ABJECTION, POWER, AND REAPPROPRIATION: THE DIFFICULT CONCEPTUALISATION OF WOMEN'S SEXUAL PAIN IN FRANCE AND ENGLAND

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Abstract

Women's sexual pain, understood as genital pain when penetrative sexual intercourse is attempted, is a 'common but neglected' issue (Mitchell *et al.*, 2017, p.1), affecting women of all ages. Discourses around it can be complex, and include many sources, including medical, psychiatric, and healthcare communication (Basson *et al.*, 2000), socio-political commentary, and studies on how this pain connects to perceptions of gender, as a problem which affects only women and people with vaginas and vulvas. Within complex healthcare structures in England and France, both of which comprise state-funded and private elements, the maintenance of the neglected status of women's sexual pain requires conceptualisations of it to operate in a specific way. It also requires individuals in these systems, and women accessing them, to participate in, reinforce, challenge, and resist the existing structural and individual power dynamics which construct these experiences. Accordingly, women's sexual pain is uniquely positioned as a lens through which to examine how these gendered experiences affect women unequally, and how the way that they are described and treated has profound consequences.

This thesis uses an innovative cross-national methodology, including data from bilingual semi-structured interviews, to show how certain women are disadvantaged by this pain more than others. Selected discourses of sexual pain, including healthcare guidelines and definitions, are consulted concurrently to form an impression of women's experiences within these complex structures. This research provides valuable insights into the experiences of women affected by sexual pain, and demonstrates their awareness of, and formidable challenges to, the systematic power imbalances which may marginalise them. It shows that there are healthcare professionals who embrace the activism of their work, striving to create a common, accessible, vocabulary of sexual pain which hears the unspeakable of pain and trauma, while respecting the power of silence. Though sexual pain experiences were often reported in these interviews as arduous and life-altering, this study reveals practices of resisting marginalising power dynamics, and of defying limiting, reductive conceptualisations of pain in both England and France.

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1: INTRODUCTION

1.1: The Conceptualisation of Women's Sexual Pain in England and France

Women's sexual pain, understood as pain in the genitals when penetrative sexual intercourse is attempted, is a 'common but neglected' issue (Mitchell et al., 2017, p.1), which affects women of all ages. Estimates for how many women are affected remain relatively high, with some suggesting that vulvar pain can affect up to 16% of the population (Shallcross *et al.*, 2018, p. 577) in Britain, and between 8 and 20% of the population in France (Beroud-Poyet and Beltran, 2017, p. 10). The acknowledgement that, regardless of cause, chronic 'sexual difficulties tend to create repercussions on other significant areas of functioning' (Byrne and Christmas, 2002, p. 285) is seen in much of the discourse around women's sexual pain, and the destructive effects of this type of sexual issue are well documented in healthcare discourse which focuses on them (Basson *et al.*, 2000, p. 888).

Socio-political discourse related to women's sexual pain in England and France has tended to underline the specificity of women's genital sexual pain as an experience which can potentially prevent women engaging in the 'central heterogendering act of penetrative intercourse with a male partner' (Kaler, 2006, p. 50) and which can therefore '[destabilise] women's sense of themselves as gendered beings' and '[destabilise] their sense of themselves as self-aware, knowable individuals' (Kaler, 2006, p. 67). Additionally, guides written by professionals versed in therapeutic techniques for women with sexual pain underline that, for women who are unable to participate in sexual activity due to pain, it can become a marked 'absence', meaning sexuality becomes both 'overly absent and overly present' (Beroud-Poyet and Beltran, 2017, p. 56)[1]. These pain issues, then, affect many women in England and France, and can have devastating effects. They can prevent women feeling like 'gendered beings' and 'self-aware, knowable individuals' (Kaler, 2006, p. 67) and can entail difficult experiences for women, where their relationships both with others and with themselves are

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[1] This and all subsequent translations from French are my own, unless otherwise stated.

brought into question. This is significant because these issues have not simply become ‘common but neglected’ (Mitchell et al., 2017, p.1) through an accidental process, but have come to be so in England and France where classification issues can complicate healthcare encounters (Delavierre *et al.,* 2010; Vegunta, Kling and Faubion, 2016) and neglect of these problems can have serious ‘repercussions on other significant areas of functioning’ in their lives (Byrne and Christmas, 2002, p. 285). These ‘common and extremely frustrating’ sexual problems (Butler, 2005, p. 25) affect women in both England and France, and despite both countries operating healthcare structures which promise universal access to healthcare, experiences of both accessing healthcare and receiving treatments for this pain vary greatly, as demonstrated by the empirical results of this study. As a pain largely related to one gender, which crosses disciplinary and discursive thresholds, women’s sexual pain is a unique example both of how healthcare systems in two specific countries operate with regards to these specific intimate issues, and of the way that these healthcare structures function in their capacity to prioritise certain issues over others and certain women, or groups of women, over others.

This thesis examines existing discourses of sexual pain and charts the main contributions made in this field of research, outlining healthcare discourse, socio-political discourse, and information related to healthcare provision and structure in both France and England. It embraces the multi-layered discourse around women’s genital sexual pain in England and France, and it draws on intersectional theory (including Hill Collins and Bilge, 2016; Carbado *et al*., 2013) and Foucauldian theories of power (Foucault, 1998; Sawicki, 1981; Taylor, 2015) to argue that power dynamics, both structural and individual, are inextricable from women’s experiences of genital sexual pain. It provides a detailed, cross-national outline of how women’s genital sexual pain is conceptualised in England and France and how this can translate into real-life experiences of challenges in accessing healthcare. With reference to original empirical data, it addresses gaps in our knowledge of sexual pain in England and France in terms of how power dynamics and how awareness of and resistance to these can lend themselves to reappropriation of intimacy in the most challenging of circumstances. It also addresses the methodological implications of choosing to research such a subject in a cross-national frame, and how a reflexive research process lends itself to this study. It is the first study using this frame to include the experiences of non-monogamous and queer women, prioritising the idea that although sexual pain can be a 'central heterogendering act of penetrative intercourse with a male partner' (Kaler, 2006, p. 50), it does not just affect heterosexual women in long-term relationships with men (Blair *et al.*, 2015). This thesis focuses on the nuanced study of women's sexual pain in England and France, and foregrounds the fact that women affected by this pain should be at the heart of research which concerns them. By studying the way that sexual pain is conceptualised in England and France, countries which are similar in their commitment to universal healthcare, yet different in their approach to services such a gynaecologist visits, this thesis provides an insight into the experiences of both women and healthcare professionals in the two countries using a unique methodological frame.

In this thesis, I argue that the experience of women's genital sexual pain can be complex and fraught for women affected in England and France, and that the socio-political context and provision of healthcare in both England and France can compound the difficulties of this experience, on occasion making these insurmountable. These issues mean that for women experiencing pain, healthcare access is often dependent on the knowledge of the practitioners and care professionals signposting and referring to relevant services, the local availability of these services, the way that the pain is spoken about both by the women affected and the professionals they consult, and, simply, whether their reports of their own pain are seen by others to be credible. This provides a crucial insight into these problems, which speaks of the disadvantages of being affected by a particular type of health issue within complex systems of care, and within certain notions of gender and potentially marginalising factors such as socio-economic background, race, and sexual preference.

The remainder of this introduction will firstly explain the research context, giving a broad outline of the English and French healthcare systems in their relevance to women's sexual pain. It will then explain the research problem, and the consequent development of the research questions and aims to address this under-researched issue. The approach to meeting these aims will follow, and this chapter will conclude with an outline of the subsequent chapters in the thesis.

1.2: The Research Context

1.2.1: Healthcare Systems in England and France

The comparison between France and England will give a crucial insight into how state decisions can affect individual access to healthcare, and how they can mitigate the effects of life-altering pain disorders, as well as examining the way that the two countries operate in parallel despite provide differing access to gynaecology appointments and services, and their dissimilar healthcare funding structures. Though healthcare varies by location, availability of specialised, knowledgeable healthcare practitioner, and socio-economic and patient circumstances in both France and England, the comparison of these poorly demarcated pain issues will paint a complex picture of the way that different women, and groups of women, are treated unequally in both countries as a result of their social and personal circumstances, and often their backgrounds and identities, despite the apparent national commitments in policy to adequate, universal, and accessible healthcare.

A cross-national examination of sexual pain is particularly valuable as it reveals how these ‘common but neglected’ issues (Mitchell et al., 2017, p.1) are interwoven with perceptions of gender across two separate national contexts. Looking at gender as a potential lens within multiple intersecting potentially marginalising factors, including socio-economic status, cultural background, and location, highlights how the gendered element of these pain issues reinforces and shapes their status in both England and France. Windebank, in her comparison of the childcare strategies of French and British working mothers, describes the ‘configurations of political motherhood’ (1997, p. 1) in both France and England, and their importance in understanding how ‘state policy reinforces or mitigates gender inequality’ (*Ibid.*, p. 3). This study follows a similar process although the social and health issues in question may be different, and it is through these social and socio-political configurations that the similarities and differences between England and France reveal how the status of women’s sexual pain is maintained or challenged in both countries, and how this can raise awareness of the issue alongside existing multi-disciplinary discourses of sexual pain in English and French.

In both England and France, healthcare systems include both private and state-funded elements. These operate alongside insurance providers, which form an integral part of the French healthcare system, and which are an important part of private care provision in England. Healthcare in both countries contains primary care systems operating in the form of general practice (GP services) and specialist or secondary care services, which can be delivered in hospitals or clinics. Both countries provide state-managed healthcare services, as discussed below, but differ in access to services such as regular gynaecology appointments and check-ups, secondary or specialist care referrals, and the way that care is subsidised. The national healthcare contexts in England and France are fundamental to experiences of sexual pain in France and England, both for women affected by the pain and healthcare professionals involved in its treatment. With this in mind, broad summaries of both healthcare systems are included below, with the context of the COVID-19 pandemic also born in mind.

In France, healthcare coverage is compulsory, universal, and is managed by the state, provided to all residents by non-competitive statutory insurance (Durand-Zaleski, 2016). Any person who cannot contribute to the National Health Insurance fund can access universal healthcare coverage under the PUMA, the Protection universelle maladie (Durand-Zaleski, 2020). Many people also use voluntary health insurance, which is based on supplementary payments for specified services and procedures (Durand-Zaleski, 2020). This is often in the form of healthcare contributions made through employers to mutual or provident associations (Durand-Zaleski, 2016) which cover expenses, including upfront payments, for healthcare procedures or appointments. They may also provide reimbursements for procedures not fully covered by statutory health insurance.

When a person in France who is covered by the statutory health insurance visits a medical professional, they present their health insurance card, the carte vitale, which covers some of the cost of medical care, or the full cost for some chronic illnesses such as endometriosis. The remainder of the cost of the health care service is covered, for those people that have it, by voluntary health insurance such as the insurance provided by mutual associations. This means that access to healthcare in France can depend on the social and employment status of an individual, but that there are provisions for those people who are not working or who are not covered under the statutory health insurance to mitigate potential difficulties for them in accessing healthcare. As well as having primary care providers in the form of GPs, which is similar to the situation in England, individuals in France can access some specialists directly, including gynaecologists, and psychiatrists (Durand-Zaleski, 2020). This is significant to this study of women's sexual pain, as women in England cannot access NHS gynaecologists without a referral, meaning that they are less able than women in France to specify which gynaecologist they would like to consult and when they would like to consult them. It is also important to understand the way that the French healthcare system operates in this broad sense, to understand the processes that participants in France may refer to when they describe their sexual pain treatment and appointments being out-of-pocket, meaning that they are not covered by healthcare insurers. This means that they may not be reimbursed for their treatment or consultation despite potentially having made contributions to a voluntary healthcare insurance fund. In a more basic sense, it is also important to understand because the system, which is intended to be universal, is complex, and, as the participants of this study will attest, insurance and reimbursement considerations can shape individual experiences of women's sexual pain in France.

Healthcare services are free of charge for many people in England, and one of the guiding principles of the NHS is that access 'to NHS services is based on clinical need, not an individual's ability to pay' (Department of Health and Social Care, 2021). The English healthcare system is managed by the state, and is largely funded by taxation (Thorlby, 2020), with 'around four-fifths (79%) of health expenditure is paid for through public revenues' (Office for National Statistics, 2019). Private healthcare providers do exist, through personal and employer contributions, but people for whom NHS treatment and consultations are payable may also be expected to pay for state-funded healthcare up front. There is a healthcare charge for people who arrive in the England and do not meet certain professional conditions such as being a skilled worker, or certain humanitarian conditions, such as being an asylum seeker or survivor of slavery human trafficking, and this means that newly arrived immigrants, whether they have arranged private medical insurance or not before arriving, may have to pay on accessing NHS treatment and consultations where certain conditions, such as length of stay, apply. These charges may be extensive, despite the NHS Constitution for England (NHS, 2021) stating that healthcare is not based on individual ability to pay.

It is also noteworthy that the ‘precise scope of the NHS is not defined in statute or by legislation, and there is no absolute right for patients to have a particular treatment’ (Thorlby and Arora, 2016). This means that availability of treatments and care, which are managed by regional commissioning groups funded by the state, can vary both in terms of location and by health condition. In theory this means that for all residents in England healthcare is free or subsidised, apart from some services like dentists, wig fabrication, and opticians. In practice, however, this free healthcare provision does not cover all members of the population, and those people who fall inside of the circumstances sanctioned by Parliament as ineligible for healthcare treatment and access may miss out on this free access to healthcare, be charged on consulting practitioners or in the form of a healthcare surcharge, or may not have access to information about how to address these charges at all.

1.2.2: The COVID-19 Pandemic and Health Inequalities

Though the original empirical research for this thesis relates to healthcare experiences during the period from 2017 to 2019, when interviewing took place, it is important to explain the relevance of COVID-19 to this study. The complex healthcare structures which shaped, and continue to shape, experiences of women’s sexual pain have been forced to adapt to the context of an ongoing pandemic, with the risks that this entails in terms of cementing existing structural health inequalities. In this sense, the comparisons and conclusions drawn in this thesis about women’s sexual pain are more relevant than ever, in providing a specific cross-national example of how intersections of certain factors can, and do, disadvantage certain populations over others in two healthcare systems.

The healthcare systems in both England and France are similar in their commitment to universal healthcare, and their awareness of health inequalities, especially those which were cemented during the COVID-19 pandemic. England's NHS has designed the Core20PLUS5 approach (NHS England, 2022) which defines the 'most deprived 20% of the national population as identified by the national Index of Multiple Deprivation (IMD)', accounting for the social determinants of health and areas which are priorities in addressing health inequalities. This approach also aims to recognise factors including location and race among significant considerations in determining care. French government discourse on health inequalities goes further, directly referencing the way that COVID-19 has 'hit the most precarious populations the hardest' (Santé publique France, 2021) explaining that health inequalities are 'systematic, avoidable, and significant differences' in the health sector between different social groups, which are linked not only to social factors such as gender or immigration status, but also to overarching structural determinants such as social policies (Santé publique France, 2021). There is also a clear recognition that these inequalities can 'go hand in hand with disparities related to quality of life, environment and work' (Santé publique France, 2021).

Though the semi-structured interviews for this study were completed before the beginning of the COVID-19 outbreak, the way that this thesis examines how marginalising factors affect access to, and use of, healthcare services is directly relevant to the current healthcare context, where COVID-19 lockdowns in England and France have ended, but COVID-19 is still present in wider society and healthcare in both countries. The inequalities and marginalisation issues in England and France from the pre-COVID-19 period have not disappeared due to the pandemic, and it has arguably deepened many of these. Chatot (2021, p. 278) explains that lockdown periods for middle-class women 'reinforced […] relations of power (economic, material, and symbolic)' which were often disadvantaging these women prior to the start of the pandemic, also explaining that it was groups who may have previously been marginalised, such as recently arrived immigrants without access to state support, who felt the effects of the pandemic most acutely. Similarly, Bambra, Lynch, and Smith (2021, p. 3) describe how

> ‘the COVID-19 pandemic is not only experienced unequally, but is actually a syndemic pandemic, interacting with and exacerbated by social, economic and health inequalities – a rare combination of negative factors producing a ‘perfect storm’.’

They assert that the effects of the pandemic ‘could have been mitigated or avoided through better preparation’, and that these inequalities continued partly due to prior political choices, especially those related to healthcare policymaking (Ibid.p. xiv). In both England and France, the systematic, avoidable, and significant (Santé publique France, 2021) nature of these inequalities not only reflects political and healthcare policy choices that continue to prioritise certain groups over others, but also illuminates the unequal experience of the pandemic day-to-day for marginalised groups, and how healthcare inequalities were, or were not, addressed as part of the policy response to the pandemic and in post-pandemic healthcare planning (Bambra, Lynch and Smith, 2021, p. xii).

1.3: The Research Problem

Taylor, in her article ‘Female Sexual Dysfunction, Feminist Sexology, and the Psychiatry of the Normal’, (2015, p. 292), proposes a ‘feminist politics of sex’, which ‘would advocate the cultivation of pleasures (sexual or otherwise) rather than normalcy’. This article draws on ‘both Foucauldian and feminist perspectives’ to examine ‘self-described feminist sexologists’ responses to the psychiatric diagnoses of Female Sexual Dysfunction (FSD)’, including genital sexual pain issues (p. 261). Alongside this, Taylor suggests that statistically, in the USA at least, FSD ‘is in fact statistically *normal* and that, among mature women, FSD actually characterizes the majority’ (*Ibid.*, p. 282). This is echoed in prevalence studies in France, where recent findings from one study suggest that ‘chronic pelvic pain might well be a substantial health issue in the general population of premenopausal French women’, where this chronic pelvic pain includes dyspareunia, a type of sexual pain (Margueritte *et al.*, 2021, p. 2489). Similarly, Margueritte *et al*. add that chronic ‘pelvic pain symptoms among women of reproductive age are one of their most frequent reason[s] for seeking health care' (*Ibid.*, p. 2481). Painful sex is outlined as a common issue in Britain, affecting a 'sizeable minority of women' (Mitchell *et al.*, 2017, p. 1), with estimates that 7.5% of women in Britain experience this type of pain. Though the ways that sexual pain prevalence and existence are measured vary, and definitions, which often overlap, are not standardised in policy between England and France, sexual pain issues undoubtedly affect many women and, as Taylor suggests, ideas of what may be ''normal'' factor significantly into this. English and French healthcare systems, both containing state-funded and private elements, do provide services for women who experience sexual pain, and for their partners, and yet these issues continue to be stigmatising to speak about, inconsistently understood by healthcare professionals (Delavierre *et al.*, 2010), and potentially treated with derision, and questioning of women's personalities (Wilson, 1999), in clinical settings.

It may seem as though the healthcare structures in England and France have been designed with women's individual needs in mind as part of their commitment to universally accessible and appropriate healthcare. And yet, looking closer, it is clear that the systems of healthcare and health insurance in both England and France do not exist independently from issues of marginalisation and exclusion of certain women and groups of women. In fact, these marginalisations can be created, reinforced, and repeated within complex healthcare structures, and they have enormous potential to disadvantage women who may be vulnerable, unwell, or otherwise marginalised prior to their use of healthcare services. Women's genital sexual pain, in its quality as an issue which affects many spheres of women's lives, is a unique and revealing lens through which to examine how these structures work to exclude and minimise the needs of some individuals, and to prioritise the needs of others. These spheres move from the intimate power dynamics of sexual activity, to the complex negotiation of employment status and practice when the pain makes it impossible to work, to women questioning their own minds and perceptions through years, sometimes decades, of being disbelieved by healthcare professionals about their pain. This type of pain can be pervasive, destructive, and experienced as feelings including burning, cutting, or stabbing, sometimes so severe that they make it impossible to maintain a lifestyle or activities equivalent to those carried out before the start of the pain (Synne Groven *et al.*, 2015). This study will reveal that access to treatment for this pain can be inconsistent and reactive, and that it depends largely on how credible women are seen to be by the healthcare professional that they are consulting, whether the healthcare professional or service consulted is knowledgeable about the diagnosis and treatment of women's sexual pain, and whether their personal inclination is to treat these issues as problems in their own right. It also, crucially, depends on whether services exist locally for women and when these do exist, whether they are easily routinely accessible.

As this type of vulvovaginal sexual pain is experienced exclusively by women, and people who have vaginas and vulvas, it is also unique in the description, classification, and location of the pain, which has further effects on those women and people affected by it. This is a problem which not only creates disagreements in the way that this pain is classified (Ayling and Ussher, 2006), which has profound effects on women seeking treatment for it, but this unique situation can also limit understandings of the problems outside of specialist services and those healthcare providers who have a prior interest or investment in the problem. The way that unequal healthcare structures operate, then, is not only a factor in the experiences of women who are affected by this type of pain in England and France, but is itself an aspect of the way that women's sexual pain is conceptualised, which reinforces and demonstrates the difficulties in treatment seeking practices of women who are affected. In both England and France there is recognition in distinct areas of healthcare provision and services that women's genital sexual pain is a problem in its own right, worthy of specialist, and where necessary, multidisciplinary treatment. Nevertheless, the way that women's genital sexual pain is spoken about, both inside and outside of healthcare contexts, affects perceptions of the issue. This study investigates the way that women's sexual pain is conceptualised in England and France, with reference to interview data from individual women affected by the pain, and specialists and healthcare professionals involved in its treatment. It maintains that structural inequality and other marginalising factors can directly disadvantage certain women, and that sexual pain is a particularly salient issue to demonstrate this. Additionally, it maintains that the meanings of women's genital sexual pain are constructed in a way that is intricately linked to gender, and that the figurative abjection, reappropriation and renegotiation of sexual practices cannot exist outside of this. These research problems lead to one principal research question driving this thesis, which is:

How is women's sexual pain conceptualised in England and France?

The three, more focused, questions below, encourage an elaboration on several key aspects of the research problem, namely the way that socio-political conceptualisations and notions of power relations can help to understand sexual pain in a way that is relevant to healthcare practice, how women's experiences of pain can be shaped by structural power, and, finally, the impact that this study can have in raising awareness of women's sexual pain by studying it in a defined cross-national methodological frame.

1.4: The narrower research questions:

1. How does studying sexual pain within a socio-political framework, including within theories of power relations, encourage the development of a conceptualisation of sexual pain which is relevant to healthcare practice? How is this relevant to both healthcare professionals and women affected by this pain?

2. How are national health structures and practices relevant to the lived experiences of women who are affected by sexual pain?

3. What policy recommendations might emerge from this cross-national study which examines both English and French conceptualisations of women's sexual pain?

1.5: Research Aims

1. To produce a coherent, meticulous, and engaging study of women's sexual pain in England and France, which is relevant and accessible to readers in diverse settings, and which has a meaningful impact in the field of sexual pain research.

2. To engage with women who are affected by genital sexual pain and healthcare professionals in a collaborative, sensitive way.

3. To use interview data to situate this study in participant's own descriptions of sexual pain and its psychosocial contexts.

4. To define and critically appraise current perceptions of women's sexual pain in England and France.

1.6: Research Approach

The fundamental aim of this thesis is to reveal how women's sexual pain is conceptualised in France and England, with reference to multiple discourses of sexual pain, and engagement with women affected by the pain and healthcare professionals involved in its treatment. It further aims to provide accessible information to readers in multiple settings and to situate the definitions and descriptions of sexual pain in women's own explanations. To do this, a qualitative empirical approach was chosen to complement the theoretical and analytical approaches, which respectively examined selected discourse in English and French related to women's sexual pain using several key theoretical principles, and then analysed bilingual interview data by theme to draw conclusions about key issues in sexual pain conceptualisations, based on the experiences and impressions of participants affected by the pain and its effects.

The interpretative nature of qualitative research was particularly appropriate for this study, where multiple 'meanings and interpretations of the participants are the essence' of inquiry (Liamputtong, 2019, p. 9). Qualitative researchers, states Liamputtong (*Ibid.,* p. 9) can be seen as 'constructivists who attempt to find answers in the real world', by looking for 'meanings that people have constructed'. A qualitative approach employing semi-structured interview techniques was particularly apt in this regard, due to the highly nuanced and complex nature of the experiences described by participants, and a wish not to convert this to statistical data which may lose some nuance or depth of meaning. Further to this, this commitment to explore 'meanings and interpretations' (Liamputtong, 2019, p. 9) demanded a research approach which could be iterative, flexible to meet the aim of the project to ground conceptualisations of pain experiences in participants' own descriptions, and coherent enough to provide high-quality, accessible analytic results while addressing complex, highly emotional, and often sensitive personal disclosures. The use of qualitative methods here also recognises the contingent, constructed nature of the knowledge discussed, reported, and produced as part of the project.

The contribution to knowledge that this study makes can be defined in two distinct ways. Firstly, this study uses a unique, cross-national, qualitative methodological frame, which includes the experiences of women in non-monogamous relationships, women who were not in relationships at all, and queer women. Traditionally, due to the frequently interpersonal context of this pain, research has focused on heterosexual women in long-term relationships who are drawn from lists in healthcare settings (Kaler, 2006; Ayling and Ussher, 2008), and by encouraging participants to self-identify as being affected by sexual pain, this project sought to move away from this as the norm of sexual pain research, and into an approach which aims to recognise the diversity of intimate practices and desires rather than treating monogamous heterosexuality as the norm from which other expressions of intimacy and sexuality deviate. Secondly, the fact that this study is informed by both socio-political and medical discourses, and by interviews with both healthcare professionals and women affected by sexual pain in England and France makes this the first study to combine these participant groups within this tailored cross-national frame. By approaching the conceptualisation of sexual pain in this way, this study contributes to existing knowledge not only by offering a unique insight into how it is conceptualised in England and France, and by underlining what such an insight offers both healthcare professionals and women in both countries, but also by taking into account how women themselves conceptualise their pain in their own words, and prioritising this in offering such an insight.

In this respect, the project investigated meanings created by participants for their sexual pain and the sexual pain they work with, and this meant taking an approach which focused closely on details for the data collection. In engaging with healthcare discourses and guidelines to which many of the participants referred, the project focuses on the construction of multiple discourses around sexual pain and how these can shape the experiences of women affected by them. Though the relatively small and self-selecting sample for this research means that the potential for generalisability of the results is limited, it still provides an important insight into the structural inequalities and discourses which influence experiences of women's genital sexual pain in England and France.

A research approach which actively recognised these structural inequalities was crucial, as was an approach which aimed to work with potentially vulnerable participants, meaning 'peopl[e] whose strengths and positive attributes are generally overlooked, and who are confronted with differential risks and health burdens in comparison to others living in their community or country' (Wilson, 2019, p. 1526). The empirical and analytical approach to this work, then, was designed to be safe, 'culturally responsive', and to avoid any potential to increase vulnerability, or to marginalise people further (*Ibid.*, p. 1526). Similarly, the research aims were developed with reflexive research practice in mind, meaning the creation of a methodology which, as well as avoiding potentially marginalising participants, and considering the ways that participant voices were represented as part of the empirical and analytical approaches to the research, positioned the researcher as an active part of the research process, who must recognise and reflect upon what they bring to the process. Part of this was considering how the present study was being conducted in an academic setting, though it strives to ensure that results reach beyond this.

This recognition of positionality and reflexive approach coheres with an analysis informed by Foucauldian theories of power, acknowledging that power dynamics, including those involved in empirical research design, are changeable, and that knowledge is culturally and socially contingent. The additional and complementary use of intersectionality in this thesis, understood as the 'analytic tool' which recognises that 'major axes of social divisions in a given society at a given time […] operate not as discrete and mutually exclusive entities, but build on each other and work together' (Hill Collins and Bilge, 2016, p. 13) adds another layer of depth to the analysis of the interview data for this study. Though the way that the present study uses intersectionality as a tool is removed from its origins in Black feminism and Critical Race Theory', where it was developed as a concept 'to address the marginali[s]ation of Black women within not only antidiscrimination law but also in feminist and antiracist theory and politics' (Carbado *et al.*, 2013, p.

303), it nevertheless attempts to consider the multitude of factors which affect women's experiences of healthcare services due to their experiences of marginalisation, and how demographic factors may play into these. Lépinard calls for a reflexive questioning of racial privilege in her exploration of the application of intersectional feminism, and a 'feminist ethic of responsibility' (2020, p. 179) which is context-specific, '[e]mbedded in relations of responsibilities' (p. 225) and grounded in the 'concrete consequences' of 'moral impulse[s]' (p. 125), which this thesis aims to do in its reflexive methodology and clear rationale for research decisions. The destructive 'concrete consequences' of gendered healthcare inequalities are also at the forefront of theoretical considerations for this work. Careful, reflexive research practice, and grounding analysis in participants' own descriptions of sexual pain and its psychosocial contexts is intended to highlight these 'concrete consequences', and the ways that participants feel *themselves* to be marginalised or 'multiply-marginali[s]ed'.

A research approach which is qualitative, cross-national, and attempts to move away from the approach to sexual pain research where certain penetrative intimate practices are the norm, facilitates the understanding of sexual pain issues in both England and France by examining the factors contributing to women's own experiences of the pain. It also underlines how sexual pain, in its links to gendered experiences and gendered policy discourse, reveals inbuilt and changeable structural inequalities in both England and France. Examining the ways that women who experience sexual pain in France and England may be multiply-marginalised (Carbado *et al.*, 2013, p. 309) does not reverse this process of marginalisation, but in raising awareness of sexual pain experiences with healthcare professionals and policymakers in England and France, this work aims to draw attention to this 'common but neglected' issue (Mitchell et al., 2017, p.1), which can cause enormous distress and difficulties. Healthcare systems in France and England respectively promise universal health coverage 'without discrimination' in accessing preventative and curative healthcare (Ministère des Solidarités et de la Santé, 2022) and provision of NHS services without individuals being 'unlawfully discriminated against', 'including on grounds of gender, race, disability, age, sexual orientation, religion, belief' or other protected characteristics (Department of Health and Social Care, 2021). This study shows that, despite these rights being clearly stated in both French and English healthcare policy, all healthcare access and provision is not equal in terms of women's sexual pain. It will show, in a revelatory, and sometimes damning, light, the effect that this can have on individual women and their lives. It will also describe the renegotiation of intimate practices by many of these women, in the complex structures they face in navigating their experiences of sexual pain.

1.7: Chapter Outline

An approach which considers power relations is crucial to understand conceptualisations of women's sexual pain in England and France, and the Literature Review section which follows will discuss relevant literature in England and France, divided by discipline, and will identify the gaps in existing literature that this thesis aims to address. The Methodology will then demonstrate how the empirical section of the thesis is connected to these gaps and how it will contribute to understandings of this issue in England and France. Next, three thematic analytical chapters will follow, to answer the research questions and address the research aims, particularly those focusing on women's own conceptualisations of their pain, and the way that women's genital sexual pain is relatively unknown in academic research contexts and is disputed in medical and healthcare discourse. Finally, the Conclusion will set out how the findings discussed in the analytical sections contribute to understandings of women's sexual pain in England and France, and the meaningful impact that this understanding might have. It also details the potential of this work in raising awareness of women's sexual pain, and the implications of this research for future investigations and for agenda-setting in policy.

2: LITERATURE REVIEW

As there is a large amount of discourse in both English and French pertaining to conceptualisations of women's sexual pain, searches were carried out using keywords in selected databases from the year 2000 onwards. This was chosen due to the limited scope of the project, and additionally because of the way that classifications and definitions for sexual pain change, meaning the most relevant contemporary literature was sought to complement the empirical data from participant interviews. Discourse was included when it provided information relative to the classification, definition, or management of women's sexual pain in England and France, or the way that it is conceptualised in other disciplines such as socio-political theory. The review of existing discourse below is not exhaustive, nor does it have the scope to examine each of the areas in intricate detail, but it provides a broad overview of the existing classifications and conceptualisations linked to women's sexual pain in England and France, and it attempts to define how the present study will contribute to this field. The theoretical approach influenced by theories of power and intersectionality will be maintained throughout this section, which will expose the gaps that later empirical and analytical sections address.

2.1: Theoretical Approach

The literature review which follows will work within and alongside the theoretical approach for the whole thesis, which is informed by concepts of intersectionality and power dynamics, and which engages with Foucauldian ideas about structural power and resistance. The ontological framework, which is broadly social constructionist, will also be outlined. Though one of the key aims of this research is to situate the study in participants' own descriptions of sexual pain and its contexts, it is also crucial to define and explore how sexual pain can be conceptualised in the structures and healthcare discourse which may affect sexual pain experiences in France, and to explore how this study identifies and addresses the gaps in this under-researched field of study.

This section will start by discussing the choice of, and the use of, intersectionality and Foucauldian conceptualisations of power in this exploration of women's sexual pain in England and France, followed by a description of the ontological viewpoint for this thesis. Once the theoretical framework has been outlined, selected relevant discourse around women's sexual pain in England and France will be explored, to problematise the definition and classification of women's sexual pain in both countries, followed by a discussion of possible treatments and options for women affected by sexual pain in England and France. This literature will be split by discipline, considering the many different specialties that studies of sexual pain can span. It will include pertinent discussions including the idea that women experiencing sexual pain could be seen as 'difficult women', (Ussher, 2013), the way that sexology operates in France and how it is largely unknown as a speciality in its own right in England, and how women's voices have been represented in previous discourse around women's sexual pain. It will also demonstrate the gaps in the current discourse that this study addresses, and how the empirical and analytical sections which follow approach this.

2.2: Intersectionality

Intersectionality is an analytic tool which can be used to understand how individual and structural forms of marginalisation (such as race, socio-economic status, and gender) can intersect. It is grounded in social justice practice and focuses on the practical implications of this understanding of marginalisation. It can be applied to many different settings, including grassroots organisations, academic studies, healthcare structures, and other settings where multiple dynamics of power and disadvantage can be studied. Intersectionality is grounded in Black feminism and Critical Race Theory in the USA, and its creation is often attributed to Kimberlé Crenshaw, who 'introduced the term to address the marginali[s]ation of Black women within not only antidiscrimination law but also in feminist and antiracist theory and politics' (Carbado *et al.*, 2013, p. 303). As a theory and a tool which examines how marginalisation can operate, even within 'discourses of resistance' such as feminism and antiracism (Carbado *et al.*, 2013, p. 304), intersectionality is valuable when looking at how people can be marginalised in multiple ways simultaneously (Carbado *et al.*, p. 309), as well as thinking about how theory and political statements and actions can themselves be a potential site for marginalisation. Many recent uses of the theory have moved away from this emphasis upon race and how this intersects with other marginalising factors, and in its popularity as a theory it has transformed intersectionality into a more academic, depoliticised concept (Carbado *et al.*, 2013, p. 308; Hill Collins, 2015, p. 17). Hill Collins (2015, p. 17) regrounds current uses of intersectionality in its potential as critical praxis, which can 'critique social injustices that characteri[s]e complex social inequalities, imagine alternatives, and/or propose viable action strategies for change', without forgetting its origins in Black feminism and Critical Race Theory. This proposal of imagining alternatives to injustice and social inequalities will be at the heart of the way that intersectionality is used in this thesis, without forgetting the origins and political potential of intersectional theory.

Intersectionality helps us to understand how power dynamics and forms of marginalisation, which can intersect with each other, disadvantage certain people or groups over others. These types of power can be 'interpersonal, disciplinary, cultural' or structural (Hill Collins and Bilge, 2016, p. 7), and can work together as well as operating individually. Though looking at these forms of power and marginalisation might seem at first to be a purely conceptual exercise, intersectionality helps us to work out which factors marginalise people and how this marginalisation works. Once this is understood, these factors can be addressed, and this knowledge can be applied to practical settings, such as raising awareness or challenging existing policy in organisations to address entrenched forms of injustice.

Intersectionality can help in 'understanding the complexity in the world, in people, and in human experiences' (Hill Collins and Bilge, 2016, p. 1), and the nuances and potential complexity of sexual pain experiences are key to this study.

Intersectionality will work alongside Foucauldian conceptualisations of power in this thesis. This means that power will be understood as a fluid dynamic, which moves and reconstitutes itself constantly between individuals and structures who hold differing levels of structural power at any given time. Intersectional frames understand 'power relations through a lens of mutual construction' (Hill Collins and Bilge, 2016, p. 26-7), and in this thesis, considerations of how power works within healthcare structures, as well as within interpersonal and relational dynamics, will be crucial to understanding how sexual pain is conceptualised in France and England. Many women who experience sexual pain mention their gender, cultural background, socio-economic and health status, as well as their location and multiple other demographic factors, as integral to their sexual pain experiences. Exploring how women affected by sexual pain understand these potentially marginalising factors, and how they conceptualise the power dynamics of which they form a part, creates a foundation for this work. Working in a way informed by intersectionality in the analysis of participant interviews emphasises the way that forms of marginalisation affect women's experiences of sexual pain, and healthcare professionals' experiences of encountering it. This, in turn, means that the analysis will be able to raise awareness of these issues in a way that coheres with what participants felt was most important in their experiences, and which additionally imagines alternatives (Hill Collins, 2015, p. 15) to the way different forms of marginalisation were operating during these experiences.

2.3: Foucauldian Concepts of Power

Foucault's 'History of Sexuality' series, alongside Foucauldian feminist discourse, informs the theoretical approach to this study. This is particularly important when looking at the way that power both operates and transforms within the cultural contexts of England and France, and within multiple state structures. This is significant alongside the use of intersectionality as a tool which seeks to understand how power operates in different ways which may coexist. The application of Foucault's work to this study will be the approach termed by Sawicki (1981, p. 29) as a 'critical method', which reflects Foucault's concept of the 'genealogy'. This reflects a

> 'focus on discontinuities, contingencies and power struggles in order to demonstrate that the past was different from the present, the present could have been otherwise and thus the future may also be otherwise' (Taylor, 2017, p. 12).

Genealogies, are, as Taylor explains, political, aiming 'to disrupt, to open up spaces for social change' (*Ibid*. p. 12), and this is part of what the present thesis aims to do by cross-nationally studying sexual pain through the lens of power and raising awareness of these seldom studied issues. Though for this project a detailed analysis of Foucault's writings related to the history of sexual pain is not a primary aim, it is still crucial to understand that discourse and healthcare terminology are constructed, historically contingent, and can be challenged using critical methodology and the reflexive examination of the assumptions surrounding them. The present study will hold this as an essential theoretical and methodological consideration, especially in the discussion of power over subjective personal experiences. Without attempting to condense Foucault's intricate and contextualised arguments down into small generalisable statements, looking at sexual pain through a lens of power relations, with a critical eye which focuses on the future as well as the past, will be paramount to this study of sexual pain.

The writings of Foucault, and related works by scholars informed by Foucauldian concepts (for example Taylor, 2015; Ayling and Ussher, 2008), complement the lens of intersectionality thanks to their communal focus on how power, and systems of power, intersect and interact. In her recent guide to *The History of Sexuality,* Taylor suggests that Foucault wrote this series because 'sex is a privileged site through which power works in biopolitical times, and that cultivating different relations to sex might undo some of the effects of this power' (Taylor, 2017, p. 109). Biopolitics, meaning the utilisation of 'numerous and diverse techniques for achieving the subjugation of bodies and the control of populations' (Foucault, 1998, p.140), is a vital concept in this first volume and it fits into a much larger discussion of the constantly changing and interwoven forms taken by 'relations of power' (Foucault, 1998, p.103). How these concepts relate to the discussion of sexuality, its history, and how it became an object of knowledge and contemplation are also fundamental to this work, due to its focus on the status of women's sexual pain as an issue in England and France and how the gendered and neglected status of this issue is maintained.

In this way, it is important to maintain a thread of the possibilities and challenges of fluid dynamics of power which run through the participant interviews, and through the tracing of participant experiences within intricate structures and systems. The application of Foucault and Foucauldian feminist writing to the specific study of women's sexual pain is particularly relevant given the nuanced nature of the empirical results discussed in the Analysis sections of the thesis, and the way that the thesis aims to contribute by raising awareness of these issues within a theoretical frame including power relations. Regardless of the fact that allegations have come to light that Foucault engaged in sexual activity with minors in Tunisia (see Guesmi, 2021; Campbell, 2021), which may reasonably cast a new light on the use of Foucauldian theory, especially in projects such as the present thesis where non-consensual sexual activity and childhood sexual abuse are discussed by participants, this method was the most appropriate design at the time of creating the theoretical approach to this thesis. These allegations are not being ignored, nor will the present study attempt to separate a theorist from their theory. It has, however, been necessary to include the element of Foucauldian analysis previously incorporated into the study design, since the thesis was in its final stages when these allegations came to light, and a substantial amount of the analysis and critical framework relies on the theory previously chosen as part of the theoretical approach.

2.4: Ontological Approach

The ontological viewpoint for this thesis is social constructionist. This means that the ontology for this work, the philosophical viewpoint about what exists (Hathcoat *et al.*, 2019, p. 100), will uphold 'the possibility of multiple, coexisting meanings' (*Ibid.*, p. 103). The key principle of social constructionism is understood here, after Burr (2019 p. 118), as 'our knowledge of the world, including our understanding of human beings, [being] a product of human thought, language, and interaction rather than grounded in an observable and definable external reality'. Burr's description works readily alongside that of Sullivan (2010, p. 27), who asserts that social constructionism acknowledges the nuances of human experience and provides a viewpoint within which research questions can address hypotheses about the world, which 'are inevitably shifting and imperfect, rather than giving us immutable facts'. This perspective is an excellent fit for the aims of the study, as it gives space for an examination of power dynamics and conceptual ideas about sexual pain, as well as recognising the significance of participants' own words and meanings, regardless of whether they reproduce dominant discourses or contested facts about sexual pain.

A relativist, rather than realist, position was chosen to answer the research questions and meet the research objectives of this project. They are answered in a more exact way through discussions of social context and representation than through searching for "objective" and repeatable outcomes, or the search for fixed entities and experimental replication often associated with realist ontological viewpoints (*Ibid.*, p. 20). This thesis does not aim to take an authoritative or "objective" stance towards data collection, discourse, or researcher positioning, rather looking at contextual meanings and perceptions, and how this can be applied to impactful activities within the larger concern of gendered healthcare access and conceptualisations of power. Critical realism may have seemed an adequate alternative ontological viewpoint for this project, social constructionism was chosen in its place due to the potential of social constructionism to 'reject de-contextualised knowledge claims' (Pilgrim, 2014, p. 6). This work rather attempts to ground the knowledge claims created by the empirical element of the thesis in the contexts in which they were produced. This also avoids the idea that there is a 'grand narrative' to sexual pain discourse, which is a risk when employing critical realism in social sciences research (*Ibid.*, p. 6). Though the benefits of critical realism for research into such issues as sexual pain are recognised, social constructionism was instead used here after Pilgrim, in that much of the present research overlaps with questioning of ‘mental health’ as a broad concept and the problematising of diagnostic categories which do not always consider the possibility of multiple perceptions of reality. Further to this, the ‘limited development of the biopsychosocial model in psychiatry’, a model which consistently adopts critical realist stances, and its ‘failed promise as a possible example of critical realist logic accounted for’ (Pilgrim, 2014, p. 1) in mental health research, mean that critical realism and in particular the ‘critical realist logic’ associated with some medical discourse is counter to the reflexive, culturally and historically contingent approach taken to knowledge and discourse in this thesis.

There are, of course, some limitations to using a social constructionist viewpoint, particularly the idea that in focusing on representation and meaning and widely refuting truth claims, relativists, including social constructionists, can be seen to ‘thwart any attempts to take moral, ethical or political standpoints or to challenge oppression and falsehood’ (Sullivan, 2010, p. 28). It is for this reason that a broad understanding of social constructionism has been used for this thesis, one which is applicable to healthcare settings, and one which does recognise the existence of a material body which is not entirely socially constructed, alongside considering ‘discursive aspects of health and illness’ (*Ibid.*, p. 29). The use of this ontology throughout the thesis will use Sullivan’s ‘shifting and imperfect’ approach to finding and exploring meanings as part of the iterative research process, and it will counter the temptation to counter truth claims, by using this perspective critically and reflexively, and working towards the accessible, relevant, and practicable exploration of sexual pain as a potentially marginalising issue which disadvantages certain women over others.

2.5: Healthcare and Sexual Pain in England and France

When women consult healthcare professionals for their sexual pain, they will not always consult a gynaecologist or GP in the first instance, and so it must be considered that the range of healthcare providers consulted for sexual pain issues can include multiple specialities, including physiotherapists, urologists and psychiatric or psychotherapeutic practitioners. While some women who are affected by sexual pain may not consult health professionals at all, it is crucial to understand that the debates within the field of sexual pain healthcare practice repeatedly complicate, control, and channel women's symptoms in a specific way, and that healthcare literature comprises a range of guidelines, research papers, and classification debates, all of which may or may not be applied in practical healthcare encounters by practitioners.

2.5.1: French discourse

The French Haute Autorité de Santé, or French National Health Authority, in its guide to identifying, assessing, and referring patients with chronic pain issues, state that pain is 'what the affected person says it is […] regardless of whether a cause has been identified' (Haute Autorité de Santé, 2008, p. 6), emphasising the elements of chronic pain for which a cause may not be found. Others in the French discourse consulted describe how vulval pathology can assist in revealing of systemic illnesses, both related to the skin and other bodily systems (Pelisse, 2004, p. 5), while for some clinicians such as Cour and Bonierbale (2012, p. 571) the 'principle challenge' in working with sexual pain is 'appreciating the real motivation of the patient' for consulting a medical professional (Ibid., p. 571) and it is simply stated that 'a woman who feels "right in her own skin" will be comfortable in her [sexual] desire' (Ibid., p. 562). Other authors such as Buvat (2010) recall that the 'multifactorial nature' of female sexual dysfunction is 'no longer contested' (Buvat, 2010, p. 24), reaffirming that contextual and systemic inequalities can affect women who experience sexual pain. Bianchi-Demicheli and De Ziegler (2005) explain that sexual problems such as pain can indicate other 'serious medical problems' such as diabetes, kidney issues or tumours, before moving on to treatment suggestions of 'dysfunctions', including sexual pain, which they say should consider 'social, cultural, ethnic at religious contexts' of the patient which could influence their attitude towards their own sexuality (Ibid., p. 2). They suggest that specialists work together for an effective treatment plan (Ibid., p. 5) and that considering female patients who consult for sexual pain in a 'bio-psycho-social model' which focuses not only on the sexual problem, but also situates the patient within the wider context of their personal experience (*Ibid.*, p. 3), is beneficial to treatment outcomes for patients. This suggestion appears to have a more individualised approach in mind.

Others (Vasconcelos Zanotti *et al.*, 2013, p. 431) state that at the time of writing their article regarding the conceptualisation of chronic pain, discussions amongst those people affected by chronic pain largely focused on 'the legitimacy of their symptoms and the authenticity of what they are feeling'. This is hardly surprising, considering potential healthcare access challenges for women living in France (Giami and de Colomby, 2003), the fact that there is disagreement between specialists in the field about the guidelines and definitions used, even if the problems are widely recognised as causing 'profound distress' (Bianchi-Demicheli and De Ziegler, 2005, p. 1). This healthcare discourse, then, reveals that women's sexual pain has been conceptualised in French literature in a multiplicity of ways, including its relationship to other problems, women's relationships to their 'own skin', and as a significant issue, regardless of whether a cause for the pain has been identified. This reveals that even where diagnostic manuals are not the main terms of reference for sexual pain disorders, there are still disagreements about how the pain should be conceptualised in the literature consulted, as well as classified as a problem in its own right, despite the undeniable fact that it can have profound and severe effects.

2.5.2: English discourse

As mentioned previously, practitioners who come into contact with women experiencing sexual pain will not necessarily be gynaecologists, and they will range from psychosexual therapists to specialists in endocrinology or urology (Basson and others, 2000). Accordingly, meanings and conceptualisations of sexual pain issues vary between specialities, in a similar way to the meanings, understandings, and specialities involved in sexual pain management in France. For example, guidelines written by a specialist gynaecologist (Wilson, 1999, p. 117) state that dyspareunia, a sexual pain disorder, is a ‘common condition in both young and old with somatic and psychological elements’, yet Basson and others (2000, p. 890) state that it is ‘the recurrent or persistent genital pain associated with sexual intercourse’. Fugl-Meyer and Fugl-Meyer (2006) completely avoid defining it, even though their European data reflects its prevalence. Some discourses conceptualise women’s genital sexual pain as linked to a specific ‘sexual response’ which is ‘clouded by taboos’ (Archer et al., 2006, p. 825), and others describe sexual pain as a condition where the ‘psyche is willing, used to be willing or maybe wasn’t ever willing [to engage in heterosexual penetrative sex], but the soma is saying a definite “No”!’ (Black, 2005, p. 25). What is clear throughout the discourse on sexual pain, despite many disagreements and inconsistencies, is that genital sexual pain can lead to ‘impaired quality of life, [and] a decreased level of well-being and relationship issues’ (Fooladi and Davis, 2012, p. 2131).

Vegunta, Kling and Faubion (2016, p. 952) add that female sexual dysfunction ‘is common but frequently underdiagnosed’, and Raina et al. (2007, p. 1273) note that female sexual dysfunctions as an overarching category including sexual pain disorders were, until recently, ‘considered to be psychological in nature’, though there is now recognition that it these issues are ‘multifactorial in [a]etiology’. The English National Institute for Health and Care Excellence, used by clinicians as a point of reference in England (NICE, 2019) does not provide its own guidance for women’s sexual pain, or its definition or classification, leading to questions regarding how clinicians find information about sexual pain when necessary. Vegunta, Kling, and Faubion (2016, p. 952) reiterate that if sexual pain is untreated, it can be ‘associated with decreased quality of life, depression, and interpersonal conflicts’, and these effects will be demonstrated in the thesis sections which follow. In light of Graziottin’s (2005, p. 32) affirmation that any change to the definition of sexual pain ‘does not modify the category of the [sexual pain] disorder (a cancer remains a cancer even if it is complicated by unbearable pain and does not become ‘‘a pain disorder’’ even if it requires specific multimodal anthalgic [pain relieving] treatment)’ (2005, p. 32), it is easy to see how the nomenclature of these pain issues can have substantial and serious effects for women, whose pain does not change regardless of the classification arguments surrounding it.

Prior literature, then, has explored the way that nomenclature can affect experiences of accessing healthcare for genital sexual pain, and that gaps in standardised guidelines exist. Whether elements of sexual pain experiences are somatic is also up for debate, though once again the potentially destructive and multifactorial nature of the pain is emphasised in much of the literature consulted. In both the English and the French literature consulted these disagreements and contradictions are important to recognise – not just in the effects that they may have on treatment pathways, but in terms of how they relate to the knowledge of sexual pain shared between the authors of this discourse, who are largely healthcare practitioners though they may also publish academically. The approach to this thesis therefore recognises these disagreements, and rather than attempting to fill the gap in standardised conceptualisations of women's genital sexual pain, it attempts to prioritise women's own naming and conceptualisations of their pain. An acute awareness of the backdrop of these disagreements, alongside the relative lack of academic research into this area, will form an important part of the gap that this thesis attempts to address. The cross-national element of this thesis will further show the similarities and differences that these unstandardised approaches and differing understandings can have in two different national contexts and healthcare structures.

2.6: Qualitative Research and Sexual Pain in England and France

2.6.1: Representing voices

The way that women's voices are represented, and listened to or ignored, has been referenced in multiple discussions of women's experiences of healthcare which are relevant to studies of sexual pain (Kaler, 2006; Gardey and Hasdeu, 2015), and has also been referenced in both French and English government publications on women's health and gender equality, including the English government Strategy for Women's Health, which made no specific reference to women's genital sexual pain as part of the release (Department of Health and Social Care, 2021; Department of Health and Social Care, 2022). One of the key themes for development in the Strategy, which was released in summer 2022, was 'Women's voices'. The authors of the policy paper 'heard that damaging taboos and stigmas remain in many areas of women's health', which 'can prevent women from seeking help, and can reinforce beliefs that debilitating symptoms are 'normal' or something that must be endured'. The policy paper also revealed the importance to women who submitted evidence of listening to women 'who are usually under-represented in surveys and research studies' and for 'improved representation of women as individuals […] across different parts of the healthcare system'. In the public survey for this paper, '84% of respondents said that there had been instances in which they had not been listened to by healthcare professionals', 'at every stage of the journey' with healthcare-related matters, 'from initial discussion of symptoms, to further appointments, discussion of treatment options, and follow up care'.

Similarly, in the French 'National strategic roadmap for sexual health 2021-2024' (Ministère des Solidarités et de la Santé, 2021, p.5), building upon the 'National Sexual Health Strategy 2017-2030' (Ministère des Solidarités et de la Santé, 2017), Salomon underlines the importance of 'influencing public policy on sexual health using responsive data and research because a better understanding is needed to be able to take action'. This is alongside the proposed 'survey on sexualities' (Ministère des Solidarités et de la Santé, 2021, p. 16) to be undertaken in 2022 to 'make it possible to analyse trends by comparing, in particular, key indicators with those from the 2006 study by French National Institute of Health and Medical Research (INSERM)'. Though this survey was postponed due to COVID-19, it is intended to support 'knowledge, research and innovations in sexual health' (*Ibid.*, p. 16) and therefore, presumably, the 'better understanding' evoked by Salomon. The way that this 'better understanding' will affect individual women, or particular demographics of women, is not specified, just as the women's voices in the government Strategy for Women's Health were not specified in terms of whose voices were claiming that 'there had been instances in which they had not been listened to by healthcare professionals'.

Voice, then, is crucial to understand not just as an element of how sexual pain experiences might be constructed by women, but also in terms of how national structures can conceptualise, and generalise, women's voices. The discourse consulted here demonstrates the importance of outlining exactly whose voices were listened to, and whether these are representative of the demographics of the population as a whole. Prior discourse around using women's voices, especially in qualitative studies, have concentrated on how researchers shape participants' ''exact words' through the unequal power relationships present', and by 'research agendas and timelines' (Mazzei and Youngblood Jackson, 2008, p. 2), and the above examples show that where there are claims that women's voices are prioritised in strategy and research, it is helpful to specify clearly exactly whose voices are represented. How effective these English and French strategies will be, and whose voices they will prioritise, especially considering the COVID-19 pandemic, remains to be seen, and this research will show that defining exactly which women are represented and where is a crucial factor in providing healthcare to women affected by genital sexual pain. There is a recognition here that it is important to listen to women's voices, and that research must take into account women's own descriptions of their pain and access to healthcare. Despite this, in the above national policies there is no explicit reference to women's genital sexual pain, and a lack of concrete proposals for how these problems will be addressed, especially in light of the challenges of the COVID-19 pandemic. The potential of these policies to address sexual pain and the healthcare challenges that it presents are great. And yet, there is little policy recognising women's sexual pain as a problem in its own right in either England or France, and a clear and urgent gap in raising awareness and agenda-setting for these issues.

2.6.2: Sexual Attitudes in French and English Research

Despite the way that women's sexual pain is often overlooked in healthcare settings and academic research, there have been previous sociological studies which addressed the need to understand opinions on sexual attitudes, and, importantly, on sexual pain as a concept in its own right. Although the methodological frames for surveys relating to women's sexual pain in England and France (Bajos, Ferrand and Andro, 2012; Natsal, 2022) were dissimilar to the qualitative framework being used for this thesis, they nevertheless reveal that work is being done which recognises sexual pain on a national level. Bajos, Ferrand and Andro (2012, p. 510, italics in original) found that in sex research, the '*penetrative norm* appears to be such a self-evident aspect of the sexual act that sex without penetration proved to be a problematic topic to research'. Further to this, and perhaps most significantly, they found that in their work on sexuality and equality that:

> 'a clear majority view recognises male sexual needs as greater, while at the same time equality between the sexes is considered a legitimate goal in the world of employment, in the family or in political life, until one reflects that this allows for the easing of tensions between aspirations which are egalitarian and actual behaviour which is still marked by severe gender discrimination' (*Ibid.*, p. 513).

There is an understanding, then, that the way that sexuality, and particularly male sexual needs, are conceptualised revolves around the idea of male and female penetrative sex. Not only this, but it posits that the perception that males inherently have greater sexual needs fosters the negotiation of a power dynamic in which egalitarian ambitions are framed in situations marked by gendered discrimination and inequality.

Similarly, the English Natsal-3 (2022) survey of sexual attitudes and lifestyles in Britain between 2010 and 2012 found that there has been a statistical decrease over the last 20 years in how often people have sex, and that sexual difficulties, including pain, were common in all age ranges, although 'only a minority of people who had not had sex in the past year said they were dissatisfied, distressed, or avoiding sex' because of this. This survey also revealed that one in four people in a relationship do not share the same interest in sex as their partner. It could be inferred, then, that sexual difficulties including pain are actually statistically common, as suggested elsewhere in this thesis, and that differences in individual interest in sex can play out interpersonally in relationships, as well as in a wider socio-cultural context linked to perceptions of gender. These studies reveal enlightening results about sexual attitudes in England and France, and their clear link with cultural norms. Although the cross-national element of comparison is missing, these studies do go some way to address the specificities of capturing women's voices and specific opinions on their pain and sexual attitudes.

2.7: Wellbeing and Sexual Pain in England and France

2.7.1: 'Diagnosing difficult women'

Much of the current debate over classification of sexual pain disorders in both England and France stems from the fact that the causes of pain, where known, can be diverse and coexistent. There is also a current of what Jane Ussher describes as '[d]iagnosing difficult women' (Ussher, 2013, p. 63) running through the medical literature in both English and French medical guidelines. Smith-Rosenburg (1986, p. 202) references the description of hysteria by nineteenth century physicians as a feminine 'state', describing hysterical women as 'difficult, narcissistic, impressionable, suggestible, egocentric and labile', and there is an unsettling repetition of this language of ''difficult women'' in medical guidelines consulted in England, with Wilson's medical guidebook, 'Common Gynaecological Conditions' (Wilson, 1999, p. 118) stating that young women who present with dyspareunia are '[e]motionally labile during consultation', and that their dyspareunia is often a '*[cri] de c[œ]ur*' for unresolved past conflicts'. Basson, who was lead author of the consensus definition on female sexual dysfunction issues, in 'Recommendations on Sexual Dysfunctions in Women' (2010, p. 324), claims with her co-authors that women with provoked vestibulodynia, a common sexual pain disorder (2010, p. 324), where pain is felt in the vulva when it is touched, have been represented as having 'elevated rates of shyness, perfectionism, low self-esteem, and negative feelings towards sexual interaction, erotophobia, and problems with subjective sexual arousal'. This is preceded by the seemingly contradictory statement that sexual pain disorders 'are heterogenous, multisystemic, and multifactorial disorders' (*Ibid.*, p. 324). Further to the discussion of provoked vestibulodynia, Basson *et al.*'s discussion of vaginismus also claims that the group of women who experience this type of pain disorder have 'personality features' which are more present, including 'the presence of pain catastrophi[s]ing cognitions, disgust propensity, and a specific fear of penile-vaginal penetration' (*Ibid.*, p. 324).

The language of these recent recommendations clearly echoes the description of hysteria with its use of the term 'labile', and the description of 'personality features' specific to one group of women, a group predetermined by medical authorities rather than women themselves. It focuses attention on the personality states or presumed lack of knowledge of their own past issues rather than the pain at hand. The difficulties seen here are not the difficulties of women to access the treatment to which they are entitled, nor the systemic inequalities that may affect them. They themselves are the difficulty. They are 'labile', catastrophising, fearful people in this discourse, and they are 'difficult' when consultations or treatments do not work. Women who consult healthcare professionals for pain, then, whether the cause is determined or not, can be described according to supposedly pathological traits specific to women, negating their individuality and a recognition of the structural inequalities and complex, movable power dynamics they are faced with. The methodological and empirical design of this thesis will prioritise women's own descriptions of their pain, and will do this with an acute awareness of the discourse which may label them and their personality features.

2.7.2: Borderline Personality Disorder

It is also important to note the previous connections made in literature which concerns women sexual pain to 'Borderline Personality Disorder' (henceforth BPD) in an extension of this idea. This is particularly notable in the English-language discourse around women's genital sexual pain, and perhaps most explicit in Grauvogl *et al.*'s 2018 suggestion, based on their findings, that, if study results were replicated, ‘clinical assessment in professional sexual health care should include the measurement of personality disorder characteristics of women who present with sexual problems’ (p. 198). They add that their results suggest ‘clinical practice might extend its scope by focusing on more on improvement of maladaptive personality disorder characteristics’ which could foster the ‘development and recurrence of sexual dysfunction’ (*Ibid.*, p. 198). Not only do the authors of this article conflate the use of psychiatric categories such as personality disorder with their use of the term sexual dysfunction in one recommendation and of the term sexual problems on the other, but they also fail to recognise the implications of their suggestions. If many women who consult services for sexual pain also have a complex of stable characteristics, then there is certainly room to suggest that, in fact, the characteristics they describe might be rather common.

This is further qualified by the DSM-V (American Psychiatric Association, 2013, p. 645) description of personality disorders as ‘enduring pattern[s] of inner experience and behavio[u]r that deviates markedly from the expectations of the individual’s culture, is pervasive and inflexible, has an onset in adolescence or early adulthood, is stable over time, and leads to distress or impairment’. The DSM authors state that the ‘diagnostic approach used in [the] manual represents the categorical perspective that personality disorders are qualitatively distinct clinical syndromes’ (p. 646). This description presupposes that the individual who is making the clinical differentiation understands the ‘expectations of the individual’s culture’ and how these are enacted and embodied by the individual showing potential ‘personality disorder’ characteristics. Though the diagnostic criteria are expanded upon for each ‘personality disorder’, critical parts of individual personality such as race, gender, sexuality, and class are missing from this broad description. The ‘distress’ which personality disorders cause is acknowledged in this diagnostic criterion, but vital intersectional considerations of the ‘major axes of social divisions in a given society at a given time’ and how these ‘build on each other and work together’ to disadvantage individuals in multiple ways (Hill Collins and Bilge, 2016, p. 13) are striking in their absence.

In speaking about the subjective experiences of vulvodynia, Ayling and Ussher (2008) go some way to address the way that these overarching ideas about women's personality features are seen in sexual pain discourse. In their research exploring the '''psychologic symptomology'' of women with vulvodynia from a discursive perspective' (*Ibid.*, p. 296), they demonstrate how their participants 'identified a range of emotional issues associated with vulvodynia, including anger, embarrassment, fear, grief, confusion, and self-surveillance', with the 'predominant themes' from their study relating to 'the subject positions women adopt in relation to their sexuality', as '''inadequate sexual partner'' and ''inadequate woman''' (*Ibid.*, p. 298). They theorised that if women position themselves as ''adequate'' and they 'are positioned as such by their male partner' (*Ibid.*, p. 302), they may not feel pressured into engaging in painful sex. They additionally found that decisions to 'engage in coitus' were not solely linked to the presence of pain, but also (*Ibid.*, p. 301) influenced 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', in a clear prioritisation of contextual factors. Shallcross *et al.* (2018, p. 972), in their study of women's experiences of vulvodynia, also reported that participants spoke about

> 'experiencing shame and stigma surrounding sexual health in the context of the healthcare system and, in some cases, suggestions that their sexuality was unseemly, or only for the purpose of child-bearing, or the pleasure of men'.

This confirms that sexual pain can be experienced in the context of norms specific to gender as well as other identity characteristics. Recent literature on BPD has suggested that the diagnostic term is a 'disciplinary mechanism wielded to demarcate 'acceptable' norms of femininity; while emotionality and dependency are normatively 'feminine' traits, the unstable emotionality and desperate dependence of the borderline create a line of transgression which is pathologi[s]ed' (Redikopp, 2018, p. 81). Redikopp adds that feminist 'critiques of BPD tend to identify BPD as a harmful diagnostic category insofar as it constitutes a medicali[s]ation of femininity', as ‘an overwhelmingly gendered diagnosis irrefutably linked to trauma’ (*Ibid.*, p. 81) and clearly states that the

> ‘erasure of trauma’s role in BPD is part of a longer tradition of obscuring gendered, raciali[s]ed, and classed oppressions which cumulate on the bodies and minds of those rendered vulnerable and precarious. While BPD has been critiqued for its erasure of aetiological trauma, feminist and critical disability scholars have critiqued the diagnostic criteria of BPD for medicali[s]ing traditionally ‘feminine’ attributes’ (*Ibid.*, p. 81).

In her recent doctoral thesis exploring ‘Borderline Women: Sexual Difference, Abjection and Liminal Spaces’, Morris (2018, p. 109) considers ‘borderline subjectivity’ differently in her examination of ‘the borderline and abjection’. She concludes that ‘the borderline subject is the feminine subject caught between the Symbolic and the Real’, between:

> ‘territories of self and other, similar to territories comprised by regimes of power and domination, [which] rely on recogni[s]ed cuts and gaps, which are frequently challenged and undermined. Borderline subjectivity is constituted by what it is not, by what it brushes up against, but also by what rejects it or refuses to account for it. Subsequently, borderline subjectivity is the site of surveillance’.

Approaches to BPD, then, extend far beyond the diagnostic criteria in the DSM-V in prior literature linking them to women’s sexual pain. Both BPD and women’s sexual pain are linked to subjection and abjection in previous discourse, as well as resonating with much of the language questioning the personalities of the women who experience sexual pain and their positionality in interpersonal relationships. The present thesis, though it does not have the scope to examine in depth how BPD and conceptualisations of women’s sexual pain in England and France might be linked, adds to this existing literature by exposing the ways that women experienced their own subjectivity alongside and as part of their sexual pain experience, and how these complex discourses of gender and subjectivity may add to experiences of abjection, with a commitment to doing this with reference to the way that women conceptualised this in their own words.

2.7.3: Sexology and the importance of the 'subtly normative' (Bozon, 2018, p. 13) in women's wellbeing

In terms of understanding access to care for women's sexual pain in England and France, it is also crucial to define sexology as both a care speciality and as a concept in its own right. This not only facilitates an understanding of the care options referred to by participants in interview material, but also highlights the relevance of this field of knowledge to women's sexual pain in both England and France. Wylie proposes the use of the World Association for Sexology (now the World Association for Sexual Health) 'working definition' of sexology as 'a generic term encompassing the study of all aspects of sex and sexuality' (Wylie, 2005, p.23). Sexology is a practical, educational, potentially clinical speciality, often chosen by healthcare workers after a period of initial clinical or psychological practice by sexologists. It is broadly defined as a professional 'competency' awarded to a healthcare professional such as a 'general practitioner, gynaecologist, psychiatrist, midwife, nurse, psychologist' or 'physiotherapist' (Lansac and Lopes, 2016, p. 155). It therefore encompasses many different professional backgrounds within its ranks, including 'doctors, psychologists, nurses, midwives and counselors' (Giami and Michaels, 2020, p. 2). In France, calling oneself a sexologist does not require particular training (Lansac and Lopes, 2016, p. 155), but there are recognised accreditations and qualifications for those who practice. In the United Kingdom, a sexologist is 'someone who practices sexology, and the field of sexology plays host to a variety of different clinical and educational specialists' (Wylie, 2005, p. 23), which may include assessment and treatment of, and signposting for, women's sexual pain issues.

In a similar vein, Lansac and Lopes (2016, p. 156-7) explain the role of the sexologist as one which empowers clients through appropriate clinical and educational practice, helping service users 'get to know their personal resources' and exploring what they feel they are authorised to do sexually, as well as attempting to identify and counter misinformation about anatomy or sexual function. This can be through talking therapy, prescribing appropriate medication where professional competencies allow, physical approaches such as physiotherapy, or a combination of different techniques with a multidisciplinary focus. Many of the participants interviewed, particularly in France, referenced sexology and sexological healthcare consultations, and understanding of the complexity of speciality is therefore key to understanding the theory and empirical data this study makes use of.

Prior socio-political literature focusing on sexology, including Bozon (2018, p. 13), has, nevertheless, suggested that 'disciplines with a practical element such as clinical psychology or sexology continue to spread subtly normative advice to treat problems which are apparently individual', echoing Taylor's (2015, p. 259) assertion that sex, 'according to Foucault, is managed by doctors not so much to cure health problems as to enforce social norms'. Bozon (2018) also speaks of the movement in the last decades of the 20th century from community and institutional control of individual sexualities to 'reflexive', 'internalised' control measures (p. 179), again bringing to mind Taylor's description of Foucault's tracing of the development of psychiatry as a field where she claims 'indeed, we are all more or less abnormal in some way or another, and thus we are all potential targets for psychiatric power' (2015, p. 24). The potential of sexology as an enforcer of intimate norms for individuals and sexual partners is evoked by sexology researchers in France given its 'specific field of knowledge and practice' (Giami and de Colomby, 2003, p. 371).

Similarly, Beroud-Poyet, herself a psychologist and sexologist, warns of the dangers of certain longstanding misconceptions within the profession, such as the idea that sexual relationships are more straightforward between two women (Beroud-Poyet and Beltran, 2017, p. 203). This is further highlighted by Ekholm *et al.* (2021) whose research demonstrates that it is important to consider the unique relational and social context of queer women to understand their experiences of dyspareunia. Blair *et al.* (2015, p. 498) additionally underline how 'literature on genital and pelvic pain has largely focused on heterosexual women', while their study found that although the '[c]haracteristics of vulvar pain were similar across groups' of lesbian, bisexual and heterosexual women, groups 'differed in how they perceived pain to impact their relationship', showing again that experiences of sexual pain are not homogenous, with Beroud-Poyet and Beltran reaffirming that 'relationship and sexual problems are not exclusively heterosexual' (Beroud-Poyet and Beltran, 2017, p. 203).

Reference to this literature suggests that the unique position of sexologists and sexology as part of power dynamics which span large and potentially disjointed healthcare structures, as well as intimate relationships between individuals, must be recognised. The heteronormative focus of sexological practice in England and France is significant as an intersectional concern and evokes potential challenges for women who do not fit into this frame in accessing treatment. Further to this, Bozon's evocation of the 'internalised' control measures from 'subtly normative advice' (Bozon, 2016, p. 179 and p. 13) raises the important issue of the socio-cultural norms and power dynamics within which sexological practice operates. These norms, which are part of power dynamics in which women affected by sexual pain participate, can have serious and long-lasting consequences in terms of accessing treatment and in terms of examining who is prioritised in terms of healthcare opportunities related to gender and many other social and identity factors. Taylor (2015, p. 24) describes the increase in 'diagnosis and treatment of FSD [female sexual dysfunction]' as a category as 'disturbing', stating that it is 'indicative of a new stage in psychiatry's expanding grip over ever-larger numbers of people', where FSD 'actually characteri[z]es the majority' in terms of statistic prevalence, in the USA at least. Prior work considering sexology, then, has not only considered how and where sexology operates, and the clinical backgrounds of professionals who choose to specialise in it, but also the fact that it can, as a clinical speciality, help to create and reinforce psychiatric categorisations and norms, specifically those which are heteronormative, and which prioritise certain types of penetrative intimate practices. This is crucial to understand as the empirical element of this study addresses way that clinical practice in England and France is conceptualised in multiple ways within specific cultural contexts. It also reveals the ways in which sexological practice can potentially be used to embrace the individuality of each woman's circumstances, and the way that conceptualisations of what is ''normal'' can be linked to sexual therapy or sexological practice.

2.8: Nomenclature and Sexual Pain in England and France

2.8.1: Definition and Classification of Women's Sexual Pain in England and France

There are several crucial points to address when considering the way that women's sexual pain is named, classified, and defined in England and France. The first is centred upon the diagnostic criteria for the disorders, more specifically the 'International Classification of Diseases' (henceforth ICD-11, WHO, 2019) and the 'Diagnostic and Statistical Manual of Mental Disorders' (henceforth DSM-V, American Psychiatric Association, 2013). The second point focuses on how definitions and classifications vary between England and France, and how this can be problematised to understand the variety of ways that women's sexual pain is conceptualised in France and England. The third, more conceptual point, centres upon the idea of 'distress', how this is a part of certain definitions of sexual pain, and what distress means within this frame. Throughout the following section, it is important to note that although these classifications and definitions may be used in England and France in clinical or healthcare settings, these terms may be different from those used by women experiencing pain or may be used interchangeably.

2.8.2: Diagnostic Criteria

The ICD-11 and the DSM-V both contain diagnostic criteria and information on the broad diagnostic principles of sexual dysfunction, and they provide information about the specific diagnosis of sexual pain issues. The guides are used in different ways, and potentially in different contexts, with the ICD-11 functioning as a general reference guide to defining all manner of diseases, disorders and health issues, and the DSM-V maintaining an instructive, informative, approach towards perceived issues related to mental and psychiatric health. Both are referred to by healthcare professionals involved in the treatment and management of women's sexual pain issues in England and France, yet their scope and the definitions that they propose are not always congruent. Outlines of both guides are presented below, and general definitions of some of the named genital sexual pain issues are also provided with reference to both guides. These general definitions are included for clarity, as they are a reference for the diagnosis of sexual pain in healthcare practice, but the naming of individual disorders, which may often occur simultaneously, is intended only as a guide to indicate exactly what professionals or women interviewed may be referring to. The below must be approached critically, with expansion upon these terms being explored in later sections of the thesis, with reference to the empirical findings of the study and the ways in which participants themselves described their pain. It is important to remember that the definitions here, especially as they are devoid of social context and nuances of individual meaning, are often taken to refer to heterosexual, female-male, vaginal-penile penetrative sexual acts, a problematic norm which is discussed in detail in the later analysis section of this thesis.

2.8.3: The International Classification of Diseases

The ICD-11 was published by the World Health Organisation (WHO) in 2019, and it is intended to be implemented on a rolling basis, with local international healthcare systems referring to it and using it as part of their existing systems over the course of several years where it has not already been implemented (WHO, 2019). It is intended to be used internationally, in all healthcare settings, is provided in multiple languages, including English and French, and is primarily a classification tool, though it is also designed to potentially serve as a ‘multilingual dictionary’ for terminology, for recording health information (WHO, 2019, p. 2). The ICD-11, which replaces previous versions, is free to access and download electronically, and claims to provide a standard for systematic ‘reporting, analysis, interpretation and comparison of mortality and morbidity data’ (WHO, 2019, p. 1). It categorises health issues into sections, and gives codes to specific health problems, which can be cross-referenced to other codes in other sections of the guide, to aid referencing comorbid conditions. It was referred to significantly less in the participant interviews with healthcare practitioners than the DSM-V, but it is nevertheless important to understand as part of the backdrop for the conceptualisation of women’s genital sexual pain in England and France, particularly as the DSM-V is an American manual was not referenced in the French interviews, whereas the ICD-11 is international, and it would be reasonable to expect a wider awareness of it on this basis in French healthcare settings as well as English.

2.8.4: The Diagnostic and Statistical Manual

The DSM-V was published by the American Psychiatric Association in 2013, and the publication of the fifth edition followed several previous versions. The most recent version, the DSM-V-TR, was published in late 2022. This latest version contains certain amendments including a response to 'concerns from members and others in the mental health field that race, ethnoracial differences, racism and discrimination be handled appropriately in the Diagnostic and Statistical Manual of Mental Disorders (DSM)' (American Psychiatric Association, 2022, p. 1). In this respect, the most recent updated DSM claims to ensure that attention 'was paid to the risk of misdiagnosis when evaluating individuals from socially oppressed ethnoracial groups' (*Ibid.*, p. 1). There are changes to the diagnostic information given for several disorders on the basis of the concerns above, but the sexual pain descriptions below remain unchanged in the latest version of the manual. The DSM-V, rather than the DSM-V-TR, is referenced throughout this thesis when participants discuss the 'DSM', as the DSM-V-TR was unpublished at the time of completing this thesis, and with participant interviewing completed prior to 2020, when participants referred to the DSM, this is the DSM-V rather than the DSM-V-TR, although it may be useful to be aware of the subsequent amendments made.

The DSM-V is predominantly used for diagnostic reasons and in anglophone countries, though practitioners in other locations may be aware of its existence (Borch-Jacobsen, 2002, p. 325). The manual distinguishes between different types of disorder affecting psychiatric health, provides differential diagnoses, and explanatory sections to identify specific mental health issues. The Manual includes diagnostic criteria for each mental health category, and additionally notes where diagnoses may overlap. It also provides statistics for the 'mental disorders' cited, including statistical breakdown by gender, although these statistics are not necessarily generalisable to all populations in the areas where the Manual is used. It is a standardisation of classifications, fixing 'mental disorders' in a rigid descriptive structure. How this is applied in practice can vary between practitioners, and the information within it is intended as a guide rather than a prescriptive algorithm.

2.8.5: Definition Summaries for Reference

Summaries of ICD definitions are presented below in italic with the relevant code, and summaries of DSM definitions are presented in bold with their relevant page. Where both the DSM-V and ICD-11 provide definitions, both are given separately below, and where a general, non-exhaustive, description of the issue is provided, this is because neither the ICD-11 nor the DSM-V provided a description of the named issue, though it is frequently referenced in discourse around women's genital sexual pain.

Table 1: Definitions of Sexual Pain in the ICD-11 and DSM-V

Genito-pelvic pain/penetration disorder (GPPPD)	**'Persistent or recurrent difficulties' with vaginal penetration, during intercourse, which cause 'clinically significant distress' and can cause pain. These difficulties cannot be otherwise explained, for example by another health condition, substance misuse or, for example, 'partner violence', and they cause 'fear and anxiety about vulvovaginal or pelvic pain' related to penetration. Pelvic floor muscles have a 'marked tightening or tensing' 'during attempted vaginal penetration', and the problem has been experienced for at least six months. (p. 437)**

Sexual pain-penetration disorder	*Marked 'and persistent or recurrent difficulties with penetration, including due to involuntary tightening or tautness of the pelvic floor muscles during attempted penetration'.* And/Or *Marked 'and persistent or recurrent vulvovaginal or pelvic pain during penetration'* And/Or *Marked 'or persistent' fear or anxiety in relation to penetration.* *Symptoms 'are recurrent during sexual interactions involving or potentially involving penetration' despite 'adequate sexual desire and stimulation', are associated with 'clinically significant distress', and are not 'entirely attributable to a medical condition' or to a 'mental disorder', or, for example to 'insufficient vaginal lubrication or post-menopausal/age-related changes'* (HA20)

Sexual dysfunctions	DSM-V: **'Sexual dysfunctions are a heterogeneous group of disorders that are typically characteri[s]ed by a clinically significant disturbance in a person's ability to respond sexually or to experience sexual pleasure'. There are many different subtypes and factors to be taking into consideration for diagnosis, including that sexual 'response has a requisite biological underpinning, yet is usually experienced in an intrapersonal, interpersonal, and cultural context' and that in 'many clinical contexts, a precise understanding of the [a]etiology of a sexual problem is unknown' (p. 423).** ICD-11: *'Syndromes that comprise the various ways in which adult people may have difficulty experiencing personally satisfying, non-coercive sexual activities. Sexual response is a complex interaction of psychological, interpersonal, social, cultural and physiological processes and one or more of these factors may affect any stage of the sexual response.' For the problem to be considered sexual dysfunction it must 'occur frequently', 'have been present*

	for at least several months' and be 'associated with clinically significant distress'. *(17: Conditions related to sexual health)*
Female genital pain	*'A symptom of genital pain affecting females that is idiopathic. This symptom is characteri[s]ed by any type of pain in the genital area tissues, during sexual intercourse, physical activity, or rest' (GA34.6)*
Pain related to vulva, vagina, or pelvic floor	*'A condition affecting females, characteri[s]ed by any type of pain associated with the vulva, vagina, and pelvic floor tissues, either during sexual intercourse, physical activity, or rest' (GA34.0)*
Female pelvic pain associated with genital organs or menstrual cycle	*'A symptom affecting females, characterized by pain in the pelvic region associated with any of the genital organs or the menstrual cycle' (GA34)*
Vaginismus	Primarily used in the DSM-IV, later replaced, and subsumed within the category **GPPPD** in DSM-V (see above). DSM-IV-TR (2000, pp. 556) describes its essential feature as '**the recurrent or persistent involuntary contraction of the perineal muscles surrounding the outer third of the vagina when vaginal penetration with penis, finger, tampon, or speculum is attempted'**, **which may be anticipatory of**

	penetration, causes 'marked distress or interpersonal difficulty', and is not explainable by another 'disorder', or the 'direct physiological effects of a general medical condition'. The DSM-IV-TR also notes (p. 557) that it is '**more often found in younger than in older females, in females with negative attitudes toward sex, and in females who have a history of being sexually abused or traumatized**'.
Dyspareunia	*'A symptom of the genital system affecting females, caused by physical determinants. This symptom is characterized by recurrent genital pain or discomfort that occurs before, during, or after sexual intercourse, or superficial or deep vaginal penetration that is related to an identifiable physical cause, not including lack of lubrication. Confirmation is by medical assessment of physical causes' (GA12).* Also seen within the previous DSM version, DSM-IV-TR (2000, p. 554), as **'genital pain that is associated with sexual intercourse', 'most commonly experienced during coitus', but can also 'occur before or after'. It 'can occur in both males and females', differentiated in females as 'superficial**

	during intromission' or 'deep during penile thrusting'. Dyspareunia diagnosis dictates that the 'disturbance must cause marked distress or interpersonal difficulty', and must not be due to another cause, such as a 'general medical condition', lubrication problems, or 'Vaginismus'.

Table 2: Terms not listed above but relevant in women's sexual pain classifications (adapted from Butcher, 2005)

Vulval vestibulitis	Often used interchangeably with vestibulodynia (see below), pain in the vulval vestibule (the area of vulval skin around the vaginal opening).
Vestibulodynia	Pain or soreness in the vulval vestibule (the area of vulval skin around the vaginal opening).
Vulvodynia	Pain or soreness in the vulva (outer female genitalia). Differentiated as discomfort only on touching the area (provoked vulvodynia) or spontaneous (unprovoked vulvodynia). May also be used interchangeably with vestibulodynia or vulval vestibulitis, where pain is described as affecting the whole vulva (including the vestibule).

2.8.6: Distress

Given the ICD and DSM references above to distress, and in particular 'clinically significant distress' in the definitions of GPPPD, sexual pain-penetration disorder, and several of the other categories both in the ICD-11 and DSM-V descriptions of this type of pain, it is important to provide a broad understanding of the concept while recognising its complexity. It has been defined by Ridner (2004, in Bond *et al.*, 2012, p. 48) as 'a unique emotional state, with attributes including perceived inability to cope, change in emotional status, discomfort and harm'. The ABC of sexual health (Butcher, 2005, p. 25) recognises the 'frustrating' elements of dyspareunia and vaginismus when experienced by women, and it has been acknowledged by sexuality researchers that sexual pain and subsequent distress can affect many areas of women's lives. These areas include what Glowacka *et al.* (2018, p.1) call 'contingent self-worth', that is 'the pursuit of self-esteem via a particular domain in one's life', with 'perceived success or failure in the contingent domain' affecting wellbeing. Distress then, has been conceptualised as context dependent, can affect a woman's 'self-worth' and her 'self-esteem' related to sexual functioning, and may affect other areas of her life, as well as being a potentially 'frustrating' experience. Distress has even been quantified in the above study by Glowacka *et al.* among others. Bancroft, Loftus, and Scott Long also quantified distress in relation to sexual pain in their 2003 survey, but did not focus upon how distress was categorised as a concept in its own right. Despite the note in the DSM-V that sexual 'response has a requisite biological underpinning, yet is usually experienced in an intrapersonal, interpersonal, and cultural context' (American Psychiatric Association, 2013, p. 423), the meaning of distress within this context is not always clearly delineated as a concept. Recognition is not always given to the gendered and intersectional aspects of the experience of sexual pain, and the complex power dynamics and marginalising factors which can lead it to be a distressing experience for some women and not others.

Previous work has, however, directly challenged the DSM criteria of distress in vulvodynia classification in its relationship to 'other female sexual dysfunctions' (Bond *et* al. 2012, p. 46). They outline the fact that in the studies consulted for their literature review, three types of distress had been ‘investigated in research relating to female sexual problems, [namely] psychological distress, sexually-related personal distress and relationship distress’ (p. 48). They also note in relation to DSM diagnostic criteria which was forthcoming, as their review was published during the development of the DSM-V, that ‘not all women display *clinically significant* symptoms of distress’ and that the DSM-V criteria could potentially ‘exclude many women from diagnosis, treatment and research’ (p. 48, italics mine). Strikingly, they state that ‘[r]esearch into psychological distress and genital pain has produced contradictory results’ (p. 50), and they end their literature review with the reminder that when a woman is asked to measure her distress about sexual pain, the information given simply indicates whether or not she is distressed, and what is unknown is ‘why she is distressed and the meaning of her distress’ (p. 58). What appears important in this literature, then, is that healthcare practitioners and other professionals working with sexual pain consider the meaning and context of distress for individual women.

Further to this, this literature demonstrates an understanding that many specific factors can be at play in experiences of distress, and diagnostic classifications may not always recognise these factors. These may include experiences of gender, race, identity, and most certainly access to healthcare provision and opportunities. In defining distress in this way, Bond *et al.* go one step further than the DSM-V and than Bancroft, Loftus and Scott Long, in recognising that meaning of pain is an important factor in how women experience it, and that this diagnostic guide can have potentially serious consequences in access for women who are experiencing pain and distress which is not considered to be ‘clinically significant’. Though the above does not explicitly refer to intersectional and identity concerns, it directs further research, such as this thesis, towards who might be distressed and the meaning of this, as well as how this distress can preclude as well as facilitate healthcare access and encounters.

2.8.7: Problematising definitions and classifications

The difficulties in classification in both England and France have led to women's sexual pain disorders being 'overlooked' in England (Mitchell *et al.*, 2017, p. 1), with changes in classification contributing to complicating trajectories of healthcare access, and at times contributing to the worsening of pain. In France, sexual pain can be a diagnosis of exclusion, with clinicians at times showing little interest in matters of female sexual dysfunction despite their high prevalence and significant impact on quality of life (Collier and Cour, 2012). The empirical results for this study will show that in France there are limited guidelines for professionals working with sexual pain, and that the ICD-11 and DSM-V were not in general practical use in the country, despite an awareness of their existence (Cour and Bonierbale, 2012). The DSM-V and ICD-11 are both known in England, and several participants interviewed referred to the DSM-V classifications of pain, though they were keen to stress that these classifications were used only when they were of benefit to patients or service users and that they were aware that they were connected to American systems of healthcare. The way that women's sexual pain is described in French and English discourse is discussed below, bearing in mind that articles are read more widely than in their country of origin and so there is some potential for overlap in how these conceptualisations might be used or perceived in both England and France. Where classifications do exist, their contested nature can make conceptualising women's sexual pain difficult for healthcare professionals, researchers into the issue, and women affected by the pain alike. This thesis seeks, in working with a sample of women affected by the pain, to examine how they conceptualised their own pain in England and France, alongside this understanding of the terminology that may be used in both England and France. Though it does not propose revised classifications or definitions for these terms, it seeks to explore how this nomenclature contributes to the status of women's sexual pain, and in doing so to contribute this understanding to understandings which can help to raise awareness of these issues, which are often poorly understood by both the women affected by them and the healthcare professionals that they may be consulting.

2.9: Summary

The outlook, then, for women experiencing sexual pain in England and France, whose healthcare services may eschew classifying their pain immediately, is complex. In both countries there are services which attend to specific women's sexual pain matters, and women in both countries can face diagnostic delays and lack of knowledge on the part of healthcare professionals (Mitchell *et al.*, 2017, p. 1) when consulting them for their sexual pain. It is important, considering the empirical sections which follow, and also in light of the preceding discourse on classifications and definitions, to understand what a healthcare trajectory might look like when consulting healthcare services for sexual pain in England and France. This of course keeps in mind the specificity of each individual experience of sexual pain, but it is nevertheless helpful to underline in terms of the way that sexual pain disorders might be conceptualised by healthcare professionals and women affected by the pain in England and France.

Treatment pathways for women who experience sexual pain in England and France are unstandardised on a national level, with women in England often consulting a general practitioner who may then refer on to specialist services such as gynaecology, and women in France often first consulting a gynaecologist, and in some cases consulting a general practitioner in the first instance. As the empirical data will demonstrate, this patchy standardisation can foster complex experiences of care for women, and complicated experiences of providing care, sometimes within multidisciplinary settings, for healthcare professionals. Women will often have to consult multiple services before their pain is acknowledged or attended to (Haute Autorité de Santé, 2008; Byrne and Christmas, 2002, p. 284). Furthermore, it is recognised that some healthcare professionals may not be comfortable broaching the subject of 'sexual function and pleasure with their patients' and that in this case there is a need for them to be supported in their 'language' and 'when to refer patients to specialists in sexual health' in England (Mitchell *et al.*, 2017, p. 7). Analysis of empirical data for this thesis will confirm that practitioner discomfort is a problematic feature of sexual pain experiences in both England and France, and that it can affect the way that sexual pain is conceptualised not just in healthcare contexts, but also in educational settings and in wider cultural perceptions of this type of issue. The Methodology chapter which follows will explore the gaps in the literature identified in this chapter, and will outline how these gaps in knowledge will be addressed by the Analysis chapters and the conclusions of the work.

3: METHODOLOGY

3.1: Introduction

The focus of this thesis is to discover how women's sexual pain is conceptualised in England and France. The empirical element of the study therefore required a cross-national approach, encompassing both discursive elements influencing healthcare practice, and an empirical focus which worked to understand experiences of sexual pain, and related conceptualisations and experiences of potential marginalisation within healthcare systems. It also demanded a flexible, iterative approach, which was able to evolve alongside the needs of participant recruitment and changing needs of the research process, such as the requirement to undertake remote interviewing. Given the theoretical stance of the project, which prioritises understandings of the multiplicity of factors which affect healthcare experiences and conceptualisations of pain, this empirical approach also required a reflexive methodology which explored, rather than ignoring, the position and background of the researcher, and how this factored into the empirical process and the research framework as a whole.

This empirical approach was qualitative, which was chosen to answer the research questions as the 'meanings and interpretations of the participants are the essence of qualitative inquiry' (Liamputtong, 2019, p. 9), and this thesis aims to produce a nuanced account of conceptualisations of sexual pain in England and France, which is relevant to both healthcare professionals involved in its treatment and women affected by the pain. Consequently, the 'meanings and interpretations of the participants' were the most significant factor in this process, and qualitative enquiry provided the possibility of multiple meanings for concepts which may, at first, appear fixed, and a depth of participant data which reveals a range of experiences in both England and France. This empirical approach was also created following conversations with healthcare practitioners from my clinical role within the NHS, and with women who have had experience of sexual pain, to ensure that the process would be as clear and inclusive as possible, as discussed below.

As seen in the Introduction, chronic pelvic pain, including dyspareunia, ‘might well be a substantial health issue in the general population of premenopausal French women’ (Margueritte *et al.*, 2021, p. 2489), and painful sex is named as a ‘common but neglected female health problem’ (Mitchell *et al.*, 2017, p. 1) in Britain, with treatments and healthcare options potentially compounding or worsening pain experiences and marginalisation. This research design therefore also recognises that while sexual pain issues may be widespread, their multiple conceptualisations, and the unique way that these are linked to concepts of gender as an issue affecting women, may have meant that women were more reluctant to speak about this intimate issue to a stranger in research interviews. The initial research question regarding the ways in which women’s sexual pain is conceptualised in England and France, and the three narrower research questions (outlined in the introduction on p. 22), are all grounded in the wider effect that such a collection of qualitative data can have for women affected by pain and professionals involved in its treatment, and for this reason it was imperative to remember that these experiences must be treated with sensitivity and respect.

Adding to the reflexive approach, and the analytical approach outlined in the following section, this part of the thesis which describes the approach to the research design and how this was implemented in practice, explains how elements of data collection such as ethical approval, risk management and consent were constructed within this frame, and how this works alongside the theoretical approach to the project which is centred on recognition of power relations and intersectionality in its use as a practical tool for research. The resulting approach to, and eventual process of, data collection, provided rich and sometimes unexpected results, and entailed the negotiation of reflexive and other empirical processes. These processes, and the development of the design complementing the research questions and aims, is detailed below.

3.2: Research design

The research design for this project involved semi-structured interviews with four groups of participants, namely women affected by sexual pain in England, women affected by sexual pain in France, healthcare professionals involved in the treatment of sexual pain in England, and healthcare professionals involved in the treatment of sexual pain in France, totalling 28 participants overall, with 14 in each of England and France. This design attempted to elicit data, within the pragmatic considerations of the thesis project, to elucidate how sexual pain is conceptualised in England and France, in a way that was situated in participant's own descriptions of sexual pain and its psychosocial contexts. The empirical element of this study was crucial as this was the first study to operate within this theoretical and methodological frame to combine the views of both healthcare professionals and women affected by sexual pain in both England and France.

Without this empirical element, the study would have relied solely on discursive conceptualisations of women's sexual pain in England and France, and this would have been significantly less representative of women's own descriptions of their experience of sexual pain within healthcare structures in France and England. The empirical element of this study, with relatively small samples in both countries, and an analytical frame based on reflexive thematic analysis, offers a unique and deep insight into the experiences of this type of pain in England and France. Though the results from the semi-structured interviews are, of course, only one possible interpretation of the data collected, they provide an original and important insight into the lived experience of women affected by sexual pain in England and France, and they also offer a comparative insight into these experiences in the two separate countries. The empirical approach to this research design is detailed below, with the analytical approach to the data collected to follow.

3.3: Cross-national Context

France and England differ both in terms of healthcare structure and in the way that healthcare is delivered at the point of care, despite their profiles as countries with similar gross domestic product (OECD, 2022, p. 12). Both countries show an awareness of the specificity of women's health as an issue in its own right, and of the need to measure outcomes by gender demographic, as well as showing an understanding of health inequalities as a specific issue (Women's Health Strategy for England, Department of Health and Social Care, 2022; OECD, 2021). In both England and France, sociological research into sexual interests and behaviours has been undertaken (NATSAL-3, 2022; Bajos and Bozon, 2012), and the COVID-19 pandemic has had a significant effect on both healthcare systems. To harness the potential of cross-national research to 'understand contestations' (Yurdakul and Korteweg, 2020, p. 192) in healthcare access relevant to women, the cross-national methodology of this thesis will take an approach examining the similarities and differences between England and France to unpick the status of women's sexual pain as a common but neglected issue (Mitchell et al., 2017, p.1). Moreover, the salience of the comparison in this case, after Hantrais and Mangen, lies in 'understanding the process whereby this situation was achieved' as well as establishing how 'differences can be explained and whether any common causal factors can be identified despite the diversity at national level' (Hantrais and Mangen, 2007, p. 10).

For this work, the focus of the cross-national method will be on the 'diverse influences that shape and affect lives' (Hankivsky and Christoffersen, 2008, p. 279), which means considering both the national context of each country separately and how a wider cross-national comparison can enhance understandings of women's sexual pain in both countries and raise awareness in policy fora. The 'democracy and economic system, with populations comprising sizeable ethnic minorities' are similar in England and France, alongside their differences in terms of perceptions of national identity where 'France emphasises unity around its republican norms and values of freedom, equality and secularism', while 'England is liberal and emphasises diversity' (Doyle, 2008, p. 206). This provides a fertile research context for understanding these specific gendered health issues in terms of the equality between different people within both societies and healthcare structures in terms of their gender and other demographic factors, and for questioning what the meaning of freedom and diversity mean within these cross-national contexts for women affected by sexual pain. Fundamentally, this comparison demonstrates the complexities of sexual pain experiences in both England and France, examining the structural healthcare context in both countries, and identifying the ways that the dearth of research and consistent information about these stigmatised and stigmatising issues affects the way women experience themselves and their pain.

Despite this apparent scarcity of cross-national literature between England and France specifically focused on women's sexual pain, there have been explicit comparisons made in previous discourse around women's healthcare, some of which did touch on issues related to women's sexual pain. In terms of previous work addressing the sexual issues experienced by women in different European countries, Nicolosi *et al.* (2006, p. 423), in their study examining sexual behaviour, dysfunctions and help-seeking in middle-aged and elderly Europeans, compared the way that some healthcare services were accessed across Europe, and found significant variability between countries (p. 427). They underlined the fact, however, that in the survey respondents the occurrence of sexual dysfunctions was relatively high, with only a minority of those affected by sexual dysfunctions actively seeking medical care (p. 427), with some respondents attesting that this was due to cost (p. 426). Fugl-Meyer and Fugl-Meyer (2006) found in their research of sexual dysfunctions in Europe that likely 'the greatest risk factors for distressful female sexual dysfunction within a stable heterosexual relationship are the male partner's sexual dysfunctions' (p. 38), once again underlining the frequently interpersonal nature of these issues. They additionally found that investigating rates of dyspareunia and vaginismus across Europe was hampered by clear 'common methods of sampling, definition, classification of severity, and time-frame' (p. 37), echoing clinical authors such as Mitchell *et al.* in drawing attention to the ways that disagreements and inconsistencies can affect understandings of these issues.

Fugl-Meyer and Fugl-Meyer conclude their chapter by reflecting upon to extent to which society is 'prepared to meet the demands for sexual medicine/sexology consultation even if just half of those with manifestly distressing female sexual dysfunction would actually seek any kind of professional help'. This is an incisive question, and it touches the need for services in Europe to provide specialist, available and accessible services for women experiencing genital sexual pain. This idea, alongside the theoretical approach grounded in intersectionality and Foucauldian conceptualisations of power, will be carried through into the analytical sections which follow. In both England and France, services for women's genital sexual pain exist, but the cross-national comparisons made in this thesis will reveal that access to this care, and understandings of sexual pain issues in their own right, is highly contingent. They will also reveal that the outlook for women who experience sexual pain can be bleak, and that it is often dictated by fluid power dynamics and perceptions and expectations linked to gender and multiple other social factors. The cross-national comparison also highlights the neglected and contested nature of sexual pain research and discourse, and it will emphasise the way that several study participants have negotiated their relationships with this discourse to appropriate it on their own terms.

A comparison between France and England, rather than two other nations, is appealing as both countries have claimed to address health inequalities, even though many still remain, the population demographics are comparable in both countries, but with differing ideas around national identity (Doyle, 2008, p. 206), and understanding of these gendered issues is often sparse or contested in healthcare and public discourse in both England and France. Additionally, the difference in language spoken adds an element of interest to the comparison, by examining how the way that this type of pain issue is named in two national contexts can impact healthcare access for affected women. In fact, direct comparisons have already been made in the recent Cumberlege Report (2020, p. 176), which recommends that 'the NHS adopts the French model for universal postnatal pelvic floor rehabilitation', meaning providing individual care for women after giving birth, where issues such as incontinence and pain during sex might be addressed.

The author of this report, alongside recommending that England adopts the French model to pelvic floor therapy and education where clinically appropriate rather than incontinence surgery, cited the use of healthcare interventions which affect only women, including vaginal mesh procedures for urinary incontinence and prolapse, which have caused ‘crippling, life-changing’ complications for women. These can include genital sexual pain, worsening of urinary incontinence, and the numerous socio-economic and health challenges that this may entail (Cumberlege, 2020, p. ii). The report concluded that where these issues are concerned, the English healthcare system is ‘disjointed, siloed, unresponsive and defensive’ (*Ibid.*, p. ii), and that there were systemic failings leading to complications and pain for women who were fitted with mesh implants, data was missing about success rates for women, and there was a notable lack of consensus on these procedures or implants (*Ibid.*, p. 143). Most strikingly, given the comparison with France, is that NICE, the National Institute for Health and Care Excellence in England, is ‘silent on these matters’ (*Ibid.*, p. 143), bearing a remarkable resemblance to NICE’s lack of nationally agreed, detailed information around women’s genital sexual pain issues in England. Addressing the lack of standardised education about the pelvic floor in England is recommended in the Review, with the rationale that using ‘the correct terminology equips women with the language they need’ (Cumberledge, 2020, p. 175).

It must be remembered, however, that equipping women with the correct language does not address underlying inequalities which were cemented during the COVID-19 pandemic, and this does not seem to have been at the forefront of changes made since the publication of the Report such as the creation of a pelvic floor registry (Harding, 2022). The significance of this report in the cross-national context is not only in the way that France is held as a positive example of pelvic floor issue management, but it is also in the way that education and language are seen to be a potential remedy for potentially debilitating issues linked to sex and sexuality, including incontinence. As the following comparative analytical sections will reveal, experiences of sexual pain, and of incontinence, could be just as troubling in France as they were in England, despite wider recognition of the benefits of pelvic floor therapy following vaginal births. Though it is clear that sexual pain in England and France is often experienced in settings which are relational and interpersonal (Fugl-Meyer and Fugl-Meyer, 2006), and women’s gendered roles as mothers, partners and potentially as young professionals can affect experiences of this pain, there is a misconception that in France, there is more openness when discussing issues like sexuality and pelvic floor issues. As the following methodological and analytical sections will show, these cultural perceptions of France, alongside understandings of English views on sex and sexuality, are much more complex than a particular country's model of care, of observations about perceptions of sexuality, or of clinically or educationally managing one issue. The status of sexual dysfunction as a relatively common condition for which help is not often sought (Nicolosi *et al*., 2006, p. 427), gives an insight into the findings of this study in that cross-national comparisons of genital pain issues are always more nuanced, and more variable, than first meets the eye. This requires a rigorous methodological approach, considering not only the scarcity of standardised knowledge about these issues in France and England, but also the wider contexts and cross-national importance of the work.

3.4: Reflexivity

The theoretical approach to this thesis, and the research aims of engaging with women affected by genital sexual pain and healthcare professionals in a collaborative and sensitive way, as well as using interview data to situate the study in participants' own descriptions of pain and its psychosocial contexts, demanded a close examination of where the researcher is situated in the research process. It also required an understanding of the way that the possible power dynamics inherent in this research process were conceptualised and navigated. Manohar *et al.* (2019, p. 1613) assert that in 'cross-cultural and sensitive research', researchers must continuously assess their 'understanding of the phenomenon and/or context being examined' and their position as an insider and outsider to the research content, which may 'shift during the course of [the] research project'. The idea that the context of the study must be continuously assessed was paramount when conducting interviews in France in French, as a person with knowledge and experience of life in France, who was nevertheless residing in England. More obviously, perhaps, the COVID-19 pandemic, and the way that this has shaped experiences of healthcare and deepened existing structural inequalities (Bambra, Lynch and Smith, 2021) were important to consider in the reporting of the results of the study and the conclusions drawn, despite all fieldwork for the thesis having been undertaken before the start of the pandemic.

As a researcher funded by an academic institution; active healthcare professional throughout the data collection and analysis for this thesis; white woman; third-generation immigrant; occasional patient in healthcare services; and reader and participant in knowledge about sexuality, I cannot claim a neutral stance with regards to the construction of knowledge around women's sexual pain in France and England. The choice of a social constructionist theoretical stance for this project therefore attempts to recognise my position in my handling of sexuality knowledge, and the understanding that embodied experiences of sexual pain can occur and be described within complicated power relations and systems. Burr's (2019 p. 118) suggestion that social constructionist stances can lead to a conceptualisation of knowledge and understanding as 'a product of human thought, language, and interaction, rather than grounded in an observable and definable external reality' echoes the focus in this thesis on inductive method, and on the focus on the research findings as products of complex, contingent processes which are themselves anchored in fluid power dynamics. Individual experiences of pain reported in participant interviews are carefully considered within complex dynamics of power, with a commitment to recognising contributory factors in healthcare experiences and access, including gender. These considerations are key in creating study results which are accessible to healthcare professionals working in those complex systems and women affected by pain, and which increase awareness and knowledge around these experiences, especially in their gendered element.

Part of the reflexive design of this project was recognising that the collection and critical appraisal of interview material for this thesis may be emotionally challenging at times, particularly where participants revealed information about painful and distressing sexual encounters, abuses of power of healthcare professionals, and sexual violence and abuse. In practice, disclosures of abuse or violence were discussed with participants and participant distress from these disclosures was included in the risk assessment process for the data collection for the project. Participant wishes regarding privacy, information sharing, and judicial disclosure were respected. Several participants reported that they had questioned whether I was experiencing or had experienced chronic genital sexual pain, and an additional part of the reflexive process for this project was deciding whether to share details of whether I had chosen this subject because I was experiencing sexual pain personally. It was decided after much consideration, and discussion with colleagues undertaking similar work, that where the question was asked by participants, that I would answer honestly, that I was not affected by a sexual pain disorder. This aimed to make the data collection process as transparent as possible for participants while maintaining professional boundaries. Rose (2017, p. 774) reminds researchers that in practice, the 'distribution of knowledge privileges certain spaces – primarily the academy', and that the epistemological challenges of working with 'situated knowledge' (*Ibid.*, p. 773) which comes from experience that the researcher may not share must be recognised. My explicit gender identification as a woman, and my potential perceived implicit knowledge of situated experiences unique to women may have contributed to building rapport with participants, despite the relationships of power being different between us.

Part of the recognition of this as perceived situated knowledge was therefore to be as clear as possible with participants about my own experience when they requested information about this, without situating the conversation in my own experience or overstepping my professional boundaries. I reflected upon my own position, and the uneven power dynamic of holding such information about participants which they did not hold about me. Aiming to produce a meticulous and reflexive study without becoming 'overwhelmed with the responsibility of getting it right' (Lather and Smithies, 1997, p. 215) meant being as clear as possible in providing information to participants about what their voluntary participation entailed and my own role and participation in the research and analytical process.

3.5: Research with potentially vulnerable participants

Participant recruitment, interviewing, analysis, and dissemination of research findings were designed in a way that minimised potential negative effects for participants and ensured that participants were informed about the research process, and that they were free to withdraw at any time. For this reason, there was a clear statement in the native language of the participant as part of the consent form (Appendix 2) that participation in the project would in no way affect participants' access to healthcare and was strictly anonymous, and participants were asked to sign or tick this statement to indicate their agreement. It was also important to recognise, in line with the consideration of power dynamics and interweaving systems of power, that participants may recognise themselves as marginalised in some areas of their lives and not in others, or that they may not have considered themselves marginalised when they may have appeared so to others they interacted with. For example, a participant who was working intermittently and was therefore having financial difficulties which affected their ability to pay for transport to and from hospital appointments might be considered marginalised by Wilson's definition or in common understanding of the term ''vulnerable'', but they may not consider themselves to be vulnerable or in a marginalised position. This is consistent with the idea seen elsewhere in the Methodology section that the nuances of the participant data, and the way that participants themselves reported things, rather than ideas being imposed on their reports of their positionality, must be respected as much as possible in the analytic process, and that analysis and results must be inductive and driven by the participants themselves.

In practice, the consideration of how participants might be vulnerable or affected by the research process and interviews extended far beyond the interviewing process, into the analysis of the data and beyond. To attend to this, the researcher employed what Leake (2019, p. 238) terms 'critical empathy'. This means recognising 'the biases and shortcomings of empathy while simultaneously looking to establish shared goals and interests' (*Ibid.*, p. 238). Acknowledging that empathy is limited and may reflect personal bias, especially with regards to what and who researchers are empathetic towards, is important, but empathy can also be a useful and significant tool in research and healthcare practice. During this project, empathy meant being sensitive to the emotions of the participants and listening to them carefully, taking notice of verbal and non-verbal cues and attempting to react to distress in a personal and considered manner, without feeling *for* the participant, rather feeling *with* them (*Ibid.*, p. 240). This was tied into the study design which aimed to respect participants, work with them collaboratively and to situate the study in their own reflections and perceptions, while maintaining a respectful, professional distance as a researcher. This also helped to build a relationship of trust between participants and the researcher and to encourage open communication between participant and researcher, to engage collaboratively and thoughtfully.

As I am English, and working within an interdisciplinary English university structure, it was decided that as much of the data collection and analysis was to be carried out in the native language of the participant as possible, with the discussion, analysis, and reporting of the data in English. This design was chosen bearing in mind that certain participants, in practice one woman affected by sexual pain and one healthcare professional, both resident in France, may prefer to speak about their experiences in either English or French, regardless of where they were resident. Accordingly, when participants explicitly stated that they spoke both English and French and asked which language I preferred the interview to be undertaken in, I made it clear that the choice of interview language was theirs, and the interviews were carried out in the participant's preferred language, which was English rather than French in both aforementioned cases. It was key to the translation process to remember that the translations which made English text accessible to French readers and the reverse were carried out by the researcher, an English woman with experience of living in France, and of French culture, and that the translation process as well as the 'rendering of the source text' into English (Rodriguez de la Vega, 2019, p. 1631) was undertaken within 'a specific social context, determined by specific linguistic, political, cultural, and socio-economic coordinates' (*Ibid.*, p. 1628). The way that this operated in practice is shown in the tables below.

Table 3: Research activity language choices

Research activity:	**Language:**
Recruitment of participants, participant information, arranging interviews	Preferred language of participant
Interview	Preferred language of participant
Transcription of interview	Preferred language of participant
Collection of extracts for analysis and themes	Preferred language of participant
Analysis of data	English language
Discussion and reporting of data within the PhD thesis	English language
Factsheets and recommendations resulting from the study and data	Preferred language of participant/target language of recipient of factsheet

The table below further details how this was undertaken in practice with the language spoken day-to-day by participants first, and the interview language second. The commonplace language of participants – English or French – was not always the first language of participants, rather the language of the country in which they were resident at time of the interview, and the below table shows which participants decided to undertake the language in a language other than the language they used on a day-to-day basis.

Table 4: Participant Choices in Interview Language

WA-EN-001 English - English	WA-FR-001 French - French
WA-EN-002 English - English	WA-FR-002 *French - English*
WA-EN-003 English - English	WA-FR-003 French - French
WA-EN-004 English - English	WA-FR-004 French - French
WA-EN-005 English - English	WA-FR-005 French - French

WA-EN-006 English - English	WA-FR-006 French - French
WA-EN-007 English - English	WA-FR-007 French - French
WA-EN-008 English - English	WA-FR-008 French - French
WA-EN-009 English - English	WA-FR-009 French - French
WA-EN-010 English - English	WA-FR-010 French - French
HP-EN-001 English - English	HP-FR-001 French - French
HP-EN-002 English - English	HP-FR-002 French - French
HP-EN-003 English - English	HP-FR-003 *French - English*
HP-EN-004 English - English	HP-FR-004 French - French

When it was felt that there was no translation that was close enough to the meaning of the word, phrase, or excerpt of participant data in the analysis stage of this process, notes were used to show readers who could speak both languages what the participant had originally said. It is hoped that by undertaking the field research in the native or preferred language of the participant, reporting it in English as per the academic obligations of the project, and disseminating results of the project in participants' native or preferred language, the commitment to raising awareness of this issue in England and France will be achieved. This will be discussed further in the analytical approach section which follows.

3.6: Ethical considerations

It was key to the research approach informed by Foucauldian theories of power and intersectionality for this work that the ethical considerations of the data collection be as clear and comprehensive as possible. Ethical approval was first sought from Nottingham Trent University in December 2017 (Appendix 1) and was granted that month by Nottingham Trent University's Joint Inter College Ethics Committee. An amendment was also granted in June 2018 to allow for a potential survey element to the study, but this was not necessary in practice due to the rich data collected in the semi-structured interviews and the limited scope of the thesis.

To ensure that the way that the data collection was undertaken was clear to all participants, informed consent was gained from each participant via a consent form (please see the 'Consent' section below) regardless of which group potential participants belonged to, and information about the project was provided prior to seeking consent (Appendix 3), through information given to participants in their respective language about the project, as well as offering all potential participants ample opportunity to ask any questions about the research before deciding whether or not to participate. This design was created with the aim of informing participants in as thorough a way as possible about the intentions of the study so that they could make individual informed choices about their participation. Participant recruitment was undertaken via social media platforms Twitter and Facebook, and by word of mouth, which meant that there were often several messages exchanged with each participant before an interview was organised or formal consent sought.

The main divergence in participant recruitment method was between the healthcare professionals and the women affected by sexual pain, which was the case in both England and France. As the healthcare professionals interviewed for the study were approached directly by email, a process discussed further in the 'Sampling' section below, with the participant information sheet for the project attached, it was necessary to ascertain whether additional clearance was necessary for interviews to be undertaken. Information was sought from individual healthcare practitioners about whether ethical approval needed to be obtained from their governing body or council before interviews took place. In practical terms, this meant following the formal procedure for checking whether NHS ethical approval for research was necessary, and this process was followed in January 2018 following Nottingham Trent's Ethical Committee approval in December 2017. It was determined that this project, and the data collection methods used, would be considered a non-invasive service evaluation, and therefore it was not necessary to go through the NHS ethical clearance procedure. The CCGs representing the hospital Trusts where the interviews took place were notified, as per relevant guidance, and their permission sought, as well as providing details of the University's ethical clearance process and approval. The results of the study and details of publications arising from it were also supplied to them at their request. In France, individual healthcare practitioners were informed of the Nottingham Trent University's ethical approval process, and any relevant considerations were discussed at the point of consent. This was to ensure that the cross-national design of the project was prioritised, and that research was undertaken ethically with an understanding of the ethical considerations for each participant in the four participant groups outlined above.

3.7: Practicalities

The practicalities of the empirical research for this project involved defining the population of interest and a reasonable scope for a project of this size, including how many participants would be interviewed, as well as clearly defining how issues such as consent and risk would be managed in line with the theoretical, empirical, and analytical approaches of the thesis. These decisions, and their link to the aims of the research, as well as their relation to how sexual pain is conceptualised in France and England, are explored below.

3.7.1: Participant Recruitment

Recruitment for this study meant being aware of which population was being targeted by the research, as well as how the methodological frame used would address the research questions. Sampling for this study by recruiting online through social media and through word of mouth demanded strict inclusion and exclusion criteria. In practice, a call was made on social media for female participants who self-identify as experiencing sexual pain to contact the researcher if they were willing to participate in a semi-structured interview. Recruiting women who have not been formally diagnosed with a sexual pain disorder was chosen because many of the studies consulted for the literature review included only women who had already been diagnosed, or who had been recruited from hospital or specialist service waiting lists. Inclusion criteria were set so that women who were interviewed must be resident in England or France at the time of interview, must experience genital (vulvovaginal, perineal, lower abdominal) pain during sexual acts, and must consider themselves to experience sexual pain, regardless of whether a formal diagnosis had made by healthcare professional. Exclusion criteria evolved as enquiries were received during the recruitment process, for example from women experiencing pain in other parts of their body during sexual intercourse, such as their back, or women who held French or English nationality but were not based in either country at the time of interview.

Original exclusion criteria included interviewing people who experienced genital pain solely outside of sexual acts with no pain felt during sexual intercourse, and women who did not want to share their experiences for the study through the form of interview or empirical collection techniques, which were discussed with them and outlined on the participant information sheet during the recruitment process. These criteria were chosen because they maintained the focus on participants identifying themselves as having genital sexual pain rather than being diagnosed, and on allowing analysis to be informed by participants' own descriptions of their pain, while also providing ample data for the comparative element of the study and sampling within the pragmatic considerations and scope of the study. It was decided within the pragmatic considerations of the project and the project's ethical clearance that up to 10 women in each of England and France would give a reasonable impression of how sexual pain was conceptualised in England and France without providing so much data that the depth of the data collected would be replaced by a larger breadth of responses. It was also felt that a maximum of five healthcare professionals in each of England and France would meet these criteria, and it was for this reason that numbers were restricted in this way, which also aimed to prioritise the impressions of women affected by the pain over the impressions of healthcare professionals, as it is the women who are experiencing the pain which is the primary focus of the study.

3.7.2: Sampling

The sampling undertaken was purposive, a method 'used when researchers have a clear idea of the kind of group they are interested in and an approximate idea of what they want to find out' (Gillham, 2008, p. 20). Purposive sampling meant targeting specific individuals during the recruitment process through making the inclusion and exclusion criteria explicit and allowing the design to be constructed in such a way that it could be flexible and adapt to what participants described as important during the interviews (*Ibid.,* p. 31). Sampling in this way was grounded in the notion that the 'meanings and interpretations of the participants are the essence of qualitative inquiry' (Liamputtong, 2019, p. 9), and this meant considering how the participants themselves described sexual pain as well as how they situated themselves more broadly. This approach was particularly advantageous as the way pain was described was heterogeneous within the narratives of the participants. As sampling of both healthcare professionals and women affected by sexual pain was carried out in this way, and samples were not demographically representative of the whole population of England or France given the scope of the project, the results were not intended to be generalisable to the whole of society. They rather formed the basis for a contribution to knowledge founded in theoretical generalisation (*Ibid.*, p. 20), that 'the explanations developed may be applied to other individuals or groups even though their characteristics may be different'. Participants were not formally asked to complete a disclosure of their demographic characteristics, but in many interviews, information about sexual and gender orientation, cultural background, marital status, and educational background was revealed. As participants who self-identify as having genital sexual pain were sought, it was felt that recruiting by demographic characteristic may have limited the possibilities for women who self-identified as belonging to specific demographics to participate. The considerations of intersectionality and power dynamics were still crucial to the recruitment process, and it was born in mind that potential participants may have identified as women without having a vulva, vagina, or uterus, or may have fit into multiple demographic groups simultaneously and variably (for example where participants might have felt their sexual orientation or gender was not fixed), therefore questioning the idea of a formal declaration of participant demographic. One of the key limitations of this approach, despite its benefits, is that participants in this study were predominantly white in terms of racial identity, and future studies building on the present research will need to actively address this and recruit a wider sample of participants.

There was a considerable response to the English-language call for female participants affected by sexual pain online in 2018, with a smaller response from the French-language call for participants in 2019. Due to this response, it was decided that sampling from small groups of women who self-identified as having sexual pain and professionals involved in its treatment, while keeping in mind the scope of the study, would better address the research questions than methods which may include a wider sample, for example a questionnaire approach. This smaller sample would allow for any analysis and the analytic application of theory to be constructed in a frame of what participants themselves reported, and would maintain as nuanced an approach as possible. It was also key to the ontological and theoretical stance of the thesis to ground the study in constructed, variable, individual meanings and experiences, and recruiting a small sample for in-depth semi-structured interviews was coherent with this approach. This process also kept in mind Hacking's assertion that 'gigantic unsystematic ''systems" of health and justice play an important part in channelling and organizing symptoms and their display' and that systems are all made of individual people who hold 'little pieces of authority within these systems' (Hacking, 1995, p. 70). This is crucial to remember because it avoids slipping into attributing individual behaviour to "systems" but also recognises the way that systemic organisation and categorisations might influence individuals to act in a certain way. This might seem counterintuitive when the comparison is being made between two national health service policies as well as within two seemingly separate cultural contexts, but the scope of this study was to interview individuals, as well as considering policy and cultural contexts, and so this focused sample was centred around individual experiences of participants *within* healthcare systems, but also *as part of* those healthcare systems, and involved in the complex and shifting power dynamics which constitute interactions and experiences.

In addressing the gaps explored in the literature review, semi-structured interviews were chosen over other qualitative methods including questionnaires of focus groups, as the sensitive subject matter, as well as the requirements and scope of the study, demanded a qualitative method which would provide enough space for sensitivity and relative privacy in the research process, which would have been impossible to meet with focus groups, and also the possibility to access information that participants felt was important as well as non-verbal communication such as laughing and sighing during interviews, which would have been impossible with a questionnaire format. The possibilities of the sample of participants include the way that healthcare professionals from diverse background were able to give a unique insight into the workings of both private and public care provision for women with sexual pain in England and France. Further to this, interviewing women in both England and France who categorised their sexual pain in a variety of ways, and maintaining these variations, mitigated the risk of maintaining rigid diagnostic definitions or nomenclature which may have repeated dismissive language experienced by these women as part of their treatment-seeking for their sexual pain. The limitations of this sample also relate to the variety of women and healthcare professionals interviewed. The variety in backgrounds of the healthcare professionals interviewed may make it difficult to compare their experiences solely based on professional background. Likewise, the variation of experiences in recruiting the sample of women in France could complicate a cross-national comparison based on demographic characteristics or similarity in treatment pathways. These possible comparisons were not, however, the aim of the current thesis, and future research may consider comparisons on this basis where demographics and comparisons in training and treatment pathways are more rigidly captured or aligned as part of the recruitment process to give a different analytical perspective.

As part of the ethical clearance process for this thesis (Appendix 1 and Appendix 3), participants were guaranteed that they would not be named or identified in any research arising from their participation, and that their data would be held securely. For clarity and ease of reference when considering the sample of participants for the thesis, a small amount of information regarding each participant is given below. Though demographic characteristics such as sexual preference or relationship status are mentioned in analytical sections elsewhere in the thesis, it was because participants directly referenced this demographic information as an important part of their sexual pain experience. In line with the ethical stipulations of the project, identifiable information such as demographic characteristics are not provided for each participant, but relevant information which may facilitate understanding of participant experiences is given below.

Table 5 and 6: Participant Characteristics

Participant group – Healthcare professionals

COUNTRY/CODE OF PARTICIPANT	RECEIVED SPECIFIC TRAINING ON SEXUAL PAIN IF BACKGROUND OCCUPATION DIFFERENT FROM CURRENT ROLE	DESCRIBED EXPERIENCE WORKING PRIVATELY, IN STATE-FUNDED ORGANISATIONS, OR BOTH	ACTIVELY WORKING IN A SERVICE SPECIALISING IN SEXUAL ISSUES WHEN INTERVIEWED
FRANCE			
HP-FR-001	Yes	Both	Yes
HP-FR-002	No	State-funded	Yes
HP-FR-003	Yes	Both	Yes
HP-FR-004	n/a	State-funded	No
ENGLAND			
HP-EN-001	No	State-funded	Yes
HP-EN-002	No	State-funded	Yes
HP-EN-003	Yes – minimal	Both	Yes
HP-EN-004	Yes - minimal	Both	Yes

Participant group – women affected by sexual pain

COUNTRY/ CODE OF PARTICIPANT	PAIN ISSUES AS TERMED BY PARTICIPANTS	SOUGHT DIAGNOSIS/ TREATMENT	PROBLEM STILL EXISTED AT TIME OF INTERVIEW
FRANCE			
WA-FR-001	Vulvovaginal or vulvo-perineal condition (*pathologie*)	Yes	Yes
WA-FR-002	Female sexual traumatic dysfunction	Yes	Yes
WA-FR-003	Vestibulitis	Yes	No
WA-FR-004	Vaginismus	Yes	No
WA-FR-005	Vestibulodynia	Yes	Yes

WA-FR-006	Vulvodynia	Yes	Yes
WA-FR-007	Vulvovaginal condition (*pathologie*)	Yes	Yes
WA-FR-008	Sexual pain	Yes	Yes
WA-FR-009	Dyspareunia	Yes	Yes
WA-FR-010	Vestibulodynia	Yes	Yes
ENGLAND			
WA-EN-001	Vulvodynia, vaginismus, pelvic pain	Yes	Yes
WA-EN-002	Lichen planus	Yes	Yes
WA-EN-003	Lichen Sclerosus	Yes	Yes
WA-EN-004	Vaginismus	Yes	Yes
WA-EN-005	Pain like having your period but x1000	Yes	Yes
WA-EN-006	Vaginismus	Yes	‘99%’ resolved
WA-EN-007	Sexual pain that doesn’t interfere daily	No	Yes
WA-EN-008	Sexual pain to do with trauma rather than it not working quite right	Yes	Yes
WA-EN-009	Vulvodynia/Chronic pain condition	Yes	Yes
WA-EN-010	Something is **wrong** which penetrative sex makes worse	Yes	Yes

3.7.3: Interview arrangements

Flexibility in interview scheduling was key to this project in terms of working with women and healthcare professionals. Flexibility in semi-structured interview organisation meant that interview time and date were arranged to fit participant schedules, whether these participants were healthcare professionals or women affected by sexual pain. Within the financial limitations of the project funding, four fieldwork trips to France were undertaken, and travel within England was also conducted if participants preferred a face-to-face format for the interview. As fieldwork was completed in 2019 before the outbreak of COVID-19, all face-to-face meetings with participants were organised within national and local travel guidelines and were permitted at the time that they were undertaken. The format of the interview was jointly decided by the participant and the interviewer, to maximise the comfort of the participant in the hopes that they would be as confident as possible in sharing sensitive and potentially distressing information. This decision was reached by providing information about the different interview formats available, and where requested, a prior copy of the interview questions was sent. One French participant, a woman affected by sexual pain, felt that a written response, rather than a verbal one, would give her more of a chance to voice her answers and control how much of her information was represented. It was agreed with the supervisory team that this would be possible for the participant, and it was felt that the research aims would still be met if, in this case, the verbal semi-structured interview was replaced with written answers. There was also a desire on the part of the interviewer to maintain the collaborative element of the study as much as possible, and to respect the agency of the participant in deciding how much of her information was shared, which meant making a practical decision on this occasion that the participant would control the format of the interview even if it was not in the typical format used in elsewhere in the data collection.

3.7.4: Consent

Before each interview, study participants were notified that they would need to give informed consent to take part in the study, by reading and signing a consent form (Appendix 2). Where interviews were conducted by videocall or telephone, the interview was only arranged once the completed and signed consent form was received by the researcher. This was to ensure that participants understood the research process, and to ensure that they agreed with how their information would be anonymised following the data collection part of the study. Before interviews were arranged, participants were provided with information about the project and they had the opportunity to ask questions, and it was stated that they were free to withdraw from the study at any time, which would result in the destruction or removal of any data relating to them.

3.8: Mitigating risk

The ethical approval process for this project involved a detailed risk assessment, which covered three main areas. These were the potential distress to participants (both healthcare professionals and women affected by pain) of discussing sensitive issues, participants disengaging from the process and becoming uncontactable, and participants seeking medical advice from the interviewer, which the interviewer was not able to give. There was also a level of risk to the researcher, which was covered in the original ethical approval application (Appendix 1), and which is discussed in more detail below. The three risks were mitigated as follows:

3.8.1: Potential distress to participants when discussing sensitive issues

This risk was deemed to be average/high in the original risk assessment for the project, and this level of risk was maintained when the risk assessment was subsequently reviewed. This risk was mitigated by providing participants with information about their rights while participating, and where distress was perceived, providing reassurance that the interview could be stopped, paused, or relocated if this would ease distress. In practice, this meant taking time with the interviews, and encouraging participants to discuss sensitive subjects at their own pace. Signposting was also used to mitigate this risk, and conversations were prioritised with each participant once the recording was complete to check how they were feeling and to identify any potential risks before they left the interview location, or the call, or before the videocall was disconnected. These conversations were written up in a reflection sheet after interviews where necessary, detailing any support signposted, and these were anonymised and stored securely with the interview data.

3.8.2: Participants disengaging from the process and becoming uncontactable

This was a particular risk when interviews were conducted over telephone or videocall, where participants could disconnect from the interview at any time. In practice, this was not an issue, but there were several occasions where telephone interviews were in the process of being arranged and participants did not answer the telephone or confirm the time of the interview. In these cases, several efforts were made to contact the participant to check on their welfare, and different platforms were used, for example both an email and a social media message where multiple contact details were available. These messages encouraged participants to get back in touch should they wish to, and where they did, further information was provided, or interviews were rearranged at a time convenient to the participant. There was a need to balance the agency and choice of participants to disengage from the process without needing to provide an explanation and without being repeatedly contacted by the researcher, and to ensure that their welfare was not affected negatively by potentially participating in the study. This was also discussed with the supervisory team where necessary in regular supervision sessions, and this balance was key in deciding when to stop contacting a participant if it was clear that messages about the project had been received but no reply had been sent by the participant.

3.8.3: Participants seeking medical advice from the interviewer

This was judged to be a low impact potential risk for both participants and the interviewer but was nevertheless a risk. Where advice was sought, effective signposting to relevant services, or to other services who could signpost further, was undertaken. Potential participants had the opportunity to ask questions about the research at all stages of the process, and the participant consent form clearly stated that participation in the research would have no bearing on healthcare or legal rights.

3.9: Research data management and data protection

A data management plan was agreed as part of the original ethical approval application for the project before interviews commenced. Nottingham Trent University's Research Data Management Officer was consulted during the project to ensure that the plan was relevant and in line with contemporary guidance, and updated training was sought and completed where necessary. Information about anonymity was included in the participant information sent to participants, and was further discussed with participants before the interviews where necessary. All data, both electronic and paper-based, was stored in line with Nottingham Trent University's Research Data Management Policy and confidentiality and anonymisation is maintained under this same policy. This will apply to any future use of the data, and as per the participant information sheet, all data related to the project will be retained securely for six years, during which time it may be used anonymously for publication purposes, and after these six years the data will be destroyed.

The storage of data was largely electronic, with paper copies of items only kept where participants had, for example, signed paper consent forms by hand before the interviews took place. Original paper copies of documents containing participant information were destroyed by shredding and their electronic copies were kept on password-protected files on secure computers. This was originally solely on university computers, but as the COVID-19 pandemic dictated working primarily from home, it also included a personal computer which was also password-protected, stored in a locked location, and encrypted. Interview data recorded on Dictaphones was uploaded to an encrypted, password-protected, computer and removed from the device it had been recorded on. This device was later reset to avoid any trace of the information remaining. During the transcription process, participant data was anonymised and identifying characteristics such as participant profession, age, name, or location were removed. The corpus data for this project will not be stored in an institutional repository, as per discussions with the Research Data Management Officer, as ensuring that the data is closed access means that data anonymity is preserved as much as possible. Similarly, any future requests to access the data will be treated in line with Nottingham Trent University's Data Management Policy and any clarification on this will be sought from the University's Data Management team.

3.10: Risk to the researcher

In terms of ensuring interviewer safety, regular contact with the supervisory team was paramount, and where the interviewer was travelling to a location rather than conducting the interview remotely, the interviewer made provision for a close acquaintance to have exact details of interview location and time without disclosing any information about the participant or the interview itself. This was to ensure that the interviewer was safe when meeting participants for the first time in organisations, meeting rooms or other public places. Every care was made to ensure that in practical terms, the researcher was not put at any undue risk by contacting or meeting participants.

3.11: Empirical challenges

The sample for this study was not as diverse as I would have liked. Participants who might be considered vulnerable may include potential or actual participants whose first language is not English or French, meaning that women reading participant calls in social media who did not speak or read English or French would have been excluded at the point of recruitment. This may also have excluded women with differing levels of literacy or access to assistive technology, for example where calls were made on social media, which may have inadvertently excluded visually impaired participants who were not using screen readers to verbalise written text. This could be addressed in future studies by providing participant information sheets in various languages and different formats, or by the researcher being physically present if recruitment were carried out in person, where pandemic planning permitted (for example recruiting in health services or from hospital waiting lists, depending on the focus of the study). Where sample diversity concerns gender identity, this must be prioritised in all future recruitment which aims to increase the demographic diversity in cross-national sexual pain studies, as various gender identities were discussed by participants in interviews. As previously outlined in the ‘working with vulnerable participants’ section of this methodology, the focus while recruiting within the current sample was that recruitment of participants who could be considered vulnerable should be ‘strengths-based’, not ‘deficit-based’ (Wilson, 2019, p. 1534), and therefore focusing on what participants felt were their strengths, not their weaknesses, would be a strong starting point for creating of future studies in this area in consultation with concerned parties. Future projects which use the data from for this study, or which conduct similar studies, would ideally conduct research in such a way that emphasises the importance of demographic diversity. Following the choice to use intersectionality as part of the theoretical approach to this project, recruiting in a way which prioritises diversity would also need to take into account that participants or potential participants can be disadvantaged in multiple ways and attend to this. Open and reflexive conversations about the design of the project with the groups concerned would facilitate this, and would enhance and extend the fourth research aim of this project, to create meaningful impact from the project, as well as the first, to create a study which is relevant and accessible to readers in diverse settings.

3.12: Analytical Approach

The analytical approach to the thesis was designed to complement the iterative, qualitative nature of the empirical approach, and focused on the use of reflexive thematic analysis, as informed by readings of Braun and Clarke (Braun and Clarke, 2019ii), to create interpretations, and eventually results from the empirical semi-structured interview data, allowing conclusions to be drawn about the conceptualisation of women’s sexual pain in England and France. The social constructionist ontological viewpoint of this study means upholding ‘the possibility of multiple, coexisting meanings’ (Hathcoat *et al.*, 2019, p. 103) and the analytical process therefore needed to be adaptable and allow space for many variations in responses. The research aim of situating the study in participants’ own descriptions of sexual pain and its psychosocial contexts meant that participants were invited to be ‘active respondents’ in the research process rather than solely subjects of the research process (Liamputtong, 2019, p. 11), and this meant inviting all participants to take an active role in interviews and to lead the direction of the interviews with what they felt was important to discuss. It also meant acknowledging that the analytical approach would need to be adaptable and participant-driven while remaining committed to answering the research questions and meeting the research aims. The adaptability of this process allowed for a nuanced understanding of conceptualisations of sexual pain in England and France, driven by participant data and influenced by theoretical underpinnings of intersectionality, power relations and researcher reflexivity, and this resulted in a detailed analytical narrative, revealing subtleties in meaning and conceptualisations of sexual pain in England and France, and comparative findings which contribute to the field of sexual pain research.

3.13: Reflexive thematic analysis

The exciting and adaptable data collection and analysis process for this thesis meant appreciating that, in discussing the conceptualisation of women's sexual pain, participants may express a wide variety of opinions and experiences, all of which must be treated with equal importance. This thesis carries the thread of the potentially destructive 'concrete consequences' (Lépinard, 2020, p. 125) of gendered healthcare inequalities throughout, without forgetting the possibility that women affected by sexual pain may be 'multiply-marginali[s]ed' (Carbado *et al.*, p. 309) in other ways. The analytical element of the thesis, then, demanded an approach which would encompass the possibility of abstract ideas, 'concrete consequences', and the construction of themes drawn from empirical data which could reflect complex and multiple structural marginalisations. Thematic analysis, guided by the writing of Braun and Clarke (2006, 2019i, 2019ii) was an excellent fit for this approach, due to its potential as a flexible tool for working with complex, nuanced, qualitative data, and for 'identifying, analysing and reporting patterns (themes)' within it (Braun and Clarke, 2006, p. 79). This focus on a reflexive and adaptable process of actively undertaking analysis, as well as allowing for codes and interpretations to change through the course of the project is precisely why reflexive thematic analysis was chosen and is an ideal method to tell the story

(2019ii) of the data to diverse readerships. Though the thematic analysis conducted for this work will lose the very deep ‘micro level’ (Braun and Clarke, 2006, p. 98) analytic potential of for example, discourse analysis, the breadth of working iteratively with the whole data set as part of the analytic process allows for a depth of analysis which fosters the creation of accessible and rigorous analytic results.

This was preferable to a grounded theory approach where there is a more rigid concentration on the generation of new theory, or interpretative phenomenological analysis which, although it has been used in studies of sexual pain previously (for example Shallcross *et al.*, 2018), would have forfeited the flexibility in design which is so important to the cross-national nature of this project. Though interpretative phenomenological analysis might have provided alternative options for data collection and analysis for this project, the multiple theoretical and conceptual underpinnings, and the constructionist stance, of this work, were better suited to a method such as thematic analysis which had the potential to be iterative and generate results which are relevant to both women and healthcare professionals as well as nuanced. The aim of the project to create policy recommendations to contribute to equal and appropriate healthcare for all genders would be impossible without structured and coherent data and results, and thematic analysis provides a sound method to structure a nuanced and collaborative ‘analytic narrative’. It is clearly impossible to free oneself of ‘theoretical and epistemological commitments’ as a researcher, or code within ‘an epistemological vacuum’ (Braun and Clarke, 2006, p. 84), but recognition of the researcher’s positionality throughout the analysis, as well as clearly defining the ontological framework and reflexive intentions in this thesis are intended to go some way to mitigate this, though this cannot be removed completely.

3.14: Choice of reflexive analytical frame

Many criticisms have been directed towards thematic analysis as a research method, including its potential to be used as a method which includes ‘untheorised mashups’ of other theories such as grounded theory (Braun and Clarke, 2019ii, p.

589), and that it is problematic in its ‘poorly demarcated’ nature (Braun and Clarke, 2006, p. 77. Arguably, the procedural flexibility in this choice of method could lead to lack of reproducibility, poorly defined ‘philosophical assumptions’ around the research (Braun and Clarke, 2019ii, p. 590), and different interpretations of the results or theory generated.

For this study, however, the conclusions drawn were the result of defined research objectives in a particular research context with a specific research question in mind, and they were not intended to be reproduced in the same way, nor were understandings of the data designed to go unquestioned or stand as the sole possible interpretations of the interview material gathered for the project. The philosophical and reflexive assumptions of this thesis are clearly explained at the outset, which is one way that the potential for poor demarcation as a method or ‘untheorised mashups’ is mitigated. Additionally, a reflexive approach to analysis was chosen over other types of thematic analysis which may have a more positivist approach, as it was felt that codes and themes must be created from the data, rather than pre-formed in advance of analysis. The potential disadvantages of using thematic analysis, namely the introduction of researcher preconceptions, the potential lack of ‘micro level’ analysis, and the poor definitions of researcher positionality were addressed as much as possible through the use of reflexive thematic analysis over other types such as codebook. With the social constructionist ontology of the project foregrounded, and a commitment to the recognition of individual and structural power dynamics, and to making researcher preconceptions explicit, this work aims to work as reflexively as possible in its choice of analytical frame, and to situate the study in participants’ own descriptions of their pain, as per the research aims. Reflexive thematic analysis, according to Braun and Clarke (2019ii, p. 594) means creating a research approach where ‘theoretical knowingness and transparency’ are prioritised, and where research decisions are focused on engagement. It also entails ‘questioning and querying the assumptions we are making in interpreting and coding the data’, where themes are ‘actively created by the researcher at the intersection of data, analytic process and subjectivity’ and ‘creative and interpretive stories about the data, produced at the intersection of the researcher's theoretical assumptions, their analytic resources and skill, and the data' (*Ibid.*, p. 594). Reflexive analysis, then, incorporates the conclusions drawn in consulting existing literature about these pain issues, and also draws on the way that the empirical and theoretical approaches were constructed. The inclusion of multiple groups of participants and multiple analytical lenses is one of the 'creative and interpretative' choices made in this thesis, and researcher reflexivity and awareness were key to these choices.

3.15: Application of the analytical frame

Using thematic analysis as a method meant first planning reflexively how the research would be undertaken, including a consideration of researcher positionality and ethical imperatives, as described previously. Once interviews had taken place and the recordings had been transferred digitally as per the data management plan, the interviews were transcribed verbatim in their language of origin. The rationale for transcribing the interviews in the language in which they were conducted, rather than English, the language in which they would be cited in this thesis, was to leave all nuances of the French-language interviews intact for the analytical process. This was significant because some terms used by participants, such as 'je suis vaginique' (I am a person with vaginismus) had no direct translation into English, and while the language of the thesis is English, interesting and important concepts such as this were left in their language of origin to facilitate discussion of the significance of these points in understanding how sexual pain is conceptualised in France. At the transcription stage, nothing from the interview recordings was removed, and silences, pauses, and exclamations such as laughing or scoffing were retained to communicate the information from the interviews in as faithful a way as possible to the manner in which participants had conveyed their opinions. Similarly, where emphasis was given to a particular word or phrase by participants, this was emboldened in the transcription process, and in any subsequent quotations in the analysis section of this thesis. This was intended to reduce the likelihood of misrepresenting participants by emphasising incorrect parts of their impressions in the interviews. As part of the reflexive process for this thesis, the transcription of the interview data was also seen as an '*interpretative* act' (Braun and Clarke, 2006, p. 87, italics in the original) where the researcher-transcriber was not a neutral party examining the data, but rather an active part of the research process, bringing personal interpretations of elements of the transcribed data to the analysis even during the process of transcription. Following transcription, the entire data set was coded for possible themes, meaning that after a deep process of familiarisation with empirical data, codes were conceptualised as patterns, and as 'a feature of the data' which appeared significant to the concerns of the project (Braun and Clarke, 2006, p. 88), evolving as analysis continued (Braun and Clarke, 2019ii).

Once these codes had been generated, they were reviewed with their corresponding data excerpts, and were grouped together into themes and subthemes, using visual maps and Microsoft Excel, to allow for flexibility in shifting and emerging patterns. Once these themes and subthemes had been established, they were reviewed again to ascertain whether they formed a 'coherent pattern', and the 'validity of individual themes in relation to the data set' and the resulting visual 'thematic map' created was considered to see if it reflected the 'meanings evident in the data set as a whole' (Braun and Clarke, 2006, p. 91). These themes were then written up into an 'analytic narrative' shaped by the interview data (*Ibid.*, p. 93), which forms the four analysis sections and conclusion which follow.

The above process, described by Braun and Clarke as an 'analytic method, rather than a methodology' (Braun and Clarke, 2019iii, p. 84) means that the method involved in coding, theme creation and analytical reporting is flexible to the data set, rather than the data set conforming to a fixed methodology which encompasses the theoretical stance of the entire project. The social constructionist stance of this project further required the analytical process to be one which is *done*, and grounded in the importance of the process itself, and qualitative thematic analysis allowed for practical, ethical, and theoretical factors to be considered without excluding the importance of researcher positionality and the research process itself.

3.16: Dissemination

An important focus of the research questions for this study was that they must be ‘of immediate practical relevance’ (White, 2009, p. 14) and contributory (*Ibid.*, p.61), engaging with work that has already been done on the subject, without letting it ‘stifle creativity’ (*Ibid.*, p. 7). This aim was considered as part of the analysis by attempting to ground analytic choices, such as which type of thematic analysis to use, in the requirements of the reflexive and theoretical stance of the project, while ensuring that any results would be sent to the participants of the study and other parties involved, such as NHS CCGs. This meant producing factsheets which were written in plain language, both in English and French, and ensuring that anonymity was preserved in all results just as it had been throughout data collection and analysis. At the time of submission, publishing plans also included working with French journalists to add a section to a Larousse handbook regarding chronic pelvic pain (forthcoming 2023, title to be confirmed) explaining the study results and significance of this cross-national approach, and also contributing a chapter to an edited collection about the politics of intimacy. One of the most rewarding aspects of the dissemination of study information has been sharing relevant information sources, with moderator permission, on online support group Facebook pages, especially in French. This has included links to podcasts, websites, directories, and other sources that I have come across during the study which may be of interest to women experiencing sexual pain, and which were well received. I plan to provide details of any future publications resulting from the thesis or its data in this way, as well as sending details of these to participants, to ensure that the research aim of creating meaningful impact with this work and producing an engaging study which is relevant to readers in diverse settings, is met.

3.17: Analytical challenges

Many of the analytical challenges relate to the concept of reflexive practice, and the imperative not to become ‘overwhelmed with the responsibility of getting it right' (Lather and Smithies, 1997, p. 215), and of 'misrepresent[ing] or dishonour[ing] the women' and healthcare professionals who voluntarily shared their information and opinions as part of the research. In practice, this was navigated through the entire data set being consulted several times while coding and analysis was being undertaken, and discussions with the supervisory team regarding the fear of misrepresenting participants in an effort to maintain professional boundaries while conducting sensitive and reflexive research.

3.18: Potential findings in the cross-national context

Given the differences in healthcare context between France and England, a certain amount of variation is to be expected between the way that sexual pain is conceptualised, assessed, and treated between the two countries. It is also reasonable to assume, given the way that the French healthcare and insurance systems offer a greater choice in practitioner, that French approaches to women's sexual pain might offer greater flexibility and greater ease of consultation. The fact that women's healthcare in England does not, as standard, include pelvic floor physiotherapy postpartum, as is the case in France, and that education about the pelvic floor is unstandardised in England might further lead to an impression that women's sexual pain conceptualisations and approaches might be more comprehensive in France, given the importance of the pelvic floor in understandings of women's genital sexual pain in international definitions of women's pain disorders (DSM, American Psychiatric Association, 2013; ICD, World Health Organisation, 2019). It might also be assumed that specialist services, such as psychosexual clinics or gynaecological practitioners, would be better equipped in both countries to manage women's sexual pain issues than general services, given their focus on specific body areas or personal, sexual, and interpersonal experiences.

Pockets of localised information about women's sexual pain in both England and France, though both reflecting disorganised approaches to its conceptualisation and management, show that there is an interest in how it is conceptualised and the treatments available. These small pockets of interest also reflect the dedication of clinical authors in both England and France to mainstream definitions and further understandings of women's sexual pain (Mitchell *et al.*, 2017; Delavierre *et al.*, 2010). Despite this, it might reasonably be expected that working with women's genital sexual pain would be a challenging and thankless task in the healthcare systems in England and France given their design, the apparent lack of specialised co-ordination between services, and the opinions of other clinicians reflecting that women with sexual pain can be '[e]motionally labile during consultation' (Wilson, 1999, p. 118), catastrophising individuals (Basson *et al.*, 2010, p. 324) whose pain issues are 'heterogenous, multisystemic, and multifactorial' (*Ibid.*, p. 324).

In France, the experience of women's sexual pain might be considered to be more difficult or stigmatising due to the perceived prevalence of sexualised discourses and the idea that, although socially and culturally contingent, certain social groups are expected to have more sexual activity than others, and, importantly, to derive pleasure from these (Levinson, 2012, p. 449). Similarly, given the NATSAL-3 (2022, p. 2) findings that a majority of people interviewed who had not had sex in the year preceding the interview were neither 'dissatisfied, distressed' nor avoiding sex, it might be expected that findings from England will reveal that though sexual pain can be a distressing issue, the women interviewed in England might be less distressed about the overall impact that this consequent lack of activity could have on their sex lives. This tension between the social perceptions of sex, sexual activity, and pleasure will be key to these findings, and will also reveal that the way that sexual pain affects women and their relationships may not always be what is expected.

In financial terms, it is predicted that findings will reveal a complex picture in terms of the socio-economic implications of experiencing women's sexual pain for women both in England and France. Although in France, women without an income should be covered by the PUMA (Protection universelle maladie), and women without an income in England should not have to worry about the financial implications of sexual pain given that NHS treatment is free at the point of delivery, it is expected that the case for women in both countries will be more complicated than this, especially given the multi-layered structures of healthcare in both countries. Given the semi-private healthcare structure in France, the adoption of rigid sexual pain definitions, such as those put forward by the profit-minded DSM (American Psychiatric Association, 2013) or the ICD (World Health Organisation, 2019) would be useful in terms of guiding healthcare access routes, and insurance processes in particular, but given the relatively poor understanding of the many elements of sexual pain experiences, findings are expected to reveal that these guidelines might be known to healthcare practitioners in France, but are not at the forefront of healthcare guidance and access processes.

In short, given the differences in structure and funding in the French and English healthcare systems, it would be unsurprising to see differences in the way that women's genital sexual pain is identified, managed, and understood between France and England, especially among the healthcare professionals interviewed. Further to this, given the apparent common understanding of sexology as a profession in France, while work in sexological matters or psychosexual therapy seem to be largely incorporated into wider specialities such as nursing, social work and mental health services in England, it might be expected that there would be greater regulation and understanding of sexological practice in France than England, especially for women experiencing sexual pain who are considering consulting these practitioners. In even more basic terms, given the commitment of both countries in policy (NHS Constitution, Department for Health and Social Care, 2021; Parcours de santé, vos droits, Ministère des solidarités et de la santé, 2022) to providing universal healthcare which caters for the needs of diverse individuals of different genders, locations, races, sexual identities, and cultural backgrounds, one might imagine that this gender-specific, potentially debilitating issue would be prioritised in healthcare services, given the fact that citizens in both country have the right to appropriate, tailored universal healthcare. The analytical chapters below, and their resulting conclusions, will reveal the extent to which these predictions were accurate.

4: ANALYSIS – NAMING

4.1: Naming and Creating Meaning – French women

In the interviews with French women who had experienced genital sexual pain, participants underlined the importance of feeling that their pain, and their treatment-seeking for this pain, were legitimate. WA-FR-009 spoke of her search for a firm diagnosis for her pain, which was unclear at the time of the interview, and how this could help her feel that she was legitimate in speaking about it:

> ‘I would finally have a diagnosis to confirm what I’ve been saying, you know, quite simply, and so I would finally feel legitimate’ […] ‘I just keep coming back to this idea that, as I don’t have a diagnosis, my pain isn’t legitimate […] and that, you know, it’s just me’.

WA-FR-007 had already received a diagnosis of vaginismus and vulvodynia for her pain experience and spoke of how this had ‘changed everything’ for her, and how it had helped her to ‘realise that other people’ had or had had the same problems as her. She described the experience as follows:

> ‘well it allowed me to…on the one hand to have the right to be in pain […], and [to know] that it was legitimate, and that it wasn’t just in my head. That it was happening’.

The use of the word ‘legitimate’ here suggests that without the diagnosis, or pre-diagnosis, there was an impression that the pain was somehow illegitimate, unreasonable, or that WA-FR-007 did not have a right to be feeling it. WA-FR-007 not only spoke about how naming the pain meant she was able to see that others had the same pain experiences, but also to understand that the pain was not just in her head. WA-FR-009’s statement that the diagnosis would confirm what she had already been saying suggests that she had been talking about this problem already, without anyone validating or confirming what she was saying or framing it as credible. It is unclear in both statements above who is judging the legitimacy of the experiences or the pain, recalling Taylor's evocation of Foucauldian ideas about power as 'constitutive rather than repressive' (Taylor, 2015, p. 287), and suggesting that legitimacy may vary and depend on fluid fundamental power dynamics from one situation to another. Naming the pain and having received a diagnosis for the experience evidently felt advantageous to WA-FR-007, and it was seen as potentially advantageous by WA-FR-009. Here the power dynamics at play are obvious – to be able to articulate their experience in a way that is understandable or palatable to others is a crucial part of 'feeling legitimate' in the experience of sexual pain.

Conversely, feeling pain which cannot be named, or for which an obvious name does not exist to many others, including health professionals, was a frustrating experience for WA-FR-007 and WA-FR-009. The power dynamics which they were a part of meant that the first step to legitimacy in their experience was being able to formulate the pain experiences in a way which was understandable and credible to others. Recalling Foucault's description of the 'directly productive' nature of power, which exists in 'relations' that are 'not in superstructural positions' (Foucault, 1998, p. 94), these dynamics also recall the 'sort of contact prior to all discourse', 'by which two living individuals are 'trapped' in a common, but non-reciprocal situation' in clinical experiences (Foucault, 2012, p. xvi). Obtaining help for sexual pain issues within this 'non-reciprocal' power dynamic relies on women being able to articulate their issue in a way which fits with the 'contact' expected in clinical situations, and it also relies on them being seen as legitimate. As WA-FR-001 explained, 'how doctors speak to patients who have got legitimate […] worries' is crucial, and this sense of legitimacy includes women being able to access treatment to which they are entitled.

This framing of pain as something which must be named was described by several other participants, but in a different sense, as a naming which offered the opportunity to claim experiences of sexual pain and be released from the potential shame of them. This appropriation of pain experiences, and the reclaiming of the figurative space where the pain was felt, and the 'space' her 'body inhabits' was meaningful for WA-FR-004, who expressed how taking control of the narrative of her pain had been an explicit form of resistance to other narratives about it which were reductionist, dismissive, or, at best, unhelpful. She spoke powerfully about how she had sought to take control of the narrative of her sexual pain, by talking about it openly on a national French media platform, by creating online resources to 'inform' and 'guide' others who experience sexual pain, and to provide information for others about which healthcare professionals have the right to physically examine patients after her own experience of assault by a healthcare professional. She described this process as follows:

> 'When I decided to share it publicly, obviously everyone knew all about it, basically about the whole thing, and I said to them, 'just watch the report, it's really well made, it'll help you understand what's going on etc.' […] 'you know, it's just a taboo […] I'm like a spokesperson […] I wanted to get the message across 'yeah, I'm vaginique, and?'

WA-FR-004 called her pain 'Big Vaginismus himself', explaining that 'it's bordering on [vaginismus] being a friend', who she 'almost thanks' for how the experience of pain has changed her life and her understanding of herself. This personification of the pain, and WA-FR-004's use of the word 'vaginique' an adjective specific to the French-language interviews, meaning 'a person who has vaginismus', is particularly striking as a way of incorporating the pain into her conceptualisation of herself, and there is also a suggestion that this can be a liberating name, something to express to others irrespective of their potential reactions. This is very much in contrast with the way WA-FR-007 described initially being unsure of the pain's origin, and how her 'way of handling it was not thinking about it, not talking about it'. Now, she explained, she talks about it 'much more' with the people around her, and with the doctors she sees, which has meant that 'bit by bit' she has 'managed to reappropriate it'. This speaks to both Foucauldian ideas about resistance to the restrictions of biopower, and to intersectional concerns affecting WA-FR-004 and WA-FR-007's healthcare status, gender, and location. In intersectional terms, healthcare status, or rather lack of state-recognised healthcare status, clearly traverses the gendered element of these experiences, as a problem experienced only by women and people with vaginas and vulvas. Location was also described as significant, in the possibilities noted between those women able to access care where healthcare practitioners were sympathetic and knowledgeable, and those unable to access appropriate care to legitimise their experiences. Naming the pain, with or without healthcare professional assistance, has almost been an act of defiance – whereas previously legitimising actions were difficult or impossible for these women, naming them and sharing has led to reappropriation, in a Foucauldian act of resistance 'to counter the grips of power with the claims of bodies, pleasures, and knowledges, in their multiplicity and their possibility' (Foucault, 1998, p. 157).

WA-FR-006, in a continuation of the positive potential of naming, emphasised the 'certain feeling of shame' she felt when first experiencing her pain as a young woman, and how 'being able to give the illness a name, and potentially a cause, really helped [her] a great deal in coming to terms with it'. Though WA-FR-004 and WA-FR-006 were certainly involved in the complex power dynamics of sexual pain experiences, the naming of the pain was a defiant and potentially liberating event. In both statements, the pain has been claimed, and there is a feeling that putting this pain into language and being able to explain it was a significant step in the process of accepting the pain or seeking treatment. Being able to speak openly and in appropriate language about having pain which makes engaging in penetrative sexual intercourse difficult could be a helpful experience for several participants interviewed, and it could also facilitate the open and unequivocal presentation of this issue to others, without their acceptance of the issue being essential. Though in these statements, as in the quotes from the interviews with WA-FR-009 and WA-FR-007, the interlocutor or potential interlocutor is unspecified, the tone is very different. Though there may be multiple marginalising factors and challenges in accessing healthcare for WA-FR-004 and WA-FR-006, including their gender and location, their place in the fluid power dynamics of sexual pain experiences is one of potential power. They are open about how naming the pain helped to remove shame and come to terms with it, and they are also clear about what they will dare to do. Though the challenges in naming the issue may have been significant, this reappropriation can be seen as potentially liberating.

The importance of education was also underlined repeatedly by the French women interviewed, who emphasised that finding the right vocabulary for their pain and articulating it in a way which cohered with health insurance nomenclature was crucial, but also required the healthcare professional they were consulting to listen to them, and to be able to name and articulate the issue themself. Participants explained the importance of healthcare professional education so that even when sexual pain was not their main interest, they would be able to signpost to an alternative appropriate service, as well as recognising sexual pain issues in consultations. WA-FR-001 explained that online support between women through internet fora prior to accessing healthcare could help with effectively articulating issues, as well as ensuring that the healthcare professional chosen was educated in matters or able to signpost appropriately. ‘Put simply, [women] don’t dare to speak about it’ she clarified, and when they speak to a ‘doctor about it’, they are given ‘the wrong information, because it doesn’t fall within the interests of the people signposting the patients’. This serious lack of knowledge, which WA-FR-003 described as ‘an ignorance problem’ rather than a ‘gender problem’ related to her femaleness, went as far as women explaining to healthcare professionals what their problems were, as they had never heard of them. WA-FR-008 consulted a GP who did not know what vestibulodynia was, and when she needed a prescription for her physiotherapist, her GP thought she had a problem with her ear. She said that originally this had ‘made her laugh’ but it was ‘worrying at the same time’. This evokes intersections not only of access to healthcare due to location, gender, and socio-economic status where patients are paying to access these services, but also healthcare status – a woman experiencing healthcare problems alongside her sexual pain may not be able to access helpful internet fora, and she may be even less likely to attend repeated appointments until appropriate care is found. Foucauldian ideas about ‘the counterattack against the [normalising] deployment of sexuality’ through ‘bodies and pleasures’ (Foucault, 1998, p. 157) are nowhere to be seen here – these participant statements reveal an awareness of how sexuality is an object of power and state structures, but refocusing on ‘bodies and pleasures’ is not a primary concern when women are faced with ‘ignorance’ (WA-FR-003) ‘worrying’ misunderstandings of nomenclature (WA-FR-008), and receiving misleading information about sexual pain issues because of the personal interests of clinicians (WA-FR-001).

WA-FR-007 detailed the ‘pretty stigmatising’ experience of speaking about her pain with partners, and her explanation that if ‘you’re going to start talking about [the pain]’, ‘that entails answering more questions’ was echoed by other participants describing their conversations with both partners and healthcare professionals. This hesitation, combined with the difficulties of encountering healthcare professionals who are unaware of sexual pain problems or the availability of treatments of them, was a significant potential barrier for these women. In addition to lack of information and education in France which gives women no ‘idea of how their bodies work’, and a feeling of the pain being a fearful ‘unknown’ (WA-FR-004), the feelings of having to share extra details of their lives and of speaking about a potentially stigmatising problem (WA-FR-007) were compounded by several of the women interviewed consulting healthcare professionals who had no idea what the problems were. Though WA-FR-003 described this as an ‘ignorance problem’ rather than a problem related to her gender, healthcare professionals being ignorant about these problems which largely affect women speaks of a structural and educational barrier, both for women who experience sexual pain in France, and healthcare professionals who encounter it. This echoes Foucault’s statement in ‘The History of Sexuality’ (Foucault, 1998, p. 147) that:

> ‘Broadly speaking, at the juncture of the “body” and the “population,” sex became a crucial target of a power organi[s]ed around the management of life rather than the menace of death’.

In this way, considering the development of sexuality as a concept, it does not have an inherent power of its own to stigmatise – rather it has become the ‘crucial target of a power’ which is organised to manage and control. Understood in this way, it is hardly surprising that the process of bringing sexuality, and sexual pain, into discourse, feels so very stigmatising. If the way that life is managed by structures particularly targets sex, while at the same time underappreciating the prevalence and effect of women’s sexual pain, and underequipping women to understand their own bodies, the way that sexuality and knowledge about sex are controlled has a direct and profound effect on how women with sexual pain in France experience their bodies. Alongside educational background, healthcare status, and gender, this discursive bind adds complications to what can already be a traumatic experience for women affected by sexual pain in France.

In interviews where negative experiences were evoked repeatedly, it was perhaps surprising to hear of the potentially liberating nature of speaking about sexual pain. This reappropriation through naming and through understanding the meanings of pain was nevertheless accomplished by several of the French women interviewed with an acute awareness of their position within power structures, and a firmly held commitment to ensuring that other women experiencing similar pain were not subject to similar difficulties. These interviews reveal that without a clear diagnosis for sexual pain in France, it is not only difficult to receive appropriate treatment and for women to feel like pain was not just “in their heads” (WA-FR-007) despite the potential availability of treatments and adequate care, but also difficult to access signposting to appropriate diagnostic services and to understand which healthcare practitioners were knowledgeable and able to articulate the issue themselves. These interviews reveal a complex and disjointed series of healthcare encounters, and the way that structural power over discourse and knowledge shape individual experiences. They also underline potential and actual marginalising factors which affect women’s experiences, including, but not limited to, their gender, healthcare status, location, and socio-economic status. As the next section examining the data from interviews with English women will reveal, these intersecting marginalising factors were not limited to women’s experiences of sexual pain in France.

4.2: Naming and Creating Meaning – English women

The idea of expressing sexual pain experiences in the appropriate register and tone, and using the correct terminology, so that others, especially healthcare providers, might listen to their issue was also expressed by several of the women interviewed in England. This attests to the significance of sexual pain nomenclature in treatment accessibility and options for women affected by the pain. There was a particular emphasis on creating a narrative of the pain which made sense and was easily conveyed to others in participant descriptions of sexual pain, as WA-EN-009 explained:

> 'it was just quite…difficult to really understand and to define it, and to really kind of, in a way, put in into…literal words, in terms of putting it into a diagnosis, but also just kind of not really knowing…how to…explain it in a way that helped me get the treatment as quickly as I could, if that makes sense, that, I had to kind of, umm, explain it to lots of different people, and to kind of try and make sense of it myself, before anyone else could help me make sense of it'.

This was echoed in the interview data from WA-EN-002, who questioned the fact that women must often repeatedly consult medical professionals for sexual pain, instead explicitly placing the onus on healthcare professionals to listen to what women are saying:

> 'like who wants to keep going back to the doctor, again and again and again, for the, for that issue? No-one wants to do that…So, I dunno, it's just really hard. I just think it's like if someone is coming to you, telling you that they've got this pain, I think it's just, you know, telling health professionals that, you know, listen to them because no-one wants to go to the doctor…to tell them that their vagina is hurting [Participant laughs].'

Evoking Foucault's conceptualisation of the way that sex became a discursive object (1976, p. 29), and part of the relationship between 'state and individual' (1976, p. 37), the dynamic between patient and healthcare professional in consultations for sexual pain is clear in the preceding excerpts. The notion that the 'truth is not, by nature, free […], rather its production is wholly permeated by relations of power' (1976, p. 80) is clear here. The way that women expressed their truth about pain reflects this, in the fact that both WA-EN-002 and WA-EN-009 spoke of knowing how to describe this pain to 'get the treatment as quickly' as possible. This demonstrates the need to present a coherent narrative in treatment-seeking, and the lack of freedom in these participants truth about their pain, which was 'permeated by relations of power' (Foucault, 1976, p. 80). This is not only problematic in the onus placed on these participants to have the knowledge, and language, to explain what was happening, and the time and energy to explain this to 'lots of different people' (WA-EN-009), but also in the need to be 'going back to the doctor, again and again and again, for the, for that issue' (WA-EN-002). Put simply, this demonstrates the necessity of women being able to articulate their issue, and to repeatedly explain a potentially sensitive issue that 'no-one wants to go to the doctor' for (WA-EN-002).

Several participants in this group had not consulted a healthcare professional for their pain, demonstrating how perceptions of women's sexual pain may also contribute to seeking care for the issue. Despite the relative frequency of women's sexual pain, this reveals the additional challenge in healthcare status linked to gender, with WA-EN-007 affirming that she had never thought to consult a healthcare professional about her pain because the pain was not 'serious enough to go':

> 'I don't think it's anything to be ashamed about or embarrassed about, but I know that some women might be, umm, I just don't think it's recognised. By health professionals. Umm, to maybe be a condition, or to be a problem, it's, you know, if you have pain, then…that's just another part of having to deal with…you know like period pain or something, it's just another part and parcel of having to deal with **female** pain. Umm, yeah, I definitely think it's washed over'.

Not only, then, is this a question of articulating the truth about the pain in a way that functions within healthcare power dynamics, of having the ability and energy to repeat this to different people, whether this is seen as a shameful or private issue or not, but also, as WA-EN-007 explains, it is a part of '**female** pain', and so explicitly linked to gender. In sexuality's quality as an 'especially dense transfer point for relations of power' (Foucault, 1998, p. 103), the categorising of women's sexual pain as 'part and parcel of **female** pain' reveals that the way the pain is conceptualised directly affecting how serious this pain is thought to be by women experiencing it. It also evokes the way that healthcare professionals are seen not to recognise this type of pain, and how it is 'washed over' rather than named explicitly in patient healthcare interactions. This again demonstrates the importance of healthcare professional attitudes in women's experiences of sexual pain, and the importance of pain being named correctly, if it is named at all. WA-EN-007's quote reveals the difficulty of the element of gender in her experiences of sexual pain, but also its links to factors such as socio-economic status as well as location and healthcare status in the previous quotes from WA-EN-002 and WA-EN-009 regarding repeated healthcare consultations. For women who do decide that the pain is serious enough to consult a healthcare professional, repeated trips may not be possible for numerous reasons, and what is more, creating an advantageous narrative of the pain is often reliant on having the time, language, and ability to put the pain 'into…literal words' which will allow access to quick and appropriate treatment (WA-EN-009).

The idea of finding a narrative to express sexual pain could, however, be appropriated in a powerful and validating way, as described by WA-EN-010. She spoke about how sexual pain affects how she feels about herself, stating that 'it's sort of…it's one of the factors that kind of forecloses a lot of the interactions I have with other people'. She had, however, come out as queer, and said that she hoped that:

> 'within that I can find a space [Participant's voice trembles] for myself. [Pauses at length] Umm, I'm not confident, but it seems the most hopeful I've been for a while. And then there's part of me that's like maybe, maybe I have sexual pain ʾcause I've been having sex with the wrong gender? You know, that's possible. Let's see.'

This echoes her positive and moving description about how reading a piece of fan fiction which related to her experiences, in which:

> 'a similar sort of sensitivity was described [Interviewer: OK]. Umm, I'd never, I'd **no** idea other people felt this. I'd **no** idea. That it was a legitimate thing to say […] It blew my mind! And that was…that was beautiful. That was lovely, it made me feel less alone.'

Hellekson and Busse (2014, p.75) state that from 'its very beginnings, media fan fiction has been a female, if not feminist undertaking', and describe it as 'a theoretical apparatus', suggesting that:

> '[a]nyone who has ever fantasi[s]ed about an alternate ending to a favo[u]rite book or imagined the back story of a minor character in a favo[u]rite film has engaged in creating a form of fan fiction. Anyone who has ever recommended a YouTube mash-up, shared a cat macro, or reposted a GIF set has participated in the online culture of audience-generated texts.'

Put simply, this can mean creating a story which is based in an existing fictional world or with existing fictional characters. WA-EN-010's description of coming out as queer and hoping to 'find a space' within this for herself does not negate the difficulty and overarching problems that sexual pain has caused her in foreclosing 'a lot of the interactions' that she has 'with other people', but this movement may forge a new potential space for the interactions to exist. She had already, at the time of interview, found a legitimising space within the fan fiction that she was sent, and the 'beautiful' realisation that it was not only her who felt a particular way. This regaining of knowledge, alongside the potential she speaks of in coming out as queer, is immensely powerful. Though the difficulties in her experience do not disappear, Foucault's statement that power is not 'an institution' or a 'structure', or a 'certain strength we are endowed with', but rather a 'name that one attributes to a complex strategical situation in a particular society' (Foucault, 1998, p. 92) is recalled. Though Foucault suggests power might not be a 'certain strength that we are endowed with', WA-EN-010's questioning and renegotiation of her situation certainly reveals a personal strength despite complex structural inequalities in her healthcare opportunities and access for this gendered issue.

Conversely, there were many discussions through the interviews with English women about feelings of silencing, or being silenced, evoking complex intertwined discursive and structural dynamics. Speaking of how she felt her pain issues would have been taken more seriously if she were a man, WA-EN-001 said 'it affects your confidence, and [participant inhales] it's just, you just kind of like want to [participant raises voice] scream and you can't…talk'. This idea was expanded upon by WA-EN-003, who, in discussing female sexual dysfunction as a term, said that she 'object[s] to the word dysfunction full stop', as there are 'a lot of issues' for her, 'generally, within the medical profession, around problematising female bodies, problematising…umm, [pauses] things without necessarily remedying them as well', and that she finds 'the idea that there is this dysfunction' 'quite discursive'. WA-EN-008 explained that she had only spoken to one other person about the pain prior to the interview, and that this was because she does not 'talk about that kind of thing anyway', but also because she thinks she would feel 'a bit [long pause] stupid for bringing it up', as it was related to her experiences of childbirth and 'people don't really want to hear it, that kind of thing…[…] when you tell them about having a baby'. Foucault (1998, p. 100) argues that we:

> 'must not imagine a world of discourse divided between accepted discourse and excluded discourse, or between the dominant discourse and the dominated one; but as a multiplicity of discursive elements that can come into play in various strategies.'

Silencing, then, is not being forced upon women in a uniform way, by dominant discourses of sexuality and healthcare, versus their own dominated discourses of sexual pain. Rather this silencing is driven by the strategies which allow healthcare and insurance structures to maintain the status of women's sexual pain as both common and misunderstood using a 'multiplicity of discursive elements' to create a situation in which silencing of the issues is possible. WA-EN-003's evocation of the problematisation of female bodies within these structures also rhymes with intersectionality’s concern with the ‘social injustices’ that characterise ‘complex social inequalities’ (Hill Collins, 2015, p. 17) by naming the way that this problematisation, which operates discursively, contributes to lived experiences of social injustices, especially those related to healthcare access and opportunities, socio-economic position, and gender.

These feelings of silencing were contrasted with the statements of several other participants, who had found speaking about their pain to be a helpful process, and in some cases to be revelatory of how many other women are experiencing the same thing. WA-EN-009 reflected on her participation in the current study, having previously mentioned her pain to only a few people, explaining that it had ‘proven to [her that she] can talk about it, and not…feel like a freak’ even though ‘to actually put it into words is quite…complicated’. WA-EN-002 addressed the fact that she felt more research should be done in this area, suggesting that many of her female friends and family who had had pain problems without resolution were ‘walking around in pain all the time’.

WA-EN-006, in contrast with many of the other women interviewed, said that in ‘terms of sexual partners, again, funnily enough everyone’s been really nice’, and that in terms of reactions, ‘thankfully everyone’s been really lovely that [she has] spoken to about it’. She described how ‘everyone’s been really supportive’, and though it has been ‘kind of hard for some people to make sense of it’, she uses analogies such as ‘having something try and come into your eye, and then you immediately shut it, like a reflex’ to explain ‘how painful, or how automatic that reaction might have been’. Feelings of silencing, then, and of sexual pain being a subject that ‘people don’t want to hear’ about (WA-EN-008), as well as the discursive nature of classifying women’s experiences ‘without necessarily remedying them’ (WA-EN-003), were challenging for several of the participants interviewed. Nevertheless, speaking about it in a reflective way despite the ‘complicated’ nature of verbalising sexual pain experiences (WA-EN-009) could be seen as a positive act despite the worries of feeling ‘stupid’ (WA-EN-008) or ‘like a freak’ (WA-EN-009) when doing so. This demonstrates the individual nature of naming and making meaning from sexual pain experiences, with WA-EN-006 having found analogies particularly helpful in helping others to make sense of her pain.

This further shows the importance of naming, and of doing so in a way that is consistent with women's individual conceptualisations of the problem.

In summary, naming was a key concept for the women interviewed in England, who revealed an awareness of the power of discourse in their sexual pain experiences, and an understanding that representing their sexual pain to others in particular ways could yield different results. There was also an awareness that sexual pain could lead to feelings of silencing, and claims to take up figurative space with their own narratives, and to attend to the idea that this type of uniquely female pain is distinct in its qualities as both related to sexual activity and feelings of belonging to a particular gender. There were striking similarities in the accounts of the French women interviewed and the English women interviewed in terms of naming of the issue, particularly in the idea that there are multiple layers of discourse affecting sexual pain experiences, including healthcare discourse, and the legitimising potential of making sense of the pain. The complicated nature of putting these issues into words (WA-EN-009) was evoked by women in both France and England, despite there being a greater focus in the interviews with French women on education for healthcare practitioners and the importance of knowledge sharing as both a form of protection and an avenue to seek effective sexual pain treatments. Individual demographic characteristics such as cultural background and socio-economic status did not figure prominently in the interviews conducted with women in England, and yet they reveal a recognition of the complexities of experiencing this pain within state healthcare and insurance structures, and the importance of understanding the potential power of naming and discourse in improving sexual pain problems for individual women despite its under-recognised and contested status in healthcare structures.

4.3: Naming and Creating Meaning – French Healthcare Professionals

In France, the healthcare system combines both public and private elements, and patients must therefore consider healthcare payment procedures for their care and potential reimbursement of their treatment when making pain management choices. The nomenclature used by healthcare professionals in referrals in France can therefore have profound effects, with different treatments and consultations for related but separate pain issues being paid for and reimbursed by insurance providers in distinct ways. The use by multidisciplinary teams of one term over another, or the naming of a sexual pain issue by a healthcare referrer in a way which is reimbursed partly or not at all, can have long-lasting consequences for the women affected by the pain. As HP-FR-004 states:

> 'In my opinion, multidisciplinary provision is always more difficult […] you really have to see if it fits the nomenclature […] That's the question'.

In response to a follow-up question about what exactly was more difficult, HP-FR-004 underlined that the nomenclature used in multidisciplinary meetings did not always match the nomenclature used by insurance companies, potentially creating referral or reimbursement barriers for patients affected by sexual pain in France:

> 'people are not reimbursed [by insurance providers] amongst themselves in the same way, it's not the…it's not the same pricing system. To see a physio, it really needs to be a doctor who decides [to refer the patient], and, if the doctor isn't specialised, he's going to refer on to someone else, or what if he prefers just to deal with it himself'.

So in this case, while multidisciplinary approaches and specialist referrals can be beneficial for patients in supporting them with an individualised approach to their problem and their treatment, the referral and treatment process can be complicated for women using it, and 'multidisciplinary provision is always more difficult' according for HP-FR-004, even without factoring in the personal preferences of healthcare providers. Naming and the meaning given to pain by healthcare providers, then, can be a significant factor in the financial experience of sexual pain issues, and this can be reliant on many factors, including the knowledge of the healthcare professional consulted, individual members of multidisciplinary teams, and shared understandings of what certain terms or names for sexual pain issues mean. This underlines the importance of women who experience pain being able to articulate their pain in a certain way which is shaped to navigate the needs of the healthcare system that they are consulting, and the considerable effects of differences in understanding between healthcare professionals. These complications are potentially experienced alongside intersections of socio-economic status, ability to pay up front for certain treatments, sexual pain as a gendered problem, and access to healthcare services as well as the location of women who are affected by this pain. The way that problems are named directly influences the experience of sexual pain as a gendered problem, and women from diverse backgrounds and with differing access to care and knowledge of care systems will not experience the pain in the same way.

Naming the issue in the first place, then, is important. HP-FR-002 expresses further difficulty for women who experience sexual pain who may want to attend to their mental health as part of their treatment for sexual issues. Evoking women's choice of professional based on the professional's named specialities, HP-FR-002 stated that '[a]ccess to mental healthcare is not as simple as that', using the example of going to see a psychiatrist. This can be reimbursed in the French health insurance system, but this is dependent on 'which psychiatrist' is consulted. So, *in the French healthcare system, names matter.* For women to be able to access treatment, they must be able to articulate their issue, and find a service and professional which meets their needs and which they are able to navigate. Where specialist, or free-of-charge, accessible services do exist, they must be appropriate, and professionals involved in treatment must know how to facilitate access to treatment on an extended basis. In terms of power dynamics, women experiencing sexual pain with difficulties accessing treatments can be disadvantaged by state structures which 'differentiate' people who have 'means' and those who do not (HP-FR-002), and this may contribute to complex power dynamics, navigating the naming of their issue and the consequences that this has. In terms of gender equality, these problems which are specific to women have the potential to marginalise women permanently and on many levels. This shows the specific case of the French healthcare system, in that in terms of access to healthcare, there are not only barriers of knowledge and of healthcare professionals referring patients in a way which is reimbursed by the healthcare insurance system, but also a challenge in accessing the very healthcare professionals needed in terms of whether their services will be reimbursed or not. This means that treatment choices may be based not on clinical need or usefulness for women, but on ability to pay for the treatments, even if these are later reimbursed where the nomenclature used facilitates this. In terms of access to care for sexual pain, which can be a debilitating long-term issue, this points to the way in which socio-economic status and gender intersect, and also how other demographic factors such as location and prior health status might contribute to experiences of illness and access to care and support.

One way in which this challenge of naming can be mitigated, as explained by HP-FR-002, is through naming women's personal histories alongside them in the clinical setting, meaning learning 'the **story**' of their journey, especially when this has involved complex migration histories, as seen in the detailed discussion of women's sexual pain in the 'Abjection' chapter which follows. The focus on naming the issues around sexual pain with women, and learning about women's own narratives of their pain, was echoed by several of the other healthcare professionals interviewed. HP-FR-001 stated that in her sexological and psychological work, finding out how patients 'live in their body in general' is significant, and can help them to work out their 'relationship to their pain'. She also asks patients if they like their body, which is helpful in establishing their own attitudes towards their sexual pain, as is asking about patients' 'upbringing, their culture, what was forbidden [when they were young]' and their sexual history. This history-taking and discussion, explained HP-FR-002, involves therapists reflecting on their own work and themselves so that they can listen actively, but it also means 'time, first and foremost', which evokes the potential difficulties for women whose socio-economic, caring, or employment status prevents repeated consultations with healthcare professionals, a challenge related to intersecting factors which was openly recognised by HP-FR-002.

HP-FR-002 also emphasised that sexology appointments were not reimbursed by the French healthcare insurance system at the time of the interview, meaning that sometimes patients could only afford one appointment though many are needed to make progress, as 'you never get to the bottom of it in just one session, you only get there with follow-up appointments, providing that women can access these consultations easily'. This is not just a clear barrier to access for women without the means to pay for repeat consultations, but also creates financial conditions for women who may need support to be able to discuss their 'relationship to their pain' and their body, and the naming and meaning-making for their personal histories. As HP-FR-001 stated, there is a 'totally varied' effect of pain on women who are experiencing it, emphasising the importance of listening to the meaning of the pain for each individual woman. This fact, understood within the frame of a healthcare system which has both public and private elements which 'differentiates people who don't have the means from those who do' (HP-FR-002), and where access to potentially helpful treatment depends on financial means and ability to access repeated consultations, shows that meaning-making and history-taking are not always a priority given the many practical implications of experiencing severe pain.

These care practices, though, combined with reflexive practices from healthcare professionals, can make a notable positive difference to women affected by pain according to HP-FR-001 and HP-FR-002. Foucault (1976, p. 61) explains the way that the sexual body has become an extension of control, as well as the means by which power moves into affective feeling and appreciates pleasure. This theory is far from HP-FR-001 and HP-FR-002's focus, however, and the universal idea that sexual bodies react and feel through power dynamics is replaced by a more concrete emphasis on whether women can attend to pain and its 'totally varied' individual effects with disparities in access and availability to attend appointments. Though HP-FR-001 and HP-FR-002 did not explicitly mention intersectionality in their interviews, they both spoke about the way that socio-economic and cultural barriers can stop women accessing available care and the necessity of women being aware of their available care options. Though these participants are aware of the effects of multiple dimensions of power on the women and couples that they work with, they are also aware of the way that this power can be varied for different women, and their theory is less about sexuality and feelings as concepts, but how to help women in their concrete experiences of pain and marginalisation.

In an extension of this, HP-FR-002 spoke about how she feels completely ‘engaged, invested’ in sexual health work, but ‘also probably more so because [she is] a woman’, and how it is unthinkable for her that ‘a woman could be in pain and that no-one recognises that pain’. Foucault describes the ‘plurality of resistances’ (1998, p. 95) in complex power relations, recalling that ‘there has never existed one type of stable subjugation’ (1998, p. 97) which these resistances modify or work against, which connects with HP-FR-002’s statement in her activism and engagement to address the power imbalances leading to experiences of pain which is not attended to appropriately. The way that HP-FR-002 described her healthcare practice as ‘activism’, and as a ‘battlefield’ reaffirms the idea of knowledge about sexuality as harbouring the possibility for ‘resistances’ against different, changeable forms of subjugation. What is most important for her is ‘fighting for education about sexuality’, which is ‘positive’ from the ‘youngest of ages’, which includes working with ‘all guns blazing’ to try and engage patients so that they are ‘able to work with their pain’. She described her work to promote ‘sex education for all ages’ as her ‘battlefield’, because ‘speaking about pleasure really isn’t that simple’, and the process of naming and making meaning from pain as well as different forms of pleasure can be complicated. Describing this investment, and activism within her sexological work to enable women to ‘work with their pain’ and to ‘speak about pleasure’, HP-FR-002’s statements cohere with Foucault’s aforementioned writing on the possibilities of the construct of sexuality as a construct operating a:

> ‘tactical reversal of the various mechanisms of sexuality – to counter the grips of power with the claims of bodies, pleasures, and knowledges, in their multiplicity and their possibility of resistance. The rallying point for the counterattack against the deployment of sexuality ought not to be sex-desire, but bodies and pleasures’ (1998, p. 157).

It is not clear whether HP-FR-002 was familiar with the theoretical work of Foucault, but the above statements demonstrate personal dedication, especially in her identification as a woman, to recognise the shifting power dynamics and structural challenges which can impede women who experience sexual pain being able to 'work with their pain' and speak about pleasure. The 'tactical reversal' Foucault evokes is enacted clearly here – in the 'activism' of sexological practice. This practice recognises the difficulties and power imbalances that women who experience sexual pain may encounter and how helping women be able to 'work with their pain' is itself a form of activism. It could be argued, in intersectional terms, that the approach taken by HP-FR-002 is not simply a tool looking into into the causes of pain and the multiple difficulties women affected by pain may face alongside their pain experience, but in fact an example of practitioner commitment to social justice and to acknowledge how intersectional factors affect access and use of healthcare. This entails the ability to engage women to work with their pain, and also to work with the challenges that accessing this therapeutic engagement brings.

This committed approach was echoed by HP-FR-003, who spoke of the gratification of working in women's physiotherapy as a speciality, and how it makes her happier than 'you [could ever] imagine' when women's pain lessens or disappears following their work together. She says that often in her specialist work she sees a 'quick improvement' with patients, and that 'it's so nice to get' messages from patients who have had pleasurable sexual encounters after their treatments, have embarked on a new relationship, or have conceived a child, which is discussed regularly by patients as a motive for consulting a professional about their pain. A large part of HP-FR-003's work includes managing a combination of other elements in her treatment room alongside the muscular issues important in women's physiotherapy, and though it is not referenced as explicitly as HP-FR-002, HP-FR-003 spoke of how she personally reads widely around the issues in her work to ensure that what she is saying to patients is 'positive' and current, acknowledging that a huge part of her role is explaining to women how their bodies work and reiterating her own commitment to staying informed and up-to-date in her knowledge about this. A lot of patients, HP-FR-003 stated, 'do not **know** about their own pelvic floor', echoing several of the other participants interviewed in noting women's frequent lack of knowledge about parts of their own anatomy. HP-FR-003 spoke about how she shares the knowledge that she has, and recognises the individual worries of patients, stating that in many cases of consultation with patients with pelvic floor issues, she begins the consultation by simply telling patients ‘how it works’, as often patients are unaware. Foucault wrote that between ‘techniques of knowledge and strategies of power, there is no exteriority, even if they have specific roles and are linked together on the basis of their difference’ (1998, p. 98), and in this way HP-FR-003’s commitment to naming women’s anatomy, framing this naming appropriately, and sharing knowledge with patients may also be seen as a form of resistance, one which recognises that knowledge changes, and one which recognises her own role and feelings about her part in the process.

The significance of the narrative and discursive elements were just as notable in the interviews with French healthcare professionals as they were in the interviews with the French and English women interviewed. There was a focus in the interviews with French healthcare professionals on the importance of listening to how women conceptualise and name their own sexual pain, and how they understand it as a part of their lives. The nomenclature of sexual pain, as well as difficulties in accessing care and choosing treatment options based on nomenclature-related health insurance challenges were perhaps evoked most explicitly in this group of participants. Though several of the women interviewed in England and France were active in their commitment to share knowledge and experiences, the activism in the French healthcare professionals was clear, and connected to a commitment to recognise intersecting factors affecting women experiencing sexual pain. Foucauldian ideas about the possibilities of pleasure were evoked strongly by HP-FR-002 in her description of the difficulties of speaking about pleasure, and perhaps most strikingly in this group of participants, women’s personal narratives were prioritised in describing clinical work with women experiencing sexual pain, alongside a concrete commitment to recognising how sexual pain experiences and healthcare experiences can differ for women who have the ‘means’ and opportunities to access care and those who do not (HP-FR-002).

4.4: Naming and Creating Meaning – English Healthcare Professionals

HP-EN-002 explained that women's sexual pain can be very 'difficult to work with' and is often 'very resistant to treatment', and HP-EN-003 went further than this, depicting her feelings of 'a bit of a heart-sink' when working with patients who have 'been round every health professional […] known to man' without resolution of their problem, and for whom referral to outside services will likely be necessary. Narratives of the difficulty of sexual pain were striking in these interviews about healthcare work with individual women with sexual pain, as was the evocation of 'heart-sink' feelings when describing this work. 'Heart-sink' patients are described by Kjaer, Stolberg and Coles (2015) as patient cases which are 'problematic' (p. 235), 'complex cases' which doctors can '[dread] seeing' (p. 236), which can cause annoyance for doctors (p. 237) and which were also connected to feelings of 'uncertainty' among health professionals (p. 234). Though these healthcare professionals are openly discussing their negative feelings regarding patients for whom no easy solution is available, and who may be experiencing multiple problems simultaneously, the idea of there being a 'heart-sink' patient or type of patient case which is an 'annoyance' to healthcare professionals begs questions about what exactly is causing a 'heart-sink' reaction for healthcare professionals. In HP-EN-003's case, this was a frustration linked to having tried 'everything […] with a client', and it 'basically just not working'. She added that for many people who are referred to the service after having seen other health professionals without a solution, they will have been to 'a GP', for 'a gynaecology appointment', to 'other professionals' which is 'a lot' and takes 'quite a bit of time'. Though HP-EN-003 was describing a personal reaction to working with patients with complex issues, the naming and labelling of patients as 'heart-sink', with the connotations that this entails, is pronounced.

Kjaer, Stolberg and Coles (2015, p. 234) underline the importance of recognising that 'uncertainty' is part of 'people's needs', and that part of attending to 'heart-sink' reactions was recognising this uncertainty. This idea of there being 'heart-sink' patients not only questions how 'outcomes for patients' (NHS Constitution, Department for Health and Social Care, 2021) are affected when healthcare professionals are not 'supported' to manage the complexity or uncertainty of these cases within the existing healthcare system, but also what it might be like to be a heart-sink patient. As noted by Hankivsky and Christoffersen (2008, p. 279), an ‘intersectional paradigm offers […] a theoretical perspective’ which charts ‘a path to rethinking understandings of the determinants of health’. ‘Without doubt’, they add, ‘this framework complicates everything’, ‘because this approach requires moving beyond singular categories of identity to the complexity of diverse influences that shape and affect lives’. In the previous quote from HP-EN-003, there is perhaps a recognition of the complexity of the lived experiences of sexual pain which are unresolved despite the time-consuming process of going ‘round every health professional […] known to man’, and yet, the determinants of health and diverse lifestyles and experiences of women who are affected by sexual pain are missing from this statement. HP-EN-003, in this case, was explaining her own feelings about the process and being unable to help certain women, but in the nomenclature of these patients, the ‘heart-sink,’ acknowledges few of the ‘diverse influences that shape and affect lives’ (Hankivsky and Christoffersen, 2008, p. 279), and may lead us to wonder whether these patients are told or are aware that they are ‘heart-sink’ patients, and what this attitude may do to their care experiences, as well as the meanings that this potential naming may have for them should they become aware of it.

Conversely, HP-EN-004 relayed that in his work with vaginismus treatments, he mostly sees ‘a good result’, and that with vaginismus, the ‘outcome can be very good’, making it a ‘good problem to treat’, explaining that working with women with sexual pain can be a positive experience. In each interview with the English healthcare professionals, participants spoke of the meaning made from their experiences of working with women who are affected by sexual pain, and how vocalising and naming their own reactions to this can be an important part of the process of their healthcare practice. HP-EN-002 underlined the ‘empathy’ she feels for people going through sexual pain experiences which can be ‘tragic’ when patients cannot do ‘something that everybody else seems able to do’. HP-EN-003 stated that generally she enjoys her work with women experiencing sexual pain as ‘you actually do tend to see improvement’. This discussion of positive outcomes did not, however, preclude HP-EN-004’s discussion of the ‘sadness’ from seeing relationship breakdowns 'directly attributable to vaginismus', and how 'luckily' clinical supervision can help to 'negotiate' 'that sadness', as he sees his work with women experiencing sexual pain as a 'privilege'. When 'complex surrounding issues are problematic' for women, this can be 'pretty sad' (HP-EN-004), and HP-EN-002 evoked how she feels for patients 'in terms of the level of mistrust about, of their bodies', describing how what 'touches' her 'most about people who experience sexual pain, particularly if it's a primary problem […] is the sense of despair they have felt. About it ever being, umm, sorted, or improved', adding that it is 'profoundly touching' to think about this despair and what a 'devastating thing to have experienced' it must be. The 'weight of meaninglessness, about which there is nothing insignificant' described in abjection theory by Kristeva (1982, p. 2) which may come from working with women with sexual pain for whom no help is immediately available is mitigated by a process of supervision, naming issues, and personal reflection which avoids a helpless 'reality' which, if acknowledged, 'annihilates' (Kristeva, 1982, p.2). There is no mention of 'heart-sink' patients here, rather descriptions of the joy of seeing 'improvement' for patients, clinical supervision and the 'empathy' felt for patients when they have experienced something so 'devastating'. The 'complex cases' (Kjaer, Stolberg and Coles, 2015, p. 236) which doctors may dread are spoken about in terms of the sadness when 'complex surrounding issues are problematic' for women, rather than for the healthcare professionals that they are consulting. The risk of the 'meaninglessness' of abjecting these women's experiences due to dread, the complexity of the cases, or frustration, is lessened through clinical supervision, and reflecting clinically is part of this process. Meaning-making is key to this process, and naming of the complexity of working with women affected by sexual pain, who are not conceptually separated from their patient 'cases' (Kjaer, Stolberg and Coles, 2015, p. 236), is one way that the healthcare professionals interviewed negotiated the complex structural dynamics of the healthcare system of which they form a part.

Foucault (1998, pp. 105-6) claims that sexuality is 'the name that can be given to a historical construct', to:

> 'a great surface network in which the stimulation of bodies, the intensification of pleasures, the incitement to discourse, the formation of special knowledges,

> the strengthening of controls and resistances, are linked to one another, in accordance with a few major strategies of knowledge and power'.

It is clear in the interview material taken from discussions with English healthcare practitioners that their work involves 'the formation of special knowledges' with regards to the 'historical construct' of sexuality. The 'strategies of knowledge and power' at play here may include the structure of the healthcare system, in this case the English NHS, and particular discourse such as the treatment 'algorithms' created and cited by WA-EN-004 for working with women affected by sexual pain. Therapy, he stated, is moving towards more algorithm-based treatments: 'if A, then B, and it just ain't that simple'. Psychosexual therapy, in his understanding, must be flexible rather than prescriptive, or treated from an 'algorithm', and should be decided 'depending on the need or the context' of each individual patient, rather than algorithms which 'fill all that human space between […] a therapist and the client' (HP-EN-004). The resistance to 'controls', and awareness of 'strategies of knowledge and power' is subtle here but is still present. This resistance moves practical work with women who are affected by sexual pain into the realm of the 'possible, the tolerable, the thinkable' (Kristeva, 1982, p. 1), away from algorithm-based, general protocols which are not tailored to individuals, into the 'formation' and sharing of knowledge which aims to be empowering, in this case empowering to patients to lead the sexual lives that they wish to. Though this does not explicitly acknowledge the possible intersecting marginalising factors and multiple power dynamics which take place in clinical encounters, resistance to a prescriptive, potentially narrow, view of sexual pain disorders could nonetheless be seen as a form of resistance to structural controls. HP-EN-004 claimed that working with sexual pain can be 'rewarding' as it can include 'a bit of individual empowerment' for women, which might include helping them to say 'no to a current partner, or no to penetrative sex when and as they don't want'.

In direct contradiction to HP-EN-004's feelings of being able to offer 'a bit of individual empowerment' as part of his work with sexual pain, he also questioned his therapeutic role in assisting women to engage in penetrative sex, and whether the 'overemphasis on penetration 'in conceptualising sexual intercourse might, in fact, be ‘disempowering of women’. The idea of what sex, or sexual activity, might be is complex, culturally specific, and highly contingent. This was recognised by several of the English healthcare professionals interviewed, including HP-EN-004, and several interviewees raised the narrative of sexual activity meaning or including acts of penetration. HP-EN-002 summarised this as follows:

> ‘there is still a sense of that “I’m not doing everything I should be doing”, or, and “what about my partner” particularly, that he, if it’s a he, needs more than [sexual activity without penetration], you know […] But it only becomes like that because of the, I think it’s the external narrative, umm, about “that’s what sex is”. So there’s undoubtedly this sense that unless you’re having penetration, umm, then you’re not doing it properly, it’s not proper sex […] I spose the minute you embark on a program that is designed to include penetration, then you’re kind of buying into that narrative really, aren’t you. Yes, we do it because that’s what the clients have come saying they want…they want, but it is colluding with that idea’.

HP-EN-002’s response to this tension was to propose that in ‘an ideal world’, concepts of sexual activity would be ‘broad’, and ‘process focused’, not ‘goal focused’, in therapeutic work, as part of a process of intimacy which ‘may or may not’ include penetration, except where conception was a goal, as penetrative sexual activity may have a different emphasis in this case. HP-EN-004 spoke about having a ‘beef’ with the ‘overwhelming, uhh, misconception, uhh, culturally, about sexual intercourse [which] means that it’s penetrative’, while HP-EN-001 described the strategies he employed as part of therapeutic work to help couples ‘sort of remove the pressure on sex, to actually become much more intimate first’. HP-EN-002 reiterated that ‘non penetrative sex can be ‘satisfactory and satisfying’ for women and their partners who engage in alternative sexual practices, and how it is possible for some women who do not attempt penetrative intercourse because it has been too painful to have ‘really pleasurable times with their partner’. Whether this is empowering or disempowering as a practice and as a discursive process within therapy for women experiencing sexual pain is negotiable, but the complex considerations of this therapeutic practice demonstrate the social pressures and stigma potentially attached to women’s experiences of sexual pain. These are not just linked to gender and may be linked to other determining factors such as cultural background, location, race, and marital or relationship status. Here the healthcare professionals are reflexive in their practice and recognise their own part in complex societal power dynamics. They also, crucially, recognise that their 'ideal world' (HP-EN-002) where concepts of sexual activity are broader is not the world many of their patients inhabit, and their role in working in a way that acknowledges this.

Patient consultations were not the only setting in which naming was a crucial process for the healthcare professionals interviewed in England. The referrals process in the service where the participants worked also reflected the importance of nomenclature, and of the meaning given by GPs to certain issues as part of this tailored referrals process. The nomenclature of sexual pain itself is intertwined with treatment options and referral pathways, potentially disadvantaging or complicating access for certain women, or groups of women, before referrals are even made. HP-EN-002 explained that her service has 'generated' tailored 'pre-referral guidelines' alongside 'internal policies' which include tests which referrers must do before referring for sexual pain disorders, 'to exclude any organic cause'. These were created with colleagues in 'gynae[cology] and urology', 'in response to a recognition' that an underlying 'organic cause' must be ruled out before or alongside referral. This idea of excluding specific causes before referrals are made recalls Hacking's notion that perhaps 'gigantic unsystematic "systems" of health and justice play an important part in channel[l]ing and organizing symptoms and their displays', with the 'functionaries and people with little pieces of authority within these systems' working on 'those whom they catch in order to train them to fit in with expectations' of the system (1995, p. 70), and the idea of organic causes, though potentially helpful in avoiding unnecessary referrals for women for whom management in primary care may be more appropriate, can be problematic in itself. HP-EN-002 described how some acute medical practitioners are 'baffled' when no 'organic cause' can be found for the pain (HP-EN-002), often referring patients too quickly to psychosexual services even when they have an 'established relationship with a client'. This is very much echoed in the data from the interviews with the other English healthcare professionals, who explained that even when clients attend the service with issues such as lichen sclerosus which can be uncomfortable and lifelong, women often hope there will be an organic cause to their issue, as it feels like ‘it would be more easily remedied’ (HP-EN-002). HP-EN-004 described how the idea of female sexual pain disorders covers a ‘huge range’ of sexual issues which may be syphoned off to other services incorrectly if missed or incorrectly diagnosed in other services, and how throughout this process, the conceptualisation and meaning given to the pain by multiple healthcare professionals can have profound consequences for individual women affected. Foucault explains that ‘sexual irregularity has been annexed to the realm of mental illness’ (1978, p. 50), and this is clear here – when sexual pain which does not fit into predictable systems of naming and referral is the issue for patients, it is directly referred to psychosexual services, even when there might be other causes present. This can be devastating for women, and it evidences the lack of knowledge and agreement in healthcare settings in England about the way that sexual pain disorders are understood.

HP-EN-004 spoke about how he personally considers sexual pain issues as ‘psychophysiological’ problems, and how concomitant multifactorial issues can be connected, with physical issues being ‘contributory or even causative of pain’. HP-EN-002 echoed this, suggesting that a multidisciplinary approach which encompasses the ‘layering of problems’ on many different levels for women can be beneficial. An open-minded approach to sexual pain seemed important to the healthcare professionals interviewed in England, with HP-EN-004 explaining that working in a multidisciplinary way which prioritises understanding the problem a client is bringing to the service can help to make the ‘psychological versus physical divide’ seen in some medical discourse ‘less of a divide and more of a unity’. He described how ‘careful questioning’ can help to establish where the pain is and whether it might be due to a combination of factors, but also how there is not ‘enough asking’ in routine services about ‘sexual problems’. HP-EN-004 also described his feelings about other healthcare professionals asking patients about sexual issues:

> ‘Umm, uhh, psychologists may be a bit more tuned in to in, general psychologists, in this day and age, they’re more attuned to, uhh, what’s the word…uhh,

> embodiment. […] Uhh, uhh, psychological distress, err, err, there's evidence of, uhh, uhh, physical problems. Umm, so they will pick up more I think, uhh, and enquire from us whether it's appropriate to refer, umm, whether they ask routinely is another question, but that's something I've had in mind all my working life in mental health services, do we ask about sexual problems routinely? Or, do generalists in mental health and medicine ask routinely about sexual problems, and the answer is no, they don't.'

In this excerpt, it is clear that the professional practice of HP-EN-004 involves a degree of understanding how fellow healthcare practitioners conceptualise and name sexual pain, in this case potentially as an embodied experience which can be linked to 'psychological distress' where there's evidence of 'physical problems'. Foucault evokes the 'formation of special knowledges' (1998, pp. 105-6) in the description of the 'historical construct' that is sexuality, and the way that these 'special knowledges' can be created as part of therapeutic relationships within the English healthcare service involves both understanding how to name issues and understanding how other practitioners name and use them. This also leads to a questioning of what happens to women who consult practitioners who do not understand or share these 'special knowledges' (Foucault, 1998, pp. 105-106) or who are not able to articulate or name the issue in a way which is understood by their colleagues in other services. If women are not able to access appropriate services with trained practitioners due to their socio-economic or healthcare status, their location, or the simple preference of the practitioner that they consult, the health and social care system fulfilling their rights to access and use appropriate healthcare is in doubt.

Several of the healthcare professionals interviewed in England explained how the DSM-V (American Psychiatric Association, 2013), the most current Diagnostic and Statistical Manual at the time of interviewing, provided diagnostic criteria from diagnostic naming of issues like vaginismus and dyspareunia, as well as GPPPD (American Psychiatric Association, 2013). HP-EN-004 explained that the DSM-V is 'American and profit-based', meaning 'no disorder, no money, no pain, no treatment', while the ICD (WHO, 2019) is 'worldwide' though sexual pain diagnosis is 'still a work in progress'. Despite the fact that the DSM-V is American, HP-EN-004 relayed that it is still the ‘main guide’ in diagnosis, with HP-EN-001 adding that further information about sexual pain issues is not widespread, with ‘little “pockets” of, of information’ available elsewhere, which were not always of a consistent quality. At the time of the interview, terms such as vaginismus and dyspareunia had been replaced in the DSM-V by ‘GPPPD’, which as HP-EN-001 explained, means ‘female genito-pelvic pain and penetration disorder’, and covered a ‘wide area’, and was an ‘umbrella term’ for many different pain experiences. The healthcare professionals interviewed were divided on the usefulness of this change, with HP-EN-004 stating that the change had not ‘seemed to make sense so far’. He said that although it had attended to the ‘false separation between some aspects of genital pain disorders’, the term ‘doesn’t trip off the tongue, and umm, so far, is not being used in common parlance amongst professionals’. HP-EN-002 reiterated this, explaining that clients do not speak about GPPPD in consultations, rather describing their pain in terms of vaginismus. She did, however, underline that the change in classification to GPPPD can be ‘useful shorthand’ for practitioners to say ‘we don’t actually know what this this is’ and to invite healthcare professional curiosity and further investigations for patients, even when ‘treatment response is very similar’ with different problems which may fit under the ‘umbrella term’. HP-EN-002 suggested that the previous system of naming was not always adequate for individual service users, but there has been a lack of nomenclature to describe these problems in another way, echoing Mitchell et al.’s (2017, p. 5) assertion that there is a ‘lack of consensus on aetiology [causation] and classification’ for sexual pain disorders. HP-EN-002 explained how reconceptualising sexual encounters with service users in her work included a potential focus on ‘pleasure and intimacy’, as well as an emphasis on ‘contact, the pleasure of contact’. Questions regarding the way that sexual pain is described, referred to, and categorised in the ‘main guide [DSM-V]’ do not seem to prioritise these questions. Given the difficulty of naming these issues, inconsistencies, and different views on classification systems used, even between healthcare professionals working in the same service, this lack of clear naming appears to be a significant factor in conceptualising women’s sexual pain for the English healthcare professionals interviewed. This can have a knock-on effect for women, as where healthcare practitioners cite a lack of nomenclature and descriptions, and definitions are not standardised, the language with which women communicate their pain can depend almost entirely on the context and dynamic within which they are expressing it, and the way that healthcare professionals respond to this within the remits of their own knowledge.

Speaking openly about how sexual pain disorders were named in day-to-day practice, HP-EN-004 evoked how, within the service where he worked, 'increasingly […] over the last two to three years, certainly', he and his colleague had 'noted between' themselves that they were seeing 'almost a **classic** combination':

> 'whatever the cause, umm, or contribution to, err, genital pain, we see this constellation of vaginismus, or dyspareunia, combined with IBS **and** anxiety, and depression, all four pertaining, err, in a single client quite often.'

This idea of there being a 'constellation' of issues which individual clients experience suggests that the problems may be linked, without a single focal point, to co-existing issues, reiterating the importance of considering sexual pain issues as perhaps more than one 'disorder' in their naming and meaning for the women affected. HP-EN-004 stated that one third of referrals into the service where he was interviewed are for sexual pain issues experienced by women. This leads us to wonder, then, whether the sexual pain seen in HP-EN-004's professional practice is perhaps often several issues which are potentially linked, all of which may have their own distinctive healthcare options. HP-EN-004 spoke about the 'service epidemic' in women with 'vaginismus or similar', adding that 'if it's just vaginismus, and everything else is OK, that's now rare', and this encompassed the fact that the service was increasingly seeing women with sexual pain who 'present with complex problems'. The idea of there being a 'service epidemic' of 'vaginismus or similar' which is 'connected to assaultive partners, childhood sexual abuse, adverse initial experiences', or 'silly things like horror stories from friends or aunties or uncles' about 'first sex' also reflects the demand for sexual pain services where WA-EN-004 worked, and the importance of considering the multifactorial nature of sexual pain issues and 'joined up working' (HP-EN-002) with other professionals. This is particularly striking given HP-EN-002's observation that, at the time of the interview, there was not 'systematic

NHS provision' of a 'service' as it was not 'considered to be an essential…service that exists in response to people experiencing sexual pain, or difficulty'. That there could be a 'service epidemic' noted in an existing service, without 'systematic NHS provision' of services for 'people experiencing sexual pain' in other locations raises questions about what happens to women who experience the 'combination' or 'constellation' of issues, 'vaginismus, or dyspareunia, combined with IBS **and** anxiety, and depression', when there is no provision available. The above descriptions from HP-EN-002 and HP-EN-004 also reveal that factors such as abuse, assault, and 'horror stories' about sex can contribute to the pain of vaginismus, and that for many women consulting services this must be considered, and 'joined up working' with other services must be facilitated where necessary. The way that pain is named then, especially if conceptualised as a potential 'constellation' of issues or complex set of problems, may typecast women but may also be a way to conceptualise the issue which facilitates access and 'joined up working' with other healthcare specialists for the benefit of patients.

Echoing the interviews with the healthcare professionals in France, the interviews with healthcare professionals in England revealed the importance of naming, diagnoses, and understanding what pain means to individual women who may be accessing their services. There was a much greater focus, however, on the way that formal diagnostic guides might shape patient interactions in the excerpts from the English healthcare professionals, and less of a focus on reaching underserved populations or women who might not be aware of their treatment options. Between the French and English healthcare professionals interviewed, an interesting focus on pleasure was noted, though HP-FR-002 underlined the difficulty in naming and speaking about pleasure, despite healthcare professionals in both countries aiming to share specific knowledge about naming and challenging rigid concepts of sexual activity which foreground penetrative intercourse. The pressure on women to articulate issues persuasively and in a way which fits with healthcare practitioner knowledge was evoked, and the common nature of sexual pain was clearly stated in the idea of there being a 'service epidemic' (HP-EN-004) in women's sexual pain at the time of the interviews. There was much less of a focus on potentially marginalising factors for women in the interviews with the healthcare professionals in England, and on the intersecting social and structural factors which may complicate access to healthcare and compound the difficult experience of sexual pain for many women. There was, however, an exploration of positionality within complex national systems in the interviews with these practitioners in England, and an explicit challenging of unhelpful nomenclature and of the ‘lack of consensus on aetiology and classification’ (Mitchell et al., 2017, p. 5) which can profoundly affect the way that women experience healthcare for their sexual pain in England, despite the NHS aiming to be free at the point of care for women accessing services.

4.5: Naming and Creating Meaning - Conclusion

The legitimising potential of naming women’s sexual pain was key to findings around nomenclature and meaning in the interviews conducted with all participant groups for this study. Whether in referral letters, healthcare appointments, discussions with friends and family, national media appearances, or searching for diagnoses which will make meaning from the pain, naming was a key part of sexual pain conceptualisations for all participant groups. The healthcare professionals from both France and England were aware of the potential of health and insurance systems to marginalise and exclude, but through sharing knowledge, promoting education and working actively in an engaged way, healthcare professionals in both countries were aiming to work in a way which recognised their own part in problematic complex power dynamics and to carry out their professional activity in a way that was as empowering of individual women, and their choices, as possible. Commitment to sharing information and knowledge to prevent negative and damaging experiences was consistent through all participant groups, most notably appearing in the analysis of the importance of naming with the French women interviewed. This intertwines with an understanding of Foucauldian conceptualisations of power and discourse as complex, fluid, and context-dependent. Further to this, ideas about resisting negative or unhelpful narratives demonstrated that reclaiming narratives of sexual pain, including finding personal meaning in experiences, could be potentially liberating and powerful. In short, the importance of naming and discourse in women’s sexual pain was paramount in the interviews with all participant groups, and the complexity of naming these issues adequately added a multifaceted structural challenge to debilitating pain experiences and existing marginalising factors faced by women who experience this type of pain in England and France.

5: ANALYSIS: ABJECTION

5.1: Abjection of Pain – French women

Women's sexual pain experiences must also be seen within the context of healthcare structures which were at times uninformed, dismissive of women's discomfort, and which often met descriptions of intense pain with indifference when women attempted to consult services for care. WA-FR-003 spoke of how she suffered from pain for almost 20 years before finding out through an internet search what her pain might be called:

> 'I never got a diagnosis, so, umm, and […] I went to see gynaecologists, umm, who told me, more or less, that it was all in my head, that all this was taking place. And so, you start properly doubting yourself […] I was already someone who didn't have a great deal of self-confidence, you know? Maybe that was a factor too.'

This recalls the 'vortex of summons' evoked by Kristeva (1982, p.1), with WA-FR-003 having to repeatedly explain her issue without any resolution, in numerous medical appointments with various specialists she was summoned to over the course of almost two decades. WA-FR-001 also described asking herself repeatedly 'did I do something wrong?', despite the pain being the reason that she lost her job, and the fact that for some time could not even sit down, rather having to lie down, as the pain was so severe. WA-FR-009 also clearly described how she asked herself whether it 'isn't [her] who is doing all of this in her head'. This once again clearly recalls Foucault's notion that 'sexual irregularities have been annexed to the realm of mental illness' (Foucault, 1976, p. 50). To imagine consulting gynaecologists for almost 20 years, as WA-FR-003 did, as someone who 'didn't have a great deal of self-confidence', and to be told 'more or less' that it was in her 'head', is a clear example of how sexual irregularity has been placed in the realm of mental health concepts, as an irregularity for which blame is placed back on the subject who is experiencing it. WA-FR-003 reported that on one occasion where she visited a male gynaecologist with her ex-husband, she was examined, told that there was 'nothing wrong' and that 'all that, it's in your head', before the clinician asking her ex-husband 'how on earth he [could] tolerate that'. The experiences of WA-FR-003, alongside the self-questioning reported by WA-FR-001 and WA-FR-009, clearly demonstrate the movement of pain experiences to the realm of 'the head' by certain healthcare professionals, despite the issues potentially being treatable or curable. This movement of experiences which are ''irregular'' into the realm of mental illness was seen throughout the interviews with French women, and the consequences of this were profound, marginalising, and life-altering. The indifference which several of the women interviewed had to confront, and reports of healthcare professionals suggesting that these problems are in women's heads, reflect healthcare systems which not only decide what falls into the categories of regular and irregular sexual and health experiences, but also dismiss women who are forced to present themselves to healthcare providers repeatedly before treatments can be found for their pain. The 'weight of meaninglessness' described by Kristeva (1982, p. 2) as part of the abject is at play here, and it is sobering to read of decades of pain without adequate treatment, and of the torturous processes of self-questioning that lack of resolution and meaning to the pain involved for these women. The movement of pain into women's ''heads'' is not only operated by overarching healthcare structures, but also by the people employed within them, and leads us to wonder what happens to women who give up trying to 'find good specialists, good doctors' in French healthcare systems when it is 'very complicated' (WA-FR-010).

Many of the women interviewed in France emphasised that access to knowledge about sexual pain and the services and treatments available were fundamental to making the process of treatment-seeking less complex. WA-FR-004 spoke of being assaulted by a healthcare professional she had consulted for her pain, saying 'you know, maybe it's also because of that that I let it happen, because I didn't know how far he had the right to go'. She then spoke of her commitment to trying to ensure that such an assault was not repeated for other women, emphasising that when a healthcare professional is consulted, it is not always clear what will happen during the appointment, and that in her opinion, 'information should be made available about whether this doctor or that doctor has the right to work hands-on with us or not'. WA-FR-001 echoed this, describing how she felt that in searching for information she was stuck between competing currents of medical information and opinion:

> ‘I think, in all honesty, I don’t really know how it is in England, but I really think that in France, the problem’s that...there isn’t actual medical information [available], you know, there are just doctors who…[who] clash, and, I, umm, I don’t know’.

WA-FR-001 spoke of the two types of doctors in France, those who will operate on the vulval vestibule for sexual pain issues, and those who will not, evidencing the contested nature of women’s sexual pain in healthcare practices and information in France. WA-FR-001 described how patients are forced to navigate these ‘two types of doctors’, those who will try various medications to see if they offer any relief, and will then offer surgery as an option, and those who ‘are completely against surgery, but because it’s their personal belief, […], not for any scientific reasons. Because of their personal beliefs’. She described the disagreement between these two types of doctors as a ‘war’, and patients as being stuck in this conflict. This clearly evokes Foucault’s (1998, p. 98) suggestion of the connection between knowledge and power, that between ‘techniques of knowledge and strategies of power, there is no exteriority, even if they have specific roles and are linked together on the basis of their difference’, demonstrating how the technique of knowledge – here knowledge given to women about their healthcare options and how they can access these – is intrinsically linked to power, here the power in the complex fluid dynamics of interactions with healthcare professionals.

Remembering that ‘power is not an institution, and not a structure […] it is the name that one attributes to a complex strategical situation in a particular society’ (Foucault, 1998, p. 93), it is clear that in the power dynamics described above by WA-FR-001 and WA-FR-004, there is a question of how access to important information about their care would have mitigated the potential for damage. If women’s sexual pain is to move out of the sphere of the abject, where it is ‘ejected beyond the scope of the possible, the tolerable, the thinkable’ (Kristeva, 1982, p. 1), it must be grounded in the possible. This means that healthcare systems must not only recognise its existence, but also, fundamentally, recognise that women's experiences of this very real pain can be shaped, improved, and they can be protected from harm with access to individualised, accessible treatments, and information which is accurate, relevant, and accessible to them regarding their choices and their care. In terms of intersectionality and how it functions in practice, this is, of course, a challenging proposal. This said, the descriptions of difference in healthcare opinions, and healthcare practitioner inclination, paints a picture of inconsistent access to treatment and information, as well as additional risks linked to the nature of sexual pain itself. WA-FR-004's gender, and the lack of access that she had to information which may have protected her, both contributed to her profoundly negative experience of sexual pain consultations. WA-FR-001's gender, location, and socio-economic status contributed in a similar way, and though she did not report being assaulted in practitioner consultations, her diagnostic delay and the destructive nature of her sexual pain had profound long-term consequences.

Unfortunately, it was not only WA-FR-004 who described non-consensual intimate contact as part of her responses to interview questions, and several of the other women interviewed spoke of multiple injustices and systemic failings to attend to their needs, detailing their thoughts on experiencing sexual violence and abuse, and the ways that this linked to their conceptualisation of sexual pain. Kristeva's notion of the qualities of the abject as 'one of those violent, dark revolts of being, directed against a threat that seems to emanate from an exorbitant outside or inside, ejected beyond the scope of the possible, the tolerable, the thinkable' (Kristeva, op. cit., p. 1) is again recalled here, with reference to the way that these experiences were spoken about by participants. This in turn references Botting's (2008, p. 5) work on representations of repulsion, and expressions of fictional horror in everyday life:

> 'its horror lies beyond reality or hyperreality even as it is rendered almost palatable (palatable, at least, for the prurient) in fictional and generic terms. Normal and excessive, routine and repugnant, attributions of horror retroactively confirm the act as both a simulation and interruption of the (simulated) real.'

Here though, the awful nature of the treatment to which several of the women interviewed were subjected was very much grounded in their reality, and this representation moved away from abjection's intolerable and unthinkable qualities, and the 'generic terms' rendering it 'almost palatable' in Botting's expression, to a lived experience of abject horror which was rendered into words. The women interviewed who described these acts spoke bravely about the effects that these encounters had had on their lives, and explained them in terms of the real, of their concrete experiences of pain within healthcare systems which were slow to meet their needs and within which they were repeatedly dismissed.

WA-FR-010, when speaking about how sexual pain had affected her in relation to her past experiences, said 'as far as feelings are concerned, I…I don't show anything anymore'. In answer to a question regarding the use of female sexual dysfunction as a term to describe her experiences, WA-FR-010 answered that it was not an appropriate term. This was because her 'first sexual encounter was not consensual, and, well, that comes with consequences'. Similarly, WA-FR-002 described how 'rough' sex had been the start of her pain, leading to damage to her body:

> 'for me it started with a, a bad experience…with my first sexual partner, umm [pauses], he was…quite rough with me, but not in a, in an aggressive way, it was just, the-, it was just a rough, uhh, experience. And…I bled, and I obviously tore, the entrance of my vagina, and being young and…silly, didn't say anything […] and, then, umm, I started, uhh…it started getting more difficult for me to have, uhh, *rapports* [sexual activity], because, obviously I was getting…I was worried it was going to hurt, and then it did hurt, and I know that's a very vicious cycle.' WA-FR-002

Neither WA-FR-002 nor WA-FR-010 explicitly termed what they had experienced as an assault, but this activity, described as non-consensual and rough, challenges the movement of their experiences of sexual pain, as linked to this type of sexual activity, away from the conceptual and the abject, and moves it back into the real, explaining it in concise terms. There is no denial here of the unpleasant nature of this part of the sexual pain experience, the bleeding, or the self-blame this process entailed for WA-FR-002 – from her 'being young and…silly' to her evocation of the worrying entailing more pain in a 'very vicious cycle'. Both WA-FR-002 and WA-FR-010 had eventually had treatment that they had found helpful for their pain despite enduring these experiences, and both had persevered in seeking this regardless of issues with reimbursement of costs, employment status, and caring responsibilities. The healthcare systems that they accessed in France meant that they had to be the agents of this movement into the real of their sexual pain experiences. It is, nonetheless, a powerful and arguably meaningful movement to continue to seek healthcare treatment for sexual pain despite the ‘consequences’ (WA-FR-010) entailed by non-consensual or rough sexual activity, and to demand that their experiences and lives were improved despite complex and intertwined challenges presented by the healthcare structures consulted.

These situations can be disempowering, as seen above, but there were also descriptions from some of the participants interviewed of the positive ways in which sexual pain had changed their lives. Without denying the potential negative consequences of the pain, and the failure of French healthcare structures to consistently and adequately meet all needs of the women interviewed, the pain has contributed to WA-FR-008’s understanding of her own body and how it works, served as a way for WA-FR-007 to listen to her body, especially during sexual activity, and for WA-FR-005 it has contributed to a feeling of closeness to the women in her family. Though the quotes from the interviews with these women clearly demonstrate the difficulties that they faced, and were still facing, at the time of the interview due to their sexual pain, it could be argued that, as per Kristeva’s description of the abject as something with a ‘weight of meaninglessness, about which there is nothing insignificant, and which crushes’ the person experiencing it (Kristeva, 1982, p. 2), these women have renegotiated their relationship with certain elements of their pain, to find meaning, and to express this frankly.

WA-FR-008 described how the pain had ‘contributed to a sense of getting to know myself better, to understanding, umm, how my body works, my perineum works, umm, all those things which were linked, all that, you know […] that’s really great’, with WA-FR-007 explaining that receiving treatment for pain ‘was great as well for…for remembering to…to listen to my body, umm, when it was hurting, to stop, or to carry on, et cetera, you know, it was more, umm, finding ways to listen to my body when it was telling me that it was in pain, or when it was saying everything’s fine’. WA-FR-005 had been able to access support within her close and wider family, and she described her mother's interest in her pain and how this had been a positive process for her. Foucault suggests that power is 'produced from one moment to the next, at every point, or rather in every relation from one point to another', 'not because it embraces everything, but because it comes from everywhere' (Foucault, 1998, p. 92). This, then, could be seen as a subtly powerful move, to get to know one's body better, to engage with it and find ways to hear it, or to speak to others about it in a way which embraces the appropriation of one's body. This is a clear movement away from the 'crushing' of abjection and towards a prioritisation of those dynamics which these participants felt were important in their own lives, despite socio-economic and caring challenges related to their gender. Of course, not all women who were interviewed were supported or able to renegotiate their relationship with their pain in this way, but those who were found power in this practice.

It may seem at first glance that the concept of abjection and the very real processes of 'vicious' treatment and pain experienced by several of the women interviewed in France have little to do with preceding sections related to the naming of sexual pain. The potentially legitimising nature of articulating and naming pain was evoked in the interviews with all four participant groups, but is particularly salient in relation to abjection in the interviews with women in France. Being trapped in healthcare consultations with practitioners who treat the issue based on their own personal inclinations (WA-FR-001), and being told this issue was all in their head (WA-FR-003) both relate to the way that these problems are named and treated, not only within healthcare systems which confer power to test, treat, and diagnose, but also in the way that healthcare insurance controls reimbursement processes for these issues. Clear challenges in terms of gender, socio-economic status and caring responsibilities are notable here, and the consistent sharing and availability of information was highlighted as important once again by this participant group. Foucault's suggestion that sexual irregularities often move into the conceptual realm of mental illness (Foucault, 1976, p. 50) is confirmed here, and not only this, but the interviews conducted with women in France show that a clear process of abjection was taking place in many of the interpersonal, sexual, and healthcare encounters experienced by the participants of this study.

5.2: Abjection of Pain – English women

Many of the English women interviewed spoke of their genital sexual pain in terms of a conceptual separation from their bodies, recalling Kristeva's description of people 'haunted by' the abject as 'literally beside' themselves (Kristeva, 1982, p. 1). The abjection of women's genital sexual pain reflects the challenge that this pain exerts on existing healthcare structures in its quality as that which 'disturbs identity, system, order' (Kristeva, 1982, p. 4). The resulting 'concrete consequences' (Lépinard, 2020, p. 225) of this conceptual separation are profound, and affect not only healthcare consultations but other interactions and life experiences. These do not only include sexual encounters, but also ability to climb stairs in a painless way (WA-EN-002) or having to lie in bed and miss other activities because of the pain (WA-EN-004). WA-EN-009 spoke of how when her sexual pain first started, 'it was very much an issue with [her] gender', and how she 'felt like [she]'d been let down by her body, and that it kind of created unnecessary obstacles, for, umm, engaging with people sexually'. Conversely, WA-EN-010 eloquently conveyed how her pain is only 'there' when she is having sex or when she is talking about the pain, and how 'when [she talks] about it then…then it becomes real', but how otherwise she lives, when 'not having sex', 'in a permanent state of possibility that next time [she] won't be in pain'. This means that she avoids speaking to friends about it because it upsets her, but also means that she has started to feel 'very cautious, sort of not quite in the world, not…quite the same as other people […] feelings of too, a bit, aged. And sad, and withdrawn'. WA-EN-004 described the 'warped way of thinking' that she feels the pain has led to her developing, that 'she can't even put up with the pain that long, that someone else can get enjoyment out of it [through reaching orgasm during penetrative sexual encounters], let alone me', and how this makes her feel 'less of a person' without a 'sexual self'.

The 'concrete consequences' (Lépinard, 2020, p. 225) of this process of abjection are not only in the conceptual separation for these women between the pain and how it disconnects them from their bodies, but also in how it separates them from their 'gender' (WA-EN-009), makes them feel like 'less of a person' (WA-EN-004) and 'very cautious, sort of not quite in the world' (WA-EN-010). The ‘unnecessary obstacles’ for ‘engaging with people sexually’ evoked by WA-EN-009 created by the pain were not limited to sexual acts for many of the women interviewed, and the consequences of the processes of abjection were severe in terms of their perceived inability to conform to the norms of accepted sexual behaviours in their individual and social contexts. Recalling Kristeva’s conceptualisation of the abject as entailing ‘one of those violent, dark revolts of being’ (Kristeva, 1982, p. 1), ‘a terror that dissembles […] a passion that uses the body for barter instead of inflaming it’, the interviews with women in England revealed that pain felt during sexual encounters could evoke descriptions of torture and extreme physical violence. WA-EN-010 stated that when she experiences pain, ‘it feels like [her] organs are being kind of jackhammered’, with what she termed a ‘diagnosis of exclusion’ being the only explanation she was given of why penetrative sex might feel this way. She also described this pain as feeling ‘like burning, being ripped apart’. WA-EN-004 said that the pain is so bad that ‘as soon as anything…enters, it just radiates, the pain, just…you know, it goes all down my back, and, yeah it’s everywhere’, and that ‘as anything touches’ her, she ‘just like…kind of curl[s] in a ball basically’, saying that ‘it’s really difficult to conceptualise the pain’, because now ‘it’s just **everywhere**’. When asked further about this, WA-EN-004 said that the ‘doctors and their diagnosis hasn’t really helped me with that’. This language of extreme pain, also echoed by WA-EN-005, is undoubtedly ‘a terror that dissembles:

> ‘it’s kind of like having your period, but then times that [by] 1000, and being so much in pain that you have to crawl to the toilet cause you think you’re going to throw up, and I don’t think…It’s difficult to relate to someone else’s pain if you haven’t experienced something similar’.

The repeated use of language of extreme pain is indicative of the suffering and impact of this pain on the women interviewed, and the three women quoted above appeared to feel that their pain had perhaps been partially acknowledged in healthcare encounters despite being potentially unresolved at the time of interview. Given that WA-EN-005 described the pain as a ‘chronic issue’ which has become ‘a part of' her, and that this pain was experienced in 'frequent' episodes, it is striking and concerning that a pain one thousand times worse than a period could go unresolved, again evoking the misunderstood nature of women's sexual pain experiences in England. The conceptual separation seen in the previous excerpts is impossible here – the pain is very much in the present, and is extreme, placing the women experiencing it into a 'violent, dark' process of abjection which is intense and debilitating. For any sort of potential solution to this issue, women must not only articulate this extreme pain effectively, but they must also navigate the power dynamics within healthcare structures and the 'complex strategical situation' (Foucault, 1998, p. 92) that this entails, which is a formidable undertaking, particularly when intersectional factors and disadvantages linked to issues such as socio-economic status, location, or disability are concerned.

Narratives of loss also ran through many of the interviews with women in England who had experienced sexual pain, clearly evoking Kristeva's idea of the abject as the process by which a 'subject' finds that 'the impossible constitutes its very being', with the process of abjection of self as follows:

> 'abjection of self would be the culminating form of that experience of the subject to which it is revealed that all its objects are based merely on the inaugural loss that laid the foundation of its own being. There is nothing like the abjection of self to show that all abjection is in fact recognition of the want on which any being, meaning, language, or desire is founded' (Kristeva, 1982, p. 5).

WA-EN-010, in speaking about how sexual pain had affected the dynamic of her intimate relationships, evoked not only a loss of choice in the sexual encounter, but also a loss of regard for the partner involved in painful sexual acts:

> 'it, just, you just start to feel like an o-, as well, like, you just start to feel like an object. [Pauses at length] And, and like you've been violated, if…there's a certain amount of sexual pain you can, you can kind of cope with, and be like, umm, it's okay but I've always had a nice experience together […], but after a certain point, you're like well…I'm just an object to be used regardless of what I feel. For someone else's pleasure [pauses]. And then that makes you really angry with the other person. Cause they know you're in pain, right? [Pauses] Maybe that it's tolerable, or that in the moment, their, their own pleasure takes centre stage. And maybe they

> tell themselves "oh, you know, if it was really bad, she wouldn't let me do it". [Pauses] So…yeah, and that makes you hate them. That made me hate him.'

Worse here than the loss of subjectivity in sexual acts and feelings of anger towards the partner who does not stop when the pain is being felt, this excerpt also implicitly speaks of a loss of the possibility that 'next time [she] won't be in pain', outlining her feelings of loss, objectification, and abjectification. WA-EN-001 echoed this, describing how she had felt descriptions of her whole self as 'dysfunctional' had made her a 'clinical object, and…women are so much more than that'. She spoke of how she, as a single woman, had conceptualised women being able to access help for their pain as also potentially helpful for men in a relational context, and that it could be a 'pro-woman thing' without being an 'anti-man thing'. The complexities of both the intimate and the healthcare dynamics of sexual pain are exposed here, with a clear expression of the 'want' cited by Kristeva of the ability to engage with a sexual part of themselves in sexual activities, which is largely met with encounters with sexual partners and healthcare practitioners who are unresponsive to their descriptions of pain. The loss of subjectivity and of a part of the self for these women is grounded in complex relational and structural power dynamics, and in acts of 'violation' and of 'the impossible' constituting a part of their being and representing a clear abjectification of their experience, which healthcare structures seem ill-conceived, or unwilling, to address.

Experiences of abjection and of the abject described by the women interviewed in England, then, evoked complex processes of conceptual differentiation between gender, feelings of pain, loss, and experiences of individual subjectivity. Additionally, the experiences described included a breakdown of the comprehensible, and of the way that this breakdown feels like a violation as well as an objectification. The extreme burden of pain significantly worse than a period which is unknowable to others resonates with the idea of abjection as that which 'dissembles' (Kristeva, 1982, p. 4), and that which is removed from 'the scope of the possible, the tolerable, the thinkable' (Ibid., p. 1). In a repetition of the way that French women's experiences of sexual pain were linked to abjection, the extreme pain linked explicitly to women's concepts of their own gender, self, and subjectivity is not only linked to demographic characteristics reminiscent of intersectional concerns but also to the way that structures and dynamics of power operate. The extreme, torturous pain is intertwined with experiences of structural power, the ‘complex strategical situation’ (Foucault, 1998, p. 92) of existing within healthcare and other structures which govern access to care, information, and treatment, and the loss and resentment caused by interpersonal difficulties. Though women’s sexual pain is intimately connected with the theory of abjectification, the distress caused by these processes surpasses the limits of the theory itself.

5.3: Abjection of Pain – French Healthcare Professionals

The French healthcare professionals interviewed often cited how questions of pain are relegated to insignificance, pushed out of the realm of the 'thinkable' (Kristeva, 1982, p. 1), and seen by some other healthcare professionals as an 'irrelevant' annoyance (HP-FR-002). There is a recognition in some of the medical and psychiatric community in France, as HP-FR-004 explains, that in 'all-encompassing approaches' to treating genital pain, not only must the pain be attended to or relieved, but:

> 'it's also important to understand the significance of the pain in the history of a person, in their relationships with the people they're close to'.

This recognition, however, was described as inconsistently used among other healthcare professionals or providers from the reports of the healthcare professionals interviewed here. HP-FR-002 spoke about general advice from non-specialist medical professionals given to women who were told 'maybe you're not lubricated enough', or 'here's some numbing cream', directly contradicting the above idea that it is important to recognise the 'significance of the pain' in multiple areas of the life of the women experiencing it. The notion that women would simply be offered numbing cream for their pain as an avenue of treatment speaks of both a figurative numbing of the pain, but also of a very real numbing of the experience of the pain. This is not only important in terms of the embodied discomfort and the sensations that sexual pain can cause, but also in the wider life experiences of the women affected by it.

Experiences of pain are, of course, shaped by many things, but among the healthcare practitioner participants in France, there was an open challenge to this figurative numbing. The movements to which many women are subject, in a healthcare structure which has disregarded women's pain for a long time, evoke the abjecting of pain as that which 'disturbs identity, system, order' and that which challenges structural power to eventually become the 'in-between, the ambiguous, the composite' (Kristeva, 1982, p. 4) and is therefore diminished and literally numbed, on some occasions without prior investigations being undertaken (WA-FR-003). The healthcare professionals interviewed report grounding their work in the rights of women to life and to health, to the 'the ''right'' to rediscover what one is and all that one can be' (Foucault, 1998, p. 145), while recognising that they are involved in complex power dynamics and healthcare structures, and to learn and help others to find a way to 'speak about pleasure, about desire' (HP-FR-002) within these complex dynamics. Though not reversing processes of abjection which affect women who experience sexual pain, this shows an awareness and an implicit challenging of this process, and a shift in conceptual focus to understanding the 'significance' of the pain for the person experiencing it within their individual context. This also offers a reformulation of possible healthcare provision and promotes discussions of pleasure as well as management of pain.

Sexual pain, whether abstracted, invisible, or described as concrete, can have considerable, complex consequences, as seen in the analysis sections from the interviews conducted with women affected by it in England and France. Yet, as HP-FR-002 recalls, not only has pain been seen as an abject or invisible concept by some healthcare professionals in France, but has even been disregarded completely, even during procedures which involve dilation of the cervix. HP-FR-002 gave the example of this abjection using the example of the termination of pregnancy:

> 'for a long time it was thought that it didn't hurt, well yes, yes physically that does hurt', 'you know, expelling something hurts, [or] can hurt, there are women for whom that doesn't hurt.' Some 'gynaecologists who carry out medical terminations, for example, don't always include a pain management protocol into the plan'.

'The best ones do, obviously', HP-FR-002 adds, but many do not, or they do not recognise the specificity of the pain of a termination of pregnancy. The abjection of women's very real pain has taken place here, abjection understood in a Kristevan sense, that is to say abjection not as a 'lack of cleanliness or health', but rather as caused by 'what disturbs identity, system, order' (Kristeva, 1982, p. 4). This abjection has taken place in challenging what 'was thought', here the fact that terminating a pregnancy may not be painful or that such a procedure may require pain relief. Knowledge about genital sexual pain, and the way that it is produced and shared, is contingent, bringing to mind Foucault's description of sexuality as a complex 'historical construct' (Foucault, 1998, p.105) rather than an essential 'stubborn drive' (Foucault, 1998, p.103). HP-FR-003 similarly laments the lack of knowledge in some health professionals that pelvic floor physiotherapy can be useful for women affected by sexual pain, describing that many gynaecologists 'don't **know** about it', that they do not 'know that physiotherapy can help' with sexual pain issues (HP-FR-003). Knowledge about women's sexual pain, and how this idea has become intangible, challenges what 'was thought', is not part of the 'plan' for some potentially painful procedures, and is simply a void, an 'in-between' for some health professionals, such as those mentioned by HP-FR-003. In terms of how this relates to access to healthcare and healthcare knowledge, the inconsistency between healthcare professionals is stark. A woman who is consulting a practitioner who considers pain management protocols for the termination of pregnancy will have a different experience to a woman consulting a healthcare professional who does not even consider that this intervention can cause pain. This lack of consistency and comprehension in management of women's genital pain undoubtedly feeds into other intersectional factors and 'determinants of health' (Hankivsky and Christoffersen, 2008, p. 279) such as socio-economic status and prior experiences of healthcare, questioning what happens to women who are unable to change practitioners, are unaware of their rights due to lack of targeted information, or live in areas where access to appropriate services does not exist.

The importance of recognising the 'diverse influences that shape and affect lives' (Hankivsky and Christoffersen, 2008, p. 279) was referenced in terms of the lived experiences of women consulting the service for sexual pain issues. HP-FR-002, who works with women who have been trafficked before arriving in France, speaks about the complex and multifactorial pain which women who have been trafficked can experience during sex:

> 'they arrive HIV positive and the pain' […] 'it starts really with psychological pain, the **story** of their journey'

Here, there is no clear-cut definition between the genital pain reported by women and the interlinked emotional hurt or ‘psychological pain’ as HP-FR-001 described it. The pain is not just conceptualised as something which is experienced during sexual acts; it is rather a sensation linked to the whole journey of their lives, of having been trafficked into France, and complicated immigration histories which undoubtedly intersect with other potentially marginalising factors. HP-FR-002 spoke gently about her work with women who have been trafficked, describing the fact that she and her colleagues ‘know very well’ that these women ‘have been sold’, ‘as sexual objects, […] as commodities’. The abjection evoked by Kristeva, an abjection which is ‘sinister, scheming, and shady: a terror that dissembles, a hatred that smiles, a passion that uses the body for barter instead of inflaming it’ (Kristeva, 1982, p.4) is never more present than here, but the pain described by HP-FR-002 in her work with trafficked women transcends the limits of theory. HP-FR-002 recognised that the women that she works with have diverse and complex histories, and may have experienced many different types of pain, and who have been subjected to terrible things. She does not, however, abject them, removing their experience from ‘the scope of the possible, the tolerable, the thinkable’ (Kristeva, 1982, p. 1). Instead, HP-FR-002 grounds her description of her practice in the nuances of the work she does with these women, the lack of clear-cut definition between the physical pain experienced and the potential psychological pain of a horrendous journey, and she recalls her duty as a sexologist to be ready and present enough personally to ‘to hear the unspeakable’. HP-FR-002 spoke about the trust that this confidence can build between therapist and client, and the time that this takes to build, as well as demonstrating that she is not ‘there to judge’ as a therapist – that even though ‘non-judgement doesn’t exist’, it is important to try not to judge, to ‘put aside your own values, be able to hear the Other’. In terms of intersectional factors and the ‘determinants of health’ (Hankivsky and Christoffersen, 2008, p. 279), there is an explicit recognition here that diverse migration histories and prior health status will shape experiences of sexual pain and complex experiences of healthcare which cannot be separated from one another for individuals who may be consulting the services. ‘Being born in France isn’t the same as being born in India’, concluded HP-FR-002, ‘even if you’ve spent years in France’, emphasising that women’s experiences are determined by a multiplicity of factors which are crucial to attend to, including cultural background, race, and healthcare status, all of which will be intersecting in intricate individual ways for women consulting services in France.

The blame placed on many women who experience sexual pain, in a process of abjection of that which ‘does not respect borders, positions, rules’ (Kristeva, 1982, p. 4), which ‘beseeches and pulverises the subject’ (Ibid., p. 5), was evoked by several of the participants interviewed in France. In this case, rather than complex immigration histories, healthcare practitioners pointed to the way that socio-cultural dynamics can make women entirely responsible for problems in their intimate partner relationships which are part of interpersonal dynamics, rather than the fault of solely one partner. HP-FR-003 described how most of her consultations are with women who are in relationships, because the pain becomes ‘a big issue’ within the relationship. HP-FR-001 explicitly stated that vaginismus ‘puts too much focus just on the woman, making her responsible for everything which isn’t working right’ in heterosexual relationships, leading women to blame themselves for ‘everything that’s not going well in the partner relationship’. She explained that where vaginismus exists as a symptom, it can also sometimes be linked to women’s partners, who may have ‘mental blocks’, issues maintaining an erection, or whose attitudes may be ‘stifling, constantly demanding sex’. This ‘symptom’, she added ‘often…points the finger at the woman’. HP-FR-003 additionally described how she has had problems with obstructive or aggressive partners of women she was caring for, where the patient wanted their male partner to come to a consultation, and he was unhappy about this. These challenging dynamics, where blame is apportioned to women for interpersonal or relational issues which concern their sexual partners, recall Foucault’s statement that there ‘is not on the one side, a discourse of power, and opposite it, another discourse that runs counter to it’ (1998, p. 101), rather complex and fluid interpersonal dynamics which are shaped by structural and socio-cultural norms.

It also recalls Ussher’s (2005, p. 154) claim that women’s:

> ‘distress thus always has to be seen in a relational and cultural context – it is not the fecund body that leads to despair, but the way in which the woman, and her body, are positioned, and the ways in which women and significant others in their lives negotiate cultural discourses which tell us that the mantle of abjection, and subjection of the passive docile body to expert management, is a woman’s inevitable fate’.

Ussher proposes that women ‘adopt subject positions where’ bodies are not the ‘site’ of subjectivity, rather as ‘part of our experience of being women’ so that when ‘discomfort or distress’ is felt, ‘there is no experience of shame or self-blame’. Quite how women are to do this in practical terms is unclear, and the specificities of intersectional theory are missing, yet there is a clear suggestion of how women can become entangled in the processes of abjection and subjection where the subject is ‘pulverise[d]’ (Kristeva, 1982, p. 5), be blamed and shamed, and trapped in a discursive dynamic where they are responsible for much more than their own issues. For the healthcare professionals interviewed, attending to the complexity of subjective pain experiences within interpersonal and structural fluid power dynamics meant addressing sexual pain issues within wider relational and cultural contexts and working with each woman’s specific issue. This also entailed recognising that sexual pain can leave women feeling ‘marginalised, abnormal, inferior…to other people’ (HP-FR-001), that women’s pain must be seen in its own specific context and expression, which is different to other pain or pain that a man might feel (HP-FR-002), and that judging patients by demographic or case history alone is not sufficient – rather the pain must be seen in terms of how women see it affecting their own lives. HP-FR-001 described how even patients from demographics she might have expected to have a good idea about their own anatomy, such as women with a good job or an active lifestyle, do not always know where their own clitoris is, and when found, must take time to work out how they want to use it. This recognition of the ‘complexity’ in ‘social inequality’ also meant HP-FR-001 acknowledging that ‘marginality, marginalisation…isolation, shame’ can come from experiences of sexual pain, which lead to women becoming ‘truly isolated’ and avoiding intimacy with other people.

Kristeva (1982, p. 11) describes the symptom as ‘a language that gives up, a structure within the body, a non-assimilable alien, a monster, a tumor, a cancer that the listening devices of the unconscious do not hear, for its strayed subject is huddled outside the paths of desire’, describing abjection’s ‘skirting the somatic symptom on the one hand and sublimation on the other’ and how the process of sublimation can ‘keep’ the abject under control. ‘In the symptom’, writes Kristeva (1982, p. 11), ‘the abject permeates me, I become abject’, offering the explanation that the ‘abject is edged with the sublime. It is not the same moment on the journey, but the same subject and speech bring them into being’. This focus on the symptoms, or aetiology, of certain sexual pain experiences was present in several of the interviews with French healthcare professionals, following Kristeva’s notion of the ‘symptom’ as a ‘language that gives up, a structure in the body’ which is unheard by the unconscious. HP-FR-002 outlined her belief that the ‘why’ of pain must be attended to as part of sexological and healthcare work, in addition to providing advice about pain relief. She spoke of her process of discussing with clients consulting the service to ascertain ‘what kind of pain they’re really in’ from the many types encountered in her clinical practice. She described how she conceptualises pain as a ‘symptom…of something’, ‘often a symptom of an old trauma’ such as childhood sexual abuse, negative sexual experiences during adolescence, or experiences reawakened through pregnancy and giving birth. She further explained how, in her practice, she has noticed a lack of tools and protocols for certain aspects of her work, describing how the ‘physical’ is ‘favoured over the mental’ in terms of how she thinks sexual pain is conceptualised. She evoked gynaecologists who still treat vaginismus as a simple mechanical problem of the vagina opening rather than asking ‘**why** vaginismus’, explaining that the ‘why’ ‘is part of mental health’.

Despite evoking this binary conceptualisation, she also challenged it, explaining that care received by women can depend on the values of the healthcare practitioner consulted, and that the experience of pain, and of diagnosis and treatment of pain issues, is specific to the socio-cultural context of the society in which the pain is experienced, saying clinicians have ‘come through an educational setting’ where women are seen as ‘fundamentally in pain’ a lot of the time, suggesting that culturally specific conceptualisations of the manifestation of pain do play a role in how it is perceived. This can be a simple binary notion of the divide between physical and mental, or it can be a wider understanding of pain as a 'symptom…of something'. Either way, the idea that the symptom can be 'a language that gives up, a structure within the body, a non-assimilable alien, a monster' (Kristeva, 1982, p. 11) is present here. HP-FR-001 repeated this binary idea, stating that she believed sexual pain disorders are 'at the juncture' between the physical and the mental' and how, in her work, she believed she is 'very much neither completely in the psychological domain' nor the bodily**.** HP-FR-002 summarised that the conceptualisation of 'engrained, physical bodily pain' and what might be 'behind it' is 'still very complicated', and the interviews with French professionals working in healthcare reflect this. In addition to the fact that care depends on the values of the healthcare professional consulted (HP-FR-002), this evocation of the binary way that symptoms are seen as a 'language that gives up' (1982, p. 11) in the ''why'' (HP-FR-002) of sexual health was present in each of the interviews with French healthcare professionals. The abjection of women experiencing the symptoms of sexual pain, then, is closely related to the symptoms which healthcare professionals are looking to treat. How these symptoms are perceived, and how the 'listening devices of the unconscious' (1982, p. 11) are seen to function for certain women will determine the care that they are to receive. Intersecting factors such as socio-economic status, language, and cultural background will determine the kind of healthcare professionals that they can consult, and the fact that care can depend on the values of the healthcare practitioner consulted is a serious challenge to ideas about equal access to healthcare within the French healthcare system.

Reminiscent of earlier material discussed from all participant groups, the relationship of abjection to French healthcare professionals' understandings of women's sexual pain reveals the complex and often distressing experiences that women are subjected to when seeking healthcare for sexual pain issues. They also reveal that the expectations placed upon women in French society are intricately linked to these pain experiences, in expectations that women will be responsible for emotional elements of partnered relationships, as well as dealing with aggressive sexual partners who obstructed the way healthcare appointments were carried out. The lack of knowledge about anatomy and bodily functions for some French women was once again evoked, and the 'marginality, marginalisation…isolation, shame' coming from sexual pain and the isolation that this can bring (HP-FR-001). The social determinants of health, cultural background of women who experience sexual pain, and the factors including socio-economic status and location which may determine not only the care to which they have access but also the practitioners they consult, were foregrounded in these interviews. The very real conceptual abjection of women's pain was described as having devastating consequences, and the lack of knowledge, and of will to engage with, women's sexual pain demonstrated by some healthcare practitioners reveals that Foucault's notion of sexuality as a 'historical construct' (Foucault, 1998, p.105) is in fact alive and well, with ideas of pain and sexuality as a construct often misunderstood, ignored, abjected or neglected even where care and treatments exists.

5.4: Abjection of Pain – English Healthcare Professionals

HP-EN-004 described the equivalent of the introital pain of vaginismus as ‘extreme’, and equivalent to a ‘bloke’ having a ‘cheese-grater applied to his glands’, which he stated we would ‘hear a lot more about’ were it happening. He hypothesised that the ‘gender issue in perception’ with sexual pain, though ‘there’s higher prevalence [of this pain] than even erectile dysfunction’ can ‘inform adversely the […] view of it as a referable problem’. He continued to say that this reflects gendered ‘public perception as well, that it doesn’t matter so much, women are used to pain down there, they’re born to it, which is…absurd’. The gendered aspect of the experience of women’s sexual pain was referenced by several of the other healthcare professionals interviewed, and calls to mind not only the intersectional idea that gender is one of many significant contributing factors to unequal healthcare within healthcare structures, but also the assertion by Kristeva (1982, p. 5) that in conceptualising the abject:

> ‘one can understand that it is experienced at the peak of its strength when [the] subject, weary of fruitless attempts to identify with something on the outside, finds the impossible within; when it finds that the impossible constitutes its very being, that it is none other than abject’.

The suggestion made by HP-EN-004 is that we are hearing less about this extreme pain because it is being experienced by women. HP-EN-004 stated, when asked about how a sexual pain disorder might affect a woman’s wellbeing, that he ‘would think it affects a woman entirely, in her entirety. Umm, because [of], more than anything else, a sense of inadequacy’. This reflects Kaler’s study undertaken with women who experience vulvar pain (Kaler, 2006, p. 67), where she found that vulvar ‘pain destabili[s]ed women’s sense of themselves as gendered beings; in an equally profound sense, it also destabili[s]ed their sense of themselves as self-aware, knowable individuals’. That women should endure ‘extreme’ pain which ‘doesn’t matter so much’ because they are women in ‘public perception’ is not only shocking as it directly contradicts the NHS Constitution (Department for Health and

Social Care, 2021) to which people of all genders are entitled, but also in that it can affect women in their ‘entirety’, in what Kaler conceptualises as a destabilisation of the self. This process of abjection is not only linked to gender here, but to women’s entire lives and their sense of who they are. This abjection linked to gender could be accordingly considered as one of the significant ‘diverse influences’, among multiple others, which ‘shape and affect lives’ (Hankivsky and Christoffersen, 2008, p. 279).

Another, perhaps more obscure, way in which the discourse of sexual pain recalls the idea of abjection is the idea, considered by HP-EN-002 and HP-EN-003, that ‘there’s a profile for people who experience sexual pain. Umm…and particularly people with primary vaginismus’ (HP-EN-002). Both HP-EN-002 and HP-EN-003 wondered about the ‘“vaginismic husband” who’s always very obliging, and never pushy, and…that typically is the case’ for partners of women who experience vaginismus (HP-EN-002). HP-EN-003 questioned whether it was ‘a massive over-generalisation’ but said she had noticed that ‘men of women with [these] kind of disorders, can be very accommodating […] and sometimes too accommodating, and that’s why, how the problem kind of keeps…is maintained’. HP-EN-002 went further than this, saying that it was a ‘completely, uhh, personal and slightly bizarre […] observation’, but she had, at the time of the interview, ‘never had a vaginismic client who [hadn’t] had long hair’, wondering whether for women who have never experienced penetrative intercourse without vaginismus ‘something somewhere…didn’t have a chance to…grow into the idea of…umm, of **claiming** something about their own bodies developing into women’s bodies’. Though these statements were made with conditions of being simple personal observations and may be an ‘over-generalisation’, there is evidently some interest from these two healthcare professionals in the idea of there being features for women with primary vaginismus, potentially including their partners. In speaking about abjection, Kristeva (1982, p. 11) defined the ‘symptom’ as ‘a language that gives up, a structure within the body, a non-assimilable alien’ and the above contemplations from HP-EN-002 and HP-EN-003 suggest a similar conceptual alienation between women’s symptoms, body, and agency, for example in choice of partner or hairstyle. Though of course HP-EN-002 and HP-EN-003 were responding to questions about areas of interest within their professional practice, this typecasting of women with vaginismus, as if they perhaps were consciously unaware that they had chosen a certain type of husband, a certain type of hair, or a certain type of attitude to their bodies, speaks of an abjecting process to which certain women are subjected. It is linked to their gender, their physical appearance, their identity as women, and their relationship choices, as well as their status as people who experience vaginismus. This linking of identity categories and features may or may not be helpful in terms of access to healthcare opportunities and treatments, but there seems little recognition of the ways that complex structural and social factors may contribute to healthcare experiences and potential marginalisation of women with sexual pain in this questioning.

The theme of abjection was linked to the interviews with English healthcare professionals in two ways – firstly through the notion that gendered perceptions of women's sexual pain, both in the wider public and in healthcare settings can influence how it is seen and whether treatment is suggested, and secondly though the idea that there is a conceptual separation between the women experiencing this type of pain and their agency, suggesting that there may be a part of themselves which is unknown, or unknowable, to them. The profound effects of women's sexual pain are recalled here, and these descriptions evoke Kaler's theory that vulvar pain for some women led to a destabilisation of 'their sense of themselves as gendered beings' (2006, p. 67). This typecasting, alongside ideas of the symptomology of the abject, echoes the findings from the interviews with French healthcare professionals, who often spoke with a dual focus on the devastating nature of pain which can lead to 'marginality, marginalisation…isolation, shame' (HP-FR-001) and the way that gender and gendered perceptions push notions of sexual pain into the unthinkable, the abject, and the conceptual, leading to void in treatment options and understandings of the problem for women experiencing the pain. They echoed the interviews with English women less, in the idea of there being a violation as part of some sexual activity for women who experience sexual pain, rather pondering the idea of the ''vaginismic husband'' who is 'never pushy' (HP-EN-002) as a part of the problem itself. The concrete ways that women were subjected to forms of marginalisation and disadvantage within English healthcare structures were not at the forefront of these discussions of the abject, but the way that gender, and perceptions of gender, inform conceptualisations of this issue was clear. Similarly, in terms of understanding these processes through a Foucauldian lens, the typecasting of women and their partners denotes the strategic and structural power dynamics at play not only for women seeking care in their interpersonal and individual contexts, but also in the musings from healthcare professionals forming a part of the English healthcare system with the potential to abject certain women over others.

5.5: Abjection of Pain – Conclusion

Although abjection theory, and in particular the theory of Kristeva referenced here, deals in the abstract and the figurative, the results analysed here from the four participant groups interviewed demonstrate that lived experiences of abjection, the abject, and evocations of horror, distress, and invisibility are often central to women's experiences of genital sexual pain both in England and France. Given the wide-ranging discourse on women's sexual pain which includes sociological writing, medical literature, and academic and policy articles, it is unsurprising that women's experiences of sexual pain should be so wide-ranging and healthcare access and availability so inconsistent. There were, however, common themes among the participants interviewed in both England and France, and these touch on the abject and processes of abjection in a notable way. For women in France, the abject was evoked in the conceptual movement of sexual pain into the realm of mental disorder, and was linked to location, socio-economic challenges, and gender. For the women interviewed in England, this was linked to conceptual separation of a different kind, this time in the complex intertwining of subjective loss, pain, and gender, as well as in processes of disassembling concepts of known parts of their lives. In the interviews with healthcare professionals in France, the abject resonated not only in ideas of gendered roles and perceptions as in the other participant groups, but also in the horror of personal journeys which can lead to pain, and the extreme marginalisation that sexual pain experiences can create, which often co-exist alongside existing forms of marginalisation such as location, socio-economic status, and cultural background. The French healthcare professionals interviewed also described processes of abjection linked to lack of knowledge or education about pleasure and bodily function, whereas the healthcare professionals interviewed in England tended to focus more on the hidden parts of sexual pain experiences which may be unknowable to women, and which enforce the 'complex strategical situation' (Foucault, 1998, p.92) which forms the power dynamics of how these women live their lives. The legitimising potential of naming seen in the previous section seemed far from the loss and violation evoked in this abjection section, and though the reappropriation of narratives seen in the naming section, as well as the sharing of information, was seen as crucial to improving the outlook for women experiencing sexual pain, the analysis of all participant groups reveals the bleak and often absurd way that women experiencing sexual pain are understood by healthcare professionals and in public perception, as a direct result of their gender, socio-economic status, cultural background or location, among numerous other factors.

6: ANALYSIS: STRUCTURAL BARRIERS TO CARE

6.1: Structural Barriers to Care – French women

In terms of how women of different backgrounds are affected by experiences of sexual pain, the accessibility and affordability of sexual pain treatments is one way in which striking differences in socio-economic status were evidenced in the interviews undertaken with French women alongside the status of women's sexual pain as an explicitly gendered issue. WA-FR-005 underlined this element of her own experience with treatments and the social security system in France, as part of which certain healthcare treatments such as certain psychological therapies are reimbursed to patients and others are not:

> 'that, yes, that's a problem. Because…unfortunately it's something that does a lot of good, and…it's not right that we're not reimbursed for going to see a psychologist, you know […] You're poor, and on top of that, you're ill'.

WA-FR-005 also spoke about how she had had to pay 50 euros each time she wanted to attend a session of osteopathy or hypnosis, which she found helpful despite the 'financial side of things', and the difficulties that she encountered doing this, having never had a stable job. At the time of the interview, she had already found a particular specialist she wanted to consult about her sexual pain, but was unable to afford this, with the cost of the appointment added to the cost of the trip to get to the consultant appointment and to any tests or other consultations required. WA-FR-003 spoke about a similar experience of costly treatment planning. Though she described herself as cured at the time of the interview, WA-FR-003 evoked her diagnostic delay and an arduous course of pricey out-of-pocket treatments before she accidentally discovered the name of her problem on the internet:

> ‘I didn’t even have a name for it, I didn’t have a diagnosis, nobody had done the cotton-bud [diagnostic] test for me, I was treated for herpes […] afterwards I was told it was psoriasis, I bought milk…mare’s milk, I wanted asses’ milk, but it was mare’s milk that I could find […]. I found that on the internet, it was costing me 100 euros per month. […] Umm, for the herpes, umm, the doctor who prescribed the treatment, he didn’t even think it was herpes, but he said if…he said “well, if it helps”, he had no idea basically’.

Despite the similarities in paying for sexual pain treatments out-of-pocket, these two participants were affected unequally by their experiences of sexual pain alongside their experiences of gender and socio-economic status. WA-FR-003 reported that she may have been diagnosed with her condition much earlier had anyone offered her a simple cotton-bud diagnostic test, a common test for vulval problems, and that instead she felt compelled to pay 100 euros a month for milk which not even the healthcare professional who recommended it was sure would help. WA-FR-005 had found treatments which were helping, such as psychologist appointments, were not reimbursed, and that she was making decisions about accessing helpful treatments based on her socio-economic circumstances. Healthcare status and socio-economic position are at the forefront of these healthcare experiences, and they are intricately linked to the experience of the gendered issue of women’s sexual pain in France, where women who may be marginalised due to their immigration status, cultural background and employment status may already be excluded by the separate systems of healthcare and healthcare insurance. The health insurance complications referenced above explicitly limit the healthcare access and opportunities for women in France who cannot afford to pay for them, and this problem is bound to the fact that they are women, in a clear demonstration of how intersecting forms of marginalisation and concomitant structural and individual power dynamics affect sexual pain experiences in France.

In an extension of this, complementary therapies were used by several of the women interviewed, and they spoke not only of having to pay for these treatments without the prospect of being reimbursed, but also of how the nomenclature and classification of these treatments affected their ability to access and use them. WA-

FR-005 spoke explicitly about this issue, explaining how she had noticed a dichotomy between treatments for sexual pain seen to fit into mainstream medicine, and those seen to fit under the category of complementary therapy. She explained that there is ‘still a conflict’ within the French healthcare system, which ‘refuses to concede that hypnosis can be just as helpful for patients’ as traditional medical treatments, and that there ‘are loads of illnesses…which can be treated by doctors […] using alternative medicine’, once again demonstrating the disputed nature of women’s sexual pain in healthcare discourse and practice. WA-FR-010 also spoke of the usefulness of complementary therapies for her pain issue, and she laughed describing how doctors ‘just can’t understand that you can’t just cut [the pain] away with a scalpel!’ Though WA-FR-010 was in stable employment at the time of the interview and WA-FR-005 said she had never had a stable job, both spoke of out-of-pocket payments for these treatments, which clearly underlines the necessity of having the funds available to do this. Women who cannot afford these complementary therapies which may help with their sexual pain, put simply, will be forced to go without them or to find a way to pay for them which is outside of the French healthcare insurance system of reimbursement. This is a clear demonstration of the way that discursive practices have had a profound effect on the women interviewed in France and the barriers that they may create – the discourse of what is mainstream medicine and what is not filters the treatments which are available to women and excludes women who cannot afford complementary therapies before they are even able to ascertain their usefulness. WA-FR-003 depicted the way that the medical workforce is ‘helpless’ regarding sexual pain, explaining that this is one of the most discouraging elements of her sexual pain experience and diagnostic delay. WA-FR-010 also affirmed the disheartening nature of seeking help for pain, revealing that in France, women must often speak to general healthcare professionals before a specialist, and the specialist will not necessarily be trained specifically in matters of sexual pain. These statements are a clear evocation of the structural barriers faced by women in France who are affected by sexual pain, and the way that their individual demographic factors can shape their experiences for the worse. Foucault’s notion that power is ‘the multiplicity of force relations immanent in the sphere in which they operate and which constitute their own organi[s]ation’

(Foucault, 1998, p. 92) is prominent here – not only are the power relations involved in sexual pain treatments and the individual backgrounds of women significant in sexual pain experiences, but also the way that these power relations change and self-perpetuate within the structures they form.

Several of the participants interviewed discussed being dismissed by healthcare professionals that they had consulted in France, and how they felt that inappropriate treatments, which at times proved more destructive than helpful, were given to them because of their gender. WA-FR-002 described how she was physically examined by the Head of Service at the clinic she was visiting and told to 'get on with it', which she expressed quietly in her interview 'needs to be…to be looked at, a lot'. She also questioned how healthcare consultations led to her wondering if this advice was linked to her gender:

> 'I have come across occasional, uhh, positive, uhh, reactions to the doctors, but you generally get "oh well physically you're fine, so, so, you know, get on with it". And…basically to…like, sex is a, a given right to a man. [Participant's voice falters slightly] So, the fact that I'm…basically avoiding sex, because it's painful, is…is, definitely [pauses], definitely a, a, a…well, is that a female thing, I don't know?'

WA-FR-007 echoed the feeling that she was being told to 'get on with it' due to her gender, saying that the first time she went to see a doctor about her sexual pain she thought that the 'nature of the problem' and the 'fact that [she is] a…woman' meant that her pain was attributed to 'fear', and that she was told to 'take care of herself', 'drink plenty' and 'everything [would] be fine', echoing advice from her friends to 'have a joint or a bit to drink and it won't hurt'. It is evident from multiple interviews with women who experience sexual pain in France that this advice did not always work, and in fact at times made the problem worse. WA-FR-004 described how she was repeatedly treated for thrush when consulting the doctor for vaginismus, a treatment which led to infections in her genital area, and how she felt that this was because her doctors preferred to 'treat her for something' rather than 'admitting to themselves that they didn't know what was going on for her'. This was an assertion repeated by WA-FR-008, who eventually found help with a physiotherapist which has greatly reduced her pain, but only after a delay of several years. She said that finding the right doctor was ‘incredibly difficult’ and that the first gynaecologist she saw repeatedly treated her for thrush which was not actually present, a treatment which ‘completely destroyed the flora’ of her intimate area. WA-FR-005 found the damage done to her body in the name of ‘treatments’, including changes of medication, tests, and a kind of contraceptive device being implanted to be ‘almost as traumatic as if I’d never had any treatments at all’. These statements reveal that finding the ‘right doctor’ who will not prescribe unnecessary medication is not only difficult, but that the process of finding them can exacerbate problems and lead to gendered advice to ‘get on with’ sex despite pain. These experiences were ‘traumatic’, ‘incredibly difficult’, and outright destructive for the women above. In speaking about their pain, these statements show that the healthcare advice women received could itself be a barrier to the resolution of pain, by compounding the pain or creating separate but connected issues which could be traumatic. WA-FR-007 suggested at the problem for many women is that it is ‘difficult to make people accept it. When there’s no physical evidence of it […], no structural [evidence] that something’s gone wrong’. These experiences referenced by several of the women interviewed reveal the onerous and potentially destructive process of seeking help for sexual pain in France, where the first step can be convincing healthcare professionals that the pain is real, and the following steps may include trying treatments which exacerbate or complicate the problem further, with damaging long-term consequences. Women’s location, prior healthcare status, gender, and socio-economic status, as well as cultural background and prior knowledge of their rights all contribute to these experiences, and yet the consideration of marginalising factors and intersecting power relations is far from the healthcare practice described here by participants.

For several of the French women interviewed, their experiences of sexual pain were not only linked to their gender, but also linked explicitly to the fact that they were resident in France. WA-FR-002 questioned the differences in approach to pelvic floor physiotherapy after women have given birth, which is offered to all women in France but is not prioritised by commissioners as a service in England. She spoke of having over 40 sessions of physiotherapy for continence issues in France, and then, after deciding to do research herself, ‘had some physio in the UK, as well’, where the continence issue was treated ‘very differently’ and in a ‘more individualised' way. It was this approach, according to WA-FR-002, which allowed the problem to 'improve quite a bit […] not…fantastically […] but **enough** to think that [she] could survive without-, with' the continence issue. The idea of living with the issue rather than it seeking a total resolution was echoed by other participants in discussions of their pain, and WA-FR-002 also explicitly linked her continence issues to her sexual pain experience. She did add, however, that the 'bedside manner' of many of the doctors seen in France 'has been quite terrible really' despite seeing her gynaecologist at regular yearly intervals in France, which has helped her get 'things a bit sorted'. This would have been complicated in England, she explained, by the referrals process, which makes it impossible to routinely consult a regular gynaecologist without paying for private appointments or receiving a referral from a GP. WA-FR-007 described how she had preferred to consult a French sexologist remotely while residing in England in the past, explaining that in England she thought it would be 'more complicated' in terms of management, with the equivalent of GP appointments lasting over half an hour in France. WA-FR-007 felt that she could 'really take the time' to talk things through with her French GP, whereas in England there were not only waiting times following referrals to specialists, but also caps of ten minutes on appointment times, which is 'not enough time to talk about it' when it comes to sexual pain issues. Put simply, she responded, she just felt more comfortable speaking with a French healthcare professional in France, despite living in England. The complications of accessing these consultations, and of feeling that the care received would be appropriate was highly contingent, dependent on the individual situation, location, and the time and knowledge available in consultations with healthcare professionals in the country where the healthcare was accessed, revealing clear barriers to care and disparities between different women or groups of women. This is a strong demonstration of the importance of considering the 'complexity of diverse influences that shape and affect lives' when discussing the 'determinants of health' (Hankivsky and Christoffersen, 2008, p. 279), and not only of making sure that systems provide appropriate access for issues such as women's sexual pain, but that the parties within them appropriately recognise the importance of individualised care. Further to this, the differences in approach between England and France which are mentioned above evoke the way that 'special knowledges' about sexuality, and ‘the strengthening of controls and resistances are linked to one another, in accordance with a few major strategies of knowledge and power’ (Foucault, p. 105), in this case the healthcare systems in England and France and the strategies and policies within which they operate.

Perhaps unexpectedly given the debilitating pain of many sexual pain experiences, many of the women interviewed in France expressed feelings of luck, or of good fortune compared to other women or couples, in a relativisation of their sexual pain experiences. Despite having to pay out-of-pocket for several treatments that she found helpful, WA-FR-005 explained her feelings that, in France, people were lucky to ‘have a social security system which covers a lot’. In a similar vein, WA-FR-008 spoke about how she appreciated being able to renegotiate her relationship with her partner after suffering from vaginismus and dyspareunia, to move the focus away from penetration and towards ‘pleasure’, in a ‘back to basics [approach] with this new sort of sexuality’. She elaborated that despite the pain, she had kept some intimacy with her partner and maintained her long-term monogamous relationship, despite being acutely aware that this is something that many women find difficult when experiencing sexual pain. In a reflection of the numerous ways that sexual pain can affect women’s lives, WA-FR-005 explained, ‘I’m lucky, I’ll say it again, I’m lucky to have a partner who’s been accepting of this problem for over ten years’. She added that she additionally ‘consider[s herself] lucky’ to be able to keep her job, which requires some sitting down, despite the issues caused by the pain she experiences. WA-FR-009 spoke about how she felt ‘lucky, in inverted commas’ to have a partner who respects her, in a change from her previous partner, quickly revising this statement to add that perhaps ‘it’s not luck, that’s normal…[to be] with a partner who’s significantly more attentive to [the pain], and who knows how to actually stop, the moment I say stop’. The way that these women expressed feelings of luck, or in fact of feeling lucky when they considered that behaviour was normal, reflects an awareness among the participants interviewed of the potentially devastating and marginalising consequences of women’s sexual pain, and how these affect women unequally, both within healthcare systems which have been built without a widespread recognition of their individual needs, and within the complex power dynamics of intimate partner relationships, which, of course, are shaped by other national and structural power dynamics that these women are part of and subject to.

Referencing Foucault in her exploration of female sexual dysfunction (FSD), Taylor (2015, p. 24) explains that:

> ‘what is most worrisome about the diagnosis and treatment of FSD is not that it is an instance of psychiatry passing off political, moral, or social norms as science (after all, if we follow Foucault, this characteri[s]es all psychiatric practice); rather what is most disturbing is that the diagnosis and treatment of FSD is indicative of a new stage in psychiatry’s expanding grip over ever-larger numbers of people’.

With this statement in mind, we might conclude that WA-FR-005, WA-FR-008 and WA-FR-009 feeling lucky to have partners who stop sexual activity when it is painful (WA-FR-009), accepting that pain is long term and continuing to participate in the relationship (WA-FR-005) or finding other ways to negotiate pleasurable sexual experiences (WA-FR-008) demonstrates the way that the health services they have consulted and the discourse around sexual pain that they consult recognise ‘political, moral, or social norms as science’. This would perhaps include an expectation of how partners might behave when they are experiencing sexual pain, and as WA-FR-009’s quick revision of her original statement about her partner stopping sexual activity due to her pain shows, this can be discordant with their personal beliefs. The structural barriers here are discursive and they are also linked to cultural norms to which healthcare and psychiatric practice is connected, and the consequences are striking.

Equally striking here is the combination of healthcare practitioner ignorance or dismissal of intersectional factors such as healthcare status, gender and socio-economic status which may have severe consequences for women, such as WA-FR-007’s report of feeling dismissed due to being a woman, alongside the above reports of the outright failure of practitioners to help women with sexual pain adequately rather than harming them, for example by repeatedly treating them for a non-existent problem and causing further damage through this (WA-FR-008). It is hardly surprising that several of the women interviewed in France who had experienced healthcare for sexual pain in both France and England made explicit comparisons between the two countries, and although WA-FR-002's reports of physiotherapy in the UK were relatively positive, these comparisons revealed issues in both countries related to different experiences of sexual pain. Socio-economic status was repeatedly referenced in the interviews with French women, perhaps most clearly by WA-FR-005's description of being 'poor', and 'on top of that, […] ill'. Location in England or France may have influenced how the women interviewed were affected by their sexual pain, and their cultural background, as well as the relational norms they were aware of and spoke about, played a role in their experiences. This paints a stark picture of the difficulties of accessing appropriate diagnostic tests and care in both France and England, and the monumental structural barriers to seeking care in the French healthcare system when women may not have a 'stable job' (WA-FR-005) to access insurance or pay for treatments, or may be refused simple, cheap diagnostic procedures for almost two decades due to the inclination of the professionals consulted.

6.2: Structural Barriers to Care – English women

Further underlining the inconsistency in care options, the care received in the English healthcare system by the women interviewed varied widely, demonstrating a lack of consistency in the services consulted within this sample of women interviewed. WA-EN-006 had a ‘really great, very supportive’ therapist as part of accessing NHS psychosexual services, but had had to be ‘re-referred’ when her six sessions ran out and she needed more, which she said was ‘thankfully ok’, but expressed uncertainty about how the service ‘sort of assign that, and decide what you can and can’t have’. This uncertainty about how treatments are allocated, and the awareness of their subject positions within healthcare structures and dynamics, was apparent in many of the interviews for the women interviewed in England. Part of this awareness of structural dynamics, and especially of the pressure on individual practitioners within the healthcare sector, was revealed by several of the English women interviewed speaking about how they did not want to complain to healthcare professionals because they were aware of the existing pressures on healthcare professionals within the NHS. Though these interviews were undertaken before the COVID-19 pandemic, the women reported that they did not take their pain as seriously as they might were it another condition, and they did not want to complain about poor care that they had received because doctors have ‘got a lot on…their plate, kind of thing (WA-EN-002). WA-EN-007 explained that she felt ‘discouraged […] from going to the doctor, because they’re so overwhelmed’, so much so that she thinks ‘well it’s not serious anyway’ and does not go, having never consulted a medical professional for this problem at the time of interview. She elaborated further, clarifying that she felt encouraged to ‘self-medicate and self-certify’ by using the pharmacy as ‘appointments are really scarce’ in NHS primary care, which, she explained:

> ‘puts me off going, cause I don’t feel as though, like the sexual pain I have warrants having a GP appointment. Because you’re so pressurised into not having one, and going to self-certify, well, it’s not something I particularly want to talk to the pharmacy about.’ WA-EN-007

WA-EN-002 echoed this questioning of the importance of sexual pain in the English healthcare system, suggesting that 'you're not going to drop dead [from sexual pain], so, should you really be going' for multiple appointments, 'and getting this test and stuff'. She added that she believed 'there is a general feeling of that' from people she has 'spoken to about it'. Foucault's concept of sexuality as 'a means of social control and political subjugation' (Foucault, 1998, p. 122) is clear here – this problem linked to sexuality as an 'especially dense transfer point for relations of power' (*Ibid.*, p. 103) has led to these women staying away from the state healthcare services which they are entitled to consult because of a belief in the minimal and individual nature of the problem, and a reaction linked closely to the power dynamics of which they form a part. This impacts in concrete ways for women experiencing sexual pain in England – in terms of the self-monitoring reminiscent of Foucault's conceptualisation of biopower, the notion of structural power which confers responsibility to individuals or teams to decide who decides 'what you can and can't have' (WA-EN-006), and the way that this power intersects to disadvantage certain women in multiple ways based on their defining characteristics such as cultural background and sexual orientation.

The financial barriers to treatment for women experiencing sexual pain were repeatedly cited in the interviews, and these were a significant consideration in treatment-seeking for several of the women interviewed in England. WA-EN-004 had been told, despite later finding out that sexual therapy was available free with the NHS and she had been misinformed by her GP, that she would have to pay £60 an hour for sexual therapy to attend to her problem and 'have any semblance of a ''normal'' […] normal life'. She underlined how 'problematic this is', and also questioned why she was able to undergo a laparoscopic procedure to remove certain lesions for free, but sexual therapy was seen as 'like an extra […] "oh, if you want this, you can pay the £60 an hour to […] talk about it". This was unfeasible for WA-EN-004 at the time of interview, as she could 'barely afford to buy eggs and bread, let alone…£60 for therapy'. It was only when WA-EN-004 saw an 'emergency doctor' for a different issue, that WA-EN-004 was told she had been misinformed about her rights by a practitioner 'well known as very conservative, you know, a traditional doctor'. This doctor had been wrong in suggesting to WA-EN-004 that she would need to wait to have a partner before attending as there would be 'no point in having therapy until [she had] someone to share it with' and that she would have to pay for the therapy, and it was, in fact, available for free.

At the time of interview, WA-EN-004 had not tried to access therapy and in fact said that she had tried many things out, including buying a dilator which cost around £80, before feeling that she had 'given up basically', even in visiting the GP for pain related to endometrial issues. This need to pay personally for treatment which was in fact available for free with the NHS was echoed by WA-EN-010, who bought a set of dilators for £50, which was a big expense for her at the time as she 'didn't have much money'. She said that by the time the dilators arrived, she had already lost her 'nerve', and that in a 'perfect world', she would have 'gone to the physiotherapist, and been given a set of them, shown how to use them there and then, you know, encouraged'. In reality, WA-EN-010 was 'cut off from the service' she attended for this physiotherapy due to an appointment cancellation message she left being unacknowledged. She said after this experience 'it was just too complicated for [her] to go back', and she felt that this was an example of a 'a significant way in which people just are sort of ejected I think from systems like this, and from treatment pathways'. The expenditures described by these participants were due to misinformation and failures in communication which cost both participants money that they struggled to find. In terms of patient demographic and intersectional considerations, the ways in which these women were treated reveals notable variation in the advice given by different professionals, and difficulties faced by women based on their socio-economic status, the fact that they may be suffering from simultaneous medical issues, as well as their gender and ability to physically attend medical appointments.

These structural barriers were not only financial, despite socio-economic factors causing considerable difficulties in healthcare utilisation for the English participants interviewed in their access to care. WA-EN-002 described how, after attending medical services without a resolution for her sexual pain, she 'didn't go to a doctor for anything for three years, because I was fed up of going to them for that'. She explained how, after moving to a new area, she 'didn't register with a doctor for a year and a half' because she 'just didn't want to go any more', and 'didn't want to talk to anybody' 'about anything that was wrong', as her original experiences with medical care for her sexual pain left her feeling 'completely jaded'. She described how the problem causing her sexual pain, which 'basically just needed a specific type of cream' was originally blamed on past 'traumatic experiences' by healthcare professionals, and like 'subconsciously [she] hadn't dealt with something' that she felt she had. WA-EN-002 spoke about how she made sense of her pain after having a biopsy which confirmed a diagnosis for her, but until she was given this diagnosis, she saw there was a tendency among medical professionals to test for things 'that were probably cheapest to test for', describing how she had 'lost count of the amount of times' that she 'was tested for thrush, despite having no symptoms at all of thrush', underlining practitioners' financial considerations in access to diagnostic testing, and how this can be a potential barrier to women accessing appropriate care. She also stressed the importance of health practitioners 'actually…trusting women, that women know their bodies, and a willingness to investigate further' if necessary. WA-EN-001 spoke of similar barriers in primary care services in England, when her GP had refused to offer appropriate treatment, and 'ignored the consultant's recommendations 'cause they thought it was all in my head', which she felt 'would never happen to a man'. WA-EN-004 wondered how with a 'new doctor' that she was seeing, if she 'went to them and spoke about it, whether [she] would get a different response', saying that she feels 'kind of powerless in the whole situation to be honest. Cause they're…they're kind of saying it's your f-, you know, your responsibility, to deal with this, you can…employ techniques to get around it…'. This powerless feeling is significant, and it evokes WA-EN-003's statement that she did not 'feel particularly empowered…to sort of […] claim any right. For it to be any better' with regards to sex. This lack of feeling empowerment, or the feeling of powerlessness, reflects a healthcare system which is structured in such a way as to direct problems in an ordered way, where issues such as sexual pain which may not fit a straightforward order are misdirected or rerouted constantly, as seen below.

The idea of gatekeeping, meaning controlling or preventing access to service or consultations when used in the context of healthcare, was described in detail by several of the women interviewed. This barrier is reliant on the 'functionaries and people with little pieces of authority' in state healthcare systems 'channel[l]ing and organi[s]ing systems and their displays […] in order to train them to fit in with expectations' of the system (Hacking, 1995, p. 70). The way that several of the women interviewed described navigating healthcare practitioner gatekeeping, particularly with secretarial staff in primary care, demonstrated the necessity of understanding the constraints and structure of multiple elements of the English NHS to access appropriate care, as well as knowing the correct language to use, in a clear link to the significance of naming and nomenclature in accessing care for sexual pain. WA-EN-001 explained that she now suffers 'PTSD as a result of her experiences […] a result of […] the attitudes that [she's] experienced whilst trying to get help' for sexual pain, rather than as a result of the pain itself. She described how someone who 'has the same problem' as her but 'doesn't know how to explain it' 'won't get an appointment on the same day' with their GP, because:

> 'you've got to get through the gatekeeper. And it's the constant, you know, first you've got to get through the receptionist or the secretary taking the call. Then you've got to get through the nurse. Then you've got to get through the GP, then you've got to get through, uhh, the local gynae, who probably…uhh, you know, it's hit and miss, whether you're gunna get help or not. So if you then get pinged back to the GP, umm, and, you know…which is just, a horrendous process to go through.'

She deplored the attitudes that she had faced during her healthcare consultations, and diagnostic delay, as 'shocking in some cases, not maliciously so, just, I put it down to a mixture of ignorance, arrogance and prejudice'. This 'horrendous process' was not unique to WA-EN-001, and WA-EN-002 spoke of her diagnostic delay of years, and how a good healthcare professional had simply listened carefully to what she was saying. She explained that:

> 'if someone had done that […] years ago [laughs], you know, not only would I not have the emotional upset that I had, but actually, physically, I would have had a lot less, like, umm, damage done basically, 'cause it would have been treated properly'.

WA-EN-003 explained her choice to use her ‘husband’s, umm, medical insurance that he gets through work to see someone privately’ because the gynaecologist she had seen through the NHS was ‘quite dismissive’ of her issue, which ultimately required a surgical repair. Though she had to wait for the surgical repair through an NHS service, she believed the private healthcare specialist would take her ‘a bit more seriously’, which was the case, and she described the process as ‘tricky’. WA-EN-001 was sympathetic to certain healthcare professionals, stating that it takes ‘a very brave GP, to contradict somebody higher up who might have misdiagnosed. Because…then it’s their neck on the line, isn’t it.’ The ‘ignorance, arrogance and prejudice’ faced by WA-EN-001, which it would take ‘a very brave GP’ to contradict, also mirrors the dismissal of WA-EN-003’s healthcare condition, and both ‘emotional upset’ and physical damage for WA-EN-002. This ‘horrendous process’ shows potential barriers at many levels of the healthcare system for women in England affected by sexual pain, and the need for women to understand how these may work. WA-EN-003’s choice to seek private care for her issue due to a ‘dismissive’ NHS gynaecologist demonstrates how access to care can be limited by individual healthcare practitioners and their own beliefs, and raises questions about financial barriers to care for women who are dismissed by NHS practitioners, but unable to afford private care. Gatekeeping is practised by individuals within complex healthcare systems and dynamics, and these people working to fit other individuals within the ‘expectations’ of the system (Hacking, 1995, p. 70) will be bound by their own experiences, and not necessarily aware of how complex intersecting factors may be marginalising the women they are employed to provide healthcare services for.

It was not just the ways in which gender was perceived as part of healthcare consultations evoked by the women experiencing sexual pain in England. Several of these participants stated that the way they felt about their own gender and ‘cultural script’ was a notion which complicated their access to healthcare. WA-EN-003 summarised her view of the ‘cultural script’ she was a subject and part of as related directly to her gender, stating:

> ‘I think gender is probably a really significant issue. It certainly is, umm, for me, cause […] you’ve been trained to accept this and to apologise for it, rather than to stand up and say, “it’s not right and I want it to be better”. And, “I have a right for this to be better”’

She stated that she felt this ‘cultural script’ is to ‘be passive, to be seen to enjoy [sex], and to ensure the enjoyment of the partner’, and this is ‘quite difficult, if something is painful’, adding that she does not think that ‘the same kind of script exists for men’. WA-EN-010 echoed WA-EN-003’s statement regarding her right for it to be better, affirming that she thought ‘there’s a sort of cultural belief that…that sex does hurt for women. And that’s OK. And maybe it is, maybe […] is this just what sex feels like? Is this just normal? But then, why do people want to have it so much? I can’t think of anything I’d less prefer to do most of the time, than have sex with another person’. WA-EN-010 later added that she thought that ‘doctors would be more inclined to take [her] pain seriously if [she] were male’ and that she thought that she would also be more likely to take her pain seriously herself if she were male. WA-EN-001 expressed this differently, explaining that there are ‘cultural’ elements to how pain is perceived, for example ‘if you’re married or something, like you have to give the man sex, it’s part of a “normal” relationship’, but also that sex can be a type of exchange for women. Even if it is painful, she clarified, ‘really silly things’ could factor into reasons she persevered with painful sex, such as thinking ‘“well if I do this, then we’re not going to argue about the bins the next day”’, also explaining her feelings that ‘because I’m a woman, I’m just supposed to, you know, get on with it, or get over it’. This ‘cultural script’, which is intricately linked to the gender and lives of the participants, was an important factor in sexual pain experiences for the women interviewed, and despite reports of some healthcare practices which respected their agency, was one of a multiplicity of factors negatively affecting their experience of pain, including their individual cultural backgrounds, and feelings about their gender.

As seen previously, Foucault describes sexuality as ‘the name that can be given to a historical construct’ (Foucault, 1998, p. 105), which appears as ‘an especially dense transfer point for relations of power’ (*Ibid.,* p. 103) rather than as a ‘stubborn drive, by nature alien and of necessity disobedient to a power which exhausts itself trying to subdue it’ (p. 103). The way that sexuality was spoken about and conceptualised by the women affected by sexual pain in England did not, however, resemble this. WA-EN-001 stated that she thought ‘sexuality is something that is integral to you’, with WA-EN-002 describing the expression of sexuality as ‘not like a human right, it’s a human want’. WA-EN-010 said she would like sexuality to be seen as something which affects ‘the rest of the bits of your life’, meaning healthcare professionals would see her ‘as a whole person’ and address ‘how sexual pain affects […] feelings’, rather than thinking ‘you’re depressed, and that’s why you have sexual pain’. Conceptualisations of pain expressed by many of the women interviewed were not of the ‘stubborn drive’ ‘disobedient to a power which exhausts itself trying to subdue it’, but as the ‘especially dense transfer point for relations of power’ (Foucault, 1998, p. 103), which healthcare practitioners could choose to help them navigate, or could prove the uneven structural dynamic in a particularly potent way. Much of this negotiation was centred on informing women and sharing knowledge of the pain in as clear and realistic a way as possible.

WA-EN-002 underlined the importance of healthcare practitioners helping women to ‘find out what [the problem] is', even if this means that women then must face that ‘there’s nothing they can do’ to resolve it. This would remove the ‘unknown uncertainty’ of the pain for WA-EN-002, and would have been ‘nice to know’ for WA-EN-003, who was not told her issue was progressive or aware of the problems it could cause. WA-EN-008, who had experienced a traumatic labour during the birth of one of her children, stated that ‘centring’ her ‘more’ in terms of her care while keeping the ‘balance’ of care for her and her child would have been better than her ‘having to Google things’. She explained that she was not told that after this kind of birth sex ‘probably will hurt a little bit’ or offered advice or reassurance that she could return to health services if needed so they could ‘refer on’ and she would not ‘get ignored’. WA-EN-003’s statement that she did not ‘feel particularly empowered…to sort of […] claim any right. For it to be any better’ with regards to sex, and that, in her opinion the ‘script’ for women is that they ‘aren’t given a voice. About, umm, sexual pain in particular. Whatever form that may take’ also demonstrates the lack of options for women in this situation. Good healthcare professionals, then, not only know how to share knowledge in a realistic way and give a ‘voice’ to women about their own experiences, but they also help women negotiate a complex healthcare system which may not always recognise the specificities of sexual pain as an issue which, in its link to the construct of sexuality, is ‘an especially dense transfer point for relations of power’ (Foucault, 1998*,* p. 103), including complex and multiple dynamics of power which intersect.

In direct contradiction to this, WA-EN-001 underlined what she termed as ‘medical misogyny’ in the healthcare experiences that she had experienced, speaking of the prejudice that she felt was directed against her. Her GP diagnosed her with Munchausen’s syndrome, a syndrome where illness is imitated for gain, without telling her that this was their diagnosis of her situation. WA-EN-001 only became aware of this after seeing a copy of an onwards referral letter, as this presumed diagnosis had not been communicated to her by her healthcare provider, raising serious questions about the upholding of her constitutional right to manage her own treatment (NHS Constitution, Department for Health and Social Care, 2021). WA-EN-001 spoke of how she was told she was a ‘medical freak’, which was upsetting, and that she felt that as a patient, disagreeing with a healthcare professional on points such as this can lead to being ‘labelled like a “troublemaker” or “difficult” or, you know, “she’s hysterical”’. This sentiment was echoed by many of the women interviewed. Despite WA-EN-005 having navigated the English healthcare system to access the diagnostic tests she was seeking, she felt that she was ‘being passed around like a hot potato’, rather than ‘being able to talk to someone that you feel would actually want to help you’. The participants interviewed here did, in fact, often ‘claim’ the ‘right’ for things to be ‘better’ (WA-EN-003) through seeking access to the care to which they are entitled by the NHS Constitution (Department for Health and Social Care, 2021). This was despite having been labelled as a ‘troublemaker’, troubling not only the cultural scripts and gender roles assigned to them, but also the complex healthcare systems in their countries of residence. Using almost the exact same phrase, WA-EN-010 depicted being treated by doctors as:

> ‘a woman who’s too cerebral. […] there’s still a sense, just in their kind of body language, and the sort of, the words they choose, carelessly, there’s a sense in which you’re being…categorised. As in some ways, a troublemaker, and…and a difficult person and someone who should maybe slightly get over herself.’

In a further demonstration of how gender roles and cultural scripts were a barrier to appropriate care for sexual pain, both WA-EN-001 and WA-EN-010 explained that they were not in long-term relationships at the time of interview, which they cited as a demographic barrier in their experience of seeking help for sexual pain issues. The sexual pain issues experienced by WA-EN-001, WA-EN-005 and WA-EN-010 were all linked to ‘organic’ issues, but, at the time of interview, only WA-EN-001’s were under treatment she felt was helpful. Difficulties maintaining attendance at healthcare services for WA-EN-010 because of ‘other reasons’ ‘to do with [her] health’, and feelings that she was unable to participate in activities expected of her because of her ‘upbringing’ and ‘cultural background’ were marked challenges on top of being ‘categorised’ in healthcare encounters. For WA-EN-001 challenges in prior healthcare status and misdiagnosis, her location where no specialised sexual pain services exist, and her employment status, were all potentially marginalising factors which intersected with her gender. The categorisation as ‘difficult’ and as a ‘troublemaker’ is reminiscent of Kristeva’s conceptualisation of the abject as that which (1982, p. 4) ‘disturbs identity, system, order’ and ‘does not respect borders, positions, rules’. Sexual pain, and the experiences of these women, ‘trouble’ the ‘taken-for-granted’ (Lather and Smithies, 1997, p. xvi). If the healthcare system they were consulting were more receptive to the ways that they were potentially and actually marginalised, there would be less trouble to be made, and this way of being ‘categorised’ (WA-EN-010) might focus more on treatment options which are decided alongside women, recognising their agency, rather than based on certain perceived elements of their personalities.

The structural barriers described by English women were multiple, and they coexisted alongside cultural scripts which could disadvantage them or lead to them being painted as troublemakers as a result of seeking care for their pain. Sexuality’s potential as an ‘especially dense transfer point for relations of power’ (Foucault, 1998, p. 103) was clearly evoked here, with several participants explicitly speaking about how they felt trained to ignore their rights for their sex lives to be better (WA-EN-003). Self-certifying for sexual pain issues and not seeking medical appointments as the issue did not seem important enough (WA-EN-007) was a further manifestation of this, as was WA-EN-010's explanation of how she had been ejected from NHS services for missing one appointment because of a lack of communication within that service. The idea that women could be 'poor', and 'on top of that, […] ill' (WA-FR-005) in France's healthcare system were repeated in the interviews with the English women, and this focus on socio-economic status was notable in both England and France not only in terms of how women afforded their care for sexual pain, but also how they were repeatedly and inconsequentially tested for genital issues simply because they were cheapest to test for (WA-EN-002). Structural barriers in England included location, as well as access to healthcare practitioners who would simply listen, but perhaps the most striking way that different forms of marginalisation intersect here simultaneously (Carbado *et al.*, 2013, p. 309) was in terms of gender, cultural background, and socio-economic status. Access to private care was possible for some participants, but for others this was out of the question, and the cultural notion that women simply experience pain regularly was repeated consistently in the interviews with women in England. The picture of the English healthcare system drawn from these interviews is analogous to the picture painted by NHS discourse, further reiterating the contested nature of sexual pain in healthcare systems. This suggests that a system exists which serves individuals and upholds their rights to care, and yet the interviews with women in England clearly show that the way these rights are upheld is continually inconsistent based on location, gender, cultural background, and socio-economic possibilities. The structural barriers to care for sexual pain are so entrenched in the healthcare system that they can discourage women from seeking care for other problems, or force them to assume the role of ''troublemaker'' simply to access appropriate care to which they are constitutionally entitled.

6.3: Structural Barriers to Care – French Healthcare Professionals

Healthcare structures and policies are intimately connected to political choices made on a national level, and France is not an exception to this. In his description of how political power moved away from sovereignty, Foucault also describes the 'very real process of struggle' in being a political object (Foucault, 1998, p. 145) and how in the reconfiguration of structural and judicial power to become biopower, it 'was life more than the law that became the issue of political struggles, even if the latter were formulated through affirmations concerning rights' (*Ibid.*, p. 145). On this subject, he states (*Ibid.*, p. 145) that the:

> '"right'' to life, to one's body, to health, to happiness, to the satisfaction of needs, and beyond all the oppressions or ''alienations,'' the ''right'' to rediscover what one is and all that one can be […] was the political response to all these new procedures of power which did not derive, either, from the traditional right of sovereignty'.

This right, especially the rights to 'one's body' and 'to health' entails an individual being a political subject who contributes to, and who takes part in, power dynamics within larger structures of biopower. In the French healthcare system, women, as users of healthcare services, have a fundamental right to access healthcare in way which does not discriminate against them (Ministère des solidarités et de la santé, 2022), and in theory this entails their rights to health and to their body evoked by Foucault. In HP-FR-002's work, however, she underlined the necessity of outreach programmes as a critical part of providing healthcare services in France, as many women face structural barriers to accessing care and knowledge, as is also discussed in the previous 'Naming' sections. This meant not just recognising that the co-existence of both public and private healthcare structures can disadvantage women who are unable to afford private healthcare, or who fall outside of these structures, for example due to immigration status, but it also meant ensuring that those people who might not be aware of rights are supported to access the care to which they are entitled. Public health provision, she states, must include 'trying to find women' who need support such as diagnostic testing, information about sexual health and sexuality, or screening for issues affecting sexual wellbeing, and it is for this reason that there was a network in her local area which was dedicated to exactly this, which targeted women who might not know about their rights to access such services. HP-FR-003 expanded upon this, emphasising that women's rights to healthcare should not just mean the right to access healthcare, but also to be informed about what will happen to their body during treatment sessions. As part of preparing patients for their sessions, she says that she talks women through what will happen prior to their first visit to her consulting room and reassures patients that she is listening to what they say and how they feel, and that the session itself will not be painful (HP-FR-003). The right to life then, the right to be healthy, happy, and present in one's body, political and politicised as it may be, was one which the French healthcare professionals interviewed worked to uphold, while also recognising the structural difficulties, potential marginalising factors such as gender, location and existing healthcare status, and their own responsibilities as individuals and healthcare practitioners to facilitate the exercising of this right.

Several of the healthcare professionals interviewed spoke explicitly of the barrier in healthcare provision created by poor communication, evoking multiple possible dynamics. HP-FR-003 drew attention to her work with other health professionals, stating that 'the problem is the communication' between practitioners, though she stated that the internet has made things easier. HP-FR-001 described her professional history as a 'tale of meetings', 'just like it is for everyone', which sparked her interest in sexology as a speciality, explaining that she may have been drawn to a different path had she not have met the people she did. In a similar vein, she expressed that when 'working with pain, [therapists] can't work alone', underlining the importance of working with other healthcare specialists such as physiotherapists. She explained that she is 'lucky to work with people who know a lot about pain' such as gynaecologists and dermatologists who 'have a lot of respect for women' and who know it is important to 'take the time to examine them' and to 'take care' when doing this. These descriptions of the problems with, and potential benefits of, work with other professionals evoke Foucault's description of power as a 'moving substrate of force relations which, by virtue of their inequality, engender states of power, but the latter are always local and unstable' (Foucault, 1998, p. 92).

Each of the healthcare professionals interviewed, however, spoke about the importance not only about the difference in education for healthcare professionals for sexual matters and other illness, but also about the poor communication with women in state education, which HP-FR-002 suggested could help women ‘learn how to live a sexual life which is positive’, to ‘speak about sexuality in a positive way’, and to assist women in getting to know themselves and their bodies, as well as protecting themselves from sexual violence. This, alongside the mentions of intersecting forms of potential marginalisation such as location, gender, and socio-economic status in accessing these services, underlines the differences in education faced by French women and the disparities women with sexual pain might face when they have an educational background where protection from sexual violence, as well as discussions of sexuality and sexual pleasure, were not prioritised. Where poor communication between practitioners is an additional barrier to women’s understanding and treatment for their sexual pain, it is easy to see how the treatment and diagnostic delays evoked by some of the women interviewed in France are possible.

The consensus among the healthcare professionals interviewed indicated that the effects of sexual pain on a woman’s wellbeing can be ‘terrible’ (HP-FR-003), and that it can affect a woman in ‘every way, morally, psychologically, in her relationship with her partner’ (HP-FR-003). Given this, HP-FR-001’s description of hearing ‘every day in [her] office’ about ‘consultations which went very badly for patients’, which even ‘made the problem worse’ (HP-FR-001), hearing about gynaecologists examining women even when they were in ‘crippling pain’, or acting dismissively or rudely towards them, is even more striking. Though physical examinations are important for many women to help establish what any issues might be, HP-FR-001 expressed her disbelief that other healthcare professionals can communicate with women and treat them in such a negative way, saying that she leaves some consultations angry or incredulous the other professionals treat women in such a manner. That the specificities of women’s sexual pain experiences are part of this dynamic of control, and that in practical terms, women must endure the uncertainty of the dynamics of communication between individual healthcare practitioners or teams that they are consulting, is not just a demonstration of how this pain has been abjected, made into something which has the potential to disturb 'identity, system, order' (Kristeva, 1982, p. 4), and must be controlled, but also a demonstration of how the 'interlocking, mutually constructing or intersecting systems of power' (Hill Collins and Bilge, 2016, p. 26) suggested by intersectionality theory work to disadvantage women experiencing sexual pain on both a group and individual level within the complex dynamics of state and private healthcare systems.

The structural barriers described by the healthcare professionals interviewed in France were numerous, and they were linked both to attitudes of individuals within healthcare and insurance systems consulted by women, and to the structures themselves which encourage the regulation and monitoring of which symptoms and nomenclature fits within policy and recommendations. The repetition of the idea of 'luck' described by HP-FR-001 is once again suggestive of the feelings of chance involved in supporting women experiencing sexual pain, and the description of healthcare professionals working clinically with women in ways which aggravated the pain sadly resembles the experiences reported in the interviews with women in France. The structure of these healthcare encounters, both in relational and practical terms, could present challenging barriers to care for women which interacted with their location, preferences, prior healthcare status and cultural background, with some women being unaware that these services exist (HP-FR-002). The dismissal enacted by healthcare practitioners towards women experiencing sexual pain described by WA-FR-007 was also echoed in the interviews with French healthcare practitioners, and this extends to the physical examination of women who were in 'crippling pain' (WA-FR-001), which also raises the question of informed consent in the examination of women experiencing this type of pain issue. The structural barriers evoked in the interviews with French healthcare professionals connect on a deep level with the difficulties explored in the previous thematic analysis sections, and they demonstrate that the outlook for women experiencing sexual pain in France can be stark and, at times, aggravate the pain. They also, importantly, reaffirm that although the French healthcare system is comprised of both public and private elements which should theoretically offer women more choice in practitioner and treatment, factors which disadvantage, alongside the very operation of these structures themselves, severely limit these choices and the opportunities that women will have to make them.

6.4: Structural Barriers to Care – English Healthcare Professionals

Echoing the questions raised about healthcare system structure in France, multiple questions were raised in the interviews with the English healthcare professionals regarding the construction of the English healthcare system and the flexibility, and inflexibility, of its design. All of the healthcare professionals interviewed in England underlined the demographic diversity of patients consulting the service, and how any treatments required should depend on the 'need or the context' (HP-EN-002) of individual women consulting the service. HP-EN-002 also spoke about the 'huge variety' of women seen in the service and the imperative need to find out 'what is best for that individual at that point in time', as there is currently no '"cure-all" for everybody' (HP-EN-001). Given that the 'collateral damage of experiencing sexual pain' can include damage to overall wellbeing (HP-EN-002), and in many cases referral to, or discussion with, other healthcare departments, 'joined up thinking in the NHS' (HP-EN-001) is crucial in helping to provide 'what is best for that individual at that point in time'. Despite this recognition, HP-EN-001 spoke of the pressure on medical staff in England who have the ability to prescribe medication to prescribe certain medications over others, in financial and structural 'brick walls' which affect both patients and the professionals involved in their care. HP-EN-001 even referenced the risks which some healthcare professionals take, saying that personally he works well:

> 'alongside medics who are understanding the situation, who are willing to sort of try various different treatments. Umm, and of course they're under pressures from CCGs…to prescribe certain things and not other things, so…you sometimes run into some brick walls, but some medics are willing to stick their neck on the line and say "oh actually you know, I will fight my corner and I will get that prescribed for that person, even though it might push up my drugs budget and make me get earache from everybody". But yeah, some, uh, professionals are willing to go that little bit further, and that does make a hell of a difference, but unfortunately not for everybody'.

This quotation from HP-EN-001 reveals the challenges that the healthcare professionals involved in the treatment of women's sexual pain face themselves, and the ‘fight’ that may need to happen to get the right thing prescribed for the right patient at the correct time. It also shows that this willingness to ‘try various treatments’ and ‘fight’ the ‘corner’, with all of the ‘earache’ this entails, is not widespread among all healthcare professionals, and that even where healthcare professionals do make extra attempts to overcome ‘brick walls’ for their patients, this does not always make a difference for everybody, clearly suggesting that intersecting forms of disadvantage may be at work alongside structural difficulties within the English healthcare system.

The NHS Constitution promises services which are ‘free of charge, except in limited circumstances sanctioned by Parliament’, and one of the guiding principles of the NHS is that access to NHS services is ‘based on clinical need, not an individual’s ability to pay’ (Department for Health and Social Care, 2021). Several of the healthcare professionals interviewed, however, spoke about their private work and how the structural and other barriers differed in private and state-funded services. Women accessing private services for their sexual pain issues also faced obstacles in accessing healthcare, though these were not always identical to those of women accessing state-funded NHS services. HP-EN-002 described how the fact that private healthcare services for women’s sexual pain exist alongside state-funded provision can also potentially disadvantage women who use state-funded NHS services. She explained how private practitioners, such as private relationship counsellors, are much less likely to write to GPs regarding the cases of individual women with sexual pain, as a referral to private services tends to be ‘a self-referral’, and even where ‘screening tests’ are required, private practitioners might ‘say to the client “will you go to your GP and ask them to do this”, as opposed to writing a letter’, meaning that individual patients or clients are the central point of communication between practitioners. This might not seem important in terms of access to care for women who use only NHS services or cannot afford to access private care, but HP-EN-002 underlined why it is significant for women accessing both state-funded and private services. She described how it is a ‘pity’ that private practitioners may not write back to GPs or NHS treatments about treatments and sexual pain issues, because this ‘doesn’t **raise** the subject in the kind of p-, public narrative if you like, the public health narrative' (HP-EN-002). This can, in turn, affect healthcare perceptions of sexual pain as a 'referable problem' (HP-EN-004), underlining not only how the division into private and state-funded practice may disadvantage women who are not able to pay for private practice and for whom no state-funded access is possible, but also how this division can actually affect perceptions of sexual pain issues treated in private healthcare for state-employed professionals in England. This division based on gender and socio-economic factors alongside issues such as location and caring status which may preclude access to appropriate services underlines the difficulties faced by women facing multiple treatment access issues, both when they are able to afford private care and when they are not.

These issues are not only related to the structure of private and state-funded practice, but also to questions of how this pain and sexual problems are addressed by healthcare professionals. HP-EN-004 suggested that it is a 'dereliction of duty **not** to ask about sexual problems at the most general line of health enquiry', and this begs the question of what happens to women who are not asked routinely about their sexual pain, who are unable to afford treatment for it, and who live in areas where there is no available specialised service provision. Again, the abject is evoked here. Here it is (Kristeva, 1982, p. 4) 'not lack of cleanliness or health that causes abjection but that which disturbs identity, system, order', a feeling of 'uncanniness' which 'harries' a person as 'radically separate, loathsome' (*Ibid.*, p. 2), perhaps a person whose health problem is such a challenge to systems or structural power that it is not even broached in conversation. The barriers experienced here may be different from those faced by women experiencing sexual pain who can afford to access private healthcare, but they are significant in that even if a woman is lucky enough to be asked routinely if she is experiencing sexual pain, there may not be any provision for the treatment of it once identified. Women who may be marginalised in other ways may find themselves marginalised through this pain – which can entail a profound level suffering – and they have no choice but to end up 'stuck with it, and they suffer' unless they are able to pay to access private services (HP-EN-002). As mentioned previously, Foucault (1998, p. 98) notes that between 'techniques of knowledge and strategies of power, there is no exteriority, even if they have specific roles and are linked together on the basis of their difference'. Women who experience sexual pain and who are not routinely asked, or who are asked about their pain but are not provided with services are not outside of the strategies of power and techniques of knowledge related to how their sexuality is conceptualised in the English healthcare system, and yet their problems are ‘radically separate’ (Kristeva, 1982, p. 4) to the ‘most general line of health enquiry’ (HP-EN-004). The marginalisation of women who are not asked about their pain and for whom services do not exist is indisputable. For others, where service provision and healthcare provider knowledge may be patchy at best, not only is there a dearth of services, but also potentially of knowledge and interest about these issues.

This lack of knowledge and its effects on women was evoked powerfully by HP-EN-003. She spoke about her frustration that issues which can be linked to women’s genital sexual pain, such as stress incontinence, where stress is placed on the bladder muscle and women are unable to control their continence, are seen in ‘the media’ as something women ‘just kind of have to put up with’, echoing the idea of ‘cultural scripts’ seen in the interviews with women in England. She underlined her work with ‘lots of gynaecologists’ who ‘very…much want to make it better’, but used the example of stress incontinence to demonstrate how women are given ‘big pads, or something that’s basically a nappy’ rather than recommending existing ‘procedures, to actually…help with this and fix it’. She also explained that in her knowledge of midwifery training, there is a lack of information about the ‘psychosexual effects’ of birth, even when women have had an episiotomy, which is a procedure during which an incision is made at the bottom of a woman’s vagina to enlarge the opening for a baby to pass outwards during birth, a procedure which can be linked to sexual pain. HP-EN-003 also lamented the lack of information in midwifery training for psychosexual effects for women who have experienced large tears to the perineum and surrounding tissue. Similarly, HP-EN-002 described how she had once explained the potential benefits of working with psychosexual services to a gynaecologist, and that they had replied that they had ‘operated on people where [they were] almost certain’ that there was ‘nothing wrong with them, just because we were looking for something that we thought probably wasn’t there anyway’, as they were not aware that psychosexual therapies could be useful. Not only does this emphasise the importance of education for healthcare professionals which includes sexual pain as a focus, but also raises questions about what happens to women consulting these healthcare professionals, and possibly undergoing surgical procedures and other interventions which may not be necessary. With HP-EN-004 explaining the usefulness of early referrals to specialist services in 'off this track of possibly reinforcing what can be a lifelong problem', and HP-EN-003's concern that unless women are 'very pro-active', they can risk being 'kind of fobbed off' by healthcare professionals, this paints a bleak picture for women who may be 'pro-active' about their care, but may be consulting healthcare professionals who are unaware of suitable treatment options or of the existence of specialist services. HP-EN-004 spoke earlier about it being rare that women consult his service for 'just vaginismus' and that the service was 'increasingly seeing women with sexual pain who 'present with complex problems' at the time of the interview. The structural barrier of lack of knowledge among healthcare professionals can have profound consequences, then, for women experiencing sexual pain in England, and the meaning that it, and other problems related to it, is given can have 'lifelong' consequences including unnecessary surgical procedures, and further disadvantage women who are already disadvantaged by their location, prior health status and their gender, among other structural factors.

Discursive elements of healthcare interactions may seem conceptually separated from the structural barriers affecting women who consult healthcare services for sexual pain. They are, however, integral to the process of structurally marginalising certain women who are affected by sexual pain, evoking Foucault's concept of the 'directly productive' nature of power, which exists in 'relations' that are 'not in superstructural positions' (Foucault, 1998, p. 94), such as the dynamics of healthcare consultations. Further to this, Foucault speaks in 'The Birth of the Clinic' (2012, p. xvi) of clinical experience as developing into the 'unconceptuali[s]ed confrontation of a gaze and a face', 'a sort of contact prior to all discourse', 'by which two living individuals are 'trapped' in a common, but non-reciprocal situation'. This description was echoed by HP-EN-004. On the subject of his feelings about working with women with sexual pain, he explained:

> 'I have to watch that, that, you know, we are equal and asymmetrical in the therapeutic setting. Umm, but I do feel for them, especially when they've been putting up with it for so long. I'm heartened as well, that they're coming forward'.

The term 'equal but asymmetrical' explicitly demonstrates an awareness of the 'asymmetrical' dynamics in his consultations with women affected by sexual pain, and, as a healthcare practitioner who does not take part in invasive bodily procedures or interventions, is purely discursive. However, recognition of this 'common, but non-reciprocal situation' (Foucault, 2012, p. xvi) does not mean that the dynamics or participants in the situation are 'equal'. Though WA-EN-004 spoke of his commitment to his work with women who experience sexual pain, and clearly strove to treat patients as equals, the structural barriers in accessing the service where he worked, and the reasons why 'they've been putting up with it for so long' show that the dynamics of this 'situation' are not equal, even if they are certainly 'asymmetrical'. Looking at this conceptualisation from an intersectional perspective can further illuminate why this conceptualisation of practitioner and patient as 'equal' could be challenged. Though there is acknowledgement and conceptualisation of the 'gaze' evoked by Foucault (2012, p. xvi) in the quote from HP-EN-004, the 'interpersonal, disciplinary, cultural, and structural' elements of power (Hill Collins and Bilge, 2016, p. 7) are not recognised, and with them the potential 'social divisions' (Hill Collins and Bilge, 2016, p. 7) which can disadvantage 'multiply-marginali[s]ed subject[s]' (Carbado et al., 2013, p. 309). Put simply, there are many barriers which can affect individual healthcare situations. Structural barriers, among multiple others, can contribute to the power dynamics in healthcare situations, which can be affected by such issues as mental health, financial circumstances, ability and disability, or being able to articulate complex issues and experiences in an 'asymmetrical' 'therapeutic setting'. HP-EN-004's part in this discursive exchange which 'transmits' and 'produces power' (1998, p. 101) in fact shows just how unequal the dynamic is, as well as asymmetrical. Comparing this with the French healthcare professionals reveals that although the French healthcare system operates with both public and private elements, the asymmetry between practitioner and service user is maintained, alongside feelings of being 'heartened' that women are coming forward to seek treatment for sexual pain despite many obstacles (WA-EN-004) and fortunate to be able to work with them. Reports of dismissal of symptoms, ignorance, and misunderstanding or reproduction of marginalising practices were common across all participant groups, and the interviews with English healthcare professionals revealed that location, socio-economic means, and gender were just as pressing as issues for women experiencing sexual pain in England as they were in France, despite the apparent free service promoted by the NHS Constitution (Department for Health and Social Care, 2021).

6.5: Structural Barriers to Care – Conclusion

Though the structural barriers to care for women experiencing genital sexual pain in England and France may seem less theoretical and more practical than concepts of naming and of abjection, this section has demonstrated that structural barriers to care can be discursive and linked to invisible power dynamics, just as much as they can be noted in perceptible state system processes such as gatekeeping and referral procedures. Foucault's concept of the 'directly productive' nature of power (1998, p. 94) was echoed across the interviews with all participant groups, who delineated the way that power dynamics, both structural and interpersonal, contributed to their experiences of sexual pain and of working with women who experience sexual pain. The healthcare professionals in England spoke of their understandings of the barriers facing women both in private and public healthcare, and HP-EN-004 directly referenced the dynamics within women's consultations for sexual pain issues. The structural barriers discussed in these interviews included location, prior health status, financial circumstances for women, and rigid hierarchies and lack of knowledge among other health professionals as barriers for healthcare professionals to offer appropriate care for women. The French healthcare professionals interviewed spoke strikingly about the way that other healthcare practitioners dismissed or mistreated women experiencing sexual pain. The French healthcare practitioners as well as the French women interviewed explained how the system of health insurance in France can create structural barriers in accessing certain treatments, and the way that this limits choice in terms of care options. The French women interviewed explicitly cited intersectional factors including their socio-economic status and gender as structural barriers to their care, and direct comparisons between England and France demonstrated challenges in both countries due to healthcare system structure as well as the way that sexual pain is conceptualised. Many of the women interviewed in England evoked the 'cultural scripts', and societal expectations linked to their gender, and they described self-managing sexual pain issues due to understandings of the pressures on healthcare professionals and staff. Several also described feeling like troublemakers simply for seeking care, and the entrenched inconsistency in testing, knowledge, and approaches to women’s sexual pain in different parts of the English healthcare system. All participants groups interviewed described individual practitioners who were committed to providing the best care possible for women and the importance of communication within healthcare and insurance structures, but these interviews reveal that alongside processes of abjection and difficulties linked to the naming of sexual pain issues, the structural barriers to care in both England and France were multiple, multifactorial, and often insurmountable.

7: CONCLUSION

7.1: Conclusion – Participant Groups

7.1.1: French women affected by sexual pain

The experiences of sexual pain described by the women interviewed in France were harrowing at times, and included reports of inappropriate behaviour by healthcare professionals, non-consensual sexual activity with previous partners, and significant diagnostic delays for treatable issues. They also, however, revealed a reappropriation of the discourse of sexual pain, a will to build support for other women affected by the pain who were experiencing difficulties, and to speak about the pain clearly and openly, to normalise and 'take the sting out' of living with sexual pain (WA-FR-007). The complexities of the French healthcare system were evoked repeatedly by participants – a system which contains both private and state-funded elements, and within which the need to navigate intricate systems of health insurance and reimbursement of healthcare expenses can be a fundamental and regular part of healthcare experiences. Each of the ten women interviewed spoke of the profound effects that the pain had had on their lives, including loss of employment (WA-FR-001), difficulties due to a lack of sufficient education in sexuality and lack of vocabulary to express complicated feelings of pain and emotional experiences (WA-FR-004), and the loss of enjoyment in physical contact with friends and family resulting from the pain (WA-FR-010). In contrast to the English women interviewed, several of the French women interviewed had experience of living in England, and so direct comparisons were possible between the healthcare services in the two countries. This gave a unique insight into how certain issues that participants experienced were shaped by the healthcare structures and provision in the country consulted. Finding the right words for the pain was significant for many of the participants interviewed, and these words were connected intimately with experiences of healthcare service and insurance provision for the women interviewed. Analysis of this interview data reveals women's arduous processes of self-questioning linked to their sexual pain (WA-FR-005), feelings of invisibility due to the pain (WA-FR-001), and feeling lucky to have a partner who stops as soon as asked when sex is painful (WA-FR-009). Analysis of the interview data reveals that the process of ‘coming to terms’ with the pain (WA-FR-006) was fundamental to the process of receiving appropriate and adequate care, and challenging the role of ‘good woman, good wife, good mother’ (WA-FR-003) to create a new narrative was crucial for many of the women interviewed. The following analysis reveals that learning to explore the ‘space’ that their ‘body inhabits’ (WA-FR-004) was a revelatory process for many of the women interviewed, even within the constraints of healthcare processes and systems where insurance and reimbursement concerns are fundamental to healthcare consultation decisions.

The interviews with the French women affected by sexual pain spoke to the data from all of the other groups of participants interviewed, particularly the interviews with French healthcare professionals and English women affected by sexual pain. There was an explicit questioning of French healthcare structures and access to healthcare when finances were troublesome for both the French women interviewed and the French healthcare professionals interviewed, and there were calls for the way that healthcare professionals spoke to women regarding their sexual pain to be examined in both groups of participants. The way that the pain was named, and the nomenclature used in terms of the healthcare system was also significant for both groups, and the serious effects of non-consensual sexual activity and assaults were underlined by both. Conversely, the French women interviewed discussed migration histories and personal histories much less than the French healthcare professionals interviewed, and the link between mind and body was much more conceptual for the French healthcare professionals interviewed, whereas it was largely seen as a challenge to accessing care for some of the French women interviewed, whose pain had been conceptualised as medically unexplained, often without organic causes first being ruled out. Similarities can be seen between the English healthcare professionals in this way, in the wish for more knowledge about testing for the causes of pain as well as offering support for emotional elements of it. Education around pleasure, rights, and information sharing among care providers were also important for both the English healthcare professionals interviewed, and for the French women interviewed. There were fewer similarities between the

English women interviewed in terms of experiences of financial hardship, though challenges in accessing care due to socio-economic status were reported by both groups. There were no conceptualisations of ‘‘troublemaking’’ during treatment-seeking in the interviews with French women, although feelings of weariness and of having to consult different healthcare professionals multiple times were conveyed by the French women interviewed. There was also a much larger focus on monogamous heterosexual practices for the French women who participated than the English women who participated, despite several participants indicating that sexual pain had led them to question themselves and their sexual identities. The complexities of the French systems for women whose treatment needs fit under the label of complementary therapies were clear, as were the difficulties for those women whose socio-economic or employment status and location complicated their ability to access treatment and attend appointments. The French healthcare system, which WA-FR-007 described as offering more choice in healthcare professional, longer appointments, and reimbursement of healthcare costs, seems better equipped to assist women experiencing sexual pain, and yet, as for all of the participant groups interviewed, this choice and access was continuously dependent on women’s individual circumstances, their prior ‘determinants of health’ (Hankivsky and Christoffersen, 2008, p. 279), and, simply, how the multiple dynamics of power in their healthcare, and intimate, relationships benefit or further disadvantage them.

7.1.2: English women affected by sexual pain

The ten women interviewed in England, who self-identified as being affected by sexual pain, spoke articulately of diverse life experiences linked to their pain, and of the pain experiences themselves. They also spoke of varied encounters with the English healthcare system, from being removed from a clinic list for missing one appointment (WA-EN-010), to being pleased with psychosexual counselling offered by the NHS (WA-EN-006), to feeling ‘slut-shamed’ by the GP for describing sexual experiences, including one-night stands (WA-EN-004). The way that sexual pain was conceptualised, and subsequent personal understanding of it constructed, was highlighted by participants. Feelings of disempowerment in claiming a right to pleasurable penetrative sex (WA-EN-003), of ‘womanhood’ being ‘up for debate’ (WA-EN-009), and of the pain ‘inhibiting’ ‘ability to kind of be a person’ (WA-EN-009) were reported, reflecting the profound impact that this pain can have for women affected by it in England. Experiences of renegotiation of sexual practices were also explored, of hope to find a new community partly because of the sexual pain (WA-EN-010), and of meeting ‘good professionals’ who ‘recognise that it’s going to take time’ to work with sexual pain, and there ‘isn’t…an instant fix’ (WA-EN-001). These experiences were inseparable from encounters with complex healthcare systems, and from gaining knowledge of the existing barriers for women experiencing sexual pain in England. The analysis above reveals significant feelings of loss for the women interviewed, of being objectified and abjected by healthcare professionals and sexual partners, and of lengthy treatment delays due to healthcare professional knowledge base and inclination. It also reveals that among the women interviewed there was a will to share these experiences, to put their pain ‘into words’, though it is ‘quite…complicated’ (WA-EN-009), and to use their voice to get help, firm in the resolution that speaking about the pain ‘isn’t an anti-man thing, this is a pro-woman thing’ (WA-EN-001). Healthcare professionals inconsistently recognised the potential or current marginalising factors affecting the women interviewed, yet despite these factors, many of the women expressed powerfully how they had been treated, and how they recognised the ways that they might empower themselves in a system structured to disadvantage them in multiple ways. The ‘central heterogendering act of penetrative intercourse with a male partner’ (Kaler, 2006, p. 50) was considered and challenged by many of the participants, even, and perhaps most of all, under in circumstances of excruciating pain and marginalisation within the state healthcare services they consulted.

In terms of comparison with the French women interviewed, women in England affected by genital sexual pain discussed experiences of sexual violence less, although the pain spoken about by English women in the ‘Abjection’ section of their interview data analysis does reflect experiences of violence. French women spoke more about non-consensual sex, gynaecological violence, and damage to the genitals during ‘rough’ sexual encounters than women in England did. French women also spoke more about how support from other women was helpful than the women in England did. The women interviewed in France discussed the difficulties of being reimbursed through health insurance providers and the financial impact that their experiences of sexual pain and treatment-seeking had had, although several of the women interviewed in England did also raise concerns about having to pay out-of-pocket for treatments or tools, which they described as having been largely due to the lack of knowledge or inclination to help in the healthcare professionals consulted at the time. The similarities were also apparent in the fact that many of the French women interviewed had many different experiences of the healthcare system and several had given up on their pain being resolved or treated so that they could experience sex as they wished. This sense of defeat was described by many of both the English and French women interviewed. There had also been a reappropriation of intimacy for several of the French and English women interviewed, which showed a resistance to narratives of penetrative sex and of normative ideas about how sex should feel.

Comparing the healthcare professionals in England with the women affected by sexual pain in England revealed similarities in descriptions of pain affecting the whole life experience and experiences of the sense of self. There were differences in how useful multidisciplinary approaches were thought to be between these two participant groups, with English women seeming to emphasise more that healthcare professionals need to believe women rather than co-ordinate care within a healthcare team, and that if they had been believed by the first healthcare professional they consulted about their pain, their experience of it and any subsequent damage done through worsening of pain or linked problems, or treatments, might have been avoided. Feelings of ‘‘troublemaking’’ and of being subject to ‘medical misogyny’ were defined explicitly by some of the English women interviewed, whereas in the interview data from the English healthcare professionals these ideas were perhaps hinted at, but in a vague sense.

The similarities are clear with the French healthcare professionals interviewed, as well as the French women interviewed in terms of the value of diagnosis of sexual pain issues as a potentially validating process. There was less of a focus in the interviews with English women about the usefulness of sexual education early in life, and less of a focus on the benefits of pleasure, with women affected by sexual pain in England focusing more on the effects of the pain than how they conceptualised pleasure in the context of the pain. There were similarities in the way that notions of separation from the body and abjection were conceptualised in the interviews with French healthcare professionals and women affected by the pain in England, and there was also a focus on being able to articulate the pain, though WA-EN-001 warned about the risks of being seen as too articulate, or too knowledgeable about the pain and suitable treatment. For the women affected by sexual pain in England, naming the pain was significant, but making meaning from it in a way that represented their individual experiences of it and their wishes was equally important. There was an awareness which was repeatedly conveyed by participants that this type of pain can be stigmatising and difficult to speak about. Participants affected by pain in England were not always sure why this was, but they did communicate that sharing experiences or speaking about it could be a helpful process which could potentially lead to support or renegotiation of some aspects of life, such as choices of intimate practices. The structural barriers to healthcare described by women in England affected by sexual pain were financial, despite NHS services claiming to be free, and included experiences of gatekeeping when attempting to consult healthcare practitioners, and ability to attend medical appointments. The conceptual separation between bodily experiences, pain, and overall life experiences was profound for the women affected by sexual pain in England. Feelings of loss, of missing out on aspects of life, and of objectification, compounded this.

7.1.3: French healthcare professionals

Interviews conducted with four French professionals, from varied backgrounds including sexology and physiotherapy, revealed a commitment ‘to hear the unspeakable’ (HP-FR-002), to work with the most vulnerable women in French society (HP-FR-002), and to reduce the ‘marginalisation…isolation, shame’ (HP-FR-001) which can come from experiences of sexual pain. In a healthcare structure which requires full payment up front for some healthcare treatments, with others reimbursed partially or fully, experiences of sexual pain are often complicated for women both in terms of the pain experience itself and the process of seeking and accessing treatment. The interviews undertaken with the healthcare professionals in question reflected this, and they revealed the complexities of finding the right language for symptoms, for pleasure (HP-FR-002), and for reimbursement through health and social security systems. This language shaped not only the experiences of sexual pain, but also the experiences of the healthcare professionals involved in their treatment and the management of symptoms, and as HP-FR-004 stated, multidisciplinary approaches which 'work with the nomenclature' were often experienced as potentially difficult, and yet were crucial for women affected by pain. HP-FR-001 spoke of the double taboo for women of speaking about an issue related to sexuality, and of also having health problems related to this which need to be expressed but which might be poorly received by healthcare practitioners in a position to help as they were perceived as shameful. Complex interpersonal issues were discussed in the interviews with French healthcare professionals, adding to the sense that for many women affected by sexual pain, difficulties were multifactorial and navigating pain could be a process involving many aspects of their lives. The healthcare professionals interviewed did, however, reference the rewarding nature of working with women in France affected by sexual pain and the 'quick improvement' (HP-FR-003) seen with the right interventions and referrals. These interviews reveal a healthcare system which can be disjointed in terms of approaches to sexual pain, and which does not seem designed to prioritise the needs of diverse groups of women, and yet it also exposes a commitment among many healthcare professionals and women affected by pain to educate and improve access for diverse groups of women, and to continue to work proactively for better outcomes for women which embrace, rather than overlooking, individual differences in background.

The interviews with French healthcare professionals spoke least to the interview data from the women affected by sexual pain in England. There was very little explicit questioning in the interviews with French healthcare professionals about questions of sexual attraction and gender identity compared with the English women interviewed, or about non-heterosexual or non-monogamous experiences of sexual pain. In terms of similarities, there was an open recognition of the complexities of healthcare systems, and how women who experience sexual pain may fit into these, as well as how they may be marginalised by these systems by issues such as socio-economic and employment status. There was also a recognition that healthcare structures and lack of knowledge or disagreements between healthcare professionals consulted could compound this marginalisation. There was much greater focus on complex trauma and the personal histories of women in the French healthcare professional section, specifically in terms of migration and questioning of the link between mind and body, and the idea of nomenclature contributing to experiences of financial hardship or difficulties with healthcare insurance systems was similar in terms of the responses to the French women interviewed, but not in terms of the English women or healthcare professionals interviewed. Similarities can also be seen with the English healthcare professionals in terms of complicated encounters with the work of other healthcare practitioners who are uninformed about sexual pain issues, and a focus on providing knowledge, not only to women and couples they encounter in their practice, but also to other healthcare professionals. The importance of multidisciplinary teamwork was highlighted in all groups of participants interviewed, and the abilities of healthcare professionals not only to empathise with and provide treatment to women, but also to help women navigate the complexities of healthcare systems, was underlined in all participant groups.

In summary, the French healthcare professionals interviewed were not only aware of the potential of a healthcare system operating with both private and public elements to marginalise and exclude, but several of them were actively working to counter this exclusion and to recognise and reflect on their own positions in these problematic power dynamics. The difficulties in conceptualising sexual pain were a barrier to some women receiving the healthcare to which they had a right, and for others this was in addition to issues with nomenclature preventing or hindering reimbursement from healthcare insurance providers. The healthcare professionals interviewed spoke of their work with women with sexual pain as gratifying, while recognising the challenges faced by many women who experience sexual pain and consult professionals in the French healthcare system. Being present, ready to hear ‘the unspeakable’ (HP-FR-002) and working in a thoughtful, empathetic way, which recognised each woman's individual needs, was a first step in helping women affected by this pain to navigate these challenges.

7.1.4: English healthcare professionals

The interviews conducted with four English healthcare professionals, from a variety of professional backgrounds, reveal that their work in psychosexual health services was enriching and challenging, as well as 'profoundly touching' (HP-EN-002). In a healthcare system which holds as a key principle that 'outcomes are all improved when staff are valued, empowered and supported' (Department of Health and Social Care, 2021), the interviews conducted with these healthcare professionals reveal relationships with multiple healthcare providers and within complex departmental organisations. They also show that in an NHS which 'belongs to the people' (Department of Health and Social Care, 2021), the people that the NHS serves are not provided for in a uniform way, and that the people it employs show awareness of this. Analysis of the data from the interviews with English healthcare professionals shows that despite differences in personal background, preferences, and opinions, responsiveness to an awareness of structural inequalities has contributed to active work to improve treatment outcomes and knowledge among other healthcare professionals to reduce the marginalisation experienced by women affected by sexual pain. Analysis of the interview data also reveals that, despite their role in sharing knowledge of sexual practices which can focus on penetrative sex, and feelings that they may be 'buying into that narrative' (HP-EN-002), the English healthcare professionals interviewed were conscious of the importance of the contexts in which individual women were experiencing the pain. Working with women in their specific contexts, and recognising the different 'impacts' that sexual pain can have on women (WA-EN-003), were evoked in all of the interviews, and, as the analysis has demonstrated, intersections of gender, socio-economic status, relationship status, cultural background, and other factors potentially contributing to the marginalisation of women experiencing sexual pain were explicitly recognised and considered by the healthcare professionals interviewed as well as recognising their own role in state systems which marginalise.

In terms of the similarities and differences with English women, the English healthcare professionals interviewed showed sympathetic attitudes towards the difficult and frustrating experiences that women may experience in the English healthcare system, but they were more focused on their own role within this system than the women resident in England were. For the English healthcare professionals, there was less of a focus on the idea of madness or women being unable to trust their own minds than there was in the interviews with women in England, and there were fewer references to silencing and women being or feeling silenced. There was also less of a focus on the potential for queer experiences and those outside of heterosexual monogamous relationships in the interviews with the English healthcare professionals than with the women interviewed in England, and more of a focus in the healthcare professional interviews on the potential typecasting of women into certain groups or types, specifically those based on appearance or choice of partner. Within this interest, however, there were contradictions, with the importance of questioning what pleasure meant to individual women of marked importance to the healthcare professionals interviewed in England. This was consistent throughout the professionals interviewed who were working in the same service, despite differences in their original occupations.

There was less emphasis given by the English healthcare professionals than the French women affected by sexual pain who were interviewed in their discussions of how the personal interests and inclinations of other healthcare professionals may impact the extra training on sexual matters that they decide to undertake, or how this has the potential to impede joined-up working. There was also no mention of women being abused by healthcare professionals in the interviews with the English healthcare professionals in comparison to the French women interviewed, though there were references to women experiencing pain which was inflicted during gynaecological examinations. There was also less of a focus in the English healthcare professionals when compared with the French women interviewed in terms of how naming pain can be a significant movement for women to legitimise and validate their pain, or how it can become part of women's identities.

There was the same recognition of the complexity of working with sexual pain and the need for an individualised approach to managing this in both the interviews with French healthcare professionals and English healthcare professionals. There was also a similar recognition of the differences between the function and availability of state-funded and private healthcare for women's genital sexual pain, and an acknowledgement of how this can affect access for certain women, especially those who are less able to pay for private care. Intersectional factors such as migration history and prior health status were evoked more often by the healthcare professionals interviewed in France than in England, and there was less of a focus on outreach work and sex education outside of healthcare settings, especially for younger people, in the interviews with English healthcare professionals than those in France. There was however an awareness that sexual pain can affect underserved populations unequally, and similarities in descriptions of healthcare professionals in both France and England about the importance of multidisciplinary teamwork and co-ordinating care for patients, as well as possible processes of abjection and the way that women describe possible conceptual separations from their pain and their bodies.

In summary, working with 'constellations' (HP-FR-004) of problems and channelling women's sexual pain experiences in certain ways can be seen as a positive, as it can allow tailored treatment which recognises that sexual pain problems might not exist on their own, but can also be a negative, in that it typecasts women by the 'constellation' of problems they might experience. The healthcare professionals interviewed in England were aware of their own part in processes of power and potential marginalisation, and they evoked how this awareness did not mean that they were equal to women in clinical settings for sexual pain issues, despite the importance of recognising it. They discussed how classification difficulties and contradictions can have profound consequences for women, and how services for women's sexual pain are not widespread throughout England. They also recognised how there are often many steps for women who are searching for care for their sexual pain, and there can be many obstacles in accessing care, an observation which was shared among all participant groups.

7.2: Key comparative findings

Given the expectations when embarking on a cross-national study of this kind that findings would reveal both similarities and differences in how sexual pain is conceptualised, assessed, and treated between England and France, it is striking just how similar experiences of sexual pain and accessing care were in France and England. It was reasonable to hypothesise that French approaches to women's sexual pain would be more accessible and offer more choice in practitioner given the decentralised structure of the healthcare and insurance systems, and yet diagnostic delays, difficulties accessing care, practitioner ignorance or lack of training, and socio-economic, location and other practical difficulties complicated access for women affected by sexual pain as much in France as in England. Equally, as pelvic floor physiotherapy is offered as standard postpartum for women in France, a wider recognition of pelvic floor issues and their link to sexual pain might be expected in France, and yet pelvic floor issues were described in both the French and English interviews as a component of difficult sexual pain experiences.

In both England and France, specialised services for women's sexual pain do exist, and yet in both countries, services such as gynaecology are not consistently familiar with sexual pain treatment options, causes, or even terminology. Considering the very specific area of the body that these issues concern, and the promise of universal healthcare in both England and France, the failure of services in both countries to attend adequately to the needs of women who have sexual pain is not only disturbing, but also indicative of the way that this gendered issue is not prioritised by healthcare providers and funders in both countries. There are, however, pockets and small interdisciplinary groups of professionals and individuals in both countries who inform and educate women and healthcare professionals about women's sexual pain, and although these groups and individuals may not have any sway in how clinical services are commissioned for women experiencing pain, the interviews conducted as part of this research reveal that clinicians who work with sexual pain can be both committed and knowledgeable, as well as openly activist in their approach to working with women and sharing knowledge.

The stigmatising nature of women's sexual pain and the difficulty for professionals encountering 'brick walls' in providing adequate care and treatment were striking in both England and France, although in France healthcare professionals described the additional stigma for French women that they may be seen in a more sexualised way than, for example, their male counterparts. This made navigating healthcare systems and co-ordinating care within complex systems of insurance and treatment difficult, and it also added to feelings of shame for women in France. Given the relatively common incidence of these issues and their overlooked status in both countries, as well as culturally contingent ideas about acceptable sexual practices, researchers might expect to see extreme suffering described by the women interviewed, and links to ideas about fulfilling gender roles. Reports in the interviews with women experiencing sexual pain were, of course, revealing of the levels of discomfort, irritation, and difficulty that these issues can provoke, but also revealed practices in both England and France where women had renegotiated their interpersonal relationships, appropriated their narratives, and learned more about themselves as a direct result of this pain experience.

Financially, sexual pain could be a crippling experience for women in both England and France, despite the purported funded access to healthcare in both countries. Though the intricacies of navigating the French healthcare and insurance systems were clear in the French interviews, financial considerations were paramount for women in both countries, perhaps unexpectedly in England with protected free access to healthcare for many women. Findings were also surprising in terms of the definitions and classifications used, with the DSM-V (American Psychiatric Association, 2013) and the ICD (World Health Organisation, 2019) referenced relatively little in both English and French interviews, exposing the contested nature of sexual pain nomenclature, as well as the lack of policy which gives standardised approaches to these pain issues in both countries, despite the dedication of many knowledgeable practitioners being reported by both healthcare professionals and women interviewed in England and France. Perhaps unsurprisingly, the key finding of this thesis was that regardless of differences in national healthcare structure and approaches to practitioner training and localised care provision, the social determinants of health are still the most critical factor in determining ease of access and outcomes for women affected by sexual pain in both countries.

These findings, considered alongside the discourse on women's sexual pain in England and France from the theoretical sections of this thesis, demonstrate that sexual pain does not affect women equally, and that it can compound existing experiences of marginalisation and disadvantage, specifically where these are related to gender, socio-economic status, and cultural background. These conceptualisations are numerous, sometimes contradictory, and are contingent and constructed in connection with the culture, language, and form of the environment in which they are used. In this respect, complex power dynamics within healthcare structures are clear, as it is evident that the individual person conceptualising sexual pain, whether in England or France, will base this conceptualisation on prior knowledge of sexual pain, training in the field or (dis)interest in the problem if they are a healthcare professional, as well as organisational obstacles such as limitations in financial means, geographical location, and availability of knowledgeable colleagues sympathetic to matters of sexual pain.

Whichever way that women's genital sexual pain is conceptualised (and this study has demonstrated that in both England and France it is regularly conceptualised in ways that are unhelpful to the women affected), the way that women's experiences are shaped by complex structural power dynamics, their circumstances, and their access to information, knowledge, and services is still key in being able to negotiate the experience of genital sexual pain. The agenda-setting recommendations resulting from this study accordingly focus largely on the usefulness and originality of a French-English comparison, and they hold understandings of women's individual experiences of sexual pain as a key. They recommend that healthcare professionals who work with women experiencing sexual pain inform women as much as possible about their pain and ensure they have made time, despite organisational pressures, to understand what pain means to individual women. This is particularly important in light of the COVID-19 pandemic, which has reinforced existing inequalities and made healthcare access more difficult, and more complex, for people who may have been marginalised prior to its existence.

7.3: Further avenues for investigation

Further avenues for investigation drawing from the results from this study may consider using a larger sample of participants to increase the demographic breadth of the work, and, if the scope permits, comparisons between additional countries and healthcare systems within a cross-national frame. Using a methodological approach informed by intersectionality means that future work might adopt a wholly intersectional methodology, with intersectional categories and priorities as the main concern, rather than using intersectionality as a theory which informs the conceptualisations of power in the research as it has been used here. Future studies might also measure demographic characteristics of participants more rigidly, which would facilitate an understanding of the way that certain demographics of women are affected over others. This would, however, if it were in line with the reflexive and methodological concerns for the present study, need to ensure that demographic information was captured in a manner which allowed potential participants to define themselves, rather than assigning demographic categories to them. Comparative research in this area in future might sample a larger number of healthcare professionals, from a wider variety of backgrounds, to provide a separate, but no less unique, understanding of how a sample of healthcare professionals conceptualise women’s sexual pain in England and France and how these conceptualisations operate within complex structures of power and marginalisation.

7.4: Summary of contributions to knowledge

The cross-national, qualitative methodology of this thesis, exploring both discursive conceptualisations of women's genital sexual pain, and giving a detailed empirical overview of how this sexual pain was conceptualised in England and France, is the first of its kind to do so within this methodological frame. It is also the first study using this frame to include the experiences of women in non-monogamous relationships, women who were not in relationships at all, and queer women as part of this investigation, which prior studies have frequently missed. The results of this study, and the agenda-setting approach to dissemination of these, prioritise women's own conceptualisations of their pain, and though the research was undertaken in an academic setting and the interview process created accordingly, these conceptualisations have wider implications and translate into informative and insightful results which demonstrate powerful negotiations of complex healthcare systems in both England and France. Both England and France operate healthcare systems which are intended to be universal, yet women's sexual pain affects women unequally. This thesis has shown that although conceptualisations of women's genital sexual pain in England and France can be complex, and processes of abjection can marginalise, impede healthcare opportunities, and lead to profound feelings of loss and desperation, reappropriation of intimate practices when confronted with sexual pain is possible, and, despite numerous obstacles, can be both a powerful and empowering act.

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9: APPENDICES

9.1: Appendix 1: Full Ethical Approval Document

NOTTINGHAM
TRENT UNIVERSITY

JOINT INTER COLLEGE ETHICS COMMITTEE

ETHICAL CLEARANCE CHECKLIST

College of Art, Architecture, Design and Humanities; College of Science and Technology; and the Centre for Academic Development and Quality (CADQ)

(TO BE COMPLETED FOR ***ALL*** INVESTIGATIONS INVOLVING PARTICIPANTS)

All staff and PGR students wishing to conduct an investigation involving participants in order to collect new data in either their research projects or teaching activities are required to complete this checklist before commencement. It may be necessary after completion of this form to submit a full application to the Joint Inter College Ethics Committee (JICEC). Collecting primary data in the absence of ethical approval, or in the face of an adverse ethical opinion, may constitute a disciplinary offence.

If, after receiving ethical approval, factors beyond your control change your project such that the information provided in this form no longer holds, the approval will automatically become void, and you should re-apply for ethical approval. The approval process should take no longer than one month.

IF YOUR RESEARCH IS BEING CONDUCTED OFF CAMPUS AND ETHICAL APPROVAL FOR YOUR STUDY HAS BEEN GRANTED BY AN EXTERNAL ETHICS COMMITTEE, PLEASE SEND DETAILS TO THE PROFESSIONAL SUPPORT RESEARCH TEAM FOR CONSIDERATION BY THE CHAIR. YOU WILL BE EXPECTED TO PROVIDE EVIDENCE OF APPROVAL FROM THE EXTERNAL ETHICS COMMITTEE AND THE TERMS ON WHICH THIS APPROVAL HAS BEEN GRANTED.

IF YOUR RESEARCH IS TRANSFERRING INTO NOTTINGHAM TRENT UNIVERSITY AND APPROVAL WAS OBTAINED FROM YOUR ORIGINATING INSTITUTION, THERE IS A REQUIREMENT ON THE UNIVERSITY TO ENSURE THAT APPROPRIATE APPROVALS ARE IN PLACE.
If you believe either of these statements applies to your research, please contact the Professional Support Research Team AHDResearchteam@ntu.ac.uk **with evidence of former approval and the terms on which this approval has been granted.**

IT IS THE RESPONSIBILITY OF INDIVIDUAL INVESTIGATORS AND/OR SUPERVISORS TO ENSURE THAT THERE IS APPROPRIATE INSURANCE COVER FOR THEIR INVESTIGATION.
If you are at all unsure about whether or not your study is covered, please contact the Finance & Planning Manager in your Finance team to check.

Name of Applicant:	**HANNAH LORET-HOWICK**
School:	**ARTS AND HUMANITIES - HISTORY, LANGUAGES AND GLOBAL CULTURES**
Title of Investigation:	**FEMALE SEXUAL DYSFUNCTION IN ENGLAND AND FRANCE: DEFINITIONS AND REPRESENTATIONS**

STAFF	☐	**STUDENT**	☒ (*if student, please complete)
RESEARCH	☐	**CONSULTANCY**	☐

Degree Title and Level*:	**MPHIL/PHD IN LANGUAGES AND LINGUISTICS**
Supervisor (List Lead supervisor first)	**1. GILL ALLWOOD** **2. ENDA MCCAFFREY** **3. SIMON CLARKE**
Names of co-investigators (CIs) (If any of the CIs are not employed at NTU, please give the name of their organisation)	**NOT APPLICABLE**
Project start date	**27 JUNE 2017**
Estimated end date of the project	**1 JULY 2020**
Who is funding the project? Has funding been confirmed? **YES**	**NOTTINGHAM TRENT UNIVERSITY (GENDER EQUALITY IN EUROPE STUDENTSHIP)**

Briefly outline the objectives of the research. [75 words]

To investigate, within a larger framework of gender equality, how sexual pain disorders are defined and perceived in England and France by healthcare specialists and women affected by the disorders.
To consult existing medical guidance and works of social theory to allow a more comprehensive understanding of how sexual pain disorders might be seen as a gendered problem, and to contribute a comparative study between England and France to the existing literature.

Briefly describe the principal methods, the sources of data or evidence to be used, and the number and type of research participants who will be recruited to the project. [150 words]

Methods:
Loosely structured recorded interviews with:

1. **Healthcare professionals (psychotherapists, specialist nurses, sexologists, gynaecologists), recruiting predominantly from specialised female sexual dysfunction services where they exist, in general medicine, surgery, and sexual health and pain clinics in England and France.**
2. **Women affected by sexual pain disorders, recruited from online platforms (such as Twitter and online medical condition forums)**

Data sources:
Loosely structured interviews as per the attached questionnaire (to be piloted online before final data collection commences, to refine questions and make sure questions are in plain English/French)

Number and type of research participants:

1. **Healthcare professionals – two of each specialist in each of England and France**
2. **Women affected by the disorders – two of each disorder (eg. vulvodynia, vaginismus, dyspareunia) in England and in France (with awareness that women may be affected by more than one disorder at any one time)**

Do you intend to use questionnaires, scales, psychometrics, vignettes, etc that someone else has published?

NO

If YES, complete the next 3 questions
If NO, proceed 4 questions

Have you included with this application a full electronic copy or link to the above?

N/A

If you are using published the above, do you have permission to use them in the way that you intend to use them?

N/A

What steps will be taken to ensure compliance with the requirements of copyright rules for the use of published scale?

N/A

Are you developing your own research resources/instruments to collect data?

YES

If YES, complete the questions below.
If NO, proceed to the next section.

Briefly describe the research resources/instruments you are developing. [50 words]

Questionnaires for specialists in the management of female sexual dysfunction and for women affected by sexual pain disorders.

If applicable, please include an electronic copy of your own bespoke/self-developed research instrument(s) that you will use to collect data with this application.

Please find attached.

A. **Familiarisation with policy - ** Please answer *as appropriate*			
Please confirm if you are fully acquainted with the policies for guiding ethical research named below:			
NTU research ethics policy, and the procedures for ethical approval	Yes☒	No☐	N/A☐
The guidelines for ethical research promulgated by a professional association, as appropriate	Yes☒	No☐	N/A☐
NTU Data Management Policy	Yes☒	No☐	N/A☐
The Regulations for the Use of Computers (*see* NTU website)	Yes☒	No☐	N/A☐
Guidelines for Risk Assessment in Research	Yes☒	No☐	N/A☐
If you answered **NO** to any of these questions, please note that you must study these guidelines and regulations before proceeding to complete the remainder of this form.			

B. **External Ethical Review –** *Please answer as appropriate*			
Has a favourable ethical opinion already been given for this project by any other external research ethics committee[2]? An external research ethics committee means any research committee *other* than those at Nottingham Trent University. Submission of this form is *not* a submission to an external research ethics committee.	Yes☐	No☒	N/A☐
Will this project be submitted for ethical approval to any other external research ethics committee[3]? An external research ethics committee means any research committee *other* than those at Nottingham Trent University. Submission of this form is *not* a submission to an external research ethics committee.	Yes☒	No☐	N/A☐
If you answered **YES** then sign the declaration and submit with the letter of confirmation to the Research Office to keep on file. **An application to the NHS will be made for ethical approval to interview healthcare specialists. An application will also be made to the individual hospitals where interviews are to be conducted in France, as per local ethical policies. These are dependent on Project Approval for this project (submitted for consideration 4th November) and favourable ethical approval by Nottingham Trent University.**			

C. **Investigators**

---

[2] This includes the research ethics committee of another academic institution.
[3] This includes the research ethics committee of another academic institution.

Do investigators have previous experience of, and/or adequate training in, the methods employed?		Yes☒	No**☐
If involved will junior researchers/students be under the direct supervision of an experienced member of staff?	Yes☒	No**☐	N/A☐
If involved will junior researchers/students be expected to undertake physically invasive procedures (not covered by a generic protocol) during the course of the research?	Yes**☐	No☒	N/A☐
Are researchers in a position of direct authority with regard to participants (e.g. academic staff using student participants, sports coaches using his/her athletes in training)?	Yes**☐	No☒	N/A☐
** If you select ANY answers marked **, please submit your completed Ethical Clearance Checklist accompanied by a statement covering how you intend to manage the issues (indicated by selecting a ** answer) to the JICEC.			

D. **Participants**		
Clarify whether or not your research involves any do the following vulnerable groups.		
Children under 18 years of age (please refer to published guidelines)	Yes*☐	No☒
People over 65 years of age	Yes*☐	No☒
Disabled people	Yes*☐	No☒
People with mental illness	Yes*☐	No☒ **Please see note below** ***
Prisoners/Detained persons	Yes*☐	No☒
Is a DBS/Overseas Police Check required?	Yes☒	No☐
If required, do you have a DBS/Overseas Police Check? *Please contact NTU Disclosures, details can be found on the address book.*	Yes☒	No☐
What actions will you take to ensure the safety of yourself and the participants? **Regular, accurate and appropriate risk assessments, regular contact with supervisors and advisor, who all have extensive experience in data collection for research purposes. Information available to participants will be clear and accessible, and it will be made explicit that they are free to leave the study at any time if they so wish, or to contact the lead researcher for further information. Where I am unsure of an answer myself, signposting will be immediate and appropriate. Where distress is perceived in interviews (especially if these are over Skype or other remote service), an action plan will be drawn up with the participant should they end the call suddenly so that their welfare is paramount and safeguarded. This will be written up in regular contemporary reflections and data collection reports to ensure that the process is recorded accurately. Any data collected will be stored in strict accordance with Nottingham Trent University's data management policy and research ethics policy, and any data and recordings will be coded securely.**		

How will you recruit your participants? **Specialists: By direct contact, according to their speciality and their own research interests where applicable.** **Women affected by sexual pain disorders: Through online platforms (Facebook, Twitter) and forums for women affected by the sexual pain disorders in question.**		
Have you completed a risk assessment form? Please attach to the application.	Yes*~~☐~~	No☐

***** This study will not be examining disorders of mental health or people who are considered to have a mental illness, but may inadvertently include participants who have a mental health diagnosis (which is commonly seen as a co-morbidity of female sexual dysfunction disorders). I have ticked 'no' here as I will not be seeking participants based on their mental health status or any mental health diagnoses, but have chosen to leave a note as I feel it is important to outline that I am aware that in interviewing participants for the study I may encounter participants who have a mental health issue. Participants will not be asked to disclose any sort of mental health diagnosis if they do not wish to, but provision will be made to enable signposting, safeguarding and effective reporting should any issues related to mental health arise.**

Risk		
To the best of your knowledge, please indicate whether the proposed study:		
Involves procedures likely to cause psychological, social or emotional distress to participants	Yes*☐	No~~☐~~
Is designed to be challenging psychologically in any way	Yes~~*☐~~	No☐
Exposes participants to risks or distress greater than those encountered in their normal daily life	Yes*☐	No~~☐~~

E. **Special Risks**		
Does the project involve access to websites normally prohibited on university servers, for example pornography or sites of organisations proscribed by the UK Government.	Yes*☐	No ~~☐~~
Does the project involve access to investigation into extremism or radicalisation.	Yes*☐	No ~~☐~~
Does the project involve accessing and using data of a potentially damaging nature which has been obtained from a source which	Yes*☐	No ~~☐~~

<table>
<tr><td colspan="3">may not have the requisite authority to provide it. Here, potentially damaging can mean anything from information on cases of domestic abuse to data on international spy networks. In case of uncertainty please consult the Research Support Office or your School Associate Dean for Research.</td><td></td><td></td></tr>
<tr><td colspan="3">Does the project involve the acquisition of security clearances, including the Official Secrets Act.</td><td>Yes*☐</td><td>No ☒</td></tr>
<tr><td colspan="5">If you responded yes to any of these questions then this is classified as ‘Special Risk Research’ please refer to the guidance in Appendix B and ensure that these items are covered in the Risk Assessment (Appendix A). Please note that your application must be approved by your School Associate Dean for Research. This applies to both members of staff and Postgraduate Research Students.</td></tr>
<tr><td colspan="5">Is there any foreseeable risk that your project may lead to:</td></tr>
<tr><td colspan="3">Physical harm to participants or researchers?</td><td>Yes*☐</td><td>No ☒</td></tr>
<tr><td colspan="3">Significant psychological or emotional distress to participants
• i.e. Is designed to be challenging psychologically in any way
• Exposes participants to risks or distress greater than those encountered in their normal daily life</td><td>Yes*☒</td><td>No ☐</td></tr>
<tr><td colspan="3">Harm to the reputation of participants, or their employers, or of any other persons or organisations?</td><td>Yes*☐</td><td>No ☒</td></tr>
<tr><td colspan="5"><i>Chaperoning Participants</i>
If appropriate, e.g. studies which involve vulnerable participants, taking physical measures or intrusion of participants' privacy:</td></tr>
<tr><td colspan="2">Will participants be chaperoned by more than one investigator at all times?</td><td>Yes☐</td><td>No*☐</td><td>N/A☒</td></tr>
<tr><td colspan="2">Will at least one investigator of the same sex as the participant(s) be present throughout the investigation?</td><td>Yes☐</td><td>No*☐</td><td>N/A☒</td></tr>
<tr><td colspan="2">Will participants be visited at home?</td><td>Yes*☐</td><td>No ☒</td><td>N/A☐</td></tr>
<tr><td colspan="5">If you have selected N/A please provide a statement in the space below explaining why the chaperoning arrangements are not applicable to your research proposal:
My research does not involve physically invasive procedures and research interviews will be conducted one-to-one in person, or one-to-one remotely. Participants will be asked to agree to this during the consenting process, before taking part in research interviews.</td></tr>
<tr><td colspan="5">If you have selected any of the * answers for any question in section E please explain/confirm:
○ Explain why it is necessary to conduct the research in such a way as to qualify it as Special Risk research</td></tr>
</table>

- If applicable, confirm that access to websites which may be proscribed by the UK Government or may be subject to surveillance by security services will be undertaken using the University network
- Explain what, if any, steps will be taken, in addition to those listed in Section 6, to ensure that data obtained during the research project will be stored securely
- If applicable, confirm that the transmission of data obtained during the research project to any co-investigators outside of the University network will be in encrypted format and using Zend, which encrypts files during transmission.
- If applicable, explain why the transportation of research data or materials is required and that an encrypted memory stick will be used where such transportation is necessary or unavoidable

If the answer to any of the remaining questions is YES, please explain:

- the nature of the risks involved, and why it is academically necessary for the project to incur them
- how you propose to mitigate them
- the arrangements by which you will ensure that participants understand and consent to these risks
- any arrangements you will make to refer participants to sources of help, if they are seriously distressed or harmed as a result of taking part in the project
- your arrangements for recording and reporting any adverse consequences of the research

Special Risk: The study may cause significant psychological or emotional distress to participants

- **It is necessary to conduct the research in this way because the very nature of the research is to explore the discourse around and perceptions of sexual pain, and so this pre-empts asking participants about their perceptions of themselves and perhaps sensitive questions about their relationships with others and with themselves. Without asking these questions, it would be impossible to gain an understanding of how sexual pain can affect women's perceptions of themselves and to gain a genuine understanding of their opinions on the matter.**
- **Data should not need to be transported between one place and another. Any recordings made on a Dictaphone will be immediately uploaded and coded securely in line with data protection, the University's data management policy, and the research ethics policy, as well as any ethical stipulations made by the NHS and French healthcare system once ethical clearance has been received from them.**
- **The risks are that the sensitive questions being asked (please see questionnaire attached) might cause interviewees distress on thinking about emotional or difficult subjects in order to answer. It is also foreseen that participants might disengage from the interview process at any time without warning, or seek medical advice from the interviewer, who will not be able to give it.**
- **All of the above risks will be address in the research consent information sheet (please see attached) and signposting will be clear during the recruitment process. Further to this, the questions attached are subject to minor changes, and both the questions and the research consent information sheet will be piloted before formal data collection begins, and any recommendations or changes recorded and discussed in depth with supervisors.**

- **The above risks are clearly outlined in the research consent information sheet, and any consent gained will be informed. Participants will be able to ask questions about the risks and how these will be dealt with at any stage during the recruitment phase or after, and will be made aware that they are free to cease being a participant at any time.**
- **Arrangements will be made to provide a list of alternative sources of help (attached to the research consent information sheet) should participants feel the need to get extra support. They will also be free to contact the interviewer at any time during the research process for further information on support services available to them.**
- **All data collection will be written up the same day it is undertaken to ensure that records made are contemporary to the research being undertaken. Any adverse consequences will be recorded as part of this write-up, reported to the supervisory team immediately, and the participant will be safeguarded by debriefing (with their consent) and by ensuring that any signposting, decision to discontinue their participation or discussion of their participation is done with full consent, is recorded, confidential, and always in their best interests, not the interests of the study.**

Advice to Participants following the investigation

Investigators have a duty of care to participants. When planning research, investigators should consider what, if any, arrangements are needed to inform participants (or those legally responsible for the participants) of any health related (or other) problems previously unrecognised in the participant. This is particularly important if it is believed that by not doing so the participants well-being is endangered. Investigators should consider whether or not it is appropriate to recommend that participants (or those legally responsible for the participants) seek qualified professional advice, but should not offer this advice personally. Investigators should familiarise themselves with the guidelines of professional bodies associated with their research.

F. **Observation/Recording** - *Please answer: yes or no*		
Does the study involve data collection, or the observation or recording of participants? Note that data collection includes the re-use of material originally collected for a non-research purpose (e.g. client or student data already in your possession) and includes anonymous data	Yes~~☐~~	No☐
Will those contributing to the data collected (or being observed or being recorded), or the appropriate authority, be informed that the data collection, observation or recording will take place?	Yes~~☐~~	No☐
If you have answered **NO** to question to the first question in section E, because you are not undertaking empirical work, proceed to the declaration at the end of this form. If you have answered **NO** to question the second question, an application for ethical approval needs to be made to the JICEC.		

G. **Consent and Deception -** *Please answer: yes or no*		
Informed Consent & Data Withdrawal Will participants, or the appropriate authority, be fully informed of the objectives, and of all other particulars of the investigation (preferably at the start of the study, but where this would interfere with the study, at the end)?	Yes☒	No☐
Will participants, or the appropriate authority, be fully informed of the use of the data collected (including, where applicable, ownership of any intellectual property arising from the research)?	Yes☒	No☐
For detained persons, members of the armed forces, employees, students and other persons who may not be in a position to give fully independent consent, will care be taken over the gaining of freely informed consent?	Yes☒	No☐
If your research involves children under the age of 18 or participants who have impairment of understanding or communication: **N/A**		
- will consent be obtained (either in writing or by some other means)?	Yes☐	No*☐
- will consent be obtained from parents or other suitable person?	Yes☐	No*☐
- will they be informed that they have the right to withdraw regardless of parental/ guardian consent?	Yes☐	No*☐
For investigations conducted in schools, will approval be gained in advance from the Head-teacher and/or the Director of Education of the appropriate Local Education Authority? **N/A**	Yes☐	No*☐
For detained persons, members of the armed forces, employees, students and other persons judged to be under duress, will care be taken over gaining freely informed consent? **N/A**	Yes☐	No*☐
Will participants, or the appropriate authority, be informed of their right to withdraw from the investigation at any time (or before a specific deadline) and to require their own data to be destroyed?	Yes☒	No*☐
Deception		
Is deception part of the study? If the answer is no, proceed to section G	Yes☐	No*☒
If yes, please explain the rationale and nature of deception (50-75 words):		
Will participants be de-briefed and the true object of the research revealed at the earliest stage upon completion of the study?	Yes☐	No*☐
Has consideration been given on the way that participants will react to the withholding of information or deliberate deception?	Yes☐	No*☐

G. Storage of Data and Confidentiality
Please see University guidance on https://www.ntu.ac.uk/intranet/policies/legal_services/data_protection/16231gp.html. If you are a member of NTU staff you can obtain direct access to this with your staff username

and password. If you are not a member of NTU staff, please request of copy from your supervisor or course leader.		
Does the funder of your research require you to comply with policy around data management planning and access to publically funded research (RCUK funders, Horizon 2020, Wellcome Trust, etc). If yes, please attach your data management plan (please use https://dmponline.dcc.ac.uk/ to design your plan based around your funder's requirements. If you have any queries or require support please email: LIBResearchTeam@ntu.ac.uk).	Yes☐	No☒
Will all information on participants be treated as confidential and not identifiable unless agreed otherwise in advance, and subject to the requirements of the law of the relevant jurisdiction?	Yes☒	No☐
Will storage of data comply with the Data Protection Act 1998 and the law of any non-UK jurisdiction in which research is carried out?	Yes☒	No☐
Will any video/audio recording of participants be kept in a secure place and not released for use by third parties?	Yes☒	No☐
Will video/audio recordings be destroyed within six years of the completion of the investigation?	Yes☒	No☐
If your study involves video/photography please ensure that participants have completed a release form.		

Have you taken steps to ensure full security and confidentiality of any personal or confidential data collected for the project.	Yes☒	No☐
I confirm that any data will be stored in line with the University Data Management Policy. Files will be stored in a password protected computer with data coded and anonymised appropriately.	Yes☒	No☐

H. Incentives		
Have incentives (other than those contractually agreed, salaries or basic expenses) been offered to the investigator to conduct the investigation?	Yes**☐	No☒
Will incentives (other than basic expenses) be offered to potential participants as an inducement to participate in the investigation?	Yes**☐	No☒
** If you select ANY answers marked **, please submit your completed Ethical Clearance Checklist accompanied by a statement covering how you intend to manage the issues (indicated by selecting a ** answer) to the JICEC.		
The design of the participant information sheet/consent form and of any research instrument (including questionnaires, sampling and interview schedules) that will be used, have been discussed with my supervisor(s).		
Compliance with Ethical Principles If you have completed the checklist to the best of your knowledge and selected an answer marked with * or ** your investigation you will need to seek full formal approval from the JICEC.		

Please return to completed Ethical Approval Checklist with the following documents as necessary to the Research Team, Arkwright 204, City Campus, or via email AHDresearchteam@ntu.ac.uk:

- A copy of the research tool you are using
- Consent Form (if necessary)
- Data Management Policy (if necessary)
- Risk Assessment (if necessary)

Please note that the ethics form does not abrogate your need to complete a risk assessment

Declaration

☐ I have read the Ethics & Governance Statement https://www.ntu.ac.uk/research/research-at-ntu/research-integrity . I confirm that the above named investigation complies with published codes of conduct, ethical principles and guidelines of professional bodies associated with my research discipline.

☐ I have read this form and confirm that appropriate steps have been taken to mitigate the special risks associated with the proposed project.

☐ I agree to notify the Research Office of any changes or modification that may have an influence on ethical approval.

Signature of Applicant *(Research Student or Principal Investigator)* Date	
Signature of Supervisor/Line Manager *(Director of Studies/ATL)* Date	
Signature of JICEC Chair Date	

Appendix A

Task or Activity Description	**Location:**	**TBC**
Collecting interview data from women affected by sexual pain disorders		
	Persons at Risk - Affected Groups:	
	A – Women affected by sexual pain disorders	B -
	C –	D -
	E –	F -

Potential Hazard	Existing Controls	Risk level with controls	Additional Controls or Required Action & Date
Distress caused by talking about painful sexual encounters or emotive/sensitive issues		Average - high	Where distress is recognised during an interview, ensure participant is aware of their right to withdraw. Where appropriate, offer to continue at a later date or to take a break before continuing if interviewee consents. Follow up or debrief interviewees (with participant consent) within a week of interview taking place to offer support should it be

Potential Hazard	Existing Controls	Risk level with controls	Additional Controls or Required Action & Date
			necessary, outlining the role of the interviewer is not that of a medical professional.
Participant disengaging suddenly from interview/session and becoming uncontactable		Average	Gain alternative means of contact for each participant where possible (stored securely), and list of sources of help given with research consent information sheet.
Participants seeking medical advice from interviewer		Low	None. Interviewer will give efficient signposting, and consent information sheet clearly outlines the incapacity of interviewer to give medical advice or guidance.

This risk level has been reduced as low as is reasonably practicable			

Assessor’s Signature:		**Date:**	
Manager’s Signature		**Date:**	

	1st Review	**2nd Review**	**3rd Review**	**4th Review**	**5Th Review**
Assessors Name:					
Managers Name:					
Date of Review:					

Appendix B

Risk of harm to researchers, individual participants and participating organisations

Please note that this section covers risks to the research team, including yourself, as well as risks to participants.

Health and Safety

These are matters relating to occupational health and safety rather than research ethics, but if there is any significant possibility that the project may involve health and safety risks to any members of the research team, the JICEC will make ethical approval conditional on the submission of an acceptable risk assessment. In such cases, you will be asked to confirm that a risk assessment form has been submitted and approved before ethical approval will be issued.

If you are a member of staff, the risk assessment form must be approved by your Dean of School (or their nominee): if you are a doctoral student, it must be endorsed by your Director of Studies and approved by the Chair of the College Research Degrees Committee.

A risk assessment form must also be completed before fieldwork is undertaken abroad.

Special Risks

This relates to research into subjects where there is the potential to attract the attention of third party investigations into the conduct of the researcher. This would include, but is not necessarily limited to, the following:

1) Access to websites normally prohibited on university servers, for example pornography or sites of organisations proscribed by the UK Government.
2) Investigation into extremism or radicalisation.
3) Accessing and using data of a potentially damaging nature which has been obtained from a source which may not have the requisite authority to provide it. Here, potentially damaging can mean anything from information on cases of domestic abuse to data on international spy networks. In case of uncertainty please consult the Research Support Office or your School Associate Dean for Research.
4) The acquisition of security clearances, including the Official Secrets Act.

If you believe your research falls under either of these categories you will need to have your application endorsed by the School Associate Dean for Research (please see foot of the application document). This applies to both members of staff and

Postgraduate Research Students. If you are unsure who your School Associate Dean of Research is please contact the College Research Support Office/University Research Support Team who will be able to advise.

If you are planning on accessing websites which may be proscribed by the UK Government, such as those associated with radicalisation or terrorist/extremist organisations, please ensure that you access these sites using the University network. This will ensure that these activities are flagged as a legitimate part of your research. The computer usage policy (add in link) may also have relevance and should be consulted. You may need to contact IT Services to ask for certain sites to be unblocked.

Please note that the University cannot guarantee protection from investigation by external authorities, but completion of this section of the application form and endorsement by the School ADR will allow the university to assist external authorities by demonstrating that the actions of the researcher(s) were part of legitimate research activities.

Please be aware that while research into illegal activities can form part of legitimate academic enquiry the University does not permit any crime to be committed for research purposes, for example accessing images of paedophilia or child abuse.

Data obtained from Special Risk research may be especially sensitive and therefore additional consideration of data security may be required. In particular, access rights to data, security of location and revocation of access rights for any investigator leaving the project are of particular pertinence. Furthermore, the CREC recommends that physical research data should be scanned and uploaded to a password-protected server or, where this is not possible, kept in a secure storage unit, for example a locked filing cabinet or similar, on University premises.

The Terrorism Act (2006) and the Counter-Terrorism and Security Act (2015) outlaw the dissemination of terrorist publications if the individual concerned has the intention to encourage or induce others. Publications disseminated for the purposes of a clearly defined research project should not amount to an offence, because the requisite intention is unlikely to be present. However, caution is advised and the dissemination of raw research materials should be avoided where possible. In particular, documents should, wherever possible, be individually password-protected and transmitted using 'Zend' which encrypts the file during transmission. Physical transportation of research data should be avoided but, where it is necessary, it should be done so using an encrypted memory stick.

9.2: Appendix 2 - Participant consent form

CONSENT FORM

I am a healthcare professional/woman affected by sexual pain (please delete as appropriate)

Please read and confirm your consent to being interviewed for this project by initialling the appropriate box(es) and signing and dating this form above the red writing

1. I confirm that the purpose of the project has been explained to me, that I have been given information about it in writing, and that I have had the opportunity to ask questions about the research ☐
2. I understand that my participation is voluntary, and that I am free to withdraw at any time without giving any reason and without any implications for my legal or healthcare rights ☐
3. I give permission for the interview to be tape-recorded by research staff, on the understanding that the tape will be destroyed as per university protocol ☐
4. I agree to take part in this project ☐

Name of respondent	Date	Signature
Name of researcher taking consent	Date	Signature

Study contact:

Hannah Loret

PhD Student

School of Arts and Humanities (History, Languages and Global Cultures)

Nottingham Trent University

9.3: Appendix 3 - Participant information sheets

Women affected by sexual pain disorders - Participant Information Sheet

Title of study:

Conceptualisations and perceptions of sexual pain in England and France

Name of researcher: Hannah Loret

Nottingham Trent University

We would like you to consider being a part of a research study at Nottingham Trent University (UK) about women's experiences of sexual pain disorders in England and France. Before you decide whether to agree to take part, it is important that you understand the reason why this research is being done, and what it would involve for you. One of the team will go through this information with you, and answer any questions that you might have. Please do talk to others about the study if you wish, and ask if there is anything that is not clear to you. If there are any questions at any time, please do get back in touch using the contact details at the end of this sheet.

What is the purpose of the study?

This study is looking at sexual pain disorders and how they can affect how women see themselves. The main focus of the study is to look at how female sexual pain disorders (falling within a larger framework of female sexual dysfunction) might be seen as a ''gendered'' problem. We will then be looking at how this affects the way it is seen by healthcare professionals in England and France. As well as interviewing women who have been affected by these issues, we will be interviewing healthcare professionals about their perceptions and opinions. It is hoped that the study will provide a useful tool for practitioners to consider their perceptions of female sexual pain disorders, and the way women affected by these are treated within the healthcare service.

The project began in June 2017 and will run until July 2020.

Do I have to take part?

No – whether you take part or not is entirely up to you. You do not have to have been formally diagnosed with a sexual pain disorder or female sexual dysfunction to take part – if you feel that you might suffer from a sexual pain disorder and would like to discuss it, your participation would be welcomed. If you do decide that you want to take part, you'll be asked to keep this information sheet and to sign a consent form. If you decide to take part and later decide that you don't want to, you are free to withdraw at any time, without giving a reason. In the case of withdrawal, any anonymised data collected about you will be destroyed. This will not affect your legal rights or right to healthcare treatment in any way.

Who is funding this study?

The study is funded by Nottingham Trent University, and undertaken under the guidance of three experienced supervisors (at Nottingham Trent University) and one advisor (at The University of Nottingham, faculty of Medicine and Health Sciences).

This funding allows the project to be undertaken as a piece of independent, academic research. We hope that the results will be useful to staff within the healthcare system and funding bodies, and the identities of our participants will be anonymised and will not be shared with them.

What do you want me to do?

You will be asked to take part in an interview lasting approximately one hour. It will be arranged in a mutually convenient place, and at a time that suits you. The questions to be discussed can be sent to you in advance, if you wish. The interview will be carried out by one of the research team, following a pre-set schedule. You will have the opportunity to ask any questions that you have before or after the interview takes place, and the interview will take place at your own pace.

We will ask for your written permission to tape the interview, to ensure that the information you give us is accurately recorded.

What will happen to the information I give in my interview?

The tape of your interview will be transcribed. The information will be analysed and fed it into the project results. All transcriptions will be anonymised and kept in a locked cabinet at the Nottingham Trent Doctoral School. All transcripts and recordings will be destroyed six years from the date of completion of the project, as per Nottingham Trent University's protocol. Unfortunately there is currently no inconvenience allowance for this study available to compensate you for your participation, but the maximum will be done to ensure that all interviews and communication is at times convenient and suitable for you.

How will you protect my confidentiality and anonymity?

The tape will be handled only by the lead researcher, and kept in line with data protection principles and our approved research protocol. The transcript may be seen by the supervisors in the team but this will only be once it has been anonymised. Hard copies of research notes will be kept in locked filing cabinets, and electronic files are kept on password protected computers. Any anonymised recordings will be destroyed six years after the project is completed. If the study is audited by the funders, they may request to see the original research notes and transcripts, but again only the anonymised copies will be kept. You will not be named or otherwise identified in any publication arising from this project. If you have any questions about this element of the study, please do ask.

What are the possible disadvantages and risks in taking part?

No disadvantages are envisaged from taking part in this study. You would need to be willing to dedicate the time of an interview (to be organised at a time and place convenient to you) if you do agree to take part in the study. It may be that some of the questions provoke some strong emotions as they are of a sensitive nature, but interviews will be conducted sensitively and with your best interests as a priority. If you would like a copy of the questionnaire before the interview, please let the lead researcher know.

What are the possible benefits?

We hope that you will find the interview interesting, and will take satisfaction from helping to develop knowledge of this important topic. It is hoped that your contribution will help practitioners gain a better understanding of how sexual pain might be managed and how it affects how women might see themselves.

What will happen to the results?

The results will form part of a PhD thesis, and also the subject of academic publications.

The lead researcher will also publish a short, executive summary of the results and recommendations, and will circulate it amongst healthcare policymakers. It is hoped that workshops will also be held for policymakers and healthcare staff to discuss and challenge current perceptions of female sexual pain disorders.

Who is responsible if anything goes wrong?

Nottingham Trent University is ultimately responsible for the conduct of the project. This project was approved by the Ethics Committee of Nottingham Trent University on the 20th of December 2017.

Contacts for further information

Please feel very welcome to contact the lead researcher for this project, Hannah Loret-Howick, using the details below:

Hannah Loret

PhD Student

Nottingham Trent University [telephone number and email address supplied]

Professionals specialised in female sexual pain disorders - Participant Information Sheet

Title of study:

Conceptualisations and perceptions of sexual pain in England and France

Name of researcher: Hannah Loret

Nottingham Trent University

We would like you to consider being a part of a research study at Nottingham Trent University (UK) about women's experiences of sexual pain disorders in England and France. Before you decide whether to agree to take part, it is important that you understand the reason why this research is being done, and what it would involve for you. One of the team will go through this information with you, and answer any questions that you might have. Please do talk to others about the study if you wish, and ask if there is anything that is not clear. If there are any questions at any time, please get back in touch using the contact details at the end of this sheet.

What is the purpose of the study?

This study is looking at sexual pain disorders and how they can affect how women see themselves. The main focus of the study is to look at how female sexual pain disorders (falling within a larger framework of female sexual dysfunction) might be seen as a ''gendered'' problem. We will then be looking at how this affects the way it is seen by healthcare professionals in England and France. As well as interviewing healthcare professionals about their perceptions and opinions, we will also be interviewing women who have been affected by these issues. It is hoped that the study will provide a useful tool for practitioners to consider their perceptions of female sexual pain disorders, and the way women affected by them are seen within the healthcare service.

The project began in June 2017 and will run until July 2020.

Do I have to take part?

No – whether you take part or not is entirely up to you. If you do decide that you want to take part, you'll be asked to keep this information sheet and to sign a consent form. If you decide to take part and later decide that you don't want to, you are free to withdraw at any time, without giving a reason. In the case of withdrawal, any anonymised data collected about you will be destroyed.

Who is funding this study?

The study is funded by Nottingham Trent University, and undertaken under the guidance of three experienced supervisors (at Nottingham Trent University) and one advisor (at The University of Nottingham, faculty of Medicine and Health Sciences).

This funding allows the project to be undertaken as a piece of independent, academic research. We hope that the results will be useful to staff within the healthcare system and funding bodies, and the identities of all of our participants will be anonymised and will not be shared with them.

What do you want me to do?

You will be asked to take part in an interview lasting approximately one hour. It will be arranged in a mutually convenient place, and at a time that suits you. The questions to be discussed can be sent to you in advance, if you wish. The interview will be carried out by one of the research team, following a pre-set schedule. You will have the opportunity to ask any questions that you have before or after the interview takes place.

We will ask for your written permission to tape the interview, to ensure that the information you give us is accurately recorded.

What will happen to the information I give in my interview?

The tape of your interview will be transcribed. The information will be analysed and fed it into the project results. All transcriptions will be anonymised and kept in a locked cabinet at the Nottingham Trent Doctoral School. All transcripts and recordings will be destroyed six years from the date of completion of the project, as per Nottingham Trent University's protocol. Unfortunately there is currently no inconvenience allowance for this study available to compensate you for your participation, but the maximum will be done to ensure that all interviews and communication are at times convenient and suitable for you.

How will you protect my confidentiality and anonymity?

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What are the possible disadvantages and risks in taking part?

No disadvantages are envisaged from taking part in this study. You would need to be willing to dedicate the time of an interview (to be organised at a time and place convenient to you) if you do agree to take part in the study. It may be that some of the questions provoke some strong emotions as they are of a sensitive nature, but interviews will be conducted sensitively and with your comfort as a participant as priority. If you would like a copy of the questionnaire before the interview, please let the lead researcher know.

What are the possible benefits?

We hope that you will find the interview interesting, and will take satisfaction from helping to develop knowledge of this important topic. It is hoped that your contribution will help to increase understanding of how sexual pain might be managed and how it affects the way women might see themselves.

What will happen to the results?

The results will form part of a PhD thesis, and also the subject of academic publications.

The lead researcher will also publish a short, executive summary of the results and recommendations, and will circulate it amongst healthcare policymakers. It is hoped that workshops will also be held for policymakers and healthcare staff to discuss and challenge current perceptions of female sexual pain disorders.

Who is responsible if anything goes wrong?

Nottingham Trent University is ultimately responsible for the conduct of the project. This project was approved by the Ethics Committee in December 2017.

Contacts for further information

Please feel very welcome to contact the lead researcher for this project, Hannah Loret, using the details below:

Hannah Loret

PhD Researcher

Nottingham Trent University [telephone number and email address supplied]