adaptive functioning or using Connor et al.'s (2019) terminology "resiliency" for affected couples (e.g., intimacy, expressions of affection, approach sexual goals) as well as factors linked to less adaptive functioning (e.g., childhood trauma, catastrophizing, insecure attachment, negative and solicitous partner responses).

Importantly, we have studied interpersonal factors from the perspective of both members of the couple, and as such we have demonstrated that partner's perceptions and experiences are directly linked to the intensity of women's pain during intercourse. For example, and relevant to quadrant 1 (fear-avoidance) of Connor et al.'s (2019) model, partner catastrophizing about the pain is associated with women's greater pain intensity, and is due, in part, to partners reporting more negative responses to the pain (e.g., hostility; Davis et al., 2015; Lemieux, Bergeron, Steben, & Lambert, 2013). As additional examples and relevant to quadrant 4 (resilience), when partners engage in more facilitative responses to the pain (expressions of affection, focus on non-painful sexual activities) women report lower pain and better sexual functioning, and when partners report greater pain acceptance women report less depressive symptoms (Boerner & Rosen, 2015; Rosen, Bergeron, Sadikaj, & Delisle, 2015; Rosen et al., 2013).

One of the interesting—and I believe valuable—distinctions made by Connor et al. (2019) is between the concepts of distress endurance and eustress endurance of pain related to FGC. They posit that a eustress response, whereby women who have experienced FGC ignore or minimize the pain by focusing on other aspects of their lives, may be more adaptive for women

who are less acculturated; it may be adaptive because of cultural beliefs that are more consistent with an endurance response (e.g., penile-vaginal sex as the only acceptable form of sexual expression). Another relevant factor is the woman's motivations for persisting with painful sexual activity, which in other sexual pain populations are frequently interpersonal (Brauer, Lakeman, van Lunsen, & Laan, 2014; Elmerstig, Wijma, & Bertero, 2008). In other words, could there be distinct (interpersonally-oriented) motives that result in the distress versus eustress endurance responses?

In women with vulvodynia, women's pain during intercourse does indeed vary according to their sexual goals, or reasons for having sex. Specifically, women who report having sex for more approach-oriented goals—that is, to pursue positive outcomes in the relationship such as intimacy—or who endorse a stronger and genuine desire to meet their partner's sexual needs (higher sexual communal strength) also report lower pain and greater sexual and psychological well-being (Muise, Bergeron, Impett, Delisle, & Rosen, 2018; Muise, Bergeron, Impett, & Rosen, 2017; Rosen et al., 2018). In contrast, when women report having sex for more avoidance goals—to avoid negative relationship outcomes such as disappointing or loss of their partner—or who are overly focused on their partner's sexual needs while ignoring their own (higher unmitigated sexual communion), there are negative repercussions for women's pain and couples' well-being. For women with FGC, Connor et al. (2019) suggest sexual motives for endurance that relate to being more "other" oriented in the relationship and feeling obligated to have sex, which map onto the constructs of sexual communal strength and avoidance sexual goals, respectively. Thus, there appears to be preliminary evidence that sexual motivation might be helpful in understanding what leads to a eustress or distress endurance response in women who have undergone FGC. Of course, it is also possible that these responses are not mutually

exclusive and that women may oscillate between the two, possibly influenced by other factors in their daily lives (e.g., mood, relationship conflict).

In conclusion, the model put forward by Connor et al. (2019) for understanding women's responses to sexual pain after FGC is a welcome tool for guiding future research and I agree it will support more culturally sensitive care by clinicians who work with this population. Nonetheless, Connor et al., for the most part, treat the woman's psychological response to the pain as independent from the interpersonal context in which the pain is provoked. More attention to how relationship dynamics—including gender roles within a cultural framework—and the partners' responses to the pain contribute to shaping women's pain and couples' adjustment would better reflect the inherently interpersonal circumstances in which this pain is experienced. More detailed information about how, when, and where to integrate the partner in prevention and treatment in a culturally sensitive manner would also be useful for health care providers.

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