

The Impact of a Woman's Dyspareunia and Its Treatment on Her Intimate Partner: A Qualitative Analysis

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This study explored the experiences of male partners of women with dyspareunia, secondary to provoked vestibulodynia (PVD), who participated in the Multidisciplinary Vulvodinia Program (MVP). Participants were 16 men between 22 and 45 years of age. Data were collected with semi-structured interviews and analyzed for themes. Men were interviewed about (a) the impact of the woman's PVD on themselves; and (b) the impact of the MVP on themselves. Participants experienced negative psychological effects (e.g., guilt) in addition to activating emotions (e.g., frustration). They reported diminished quantity and quality of sex. In the relationship, PVD caused strain, communication challenges, and possibilities for growth. The benefits, perceived by the partner, of the women participating in the treatment program included improvements in knowledge, communication, and psychological and sexual health.

INTRODUCTION

Provoked vestibulodynia (PVD) is a specific type of localized vulvodinia causing a "burning" or "rawness" located in the vestibule, or entrance, to the vagina. A hallmark of this condition is that the pain interferes significantly with penetrative sexual activities, including intercourse. PVD is the most common cause of dyspareunia in women of reproductive age (Moyal-Barracco & Lynch, 2004), and it has a major impact on a woman's overall health as well as her relationship with her sexual partner. Women with PVD report psychological distress, sexual problems, and relationship difficulties when asked about the impact of vulvodinia on their lives (Sadownik, Seal, & Brotto, 2012a). Women also report feelings of frustration, anxiety, distress, and diminished

mood secondary to PVD (Gates & Galask, 2001; Sadownik, 2000). Studies have found that women with PVD experience sexual problems such as diminished sexual satisfaction, interest, and self-esteem (Gates & Galask, 2001; Sackett, Gates, Heckman-Stone, Kobus, & Galask, 2001; Sadownik, 2000; White & Jantos, 1998). White and Jantos (1998) reported that women with PVD were “highly likely” to have significantly diminished arousal potential, diminished interest in intercourse, negative feelings toward intercourse, and refusal of a partner’s sexual advances. Women with PVD report changes in sexual behavior, including decreased frequency (Reed, Advincula, Fonde, Gorenflo, & Haefner, 2003) and inability to engage in sexual intercourse. Women often avoid all sexual contact so as to reduce or avoid pain (Sadownik, 2000).

Since the impacts of PVD are largely experienced within the dyadic relationship between a woman and her sexual partner, research is increasingly examining the partner’s role in aggravating, maintaining, or alleviating a woman’s pain experience, as well as the partner’s role in her sexual function and sexual satisfaction (e.g., Rosen, Bergeron, Leclerc, Lambert, & Steben, 2010; Rosen et al., 2014). Still, research exploring the impact of a woman’s PVD on her partner’s psychosexual health and their overall interpersonal relationship is rather limited. To date, most of the research exploring relational aspects of PVD has focused on the woman, and available data on effects on a partner are limited. Nylanderlundqvist and Bergdahl (2003) found evidence of greater symptoms of depression in male partners of women with PVD compared to controls. However, one study found that men’s relationship satisfaction and sexual distress in PVD-affected couples did not significantly differ from levels found in a comparison sample (van Lankveld, Weijenborg, & ter Kuile, 1996). This study further found that women with PVD experienced significantly more distress during sexual interactions in comparison to their partners, while the partners reported low levels of sexual distress overall. More recent studies have shown deleterious effects on the male partner. A qualitative study by Connor, Robinson, and Wieling (2008) showed many partners experiencing negative emotional consequences coping with PVD; other research corroborates these qualitative results, with almost 73% of male partners in one study reporting a negative impact of provoked vulvar pain on their relationship (Smith & Pukall, 2014). In this latter study, partners also reported significantly decreased erectile function, less sexual satisfaction, and poorer sexual communication compared with partners of control women.

Research on the impact of PVD on relationship adjustment is similarly mixed. Quantitative research using self-reported data from women has found no reduction in relationship adjustment as a result of PVD (Meana, Binik, Khalifé, & Cohen, 1997; Reissing, Binik, Khalifé, Cohen, & Amsel, 2003; van Lankveld et al., 1996). Qualitative methods, however, report significant relationship problems arising from PVD (Connor et al., 2008; Sackett et al., 2001; Sheppard, Hallam-Jones, & Wylie, 2008). In the study by Connor et al. (2008), many couples also felt different from couples who they perceived to be sexually healthy, and all couples had altered their sexual lives, some with marginal satisfaction, to accommodate the pain associated with PVD.

The treatment of a woman’s sexual pain is complex and challenging. Multidisciplinary approaches to pain management have received strong empirical support (Stanos & Houle, 2006). This approach to PVD, which integrates care by gynecologists with expertise in vulvovaginal pain, psychologists with expertise in sex therapy and pain management, and pelvic floor physiotherapists, has shown beneficial effects on dyspareunia, sexual functioning, and psychological well-being (Brotto, Yong, Smith, & Sadownik, 2015; Sadownik, Seal, & Brotto, 2012b). We have previously reported the results of a qualitative study exploring the impact of PVD on affected women (Sadownik et al., 2012a) and also on the impact of our Multidisciplinary Vulvodinia

Program (MVP) on women (Sadownik et al., 2012b). In our program, partners of women with PVD are invited to attend an educational seminar about PVD and the impact of PVD on a woman's, and couple's, sexual health. Anecdotal feedback from partners has been a reportedly positive effect of receiving this information on their feelings of self-efficacy to cope with the presence of PVD in their relationship. Many partners shared stories about the impact of the woman's experience of sexual pain on themselves and their relationship.

To further explore these anecdotes and examine the experiences of male partners of women with PVD, we carried out in-depth individual interviews with a subsample of male participants whose female partners had already completed the MVP. Little is known about how treatment for PVD may extend beyond the woman to affect her partner. We therefore also explored the impact on the men of their female partners' participation in the MVP, as well as how men could be further supported by our program. Knowing how men are affected when their partner receives treatment for PVD and what additional support they wish to receive may guide the development of interventions aimed at helping couples cope with and manage this condition.

METHOD

Participants

All women ($N = 101$) who had completed the MVP from 2012 to 2013 were contacted by the program assistant via e-mail, sent a brief description of the study, and asked to pass the invitation on to their current male intimate partners (with a relationship duration of more than six months). At the time of their entry into the MVP, 33 of these women were single, 13 were dating, 25 were in common-law relationships, 27 were married, and three did not indicate their relationship status. Ninety-five women reported being heterosexual, four bisexual, and two did not indicate their sexual orientation. Interested partners then contacted the program assistant directly for more information about the study and, if they were interested in participating, scheduled an interview. In total, 20 male partners expressed initial interest in participating, of which 16 participated in an interview. The 16 male partner participants were of mean age 32.5 (range 22 to 45 years) and mean relationship duration of 5.72 years (range 9 months to 17 years). The men were married ($n = 9$), common-law ($n = 3$), or dating ($n = 4$) at the time of MVP participation. At the time of their MVP baseline assessment, the female partners of these male participants self-reported a mean level of vaginal pain of 6.7 (SD 1.7, range 2–9) on a scale of 0 (*no pain*) to 10 (*worst pain ever*). As a proxy to assess whether the current male participants were likely similar to the larger group of men whose female partners participated in the MVP, we compared the demographics (age, relationship duration, relationship status, and baseline level of pain) of women whose partners participated in this study to the larger group of women who participated in the MVP; no significant differences were found ($ps > .05$).

Procedure

A trained male research assistant who was not involved in the treatment of women in the MVP conducted the interviews. The interviews were conducted via Skype or telephone. Two open-ended questions were used to elicit participants' stories: (1) "What has been the impact of your

partner's PVD on your life?" (2) "What has been the impact of your partner participating in the MVP on your life?" A semi-structured interview guide developed by the investigators and based on responses to the first question guided follow-up questions. Note that the interview guide did contain some prompts to have partners reflect on potential negative and positive impacts of PVD on their lives. Although all partners were asked about the impact of PVD on their lives, not all partners were explicitly asked about negative and positive impact due to the semi-structured nature of the interviews. The interviews (ranging in length from 15 minutes to one hour) were recorded, transcribed verbatim, and then read independently by three of the four authors. Each transcript was identified by a unique ID number. The data-analytic approach was largely guided by thematic analysis in that the researchers aimed to identify and describe patterns in the data (Braun & Clarke, 2006). After an initial immersion in the transcripts during which preliminary impressions were noted (familiarization with the data; Braun & Clarke, 2006), the researchers identified themes emerging from the data. The researchers then met and compared the themes they had identified. Dominant themes identified by all three researchers were used to develop a coding framework. The transcripts were subsequently reread by all authors and coded appropriately. The coded data were then reviewed in a horizontal manner to explore the emerging themes and subthemes; themes were refined, representative excerpts were cut and pasted from the transcripts, and the manuscript was produced (Braun & Clarke, 2006).

The men were not remunerated for their participation. The clinical research ethics board at our university and academic hospital approved this study, and all participants provided written consent.

RESULTS

Question 1: What has been the impact of your partner's PVD on your life?

The major themes identified in our analysis were (a) psychological stress; (b) sexual distress; (c) relationship strain; (d) communication challenges; and (e) growth opportunities. These themes will be described and illustrated with quotations from participants. Themes and subthemes are outlined in [Table 1](#).

Theme 1: Psychological Stress

Negative Inhibiting Emotions. Almost all partners reported psychological stress, which included negative inhibiting emotions such as "depression," feelings of "despair," and a deep sense of "loss." Men linked their emotions to the lack of physical intimacy: "Not being intimate for so long just made me depressed." Men reported withdrawal from their partner, low self-esteem, a sense of failure, and persistent feelings of guilt: "Maybe it's not her problem, maybe it's me, maybe I'm doing something wrong . . ." Men expressed worry, shame, fear of causing pain, cycles of blame, and social isolation from friends and family:

Partner: I don't want to bring up anything that will make her more upset and I don't wanna make her feel even worse about it than she already does . . . So I sometimes feel like I can't talk to her about it or anybody else.

TABLE 1
Main Themes and Subthemes

| <i>Question 1: Impact of Provoked Vestibulodynia on Partner</i> | N | <i>Question 2: Impact of Multidisciplinary Vulvodynia Program on Partner</i> | N |
|--|----|--|----|
| Psychological stress | | Enhanced knowledge | |
| Negative inhibiting emotions (e.g., depression, loss, guilt) | 12 | Information | 6 |
| Negative activating emotions (e.g., anger, frustration, anxiety) | 5 | Understanding | 7 |
| | | Improved communication | 5 |
| | | Psychological benefits | 9 |
| | | Sexual benefits | 11 |
| Sexual distress | | | |
| Diminished sexual experience | 14 | | |
| Constrained intimacy | 7 | | |
| Relationship strain | 14 | | |
| Communication challenges | 5 | | |
| Growth opportunities | 2 | | |

Negative Activating Emotions. Negative activating emotions included anger, anxiety, and bubbling-up frustrations:

Partner: I felt, well, I've done everything I can . . . she asked me to take it slow and you know, make sure she was comfortable and all that and I'd do all that. And I felt like I put a ton of effort into that and I'd feel as though those efforts weren't being rewarded because her body wasn't responding correctly.

Theme 2: Sexual Distress

Diminished Sexual Experience. Almost all partners reported sexual distress. Men described a decrease in the quality ("it's just not enjoyable") and quantity of sex they experienced. Men spoke often about the fear of "hurting" their partner:

Partner: On top of it [sexual intercourse] being painful for her, there is the added [worry] about hurting her, so the whole experience [is] just kind of prescribed or not really special.

Throughout the interviews men expressed feelings that their sex life was "not normal" and that they were "missing out" on what is the "norm" for other men:

Partner: . . . the lack of the ability to have intercourse . . . would make me feel, kind of excluded from, you know this big activity that, an important activity, that I would anticipate that a lot of other people are getting to participate in.

Constrained Intimacy. Several men also reported a general lack of physical intimacy:

Partner: It hasn't just interrupted our sex as intercourse; it's disrupted a lot of physical intimacy for us. Just because it's there it came to a point where any physical intimacy started becoming associated with failure in that sense.

Further, partners mourned the loss of sexual spontaneity and ease that they enjoyed prior to PVD:

Partner: Like I would dream about having intercourse and usually with somebody else because my wife couldn't and it wouldn't actually be a dream about you know, cheating or, wanting to be with someone else it would be just that physical act of pain-free intercourse, you know emotion-free or not emotion-free but hang-ups-free intercourse, I guess . . .

Some partners also cited “disruptions,” “roadblocks,” or “walls” to intimacy that were sparked by PVD’s “interference” with sexual function. They felt disconnected in a manner that exceeded the physicality of penetrative sex:

Partner: I know for me [sex is] a really significant part of being, like, connected. So I started to lose a sense of us being intimate partners as a result of it.

Theme 3: Relationship Strain

A woman’s PVD tended to have a profound negative impact on existing relationships (“it caused a fair bit of fighting”). Partners questioned the viability and meaning of their relationship, as well as their role within the relationship:

Partner: When you hit your ultimate frustrations, I start to contemplate things as far as: Do I want to be here? Do I want to be in this relationship? Is this something I want to do forever?

They entertained doubt about their partner’s attraction to them and their abilities to satisfy their partners sexually:

Partner: I guess I—because I felt, uh, for a long time that she wasn’t that interested in me anymore . . . My life was not happy, a lot was missing from my life. I—I was happy with her, I loved her and, uh, I was committed to her and, but I guess sometimes I felt that she wasn’t as committed to me.

Theme 4: Communication Challenges

Several partners described a great deal of communication challenges that occurred as a result of PVD. They reported difficulty in speaking to one another about PVD’s “interference” in their lives, and trepidation about broaching the topic:

Partner: Because it’s an emotional subject and touchy, bringing it up became quite a heavy experience . . . it feels it’s like we’re carrying a ship on our shoulders—just a big heavy weight.

Many reported a significant level of avoidance of discussing the problem with their partner or others:

Partner: I certainly felt, uh, frustration and a sense of loss and, uh, and I just had to keep that to myself as much as I could.

Theme 5: Growth Opportunities

A minority of the partners reported that PVD had a positive impact on themselves and their relationship. These individuals reported that coping with their partner's sexual pain led to individual maturation:

Partner: My ability to understand her and empathize with her improved and so perhaps there were positive . . . that that was one positive outcome of her condition.

Some partners felt that dealing with PVD had resulted in team building and a sense of being closer as a couple:

Partner: Anytime you deal with something as a couple, a hardship, I mean not just a couple, but any two individuals that go through tough times together it brings them closer together so that they can survive it.

Question 2: What has been the impact of your partner participating in the MVP on your life?

Theme 1: Enhanced Knowledge

Information. A major theme that was identified was that the program enhanced the partner's knowledge about PVD.

Partner: I've actually learned quite a bit about it but I didn't really know before.

Partner: My life changed because I could make better decisions as opposed to stumbling blindly in the dark or having to go and find that information yourself [that I] would not have been as capable of . . .

This theme was reinforced when partners were asked a follow-up question about how the program could support them further. Partners requested that more information be delivered directly to them as most of the information they received was relayed through their partners. They sought further information about the nature of pain, the psychological and emotional impact of the pain on the woman, and how to best "support" their partner.

Understanding. Some partners applied the information that they received to their own personal issues, and this led to a greater understanding of their partners, themselves, and their own situations:

Partner: It was hard for me to understand why she didn't want to have sex with me, at least initially and then um . . . and then I just think that if people understand what the partners are going through, like if men understand what their female partners are going through, um, maybe it would save a few more relationships.

Theme 2: Improved Communication

The program helped to facilitate some couples' communication about resultant issues. First, partners felt that the MVP helped create an "understanding" of what the problem was so that couples could begin to talk about the problem:

Partner: I went to the meetings with her and with one of the doctors at the beginning and at the end of the program—so I got some information about it and she got more information about it and we had a little more of a vocabulary to talk about the pain issues and kind of an understanding around some of the, call it the technical aspects of it, or why it happens, or maybe not why it happens, but the nature of it, the nature of the pain. So it definitely really helped around communication.

Other partners noted an increased "openness" or receptivity from the women to talk about the problem:

Partner: The biggest thing from before the program and then after the program was sort of being able to talk about it with her because before we never talked about it. So I guess that was a positive thing—we actually talk about it.

With regard to this theme, partners felt that the MVP created a more assured "space" for the couple to communicate more effectively to address PVD's impacts on the woman and their relationship.

Theme 3: Psychological Benefits

Several men described psychological benefits: "The first impact was just feeling hope . . ." and "normalization of it was the biggest factor—like there wasn't something wrong with us." Some men were unable to identify any direct impact on their own health but rather spoke in terms of "it helped me because it helped to decrease her stress." For some partners, the program reinforced the notion that there is no "silver bullet" cure to PVD, which remained frustrating; however, several cited the program as nevertheless helpful in facilitating a better attitude toward coping with PVD in their lives and in their relationship.

Theme 4: Sexual Benefits

Men also described sexual benefits, including being "able to work intercourse back into" their lives. Most reported an increased "frequency" and quality of sexual experiences. They reported a "diffusion of tension" or "stress" and a greater ease in taking sexual initiative themselves—"she's open to trying [intercourse] now":

Partner: We would try to have sex and instantly we would notice the ease in doing so, uh, was, uh, greatly increased and, uh um, she would just—I dunno, a couple times she was just so elated by it that we actually didn't continue the process. We just kind of stopped and she was just, basically the rest of the day she was just ecstatic that she wasn't in excruciating pain.

Follow-Up

A follow-up question to Question 2 asked partners to clarify what the program could do further to support them. While all partners requested more information, some partners shared a distinct sense of “isolation” and exclusion, and several partners expressed a desire to meet other partners in an environment without the women present to discuss their own experiences with coping with sexual pain in their relationship: “It’d be good to talk to other people going through the same issues. What the women go through is physically and mentally hard. But it’s mentally hard for the guys too.” They were interested in a space where not only would they not feel censored by their fear of hurting their partners, but where they could also connect with a network of other partners who understood their particular distresses and challenges: “That would have been helpful for me even to just kind of understand what struggles other people are going through.” A small number of partners were also interested in the MVP playing a greater role in facilitating connections to expert practitioners and personal and couples’ counselors.

DISCUSSION

Impact of PVD on Male Partners

The first goal of this study was to explore male partners’ experiences of women’s sexual pain secondary to PVD. The major themes identified in our analysis were (a) psychological stress; (b) sexual distress; (c) relationship strain; (d) communication challenges; and (e) growth opportunities. This study adds further evidence that woman’s sexual pain has a major impact not only on the woman herself, but also on her partner’s psychological, sexual, and relationship health. Indeed, similarities were noted between our current findings and that of previous qualitative research that examined the impact of vulvodynia among women who had participated in the MVP (Sadownik et al., 2012a). For example, feelings of stress, frustration, anxiety, and depression were reported by both women who had participated in the MVP and participants in the current study (Sadownik et al., 2012a).

A great deal of distress can result from a man’s or woman’s expectations about what “real sex” or “normal sex” should be like and how their current situation does not meet these expectations. Indeed, the coital imperative as a banner for “real sex” is a silent force in many couples’ experiences with dyspareunia. It appears that most women take up the position of “inadequate woman” and “inadequate sexual partner” when unable to regularly engage in sex (Ayling & Ussher, 2008; Sadownik et al., 2012a). Many women are negatively impacted by the pervasive belief that penetrative sex is “real sex” and centrally linked to “real womanhood” (Kaler, 2006). Taking up the “inadequate woman” position leads to self-silencing, shame, and isolation, and breeds space for a partner’s misinterpretation of behaviors and emotions around sexuality. Our study illustrates that men can also be vulnerable to taking up a position of “inadequate lover.”

Within our study, almost all partners reported experiencing sexual distress related to PVD. Their sex lives were affected in terms of both quantity and quality, and men reported fear of causing their partner pain. PVD is a unique pain condition in that the pain is often triggered by a partner during sexual activity; while previous research has not explored the impact that being the “trigger” for pain has on partners of women with PVD, our study suggests that many men

are psychologically and sexually affected. Our study also suggests that male partners may feel abnormal and that they are missing out sexually. The impact of the coital imperative has not been considered from the perspective of male partners of women with PVD, and would be an interesting future course of research to explore questions of gender, masculinity, and sexuality when male partners have historically been viewed as having more desire for penetrative sex compared to women (Baumeister, Catanese, & Vohs, 2001).

The negative psychological and sexual effects of PVD on both partners can result in significant communication issues. The theme of communication—both as an effect of sexual pain on relationship communication as well as a beneficial impact of the treatment program on communication—was identified. There is emerging evidence that a male partner's communication style can have an impact on a woman's experience with PVD (Rosen, Bergeron, Glowacka, Delisle, & Baxter, 2012; Rosen et al., 2010; Rosen et al., 2014). For example, facilitative responses—that is, partner reactions that encourage efforts at coping with the pain in a helpful way (such as expressing happiness that the partner is engaging in sexual activity)—may help to reduce the intensity of a woman's vulvar pain and improve her sexual satisfaction (Rosen et al., 2012). Solicitous and negative responses may contribute to more pain and less sexual satisfaction, respectively, for a woman with PVD (Rosen et al., 2012; Rosen, Bergeron, Lambert, & Steben, 2013). Solicitous responses include exaggerated expressions of sympathy, attention, and support (e.g., suggesting that the woman stop sexual activity). Examples of negative responses include partners expressing anger, irritation, disappointment, or frustration toward the woman. The association between negative partner responses and women's sexual satisfaction may be mediated by the level of relationship satisfaction (Rosen et al., 2013). Specific partner-communication styles were not thematically apparent in the current study; future qualitative research exploring male partner responses in the context of PVD will help to further elucidate how they influence a woman's pain and impact the couple's experience.

Awada, Bergeron, Steben, Hainault, and McDuff (2014) noted that “better communication about sexuality is a robust correlate of increased sexual satisfaction.” There is also preliminary evidence that a couples-based cognitive behavioral therapy program significantly improves dyspareunia, but has only marginal effects on relationship satisfaction (Corsini-Munt, Bergeron, Rosen, Mayrand, & Delisle, 2014). The effectiveness of this intervention to address the impact of a woman's sexual pain on her partner and to educate and support partners in interacting with women in a constructive manner awaits further study. Given that partners both elicit and witness the woman's pain, they are an important variable in the woman's pain experience and in her recovery. The experience of chronic pain is a complex process that can be mediated by a number of intrapersonal and interpersonal variables that are present at the time of the sexual experience and outside of the sexual experience.

Impact of Participation in the MVP on Partners

The second goal of this study was to explore the impact of the women participating in a multidisciplinary treatment program on their partners.

There was an overall positive appraisal of the program with partners expressing the therapeutic effect of receiving accurate information about PVD and sexual health. Education can address many of the negative emotions that arose from a lack of understanding of their sexual situations. Participants expressed a wish for more partner-focused material in the program. Previous studies

have reported that women benefit from education, normalization of their experiences, and the opportunity to meet others in similar situations (Brotto, Sadownik, & Thomson, 2010; Sadownik et al., 2012b). Participants in our study suggested adding partner-specific sessions as a means of providing knowledge and facilitating a supportive environment for them to share. Thus, this study would suggest that male partners would also benefit from educational and networking opportunities. An intervention that targets the partner's role in the pain experience, the partner's response to the woman's pain, and the woman's responses to her own pain within and outside of the sexual setting has the potential to improve the quality of life for both partners, and to possibly aid in the woman's recovery from pain. Connor et al.'s (2008) phenomenological study of couples coping with PVD described the significance of knowledge, information, and understanding of the PVD diagnosis to a couple's sense of efficacy in coping. Connor et al. (2008) also reported that most couples in their study reached a point where they cocreated new intimacies in their relationship that did not include vaginal intercourse. These couples emphasized mutual support and acceptance, described a greater emotional bond from experiencing these challenges as a team, and felt fortunate that their relationship was not reliant on intercourse (Connor et al., 2008). While several participants in our study discussed sexual benefits of their partner going through the MVP, these benefits were often discussed in relation to intercourse (e.g., being "able to work intercourse back into"). More research is needed to understand what factors contribute to couples' decisions to pursue vaginal intercourse and/or to form new intimacies in their relationships that decentralize intercourse, and to understand whether treatment changes couples' perceptions regarding the "coital imperative." Recent research does suggest, for example, that higher levels of acceptance of PVD-related pain is associated with greater sexual satisfaction for both women and their partners, which may help couples engage in sexual activity that is rewarding and less painful (Boerner & Rosen, 2015).

The current study also suggests that men may experience psychological benefits, such as feelings of hope and normalization, when their female partners receive multidisciplinary treatment for PVD. These findings are similar to those previously reported by women who participated in the MVP and who were asked, "What has been the impact of the MVP on your life?" (Sadownik et al., 2012b). The partners in the current study expressed a want for partner-only sessions; future research may consider comparing partner-specific versus couple-oriented sessions in order to determine if distinct benefits arise from each type of session and which partners/couples would benefit the most from these different formats. Some partners in our program also acknowledged that the MVP had an impact on their ability to communicate more easily about the problem. Practicing more effective communication strategies within their relationships—as well as effective emotional strategies (i.e., healthy outlets for negative emotions)—may be key in supporting partners. The communication challenges that are at once relational as well as steeped in cultural mores may be channeled either into negative emotions, or, as a couple, potentially transformed into opportunities to learn to grow together as a team. It may be that those couples who have ways to overcome the communication challenges in their relationships have less negative emotions (not none, but less) and are more able to see positive gains from their experience with PVD.

Limitations

Our study uncovered some interesting information about the experiences of male partners of women with dyspareunia secondary to PVD, however, the study has a number of limitations.

Firstly, the authors who conducted data analysis are also all involved in the MVP, which may have affected how participants' responses were interpreted. Our study focused only on the perspectives of male partners who were in established relationships with women with PVD who sought treatment. As a result of participation in the MVP, it is possible that participants' perception of the impact of PVD on their lives had been altered or biased. The low response rate, the corresponding small sample size, and the specific context limit the generalizability of the findings, and may reflect sampling bias; it may be, for example, that we interviewed men who were highly motivated and/or whose female partners or themselves benefited more than others from participating in the MVP. The perspectives of female sexual partners were not explored, nor were the perspectives of either male or female sexual partners of women with PVD who were in new relationships (i.e., less than six months' duration). Given that the mean duration of the men's relationships was over five years, the male partner's perspective may have involved some recall bias. It would be interesting to prospectively follow the experiences of the male partner through the woman's whole journey—from diagnosis through to treatment and recovery.

Implications

Male partners of women with sexual pain also suffer. Our study illustrates that men can benefit from women participating in a multidisciplinary vulvodynia treatment program. Health care providers in this field should explicitly inquire not only about the couple's relationship health, but also about the male partner's psychological and sexual health. To date, PVD has largely been framed as a woman's problem, and the treatments, and treatment outcomes, have predominantly focused only on the women as the target of care. This study also suggests that for some men it is important to find a place where partners can express their experiences coping with PVD while connecting with other partners with similar experiences. The practice of thinking through the sources of their negative emotions (many of which may be culturally fed and maintained by silence) could be helpful to them, and informing of strategies to mitigate their destructive effects. Finally, creating tangible, sustained support systems may be desirable for partners—for example, online groups, in-person informal meetings, or facilitated formal meetings.

Conclusion

Partners of women who experience dyspareunia secondary to PVD report a primarily negative impact of that pain on their own psychological and sexual health. The themes arising from the analysis of partner interviews provide fruitful feedback for supporting the male sexual partners of women with PVD. This study is one of the first qualitative studies to involve partners of women with PVD and adds to a growing literature highlighting the impact of PVD on partners and the importance of including them in treatment.

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