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Investigating the Experiences of Evangelical Couples Coping with Painful Intercourse During Early Marriage

A Dissertation by

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Orange, CA

School of Communication

Submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy in Communication

May 2024

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April 2024

Investigating the Experiences of Evangelical Couples Coping with Painful Intercourse During Early Marriage

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DEDICATION

This dissertation is dedicated to my dear friend, who I said all the wrong things to before becoming educated about painful intercourse. Your grace, courage, and tenacity have been the foundation and fuel for this work.

I would also like to dedicate this research to the couples who participated. Thank you for finding the courage to share your story with a total stranger. May the pain you have endured and the harmful messages that have been spoken over you lose their power as you keep stumbling through marriage together and embracing hope and healing.

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LIST OF PUBLICATIONS

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ABSTRACT

Investigating the Experiences of Evangelical Couples Coping with Painful Intercourse During Early Marriage

by Arielle L. Leonard Hodges

Women who internalize evangelical purity messages face heightened risk for persistent pain or difficulty with penile-vaginal intercourse. Drawing on research in communication, psychology, and sexual medicine, the aim of this multilevel qualitative study is to increase understanding of how evangelical couples communicatively cope with painful intercourse and the memorable messages they believe contribute to their experiences of coping. This study involved conducting qualitative interviews with 20 evangelical married couples (40 total spouses) who currently or recently experienced a wife's persistent pain during (attempted) penile-vaginal intercourse and 16 female clinicians (pelvic floor physical therapists and mental health professionals) who regularly work with women or couples affected by painful intercourse. Interview data were abductively analyzed at the individual level, couple-level, and across data points using the flexible coding method and assisted by thematic analysis. Guided by the Theory of Memorable Messages, the findings of this study illuminate how sexual socializing messages received in and outside of religious contexts may set the stage for delayed support and subsequent emotional and communicative challenges, whereas other messages may intervene in the trajectory, facilitating couples' ability to work as a team, seek support, and reframe their individual and shared experiences. This study supports and extends extant interdisciplinary literature by revealing the social context of female sexual pain, utilizing multiple data points to provide in-depth insight into the phenomenon of coping with painful intercourse, and illuminating timing and co-

occurrence of memorable messages as important aspects of their function and memorability. Practically, the findings offer couples, practitioners, and evangelical Christian leaders possible points of communicative intervention that may empower couples and facilitate the coping process.

Keywords: sexual pain, memorable messages, coping, support seeking, religion

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LIST OF ABBREVIATIONS

Abbreviation	**Meaning**
PVI	Penile-vaginal intercourse
WPP-PVI	Women's persistent pain with penile-vaginal intercourse
ToMM	Theory of Memorable Messages

LIST OF SYMBOLS

Symbol	Meaning
M	Mean
SD	Standard Deviation

1 Introduction

> Mentally, I would say that my faith has been the thing that has allowed me to work through this. But it's also difficult because in the beginning, it was the thing that made me the most *mad* about it. I was like, "What?!" I believed God when he that sex is a good thing. I believed it. And I think to believe it and then not to be able to experience it is like [*pauses*] I don't even know the word for it. It's so soul-crushing because I *believed* you when you said this, and I'm not experiencing that, and I don't know why I'm not experiencing that because *other* people experience it. What is it about me that makes it so that I can't experience it? (Jasmine, newlywed seeking treatment for vaginismus)

Like Jasmine and several other female Christian millennials, I was a poster child for the evangelical purity movement. I wore a purity ring inscribed with "True Love Waits" when I was in high school, believing that premarital sex was a sin, but that married sex would make headlines (Estrada, 2022; Manning, 2013, 2017). Christian purity messages encourage couples to remain sexually abstinent until marriage. Given how intimately intertwined evangelical Christianity was with my experiences in romantic relationships, I have always been puzzled by the relative lack of attention given to religion in interpersonal and health communication research, especially concerning issues of sexual health and intimacy. Religion frequently looms in studies of sexual communication (Aragon & Cooke-Jackson, 2021; Coffelt, 2018; Coffelt et al., 2021; Holman, 2021), however, religious couples' sexual communication has received minimal systematic attention in communication research (Kosenko et al., 2016; Leonard et al., 2022; Leonard Hodges & Bevan, 2023; Manning, 2013, 2014, 2015, 2017).

Many people express feeling underprepared for sex because of religious socialization (Frydman, 2022; Rubinsky & Cooke-Jackson, 2017). More troublingly, research has linked psychological, physiological, and relational harm in women's sexual relationships to religious socialization about sex (Estrada, 2022; Gregoire et al., 2021). Many evangelical Christian women attribute chronic pain with sexual intercourse to heteronormative sexual scripts promoted within the evangelical purity movement (Azim et al., 2020; Happel-Parkins et al., 2020). In some cases, these scripts have perpetuated spousal rape or abuse against women who feel obligated to have sex and push through the pain (Gregoire et al., 2021). Yet, clinicians—including therapists and gynecologists, who might be the first point of contact for individuals or couples affected by female sexual pain—are often ill-equipped to treat sexual issues generally and in devout religious individuals specifically (Abdolrasulnia et al., 2010; Blass & Fagan, 2001; Byers, 2011; Noland, 2021; Slowinski, 2001).

Communication in multiple contexts is therefore central to the experience and management of sexual pain. At a macro-level, the etiology of sexual pain may in part be attributable to religious purity messages (Azim et al., 2021; Reissing, 2021). Pain also affects communication processes within multiple communicative contexts. Pain is subjective and measured through cultural lenses of interpretation (Hintz, 2020), so clinical intervention or emotional support for the pain experience requires communication (Hintz & Venetis, 2019). Sexual pain is inherently interpersonal, affecting and being affected by romantic partners' communication and relational quality (Rosen & Bergeron, 2019). It is possible that couples use communication to disrupt the sexual pain trajectory in ways that facilitate their ability to cope, enhance relational health, and even reduce pain. The broad goal of this study is to gain a nuanced and in-depth understanding of the sexual pain experience by examining the communication that

occurs at multiple social ecological levels of influence (Bronfenbrenner, 1977). More specifically, this study seeks to explore the function of memorable messages in the interpersonal processes of coping and support for couples practicing evangelical Christianity.

1.1 Problem Statement

An estimated 14% to 34% of premenopausal women experience recurring sexual pain (Rosen & Bergeron, 2019; cf. Azim et al., 2021). Sexual pain can occur before, during, or after attempted intercourse. Recurring or persistent female sexual pain is often operationalized as *dyspareunia*, or persistent pain with penile-vaginal intercourse, or PVI) or *vaginismus* (difficulty or impossibility of vaginal intercourse, associated with fear and avoidance) (Reissing et al., 2014), and researchers have long debated whether sexual pain should be classified as a sexual dysfunction or a chronic pain condition (Hintz & Venetis, 2019; Meana & Binik, 2022). Persistent sexual pain is biopsychosocial in nature, and possible causes include, but are not limited to, physical health conditions (e.g., endometriosis), injury, hormonal imbalance, anxiety or depression, or fear of sex (Graziottin & Gambini, 2017; van Lankveld et al., 2010). Thus, treatment may involve cognitive behavioral therapy, pelvic floor physical therapy, sex therapy, or some combination of these. The multifaceted nature of female sexual pain conditions and the lack of understanding within medical contexts makes diagnosis difficult, and women often do not receive treatment or are unaware that treatment is available for years after the onset of symptoms (Hintz & Venetis, 2019; Scott et al., 2022). Therefore, I use the term *women's persistent pain with penile-vaginal intercourse* (WPP-PVI) to refer to dyspareunia, vaginismus, or some intersection of these (Azim et al., 2021), regardless of etiology.

Compared with other acute and chronic pain conditions, WPP-PVI is inherently interpersonal, affecting both partners' sexual functioning and relational and sexual satisfaction

(Rosen & Bergeron, 2019). In fact, individuals in heterosexual relationships who are unable to engage in penile-vaginal intercourse (PVI) experience more negative consequences in their sex lives and romantic relationships when they view PVI as “real sex,” compared with those who are able to redefine and broaden their perceptions of sexual intimacy as not necessarily exclusive to PVI (Bairstow et al., 2018; cf. Hintz, 2019a, 2019b). Overall, WPP-PVI may take a toll on couples as they navigate the stressful process of diagnosis and treatment (Hintz & Venetis, 2019), while trying to develop and maintain their sexual intimacy—possibly for the first time (Azim et al., 2020).

For couples who grew up in evangelical Christian households, this experience may be heightened by the ubiquitous purity messages embedded in the religious discourse. Women who grow up in conservative religious contexts may be at greater risk for sexual pain or dysfunction (Estrada, 2022; Reissing, 2021), due to internalized sexual guilt accompanying messages that convey premarital sex is sinful and married sex is for procreation (Azim et al., 2021). At the same time, evangelical purity discourses also contextualize (heterosexual) sex within marriage as “sacred,” “beautiful,” and a “gift from God” (Azim et al., 2020; Irby, 2019; Leonard Hodges & LaBelle, 2024). Heteronormative discourses about sex prevail in evangelical circles and glorify what critics have deemed the “coital imperative,” which upholds PVI as the most desirable or legitimate form of sexual intimacy (McPhillips et al., 2001).

Given the perceived authoritative nature of the Bible, difficulties may be amplified for marital partners who subscribe to an evangelical worldview, especially those with little to no prior sexual experience (Azim et al., 2020; Azim et al., 2021). This is particularly concerning given that evangelical Christianity is the most practiced religion in the United States, comprising 25% of the US adult population (Smith, 2021). Distinct from Catholics, Protestants with an

evangelical *worldview* affiliate in multiple ways and extend beyond those who claim the label of being "*an* evangelical." In 2018, Gallup reported that 41% of Americans identify as "born again or evangelical" and are much more racially diverse than people assume, since Black evangelicals are typically politically democratic (Newport, 2018).

For many evangelicals, the discovery of WPP-PVI may post-date a lifelong marital commitment (Azim et al., 2020; Happel-Parkins et al., 2020). However, divorce or separation is typically prohibited in conservative evangelical communities barring infidelity or abuse. Thus, understanding how evangelical couples cope with WPP-PVI may provide theoretical insight into how romantic partners navigate difficulty when placed in a situation they cannot easily get out of—a situation that, for many, was made worse by trying to do the right thing. The following section discusses the rationale for this line of inquiry.

1.2 Rationale

Studying how evangelical married couples cope with WPP-PVI during early marriage has timely interdisciplinary value, in terms of both theory development and practical importance. First, theorizing about the dyadic nature of sexual pain is a largely recent endeavor that has taken place almost exclusively within the fields of psychology and sexual medicine (Meana & Binik, 2022; Rosen & Bergeron, 2019). For almost 10 years, scholars have implored researchers to take an interdisciplinary, theory-driven approach to the study of sexual pain, given that it is a biopsychosocial issue that often requires multidisciplinary treatment (Bergeron et al., 2015; Meana & Binik, 2022). In fact, Rosen and Bergeron (2019) note that interdisciplinary research is suitable for exploring the sociocultural factors that contribute to sexual pain, which have received little scholarly attention.

Accordingly, four developments within the past several years of interpersonal and health communication theorizing and research provide an apt entry point for an interdisciplinary, theory-driven, multilevel study from a communication perspective. First, there has been an influx of recent communication studies on female sexual pain, and these studies have called for greater attention to the perspective of partners and doctors (Hintz, 2019a, 2019b, 2023; Hintz & Venetis, 2019; Scott et al., 2022). Second, the field of sexual communication research has only recently begun to form a disciplinary identity within the broader field of communication studies (Coffelt, 2021a, 2021b; Cooke-Jackson & Rubinsky, 2021), with scholars highlighting the need for sexual communication theory-building and more advanced methodological and analytical approaches to qualitative research (Manning, 2021). Third, in a robust line of research on sexual communication in non-normative relationships, Rubinsky (2018, 2019a, 2019b, 2020, 2021a, 2021b, 2022; cf. Rubinsky & Cooke-Jackson, 2018) has argued that sexual communication is inherently identity-laden, with individual and group-based values, norms, and expectations driving the way that people communicate in intimate contexts. Finally, scholars studying romantic relationships have recently initiated dialogue about the importance of attending to identity in studies examining couples' stress, coping, and support behaviors (Ogolsky, 2023; Randall et al., 2023; Shrout et al., 2024). Thus, drawing from bodies of research spanning communication studies, psychology, and sexual medicine to inform an investigation into evangelical couples' experiences of sexual pain can shed much needed light on the sociocultural dimension of how couples cope.

From a practical standpoint, chronic pelvic pain costs the United States healthcare system almost three billion dollars per year (As-Sanie et al., 2021). Moreover, delayed sexual debut is associated with greater sexual difficulty (Sandfort et al., 2008), and an "unconsummated

marriage" is grounds for divorce in some cultural contexts (Bairstow et al., 2018), including many states within the US (California Courts, n.d.). Examining this issue has financial, legal, and social justice implications. Azim et al. (2021) articulated the need for research exploring the link between religiosity, sexual guilt, and sexual pain in "religiously conservative women who wait until marriage to become sexually active" (p. 780). In addition to the peer-reviewed studies mentioned thus far, evangelical speaker and author Sheila Gregoire partnered with a public health specialist to conduct a survey of over 20,000 predominantly Christian women (Gregoire et al., 2021). Just over 25% of the sample experienced physical pain that made sex less enjoyable, while almost 7% were unable to have penetrative intercourse because of the pain. The growing outcry among women impacted by the evangelical purity movement indicates the need for greater attention to this topic.

To this end, this multilevel qualitative study investigates how evangelical couples experience and cope with WPP-PVI during early marriage. Drawing on research in communication, psychology, and sexual medicine and guided by the Theory of Memorable Messages (Cooke-Jackson & Rubinsky, 2021, 2022), I examine couples' individual and joint coping strategies and the salient messages they believe have contributed to their (in)ability to cope. Given the biopsychosocial nature of sexual pain (Meana & Binik, 2022; Rosen & Bergeron, 2019), this research is designed to gain a deeper understanding of the multidimensional experience of sexual pain and couples' coping strategies.

To achieve this understanding, individual, in-depth qualitative interviews were conducted with both marital partners, as well as female clinicians who regularly work with women and/or couples affected by female sexual pain. Partners and clinicians may be the primary sources of support for (evangelical) women coping with sexual pain (Happel-Parkins et al., 2020; Hintz,

2019b; Noland, 2021; Sadownik et al., 2017), yet their subjective experiences on the topic have received minimal attention in scholarly research across disciplines (Bergeron & Rosen, 2021; Culley et al., 2017; Hintz, 2019a, 2019b; Hintz & Venetis, 2019; Lovell et al., 2023; Rosen & Bergeron, 2019). Thus, giving voice to male partners and clinicians, in addition to female partners, not only provides nuanced insight into individual and dyadic coping process but also contributes to a more comprehensive picture of the biopsychosocial nature of sexual pain (Bergeron & Rosen, 2021; Meana & Binik, 2022; Rosen & Bergeron, 2019).

In the following chapter, I provide a detailed review of the multidisciplinary literature linking sexual pain, communication, coping, and religiosity and advance four research questions that seek to address methodological limitations, bridge disciplinary perspectives, and build on interpersonal and health communication theory. In Chapter 3, I describe the methodology I used to answer the research questions, including my research approach, reflexivity, research design, and analysis method. In Chapters 4 and 5, I discuss and interpret the findings, theorizing about how they contribute to scholarly knowledge. Finally, in Chapter 6, I discuss scholarly implications, practical contributions, and research pathways forward.

2 Literature Review

Like other forms of chronic pain, sexual pain is inherently communicative. Hintz (2020) argued that pain must be communicated to be managed and treated. Moreover, researchers have linked sexual pain to religiosity (Azim et al., 2021; Reissing, 2021). Yet, the relationship between religiosity, communication, and painful sex is complex. In this literature review, I first offer some brief background on sexual pain research. Then, I discuss the connection between religiosity, communication, and sexual pain, explaining how studying evangelical couples' experiences during early marriage can help provide insight into existing ambiguities in the literature. Finally, I position the proposed study within the interpersonal and health communication literature, concluding with the study's guiding research questions.

2.1 Defining Sexual Pain

An estimated 14-34% of pre-menopausal women suffer from persistent or chronic sexual pain, despite the stereotype that painful sex is more common among older women (Azim et al., 2021; Hintz, 2019a; Rosen & Bergeron, 2019). *Dyspareunia* (pain with penetrative intercourse) can occur because of physical conditions or changes such as childbirth, endometriosis, polycystic ovarian syndrome, or pelvic floor dysfunction. Dyspareunia can also be the result of psychological factors such as childhood maltreatment, sexual abuse, fear of penetration, or fear of pain. However, specific diagnoses are often very complicated; in fact, Meana and Binik (2022) call painful sex a "biopsychosocial puzzle."

Vaginismus, which refers to involuntary muscle spasms or contractions that make penetration painful or impossible, has been combined with dyspareunia in the DSM-5 as a single diagnosis of genito-pelvic pain/penetration disorder (GPPPD), which is diagnosed by the presence of persistent pain with penetration, fear of penetration, and avoidance of penetrative

activities (Azim et al., 2021). This diagnosis has been contested by researchers who point out that it does not capture the experiences of women who have never been able to have penetrative sex, which is often referred to as "lifelong vaginismus" (Reissing et al., 2014) or an "unconsummated" relationship (Bairstow et al., 2018). Moreover, viewing GPPPD as a psychological condition minimizes the importance of how sexual pain impacts both physical and relational health. In fact, physicians who attribute sexual pain to a psychological disorder invalidate and contest women's pain, which is a key reason that women are misdiagnosed (Hintz & Venetis, 2019). Many scholars contend that genito-pelvic pain should be viewed and studied through the lens of pain management models, which capture the biopsychosocial, holistic impact of sexual pain on women's lives (Bergeron et al., 2011; Hintz & Venetis, 2019).

2.2 Communication and Sexual Pain

For the past 10-15 years, psychologists Natalie Rosen, Sophie Bergeron, and their colleagues at the *Couples and Sexual Health Laboratory* in Canada have worked hard to examine the role of communication, cognition, and emotion within heterosexual couples' experiences of painful sex, especially *vulvodynia*, or chronic, unexplained pain of the vulva (Bergeron & Rosen, 2021). One of their most prominent contributions has been Rosen and Bergeron's (2019) Interpersonal Emotion Regulation Model of Female Sexual Dysfunction (cf. Meana & Binik, 2022), which emphasizes the dyadic nature of painful sex and depicts how both partners' emotion regulation mediates the relationship between distal and proximal factors and relational, sexual, and psychological outcomes.

Distal factors such as trait anxiety, sexual communication, and social/contextual factors (e.g., culture, invalidation from doctors, etc.) predate or exist outside of the sexual encounter. For example, one study found that both partners experienced improved relational outcomes when

they engaged in more collaborative sexual communication (Rancourt et al., 2017). Moreover, cognitive behavioral couple therapy treatment improved collaborative sexual communication, which increased both partners' sexual satisfaction, improved women's sexual function, and decreased women's sexual distress (Rancourt et al., 2022). In Bergeron et al.'s (2021) study, perceived partner responsiveness, or the degree to which a partner felt emotionally understood and validated in daily life, afforded both men and women better sexual function. Moreover, actor and partner effects showed that women had higher satisfaction when they felt understood, and women and men both had higher satisfaction when men felt understood (Bergeron et al., 2021). Thus, distal factors seem to have a greater impact on global qualities of sexual and relational well-being such as sexual satisfaction, relational satisfaction, and sexual functioning, whereas *proximal factors* appear to have the greatest impact on the pain experience for women.

Proximal factors manifest during the sexual episode, and may include pain catastrophizing, mood, and partner responses (Meana & Binik, 2022). Of all the variables within the female sexual pain literature, partner responses have been the most robust predictor of women's pain experiences and *both* partners' sexual functioning in actor-partner interdependence models (Meana & Binik, 2022). Partner responses can be *facilitative* (expressions of empathy and encouragement that facilitate adaptive coping, such as suggesting partners try a different sexual position), *solicitous* (expressions of sympathy and instrumental support, such as suggesting partners cease sexual activity), or *negative* (expressions of hostility or criticism). Perhaps unsurprisingly, facilitative responses are the only of the three response types that have consistently been shown to decrease pain and improve *both* partners' sexual functioning (Rosen et al., 2010; Rosen et al., 2012; Rosen, Bergeron, et al., 2014). However, negative responses and even solicitous responses worsen pain for women and sexual outcomes

for both partners, even though women are often satisfied with solicitous responses and perceive them positively. Solicitous responses can worsen women's pain because they reinforce pain catastrophizing and encourage avoidance of sexual activity, which contributes to a feedback loop (Maunder et al., 2022; Rosen et al., 2010). This may create a dilemma for couples, as engaging in intercourse despite pain can *also* worsen sexual functioning and pain.

Hintz' (2019a, 2019b, 2023) line of research at the intersection of interpersonal and health communication reveals how women with vulvodynia disrupt heteronormative sexual discourses that reinforce the "coital imperative." For example, through qualitative interviews, Hintz (2019b) found that women with vulvodynia had difficulty discussing their pain with their partners. They were unsure of how much to disclose, experienced shame, and were afraid of losing the relationship. At the same time, many women talked about how they (individually and with their partner) reframed the illness, redefined intimacy, and refocused the relationship on other aspects, all while being careful not to dismiss their pain.

Critical analyses of this same dataset revealed that some women felt vulvodynia threatened their identity as women (Hintz, 2019a; cf. Ayling & Ussher, 2008), and that they struggled the most when communicating about this aspect of vulvodynia with their partners, compared to other aspects of the condition (Hintz, 2023). Some women reified heteronormativity by expressing their frustration at how sexually driven men were, and others even offered to have sexually open relationships (i.e., allow their partners to have sex with other women; cf. Lovell et al., 2023). However, they also "disrupted" sexual norms through demanding their partners be involved through 1) empathic listening, 2) doing their own research, 3) accompanying them to appointments, and so on. Thus, macro-level sexual discourses inform how women negotiate their

identities when experiencing sexual pain and may also permeate micro-level interactions, accounting for why some male partners may respond with negativity to pain expression.

Herein lies the dilemma of the "biopsychosocial puzzle": when experiencing a female partner's pain with intercourse, couples who reframe sex to include non-penetrative forms of intimacy may be quite sexually satisfied (Bairstow et al., 2018; Hintz, 2019a; Lovell et al., 2023; Reissing, 2021), as they expand their sexual scripts and learn to collaborate. However, they may also avoid penetrative activities and become fixated on the pain, which can reinforce pain cognitions and avoidance behaviors. This poses a problem for couples who wish to engage in pain-free PVI intercourse, whether for pleasure or procreation—a value held by many religious couples.

2.3 Religion and Sexual Health

Many people intuitively link their experiences of sexual pain, shame, and dysfunction to the religious norms and values they internalized through sexuality socialization, or "the process of acquiring knowledge, norms, attitudes, cultural symbols and meanings, codes of conduct, and values about a wide range of topics concerning sex and sexuality" (Warner et al., 2020, p. 160). For example, Aragon and Cooke-Jackson (2021) found Latina and Latinx women and gender minorities recalled messages emphasizing conservative familial views or religious beliefs (e.g., sex is only for marriage and procreation), as well as the message that wearing tampons was a sin and implies sexual promiscuity or the end of virginity. Scott et al.'s (2022) study of women with chronic pelvic and genital pain conditions evidenced that religious and cultural taboos around menstruation may have delayed women's treatment-seeking for their chronic pain.

Although religiosity appears to be linked to sexual pain and dysfunction, Mutlu and Koc (2021) did not find significant differences in religiosity between Turkish women with and

without vaginismus. However, the authors noted that since sex is taboo within this cultural context, it is possible the women who participated—who were patients at an outpatient psychiatry clinic—may have been less religious or had more variation in religious conservatism/liberalism, since they were willing to seek sexual health treatment.

Indeed, the effects of delayed sexual debut may explain in part the degree of sexual dysfunction women experience. In a mixed-methods survey, Frydman (2022) found that many Orthodox Jewish women enter marriage feeling underprepared. Those who were not sexually active before marriage were more confused, less satisfied, more anxious, more embarrassed, experienced less pleasure, and were more afraid than those who were sexually active prior to marriage. Too, at least one woman in the sample reported chronic sexual pain. Women described what Frydman (2022) labeled the "quick shift" from sex being forbidden to being permitted, encouraged, and even required. Some women in Frydman's study still felt like they were "scandalous" years into their marriage when engaging in sexual activity. At the same time, other women resisted Orthodox Jewish prescriptions to have intercourse right away, slowly developing sexual intimacy with their partners over time. Evangelical women have similar experiences of sexual dysfunction, chronic shame, and accompanying pain with sex (Azim et al., 2020; Estrada, 2022; Happel-Parkins et al., 2020) which is often amplified by cultural and religious socialization about gender roles (e.g., "duty sex" and heterosexual gender scripts: see Gregoire et al., 2021). Though communication, religiosity, and sexual pain are clearly linked, scholars are still investigating the mechanisms that link them.

2.4 Linking Communication, Religion, and Sexual Pain

To date, Azim et al. (2021) offers the most compelling quantitative evidence linking religious messages and sexual pain. In their study of almost 600 sexually active college-aged

women, they found that sex guilt fully mediated the relationship between religiosity and painful sex. In other words, those who were more religious were more likely to have feelings of guilt associated with sex, likely because of their religious socialization, which increased pain levels. Intriguingly, there were no statistically significant differences between women with and without pain on beliefs about gender roles and degree of sex education. Also, women with more conservative religious affiliations did not have more pain than women who had less conservative religious affiliations.

However, similarly to Mutlu and Koc (2021), Azim et al. (2021) note that women who wait until marriage to have sex may also have more traditional beliefs about sex and gender and may be more religious, compared with the sample reflected in their study, so the authors call for researchers to study the impact of sex guilt within marriage relationships for women who abstained. Delayed sexual debut has been associated with greater sexual difficulty (Sandfort et al., 2008). Although some data suggest evangelicals have premarital sex at similar rates as the general population, other polls show that regular churchgoing evangelicals have less premarital sex than the general population (National Association of Evangelicals, 2012) or believe to a far greater degree that premarital sex outside of marriage is unacceptable, even in committed relationships (Dimiant, 2020). Azim's qualitative studies of evangelical women (Azim et al., 2020; Happel-Parkins et al., 2020), and Gregoire et al.'s (2021) survey of 20,000 predominantly Christian women's marital sexual experiences, have shown how socialization within evangelical contexts may contribute to women's greater difficulty with sex (Estrada, 2022), even in the absence of prior sexual abuse.

In fact, Happel-Parkins et al.'s (2020) interview study with eight Christian women in the Southern United States was inspired in part by the first author's pelvic floor physical therapy

practice. She had noticed many of her patients who did not have a history of sexual abuse, yet presented with severe dyspareunia mirroring symptoms in rape survivors, identified as Christian and had grown up immersed in the Christian purity movement. Studies have confirmed the negative sexual and psychological impact people—especially women—have experienced from the gendered sexual messages propagated during the purity movement (Estrada, 2022; Gregoire et al., 2021). Azim et al. (2020) found that a lack of adequate sexual health messaging, an emphasis on abstinence and the danger of sex, lack of emphasis on pleasure and enjoyment, and messages from friends (e.g., that sex would be painful and that women should drink wine on the wedding night), all negatively contributed to women's experiences with sex. Women attributed their lack of knowledge about their bodies and their negative experiences to the messages they had heard in evangelical Christian contexts. Similarly, Gregoire et al. (2021) found that women who had internalized harmful gender-based beliefs about sex and marriage from evangelical contexts were more likely to have dyspareunia and vaginismus, even if they did not currently hold those same beliefs.

Taken together, the recent findings on intersections of communication, painful sex, and religiosity, especially evangelical Christianity, provide a timely entry point for building on existing sexual health scholarship in two important ways. First, an in-depth look at the perceptions and experiences of partners within the same dyad can further illuminate the nuances of couples' joint experiences of coping with sexual pain and extend the limited extant knowledge of the male partner's experience (Lovell et al., 2023). Doing so in the context of evangelical couples can reveal how couples make meaning of unexpected difficulty when they may have no other choice but to make their relationship work. Second, the social context of sexual pain can be further explicated by examining clinicians' communication with women and couples.

2.4.1 Looking at the Couple: Dyadic Coping

Rosen, Bergeron, et al. (2014) note the relative absence of research exploring the impact of female sexual pain on women's partners. Rosen, Bergeron, and colleagues have conducted the bulk of dyadic studies on the female sexual pain experience, yet this research has been almost entirely quantitative and from a psychology perspective (e.g., Bergeron et al., 2021; Rosen, Rancourt, et al., 2014; Rancourt et al., 2022). Qualitative research on this topic reveals the emotional meaning and perceptions attached to the experience of managing chronic sexual pain, including feelings of inadequacy (i.e., as a woman and as a partner), fear of losing a partner, and difficulty disclosing about sex on the one hand, and self-advocacy and reframing of sex on the other (Ayling & Ussher, 2008; Hintz, 2019a, 2019b). These qualitative studies of female sexual pain consistently call for attention to the *partner's* perspective in their future directions (Dogan et al., 2023; Hintz, 2019a, 2019b; Scott et al., 2022). Yet, only a handful of peer-reviewed studies have used a qualitative approach to examine male partners' subjective experiences of female sexual pain (Culley et al., 2017; Lovell et al., 2023; Sadownik et al., 2017).

In a qualitative interview study of male partners of women with endometriosis, Culley et al. (2017) found that men in the UK identified positive impacts of the diagnosis on their relationship, such as strengthening the relationship and learning how to support their partner better. At the same time, men also felt tension between allowing themselves to feel distressed and dissatisfied, and yet not wanting to blame their partner, which they perceived to be selfish. Although not many men experienced severe distress and reported that they had come to accept the situation, male partners did experience a significant impact. In fact, most men indicated this was the first time they had been asked about how their wife's endometriosis had impacted them. Men felt helpless, frustrated, worried, and angry at the situation—yet they often minimized or

concealed their own emotions, believing theirs were less important than their partners' emotions. They described how they took the emotional brunt of their partners' feelings while assuming the role of bravery, though they wished they had more support from their partner, family, and healthcare providers, who often did not realize the extent of the impact of endometriosis on couples. The findings of this study mirror findings in communication research on men's experiences of a partner's miscarriage (Horstman et al., 2021; Horstman et al., 2023).

Moreover, Sadownik et al. (2017) conducted phone and Skype interviews with 16 male partners of women with vulvodynia who were undergoing a multidimensional treatment program. Men described feelings of loss, depression, shame, fear of causing pain, and guilt that they may be doing something wrong (i.e., sexually). They also reported activating emotions like anger, frustration, and anxiety. They discussed the impact on their relationship, including diminished sexual experiences, constrained intimacy, relationship strain, and communication challenges such as fear of bringing up how they were feeling with their partner. At the same time, some men felt that the experience gave them the opportunity for personal and relational growth—increasing their empathy for their partner and bringing them closer together as they worked as a team. The multidimensional treatment vulvodynia program their partners were in also normalized men's own experiences, enhanced their knowledge, opened lines of communication, and paved the way to pain-free intercourse. Still, they felt isolated and wished they could have a place to connect with other men affected by their partners' dyspareunia, where they could share freely. Sadownik et al. (2017) note that these findings suggest men, like women, may also take up the position of an "inadequate lover" when they operate within the discourse of the coital imperative.

Lovell et al. (2023) further explore male partners' experiences of female sexual pain through open-ended surveys and virtual (i.e., Skype and phone) interviews. Extending Sadownik et al.'s (2017) findings, they found that men felt their partners' pain signaled something was wrong with *them*, only until women received a diagnosis from an authoritative (i.e., medical) source that provided an organic cause. Diagnoses brought men and their partners great relief, however men felt like they were on the outside of the treatment process in the way their partners and medical providers communicated with them (e.g., their female partner asking them to stay in the car or a doctor ignoring them during an appointment).

Interpersonal difficulties also arose for men in this sample. For instance, one man felt hopeless and powerless when his partner did not engage in the prescribed treatment for sexual pain, yet men found it difficult to initiate conversations with their partners about treatment or the pain experience in general, as they were frequently met with frustrated responses. Moreover, men felt like perpetrators, since they saw themselves as the cause of their partners' pain, and they often felt ashamed of desiring sex because of this. Moreover, they expressed a greater desire for intimacy and connection than PVI, yet described feeling misunderstood by their female partners, who believed they were more upset about not being able to engage in PVI than they actually were, even after they (i.e., men) had provided reassurance. The authors suggest that future researchers "explore how both individuals within the same couple understand and respond to [female sexual pain], and the ways in which they overlap and diverge" (p. 18). Yet, even fewer qualitative studies have analyzed *both* partners' experiences together. Culley et al. (2013) used the same dataset from women with endometriosis and their partners, but this study accounted also for women's experiences. They found that couples felt endometriosis took a toll on their intimacy, yet they did not receive resources in their medical treatment for how to broach the

diagnosis together. While many couples learned to work together to navigate sexual intimacy, "for some couples, sex had become a minefield, so fraught with difficulties that they wanted to avoid physical contact altogether resulting in a loss of closeness and intimacy" (p. 14). Moreover, men were less likely to seek support.

Communication research on couples' experiences of miscarriage, infertility, and other health conditions speaks to the importance of hearing both partners' accounts and analyzing them in juxtaposition. For example, Holman and Horstman's (2019) mixed methods study found that men and women processed miscarriage differently, and that the themes that emerged in individuals' processing narratives were related to unique outcomes. Moreover, couples who overlapped in narrative sequence, that is, used the same narrative structure to talk about how they made sense of miscarriage, experienced less distress than couples who did not.

While some communication scholars have noted that actor effects may be stronger than partner effects in studies analyzing dyadic processes and may therefore be sufficient to explain certain interpersonal communication phenomena (Goodboy et al., 2023), other studies, especially within health contexts, reveal the importance of examining couples' experiences together. For example, Checton et al. (2012) found that patients with chronic illness and their partners were less likely to disclose how they felt about the illness if they perceived greater illness interference (i.e., felt the illness was interfering with their daily life), yet more likely to feel they were coping with the issue if they felt they *could* self-disclose. Also, partners who had more uncertainty about a prognosis were more likely to perceive illness interference than patients, making them less likely to self-disclose. Finally, the more that patients perceived illness interference, the less they felt they were able to manage the illness. The findings suggest it can be difficult to coordinate dyadic coping dyad members may experience an illness differently, which may inhibit them from

sharing how they feel. Moreover, in their study on communal coping in couples managing chronic illness, Basinger et al. (2021) speculate that they did not find partner effects because their sample consisted of people managing a range of illnesses. They call for research examining a single condition to explore how partner support functions and suggest that partner effects may be stronger for couples managing a stigmatized condition such as diabetes or addiction. Examining both partners' subjective interpretations (i.e., through qualitative methods) may shed nuanced light on dyadic processes that is hard to capture in quantitative research.

Investigating the perspective of male partners of women with persistent pain during intercourse is vital for informing research and practice. Understanding what male partners are perceiving may provide greater insight into why and under what conditions *negative* and *solicitous* partner responses occur, as well as the barriers to *facilitative* responses—all of which can modulate the pain management and treatment experience for women (Meana & Binik, 2022). Moreover, examining how couples' accounts relate to each other has the potential to establish a more comprehensive picture of why some couples are more distressed than others for reasons beyond an inability to reframe intimacy (Bairstow et al., 2018; Hintz, 2019b). A host of other factors contribute to couples' individual and joint ability to cope with health issues, such as culture, power, timing of an injury or illness, communal orientation to stress, the nature of a stressor (i.e., stigma), and relational maintenance, among others (Afifi et al., 2016; Afifi, Basinger, et al., 2020; Afifi, Zamanzadeh et al., 2020; Basinger et al., 2021; Crowley & Miller, 2020; Greene, 2009; Ledbetter et al., 2020).

Couples who know about a woman's pre-existing diagnoses (e.g., vulvodynia, endometriosis, vaginismus) or who had previously experienced sexual pain (i.e., in previous relationships) may have a different experience navigating sexual communication and coping,

individually and together. Marriage is a stressful transition for couples, even those who were cohabiting prior to marriage (Blalock & Bartle-Haring, 2022). This stress may be amplified for evangelical couples who may be cohabiting for the first time, having intercourse for the first time, and/or trying to make sense of and seek treatment for sexual pain. Additionally, their overlapping or divergent perceptions may explain similarities and differences in the way that couples cope with difficulty (e.g., Holman & Horstman, 2019).

2.4.2 Looking at the Social Context of Sexual Pain

In addition to the value of qualitative dyadic research, sexual pain scholars have pointed out the need for more research on the *social context* of the treatment and management process (Meana & Binik, 2022). The social context of sexual pain can include sociocultural experiences surrounding sex, internalized shame and stigma, and reluctance to talk to doctors for personal or cultural reasons (Rosen & Bergeron, 2019). Rosen and Bergeron (2019) note the social context as an important yet underexplored distal factor within the dyadic process of coping with sexual pain, inviting scholars to conduct interdisciplinary research. In addition to the aforementioned rationale for examining religious couples with WPP-PVI, two aspects of the extant literature provide insight into how the *clinical* context may shape couples' coping.

Lack of Clinical Training. Clinicians receive inadequate training regarding both sexual health and religion, as well as their intersection (i.e., sexual health issues faced by religious couples). Studies consistently show that healthcare providers—including MDs, OB/GYNs, and even psychologists—receive little training on sexual topics in medical school or graduate school (Kemble et al., 2023). Byers' (2011) review, based on mainly Canadian samples, found that less than half of psychologists ask about sexual health issues during intakes, while doctors typically do not ask patients about sexual health. This is unsurprising, given that sexual health makes up

0.2% to 0.3% of medical school training, with those hours focusing on biology and physiology over issues of sexual satisfaction and relational health (Noland, 2021). Less than half of medical schools in the US and Canada provide training on sexual dysfunction (Noland, 2021), resulting in inconsistent responses among doctors when treating patients (Abdolrasulnia et al., 2010).

Moreover, clinicians often rely on culturally biased measures of sexual (dys)function. Atallah et al. (2016) found in their review of sociocultural and ethical issues within the sexual dysfunction literature that sociocultural beliefs, values, and practices shape individuals' and couples' experiences of sexual dysfunction. What is perceived as dysfunction in one culture may not be perceived as such in another culture. For example, low sexual desire may be perceived more negatively in Western cultures like the United States than Eastern cultures like East Asia, where people hold differing expectations and meanings for "desire." Sexual function tends to be operationalized using measures developed in Western cultures that reflect Eurocentric values. Atallah et al. (2016) contend that extant research may not reflect reliable data for the prevalence of sexual dysfunctions globally. The authors advocate for culturally sensitive approaches to sexual healthcare, including showing sensitivity to culture and religion in assessment and being mindful of how symptoms are impacting an individual or their relationship (cf. Blass & Fagan, 2001). As Slowinski (2001) notes, "A person's religious orientation is often what gives meaning to his or her life. Religious issues are to be addressed with respect. Questioning or challenging fundamental assumptions about life can be threatening" (pp. 272-273). Investigating religious couples' perceptions of how their beliefs facilitate or constrain their ability to cope with health issues may provide insight into how clinicians can improve their communication with religious patients and clients.

Clinical (In)validation. Treating sexual pain is further complicated by clinicians' reported difficulty treating chronic pain in general, and their subsequent invalidation of patients' pain. In comparing in-depth interviews with chronic pain patients and with doctors of "failed" chronic pain patients, Kenny (2004) described the tension these groups face in communication. Patients want their pain to be validated, perceiving a primarily *biogenic* cause for their pain and psychological outcomes as a *result* of their pain, while doctors operate through a *psychogenic* model, often attributing patients' pain to psychological issues that they believe are manifesting in physical symptoms. They are thus quick to refer patients to psychologists (cf. Hintz & Venetis, 2019). A vicious cycle emerged in Kenny's (2004) study wherein patients felt delegitimized when given a psychological diagnosis, and consequently, their lack of acceptance of the doctor's diagnosis exacerbated doctors' negative perceptions of them. Also, doctors seemed unable to offer resources to address the psychological causes they asserted. Kenny noted that both patients and doctors ultimately engaged in *typecasting* (i.e., relying on stereotypes), which may explain "why doctors and patients alike continue to engage in the exhausting situations that leave both parties depleted. They are struggling to maintain their identity and integrity" (p. 303). Based on the findings, Kenny suggests a biopsychosocial approach to the treatment of chronic pain.

Unfortunately for chronic pain patients generally and women with sexual pain specifically, this invalidation may prolong treatment as women experience inaccurate or invalidating advice. *Disenfranchising talk* functions to discredit, silence, and stereotype patients, which harms patients' agency, undermines their credibility and self-trust, harms access to care, support, and resources, causes people in their social networks to question the validity of their pain, and erodes trust in the patient-provider relationship (Hintz, 2022).

Women with sexual pain are often invalidated during medical encounters, frequently engaging in communication work to legitimize their pain (Hintz & Scott, 2021). For example, in one study some women reported that their doctors continued to test them for sexually transmitted infections (STIs), urinary tract infections (UTIs), or yeast infections even when they had received multiple negative results already, including one woman whose doctor insinuated maybe her husband had been cheating on her (Hintz & Venetis, 2019). Women also report receiving suggestions from doctors, friends, or family to have alcohol, watch pornography, or "just relax" (Happel-Parkins et al., 2020; Hintz, 2019b; Hintz & Venetis, 2019). Conversely, women with sexual pain who experience patient-centered communication, such as validation of their pain, acknowledgement of their frustration, empathy, information provision, and joint decision-making, experience positive medical encounters and are more likely to adhere to treatment (Hintz & Venetis, 2019; Leusink et al., 2018, 2019). Evangelical women specifically have described validation from pelvic floor physical therapists as a turning point in their physical (and spiritual) journey of healing from sexual pain (Azim et al., 2020; Happel-Parkins et al., 2020).

Researchers have therefore called for more attention to practitioners' perceptions and experiences when treating sexual pain (Scott et al., 2022). In a focus group study with 17 Dutch general practitioners (GPs), the authors found that male GPs, GPs who felt undereducated, and GPs who experienced professional uncertainty had the most difficulty diagnosing and treating vulvodynia, whereas being female and knowing the value of asking patients about sexual health issues appeared to facilitate the diagnostic process (Leusink et al., 2018). Moreover, Beck and Ragan (1995) found that during gynecologic exams, nurse practitioners used personal disclosures to facilitate *relational goals* such as minimizing face threats and embarrassment, framed directives as suggestions to achieve *medical goals*, and used person-oriented communication to

achieve *educational goals*. Taken together, the research on patient-provider communication suggests clinicians may struggle already to treat chronic pain, while also being under-qualified to diagnose and treat sexual pain specifically, as well as sexual pain/dysfunction in religious individuals or couples. At the same time, some clinicians may be keenly attuned to their patients or clients. Research conducted by Azim et al. (2020) and Sadownik et al. (2017) asserts provider messaging may account for couples' ability to cope via the information and validation they provide (Azim et al., 2020; Sadownik et al., 2017), yet while this research is suggestive, it is not entirely clear how provider communication might contribute to dyadic coping.

2.5 The Current Study: A Multilevel Analysis

From a social ecological systems perspective (Bronfenbrenner, 1977), the experience of female sexual pain in evangelical women occurs within a nexus of nested environmental systems. To date, most qualitative studies on sexual pain have examined women's subjective experiences (i.e., the *individual level*) and how religious and cultural discourses of heteronormativity and disenfranchising talk perpetuated within Westernized medicine may contribute to pain and inhibit women's coping and treatment (i.e., *macro level*: Gregoire et al., 2021; Hintz, 2019a, 2019b, 2022; Hintz & Venetis, 2019).

In the current study, I sought out to better understand the *micro-level* and *meso-level* factors that impact the experience of female sexual pain—for women *and* for their partners. Based on Bronfenbrenner's (1977) framework, micro-level influences on each couple member's experience (including women's pain) may include each other, friends, family, churches, and healthcare systems, whereas meso-level influences reflect how micro-level players interact with each other (e.g., communication *between* women's husbands and friends, pastors, or family). Thus, examining women's coping and support experiences in *conjunction* with their partners'

experiences and the perspectives of the clinicians most likely to provide treatment may illuminate factors that contribute to female sexual pain at the micro-level and meso-level, thereby providing a more holistic understanding of the biopsychosocial experience and treatment of sexual pain (Meana & Binik, 2022; Rosen & Bergeron, 2019).

2.6 Guiding Theoretical Framework

Since communication is central to the experience and management of female sexual pain (Hintz, 2019a, 2019b, 2020), this research is informed by interpersonal and health communication theory. Extant research suggests that the messages about sex and sexual pain that women and their partners hear from religious leaders, doctors, network members, *and* each other may be central to their (in)ability to cope, seek, and maintain support and may have a direct or indirect impact on the pain experience (Azim et al., 2020; Happel-Parkins et al., 2020; Hintz, 2019b; Hintz & Venetis, 2019; Lovell et al., 2023; Rosen & Bergeron, 2019). For the current study, the Theory of Memorable Messages (ToMM: Cooke-Jackson & Rubinsky, 2021, 2022) was selected as the guiding theoretical framework to further understand how memorable messages shape the ways in which evangelical couples experience and cope with WPP-PVI.

2.6.1 Theory of Memorable Messages

The Theory of Memorable Messages (ToMM; Cooke-Jackson & Rubinsky, 2021, 2022) illuminates how messages that are memorable over time and “stick” with individuals can shape their health experiences and behaviors. Knapp et al. (1981) first forwarded the construct of *memorable messages* (MMs) after surveying people about messages they believed had impacted them significantly. The authors operationalized MMs as short, positive messages, usually communicated by an authority figure in the context of advice-giving or support, that people perceive to have a long-term impact on their identity and behavior.

This concept gained traction among communication scholars, especially within interpersonal and health communication research. Cooke-Jackson and Rubinsky (2018) reviewed 30 years of MM research, finding that: (a) MMs had been used to explore messages facilitating breast cancer prevention and sexual health, (b) MMs also include messages that have negative impacts on behavior and identity, and (c) future research should examine how MMs that were impactful on behavior or identity at one time may no longer have that impact. The idea that negative MMs may cease to be impactful led to the idea of *message disruption.*

Cooke-Jackson and Rubinsky (2021) theorized about message disruption in their Theory of Memorable Messages (ToMM; cf. Cooke-Jackson & Rubinsky, 2022), arguing that ToMM is perfectly suited to capture sexual health experiences. They conceptualized MMs as messages that (1) are recalled for a long period of time, (2) are made sense of retrospectively, (3) have a lasting positive or negative impact, (4) play a role in identity formation and behavior (and evaluation of identity and behavior), and (5) are "most saliently defined by their impact, not their form, delivery, modality, or content" (p. 91). In other words, a message is "memorable" when the recipient of the message feels it has played a role in their identity formation or behavior, whether the message takes the form of a single interpersonal exchange, a message from the media, or even a *message gap* (i.e., the perceived absence of sexual health information), which in itself functions as a message. Importantly, Cooke-Jackson and Rubinsky (2021) contend that people can use intervening messages to offset or disrupt the trajectory of harmful negative or absent memorable messages.

In the previously mentioned survey of over 20,000 women, Gregoire et al. (2021) sought to answer the question: "What if our evangelical 'treatments' for sex issues make things worse?" (p. 11). The researchers identified harmful gender-based messages promoted within self-help

books written by evangelical authors that emerged during the evangelical purity movement, and constructed survey questions about these messages. They found that the more a woman believed "A wife is obligated to give her husband sex when he wants it" (p. 16), the more likely she was to have vaginismus. Interestingly, their findings indicate that women's perceptions about various harmful beliefs had changed over time, and that even women who no longer believed these harmful messages were still negatively impacted if they embraced those beliefs when growing up. Based on Gregoire et al.'s (2021) survey data, which they triangulated with focus groups and interviews, the authors offered suggestions for couples to reframe harmful messages. This reframing could be considered a form of message disruption or an intervening message as defined by ToMM. However, given the audience and nature of Gregoire et al.'s (2021) book (i.e., popular press), the research is atheoretical.

ToMM provides a novel framework for informing a systematic investigation into how memorable messages function theoretically for evangelical couples who are coping with the multilayered issue of women's persistent pain with penile-vaginal intercourse (WPP-PVI). First, spouses may internalize messages communicated by family, friends, physicians, the media, and those in their faith community that impact how they make sense of their pain experience (Rubinsky & Cooke-Jackson, 2017). Flood-Grady et al. (2023) examined memorable messages between parents and children about depression by surveying young adults diagnosed with depression. Oftentimes, children received a MM after disclosing a diagnosis. Perceptions of parental social support, stigma toward depression, and relational satisfaction with the parent varied depending on the *type* of MM people reported (e.g., "We will be there" vs. "Depression isn't real"), however there were no significant differences in treatment-seeking based on MM

type. Still, there is evidence that naturally occurring memorable messages in interpersonal contexts impact health behavior (Cooke-Jackson & Rubinsky, 2018).

It is also possible that memorable messages help couples cope with the process of treatment and recovery from sexual pain. Research on coping and resilience shows that memorable messages can provide individuals with hope and strength during difficult times (Lucas & Buzzanell, 2012; Merolla et al., 2017) and may function as a form of anticipatory resilience (Boumis et al., 2023). Many people derive strength from their religious and/or spiritual beliefs, and qualitative research has shown that religious individuals draw from spiritual resources when coping with difficulty individually and as a couple (Buzzanell, 2010; Russell et al., 2021; Waldron et al., 2020). Faith-based messages heard in religious contexts may both help and hinder evangelical spouses navigating female sexual pain.

Moreover, Willer (2014) surveyed 233 women who had been treated for infertility about compassionate memorable messages they had received from healthcare providers. Nonverbal messages of care (e.g. compassionate touch, being present physically) and messages that privileged the patient above the doctor were viewed as more compassionate than those which conveyed empathy, offered hope, and reflected patient-centered communication. Notably, the more compassionate a doctor, the less stress women had about treatment, which reduced infertility-related stress in their marriage and other relationships. Sexual pain is a sensitive issue that may mirror emotional experiences that couples with infertility encounter (Lovell et al., 2023), so the memorable messages women hear from clinicians may be an important factor contributing to the treatment and coping process.

Couples’ own interpersonal communication may also consist of memorable messages that help or hinder each partner’s ability to cope, individually and dyadically. Partner responses to

sexual pain can be *facilitative* (empathic and encouraging), *solicitous* (offering instrumental support), or *negative* (expressing anger or hostility) (Rosen & Bergeron, 2019). It is possible that a facilitative response may function as a positive memorable message that disrupts the negative trajectory of negative messages, while negative partner responses may have the opposite effect.

For individuals or couples who grew up in the wake of evangelical purity culture (i.e., as opposed to those who converted to Christianity as adults), religious-based memorable messages about sex have already been ingrained. Some evidence points to the way that Christian women and their partners may go through a period of deconstruction, shifting the narrative about sex within marriage being "beautiful" and "sacred" to a more realistic outlook that encompasses their lived experiences (Happel-Parkins et al., 2020). ToMM provides an entry point to further explore how or whether couples use new memorable messages to shift this narrative, individually or together (Gunning et al., 2020).

Importantly, Cooke-Jackson and Rubinsky (2022) note the opportunity to explore what makes messages memorable, and how MMs "characterize and affect the relationship between the sender and receiver of the message" (p. 7). Memorable messages are contextual (Horstman et al., 2023), and the source or sender of a memorable message may not know that a message they conveyed or conversation they had was memorable to the receiver (Merolla et al., 2017). Additionally, while men in heterosexual relationships tend to be women's primary support provider amidst intimate health difficulties such as miscarriage or sexual pain (Horstman et al., 2021; Sadownik et al., 2017), men are also affected by these issues and benefit from having the support of their partners (Bergeron et al., 2021; Horstman et al., 2021). Thus, exploring the perspective of *each* partner, as well as clinicians—whose support (or lack of support) may carry weight for each partner and for the couple as a unit (Hintz, 2022)—can provide greater insight

into how couples cope and the role of MMs in their coping. It is both intriguing and theoretically important to explore what the message sender perceives about interactions that may be internalized by message receivers (Merolla et al., 2017).

In all, attending to the way individuals and couples perceive their (in)ability to cope and seek support is important, since women with sexual pain and their male partners both have reported the desire for more support individually and as a couple (Culley et al., 2013; Hintz & Venetis, 2019; Lovell et al., 2023; Sadownik et al., 2017). Identifying the factors that facilitate coping may equip couples and clinicians with evidence-based resources to promote intimacy, relational equity, and flourishing. Moreover, evangelical couples may hold traditional views about gender yet have no choice but to reframe heterosexual scripts to cope, recover, and maintain intimacy—a process that can take several years. Locating the strategies and related messages that create, shift, and reinforce this narrative is important for helping couples cope and seek healing, individually and together. Thus, I propose the following research questions:

RQ1: What helps couples cope with the biopsychosocial experience of sexual pain?

RQ2: What factors motivate couples to seek or avoid support in managing or resolving their shared challenges with sexual pain?

RQ3: What memorable messages do spouses perceive contribute to their individual and shared experiences of coping with sexual pain?

RQ4a: What factors do clinicians believe contribute to women's/couples' ability to cope with, seek support for, and heal from sexual pain?

RQ4b: How do clinicians account for religious identity when treating female sexual pain?

3 Methodology

3.1 Methodological Approach

I conducted a multi-level qualitative interview study to answer the research questions, guided by an abductive, iterative approach and informed by the goals and assumptions of qualitative research. Qualitative researchers seek to provide rich description of social phenomena, often with the intention of contextualizing quantitative findings, building new theory, or revealing the situated meanings of social behavior (Luker, 2010; Manning, 2013; Manning & Kunkel, 2014; Tracy, 2010, 2020). For this study, I adopt an *interpretive* qualitative approach, assuming that reality is in flux and that there are multiple truths to discover, which, even when contradictory, ultimately reveal something about social reality and the phenomenon of interest (Manning & Kunkel, 2014; Tracy, 2020). Interpretive qualitative studies can draw from existing theories as heuristic devices to interpret the data and can also "help to explore connections between seemingly disparate areas of relationship research" (Manning & Kunkel, 2014, p. 5). The Theory of Memorable Messages (ToMM: Cooke-Jackson & Rubinsky, 2021, 2022) and concepts from the interdisciplinary bodies of literature on coping and sexual pain served as heuristic or sensitizing devices that informed the development of interview questions for this study (see Appendices A and C).

To gain a more comprehensive understanding of how evangelical couples cope with WPP-PVI and enhance the trustworthiness of the findings, I adopt the notion of *crystallization* (Ellingson, 2009, 2014; Tracy, 2010). Whereas *triangulation* implies that the researcher can discover the singular truth of a phenomenon from multiple angles, Ellingson (2009) forwarded a *crystallization* framework to capture the interpretive, subjective, and fractured nature of qualitative research:

> Crystallization combines multiple forms of analysis and multiple genres of representation into a coherent text or series of related texts, building a rich and openly partial account of a phenomenon that problematizes its own construction, highlights researchers' vulnerabilities and positionality, makes claims about socially constructed meanings, and reveals the indeterminacy of knowledge claims even as it makes them. (p. 4)

Tracy (2010) explains that, like a crystal, a social phenomenon has many different facets that capture different angles of social reality. She notes that multiple methods, data points, researchers, and theoretical frameworks can inform the research process, providing "a more complex, in-depth, but still thoroughly partial, understanding of the issue" (p. 844).

In aiming to provide a multifaceted understanding of evangelical Christian couples' experience of female sexual pain, I contribute to the existing literature by adding the voices of partners and clinicians to this inquiry. *Partners* and *clinicians* may be women's primary support systems when navigating sexual pain and can directly influence the pain experience, yet their perspectives are still largely absent from the female sexual pain literature (Hintz, 2019a, 2019b; Scott et al., 2022). Partners are affected by *and* affect the process of sexual pain (Rosen & Bergeron, 2019), so understanding their own biopsychosocial experience may better inform theory development and intervention work with couples (Culley et al., 2017; Lovell et al., 2023; Sadownik et al., 2017). Thus, my primary data set consists of interviews with heterosexual evangelical couples living in the United States. Aside from the sheer number of evangelicals Christians in the US (Newport, 2018; Smith, 2021), evangelical couples provide a unique context from which to explore the coping process and the way memorable messages may function and intervene in that process (Cooke-Jackson & Rubinsky, 2021). Heteronormative sexual scripts that position PVI as the most meaningful form of sex and women as sexually subservient are

hegemonic within evangelical purity discourses (Gregoire et al., 2021; cf. Bairstow et al., 2018). This may leave couples with no choice but to reframe their view of intimacy and figure out strategies to cope with their disillusionment (Azim et al., 2020).

Adding another facet to this inquiry, I concurrently interviewed female clinicians who have worked with women or couples affected by female sexual pain. Women experiencing WPP-PVI or other distressing sexual health issues may be more likely to seek treatment from and feel supported by female practitioners (Leusink et al., 2018, 2019; Willer, 2014). In addition to the need for more research from the clinician's perspective, examining clinicians' perceptions in conjunction with patients' or clients' perceptions may provide greater insight into the experience of sexual pain than any one perspective could alone (Kenny, 2004). Investigating different angles of the sexual pain phenomenon through a crystallization framework is suitable for providing a more textured and comprehensive picture of the micro-level and meso-level influences on the sexual pain (Bronfenbrenner, 1977). Though sexual pain and evangelical purity messages transcend geographical boundaries, for the current study I focused on couples and clinicians living in the United States to further understand the sociopolitical factors that may be impacting intimate health and sexual education in the US, where women's health is historically underfunded (Cooke-Jackson et al., 2021; Hintz, 2022).

3.1.1 Self-Reflexivity

I first learned about genito-pelvic pain when someone close to me was diagnosed with vaginismus. At the time, I knew almost nothing about this condition. I also did not know that I was saying all the wrong things as I tried to support her—until I began reading pelvic health education material and scholarly research about the communication experiences of women with sexual pain (Hintz, 2019a, 2019b; Hintz & Venetis, 2019). Vaginismus took a major toll on my

friend's mental and relational health, which is a common experience for women with chronic sexual pain and difficulty (Rosen & Bergeron, 2019). She strongly attributes her experience to her (evangelical) Christian upbringing. Later, I experienced my own journey with pelvic floor dysfunction, but my experience felt exponentially different from my friend's, even though I also grew up in the context of evangelical Christianity and still hold to tenets of an evangelical worldview (Russell et al., 2010). I began wondering why I was so much less stressed about the pain, and indeed, why couples have such different experiences with female sexual pain (Reissing, 2021; Hintz, 2019b).

It was important for me to engage in practices of self-awareness or self-reflexivity throughout the research process (Small & Calarco, 2022; Tracy, 2010, 2020), given my experience with the topic. Whereas quantitative researchers work to develop valid and reliable instruments such as surveys, to capture participant attitudes and beliefs while minimizing researcher bias, in qualitative research the *researcher* is the instrument (Pezalla et al., 2012). Thus, although qualitative research assumes researcher-participant intersubjectivity and does not require researchers to distance or remove themselves from the research process, a researcher who is not self-aware may make research decisions and interpretations that lead to claims that do not credibly capture participants' own interpretations and experiences.

To facilitate reflexivity, I practiced Tracy's (2010) principle of *sincerity*, or genuineness, honesty, and transparency about biases throughout the research process from start to finish. I kept self-reflexive memos about my reactions to and interpretations of the data, including unforeseen emotions that arose through the research process (see Figure 1). I also kept an audit trail, or a detailed record of my research decisions, to maintain honesty about the research process and explain any adjustments to the research protocol or study design (see Table

1 for excerpt from audit trail). Moreover, after each interview I tracked my initial interpretations and personal reactions and emotions through field notes, which were written or audio-recorded. Sample prompts I responded to in each field note, adapted from Tracy (2020), included: "Where did the interview occur? Under what conditions?"; "How well do you think you did asking questions? How was the rapport?"; "To what extent did you find out what you really wanted to find out in the interview?"

Table 1

Excerpt from Audit Trail

10/1/23

- After completing our first pilot interviews on 9/22/23, I revised the interview guide slightly, tweaking the wording of some questions and moving some questions to the end as "if we have time" questions.
    - Changed "sexual pain" to "sex" in some places
    - Added question about virginity
- Changed wording in demographic questions - rather than "during the last 3 months," "during a typical month"

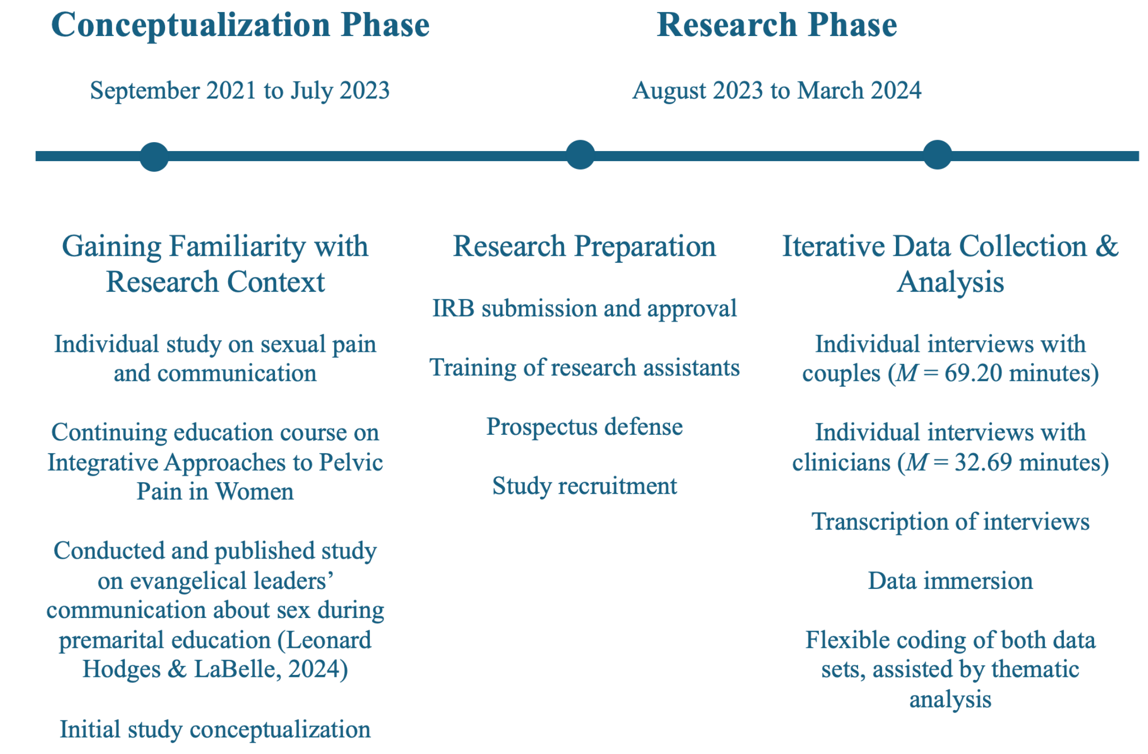
10/4/23

- Got botted to death (40-50 responses for each survey within about an hour or less, coordinates in other countries on other continents)
- Paused data collection, added some extra screening precautions to prevent bots
- NO SOCIAL MEDIA POSTING FOR NOW
    - Just sending to gatekeepers and listservs
    - Modifying recruitment script email version to say not to share on social media, please distribute via email or text

Without self-awareness, a researcher may fall prey to interpreting the findings through the lens of their own experiences. Again, qualitative research is inherently subjective, and some scholars argue strategies like "bracketing" that seek to remove the researcher's role in the process may not only be impossible but also problematic (Olmos-Vega et al., 2023). However, *reflexivity* is crucial, in that it allows the reader to see how the researcher arrived at their interpretations of the data.

Figure 1

Timeline



3.2 Participants

3.2.1 Evangelical Couples

Twenty heterosexual couples (40 total participants) were recruited for individual, semi-structured interviews. Couples were eligible to participate if (1) they were over 18 years old, (2) living in the United States, (3) in a heterosexual marriage, (4) both partners subscribed to tenets of an evangelical worldview (e.g., high view of the Bible, personal relationship with Jesus, active church involvement, see Russell et al., 2010), (5) the wife was currently experiencing recurrent/persistent sexual pain (i.e., pain with each attempt at penile-vaginal intercourse for at least 3 months) or experienced recurrent/persistent sexual pain within the past five years, and (6) the pain/difficulty has occurred (or did occur) since couples' first attempt at intercourse. These

inclusion criteria ensured a narrow enough range of experiences to reach data saturation (Hennink & Kaiser, 2022), yet allowed enough variation for a heterogeneity of the sample. Heterogeneity allows the researcher to examine how variables of interest may relate to each other (Small & Calarco, 2022). For example, couples were not required to *identify* as “evangelical” or to have been sexually abstinent before marriage, which provided some variation in religious conservatism. They were also not limited to a particular geographic region of the US or required to have a sexual pain diagnosis (Lovell et al., 2023).

Participants ranged in age from 22 to 38 years old (M = 28.40, SD = 3.81). The majority of participants self-identified as White or Caucasian (n = 33; mixed race/ethnicity: n = 3; African American/Black: n = 2; Latino/Hispanic: n = 2). Most participants held a bachelor’s degree (n = 20) or graduate degree (n = 10; some graduate school: n = 3; some of a four-year degree: n = 3; two-year degree: n = 1; some of a two-year degree: n = 2; high school grad/GED: n = 1).

Of the 20 couples (N = 20), couples reported a joint income of $20,000 to $40,000 ($n$ = 2), $40,001 to $60,000 ($n$ = 4), $60,001 to $80,000 ($n$ = 2), $80,001 to $100,000 ($n$ = 3), $100,001 to $150,000 ($n$ = 7), and over $150,000 ($n$ = 2). All couples had access to health insurance. Couples lived in the Midwest (n = 2), Northeast (n = 5), Southeast (n = 4), Southwest (n = 3), and West (n = 6). The length of couples’ marriages ranged from 4 months to 14 years (M = 4.00 years, SD = 3.34 years), including couples married less than two years (n = 3), two to five years (n = 13), six to 10 years (n = 2), and 11 to 15 years (n = 2).

Participants’ reported sexual satisfaction ranged from 1 to 5 on 5-point Likert scale (M = 3.41, SD = 1.05). Relationship satisfaction ranged from 2 to 5 on a 5-point Likert scale (M = 4.58, SD = 0.67). Participants’ reported frequency of sexual activity (e.g., intercourse,

outercourse, oral sex, etc.) during a typical month included less than once a month (*n* = 1), one to three times a month (*n* = 6), weekly or about weekly (*n* = 14), or several times a week (*n* = 19).

Of the 20 couples interviewed (*N* = 20), PVI was regularly pain-free (*n* = 6), chronically painful (*n* = 11) or impossible (*n* = 3) at the time of the interview. Sexual pain/difficulty was described in multiple ways which were not mutually exclusive (diagnosed or undiagnosed vaginismus: *n* = 15; painful sex/dyspareunia: *n* = 5; endometriosis: *n* = 2; vulvodynia: *n* = 1). For 11 couples, PVI was impossible for least the first three months of marriage, ranging through 11 years (this includes couples who were still currently unable to have PVI). Of the 40 participants, five (all husbands) had had PVI in previous sexual relationships.

Participants (*N* = 40) reported attending church or church related activities *together* less than once a month (*n* = 1), one to three times a month (*n* = 3), weekly (*n* = 18), or several times a week (*n* = 18). They also reported engaging in *personal* spiritual activities (e.g., prayer, devotions, reading the Bible) one to three times a month (*n* = 1), weekly (*n* = 6), or several times a week (*n* = 33); and engaging in spiritual activities *together* rarely if at all (*n* = 4), one to three times a month (*n* = 5), weekly (*n* = 11), or several times a week (*n* = 20). Though religious denomination was not collected in the demographic data, participants self-described a variety of expressions of Christianity (e.g., Anglican, non-denominational, charismatic, Seventh-Day Adventist). Several participants described converting to (evangelical) Christianity later in life (i.e., developing a personal relationship with Jesus) after growing up in homes that were "culturally" or "nominally" Christian (*n* = 8), Catholic (*n* = 2), or non-religious (*n* = 2).

3.2.2 Clinicians

Sixteen clinicians (*N* = 16) who have worked with women or couples affected by female sexual pain were also recruited. Clinicians were eligible to participate if they were (1) 18 or

older, (2) female-identifying (see rationale under Methodological Approach), (3) living in the United States, (4) a current or former gynecologist, pelvic floor physical therapist, or mental health professional (e.g., marriage and family therapist, psychologist, etc.), and (5) regularly work with women or couples affected by female sexual pain or religious patients/clients with sexual difficulties. The reason for criterion (5) was to ensure that the data illuminated clinicians' perceptions of women or couples who are affected by heteronormative and/or religious sexual scripts, based on their experiences and expertise.

The clinician sample included 11 pelvic floor physical therapists and five mental health professionals (see Table 2) ranging in age from 25 to 55 years old (*M* = 35.19, *SD* = 8.98). They had been practicing in their profession for a range of 3 months to 30 years (*M* = 7.42 years, *SD* = 6.99 years). The majority of clinicians identified their race or ethnicity as White/Caucasian (*n* = 10; Asian/Pacific Islander: *n* = 3; African American/Black: *n* = 2; Refused: *n* = 1). They described their own religious affiliation in multiple ways (Christian: *n* = 4; non-denominational Christian: *n* = 3; practicing Catholic: *n* = 1; Hindu: *n* = 1; agnostic: *n* = 2; atheist: *n* = 2; non-religious: *n* = 3).

Table 2

Clinician Demographic Information

Name	Profession	Years Practicing	Region of U.S.
Meredith	Clinical Psychologist	11-15 years	Northeast
Penny	Pelvic Floor Physical Therapist	2-5 years	Midwest
Phoebe	Pelvic Floor Physical Therapist	6-10 years	Midwest
Paulina	Pelvic Floor Physical Therapist	< 2 years	South
Maya	Licensed Professional Counselor	6-10 years	Northeast
Piper	Pelvic Floor Physical Therapist	2-5 years	West
Pam	Pelvic Floor Physical Therapist	< 2 years	South
Priscilla	Pelvic Floor Physical Therapist	2-5 years	South
Margaret	Clinical Psychologist	11-15 years	West
Paris	Pelvic Floor Physical Therapist	11-15 years	South

Pearl	Pelvic Floor Physical Therapist	2-5 years	South
Priya	Pelvic Floor Physical Therapist	6-10 years	South
Patty	Pelvic Floor Physical Therapist	2-5 years	South
Monique	Licensed Marriage and Family Therapist	2-5 years	South
Megan	Licensed Professional Counselor	6-10 years	South
Paula	Pelvic Floor Physical Therapist	> 30 years	West

Note. Names are pseudonymous. For easier identification, mental health professional pseudonyms begin with "M." Pelvic floor physical therapist names begin with "P."

3.3 Procedures

3.3.1 Recruitment and Screening

Upon receiving approval from the Institutional Review Board, couples and clinicians were recruited using purposive sampling (Creswell, 2013; Patton, 1990). Specifically, I used a combination of convenience sampling, snowball sampling, and criterion sampling. I shared recruitment flyers (see Appendices G and H) with personal and professional networks and encouraged network members to share the flyers with others. Flyers were shared in four ways: first, digital flyers were posted on social media accounts (e.g., Facebook, LinkedIn, Instagram) and academic and medical listservs. Second, as an insider in the evangelical community and the pelvic pain community, I contacted and provided flyers to gatekeepers within my social network (e.g., friends, church members, pastors, pelvic floor physical therapists) and outside my network (e.g., vaginismus and dyspareunia support groups; pastors at megachurches; therapists and counselors that market themselves to people with pelvic pain, sexual dysfunction, and/or Christian women/couples; counseling centers at evangelical Christian colleges; social media influencers who discuss sexual pain, pelvic health, and/or evangelical purity culture). Third, I contacted clinicians referred to me by participants and gatekeepers, and I contacted health organizations (e.g., gynecology and pelvic floor departments at large healthcare organizations)

and provided them with the study information. Fourth, I shared flyers with participants at the end of interviews to pass along to others.

Interested individuals completed respective Qualtrics interest surveys (see Appendices I and J). When I first published the surveys and posted them as public links on my personal social networking sites, I received dozens of responses within an hour. After checking the geographical coordinates of interested individuals, almost all were responses outside of the United States, despite the inclusion criteria. I paused the data collection for the screener surveys and added additional security measures to prevent scammers and bots from taking the survey. From that point forward, I only recruited in electronic spaces by posting on private social networking sites, Instagram stories (which function differently even if a link is public), and via private email or messenger to gatekeepers. My graduate research assistant and I regularly checked the interest survey data during the recruitment period and contacted individuals who met the inclusion criteria to schedule interviews and answer any questions they had about the study.

3.3.2 Interview Procedures

All but one of the 56 total interviews with couples and clinicians took place via Zoom. One clinician was interviewed in person at her office in Southern California. Despite the drawbacks of interviewing via Zoom (e.g., technological difficulties, inhibited rapport), recent studies have shown that conducting qualitative interviews via video conferencing may not reduce the quality or quantity of self-disclosure and can sometimes enhance data quality (Jenner & Myers, 2019; Namey et al., 2020, 2022). To ensure each participant had ample time to provide their informed consent, consent was obtained electronically (via DocuSign) prior to the start of the interview. Then, at the scheduled time of the interview, the researcher explained the informed consent process again and answered any questions before recording. Each participant received a

reminder via phone or email before the interview with the scheduled time and location (i.e., Zoom link). All interviews were audio-recorded and transcribed verbatim with the assistance of Cockatoo, an AI-powered software. Semi-structured interview guides were followed that were modified slightly throughout the course of the data collection to rephrase questions for clarity or follow salient ideas that emerged in participants' accounts (Lareau, 2021; Small & Calarco, 2022).[1]

Couple Interviews. In-depth interviews with couples were conducted separately with each partner, to promote greater transparency. I interviewed wives and a trained male research assistant who is an insider in the evangelical community and has experience with the topic interviewed husbands. Given the stigmatized and intimate nature of the topic and gender roles within evangelical communities that often regulate how much unmarried men and women disclose in interpersonal settings (Leonard Hodges & LaBelle, 2024), it was suitable to seek the assistance of a male interviewer. Moreover, one of the few qualitative studies on vulvodynia from the male partner perspective also used a male interviewer (Sadownik et al., 2017).

We began interviews on Zoom by greeting couples together, before breaking off into separate Zoom meetings in separate, private spaces (only two sets of spouses were not interviewed concurrently, due to scheduling conflicts). We introduced ourselves by briefly sharing our relation to the topic to facilitate comfort and openness, since many couples feel alone and isolated in navigating sexual pain (Culley et al., 2013). We each selectively disclosed during interviews when we assessed a participant may be experiencing shame or discomfort from something they shared. These strategies proved to be effective, which was reflected in

[1]See Appendices B and D for the original versions of each interview guide, and Appendices A and C for the final versions.

participants' openness and the rich data quality. We also received this feedback after conducting one pilot interview with a couple who met the inclusion criteria.

Individual interviews began with a brief overview of the study and reminders about how we are protecting the data (see Appendix A). After hitting "record," the interview portion began with some introductory questions to build rapport and learn more about the participant's relationship with their spouse (e.g., "How did you two meet?" "How important was it to you that you marry someone with the same faith?") and the kinds of messages the participant had heard about sex growing up (e.g., "Before we get to your experience with the topic of painful sex, I'd like to know, what were the kinds of things you heard about sex and intimacy growing up?").

The core interview questions were informed by the interdisciplinary literature on coping (i.e., dyadic coping, resilience, social support) and sexual communication (e.g., Afifi et al., 2016; Afifi, Basinger, et al., 2020; Horstman et al., 2021; Rosen & Bergeron, 2019) and the Theory of Memorable Messages (ToMM; Cooke-Jackson & Rubinsky, 2021, 2022), which served as sensitizing concepts, or organizing ideas (Tracy, 2020). After introductory questions, participants were asked questions about their experience of discovering, coping with, and seeking support or treatment for sexual pain that began with an open-ended prompt: "So tell me your story of navigating sex with your partner. Feel free to be as explicit or not explicit as you want." In line with Rubin and Rubin's (2011) notion of responsive interviewing, introductory questions and the broad prompt that followed provided context from which to ask relevant key questions and follow-up questions throughout this portion (e.g., "Have you or your spouse sought out any kind of support or treatment?" "Some couples navigating sexual pain have said that communicating about it with their partner can be really challenging, while others have said that it brings them closer together. What has been your experience?"). Participants were then asked more

specifically about the memorable messages they believed had helped or hindered their ability to cope (e.g., "How much have you shared with others about your experience?" "How have others' responses to your experience of painful sex helped or hindered your coping process?" "What was it about these messages that made them so impactful for you?").

To further elucidate the function of religious messages in the coping process, participants were asked, "What has been your experience of God throughout this time?" Finally, participants were asked concluding questions (e.g., "What advice would you give to other couples experiencing what you have experienced?" "Is there anything you want to add to what we already talked about, or anything I should have asked you that I didn't think to ask?"). Apart from clarifying questions, questions were open-ended to facilitate disclosure with follow-up probes on hand.

After the interview portion, demographic information was collected (see Appendix E) and each participant was compensated with a $50 electronic Visa gift card. Couple interviews ranged in length from 36 to 100 minutes (*M* = 69.20, *SD* = 15.65) and resulted in a total of 712 single-spaced pages of transcripts.

Clinician Interviews. I followed a separate semi-structured interview guide for clinicians, that was similarly modified after the first few interviews (see Appendix B for final version). After introducing myself and the nature of the study, I asked open-ended questions with follow-up probes on hand. The first question was meant to build rapport ("So tell be a little bit about your professional background"). The key questions were written in a way that would complement or clarify couples' responses, while also being informed by interdisciplinary health communication research (Baker et al., 2017; Byers, 2011; Kenny, 2004; Slowinski, 2001). Questions asked about what clinicians' typical female patient/client with sexual pain is like, the

similarities and differences they notice in sexual pain patients/clients, what their goals are, and what they feel would help make them more effective in treating sexual pain. Clinicians who stated that they worked with religious patients or clients were asked, “Do you notice any differences in patients’/clients’ ability to heal or cope, based on their specific religious affiliation or denomination?” and probed further if they specifically worked with evangelicals. Clinicians who had experience working with couples or hearing from female patients about their relationships were asked, “What do you think distinguishes the women/couples who cope more adaptively from those who cope less adaptively?” I concluded the interview portion by asking if there was anything they wished to add.

At the end of each interview, I collected demographic information (see Appendix F) and compensated each participant with a $50 electronic Visa gift card. Clinician interviews ranged in length from 25 to 46 minutes (M = 32.69, SD = 6.45) and resulted in a total of 152 single-spaced pages of transcripts.

3.3.3 Follow-up and Member Reflections

Small and Calarco (2022) note the importance of follow-up within interview research, or the degree to which a researcher follows up on salient ideas or themes. Follow-up can take several forms and is important because it reflects the number of hours a researcher has spent in the field and the confidence the reader can have in the researcher’s claims. To ensure participants’ perceptions, interpretations, and accounts were reflected in the findings, my male research assistant and I followed up on emotional “bread crumbs” as indicated in participants’ facial expressions, vocal tone, and kinesics (Small & Calarco, 2022) by asking new questions within interviews. Interpretations of findings were checked with subsequent participants, for both the couple and clinician interviews.

Follow-up can also include a second interview with the same participant or following up with a different participant about emergent ideas as a means of validating the findings (Small & Calarco, 2022). While the timeline of this dissertation precluded me from conducting multiple interviews with each participant, I conducted *member reflections* with four couples. Tracy (2010) notes that the term "member checks" reflects more of a realist assumption, while "member reflections" reflects more interpretive and post-structural paradigmatic assumptions. I conducted *dyadic* (i.e., joint) interviews via Zoom with four couples. I selected couples for member reflections who varied in relationship length, prior knowledge of sexual pain, race/ethnicity, and primary coping strategies and support systems to ensure I had enough representation to check interpretations of specific findings.

I loosely followed a brief semi-structured interview guide (Appendix K). I began by checking in with the couples (e.g., "If each of you could describe the last [X weeks/months] in one word, what would it be?"). After sharing the findings with couples verbally or letting them read a summary, I asked, "In what ways do you feel like I have accurately captured your experience with this topic? What do you resonate with?" and "Where do you think I've misunderstood or misrepresented your experience, individually or as a couple?" I concluded by asking if there was anything they wished to add or anything they would change about the advice they would give couples based on learning more about the findings. Any time I referred back to couples' original interviews, I only referred to points that both partners had mentioned or points a partner explicitly mentioned sharing with their partner, to protect confidentiality.

Notably, my initial plan for follow-up interviews was to briefly summarize the findings before moving into the member reflection questions. I realized during the first interview that the information sheet I provided was far too detailed to cover in full, as 30 minutes was the

timeframe I had given couples when I contacted them about a follow-up interview. Therefore, I sent the summary of findings in advance to the other three couples and during interviews focused on the findings that resonated the most or least, individually and dyadically. Follow-up interviews ranged from 39 to 76 minutes ($M = 58.50$, $SD = 17.76$) and resulted in 59.5 total single-spaced pages of transcripts.

Follow-up and member reflections helped me refine my analysis and allowed me to gain more confidence that I had reached data saturation (Hennink & Kaiser, 2022; Small, 2009). Data saturation occurs when participants' responses become redundant and yield no new themes or insights with regard to the study's purpose, which indicates that the researcher has an adequate sample size (Hennink & Kaiser, 2022). When I heard no new themes or patterns repeated within and across different data points (i.e., husbands, wives, clinicians) in relation to the research questions, I was confident I had reached saturation.

3.4 Data Analysis

I used Deterding and Waters' (2018) flexible coding method to analyze interview data, given the iterative nature of the study (i.e., moving cyclically between existing literature and emergent findings that arise during the data collection process). Flexible coding is a data analysis procedure that allows qualitative researchers to more systematically analyze larger interview data sets guided by theoretical concepts. Deterding and Waters (2018) argue that flexible coding inverts traditional approaches to data analysis like grounded theory, since techniques like granular line-by-line coding can be more difficult to accomplish with data sets comprising more than 10 interviews. Moreover, flexible coding assumes the researcher is engaging in "some combination of induction and literature- or theory-based coding; research that is not completely inductive, even in the first steps of analysis" (Deterding & Waters, 2018, p. 720). Given that the

study's conceptualization, data collection, and analysis process was informed by interpersonal and health communication theory, I viewed flexible coding as a suitable analysis method.

3.4.1 Flexible Coding

Preparation Stage. The process of flexible coding begins with preparation of the data for analysis (Deterding & Waters, 2018). After using AI-powered software to generate transcripts, I listened to each interview, making corrections as needed, eliminating vocal fillers (e.g., "you know," "uh") when they did not add to the meaning of the interview, and adding in nonverbal expressions to denote tone, volume, and emotion, with the help of my graduate research assistant. I then removed names and identifying information (e.g., places) and replaced them with pseudonyms or generic descriptors.

In the reporting of the findings in the following chapters, rather than noting each time emphasis is added, a participant's increase in volume is noted by capital letters (e.g., HELLO), vocal emphasis of a word or phrase by italics (e.g., *hello*), words that are drawn out by the addition of extra letters (e.g., helloooo), and pauses or interruptions by em dashes (e.g., —). Other nonverbal indicators (e.g., when a participant laughs) and points of clarification are italicized and included in brackets (e.g., [*laughing*]). Words that are changed for clarity or anonymity are placed in brackets (e.g., [hello]). Omitted words are indicated by three periods (…) and omitted sentences or longer portions of text are indicated by four periods (….). Participant names are included with each quotation, except when doing so would risk a breach in confidentiality or when a brief quote is provided as an example within parentheses. Researchers are denoted by "R." In line with flexible coding (Deterding and Waters, 2018), I uploaded transcripts and demographic data to the QDA software NVivo 14 to aid in the data analysis process.

Stage 1: Index Coding and Memoing. Stage 1 of flexible coding involves data reduction through *index coding* each transcript according to major topics or interview questions. Importantly, the index coded project can be archived for easier use of the data in future research projects (Deterding & Waters, 2018). Given the iterative nature of the study (i.e., guided by topics but sensitive to salient issues), I index coded large chunks of data according to the major topics derived in part from the interview guides (see Appendices A and C) and in part from the issues that became important during interviews.

I index coded couple interviews at the following topics: Relationship History; Discovering Chronic Pain; Pain Experience & Attributions; Relational Communication; Support; Conception of Sex, (Memorable) Messages; and Advice to Others. I index coded clinician interviews at the following topics: Professional Background & Training; Typical Patient & Treatment; Help to Coping, Support, Healing; Hindrances to Coping, Support, Healing; Perceptions of Religion; and Desired Resources. I also created two index codes called Great Quotes (Couples) and Great Quotes (Clinicians) where I coded poignant quotes for later reference. After immersing myself in the data by carefully listening to, reading, and index coding each entire interview, I wrote analytic memos for each interview to reflect on possible theoretical concepts and thematic patterns in relation to the research questions for the current study. I also kept track of possible *analytic codes* (see below).

Stage 2: Analytic Coding. Stage 2 involves applying analytic codes to the interview data, which may reflect a priori theoretical concepts from the literature, in-vivo language used by participants (i.e., directly quoted words or phrases), or other concepts that reflect thematic patterns (Deterding & Waters, 2018). After index coding each interview, I created a list of possible analytic codes that answered each research question. The process of analytic coding was

iterative, and I drew from principles of thematic analysis (Braun & Clarke, 2006; Owen, 1984) to refine, collapse, and label analytic codes. Specifically, I paid attention to repeated or recurring words, phrases, or ideas within and across interviews. Some analytic codes became participant attributes (e.g., prior knowledge about sexual pain; degree of teamwork) which I explored further in Stage 3.

Notably, throughout the coding process I drew from ToMM's broad conceptualization of memorable messages throughout the coding process (Cooke-Jackson & Rubinsky, 2021, 2022), looking for instances when participants described (1) brief verbal or nonverbal messages that "stuck" with them (e.g., responses to disclosing about sexual pain, advice from parents, quotes they remember from sermons, etc.), (2) a general message they perceived from a specific source(s) even if they could not identify the message (e.g., many participants said the impression they received from their church and Christian culture was that "sex was bad until you are married," though they often could not pinpoint specific messages that communicated this), (3) message gaps (i.e., an absence of desired information or messages participants with they had heard, see Cooke-Jackson & Rubinsky, 2022), and (4) qualities of messages identified in (1), (2), or (3), such as why and how messages were impactful or memorable, the context of the message (e.g., the temporal and environmental conditions in which it occurred), and the message source or sources.

I entered a preliminary list of analytic codes into NVivo 14 and applied them to each couple index code except for Relationship History, and each clinician index code except for Professional Background & Training and Desired Resources. However, in some cases I recalled a relevant portion of a participant's account from the data immersion phase, which prompted me to revisit the index codes that were not relevant to the current study's research questions. In

many cases I applied multiple analytic codes to the same excerpt. Throughout Stage 2, I frequently utilized NVivo 14's querying features to see where codes clustered together, which prompted me to adjust the labeling of analytic codes when necessary or collapse them into hierarchical codes to capture thematic interpretations. For example, I initially had two codes labeled "Husband's Emotional-Spiritual Labor" and "Husband's Anger and Frustration." Both of these were index coded at Relational Communication. A query indicated that most of the quotes coded at "Husband's Anger and Frustration" were also coded at "Husband's Emotional-Spiritual Labor," but that the emotional-spiritual labor code involved the regulation of other emotions besides frustration. After reviewing the quotes coded at a separate code labeled "Wife's Concealment of Pain" and seeing similar qualities in the quotes coded at "Husband's Emotional-Spiritual Labor" (e.g., the desire to protect a partner from emotional pain), I collapsed these into the analytic code "Emotional-Spiritual Labor."

To ensure I had selected and organized codes appropriately, I supplemented the NVivo analysis with a tactile approach that allowed me to engage with the data in a different way, which aligns with the assumptions of crystallization (Ellingson, 2014). I wrote down every analytic code listed in the analytic coding section of my NVivo project on color-coded index cards, physically arranging them into columns representing each research question. This process allowed me to visually see how codes related to one another and further refine the coding scheme. Alternating between arranging index cards and the querying process I described above, I condensed over 100 analytic codes into the final 48 analytic codes (including two sub-codes).

I organized analytic codes within 12 broader categories that answered the research questions, using the same strategy to label each category as I did to label codes (e.g., using a priori theoretical concepts, in-vivo phrases). I then entered the final analytic codes into a

codebook organized by categories, provided conceptual definitions for each code, and linked illustrative quotations to each code (see Table 3 for an excerpt from the analytic codebook, and Table 4 for a summary of the findings).

Stage 3: Refining and Testing Findings. Finally, assisted by NVivo 14, in Stage 3 I was able to "identify trends across cases, investigate alternative explanations, and quickly locate negative cases that help refine or limit the theoretical explanation" (Deterding & Waters, 2018, p. 731). I again used the querying feature to examine links between and among analytic codes and participant attributes (e.g., for couples: gender, geographical region, prior knowledge of sexual pain conditions; e.g., for clinicians: professional title or years in profession). I consulted these queries, prior literature, fieldnotes, and the codebook to aid in data interpretation. This step enhanced the study's methodological rigor and theoretical utility of the study.

3.4.2 Analyzing Multiple Levels of Data

The first three research questions sought to document couples' experiences at the individual and dyadic levels. Qualitative researchers have noted the difficulty of analyzing the couple as a unit in interview studies in which partners are interviewed separately, which often leads to ambiguity in methods sections that make it difficult to discern how researchers arrived at their conclusions (Collaço et al., 2021; Manning & Kunkel, 2015). Scholars who have developed methodical solutions to this problem still note the complexity and limitations of such approaches. For example, Collaço et al. (2021) explain the difficulty of systematically organizing and interpreting data when partners' perceptions of the same event differ or when one partner is not asked a question the other partner was asked because of the issues that became salient in their respective interview. Moreover, they articulate ethical concerns around confidentiality that

emerge when following up on lines of inquiry with the same participant or presenting dyadic data in the research report.

To account for these common issues, I analyzed the couple data individually and dyadically throughout the flexible coding process in the following ways. First, since all but two couple interviews involved simultaneous interviews with spouses[2], my research assistant and I each recorded our individual fieldnotes immediately following or soon after the interview, after which we compared and discussed how spouses' perceptions converged and diverged and what the implications may mean for the interpretation of the data.

Second, I index coded spouses' interviews one after the other for each couple, writing separate analytic memos for each spouse but noting where accounts and perceptions converged or diverged. Third, where I began seeing repeated gender-based patterns that may capture something unique about wives' or husbands' experiences, I labeled analytic codes accordingly (e.g., "Wife's Autonomy & Control"). Fourth, during Stages 2 and 3 of flexible coding, I utilized NVivo 14's querying features to examine whether certain codes were representative of specific attributes, such as gender, couple[3], and prior knowledge of chronic sexual pain. Each time I ran a query, I reviewed the query results and the initial codes that I queried, since, for example, a code that consisted of mostly husband references may not always reflect husbands referring to their own experience, which in some cases nullified my initial interpretations of the query. Examples of queries are provided throughout the next two chapters where relevant. In all, these steps allowed me to form more credible interpretations at the individual level and the couple level.

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[2]For two couples, spouses were unable to be interviewed at the same time. Interviews were conducted as closely together as possible.
[3]Each couple was given a unique numeric identifier.

The fourth research question sought to document clinicians' perceptions. Additionally, I wished to analyze individual- and couple-level data in conjunction with clinicians' perceptions to gain a crystallized insight into the phenomenon of sexual pain. I initially planned to apply analytic codes from the couple data to the clinician data where they overlapped (e.g., when all three data points contained mention of the same idea, such as "husband's support"). However, since RQ4 was worded differently from the first three research questions, I first analyzed RQ4 on its own using the flexible coding process detailed previously.

After finalizing the analytic codes and categories that answered all four research questions, I compared the couple and clinician codes, looking for conceptual convergence or divergence. When codes overlapped conceptually (e.g., "Different Valid Reason" and "Overlapping Conditions," see Table 4), I reviewed the references coded at each and the interpretations I had written about in the codebook, consulting the audit trail if necessary (i.e., field notes, analytic memos, initial coding schemas). To answer RQ4, I wove the findings together any time they "open[ed] up a more complex, in-depth, but still thoroughly partial, understanding of the issue" (Tracy, 2010, p. 844). In other words, I feature quotations or reference previously mentioned findings when the theoretical or practical understanding of couples' coping and related memorable messages can be better understood by examining the data sets in conjunction with one another. In the following two chapters, I present the findings from this multilevel study, crystallizing the findings by showcasing how the three data points converge and diverge and the possible implications of these multiple viewpoints.

Table 3

Excerpt from Analytic Codebook

Category	Analytic Code	Description	Example
RQ1			
(Re)framing the Sexual Pain Experience	(Re)defining Intimacy	Couples redefined "sex" to include non-penetrative intercourse. This afforded couples benefits (e.g., taking intercourse off the table on the wedding night, preparation for inevitable future need to redefine intimacy, figuring out what partner likes) and challenges (e.g., contending with premarital sexual activity, cognitive dissonance around perceptions of PVI).	"I tried to look at it as, okay, we can find different ways to be intimate and that, I think kind of could help our relationship because there are probably other times when we will be married but not be able to have sex, if we have kids and stuff like that. And so, kind of all of those things." (Rikki)
	Assigning Blame to External Factors	Partners who attributed sexual pain or low libido to evangelical purity culture, early childhood experiences, or an involuntary physiological issue, rather than something inherently wrong within themselves or their relationship, described less feelings of brokenness, frustration, and/or inadequacy.	"I'd give absolutely anything to like, just tell people, 'Look. Your sex life could be damaged for a very very very long time if you let this—if you let your wife feel guilty about this thing. Because there's just—there should be no guilt at all. It's just—again, like a physical ailment, it's like you hurt your back, you throw out a disc in your back and you can't have sex. Or you're taking a medication, you can't get an erection. This is like that!'" (Noah)
	Healing as a Long and Non-linear Journey	Couples reframed the sexual pain experience as a long and non-linear process of healing, which reduced the pressure to solve the issue quickly.	"So, on that side, the painfulness of sex, of intercourse, has not been a problem in our relationship, because it's—it's not useful for me to get frustrated with it because there's nothing *I* can do to control it. And the levels that you have to go

			through in order to unravel that, I always knew that that would start psychological long before it got to physical. And that's a *long* journey." (Spencer)
	Finding Opportunity in the Pain	Several couples framed the pain experience as an opportunity to grow closer to each other, experience spiritual growth, and help other couples in the future.	"I feel like because we *chose* to go in the direction of growing together and like working on it, I feel like it's kind of brought us close together and then our relationship with God has definitely grown because of it." (Isabella)
Stumbling Through it Together	Cultivating Teamwork	Couples emphasized how helpful it was to feel like they were on a team or how unhelpful it was when they did not feel like they were a team. They worked together to troubleshoot during sexual episodes (e.g., switching positions, inserting fingers, etc.), to problem-solve (e.g., researching solutions, attending doctor's appointments together), and to tag-team emotional support.	"What helped us through that [feeling]? I mean, I guess, I mean, this sounds super cliche, but I mean, just that knowing that we were in it together and that we had each other's support." (Ryan)
	Analytical vs. Arousal Mindset (sub-code)	Problem-solving and engaging in treatment for sexual pain often placed both partners in an "analytical" mindset, which reduced arousal for both partners and became a feedback loop.	"If I can't pinpoint why, then I don't know how to fix it. And it just feels like a mental game. Like I just need to focus harder, feel more sexual. And I think I'm better at not thinking those thoughts [*nervous laugh*]. I'm trying to be patient, but it definitely is still quite frustrating to not know how to achieve one of the goals of having sex." (Claire)
	Emotional-Spiritual Labor	Both partners described the emotional labor (which was often linked to spiritual motifs)	"And so I felt very kind of alone. And for the first little bit, I felt like I couldn't talk

	that they engaged in to create space for each other to share their emotions, and to help prevent each other from feeling worse about sexual pain. For women, this often looked like concealing pain or emotions. For men, this looked like concealing negative emotion and providing encouragement.	to [my wife] about it because I didn't want to make it about me." (Franky)
Encouragement without Pressure (sub-code)	Most husbands were positive and encouraging in a way that did not pressure their wives to have intercourse or seek immediate treatment. In fact, most husbands who knew that sex was painful or impossible for their wives halted sexual episodes, despite their wives wanting to push through. However, this posed a dilemma for husbands since they did not know how to broach the subject with their wives.	"I've been seeing [my wife] kind of losing a lot of that hope that anything could change. And so it becomes much harder for me to hope. Because as much as I don't want it to be true, a lot of what we are dealing with is—*is* up to her. And it's up to her doing the work that the physical therapist outlines, the exercises. And it's up to her willingness obviously. And on my end I really can only do so much." (Parker)
Meaning-Centered Sexual Communication	Couples worked to synchronize and deepen their sexual intimacy through sexual communication. It was often easier to communicate about pain during sex than to discuss the relational implications of the sexual pain experience. Couples found relief and closeness in discussing the emotional meaning of their verbal and nonverbal communication.	"At one point when we started trying to have sex and then I just had a complete breakdown and actually cried and he was like, 'Well, this is different you know … Usually you just shut down and you turn off and so you're actually feeling which is really good. You're grieving.' And I was like, 'You're right.' And so I think that began to turn a corner of having more conversations … about our bodies and sex." (Grace)

Table 4

Summary of Findings

Category	Analytic Codes
RQ1: What helps couples cope with the biopsychosocial experience of sexual pain?	
(Re)framing the Sexual Pain Experience	(Re)defining Intimacy Assigning Blame to External Factors Healing as a Long and Non-linear Journey Finding Opportunity in the Pain
Stumbling Through it Together	Cultivating Teamwork *Analytical vs. Arousal Mindset Emotional-Spiritual Labor *Encouragement without Pressure Meaning-Centered Sexual Communication
Outside Support	Holistic Treatment Selective and High-Quality Network Support (Emotionally Honest) Prayer
RQ2: What factors motivate couples to seek or avoid support in managing or resolving their shared challenges with sexual pain?	
Factors Motivating Couples to Avoid, Delay, or Withdraw Support	Thinking it Will Resolve No (Perceived) Need or Benefit Shame and Stigma Disclosure Dilemmas Disenfranchising Talk Inaccessibility More Pressing Stressors
Factors Motivating Couples to Seek Support	No Change or Worse with Current Approach Different Valid Reason Need for Emotional Support Referral or Recommendation Mediated Sexual Health Information
RQ3: What memorable messages do spouses perceive contribute to their individual and shared experiences of coping with sexual pain?	
Anticipatory Socialization: From Worst Sin to Best Gift	Purity Culture Messages Unrealistic or Romanticized Ideal Incomplete, Inaccurate, and Vague Sexual Health Information
Dismissive Responses	Hasty Sensemaking Simple Solutions Insensitivity and Dismissal
Intervening and Buffering Messages	Validation Advocacy Flexible Sexual Expectations Spiritual Truths

RQ4: (a) What factors do clinicians believe contribute to women's/couples' ability to cope with, seek support for, and heal from sexual pain? (b) How do clinicians account for religious identity when treating female sexual pain?	
Systemic and Structural Factors	Knowledge
	Multiple Layers of Shame and Stigma
	Moral, Medical, and Media Messages
	Access to Holistic Care
Individual Factors	Sense of Self
	Overlapping Conditions
	Buy-in
	Autonomy and Control
Relational Factors	Sexual Communication
	Partner Support
Religious Considerations	Long Journey
	Religious Identity Negotiation
	Perceived (Dis)similarity
	Current Partner as Only Reference Point

Note. Analytic sub-codes are indicated with an asterisk (*).

4 Findings and Discussion of Couple-Level Data

In this chapter, I discuss the interpretive findings from a multilevel analysis of qualitative interviews with wives and husbands about the phenomenon of coping with sexual pain, specifically women's persistent pain during penile-vaginal intercourse (WPP-PVI), and the memorable messages that shape the coping experience. The findings are divided into sections corresponding to each research question, and points of convergence and divergence in accounts are discussed when relevant (see Table 4 for a summary of the findings).

4.1 Coping with Sexual Pain

Research question one asks, "What helps couples cope with the biopsychosocial experience of sexual pain?" Multiple participants indicated that the way they coped with and communicated about sexual pain mirrored their day-to-day coping mechanisms and communication about their stressors, both positive and negative (e.g., prayer, avoidance, pornography use, etc.). However, the complexity of the coping process became evident during the first few interviews, as participants articulated the emotional, relational, spiritual, and physiological dimensions of sexual pain. For instance, when I asked Holly about what has helped her cope with the experience of sexual pain the most, she mused, "if you're talking about coping and just being okay in the midst of it, it's a lot of talking to my husband. But in terms of trying to not get stuck in this place, it's a lot of my therapist." Therefore, I kept in mind the biopsychosocial nature of sexual pain when generating the following three themes and corresponding analytic codes (Meana & Binik, 2022) which capture spouses' individual and joint experiences.

4.1.1 (Re)framing the Sexual Pain Experience

Most couples were caught off guard by persistent sexual pain and therefore had to both *frame* (i.e., make sense of) and *re*-frame their experiences. Spouses described many individual and dyadic (re)framing behaviors that appeared to relieve the emotional toll of sexual pain, create a deeper interpersonal connection, and put their experience into perspective.

(Re)defining Intimacy. Spouses repeatedly articulated the ways in which they defined and redefined "intimacy," either purposefully or out of necessity. This type of reframing included redefining sexual intimacy to include non-penetrative sexual activities such as oral sex, manual stimulation (e.g., hand jobs, sliding on each other), and cuddling naked together. For example, Caleb[4] expressed:

> And so I have had to really work at that in redeeming that, like, yes, we're not having penetrative sex on a frequent basis, but how can I feel as close to my wife as possible in the acts of sex that we *do* have. I think that's been important. I don't know if I ever thought that was gonna be important, but I think it's been just *extremely*, *extremely* important to feel like I see her and that she sees me, and that we are close to one another even in light of not being able to have the type of sex that I mentally pictured or that the rest of the world might be experiencing.

Couples also expressed more generally the importance of redefining intimacy to include non-sexual activities (e.g., taking a walk, reading a book next to each other), which disrupted the messages they had heard growing up in evangelical communities that painted sex as the penultimate part of marriage. These data extend Lovell et al.'s (2023) findings, revealing how

[4]All participant names are pseudonymous.

both partners reframed a "coital imperative" to an "intimacy imperative" and illuminating some of the nuance of this process.

Most couples described a process of *re*defining their view of sex after discovering that it was chronically painful or impossible. However, of the seven couples for whom one or both spouses knew *prior* to marriage of the possibility that sex would be difficult, four described having conversations before the wedding night about taking PVI off the table for the wedding night and/or honeymoon—conversations initiated by husbands. For example, before getting married, Fiona went to the gynecologist for a Pap smear, which was so painful that the doctor could not insert the speculum. She recalled getting in the car and calling her then fiancé, crying and expressing concern they would not be able to have sex:

> And he was *amazing* about it from the very get go. … HE was the one who said, "Okay, so our wedding night, intercourse is *off* the table. We're NOT doing that. After our wedding, when we're exhausted and we are riding high on emotions and feeling all the things and perhaps a little bit tipsy we're not having intercourse. We'll just do what feels right and you tell me when to stop." And so we did that, and it was great. … And pretty much our whole honeymoon was kind of like that. We had a very long honeymoon and it was really fun. It was very wonderful. Um, really, really chill. And we [*giggles*] we call it vegan sex when we don't attempt intercourse.

Couples who had purposefully redefined "sex" prior to getting married as including non-penetrative acts appeared to experience the least distress when their first attempt at penetration was unsuccessful. Participants described how this strategy reduced the pressure on the wedding night (see Frydman, 2022) and gave them the opportunity to learn about each other's sexual

preferences, which would be valuable for future time periods where couples may not be able to engage in intercourse (e.g., sickness or injury, post-partum, aging).

Despite the value of redefining intimacy, several wives frustratedly or somberly expressed cognitive dissonance related to their religious socialization. For example, when asked if and how their definition of "sex" had changed over time, some women noted that expanding their definition of sex to include non-penetrative acts, though comforting, also meant that they had to contend with their premarital sexual activity. As Jasmine reflected,

> Before I got married, I think I would say that sex is like the penetrative portion of it, like that's what sex is. Now more so I'm seeing that that was … that's not true [or] all-encompassing, which also I think makes me feel [*pause*] I think a little bit ashamed in a way, because I know that we struggled before we got married, so then now that my definition has changed, and it's not just this one portion, now I'm like, "Oh *gosh*, then this is really terrible [*nervous laugh*] because we struggled before." Like sex is like all the foreplay and all it's ALL of it. So I'm like, "Oh no, this is terrible because then did we have sex before?"

This finding builds on previous studies that have emphasized the benefits of reframing intimacy when intercourse is painful or impossible (Bairstow et al., 2018; Frydman, 2022; Hintz, 2019b) by elucidating the way religious meanings may constrain couples' ability to do so. Additionally, despite being able to redefine intimacy, many participants nonetheless grappled with disappointment, either because they viewed PVI as the most intimate form of intimacy, or merely wanted to have the choice or option of having pain-free intercourse. As Grace recalled:

> I think, eventually when we did try [PVI], we're like, okay, technically even though this hurts a lot, there's some level of consummation, but it definitely did not—I just felt

> sometimes like we haven't—we've made these vows, but are we really married? Because this seems, this is like the *thing* that's always defined it. As a Christian, like, okay, you're not having sex and then you are. Yeah, and so that's why I think a part of me stopped even really looking forward to, "this is gonna feel great" to being like "this is something we have to do to be married." So I think when it didn't happen, it just—it did feel like a cosmic joke in some ways. Like it felt very personal, I guess.

The idea of painful or impossible sex being something that women did not "choose" recurred throughout interviews with wives, who were often more satisfied with non-penetrative forms of sex. As Holly explained:

> [There's] something to be said for pursuing the healing so that I can have the *choice*. I think that has to be the route that I take. I want these to be my decisions and not decisions that have been taken away from me. But that's all of my motivation. Because if you were to be like, "Holly, do you really want to have penetrative sex?" I'd be like, "No, I don't actually."

Confirming and building on Lovell et al.'s (2023) research, men and women in this study "both centered and decentered" (p. 8) PVI, which was connected to their definition of marriage and the religious meaning ascribed to PVI. Moreover, for some women, redefining intimacy was fraught, as it could reinforce shame related to premarital sexual activity or serve as a reminder that the difficulty of having PVI was not their choice. The notion of pain being something outside of couples' control reflects another reframing strategy that helped couples cope.

Assigning Blame to External Factors. When sex was painful or impossible or when women had low or no libido, both partners often described feeling frustrated or feeling like something was wrong with them. Wives overwhelmingly felt "broken" or "guilty" while several

husbands described feeling “inadequate,” “unwanted,” or “rejected.” For example, one couple was not able to have PVI for the first 11 years of their marriage and struggled for years to make sense of the problem. The husband reflected:

> For as long as humanity has existed, people have been having intercourse, because that’s how the species continues. But we’re not able to do this very *fundamental* human action. It’s a very basic foundational thing to human experience. And we’re physically or somehow otherwise incapable of doing it. And it’s supposed to be easy—like 15-year-olds accidentally get pregnant all the time [*laughing*]. And a thousand more times that they’re doing it and they don’t get pregnant. So like, what’s wrong with *us*? What is *broken* about us? What is *wrong* about us? In our bodies, in our brains?

Similar sentiments have been noted in previous qualitative studies on heterosexual partners’ experience of sexual pain (Ayling & Ussher, 2008; Culley et al., 2017; Hintz, 2019a; Lovell et al., 2023; Sadownik et al., 2017), which scholars link to heteronormative sexual scripts that ascribe value to gender based on sexual ability or performance (Hintz, 2019a). In the current study, several spouses assigned blame to factors outside of the wife’s or husband’s control, such as evangelical purity culture, negative childhood experiences (e.g., shameful sexual messages, sexual trauma or abuse), the nature of living in a “broken world,” or an involuntary physiological issue or disability.

This reframing behavior functioned to shift blame away from stable internal factors (Manusov & Spitzberg, 2008). As Ryan noted, “And it was just—I mean, it was subconscious. It was a reflex, not a decision. It was very *deeply* in there somewhere.” Moreover, early on in Holly’s marriage, she perceived her husband as being upset at her when she did not want to engage in any sexual activity after he returned from an overseas work assignment. Her husband,

who grew up Catholic and was a devout atheist before converting to Christianity, only learned about evangelical purity culture through Holly. He explained how viewing Holly as a victim of the "systemic trauma" she incurred from purity culture eased his own disappointment and increased his empathy for her. As Holly reflected on her husband's communication now compared to the early months of marriage, she noted:

> There's a lot more of a sense of "I'm mad at the people who did this to us," instead of, "I'm mad that my wife can't have sex with me." Not that [he] ever really [was] super deep into that other one, but that has, I think, been an important, or at least a valuable shift for me of like, when I'm frustrated and angry with myself and he's frustrated and angry, it sort of takes it out of being mad at each other or mad at me and gives us a direction to sort of put that into that is, I think, more accurate and also a little bit more productive.

Importantly, for a few couples who periodically or eventually experienced pain-free intercourse, husbands' feelings of rejection seemed amplified when a wife had low libido or did not want to engage in sexual activity. As Noah reflected:

> When it was *pain* it was like okay, it's—she's not—it's not that she doesn't want me. It's not that I'm messed up in some way, or there's like a lack of intimacy. It's just, she has a physical ailment, just like *I* wouldn't be able to have sex if I was on a medication that meant I couldn't have an erection or I was injured or my back was injured or something like that. But yeah, it's—the painful sex for me hasn't been hard. It's been like, where the sex isn't wanted or enjoyed, when there isn't pain.

The data from this code extend the findings in Lovell et al.'s (2023) research by revealing how both partners negotiate their identities throughout the chronic pain trajectory. Like Lovell et al.'s

(2023) participants, men in the current study found relief when they could attribute their wife's pain to an organic cause; however, when a wife began to experience pain-free intercourse but was uninterested in sex, feelings of inadequacy resurfaced.

Healing as a Long and Non-linear Journey. Framing the process of healing as a long and non-linear journey also provided solace. Spouses repeatedly reflected on how the first few weeks or months of marriage, they thought that the pain would resolve itself or be something that they could fix quickly. Over time and after seeking professional support, they realized it would be a longer process, using phrases like "long journey," "long road," "long battle," and "long game." When asked about what some of the most valuable messages have been that Olivia had received throughout her sexual pain experience, she replied:

> The one thing that comes to my mind right now is just that my pelvic floor physical therapist always emphasized that healing is never linear and that it can be up one day and down the next, but that just because you might regress a little bit doesn't mean that you're gonna be in pain for forever and can always—even regression is part of moving forward and healing.

The shared commitment to lifelong marriage seemed to facilitate spouses' ability to reframe their journey as long-term. As Kyle recalled:

> We had prefaced it, of like—and I had prefaced it even before the wedding, of like, "We are going to take the honeymoon as slow as we need to. And if it doesn't happen, that's fine. We've got forever."

When I asked Kyle's wife in her own interview what has helped her get through the sexual pain experience the most, she pointed to Kyle's perspective and patience. This finding hearkens back to the importance of jointly redefining sex and the pressure that was relieved for couples who

were anchored by their shared values. Moreover, messages from clinicians and partners seemed to facilitate the ability to reframe.

Finding Opportunity in the Pain. A final way that couples reframed sexual pain was reflected in the ways they found value or purpose in the experience. Specifically, couples reflected on how the experience provided them opportunities to develop their communication skills, grow in their Christian faith and spiritual virtues, deepen their intimacy with each other, and be a "blessing" to others who might need encouragement when facing similar struggles. For example, Grace recounted how she was able to provide emotional support for a friend of hers who was going through cancer treatment and about to get married and have sex for the first time.

Moreover, couples who had not disclosed about their experience of sexual pain, or for whom wives were uncomfortable with their husbands sharing with others, described how the sexual pain experience bonded them together. As one husband thoughtfully articulated:

> I think in the hope that is necessary to survive any form of suffering or unfortunate events, whatever the case is, I think in [sexual pain] specifically, that is the hope is that you draw closer to your spouse. … I find a lot of comfort that in a sense there's nowhere else for me to go with this. I think it's a pain point, but it's one that brings it into [*inaudible*]—it's kind of like a couple who's suffered loss together, and how they continually—they witnessed it, they were part of it, they walked through it, and they come out on the other side. I look at that aspect a lot, and I find a lot of rest there, in times with the Lord.

In all, reframing the multidimensional experience of sexual pain was an important coping mechanism for couples as they sought to make sense of their experience and cope, confirming and extending previous scholarship on sexual pain (Bairstow et al., 2018; Hintz, 2019b; Rancourt

et al., 2022). Scholars have theorized that couples who view a health stressor as a joint problem and take joint action to meet it can be energized to reframe the stressor, which may reduce the stress it causes (Afifi, Basinger, et al., 2020). The next theme considers how spouses jointed together (or desired to) through the sexual pain experience.

4.1.2 Stumbling Through it Together

Though several couples had (as one participant put it) "pushed the edges" of their sexual boundaries before marriage (e.g., engaging in oral sex, dry humping, or cuddling together naked) and five husbands had had intercourse in previous relationships, all 20 couples in this study had saved PVI with each other for marriage. Moreover, no spouses mentioned cohabiting before they got married. Most couples planned their wedding, got married, moved in together, and had at least one other major life event occurring (e.g., graduating from college or graduate school, moving, starting a new job, etc.) all within a short timeframe. Thus, for most couples, the start of their sexual relationship or at minimum their experience with PVI occurred during a significant transition. As Bree noted, "you're just kind of like, stumbling through it together." The following analytic codes capture the ways that couples clumsily, frustratedly, and lovingly learn how to relate to each other sexually and navigate the relational challenges associated with sexual pain.

Cultivating Teamwork. Foundational to couples' ability to flourish was the perception that they were on a team and were "in it together." During the data collection phase, there were a handful of couples who seemed to have greater distress in their relationships than other couples. A coding query of the Cultivating Teamwork code confirmed my speculation that couples who described or nonverbally presented with less distress and turmoil in their relationships repeatedly talked in their interviews about working as a team. They specifically described working together to troubleshoot during sexual activity (e.g., switching positions, inserting fingers before trying

penetration), identify the problem (e.g., researching for answers), and provide mutual emotional support (e.g., listening to each other's struggles, husbands attending wives' medical appointments).

A few wives relayed how their husbands attended pelvic floor physical therapy appointments with them. Brandon reflected on his experience of his wife's physical therapy and how it helped bring understanding that improved their communication:

> But at that point, there was a lot of emotional therapy we had to go through and communication so that when [she] *went* to [physical therapy], I was able to be supportive. I think if I was the me like a week after our wedding and we had gone there, my brain would have said, "[My wife's] got a hundred issues." And I probably would have defaulted to, "it's *her* issues." But because we had successfully had sex without it, and because we were able to support each other better, be more emotionally available, that probably made the physical therapy skyrocket.

Brandon's retrospective account reveals the contextual nature of teamwork throughout the pain trajectory, which could be modulated by emotional and relational health. To add to the complexity, the couple-level analysis revealed that for a handful of couples, a husband perceived sexual pain as a shared problem they could work through together, while his wife perceived the problem as her own. Grace and her husband are one example, however the exchange with Grace below reveals why she may have felt more of the burden:

> Grace: He's not done any—he's not in therapy or anything like that. I know he's talked to a few of the guys in our group and I know that was helpful. But yeah. So, I'm feeling actually pretty resentful about therapy right now. And I would rather go together than just be going myself at this point.

> R: Mmm. For what reason would you rather be going together than by yourself?
>
> Grace: Because I think I would feel like it's less all on me. That I have to do therapy so that I can figure out what's wrong with me and what's causing my body to respond this way. And especially because I feel like pelvic floor therapy is helping, like obviously things are not perfect, but it's definitely helping. And so I think it's just—that definitely seems to be the theme. So, if we went together, I think would feel like, oh, we're working on our relationship and our marriage. And it's not just about fixing me.

The present finding may have implications for research on communal coping, which occurs when an individual perceives that a stressor is shared (i.e., "our" problem, versus "her/my" problem) and takes joint action to address the problem (Afifi, Basinger, et al., 2020). Grace's quote illustrates how a perception that a problem is one's own may not necessarily reflect what they desire.

Analytical vs. Arousal Mindset. Cultivating teamwork presented a challenge that I identified as an analytic sub-code. A thread that cut across the coping experience, as couples fumbled through the early stages of their marriage, was that problem-solving and engaging in treatment for sexual pain often placed both partners in an "analytical mindset instead of an arousal mindset" as Owen put it. This mindset had the potential to reduce arousal for one or both partners and became a feedback loop wherein frustration or reduced arousal were reinforced during sexual intimacy (see Lovell et al., 2023 for similar reports from men). During a follow-up interview, one participant said this finding resonated with her:

> That was always a big piece for me was yeah, [*speaking quickly*] "Am I aroused? Am I not aroused? Why am I not aroused? I wish I was aroused. I'm tired of not—" It was—

> yeah, that was always on my mind instead of just focusing on something as like, "this is helpful to my body or this is helpful to our relationship outside arousal."

Wives tended to be focused on their arousal levels and figuring out solutions for their pain during sexual activity, often being the partner to initiate penetrative sex. Husbands, especially those whose wives had not disclosed sexual pain until later in their marriage, were concerned about hurting their wives (Lovell et al., 2023). Greg recounted what intercourse was like when his wife started to experience pain-free intercourse and tried to reassure him that she was not in pain:

> I was definitely split-minded, like I couldn't fully enjoy what is going on, because there's still a part of me that's listening, waiting. And then, if she would make a noise or something or say something after that time, I'm just—it's dual-minded at that point. Like, I'm thinking about it, making sure, did she just say it's okay, and I need to make sure that that's true? So yeah, it definitely split my brain for a while. I would say that that probably lasted for at *least* two years.

Greg's quote may reveal the communication context of *solicitous partner responses* or heightened attention to pain and expressions of sympathy (Meana & Binik, 2022). It is possible male partners increase solicitous responses *after* learning of a female partner's pain. In all, the biopsychosocial nature of the "analytical vs. arousal" dynamic that many couples experienced reflects how determined couples were to figure out PVI, even couples who had expanded their definition of sex prior to marriage.

Emotional-Spiritual Labor. Another aspect of couples' coping experience was engaging in emotional labor, which was often couched in spiritual language in couples' accounts. Several women concealed their pain, sexual dissatisfaction, or related emotions, because they did not want their husbands to feel inadequate. Alexis and her husband were unable to have PVI on their

wedding night, which they both attributed to a traumatic event that occurred on their wedding day. Two weeks later, they were able to have intercourse. I asked Alexis at what point she disclosed her pain to her husband:

> I think the minute it worked I was like, "This really hurts, please stop." Yeah, I don't think I hid it. It was more later along that where it didn't hurt as bad but it was still really uncomfortable where I would kind of keep my mouth shut more because I felt really *bad* for him. And then I would—and then I started to hide it more because, yeah, I didn't want to hurt his feelings and I wanted him to be happy.

She described how the cycle of concealing pain and related emotions continued over time, which she described as "just that cycle of isolation and lies that the enemy [Satan] tells to make it so we can't actually work together." For many women, sharing the extent of their pain was a turning point in their communication with their partners. Sierra recalled once feeling unsure how and when to discuss the pain and discomfort she often felt when having intercourse:

> I remember sitting on that thought for a while and thinking, "How the heck am I gonna explain" like—because it's crushing right? I think it's like ultimately it's just one of the most crushing conversations you're gonna have with someone, namely the partner for the rest of your life. And so I remember praying about it, thinking about it, mulling over for a while and then I think I remember being in our bed one night and turning over and being like, "I'm so sorry. I *can't* do this." He probably was asking [for sex] and I was probably like "I can't. Like I can't," and explaining, "It's dry. I feel uncomfortable. I get tense."

While women's emotional-spiritual labor was often linked to concealing pain and emotion, men's emotional-spiritual labor involved concealing negative emotion and providing

encouragement and a positive outlook. Grace noted that her husband "definitely just took on the role of cheerleader," an experience shared by many women in this study.

In husbands' individual interviews, they often described the complexity of these emotions, which has been captured in research documenting male partners' experiences of supporting women through sexual pain (Lovell et al., 2023; Sadownik et al., 2017) and miscarriage (Horstman et al., 2021). When Caleb was asked what he felt the moment he realized his wife's inability to have intercourse would not be fixed overnight, he explained how he had a "sudden shift in perspective" that was:

> not only disheartening for myself, but disheartening for my wife, in that I need to show up in a particular manner. I need to show up for her as patient. I need to show up as encourager sometimes. I need to show up as consoler as well.

This could become difficult in the heat of the moment for husbands; Owen recalled a few times when he felt sexual frustration and disappointment:

> Like we would start going and then she would hit that wall, and I'd be like "Oh okay." And just that kind of like, I really want to ask her to help me climax right now, but I know that's not the place and I'm just gonna have to swallow that.

However, several men described another dilemma when they sought to provide their wives with encouragement, which is reflected in the analytic sub-code below.

Encouragement without Pressure. Apart from a few husbands who explicitly expressed their frustration and hurt when their wives experienced pain (which wives confirmed in their separate interviews), husbands largely wanted to be encouraging, supportive, and positive to provide their wives hope for pain-free intercourse. However, they did not want their wives to feel pressured to have sex or seek treatment. As Kyle adamantly explained,

I've told her, I was like, "I will be as much of an encourager as you need me to be, but I will not—I don't want to be the one who is like, 'Did you practice your dilators today?' I don't want to be the nagging husband who just is a broken record trying to have sex."

Wives expressed their appreciation of husband's emotional labor, such as Jasmine who noted,

> I think [he] has been and he was *extremely*, extremely supportive. He was never—he never pressured, anything like that. I think he was very supportive and very encouraging in a way that didn't make me feel like, "Oh, this needs to be sorted out *now*."

For one couple, however, the fear of adding pressure resulted in miscommunication. Logan frequently avoided initiating sexual intimacy and discussing his and his wife's inability to have penetrative sex, which his wife had interpreted as rejection. He reflected:

> I felt like I was being thoughtful or considerate, trying to not bring it up. After the fact, I realized that I was kind of like—[referring to himself] you're an idiot, you should have tried something because we might have gotten further and done more to seek help or something.

Holly's husband found a creative solution that seemed to provide constructive encouragement for Holly, who had begun using vaginal dilators after a one-time consultation with a pelvic floor therapist. She described initiating a conversation with him, in which she told him:

> "My motivation to address this is complicated, especially to do it in a shared way. This is something that I don't really want to deal with. And if I was going to, I would just sort of want to run and hide and do it on my own. And I know that that's not actually what's going to be helpful. And so I'm not asking you to initiate when you want me to dilate, but we kind of both know what needs to happen. So just asking me if I want—to be like, 'Hey, is this something you wanted to do tonight?' So I still have the agency to say yes or

> no and I don't feel as much of that pressure, but it's also just like a way to open the conversation". … So it's more that. It's this sort of, he'll just go, "Hey, is this something you wanted to do?" And he'll clean them and get them ready and things like that.
>
> [*Researcher makes awed face*] Yeah, it's very sweet.

In all, spouses frequently described the emotional and spiritual labor that they engaged in to cope with the emotional toll of WPP-PVI. This finding extends previous studies (Lovell et al., 2023; Sadownik et al., 2017), revealing how both partners may be cautious in how much of their emotional experience they share out of concern for their partners. Moreover, evangelical couples may retrospectively view their emotional concealment as driven by spiritual forces (e.g., a cycle of isolation from Satan), while simultaneously drawing on their spiritual values as rationale *for* concealing emotion.

Meaning-Centered Sexual Communication. Expressing the emotional meaning of the sexual pain experience was one of the most difficult yet valuable coping strategies for couples. Couples worked to synchronize and deepen their sexual intimacy through communication. Multiple women described how it was often easier to communicate about the physical pain than to discuss the relational implications of the WPP-PVI (e.g., desire to have children, treatment process, or social comparison to previous partners or porn stars), which supports previous research (Hintz, 2023). As Danielle reflected, with some discomfort in her voice,

> I think it's always harder to talk about the process versus just like being intimate with each other. And I'm pretty good about being like, "Hey, this is as far as I can go right now. I'm not—I don't want to do anything else or can we try something different." But in terms of like what it actually means for us long-term or actually healing from this, we don't have those conversations very often.

Similarly, Olivia reflected on a cycle of communication she and her husband had experienced earlier on in their relationship, when she told him she was concerned he was comparing her to his past sexual partners. She mused,

> Talking about the *painful* sex—like the *pain* wasn't ever really the focus to be honest because there were just such bigger fish to fry that—it was more like talking *about* sex that was the thing because—and I don't think that the two are necessarily separate.

Many couples described how, once they began to mutually share their emotions about the sexual pain experience or clarify the meaning of their reactions during sex (e.g., frustration, disappointment), they experienced greater relief and closeness. Caleb recounted,

> I think, just to be completely vulnerable in that, in the journey, it's just felt—I felt overwhelming emotions, and I've just suppressed them. I've just been like, "I don't really—I just—I need to keep going forward. I can't deal with this now." But I think the more and more I've been trying to open that door to sharing those emotions with [my wife], being vulnerable with her about what I fear in this whole experience, I think in a way that's given me an access to God.

Caleb's experience reaffirms the comfort male partners may find when they feel when they can share with their female partners their emotions around intimate health issues (Bergeron et al., 2021; Horstman et al., 2021). In all, it was important for couples to stumble through the sexual experience together, however as suggested in previous research (Checton et al., 2012), the different ways couples experience the health condition and the dilemmas related to disclosure could make it difficult to cope dyadically.

4.1.3 Outside Support

A final reason couples believed they were able to cope with the sexual pain experience was the support they received outside of their spouses at the physical, emotional, and spiritual levels. Notably, receiving outside support often catalyzed greater intimacy and understanding between spouses.

Holistic Treatment. Couples individually and dyadically sought a range of treatment options for the physiological and psychological aspects of the sexual pain experience, citing treatment that focused on bridging the mind and the body as the most helpful (e.g., pelvic floor therapy). In fact, compared with all other forms of support, pelvic floor physical therapy was referred to the most often by both husbands and wives when asked what had helped them the most throughout their experience. Even women who had access to other forms of support such as psychotherapy, social support, or mind-body treatment programs recommended pelvic floor therapy as a first point of support for struggling couples. Only three women described negative pelvic floor therapy experiences, although these same women were later able to find pelvic floor therapists who were incredibly helpful.

Kacey enthusiastically stated, "after I started going to [my pelvic floor therapist], it was a complete game changer" for her and her husband. Of the four clinicians she shared about, including her talk therapist, this pelvic floor therapist was the only one she mentioned by name throughout her interview. Like one other participant, Kacey's pelvic floor therapist treated her with acupuncture after going above and beyond to assess what she needed. This was the opposite experience from her previous pelvic floor therapist who had only given Kacey dilators and was confused as to why Kacey was able to use them without any problem.[5]

[5] Dilator therapy is often recommended for women with dyspareunia, however it may not be the needed treatment.

The reason pelvic floor therapists appeared to be "game changers" for couples (a term that three participants used) was the validation, empowerment, and education they received during therapy sessions. Pelvic floor therapy was where most women began to see improvement in both their physical and emotional experiences, as they learned more about their bodies. As Lily recalled, "It went from impossible to painful. So that was a big leap for me." Several participants described the motivation and hope they felt when they had "small wins," which their pelvic floor therapists often took time to rejoice with them about. The following excerpt from Travis's interview reveals the value that both partners felt from positive experiences with pelvic floor therapists:

> R: So if you would say or rank the top five things that have helped you guys cope through this time, what would you say they are?
>
> Travis: I would say her pelvic floor therapist is one.
>
> R: The top one?
>
> Travis: [*laughing*] I would say it's top one, yeah, because that—when [my wife] first saw her and—it was game changer. She felt a difference and I saw the difference it made in her, and it made me so happy.

Notably, even participants who sought other forms of intervention noted the value in a holistic approach. One couple had flown to New York together to get Botox injections for the wife's vaginismus after 11 years of trying to have penetrative sex to no avail. The wife explained:

> I guess there are some places that just shoot you with Botox and send you on your way, but this place does like, they have a psychosexual therapist that works with you before and after, there's a pelvic floor therapist that works with you immediately after the procedure, and they provide you with dilators and all kinds of materials and resources,

> and they follow up with you every so often. So it wasn't just like shooting you with Botox and that's it. So there was a lot of things involved, which was really great.

A few couples had not sought any forms of professional help but had experienced reduced pain with different kinds of lubricants or penis rings/bumpers that acted as a buffer to prevent deep penetration. However, the couples who had sought more holistic forms of treatment appeared to experience the greatest benefits (e.g., empowerment, improved communication with partners).

Selective and High-Quality Network Support. Several couples turned to their friends, family, church community, or virtual support groups for support for their individual and shared experiences with sexual pain and associated relational difficulties. For example, Alexis and her husband had recently experienced a major turning point in their relationship after being more emotionally vulnerable with each other than they had since they got married, which Alexis described as "the closest thing to a conversion experience I've ever had, since I've always been a Christian." She explained that, in comparison with her previous church:

> So much of my ability to be where we are here today is our church. … They've become Team [name of husband] and Alexis and they're watching the kids when we're out doing—Like, we also have a community that is behind our marriage, which I've always believed in and known is so necessary, but it doesn't always mean that you have it.

The value of social support for women's experience of persistent sexual pain has been documented elsewhere and may even be a catalyst for couples seeking medical support (Banaei et al., 2023). Yet, couples were very selective in who they shared with and how much they shared, based on prior experiences of disclosure (with that person/group or with people in general) or the responses they anticipated (Greene, 2009). Claire commented, "Just last month, I think we've talked about like, 'Well if it ever comes up, are we comfortable sharing with this

person or with our parents?' So, I think we're becoming more open to that thought of just being more honest about it." Notably, only a few husbands had sought social support for their individual experience of WPP-PVI. Those who did not generally attributed this choice to their wife's privacy boundaries or their own feelings of discomfort, which is further explored in the next major section on support seeking.

The couples that benefited most from social support described network members who listened, empathized, and asked questions, even if they could not relate to the sexual pain experience (Voorhees et al., 2023). For example, Rikki shared that she had sought support from a few close girlfriends:

> Rikki: They were really supportive and understanding which I really appreciated, so that was helpful.
>
> R: That's awesome. What kinds of things did they say or do that felt supportive to you?
>
> Rikki: They would just ask me questions about how it's going and about how I'm handling it and just have compassion for the situation in general. And so I think just being a good listening ear and being willing to empathize.

A few wives described virtual support groups (e.g., Facebook groups, synchronous support group meetings) as being instrumental to their coping process. Taryn recalled joining a virtual holistic recovery program marketed toward Christian women with sexual pain. The course included weekly Zoom calls with other women experiencing sexual pain, including the course instructor who had recovered through the program's principles. Taryn explained:

> So not only did I have the course content and the course instructor, but once a week I also got on a call with *all* these women who are experiencing painful intercourse and going through this. And so honestly when [the course instructor] told me about that aspect

> [during the consultation], I was like "That's enough for me. I just want to know someone who's going through this." Because I literally never met anybody with vaginismus *ever*. I didn't know *anybody*. Like I thought I was alone, I thought I was broken.

It is important to note that several other women described virtual support groups as being unhelpful and discouraging. Maddie recalled joining a Facebook group for vaginismus that she described as "really *terrible*":

> I joined it looking for support and because I didn't know anybody else that was going through this, but when I was in the group everybody was *so* negative. It was just like, they're like, "15 years I'm not healed." They were just like, "This is never gonna get better." "My husband's leaving me." And instead of looking—you know, finding hope that this can be healed, it was just really negative.

Thus, support from women going through the exact same thing could backfire if it prompted wives to despair or lose hope. Some women also described the potential of upward comparisons (i.e., comparing themselves to women who were progressing more quickly; see Collins, 1996) in support groups for sexual pain.

In all, couples who had positive experiences of sharing with others experienced a sense of relief. It has been well-documented that perceived support, or perception of emotional support being available, is more effective in reducing distress than the quality of enacted support, or the actual supportive message (High & Dillard, 2012; Jones & Koerner, 2015). The findings in this study seem to support this contention. As Claire pondered, "I think every time we share it feels like a little bit of the burden is lifted. And again, like I said, just knowing that we're not alone. And that sexual struggles are maybe not normal, but common, at least." That said, specific supportive messages did matter to participants, as the findings from RQ2 and RQ3 will show.

(Emotionally Honest) Prayer. Participants described individually or jointly praying to God for wisdom, direction, protection from the "enemy," and spiritual virtues (e.g., patience, strength) that would help them cope emotionally and lead them on the right path to healing. While a few participants described experiencing relief and comfort from prayer alone, several described experiencing God's comfort and guidance *through* the prayer or support they received from friends, the people in their church community, or clinicians.

Spencer, on the other hand, identified the church culture in the South as being distinct from the support and marital preparation he experienced from God:

> With God, I'm really—I am *really* thankful that he prepared me in the ways that he did for the circumstances I'm in. I don't think that I'd be able to deal with my wife and I's situation interpersonally and sexually without the kind of person he's formed me into. And the more I lean into *that* person, the more I pray before conversations, the more I meditate on his character, his word, and try to embody that, the better my marriage; the better I listen, and treat my wife to the fullest of her image-bearing of God. I don't do that perfectly. I definitely don't. There's a lot of ways I could be deeper in my relationship with God. But I—in regards to my marriage and our sex life, just *really*, *really* thankful that God has formed me into the person who I am, so that I can deal and hopefully lovingly deal with the situation. In terms of my faith, my faith in God, it just strengthens it. In terms of my faith as an evangelical Christian, it definitely frustrates me a lot with the church. The lowercase "c" if we need to distinguish.

Spencer's quote is an exemplar of the frustration that many spouses—especially husbands—expressed regarding the sex culture the evangelical church had perpetuated, which they distinguished from traits they believed God held. Scholars have identified evangelical Christians

making this distinction elsewhere (Leonard et al., 2022). Conversely, some participants did not make this distinction, which created a degree of inner turmoil. Jasmine's quote in Chapter 1 provides an exemplar of the emotional honesty that several participants described when reflecting on their prayers to God, which often consisted of anger and frustration—especially for those who felt like they had done the right thing by waiting for sex until marriage. As Claire reflected, crying softly, "If God made sex to be a gift for us, why is it so hard?"

Comparatively, several spouses articulated a spiritual disconnect. Hugo recalled, "I don't know that we were like, 'God help us figure this out.' I think we were more just like, 'Let's just figure this out. Why does it hurt for you?'" Some participants suggested this reflected a general dynamic in their relationship with God, where they felt they could not be emotionally honest with him. Others articulated a discomfort around asking God to intervene in their sex lives, which may reflect a broad discomfort with sexual communication that many participants had experienced or the stigma that religious culture associated with sexual topics.

4.2 Seeking and Avoiding Support

The second research question (RQ2) asks, "What factors motivate couples to seek or avoid support in managing or resolving their shared challenges with sexual pain?" Given the biopsychosocial experience of sexual pain, couples identified a variety of forms of support they sought or wished to seek, as alluded to in the Outside Support findings. *Professional* support included gynecology appointments, pelvic floor physical therapy, mind-body programs for healing vaginismus, talk therapy or counseling (both individual and couples counseling), and sex coaching. *Social* support included sharing with network members, either individually or as a couple. During the data collection phase, it became clear that the terms "seek" and "avoid" did not fully capture the range of support-seeking behaviors couples identified in their stories of

painful intercourse. In this section, I detail the analytic codes that capture the factors motivating couples to avoid, delay, or withdraw forms of support, followed by codes reflecting factors motivating couples to seek support for the first time or seek additional forms of support.

4.2.1 Factors Motivating Couples to Avoid, Delay, or Withdraw Support

Thinking the Pain Will Resolve. The most commonly mentioned reason couples avoided or delayed seeking professional treatment was the belief the pain would resolve or that they would be able to "figure it out" on their own. This includes couples who knew about the possibility of sexual pain or difficulty prior to marriage. For example, Lily, who had never been able to use a tampon but figured that sex with a partner she loved would be different, recalled how "even that took me a year to even go to the gynecologist, because I was like, 'Well, maybe it'll resolve on its own.'" Couples attributed the belief that the pain would resolve or that they would figure out sex with their spouse to the messages they had heard about sex. Olivia explained that on her wedding day:

> It was painful, but tolerable, I guess. And I also was told that it was to be expected for it to be painful. … I was like, "Oh, it's probably gonna go away. They say that it hurts for like two weeks or whatever anyways." That's what I'd been told. And then it didn't.

Ryan laughingly recalled, "Every *once* in a while, we might try, you know, just like, 'Hey, let's check. Let's see if anything's magically different now.'" Husbands and wives alike identified thinking that they would figure it out or that it would resolve on its own as a key reason they waited to seek support.

No (Perceived) Need or Benefit. Some couples intentionally chose not to seek support or seek certain types of support because they did not feel the need (i.e., the pain was tolerable, they were satisfied with their current sex life, or they were not married yet) or did not see the

benefit. For example, Noah recalled how his wife wanted to see a sex therapist early in their relationship, but he had not agreed to it: "I've always had kind of a general resistance to therapy because the therapy I have tried has just been very unhelpful. And it's—like in some cases it's felt counterproductive." Many participants, including Noah, expressed regret about not seeking support earlier and believed they may have been in denial about their need for support. For example, when reflecting on why she did not seek medical intervention sooner, Olivia reflected, "I think part of it is that the pain wasn't linear, so sometimes it would be worse than others, and so the times when it was better, I think I would convince myself that I didn't *need* help."

Importantly, messages participants had heard about the pain resolving itself or couples figuring out sex together seemed to be the reason some women who knew they had difficulty with vaginal insertion did not seek support *before* getting married. Micah recalled conversations he had had with his wife when they were dating, since he knew she had never been able to use a tampon:

> I was like, "I'm your boyfriend, not my role [to give advice]. But should you get that looked at?" She's like, "Well, I'm not getting married anytime soon." Like, okay, that's interesting. And then we get engaged. I'm like, "Well, should you make an appointment with your doctor?" It's like, "Well, yeah, but you know, I don't know. It's not—" And so it was kind of going back and forth until like a month before we got married.

Some spouses indicated that they did not see the benefit because of the stigma and shame that came with sharing, such as Ryan, who recalled, chuckling skeptically, "But how do you bring that up? I certainly never found the way, nor was I clear what the benefit would be, I guess, probably maybe besides the weight being lifted of carrying the burden alone." The stigmatized

nature of sexual pain and sex in general was a thread that is reflected throughout the remaining reasons couples avoided seeking support.

Shame and Stigma. Participants described feeling embarrassment, shame, and discomfort due to the stigmatized nature of sexual communication generally, their perception of their sexual pain experience specifically, and prior stigmatizing responses they had received. For some couples, this is why they avoided seeking both professional and social support when they realized that sex was chronically painful or impossible. When asked about how others have responded to her experience, Isabella explained:

> I really didn't tell a lot of people. I feel like I was very kind of—not ashamed of it, but just very much like, nobody's gonna understand or be able to—almost like fear of feeling judged around it. … I *wanted* to tell people, like people in our community group and all that, but I really kind of kept it quiet for the most part because I think I just was kind of a little bit embarrassed by it, or just felt like I'm the only person—like if I say this, nobody else is going to really understand.

The fear that others would not be able to relate or understand cut across interview responses, especially regarding sharing in church contexts. When thinking about the Christian culture in the state he lived in, Spencer embitteredly reflected:

> Yeah, [Southern] church and purity culture angers me a lot, because it's not even that I'm not allowed at the table, it's that there's not a table. We won't—there's not room for *anybody's* story, any variant. And we're just *not* interested in talking about sex. Or, we're not interested in talking about a lot of real life situations, unless it's the textbook approach. That's the only narrative that really breaks through.

I wondered if there would more couples in the Bible Belt (i.e., the South) who experienced shame and stigma around support-seeking, however a query showed that only a slightly elevated number of participants from the South described the shame and stigma associated with help-seeking. Though I cannot draw a quantifiable conclusion from this query, the fact that couples living in all regions of the US experienced discomfort seeking support is a testament to the stigma associated with sexual pain in general and the taboo nature of sexual communication in the evangelical church and religious spaces.

Disclosure Dilemmas. Some participants wished to disclose their sexual pain experience with social network members but were confronted with dilemmas related to disclosure timing (e.g., it felt too soon to share), a wife's privacy boundaries, or being in a close-knit community. Two participants from different couples had fathers-in-law who were the pastor of the couple's church. A few husbands noted that their wife's sexual pain was not their information to share, and some wives conveyed that sentiment as well. Brandon described this dilemma when reflecting on how he and his wife later shared about her sexual pain with an older Christian couple:

> I'm okay being an open book, but I can't do that without [my wife's] permission and without—and for her, I think for a woman it's a different issue. Like probably different stigmas about it, stuff like that. So I didn't think I was able to talk to anybody about it. And so I think I only talked to one guy … and I couldn't really go into detail about it either. Just because there's the idea that you don't talk about the details of sex. And I think that was, that was probably one of the more difficult things was that we couldn't get into details. So we'd have to be vague about it and then they would have to give us vague advice or vague support back.

Brandon's quote may speak to the complicated nature of disclosing about stigmatized health conditions that primarily reside with one partner but affect both partners (Checton et al., 2012; Crowley & Miller, 2020; Holman & Horstman, 2019). Communication privacy management theory would suggest that all the couples in this study were "co-owners" of the information that a wife was experiencing sexual pain (Petronio, 2002). Scholars have suggested the value in disclosing with people who have experienced similar situations, which could reduce shame and stigma (Bute & Brann, 2015; Greene, 2009). However, as illustrated in the Selective and High-Quality Network Support code identified earlier, seeking support from others who have gone through the same situation may reinforce feelings of shame, if spouses compare their own journey to another's.

Disenfranchising Talk. Couples described disenfranchising talk in medical encounters (mainly from gynecologists) in which women's concerns were dismissed, invalidated, and/or oversimplified (Hintz, 2022; Hintz & Venetis, 2019). I asked Nicole, who had experienced instances of her pain being dismissed by doctors, whether there were any other forms of treatment and support she wished to seek out. She exasperatedly pondered,

> And so I think just the combination of all of that with how it's been treated and how *most* people have responded to me telling them how my experience has been just makes me not even really want to go to anybody because then it's like, how many people do you have to *go* through before you finally find somebody that will believe you?

Although disenfranchising talk also occurred in interpersonal settings, couples articulated that disenfranchising talk among medical professionals made them reluctant to continue seeking care or to seek certain types of care in the future. This is problematic, given how important holistic treatment was to both partners. The current finding supports and extends scholarship that links

disenfranchising talk to reduced care and support for women with chronic sexual pain (Hintz & Venetis, 2019; Scott et al., 2022).

Inaccessibility. Participants described factors like travel time, cost of treatment, lack of insurance, or lack of knowledge about available resources as reasons for avoiding, delaying, or withdrawing support. For several couples, the nearest pelvic floor therapist or gynecologist was a one-hour drive away. Moreover, many couples did not know there was treatment available until months or years into their marriage. Even couples who sought support often had to delay or withdraw specific forms of support, especially those not covered by insurance (e.g., several women had stopped pelvic floor therapy). This was especially true when couples felt they were not experiencing a return on their investment. Kacey described the first pelvic floor physical therapist she saw before finding her second one who was a "game changer":

> I went to this one and *she* did not help me with anything. She asked me to do something, and then she was like "Hmm." And then walked out of the room, and I was like [*makes quizzical facial expression*]. I was like, "Hmm??" After I'd been seeing her for a few weeks. And it was expensive. We were not—like my mom usually pays for my doctor's appointments, but I was paying for these and our insurance wasn't covering them, and it wasn't working.

Thus, some couples described withdrawing support after plateauing from a treatment that they had invested significant resources into. This was especially true if they had a negative experience with the treatment.

More Pressing Stressors. Finally, participants often made the conscious choice to prioritize more pressing stressors over others, including some aspect of the sexual experience (e.g., couples therapy over pelvic floor therapy) or other life events (e.g., moving, raising

children, transitioning to a new job, processing unrelated trauma). Maddie recounted how her first year of marriage was fraught with difficulty for reasons unrelated to her sexual pain or relationship with her husband. She explained:

> I did not tell my therapist that I was having painful sex until like *right* before I went to my doctor's appointment. I was like, "Oh by the way, I'm going to doctor for painful sex." And she was like, "Why have we not spoken about this?" And I was just like, "I don't know. I felt like my life was falling apart and had other things to talk about! It just felt not as important."

Grace, who was already in pelvic floor therapy and seeking professional spiritual support, had just recently started talk therapy, which she said she did not feel emotionally prepared to do. She captured the sentiment of several women when she said, "I'm just tired of feeling that I can't function without five therapists … That I'm like, I need so much help to just do the things that everyone else is doing without help." Given the biopsychosocial nature of sexual pain and the fact that the couples in this study were often undergoing multiple major life transitions at once, many couples described the difficult but necessary decisions they made to prioritize various forms of support.

4.2.2 Factors Motivating Couples to Seek Support

The factors that ultimately prompted couples to seek support reflect the inverse of many of the aforementioned factors. Notably, much of the social and professional support that couples described was mainly to support wives' physical and emotional health, although a few husbands or couples sought counseling to process issues that were tangentially related, such as a husband's pornography use or addiction.

No Change or Worse with Current Approach. Couples often sought clinical intervention for the first time or sought a new form of intervention after weeks or months of trying different solutions to no avail (e.g., trying different sexual positions, drinking wine, using vaginal dilators or fingers, or "Googling" to find answers). Rikki ultimately went to a doctor after "several weeks of trying and [my husband] not being able to get inside of me, except maybe like once or twice, and the once or twice was so painful." For other couples, trying to have intercourse created a feedback loop that reinforced the pain and emotional associations each time they tried. As Olivia remarked, "Yeah, so actually the pain got worse over time. It like regressed."

Other participants described investing in new forms of support when others were not enough. Through pelvic floor therapy, Lily was able to successfully have PVI with her husband. However, she explained:

> But it was still painful. So I was like, well, I'm not at the end of my journey yet. So I need to keep looking. So this year, I found this online course [that's] kind of like a mind-body online course approach with weekly Zoom meetings and integrating the dilators and going through all the steps.

Seeking additional support helped couples meet their individual or joint goals. Notably, several couples wished they could engage in a new approach of support, but were precluded because of More Pressing Stressors, Inaccessibility, or Disenfranchising Talk, as described previously.

Different Valid Reason. Sometimes, women or couples only sought support for sexual pain and associated relational difficulties when they had an overlapping physical or relational health issue (e.g., pregnancy, injury, mental health concerns, emotional/sexual betrayal). When asked why she had sought counseling, Erin explained:

> It was an all-around like vaginismus, depression, and I was just having *such* a hard time opening up to [my husband] and feeling like I could be safe and comfortable both emotionally and physically. And so it just got to the point of like, okay we've hit one year of marriage and I feel like, wow, I still have all these walls up, and I can't seem to take them down. So *that* was why I sought counseling. … [A]t this point sex was like so far off the radar.

In a follow-up interview for member reflections, one wife who is a clinical psychologist and has a chronic overlapping pain condition strongly resonated with this analytic code. She articulated some of the logic that may undergird this motivating factor:

> I think for me, when I think about my own experience, it is *hard* to just decide that this … is important enough to pursue on its own. There's a value judgment about whether it's worth it or not. … There's a sort of like "No I'm gonna show up, I've decided this matters enough to me, and I'm not gonna hide behind another concern. I'm going to tell you, the professional, the clinician, whoever, 'Hey, you need to help me with my sex life.'" And like, agh! Again, how do you say that to somebody?

This code reflects the stigmatized nature of sexual pain and the difficulty that participants had with disclosing and seeking treatment. Although some spouses (like Erin above) seemed to consciously choose treatment for more pressing issues, the delegitimization of chronic pain that many women experience undergirded many women's choice to only seek support when there was a different, more socially sanctioned reason (Hintz, 2022).

Need for Emotional Support. Several spouses (primarily wives) described the need to verbally process their experience or described reaching a point where they were desperate to share with someone, even if they did not know whether they would receive a positive or helpful

response. As Noah recalled, "I think [my wife] was *much* more active about talking to friends about it because she was much more distressed by it than I was." Some couples made the decision to seek support together. When I asked Claire what prompted her and her husband to see support from a male pastor and his wife whom they were close to, she responded:

> We needed to deal with [the sexual difficulties], we couldn't just pretend like we were gonna just solve it on our own. I think [my husband] just wrote out a text [to the couple] and I said, "Send it." And then they reached out immediately and were like, "Yes, please come talk with us!" And I think we scheduled it for the next weekend. But yeah, I think it was just a *slow* journey to that point. But yeah, we just reached a point where we knew we had to get help.

Similarly, after explaining how much shame he and his wife felt about their inability to have PVI and the stigma around sex in church contexts, Ryan stated:

> I would say at first, those kinds of ideas, true or otherwise, kept us isolated and it kept us silent. And then in the later years, I think maybe as we got older, as we matured, as we got more frustrated, as we got more tired of it being the case, I think our willingness to talk about it probably increased, to look for help rather.

The desperation that many spouses and couples felt ultimately prompted them to share. However, not all responses were helpful, as the findings from RQ3 will illustrate.

Referral or Recommendation. Many women and couples got the care they needed after a referral from a network member or clinician. For example, the couple that Claire and her husband reached out to had suggested they seek professional help from a gynecologist. Then, Claire's gynecologist referred her to the pelvic floor physical therapist who was instrumental in their healing journey. Other couples experienced a similar string of recommendations, however,

like many women with chronic sexual pain (Hintz & Venetis, 2019), not all couples experienced a positive or helpful response after receiving referrals. In some cases, the couple did not feel comfortable with the clinician, or the clinician's recommended solution was unhelpful or dismissive. When asked what advice they have for other couples, several participants emphasized the importance of seeking out recommendations and continuing to find trustworthy sources of support. As Kacey fervently expressed:

> If someone doesn't listen to you, go find somebody else. As far as a doctor or physical therapist. Cause like I said, I had two, and the second one was literally a Godsend, but I would never have got to it if I hadn't talked [to my therapist]—like if you have a therapist, tell your therapist! Don't wait!

Mediated Sexual Health Information. A final factor motivating support-seeking was learning about chronic sexual pain through mediated sources (Cooke-Jackson & Rubinsky, 2021). Six women mentioned learning about conditions like vaginismus or dyspareunia from blog posts, Facebook posts, or podcasts they were either following or happened upon by chance. Most of these resources were social media influencers who commented on some aspect of Christianity and purity culture. For example, Lily energetically recalled:

> I found this Christian blog. I don't even remember how I found it. I mean, Facebook probably just showed it to me because it knows everything about me and it showed me this Christian blog. And I'd never even done Internet searches on it too, which is wild. Because I was like, you're ashamed and embarrassed, so you don't even want to Google search this kind of stuff. … But somehow I was shown this like Christian blog from this woman who had been through the same thing.

In all, a nexus of factors contributed to spouses' desire to seek or avoid support for the multidimensional experience of WPP-PVI. The following section reveals the link between memorable messages and couples' coping and support-seeking behaviors.

4.3 Memorable Messages and Coping

The third research question (RQ3) asks, "What memorable messages do spouses perceive contribute to their individual and shared experiences of coping with sexual pain?" The Theory of Memorable Messages (ToMM) views memorable messages as a form of anticipatory socialization, in that they "tell people what to expect or how to feel about their identity, their family, relationships, their health or illness, and their role in the world" (Cooke-Jackson & Rubinsky, 2022, p. 7). Moreover, ToMM advances the notion of *message disruption*, positing "intervening messages" can enter individual's socialization process throughout the lifespan and serve as a buffer that protects individuals from harmful messages or disrupt the impact that harmful messages have already begun to incur.

Using these notions as sensitizing concepts in my analysis, I identified (1) messages that served as anticipatory socialization for spouses as they made sense of and coped with painful intercourse, (2) messages that disempowered spouses by creating or reinforcing negative emotion or interfering with their ability to seek or maintain support, and (3) messages that intervened or buffered spouses from the negative effects of messages identified in (1) and (2). In the following sections, I discuss the analytic codes that represent each message type (see Table 5 for specific examples of each analytic code). In Figure 2, I represent the findings from interviews with couples by linking memorable messages to coping strategies and support-seeking behaviors.

4.3.1 Anticipatory Socialization: From Worst Sin to Best Gift

Couples represented a variety of different Christian denominations adhering to evangelical teachings (e.g., non-denominational, Pentecostal, Anglican). Most had grown up in Christian or "culturally Christian" homes, however a few participants grew up in Catholic or non-religious homes. Regardless of upbringing, couples repeatedly described the sexual experience as "flipping a switch," an idea that has been captured in recent studies on religiosity and sex (Frydman, 2022; Irby, 2019; Leonard Hodges & LaBelle, 2024). Participants had either grown up during the height of the purity movement (i.e., the early 2000s), hearing messages centering male arousal and pleasure, or had grown up more recently amid evangelical leaders seeking to correct some harmful teachings perpetuated in the church and within media by discussing the beauty and *mutual* pleasure that sex should bring (Leonard Hodges & LaBelle, 2024). Both socialization approaches seemed to create difficulty for couples in this study when sex was painful or impossible. Holly comically described the effect this had on many participants, but especially wives, after I asked what messages she had heard about sex growing up:

> Well, one, you know, premarital sex is a sin. That's *terrible*. It was not said, but it was treated like the worst possible sin. Like, that was the really bad one. If you steal a few dollars from somebody, we'll forgive you. But if you have premarital sex, there's no grace. A lot of the like, "but then you get married and then it's supposed to be the most incredible thing in the whole world." It's like a light switch where you just have the best sex that anyone has ever had.

It is noteworthy that several participants could not recall specific conversations or singular messages that conveyed this idea, but it was a message that they had deeply internalized. The

analytic codes below delineate three categories of socializing messages that appeared to contribute to the overarching difficulty of "flipping the switch" and the resulting impact on couples' ability to cope with sexual pain.

Purity Culture Messages. The purity culture messages that spouses heard came primarily from Christian marriage books, pastors, church leaders, and parents, in the context of sermons, premarital counseling, or parent-child conversations about sex. The most frequently mentioned and impactful purity culture messages were teachings that (a) premarital sex is a sin, that (b) men want, need, or are entitled to sex in marriage, and (c) women are responsible for men's sexual purity (e.g., "modest is hottest," "if a wife didn't give enough sex to her husband then he would just watch porn or have an affair"). These messages largely informed how they made sense of and felt about their sexual pain and how they communicated with their partner. Fiona described the effects of these messages prior to getting married:

> I remember feeling both that feeling of my body is a temptation, my body is a weapon, my body is this thing that has an undue amount of power over the people around me and I need to control it. Like my body is something that people lust after. … I think one of the main things that I took away from that whole experience was that I was kind of the one who was the steward or the keeper of especially my and [my now husband's] physical relationship. As our as our emotional relationship developed, I was always the one who had to pump the brakes and say "No, this isn't okay for us to be doing right now." And that isn't to say that [he] ever *pushed* me to do something that I was uncomfortable with, because he *never* did.

When combined with the gendered "obligation sex" message (Gregoire et al., 2021), spouses believed that these purity culture messages contributed to physiological and psychological

responses in women as they tried to "flip the switch" during the early days of marriage. For instance, Derek and his wife both indicated how she had only orgasmed once during sex because she would often feel overstimulated. Derek recalled how this relates to the times he and his wife would make out and touch each other prior to marriage:

> I would say that it would, knowing what we know now, it almost taught my wife with like muscle memory, to get to a point of it feeling good and then stopping. Because she *didn't* want to keep going. She wanted to save that moment. So, then it was like, it got to the point where it was like—for her it was also a very overstimulating feeling. So, it got to the point where it was overstimulating, it started to feel good, and then we'd [stop].

This experience was echoed across multiple interviews, in which women described a significant drop in their sexual desire and arousal after getting married. Other women attributed the drop in desire to the pain cycle that was reinforced as they tried to problem-solve and figure out how to have PVI intercourse. As Lily put it, "obviously like if you stabbed a man every time he had sex he would not want to have sex either."

For many spouses, women's low libido seemed to be more disappointing to both partners than an inability to have intercourse or pain with intercourse, echoing Tucker and Hintz's (2024) recent work documenting the "orgasmic imperative" perpetuated in sexual discourse. Brandon, who had been sexually abused as a child, reflected on the first few months of his marriage:

> I didn't understand what sex was supposed to be. And so the fact that we weren't able to do it, I was like, "She doesn't love me. She doesn't want to satisfy me. Or she doesn't want me to satisfy her." … So she would just shut down, and I would try to communicate *about* sex so that we could get better or at least successfully have intercourse. And that was kind of a point of contention, because I was like, "Can we like—let's do whatever

possible. Tell me what feels good, what you want or need." And she didn't know what to tell me because she didn't know herself. I had looked at porn for years so I *personally* knew what physically worked for me.

Women's shame and frustration about having low desire was compounded by the fact that did not know what would increase their arousal. Lily said, with tears in her eyes:

> I almost want to say that I don't know what my sex drive is. I don't know what my libido level is. I almost like don't know myself because of this. It's kind of like, if you're blind asking someone how their vision is. It's like well I'm blind so I don't—or it's like asking them, "Do you like this color?" It's like, "Well, I'm blind. I can't tell you whether I like this color or not."

Owen noted his own internal conflict, since he was more nervous about having intercourse than his wife was prior to getting married: "I think this is a side note from some of the messaging around sex, that males are like just fervently, constantly hungry and wanting it. And I'm like, what if I'm not though? What if I'm afraid?"

Data from some couples indicated that a few husbands did feel entitled to intercourse (e.g., "he gets in a really bad place and I can't satisfy him in the way that he wants"), however, far more women expressed that the socialization message that men want and need sex prompted them to caricature and distrust their husbands, even after husbands had indicated they were content and happy with non-penetrative forms of sex. In turn, this prompted husbands to feel misunderstood (Lovell et al., 2023). When asked about her sexual communication with her husband, Fiona expressed:

> So, when we do butt heads about it, it's usually because of that. Because I've said something that makes him feel like I don't trust him. And there isn't a single thing he's

> ever done to make me feel uncomfortable or like I can't trust him. It's just my brain, like, lying to me about my marriage [*scoffs*]. [For example,] if he even so much as suggests, … "At some point in the next three weeks, would you be okay with trying intercourse?" And my first reaction is tense up, deflect, redirect the conversation. But then if I kind of come back to that or reference that conversation in context of … "Oh, I feel like I *should* be able to give this to you but I can't, and that's hard," it comes to him from a place of me feeling like I *owe* it to him, or me feel like I'm depriving him of something that he deserves or that he needs, and that's *really* hard for him.

These data illuminate the context and experience surrounding moments when men feel like their female partners perceive them as perpetrators (Lovell et al., 2023).

A final negative effect of purity culture messaging for a sub-set of participants (both women and men) was the perception that WPP-PVI was happening because God was punishing them for "sexual sin" such as premarital sexual activity or pornography addiction before or during marriage. When explaining why she did not seek support for the first year and a half of marriage, Olivia tearfully reflected:

> I think also I had shame around anything I had done sexually *prior* to getting married, where—[*tearing up*] Ah. I'm not gonna cry. … Where I felt like, maybe like I deserved it? And maybe it's like it would go away once I had—I don't know, like [*tearfully*] like it was like a punishment and I guess I needed to do my time. … I think I still feel that way. Not necessarily that I think that that's right, but I think a part of me believes that.

One participant, whose father-in-law had stated "I would rather go be with Jesus than you guys mess up" after finding out she and his son were going on a backpacking trip alone together before they were married, poignantly captured the essence of the current analytic code in relation

to couples' anticipatory socialization, particularly for women: "The narrative I feel is around those things is like, if you're dating and you do sexual things you're horrible, and then if you're married and you *don't* do sexual things then you're horrible." The latter part of this statement is captured in the following analytic code.

Unrealistic or Romanticized Ideal. Several messages couples received from purity culture reflected an unrealistic or romanticized ideal of sex, which participants saw reinforced in societal messages (e.g., TV shows, movies, pornography) and messages from network members (e.g., romanticizing the wedding and honeymoon). As one couple explained in a follow-up interview, when reflecting on how sex was impossible for them for many years:

> Husband: Yeah, right, because you already, even when you haven't talked to anybody about it, you already know that it's not normal. Or at least that's like a very consistent messaging from the entire universe, right? …
>
> Wife: Yeah, like in *and* out of the church.
>
> Husband: Yeah, oh yeah, yeah, and it's always sexy and always fun and it's never awkward or like you trip taking your pants off, you know?

In evangelical Christian contexts, couples frequently described hearing that sex was "God's design" and meant to be fun, easy, and pleasurable for both partners. Participants heard these messages in premarital counseling, from parents, and in church sermons. When asked where he had received these messages, Noah stated, "certainly Song of Solomon. Some of the language there, and that *does* get presented to you when you're growing up as like, here is sort of a romantic ideal of early marital passion."

Researchers have noted that evangelical purity messages which emphasize the beauty of sex within marriage aim to delay sexual debut until after marriage (Manning, 2017) and promote

deeply held values about what evangelicals believe to be "God's design" (Leonard Hodges & LaBelle, 2024). On the one hand, a few couples in the current study appreciated such messaging and experienced it as a positive, *intervening message* in their anticipatory socialization (see Flexible Expectations code under "Intervening and Buffering Messages"):

> Danielle: I've only come across two pastors who talk about it in a way of like "oh like this is a good thing."
>
> R: What are the things that those pastors have said?
>
> Danielle: I think they teach what God intended for sex, of like, this is a beautiful union between two people, and it's not that we just *don't* want to do it before marriage and *do* want to do it after. It's like, no, this is a way to cultivate intimacy with someone and something that is very much God-designed. They always say, "He designed the parts for them to be together, work together, move together," and it changed my whole perspective. And I listened to a lot of those podcasts and sermons and stuff in college. So I was kind of reconstructing my view on all of it, because I didn't really have a view other than [*strict tone*] "Don't do this before you're married" kind of thing. And so just having a healthier perspective on like, you get to do this and it's a *gift*.

However, what for some couples appeared to be an intervening message that provided a positive lens through which to view sex (even in non-penetrative forms) served as a negative, or at least confusing, socialization message for other couples after discovering WPP-PVI. As Caleb explained:

> I think one of the Christian band-aids is—it's not a band-aid because it is true, but I think, it can be misused in my mind of, "God created sex, so sex is good," is the redemptive arc from people who haven't heard a lot about sex or who had a bad view of sex. So, if we go

> to have sex and instead sex is painful, I'm like, "Oh, but you created sex and it's supposed to be good."

Caleb's qualifier that "it's not a band-aid because it is true, I think" is reflected in many participants' accounts in the context of them grappling with messages about the sexual ideal. The message that "sex is good" heard in Christian contexts appeared to create cognitive dissonance for women and men alike as they sought to make sense of their sexual pain experience. Jasmine explained:

> It's hard for me to wrap my head … around the fact that something that God calls good isn't *good* for me. … It's not just not good, it's *painful*. And it's hard because our definition of "good" is not always what God calls good, right? So even remembering that like sex is still *good* and it's still enjoyable … It's just the fact that there's pain associated with something that God has called good is a hard concept for me to grasp.

This dissonance prompted many to feel anger towards God and/or the evangelical church, which facilitated coping as illustrated in the code, Assigning Blame to External Factors. Compounding the frustration were the messages many couples described hearing from wedding guests or from network members early on in their marriage. Lily articulates these messages and their impact in the following exemplar:

> I remember just coming home from the wedding night back to his place, and then just *trying* and being—both of us were really frustrated, because I was like, "Well I really want this to happen," and he was like, "Well we have to finish because it's the wedding night. Like, that's what you do." When you're a Christian, everyone romanticizes the wedding night. People are winking at you during your reception. And everyone, family, is all making comments about like, "Oh, you guys won't sleep tonight!" And just kind of

all this pressure on you to see it all the way through. And I just remember he got mad, he got really angry, but it's like, I don't blame him because I was also just confused. And I feel like we had these false expectations that we hadn't even put on ourselves.

The Unrealistic and Romanticized Ideal that was reflected and reinforced across multiple message sources may indicate that the co-occurrence of messages is one reason messages may become memorable. Reinforcement or co-occurrence may speak to "the nature of memorability of these messages" (Cooke-Jackson & Rubinsky, 2022, p. 8).

Incomplete, Inaccurate, and Vague Sexual Health Information. A final set of socializing messages contributing to the difficulty of "flipping the switch" included memorable messages and conversations lacking complete, detailed, or accurate information. Participants discussed these messages when asked about messages they wish they *would* have heard that may have made the process of coping with sexual pain easier. They also mentioned messages in this category unprompted (e.g., while sharing about incomplete messages they heard as children).

Many messages about pain that participants had heard growing up and upon getting married from family members and peers are reflected in extant literature (e.g., that chronic pain is normal, or normal at first but will resolve: see Hintz, 2019a; Scott et al., 2022). Numerous scholars have documented how adolescents often hear inaccurate and incomprehensive sex education, despite their overall desire to hear comprehensive sexual health information (Cooke-Jackson et al., 2021; Gunning et al., 2020; Holman & Koenig Kellas, 2015, 2018). Scholars have also identified parents' own barriers to parent-child communication about sex (Holman, 2021), such as their own shame or religious taboos. In the present study, some participants' parents had similarly focused on the dangers of premarital sex (e.g., pregnancy, STDs).

Yet, compounding the inaccuracy and incomprehensiveness of messages about pain were messages that implied couples would be able to figure sex out once they were married, and that sex would be easy if they were in a loving and emotionally healthy marriage (e.g., "they made it seem … like sex was kind of like a litmus test of your marriage"). Thus, inaccurate and incomplete messages were also oftentimes vague, which participants attributed to the taboo nature of sexual communication and purity culture norms, such as the notion that talking about sex too soon before the wedding or being too explicit would make couples want to have premarital sex. Evangelical leaders leading premarital counseling or education may focus mainly on spiritual and emotional dimensions of sex, outsourcing discussions of the physiological aspects of sex to Christian marriage books or medical providers (Leonard Hodges & LaBelle, 2024). The findings in the present study reveal the negative impact this choice may have on couples and suggest the need for improving evangelical premarital counseling curriculum.

Notably, a few husbands described a positive perception of the "you'll figure it out" message, because they viewed it as an opportunity to grow closer to their spouse when they got married. Overall, however, the following exemplar from Claire captures the essence of incomplete, inaccurate, and vague messaging that couples experienced growing up and during engagement. After she was asked what she remembers learning about sex during the few premarital counseling sessions she and her husband had, she stated:

> I don't think it was anything specific. I think it was just like—[my husband] describes it as like someone teaching you how to drive a car without actually trying. That might not be the most helpful, but once you've tried, then you can understand the mechanics of it and what you actually need to know. … Our expectation of it was that it was going to be easy, and—yeah, it's just like that one thing that you can't really—as we understood it,

you can't really work on before marriage, so you're just going to get married and then figure it out. And yeah. … We just thought … we're cultivating our relationship emotionally and spiritually, in all of these ways and then when we get married, then that's when the sexual aspect begins and we'll just—it's like the last missing piece and it'll be great.

Several couples attributed their delay in seeking support or help to absent and inadequate messages about sex. In the following exchange, Brandon passionately expressed what many participants described feeling throughout their interviews:

R: And so it's like you guys tried to do those things and it's not good! And so *that's* frustrating, it sounds like. I wonder if it's like, this was the message, this was the promise.

Brandon: Yeah! Right, and we had the mindset too that we were like, if this *wasn't* the promise, why did nobody tell us? We felt very betrayed that there were dozens of adults in our life that nobody bothered to tell us that it's not always easy or that—like, "Communicate about a few different things, and that will really help."

In all, participants described wishing they would have heard more details before getting married: not necessarily every detail, but at minimum the possibility that persistent sexual pain exists but is not normal, and that there are resources that can help. The value of this information is reflected in the accounts of couples who knew about sexual pain conditions before getting married. These couples were more easily able to redefine intimacy and described less distress about the inability or difficulty of having PVI.

4.3.2 Dismissive Responses

Throughout couples' trajectory of discovering and seeking support for WPP-PVI, spouses received negative messages from clinicians, network members, church leaders, and occasionally each other, that ranged from discouraging, to invalidating, to dismissive. Although most of these messages reflect others' attempts to make sense of and treat WPP-PVI, some also reflect advice that spouses received regarding the relational issues accompanying sexual pain. Since most couples found their relational distress more difficult to cope with than the pain itself, examining these messages is important for understanding the sexual pain experience.

Hasty Sensemaking. The hasty attempts of clinicians, friends, family, and partners to make sense of the pain invalidated women's pain experiences and in many cases, reduced their desire to seek support or continue receiving specific types of support. Hasty sensemaking included a range of unhelpful questions and assumptions, hurried misdiagnoses, and drawing from one's own experiences to make sense of the pain, which all functioned to dismiss one or more aspects of participants' unique and multidimensional experience of sexual pain.

Questions and assumptions primarily regarded women's relationship quality (e.g., "well, maybe you don't feel emotionally connected to [him] because you've shut off emotionally to [him]"), or an assumption of past sexual abuse. Lily recalled,

> I remember my husband told our current pastor and the first thing the pastor asked was like, "Well does she have any sexual trauma?" That's kind of the first thing that people ask, and because I *haven't* been through any of that I'm almost like, well then it's like [something's] double wrong with me.

To provide another example, when Holly began experiencing a drop in arousal after marriage, she recalled her husband questioning her sexuality:

> At one point he was like, “Are you *sure* you’re not asexual?” And I was like, [*irked*] “I’m not ace. I know I’m not ace.” But he kept asking all of these questions like almost over and over and over again because he was scared.

Women’s clinicians, who also asked about women’s relational quality and past sexual abuse, frequently dismissed women’s pain or perceptions about their experience, which led to misdiagnoses (Hintz & Venetis, 2019). Taryn recalled seeing a midwife she was referred to by a nurse who had (ironically) finally validated her experience by saying, “this sounds like vaginismus.” Referring to the midwife, Taryn described it as “the *worst* experience of my life. She was literally like, ‘This doesn’t sound like vaginismus.’ And they also tested me for BV and yeast *at* the urgent care because I had had the history of BV and yeast.”

Moreover, in almost every case where network members’ (i.e., friends, family) messages caused women to feel dismissed or couples to feel discouraged, it appeared that the message sender, often well-intentioned, was drawing from their own experience to make sense of the situation. Victor recalled sharing about his wife’s sexual difficulty with some of his closest Christian friends:

> Victor: I’m like, “Did *you* guys have similar experiences?” And they’re like, “Oh yeah. Oh yeah.” Like they *all* suffered from this. But for *them* it was like three to six months. … I felt comforted knowing that, but I’m like, “And what did you do?” And they’re like, “Well, you know, we’ve talked about it and this, that, and the other, but outside of that, that’s been it.” Just because like [my wife’s] experience is I feel like just a little bit more severe and maybe a little bit more unique than them. …
>
> R: Yeah. What would you say is your feeling as you saw your experience were kind of going past the experience of your peers? What was that feeling for you?

Victor: Sad. Just sad. I think I was just really, I think I was—in my head, had kind of said, "This is going to be a few months, and I can really chin up for that and then it will be okay, and it'll be done." And then it wasn't.

It is noteworthy that several participants described hearing hasty sensemaking messages from multiple different message sources *while* they were in the process of making sense of the sexual pain experience themselves. As seen in the Unrealistic and Romanticized Ideal code, it is possible hearing multiple trusted sources convey the same information in a way that invalidates or contradicts one's own experience contributes to the memorability of messages or may provide information about the context of memorable messages (Cooke-Jackson & Rubinsky, 2022).

Moreover, it is noteworthy that several women retrospectively perceived some truth to certain hasty sensemaking messages (e.g., that relational dissatisfaction or previous trauma was contributing to the pain) or regretted not getting help sooner when they had been referred. Gunning and Taladay-Carter (2023) found that women experiencing invisible illness felt validated and enfranchised when their grief was met with nonverbal expressions of empathy and verbal expressions of belief, compared with action-oriented messages. The findings of this study support the contention that the timing of solution-focused messages is critical, as many women felt like others were problem-solving or explaining away their pain before hearing more of their story or sitting with them in the grief and confusion.

Simple Solutions. Couples frequently recalled how others offered simple solutions such as drinking wine, relaxing, using more lube, taking a hot bath, praying, or reading the Bible. Many of these kinds of messages have been documented throughout chronic pain and sexual pain literatures (Gunning & Taladay-Carter, 2023; Hintz & Scott, 2021; Hintz & Venetis, 2019; Kenny, 2004). Simple solutions also included bad advice and disenfranchising talk. Several

women who were unable to use tampons or complete Pap smears before getting married due to the pain were told by doctors or network members to wait until after they had sex because it would be a "different atmosphere or "different environment." Women who wait for marriage to have PVI may therefore be uniquely negatively impacted by simple solutions.

Aside from three women who experienced simple solutions in a positive way, for most women in this study, simple solutions reinforced their feelings of brokenness, increased their frustration, invalidated or dismissed their pain, and assumed a quick fix to sexual pain that couples had not already tried. When asked about why it was difficult for her to use vaginal dilators in the presence of her husband, Jasmine exasperatedly explained:

> It just—I don't know, I feel ashamed because my body isn't doing what it's supposed to do, and that's also one of the things I remember even in my [medical] exams. They're telling you to relax, like the whole—which one of the nurse practitioners told me to do. Like, "Oh maybe drink a glass of wine and try to relax." But it's difficult, because if I could relax I promise that I would. And it's something that other people don't fully understand, but like I'm actually trying to relax. Give me the benefit of the doubt that I'm actually trying very hard to relax, but my body is not doing what I'm asking it to. It's not *doing* what it's supposed to *do*.

Jasmine's sentiments echo findings from research on women who have difficulty orgasming (Tucker & Hintz, 2024). The medical invalidation Jasmine and others received contributed to shame that made it difficult to be vulnerable in her relationship. Overall, solutions that oversimplified the biopsychosocial experience of sexual pain seemed to function as memorable messages that reinforced feelings of failure or reinforced pain.

Insensitivity and Dismissal. The current analytic code represents messages that ranged on a continuum from insensitivity to literal dismissal (i.e., a doctor telling a patient they cannot do anything more for her). These messages often *included* simple solutions but were distinct in that they reflect the emotional valence of the message. As other studies on intimate health have found (Horstman et al., 2023), several spouses described hearing messages that brushed off their concerns or reflected insensitivity (e.g., asking when the couple wants to have children). Moreover, several women explained how others responded with confusion or shock. Many spouses' experiences are captured in the variety of responses Erin describes below:

> Man, it's hard because the couple of friends I have that are not married, they grew up in the same very conservative mindset where sex is not talked about, so they really did not even have a framework for it. So that was one girl where it looked *really* shocking to her of she didn't even know that was a possibility. … And then the response I think I got twice from people which is so frustrating was, immediately it was not checking in on how I'm doing. It was, "Oh how is [name of husband, with added emphasis] handling that?" And so just reiterating kind of the fears and the thoughts I've had that like this really is—like [he] needs to be happy or pleased by this and he's not. I had two friends say that to me of, "Wow, that must be really difficult for [your husband]," without acknowledging that that would be hard for me too.

A few women also recalled the insensitivity they perceived when physicians did not read their charts showing their medical history related to pain with Pap smears or intercourse. Danielle, who has vaginismus, recalled:

> Danielle: So the nurse I had who was just taking my intake paperwork and asked me questions, … I was like, "I experience these things," and she's like, "Are you sexually

active?" And I go, "Well kind of," and she's like, "What do you mean?" And then I was like [*pretending to cry*] Bwahh! So I was like, oh my gosh I wasn't expecting to cry this morning. … She very well did not read my paperwork. She was just asking her standard questions. So just kind of dismissive on that end. …

R: What do you think it was about that question that brought up that emotion for you?

Danielle: Yeah, I think part of it is like—I think somewhat the lack of understanding that some people have of like, you don't need to be having intercourse per se to be sexually active, but she just didn't get that. [*slight frustration*] And I was like, okay, is he inserting his penis into me? No. Do we touch everything? Yes. Like, what am I supposed to say right now? And I think it had just been such a long time coming for that appointment, to be met with anything but like, "Oh, let's talk about this."

Finally, several women described doctors who effectively dismissed them from the medical interaction when they could not complete a Pap smear or when multiple diagnoses or solutions had been exhausted (e.g., "Well, then I have nothing for you"). Overall, Insensitivity and Dismissal messages contested one or more aspects of the pain experience, which fueled wives' *and* husbands' frustration and medical mistrust and sometimes made them hesitant to pursue further treatment (Hintz, 2022). In some cases, the physical and emotional trauma wives experienced during medical exams prompted husbands to be more cautious and heightened to the awareness of the pain than they already were (e.g., "approaching intercourse for me is still a tough one because I don't want to add on to those experiences"). This finding may provide further insight into the context surrounding solicitous responses.

Cooke-Jackson and Rubinsky (2022) have called for examination of "the contexts within which [memorable messages] are most salient, most productive, or most detrimental" (p. 8).

Dismissive responses to women's sexual pain reveal the highly contextual nature of memorable message decoding that researchers have documented. Horstman et al. (2023) contend that "A message receiver's speech community, identity goals, and relational culture inform their decoding of a memorable message" (p. 748). Dismissive messages reinforced the stigma and shame women felt about sharing with others, delayed treatment-seeking, and made it difficult for couples to assign blame to external factors since supposedly credible and trustworthy sources (e.g., doctors, pastors) were essentially confirming to women that they were, in fact, broken. Fortunately, the story does not end here, as couples recounted many messages that appeared to intervene or serve as a buffer for early socialization messages and dismissive responses to pain.

4.3.3 Intervening and Buffering Messages

In their accounts of coping with persistent sexual pain, couples recalled memorable messages that countered socializing and dismissive messages that had shaped (or could have easily shaped) their individual and shared experiences with sexual pain. The remaining analytic codes reflect these messages.

Validation. Several couples described messages that validated women's thoughts, feelings, and pain. These messages often contained empathic communication and helped women feel less alone, less broken, and like the pain was not their fault. At the bare minimum, participants recalled messages that passively validated women's experience by giving credence to their experience or not *in*validating them. For example, in the wake of a dismissive medical encounter, Alexis saw a naturopath, noting "it didn't *really* help that much, but at least it felt like she was taking me seriously." For many women, receiving a diagnosis or learning of a possible diagnosis through a mediated source provided validation. When Lily came across a blog post that featured a book about a woman experiencing sexual pain, she recounted:

> That was the first time I'd ever heard that someone else had gone through that. For me, even just knowing that one other person in the world had gone through the same thing, I was like okay well maybe it's not that I'm broken and alone it's like, there's actually—and then you know, over the years I'm like actually this is like really really common.

Learning that others had successfully gone through the process of sexual pain seemed to function to give couples hope (e.g., "most of these people that we're talking to are a *lot* farther down the road than us and can actually say like, 'it gets better and there's hope.' And that there is actually things that we can work on"). Several participants also described the validation and hope pelvic floor therapists provided and the impact it had on women's identities. One husband recalled:

> It was like her *first* pelvic floor appointment, the pelvic floor therapist was like, "Wow, you're actually not that bad. This isn't that bad. This won't take that long." I think my wife was just kind of like, "Oh, I'm not that broken." And then like pretty soon after that, within the week we had penetrative sex for the first time. And she had no pain.

A key point in many women's recovery seemed to be hearing validation from a clinician that their pain was common and real and that there was actually a problem, while also receiving reminders that they were not broken and that there is hope. This finding supports previous research documenting how diagnoses can shift the perception that sexual pain signifies something inherently wrong with one or both partners to a biogenic cause (Lovell et al., 2023).

Notably, diagnoses or hearing others' stories could also be perceived negatively or could be difficult to process. For example, receiving a vaginismus diagnosis was a relief to Maddie's husband, but Maddie was in tears because of the grief that came with the diagnosis and because she knew healing could take years. In their research on memorable messages in the context of invisible, physical illness, Gunning and Taladay-Carter (2023) note that "though receiving a

diagnosis helps patients make sense of their illness experience, it may also spur a grief process" (p. 8). Social learning theory suggests that change is motivated by witnessing others who have gone through similar experiences *and* seen improvement or overcome seemingly insurmountable difficulties, compared with those who may have easily experienced change (Bartholomew Eldredge et al., 2016). The findings in this study warrant further exploration of how social modeling could be utilized in health interventions for couples experiencing sexual pain.

Additionally, participants described the empathy they received from friends which sent the message that their experience was valid. Grace recalled,

> One friend, I think the most helpful was she just truly weeped [*sic*] with me and just grieved. And I think just was like—she's been married a few years and was like, "Sex is just complicated at the best of times and it's always changing and it's never just this thing you get and you just, now you got it." But I think her just grieving with me was probably the most touching.

Fiona was grateful to have friends who "have basically just been willing to sit there with me and be like, 'yeah, that's really hard. I'm sorry, that sucks.' And just empathize and asked questions when appropriate and been receptive when I've brought it up." She went on to describe a memorable interaction with a close friend:

> When I first got married, I remember I was at Target with my best friend. And it was our first time together since I'd gotten married. And we walked past the contraceptives aisle or whatever it was. And she was like, [*excitedly*] "Oh, do you need to buy a pregnancy test yet?!" And I was like, [*uncomfortably*] "No, and I probably won't need to for a while!" And that was really painful for me for some reason. And she IMMEDIATELY got it and has not—has been SO careful and so wonderful about talking to me about it

> since then. And any comment about our future family or anything has been caveated with, "Okay, Lord willing this happens, because I know that you want a family, but you know all kinds of things could happen instead" and just, she really holds space for me in a really beautiful kind of way.

Fiona's account further reveals the contextual nature of memorable messages. It is possible that a message becomes memorable and meaningful in the wake of receiving a negative message from the same message source previously, even a message that was unintentional.

A few husbands also recalled validation from their wives when they reached a point where they felt comfortable enough to share their emotion around the sexual experience. For example, Franky had felt shame and responsibility around his wife's pain, and felt alone in his experience even after sharing with some friends who were supportive but could not relate:

> [My wife] and I started to talk about it, and she started to encourage me like, "No, this is not your fault. This is not—like you didn't do anything wrong. This is just something that happened and no one is in the wrong for it. You don't need to feel shame around it." And so since then, it's been a lot better.

For many participants, experiencing validation and empathy occurred in the wake of dismissive and invalidating interactions. In her publication advancing the Disclosure Decision-Making Model, which centers on disclosure of health information, Greene (2009) suggests that "the order of who was told (and why) is likely linked to relational quality, anticipated response, and confidence in keeping the secret" (p. 246). Although the data in this study were cross-sectional and preclude generalizable claims, the data indicate that message timing may be an important point of exploration in both the information management and memorable message literatures.

Advocacy. A distinct but related sub-set of messages reflected how partners and clinicians advocated for women by going above and beyond to find solution, as well as reminding women the treatment was for *her* pleasure and well-being (i.e., that she mattered) and acting in a way consistent with this message. Prior to redefining intimacy, many couples began their marriage with wives frequently initiating sex and pushing through the pain (or trying to). Husbands who knew of their wife's pain were typically the ones to halt intercourse, which sent a positive message to wives who felt advocated for. For example, after doing Internet research on sexual pain and reading other women's cautionary tales, Taryn had developed the idea that her husband might cheat on her if she could not have PVI, which created a high degree of distrust:

> It was almost like he was two different people to me. Not that he really was, but there was this [husband's name] that I knew he was and wanted him to be. And then there was this [husband's name] that everyone told me he was that only loved me for these things.

Taryn did not recall hearing or believing this message in her upbringing, however many other participants in this study recalled purity culture messages conveying this same sentiment through the "obligation sex" message. The following exchange occurred when I was about to end the interview with Taryn and captures how many women described their feelings about their husbands' support:

> Taryn: Something I thought of that I think made a big difference was that when I was having pain with sex, [he] was the one to be like, "I think we should stop doing this." And I think that that was helpful. So I wanted to say that. But that's it.
>
> R: What do you think was helpful about that?

Taryn: I think that he prioritized my health and my general wellbeing. And that me not having pain was more important to him than having intercourse, you know, just like getting to have intercourse. So I think that that was like a *big* part of it.

Moreover, spouses repeatedly described the ways that clinicians—particularly pelvic floor therapists—advocated for wives, and the impact that seemed to have on their identity, behavior, and consequently their relationship quality. Lily's quote below demonstrates the power that pelvic floor therapists had to disrupt dismissive messages for women:

> Even telling my mom and she was like, "For him, you have to do this for him. Imagine what *he's* going through." And when I went to pelvic PT, that was the first time when [the therapist] was like, "you have to do this for *you*. This is going to improve *your* quality of life. You're going to find pleasure in sex one day. This is for *you*. And sure, you can do like, one of your motives can be for him, but that can't be your only motive."

Lily expressed that her husband was happy she had decided to go to pelvic floor therapy. Indeed, several husbands expressed pelvic floor therapy being "game-changing" for *both* partners. In addition to the education therapists provided many men with directly, therapists also helped wives feel more empowered, which provided wives an inner strength they brought into the relationship. Seeking treatment also sent the message to husbands that wives wanted to work on the relationship, which relieved some of the feelings of powerlessness and frustration that men felt (Lovell et al., 2023). Kacey's comment below captures the meaning that pelvic floor therapists' advocacy messages held for many women:

> She really advocated for me. She explained what she was doing, and how it was like—"I'm doing this, you should see this happen. If you don't, let me know." Then when I'd come back she'd be like, "How is this going? What's happening with this? Have you

> specifically—" She just was very thorough and she actually cared while the first one, she didn't really care. I'm already looking at myself like that, I really don't need you to do that. So I just yeah, I mean she fully explained everything to me. She helped me to find resources. Things to do at home. … *Very* much advocating for me. Going out of her way to do things she's literally never done before to help me when other people are like, "Yeah, [your husband] just needs to get it together."

Again, these data indicate the memorability of messages may be shaped by message timing and the quality of the message compared with previous messages. This may provide some insight into the social support literature. Verbal person-centeredness, or the degree to which a verbal message acknowledges, explores, and validates the support receiver's emotions, has historically been viewed as the most important social support quality, even though verbally person-centered messages do not consistently help reduce stress (High & Dillard, 2012). It is possible the timing and context of a verbally person-centered message predict whether the message will be effective in reducing stress.

Flexible Sexual Expectations. Participants recalled messages from mentors, Christian sermons, podcasts, and books that shifted their sexual expectations, thereby intervening in the harmful trajectory developed by purity culture messages. The messages that appeared to benefit them the most revolved around PVI not being equal to sex, the notion that couples can take it slow and do not have to have intercourse on the wedding night, and debunking the romanticized ideals about sex in media and the church (see Leonard Hodges & LaBelle, 2024). The couple-level data also reveal how memorable messages that informed one spouse's behavior permeated through the relational system to positively impact the other spouse. For example, Spencer was asked what his first thought was when his penis was unable to penetrate his wife's vagina on the

wedding night due to the pain. His response captures the value that couples found in messages that had shifted sexual expectations:

> Well, we'll just have sex other ways … We had found a podcast [from Sheila Rae Gregoire]. Basically, one of her episodes was on like what to do during the wedding night. And she just said, "You're now married. You have plenty of time. Start slow, and just take each step as it comes. Just get used to being naked around each other. Just get used to touching each other's bodies. You don't have to go all the way to everything you can do before the end of the honeymoon." So that really was my mentality.

This prompted Spencer to reassure his wife early in their marriage that non-penetrative sex counted as sex, which became a memorable message to her that she shared about in her own interview. Thus, intervening and buffering messages that some spouses heard from mentors, clinicians, and Christian leaders who sought to disrupt purity culture became memorable messages for the other spouse, which facilitated their co-creation of meaning around their sexual experiences and therefore their ability to cope.

Notably, without prompting, seven different couples referred to author and speaker Sheila Rae Gregoire as being instrumental in helping them redefine intimacy, prioritize women's pleasure, and make sense of their experience. Several couples who had read her books (e.g., Gregoire et al., 2021) after getting married wished they had known *before* getting married that it was okay not to have intercourse on the wedding night. However, it is important to note that even couples who did redefine intimacy prior to marriage by taking intercourse off the table experienced shame, frustration, and a drop in libido during the early months of marriage.

Possible reasons for this include the timing of the message or the "intervening" message becoming a new "romanticized ideal." Jasmine, who did not mention reading Gregoire's work

but had heard messages about sex being beautiful and good after getting engaged to her husband, reflected, “I think in my head was it was kind of too late for me to just associate sex with being something that’s *only* good and not something that comes with a lot of pain or struggle or lack of desire.” When I probed Fiona about the frustration she felt since she was still having trouble despite the fact that for her, “the narrative [had] shifted completely,” she exasperatedly explained:

> I’ve done everything I can to remove the goal of intercourse from my brain. I see this as being good for my relationship and good for me, so I’m doing it. And I don’t know what else I can even do to change my expectations or to show up for my body or to cultivate trust in a relationship. Because all the books make it sound so simple, of like, “Oh, just do these five things.” And I’m like, I’ve done all of them! I’ve done 10!

Holly speculated about this in her interview, since she had read *The Great Sex Rescue* before getting married and did not attempt PVI on the wedding night, but was still unable to have PVI after almost two years of marriage:

> I joke about like, I love Sheila, she’s published stuff that’s been so helpful, and she’s also connected me to a system of resources beyond her that are designed to support women or things like that, and a *shocking* amount of them—it actually is not surprising at all—a lot of them exist within the same theological assumptions that purity culture does. And they change the outcomes, right? They say, “Well, God wants something different than we thought he did,” but they don’t challenge a lot of the baseline assumptions. … I know she and her husband have some books that are basically designed so that everyone can have fabulous orgasms.

When I probed Holly about why she did not appear to be frustrated with this messaging, she explained:

> [S]he was the first *Christian* voice that I encountered talking about it. So there's like a little bit of a halo around her head for me, because she was the first person of faith to ever talk about it. And so I think there's a lot of ways that I have just sort of exempted her. [*Holly and researcher laugh*] And that's like my own bias of like, of listen, you opened the door for me to be able to think about this and talk about this and I'm very indebted to that. So even though with more time and thinking, and I have a lot more criticisms, but like I owe her a lot. So she gets a pass."

Holly's commentary reveals how perceptions of message source similarity (i.e., another Christian speaking out against purity culture) may be important for understanding the memorability of memorable messages. Moreover, the findings in this code reveal that intervening messages that take hold at a cognitive level for some individuals may not infiltrate into identity formation and action under certain conditions (e.g., heightened pain responses, anxiety, etc.).

Spiritual Truths. A final set of intervening and buffering messages consisted of Bible passages and words of wisdom that helped couples make sense of their experience and reduce the negative effects of socializing messages and dismissive messages. The reason I labeled this code "spiritual truths" instead of "biblical truths" was because participants often recalled teachings or interpretations of Bible passages they heard from others which corrected their prior interpretations of the Bible they had grown up with. For example, one husband described a class he had taken at the Bible college he attended, after getting married. The class had discussed a more egalitarian view of gender in marriage and in the church, reinforcing what he already knew

to be true deep down but had not been taught in the conservative Southern culture he was raised in. He fervently explained,

> The amount of anger I felt during that whole semester was DEEP, because I—I was trained to, in some way, at the end of the day, look at women as if they're supposed to be under a male, and that at the end of the day, they *can't* lead other people in the church. They can lead other people in the secular world, but that doesn't matter as much as the church, so they're less than. So that class broke that. And the net positive result on my marriage is witness to its truth.

Spiritual truths also disrupted the belief that several participants had internalized about sexual pain being a punishment for current or prior sexual sin. As Kyle noted, using language that hearkens to teachings of the Bible, "I've gone through bits of like, 'Is this punishment for my previous addiction?' And have to remind myself that that is *not* how God works, and that he is a graceful and merciful God, not a revengeful God."

Furthermore, whereas couples generally described messages about wives pleasing their husbands (i.e., obligation sex messages) as harmful, husbands perceived similar messages when directed at themselves as positive. Several husbands recalled how spiritual mentors and teachers had told them growing up or prior to marriage that it is important to prioritize their wife's pleasure and to think of sex as an act of service. This became a bedrock for many husbands, like Noah, who reflected, "It was helpful, I think, having that sex as an act of service thing … in my head, because it reminded me, 'Well, the point of it is for us together. It's not about me.'" Notably, he went on to say, "I definitely didn't go in with rose-colored glasses, expecting sex is this awesome thing that would be happening every day. But I definitely expected there would be more than two good sexual experiences in the whole first year." The cognitive dissonance

expressed by many participants confirms and provides context for Cooke-Jackson and Rubinsky's (2021) proposition that messages may be more helpful at certain points in time than others.

Participants also drew from the Bible to make meaning of their "trials" and "hardships" (terms used only by husbands). When asked about how he accounted for feeling closer to God from the coping experience, Logan explained,

> Somewhere in the Bible it mentions going through trials and stuff. Everything happens for a reason. If this is a particular trial that God puts in front of us, it's just for us to learn something about ourselves and about him and how we can grow not only as a person, as a Christian, but also as a child of his.

In a similar vein, Lily reflected,

> A couple times I've prayed and been angry about it, like, "God, why?" But you look at the Bible and there's *so* much of Job and David. And I think to me it's really comforting when I read the Bible and there *are* those prayers, those Psalms that are like literally just someone who's really angry at God and is crying out to God. And so I don't feel bad having those prayers some nights that are just like, "Why God?" or like, "*You* created this problem, you fix it!" Like, I've definitely prayed that. But I feel like I've had less of those types of prayers recently more just like, "God, this is in your hands. I truly want this to be resolved. I truly believe that this will be resolved."

The Biblical and spiritual messages participants drew from helped them in their ability to Find Opportunity in the Pain and normalize (Emotionally Honest) Prayer. In this way, spiritual resources aided the coping process for couples in their individual and shared struggles. Table 5 below summarizes the findings for RQ1, RQ2, and RQ3, showcasing the ways that memorable

messages may be linked to evangelical couples' ability to cope with sexual pain during early marriage. This summary is illustrated in Figure 2.

Table 5

Possible Links between Memorable Messages and Coping

Analytic Code	Typical Message Content[a]	Possible Impact on Coping & Support
Anticipatory Socialization: From Worst Sin to Best Gift		
Purity Culture Messages	• "Premarital sex is a sin."[b] • "Men want, need, or are entitled to sex in marriage." • "Women and girls are responsible for men's sexual purity." • "Men will be tempted to use pornography or have an affair if women do not give them sex."	• Difficulty *(Re)defining Intimacy*[c] (i.e., contending with premarital sexual activity; negotiating meaning and definition of "sex") • Wife's distrust in husband • Wife's steep drop in libido after getting married • Catalyst for *Analytical vs. Arousal Mindset* (i.e., hyper-fixation on figuring out PVI and not hurting wife), *Emotional-Spiritual Labor*, and *Meaning-Centered Sexual Communication*
Unrealistic or Romanticized Ideal	• "Sex (in marriage) is fun, easy, and pleasurable for both partners." • "Sex is beautiful, sacred, and God's design." • "Sex is sexy." • Messages romanticizing wedding night and honeymoon	• Range of negative emotions (confusion, shock, frustration, anger) • Cognitive dissonance regarding faith • Catalyst for *Assigning Blame to External Factors*, *Emotional-Spiritual Labor*, and *Meaning-Centered Sexual Communication* • Delayed support (*Disclosure Dilemmas*, *Shame and Stigma*)
Incomplete, Inaccurate, and Vague Sexual Health Information	• Focus on dangers of premarital sex (e.g., pregnancy, STDs) • "Sex will be painful (at first)." • "You'll figure it out." • "Sex will be great if the relationship is healthy."	• Delayed support (*Thinking it Will Resolve*; *No [Perceived] Need or Benefit*; *Shame and Stigma*) • Range of negative emotions (frustration, anger, confusion)

Dismissive Responses		
Hasty Sensemaking	• Unhelpful questions and assumptions about cause of pain (e.g., sexual trauma, relationship problems) • Misdiagnoses • Reference to message source's own experience	• Dismissed one or more aspects of the sexual pain experience • Delayed or withdrawn social support or intervention • Sadness and grief when the pain did not resolve
Simple Solutions	• "Sex will be easy and less painful in a different atmosphere." • "Drink wine." • "Just relax." • "Use more/different lube." • "Read the Bible or pray more." • *Disenfranchising Talk*	• Delayed or withdrawn social support or intervention • Reinforced feelings of brokenness, failure, and insecurity • Assumed a quick fix to sexual pain that couples had not already tried • Range of negative emotions (frustration, shame, anger) • Difficulty *Assigning Blame to External Factors* • Catalyzed *Selective and High-Quality Network Support* (i.e., to avoid hearing more simple solutions) • Some reduction of pain and discomfort
Insensitivity and Dismissal	• Silence/no response • Asking when couple wants to have children • Greater concern with how husband is doing • Responses of shock and confusion • Clinician not reading medical chart • Clinician using *Disenfranchising Talk* (e.g., contesting pain, clinician saying they can do nothing else since they have tried everything)	• Strong negative emotion (anger, frustration) • Medical mistrust • Avoided, delayed, or withdrawn support from social networks and clinicians (*Shame and Stigma*, *Disclosure Dilemmas*) • Catalyst for *Analytical vs. Arousal Mindset* (husbands do not want to reinforce traumatic medical experiences)

Intervening and Buffering Messages		
Validation	• Passive validation (i.e., legitimizing experience) • *Mediated Sexual Health Information* • Nonverbal presence ("sitting with" or "grieving with") • Empathic responses • Asking thoughtful questions cautiously	• Feeling less broken, less alone, and less like it was their fault • Reduction of pain and discomfort • Catalyst for viewing *Healing as a Long and Non-linear Journey* • Easier *Assigning Blame to External Factors* and *Cultivating Teamwork* • Grieving the messages and events leading to sexual pain • Support-seeking (*Holistic Treatment*, *Selective and High-Quality Network Support*)
Advocacy	• Going above and beyond to find a solution • Husband halting PVI • Education about anatomy and sexual health	• Energizing emotions (empowerment, hope, relief, validation) • Wife feeling like her needs mattered • Reduction in husbands' feelings of powerlessness and frustration • Catalyst for *Cultivating Teamwork*, and *Meaning-Centered Sexual Communication* • Support-seeking (*Holistic Treatment*)
Flexible Sexual Expectations	• "Sex is more than PVI." • "You can take it slow and don't have to have sex on the wedding night." • Debunking romanticized ideals about sex in media and the church • New form of Unrealistic or Romanticized Ideal (e.g., "Sex can still be great!")	• Easier time *(Re)defining Intimacy* and *Finding Opportunity in the Pain* • Less distress on wedding night and throughout early marriage • Increased frustration when PVI is still painful or impossible

Spiritual Truths	• Bible verses/stories (e.g., Job, Jonah, David) • Corrective teachings or interpretations of Bible verses/stories • "Suffering is normal and purposeful." • "A husband should be sacrificial and prioritize his wife's pleasure." • "God is gracious and merciful."	• Reduction of shame related to premarital sexual activity. • Catalyzed *Assigning Blame to External Factors* and *Finding Opportunity in the Pain* • Normalization of *(Emotionally Honest) Prayer* • Range of positive and negative emotions (e.g., anger at church culture)

Note. Typical message content and possible impact on coping and support are not meant to be read in a particular order or linked in a particular way; also, establishing causal relationships between codes is beyond the scope of this qualitative analysis.

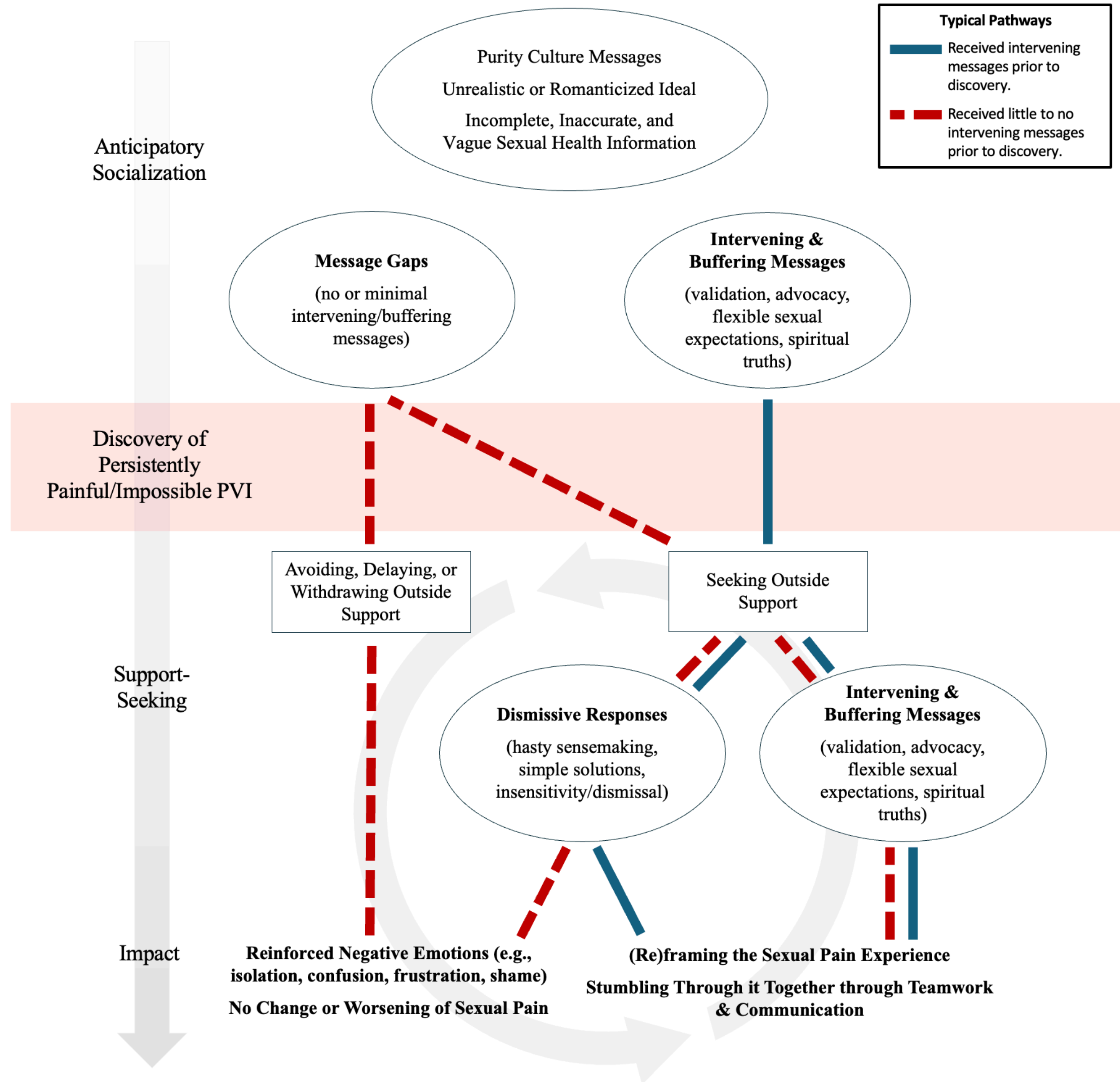
[a]Message sources included friends, family (parents, siblings, extended family members), clinicians (pelvic floor therapists, gynecologists, mental health professionals), Christian media (books by evangelical authors, Christian podcasts, social media influencers), secular media (movies, TV shows, podcasts, books), coworkers, church contexts (pastors, lay church leaders, youth group, sermons), and educational contexts (teachers, professors, lectures).

[b]Quotation marks are added around typical message content illustratively and may not reflect exact messages participants heard.

[c]Analytic codes answering RQ1 and RQ2 are italicized to facilitate easier identification.

Figure 2

Interpersonal Coping Model of Painful Intercourse in Evangelical Couples



Note. This model represents typical pathways that one or both partners followed through the trajectory of discovering and coping with WPP-PVI. The model is not meant to be predictive and does not claim to capture the range of additional messages and factors at play.

4.4 Summarizing Couple-Level Data

Anticipatory socialization about sex (Cooke-Jackson & Rubinsky, 2022; Warner et al., 2020) set the stage for couples' experiences of discovering and coping with WPP-PVI. Spouses often recalled socializing messages they heard during adolescence that conveyed premarital sex is the worst sin one could commit, but marital sex is God's great and beautiful gift. This notion was reinforced throughout their youth, adulthood, and during engagement, via messages from parents, religious/spiritual authorities, mentors, friends, and Christian and secular media. For participants who did not grow up in the evangelical community, these messages typically were received at some point after conversion or during premarital counseling.

Moreover, the morally valenced socializing messages they received often contained incomplete, vague, or inaccurate sexual health information. The difficulty for most couples resided in the expectation they should be able to psychologically and physically "flip a switch" on their wedding night, despite the messages they had internalized and the ways those messages had manifested in their bodies and relationships (Azim et al., 2021; Gregoire et al., 2021). Nonetheless, some spouses recalled positive messages about sex (e.g., "you don't have to have sex on the wedding night" or "sex is much more than PVI") that may have intervened or buffered them from the negative effects of myriad harmful or absent messages.

The findings from interviews with couples revealed two primary pathways that couples typically followed through the trajectory of the WPP-PVI experience. Couples who had *not* received memorable intervening and buffering messages tended to experience greater confusion and frustration when sex was excruciating or impossible on the wedding night, though many couples were not concerned since they had heard that sex would be painful at first during the (Azim et al., 2020; Happel-Parkins et al., 2020; Hintz, 2019a). However, when the pain did not

resolve or sex was still impossible, some spouses did *not* seek support (e.g., social support or medical intervention). This seemed attributable in part to socializing messages (i.e., that sex was supposed to be "great," which reinforced shame and stigma; or the belief that over time the pain would resolve). The typical impact of delayed support was that negative emotions and pain were reinforced, and partners experienced greater difficulty in their sexual communication as they became more isolated from each other (Bergeron & Rosen, 2021; Meana & Binik, 2022; Rancourt et al., 2017; Rosen & Bergeron, 2019).

Couples in which one or both partners received messages that intervened or buffered them from the effects of socialization messages tended to fare better during early marriage. For example, couples who had heard that they did not have to have intercourse on the wedding night articulated less distress (e.g., less crying, confusion, or fear) the first time they could not have (pain-free) PVI. When they realized penetration would be *chronically* painful or impossible, they were disappointed, but were more easily able to reframe their sexual experience. In fact, even when one partner had heard this message and conveyed it to their spouse, this served to buffer the spouse's own experience as well. When these couples sought support and received a positive response from a doctor, friend, or church member that further disrupted the trajectory set forth by anticipatory socialization, such as an accurate diagnosis or a reminder they are not broken, they seemed better able to reframe their sexual pain experience, individually and together. Moreover, though it was not easy, they could stumble through the confusion as a team and communicate more effectively. When these couples received a dismissive response, the intervening messages they had received *prior* to discovering sexual pain seemed to buffer them from the negative effects of these responses.

For couples who had no or minimal intervening messages prior to discovering WPP-PVI, the responses they received when they sought support were crucial. Those who received intervening messages when they sought medical intervention experienced a turning point in their journey, and over time were able to work together as a team. Partners or couples who received a dismissive response experienced reinforced negative emotions and the pain often continued or worsened.

The findings of this study suggest that the *timing* of a memorable message may be critical to couples' coping experience. Couples who had prior knowledge about sexual pain, or who had received intervening messages from parents, media, or mentors countering various socializing messages seemed to be protected from the dismissive responses that inevitably accompanied the sexual pain experience (Azim et al., 2020; Happel-Parkins et al., 2020; Hintz & Venetis, 2019). These messages often served as a talking point for couples as they co-created meaning around the sexual experience, which may have strengthened their relationship in such a way that served as a protective buffer as well.

A few important caveats are worth noting. First, what one partner perceived as an incomplete message (e.g., "you'll figure it out") may have been perceived as an intervening message by the other partner. The pathways are meant to be read based on how an *individual* classifies the particular message, since memorable messages are made sense of retrospectively (Cooke-Jackson & Rubinsky, 2021). Moreover, the cyclical symbol that underlays the bottom half of the Figure 2 symbolizes the notion that the coping process is not fixed or based on statistical pathways. For instance, couples may have delayed or avoided support for years but experienced a point of intervention that catalyzed them to begin stumbling through the process together, which catalyzed support-seeking. Or, they may have heard an intervening message after

several years of marriage which then prompted support-seeking. Additionally, this model is meant to link memorable messages to coping and support and does not portray various other factors showcased in the findings (e.g., emotional-spiritual labor, message co-occurrence, inaccessibility to support, etc.). The conclusion section of this study explores these additional factors with more depth and illustrates them in Figure 3.

5 Findings and Discussion of Clinician Data

The fourth research question (RQ4) asks, (a) "What factors do clinicians believe contribute to women's/couples' ability to cope with, seek support for, and heal from sexual pain?" and (b) "How do clinicians account for religious identity when treating female sexual pain?" I conducted clinician interviews with 11 pelvic floor physical therapists who regularly treat women experiencing persistent pain with PVI, and five mental health professionals who specifically market themselves to women and/or couples with sexual pain and dysfunction (see Table 2). Each clinician also had enough experience working with religious women and/or couples to speak to RQ4b, and several could recall working with evangelical women or couples in particular. Clinicians were eager to share their experiences, and each conveyed a deep devotion to and passion for their work.

About halfway through the data collection, I noticed many clinicians noted that there was no typical patient (e.g., "I don't think there *is* a typical. Every single person is unique. Every nervous system, every brain, every body"). When asked about religion specifically, they described differences as being less about religion than other factors such as moral conservativism, parental upbringing, education level, and societal messages about sex. However, many also saw religion as interrelated with these factors. Because clinicians could not precisely establish the relationship between religion and coping, the analytic codes below reflect findings

from part (a) and part (b) of the fourth research question. Moreover, embedded in almost every clinician interview was frustration and empathy for the women they worked with who were expected to "flip the switch" sexually. The following analytic codes represent the factors clinicians believe contribute to the sexual pain journey for women and their partners, as well as the ways clinicians seek to account for these factors during the treatment process. I weave findings from the first three research questions into the findings here where they provide a more multifaceted picture of the coping experience.

5.1 Factors Influencing Coping, Support-Seeking, and Healing

5.1.1 Systemic and Structural Factors

The first set of factors relate to issues clinicians identified as systemic or structural. In other words, clinicians believed societal discourses, medical systems, and religious structures gave rise to the following factors which ultimately shaped women's or couples' ability to cope, heal, or seek support.

Knowledge. Clinicians identified knowledge about care options and comprehensive sex education (or lack thereof) as primary reasons for women's or couples' support-seeking behaviors. When I asked pelvic floor therapists in particular what they believed prevented women from seeking clinical intervention, they were quick to mention the lack of awareness that physical therapy is an option for sexual pain (e.g., "Well, I think number one, not knowing that it exists [*sniggering*]. Not knowing that there are people out there that specialize in this and can help"). As Priya[6] pointed out:

> Like as long as you know that, okay, if you have back pain, you go to a PT, so that's understood. Everybody knows that. But then, oh, you have painful sex, and you can

[6] Pseudonyms for pelvic floor therapists begin with "P"; pseudonyms for mental health professionals begin with "M."

actually see a doctor for that, that's a question mark. So yes, education is like—lack of education is a big, big factor.

Consequently, pelvic floor therapists and mental health professionals alike enthusiastically described how they seek to provide education and psychoeducation for clients and patients. When I asked Monique how she helps clients reconstruct their views on sex while still practicing their faith, she explained, "So just giving them some education, some psychoeducation on their bodies and what it's made to do. And normalizing that! Normalizing that it's *natural* to have those desires and it's made to have with a partner."

Clinicians also explained how they educated women/couples about the pain experience and provided validation to women that their bodies are doing what they are supposed to do. For example, Paris explained how she discusses with her patients the range of messages they hear about sexuality from family, friends, media, partners, and religion, "and then we talk about how the physical body responds to all of that thought," such as pain with tampon insertion or medical vaginal exams. She then says to patients, "And your body's really smart! It doesn't want that to happen again. So, it is trying everything it can do to *prevent* you from being in pain."

Several pelvic floor therapists explained how they frequently told women that sexual pain is "common, but not normal." Paula, who has worked as a pelvic floor physical therapist for over 30 years, used this phrase when explaining how unique each patient is:

> Paula: While I love all the online community and the support, a lot of patients will go on and be like, [*enthusiastically*] "OH! *That's* what I need! Or *that's* what I need!" And I'm like, it's a blessing and a curse, because you get the support, you can get information, but their story is not your story. So that's where—yeah, I think the commonality is that we'll shake our head when patients start talking. [It's] like, "We can help you because yes, we

have HEARD about the ability not to have pain-free sex or not to have orgasm or not to—these are what we call 'common but not normal.'" And so *there's* the typical symptomology, but then again, every single story is just unique and different.

R: Do you use that phrase, in the office, common but not normal?

Paula: Yes, the whole profession does. Like we all do.

R: Really?

Paula: Yes, we say "This is SO common but not normal," and then society teaches us that it *is* normal. And so [patients are] like, "Really?" And so I'll get women in here who are like, "I know I'm the only one." Because maybe also they *haven't* gone online, or they just haven't even—or they've talked to somebody and they've been dismissed or *whatever*, and they are convinced no one else is suffering. And these are very intimate issues anyway! They're hard to discuss!

Paula's quote illuminates two of the findings from the couple data. First, it affirms the comfort many women felt after being exposed to mediated sexual health information, while highlighting the importance of seeking a professional opinion before making comparisons based on Hasty Sensemaking messages or mediated support group posts. Second, is noteworthy that pelvic floor therapists universally use the phrase "common, but not normal" to describe pelvic floor dysfunction (a quick web browser search for the exact phrase "common but not normal" confirms this assertion, as almost every search result discusses pelvic health; e.g., National Association for Continence, n.d.).

Several couples mentioned that learning how common sexual pain was served as a turning point in their journey. In fact, I had originally created an analytic code from the couple data labeled "not normal, but common," a phrase used explicitly or in some variation by multiple

spouses. It is noteworthy that women who used this phrase (or whose husbands used this phrase) had gone through pelvic floor physical therapy. For couples, however, the emphasis seemed to be placed on the fact that sexual pain was *common*, whereas the emphasis for pelvic floor therapists appeared to be on pain being *not normal*. In fact, some spouses even used the term "normal," to mean common, such as Grace ("So I kind of had a sense of like, this is normal. And also, [*pause*] this is not normal") or Micah ("She's like, 'Oh! I'm not broken.' It's like, no, this is very normal").

Thus, the messages that couples received through their clinicians and other sources seemed to debunk the misconceptions that pain is normal, while simultaneously and perhaps more importantly providing women with a sense of hope. This finding may be useful in informing health messaging about sexual pain to counteract "seemingly contradictory sexual misconceptions, [where] women with [sexual pain] are caught between initially expecting painful sex and subsequently feeling ostracized when pain continues" (Hintz, 2019a, p. 118).

Multiple Layers of Shame and Stigma. Clinicians also believed shame and stigma around sexuality and sexual health prevented women or couples from seeking care in general or seeking specific types of care (e.g., counseling, pelvic floor therapy, dilator use, etc.). When I asked Meredith what she believed kept women from seeking support, she expressed, "Ultimately, shame and guilt. And I think there is some degree of taboo about getting help, especially, you know, outside of their religious organization. Um [*pause*] and I think it's just embarrassing." Clinicians believed that despite a greater openness around sexuality in current Western society compared with the past, the way the American medical system is structured reinforces stigma and shame. As Phoebe pointed out,

> You typically see your PCP or OBGYN for five to seven minutes and they're just doing their thing and then they're gone, so I think that rushed sense of appointments does not help people feel like they can open up. So I think that's a big barrier as well.

Several clinicians theorized that religious patients or clients may experience multiple layers of shame, which may account for why it can take them longer to heal (see Long Journey code below). Paris insightfully articulated how shame and guilt impact all people, but:

> There's this very complicated guilt that even comes out *more* when we're talking about someone who's religious. Because they've had very heavy guilt *before* getting married, and that they were probably interested in sexual activity, but weren't able to participate. So it's like, I feel *guilty*, I feel *shameful* that this is even on my mind, or that I'm interested. Now, this obscure date and time that we've chosen that's like going to flip the switch. Okay, NOW, I signed a piece of paper and NOW that indicates that everything is okay. So from here on out, I'm supposed to go from being completely celibate and having been completely pure, having no thoughts of sexual activity, to now being SOOO interested and wanting to just serve my husband all the time and be there for all of his needs and be a sexual goddess, and I'm supposed to LOVE it. And like, WHAT?! …. So it's like, you're screwed either way. You're never gonna win. You're always guilty about something because you're never doing it right, ever.

This hearkens back to one wife's commentary stated earlier: "The narrative I feel is around those things is like, if you're dating and you do sexual things, you're horrible, and then if you're married and you *don't* do sexual things then you're horrible."

To provide a counter-narrative to shame and stigma, pelvic floor therapists and mental health professionals alike often described how they would validate the difficulty of these

emotions for women who waited to have PVI until marriage. The clinicians in this sample sought to minimize shame by affirming patients' courage to seek treatment, validating their pain, and creating a trusting environment. As Piper noted, "I really want to create a safe space for someone that probably hasn't felt very safe in their body in a long time."

Moreover, to destigmatize and normalize sexual health, clinicians described the value of personifying anatomy and using humor to neutralize perceptions of sexuality, which helped women reconnect with their body. Margaret laughingly explained how in "sensate focus, the activities are like, 'give your genitals pet-friendly names.' Or it's like, you 'do this and that.' … And I'm like, you can always just blame it on the therapist giving you these ridiculous assignments." She noted how this activity created a more lighthearted and less serious sexual environment, which she often saw in religious couples. Notably, only three couples of the 20 interviewed described using humor as a means of coping with WPP-PVI. Another approach to personifying anatomy is reflected in Meredith's quote below:

> We talk about slowly reconnecting and working through and processing some of the emotions they have as well as how their vulva has felt. I mean, if you were to kind of have that narrative like well what do you think it's been like for your vulva given all that's happened? What do you think your vulva is feeling? Why do you think your vulva is feeling that way? And usually they can understand why they got to this point and why their vulva reacts that way. Well, yes, your body shut off because it kept being in pain! And it doesn't want to feel it! So, it did that to protect itself.

It is noteworthy that clinicians in the current sample, whose sessions were typically 45 minutes to one hour long, were afforded time and consistency with patients or clients that may have more easily facilitated reduction of shame.

Moral, Medical, and Media Messages. Clinicians believed that inaccurate, shaming, and disenfranchising messages women had heard about sex and sexual pain came from doctors (especially gynecologists), religious leaders, media, friends, and family and these messages delayed or prevented care for women and couples. Echoing the messages couples described, these were dismissive messages. For example, Meredith shared throughout her interview about a Mormon couple she worked with. Referring to the wife, she said:

> And she had nobody to talk to or ask about it until I think one time she got up the gumption to say something to someone who just kind of looked at her and said, "Yeah, you know, just keep trying, it gets better." But it never got better.

In addition to describing messages that normalized and minimized pain, clinicians also accounted for the impact of multiple sources conveying a similar message in ways that complicate women's sexual wellness. In their interviews, two clinicians referenced Emily Nagoski's (2015) book, *Come as You Are: The Surprising New Science that Will Transform Your Sex Life*. When I shared with Maya some of the mixed messages that evangelical couples hear about sex, she ardently exclaimed, "Oh my God! For anyone, too, especially for women—sorry for yelling." She went on to explain Nagoski's typology of sexual messages:

> There's the media message, the moral message, and the medical message, and the moral message is what you're discussing here, right. If you have sex you're bad or wrong unless you do it in this very specific context in which case [*mocking*, *satirical tone*] "it's supposed to be a gift that you share and mehhh." [*tone shifts back*] But there's also the media message which is like, "Well definitely you must have had like 800 orgasms, and you own a vibrator and you're sexually liberated," right? And then there's the medical message which is, "If you can't have sex how our medical model says, which by the way

> is based on male sexuality, then you're fucked up, broken, and wrong and you have to go to the doctor." It's—oh God, it's just insane man, how much pressure exists on this.

Although most pelvic floor physical therapists found it more difficult to pinpoint perceived differences between religious and non-religious women/couples they work with, mental health professionals relayed some insightful points. Margaret regularly works with Christian women and couples. She noted:

> I think that it might be harder for couples with a faith-based background. And I don't know if it has more to do with the culture of the church or it being such a prized goal that it's a lot of times, in a well-meaning sense, people promote certain actions. And so we go and we hit the finish line and we're like, now there's my prize. Now it should all kind of come about how we desire. So, I think there can be even *more* emotional disappointment, in a way, than I see in couples who *don't* have that background.

The Unrealistic and Romanticized Ideal messages couples heard results in this notion that sex is a "trophy" or "prize," which compounds the disappointment of WPP-PVI. Comparatively, Maya, who regularly works with queer clients experiencing pelvic pain, speculated:

> I think to be queer in general, you have to already overcome social scripting that tells you how sex "should" be. And so, they have a lot less trouble overcoming pelvic pain because they're already sexual outsiders, and they've already had to break down a lot of those scripts.

Research has shown that the identity-laden nature of sexual communication and the impact of heteronormative sexual scripts transcends the bounds of gender and relationship types (e.g., polyamorous, LGBTQ, BDSM; Rubinsky, 2021a). However, revising sexual scripts may be a more complicated task for couples who attach spiritual meaning to PVI (Slowinski, 2001).

Access to Holistic Care. Clinicians identified access to holistic care as a factor affecting women's/couples' ability to seek or maintain support. At a basic level, clinicians perceived finances, health insurance, location, and time as some of many resources that impact whether women and/or their partners seek support. However, they repeatedly mentioned that many women may need multiple forms of treatment to meet their goals. As Pam explained, "You can get the body as ready as we want, but if your mind isn't there, then it's not gonna—all the pieces of the puzzle have to go together." In fact, three pelvic floor therapists used the puzzle analogy when describing the treatment process (Meana & Binik, 2022). Monique noted, "When healing is taking a while, it means that there are blocks somewhere" which could be related to emotions, stress, nutrition, or physical and medical concerns.

The link between the psychological and the physical was so important for clinicians that many clinicians had sought formal (e.g., continuing education) and informal (e.g., personal research) supplemental training or partnerships related to sexual health, mental health, or pain science, to provide more holistic support for their patients or clients. For example, Paula told me a story about a Christian woman who she treated for vaginismus earlier in her career. The woman had progressed through her dilator therapy to the point where she did not have pain. Paula excitedly told her patient that her "homework" was to go have sex with her husband and report back about whether there was discomfort:

> And she looked at me and she goes, "I can't do that homework." And I'm like, "Yeah you can! I'm giving you the green light, like GO DO IT! Aren't you excited?!" And she goes, "Paula, I caaaan't. I know you're telling me I can here [*pointing to pelvis*]. I can't HERE [*pointing to brain*]."

This had prompted Paula to seek additional training and partner with clinicians who offer psychotherapy and sex therapy. Similarly, Piper had done her own research to better support her patients:

> I think that we do our patients a really big disservice when we don't talk about the other factors. It feels very siloed, like, oh, *I* deal with like, the physical manifestations of pain. But then like, I'm going to refer you out to somebody else who you may or may not actually follow up on that referral for mental health services … or any other services. And at the same time, I felt kind of wildly unprepared for how intimate and vulnerable that specific diagnosis can be and how—I just wanted to better support my patients. So I wanted to have a better toolbox to do that.

Three of the mental health professionals I interviewed received training to do sensate focus or somatic therapy that would teach women and couples techniques to change pain loops and reduce feelings of shame. Like many clinicians, Paris noted how "the gold standard" would be having patients do pelvic floor physical therapy and sex therapy at the same time, especially with patients who have religious, cultural, or personal trauma attached to sex:

> I also warn them, there might come a point where we're making some gains, but still it doesn't feel like you're making leaps with your partner. So at that point, you might have to loop in sex therapy just to help you through navigating some of that situation.

Couples' accounts confirm the value of holistic care and clinicians' Advocacy (i.e., going above and beyond to find supportive resources), which functions as a memorable message that facilitates coping and healing. It is noteworthy that Claire referred to the pelvic floor physical therapist she and her husband saw together as "our therapist." Claire was somber throughout most of her interview, but she smiled when she brought up her pelvic floor therapist: "Our

therapist is a Christian as well, and just very, very personable, and really is wanting us to work through the physical *and* the emotional aspects of it." Claire's therapist had also taught them sensate exercises they could practice together. Couples who are unable to seek holistic care may benefit from finding a clinician that provides their most immediate support need but has training or experience in therapies that link the mental and physical aspects of sexual pain (Rancourt et al., 2022).

5.1.2 Individual Factors

Sense of Self. Clinicians described aspects of their patients' or clients' sense of self that may contribute to their ability to cope or experience healing. Some clinicians discussed their observations that women or their partners attributed sexual pain to something inherent in themselves, which is reflected in the couple data from the current study as well as previous research (Ayling & Ussher, 2008; Lovell et al., 2023).

Clinicians speculated how low self-esteem and self-defeating behavior may hinder women in their ability to cope and to manage their pain. Monique reflected:

> Some of them feel less *than* if they're not able to have pain-free sex as well. And thinking that their worth and their value is tied into that as well and that their partner might leave them if it's not something that they can do pain-free.

Pelvic floor therapists also described patterns of self-defeating thought and behavior that could interfere with treatment. Pearl mused:

> Sometimes I think that hang-up for the home exercise could be fear of failure too. … If they attempt [dilating] once, and they're like, "Okay, this isn't so bad" but then they to a specific size that is painful, and then it's kind of like that fear avoidance or, "I failed at this point. Maybe by this point, I should have been further along."

Conversely, Pearl also noted that some of her female patients have a "no pain, no gain" mindset. When I asked whether she thought these patients progressed more quickly in pelvic floor therapy, she chuckled, saying, "Yeah, no I don't think they progress any faster at all. And if anything, maybe even slower too." This finding provides clinical insight into the self-defeating cycles some couples described that may interfere with the therapeutic process.

Clinicians articulated several ways they sought to build women's self-esteem and facilitate treatment. First, they validated women's pain and celebrated small wins with them. For instance, Paulina recalled a female patient whose partner was frustrated when they tried to have sex: "And she was really down about it, and that was part of our therapy session of just being like—I forgot exactly what I said, but like celebrating her wins and giving her tools." Clinicians also described disclosing ingroup identities (e.g., religion, experience with pelvic pain) to empathize with patients or clients when appropriate. For example, Megan has endometriosis and previously experienced vaginismus and vulvodynia. She explained:

> The other thing I say is "Your body *wants* to heal." When you're in pain, I felt very betrayed by my body. I felt like, "Did I do something wrong?" I used to joke around—I don't believe in reincarnation, but I used to say, "I must have been a horrible person in my past life [*chuckles*], I don't know what I did to deserve this," when I was in constant pain. And so I would kind of talk about this. I'm like, "You don't deserve this. No one deserves this."

Megan's experience of pelvic pain had prompted her to become certified in eye movement desensitization and reprocessing (EMDR) therapy from a specialist who specifically works with chronic pain patients. Given the harmful effects of doctors discrediting and contesting women's pain and attributing pain to psychogenic instead of biogenic causes (Hintz, 2022; Hintz &

Venetis, 2019; Kenny, 2004), I probed Megan further to learn how she addressed the pain experience in a therapeutic context when pain is psychogenic at least in part (i.e., in the case of vaginismus). She explained:

> With my clients, I talk a lot about the science behind pain. Because—and I, so we also talk a lot about it's an "and-also" you know, like the dialecticals. And so I say, "You *are* in pain, AND ALSO, we are going to try to work to make your pain better." I don't know that your pain is gonna go away." But I do say—and some people would disagree with me on this, and I'm not 100% sure I'm right. But here's how I feel about this. *I* want to give them hope. *I* think the perception of having hope, of having—is so important for healing. And so I say, "If *I* got better—I don't know where you'll end, but *I* got better. And I was a really complex case. Basically I was a hot mess."

Megan's story provides one example of how a clinician might draw from social learning principles to instill hope (Bartholomew Eldredge et al., 2016). Moreover, the value of Megan's approach is supported by women's accounts of memorable messages that simultaneously validated their pain and provided them with hope that healing is possible.

Overlapping Conditions. Clinicians indicated that complex trauma or overlapping physical or relational health conditions (e.g., endometriosis, complex PTSD, chronic stress and anxiety, relational distrust) could modulate the recovery and treatment process for women with WPP-PVI and their partners. Penny exasperatedly explained,

> Endometriosis is one that I'm like—it's just really common in the patient population that I see and treat and that is *really* hard because it is *so* multifaceted and oftentimes they will have had multiple surgeries and so you're also going against the scar tissue that they have in their abdominal pelvic area. So it's just a very complex hard patient to treat when

> they have endometriosis and PCOS and that kind of uterine fibroid, like all that kind of extra stuff. So I would say *that* is really hard.

Paula explained how chronic stress and anxiety can cause or exacerbate pelvic floor dysfunction, noting how pelvic floor therapy clinics saw a rise in their caseloads during the COVID-19 pandemic. I speculated with her about how the stress of marriage and cohabiting for the first time may affect evangelical couples, and she added in agreement, “Throw in then whatever messaging you’ve received through your religious institution, throw in pandemic, throw in all that.”

Given that more than half of the husbands in the couple data mentioned current or previous pornography addictions or struggles, I asked Margaret whether she thought this was a coincidental or meaningful trend. Like others have noted (Gregoire et al., 2021), Margaret speculated energetically, “I think it is just such a statistical coincidence. But I also have patients where the husband is not affected by that. I’m like [*relieved face; tone changes to excitement*], one less thing to deal with. I’m so excited!”

Although overlapping conditions could lengthen recovery time, paradoxically these conditions often brought women into counseling or pelvic floor therapy in the first place. Many pelvic floor therapists noted this specifically, such as Priya who speculated that the majority of women she treats for painful intercourse originally began therapy for a different issue such as urinary incontinence or postpartum recovery:

> Yeah, unless the patient is like, “Oh, that’s the end of the world” and they are like really in pain and they just—their marital life is affected, or their social life is being affected, they don’t—like I’ve seen that people don’t even acknowledge it, though they have pain. Like even patients, that’s like, “Okay, it’s fine, it’s not a big deal.” But if they have back

> pain or if they have an elbow injury, they would rush to a PT or rush to a ortho. But for this, they usually take a back seat.

As Penny quipped, "It's hard to tell your doctor that sex hurts! It's probably a little easier to tell your doctor that you're leaking pee." The trend of women seeking support for overlapping issues is reflected in the couple data when couples sought support for some aspect of the sexual pain experience when there was a Different Valid Reason. The current sample of clinicians accorded legitimacy to women's sexual pain; this validation alone may provide encouragement for women who are hesitant to seek treatment because of shame or stigma.

Buy-In. Clinicians described women's (and their partners') readiness and willingness to engage in treatment as an important factor that could modulate treatment outcomes. Three clinicians used the term "buy-in," and many echoed this notion. Monique noted that women and couples who want to seek marriage and family therapy "definitely need to be ready to step into that space, because it's hard. You're diving into some deep emotions. It gets really overwhelming!" During the analytic coding process of the couple data, I initially had created and applied analytic codes labeled "Readiness and Willingness" and "Treatment Fatigue." Though there were not enough data to saturate these as final analytic codes, several women described the exhaustion they felt from seeking multiple forms of support for sexual pain, and a few described not feeling emotionally ready to engage in certain forms of support. As Grace commented,

> I was just even telling [my husband] this morning, I'm just like—I just feel like I don't have this in me right now to do all this kind of self-analysis and reflection. And then I just also—it makes me feel more broken.

The importance of buy-in for women and couples seeking treatment hearkens back to the value clinicians saw in suggesting patients pause certain forms of treatment (e.g., pelvic floor therapy)

to seek other forms of treatment (e.g., psychotherapy) that may render care more effective. Couples who feel pressured to quickly fix their difficulties with PVI may benefit from reframing Healing as a Long and Non-Linear Journey and waiting to seek certain forms of support until they feel emotionally and physically ready.

Autonomy and Control. Clinicians believed empowering women to have autonomy and control in their treatment and in their romantic relationships facilitated healing and coping. As Paula expressed, "I always say my goal is for them to become the CEO of their body. I'm an educator for them. I get linked up with them to show them the path towards healing." Clinician interviews suggest that feeling empowered may be a mechanism driving women's identity construction and behavioral change when they hear intervening memorable messages from their clinicians. Paris noted, "I think sometimes the first thing that gets them there is guilt." When I asked what she thought differentiated women and couples who are less distressed by sexual pain from those who have a harder time coping, she reflected:

> So, a female that realizes that some of these goals are her own. So she's not coming to PT only because she wants to be able to have sex so that her partner won't leave her. That's a *different* situation than "*I* want to come to PT so that I can learn more about my body and learn more about sex so that I can have sex that I like. And that I can embark on this journey with my partner together and we can both be getting something out of it." So I think buying in that this is for you too is a *big* piece of it.

Clinicians used communication to empower women by being clear about every step they were taking during treatment. For example, I asked Pam how she responds if a patient does not want to do an internal vaginal exam. She responded,

> Yeah, so I always say, "We don't have to do anything you don't want to do." And I will say, "There are so many other things that we can look at because with pelvic floor, you're looking at the whole body and so if there's tension anywhere else then we want to address that because it's all connected." So I try to make them feel comfortable and know that they're still autonomous in what they want to have done with their body, and then at that point, what I'm thinking is, okay we're addressing the tension here and we're getting them relaxed and they're getting used to just being touched or my touch then maybe eventually we can open up discussion again for doing an internal exam.

Another example of how clinicians sought to promote autonomy is reflected in Megan's comment below:

> And I'm like, "Also, you don't have to agree with me. You don't have to be a feminist." And that's one thing I always tell them. "You can *always* disagree with me," which is interesting because a lot of them are people pleasers. And I say, "I know. I *know* you're a people pleaser. I *know* you're a perfectionist and you've been shoving it down. And here we are, the body keeps the score. So you can just, you can raise your hand. That can be, "Mm-mm. No." Like I want them to feel comfortable and take up *space* and say, "No, I don't like that." And in fact, the first time that they get kind of defensive or angry, which can take *months*—not that I'm trying to make them mad, but you know what I mean—I'll say, "I'm *so glad* you said that. Your anger is so welcome here."

Thus, for Megan and a few other clinicians, providing space for a client's authentic expression of their needs and values was an important part of providing women with a sense of autonomy. Clinicians also described how they reminded women the process of healing was for them and not their partners. As Priscilla noted,

> I have patients who I actually have to have that conversation with where it's like, "This is *not* a duty. This *should* be pleasurable. It's a form of connection. It is not a thing that you should have to do against your will. Like you have autonomy over your body. You can *choose* if you want to engage in sexual activity. Like it's not something that you *have* to do because you're married."

Notably, although Patty shared similar sentiments as the clinicians mentioned above, she also told me about a female patient with vaginismus who was seeking pelvic floor physical therapy solely because mother wanted her to get pregnant, even though the patient and her husband were very happy with non-penetrative sex. This astonished Patty, who said the patient seemed genuinely okay with seeking therapy for this reason. Nonetheless, most clinicians described patients—especially their religious patients—as benefiting from messages that encouraged autonomy and control.

The couple data support clinicians' contention that autonomy and control gained through the treatment process empowered women, which appeared to facilitate their recovery. For example, Brandon recalled how even before his wife began physical therapy, "when she had control over the situation [through initiating sex and being on top], she was able to relax enough that we were able to have intercourse."

5.1.3 Relational Factors

Sexual Communication. Clinicians described the importance of interpersonal communication *during* and *about* sexual activity as important to couples' ability to cope and heal. They described the value of communication about pain and pleasure during sexual activity, as well as communication about the meaning of sex. Both are captured in Paris's quote below:

> And then, communication. I mean, that's a broad term, but like being able to talk to your partner about "This is what I'm physically experiencing. I'm now appreciating that these other pieces might have an impact on it. I'd like to talk to you about that, about that experience. I'd like to talk to you about what sex means to *you* in our relationship." And not just the back-and-forth frustrated part of like, "ugh, this isn't working again, ugh, ugh, ugh." Like, you have to have a discussion outside of that.

Monique explained that when facilitating couples therapy, she asks partners what sex means to each of them and what their goals are, which is often the first time couples have this discussion:

> A lot of times them and their partner haven't had that conversation that those other things outside of intercourse are okay! And their partner still enjoys those, and it's still important, and it's better than not having any of it at all. And a lot of times they don't know that because they haven't been able to communicate and talk with their partner enough about that.

Given the scope of their practice, pelvic floor therapists often referenced blogs or books to female patients who were having difficulty communicating with their partners during sexual activity. A few also recalled providing pelvic health education and guidance to partners directly when partners accompanied women to therapy appointments. These interactions could create a ripple effect, as Phoebe explained:

> I feel like once [male partners] get over [feeling nervous] and we kind of work on it for a little bit, then they start to ease up and then they start to ask their partners questions like, "Oh does this feel okay? Is it too much? Is it not enough?" And what we kind of talk about at the end usually is like, you should be asking these questions during sex, right. Sex isn't just like doing the moves and then you're done. Like sex, you should be

> *communicating* while you're doing this. That way you *know* if your partner is having pain or problems or if they *are* enjoying it. It shouldn't just be this muted act!

However, the complexity and difficulty of sexual communication that many evangelical couples articulated emerged in Meredith's explanation of her work with a Mormon couple experiencing a wife's pain with intercourse:

> Because of the trauma to her body, we've now just started an intervention where—because [her husband's] the stimulus, he's the source of fear and arousal for her body—because after they do breast-chest-genitals off limits and then it's on limits, and she said she still feels discomfort when he touches any part of her vulva. So she asked him like she does medical professionals, "Tell me what you're going to do before doing it." And while it lessened the anxiety it wasn't enough. … There are some people and that may be the case with her that at some point she needs a trauma treatment like an EMDR. But we'll wait and see if the conditioning will change it first. That *said*, in her own therapy, we're working through some of these negative messages and helping her find her voice.

Disempowering messages women receive about sex combined with the perception of threat they may associate with well-meaning partners after repeated attempts at painful intercourse may account for the difficulty the couples in this study had in their communication. Previous research indicates women in heterosexual relationships may avoid affection for fear of it leading to sexual activity and consequently, sexual pain (Rosen & Bergeron, 2019). Moreover, like some of the men in the current study, male partners of women with sexual pain have described feeling like they are "perpetrators" based on how their partners respond to their sexual initiation (Lovell et al., 2023). The clinician findings illuminate the confusing feelings of distrust women in the current study described. This knowledge may be important for couples in their effort to

empathize with each other and their ability to Assign Blame to an External Factor when communicating during and outside of sexual activity.

Partner Support. Communicating about sex does not always imply that a partner is involved in the process of recovery. Clinicians perceived that women whose partners were supportive and involved in the treatment process fared better and were more able to fully recover, since treatment could often plateau without a partner's involvement. As Penny reflected, "to speak to the psychosocial aspect, is if they don't have a loving, respectful, kind partner, I think that's a big part of it too." As Maya elaborated:

> Our culture pisses me off too because women are expected to be the more emotionally intelligent partner and therefore carry the bulk of communication with their heterosexual male partners. So I do notice that they fare better if they're not expected to—*even* if it's never spoken aloud, they're not expected to be the one who's supposed to handle everything and handle the emotional labor and the burden of *knowing how* to say words and communicate them to their partner. If that's more of a shared endeavor it usually bodes well. And I've seen that!

In fact, a few clinicians mentioned times when women they worked with got "stuck," with their progress plateauing or regressing until partners became involved in the treatment process through sex therapy. As Pearl recalled:

> So I had a patient where I was like, "I just don't think you're ready for [pelvic floor therapy]." And so I referred her to a sex therapist, and she had been working with her for a while and then got her husband involved and so they did couples therapy with their sex therapist. And *then* she came back to see me and we *definitely*—we made like a huuuge jump compared to where we were before.

Clinicians noted that most partnered women they work with have supportive partners, although a few could recall stories of women whose partners placed pressure on women's recovery. Paula underscored the advantage that male gender socialization may afford heterosexual male partners:

> So, I will say 90% of men are incredibly supportive when they're in our office. They are here because they want to, by nature, they want to fix it. They want to help. They want to do something. I think that makes them feel better. And I also see minds blown when we start breaking it down, and they're like [*makes awestruck face*]. What! They're not trained in the anatomy, they don't know—they had no idea you have like over 30 muscles attaching on the pelvis. They don't even know the difference between the vagina and the vulva. They don't know any of that! I mean a lot of women don't either, right?! So that is really fun and really empowering because then they do have this new knowledge base, and knowledge is power for the couple too.

It is noteworthy that male partners of women with sexual pain have reported feeling like they are on the outside of medical encounters, despite a desire to be involved in and feel agency in the process (Lovell et al., 2023). This may be attributable in part to the nature of pelvic floor therapy compared with a gynecology exam room. Couples' accounts confirm the value of gaining and applying knowledge learned through pelvic floor therapy as a team. Regardless of whether they sought treatment, wives viewed their husbands' support as instrumental in being able to cope.

5.2 Religious Considerations

Many clinicians described religious factors in relation to the systemic/structural, individual, and relational factors discussed above. The analytic codes below reflect specific ways clinicians believed religious identity contributed to and manifested in the coping and healing process.

Long Journey. Several clinicians speculated that women who wait until marriage to attempt penetration may take longer to heal, especially if they had been socialized in religious contexts. As Maya animatedly expressed,

> One of my things that I rant about or that I notice with people is like you're brought up in a cultural setting—regardless of religion too—that says "Oh you're a slut. You're bad if you have sex. You need to keep your legs crossed, keep it together, it's your fault if you get molested" like whatever it is, then they get married and on their wedding night their pussy's supposed to magically open? That's like not realistic for many people. So I do see that a LOT, a lot.

Moreover, it could take time to unravel years of sexual messaging and multiple layers of shame women may experience. Paula mused, "There are so many layers and even just getting a patient or a woman comfortable talking about that, yeah it's an art in and of itself!" A few pelvic floor therapists mentioned that they have had some religious patients that were more reluctant to use vaginal dilators or wands, since they perceived them as similar to sex toys.

Nonetheless, one clinician (Priscilla) noted that the women she has treated who are "very forward with their religious beliefs" tend to progress *either* very slowly or very quickly:

> It's funny because they're either on one extreme or the other, where it either takes a really long time to get to the bottom of things or progress through treatment because we're having to just unpack really slowly, or just unlearn a lot of things or our treatment sessions sometimes look more like mental health therapy versus physical therapy. And then on the other hand, … I can think of one or two [patients] in particular that are just very like, "Okay, this is what I thought it was because of religion and now that I know that it's not, I want to do everything that I can to unlearn and undo so that I can have a

> good marriage." … Those are the patients who I'm seeing twice a week, who are doing their home exercise programs, who are emailing me and asking if they can send me a video of themselves doing their bridges to see if they're doing it correctly. … They're basically taking everything that I tell them and absorbing it like a sponge.

A few couples indicated that pelvic floor therapists framing sexual pain as a long journey was helpful for them in their coping process. Yet, Priya noted that it is sometimes difficult for her to share this with patients:

> Especially if it is vaginismus or people who have *always* had painful sex—it is a very long process. … Just like if you come to me and I tell you that, "Okay, we have chances of making this better, but it's not going to take you four weeks or six weeks. It might take a few months to even a year." So listening to that, some people are disheartened. Like, "Okay, I still have to live with it for a year." But then people who have been in that position for like 12 years or 20 years, for them, that one year is still a ray of hope.

Indeed, evangelical couples who had gone months or years without knowing that there was hope for healing their sexual pain were ecstatic when they learned about treatment options. Priya's comment again indicates the importance of examining *timing* or *sequence* as a part of the memorable message context, not only for messages that express healing as a long process, but also other messages received throughout the sexual pain trajectory.

Religious Identity Negotiation. Clinicians described different ways they cautiously and respectfully sought to help women and couples negotiate their religious identities, which was a delicate task since patients' or clients' religion could at once be a source of support and pain. As Megan said of her Mormon client, her religion "is a *thread* that flows through her. It's her *support* system." Moreover, Piper reflected on the *mikvah* (or ritual cleansing, see Frydman,

2022) that many of her Orthodox Jewish patients practice, which allows couples to be physically intimate again after two weeks of being apart:

> I think so many of my patients feel really empowered by that and feel really like this is this beautiful thing, but then there are others who feel like, "Wait, so am I unclean? Am I—like, what's *wrong* with me? Why do I need to be cleansed?" You know? So I also see those variations just within religions where it's like, some people feel really honored and really like—that this is this beautiful ritual that they get to participate in and other people feel really oppressed by it.

Mental health professionals described providing space for clients to express grief, anger, and resentment towards God and their religious community and to aid them in "deprogramming" the messages they had heard growing up to the degree they were comfortable with.

The couples I interviewed currently practiced their faith, which was an intentional choice in my recruiting to better understand how religious messages help and hinder coping. During the first few interviews with mental health professionals, I inquired as to whether they thought it possible for women to maintain their faith after contending with so many harmful messages. Maya explained how she helps clients negotiate their identities based on the degree of religious commitment they have communicated. When I probed further about her candid thoughts, she mused, "I do think it's possible to be—to remain in a religious faith tradition or community and have what I would call healthy sex, aka not psychologically damaging sex. But like, good fucking luck." On the other hand, a few other mental health professionals emphasized the hope that their clients' religion provided. Monique, who identifies as a Christian and markets herself to Christian couples, noted how she tries to first "validate and normalize" the grief and confusion many Christian couples are experiencing, and over time may draw on clients' faith as a means of

reframing the experience as hopeful and purposeful. Below, Megan's comment captures the tension some clinicians articulated:

> [T]he biased part of me is like, "Oh my gosh, why are you TELLING people this, to these evangelical religions? This is so awful. I don't agree with it personally." But then I'm like, "But that's not up to me. This is their choice. This is *their* religion. And if their religion or their spirituality is giving them love and hope, if it's helping them get through the day, to me, that's a good thing."

Taken together with the findings from the couple data (e.g., [Emotionally] Honest Prayer and Spiritual Truths), the clinician data indicate the importance of understanding what a patient's or client's faith means to them and what *they* perceive the relationship is between their religion and their sexual pain, before presuming a specific relationship or meaning (Slowinski, 2001).

Perceived (Dis)Similarity. Relatedly, clinicians perceived that patients or clients may feel more comfortable seeking care from a religiously similar health provider. When I asked Maya why women or couples might be hesitant to seek counseling for sexual pain, she noted:

> I think a lot of people, particularly people of a religious faith tradition as well, might be afraid to seek counseling because they are worried that their secular therapist is going to blame their religion or tell them not to do it anymore.

Priscilla noted how the website for the company she works for "states that we are LGBTQ friendly and provide that care. So a lot of those things kind of scream like 'this does not fall in line with my beliefs.'" Two of the clinicians who identified as Christian noted how they might disclose that they too are religious with patients or clients who express religious belief. Monique explained, "It just makes clients [feel] more comfortable and safe that I understand their principles and their morals and things like that."

The couple data confirm clinicians' speculations. Isabella's comment below captures the value that many couples placed on seeking support from religiously similar providers:

> And I ended up finding a Christian therapist that took our insurance, and it just kind of aligned perfectly. And I really wanted somebody who would be understanding for that side of things. And so it was really helpful to be able to find someone who was a professional, but also had that Christian background … I think because I still felt very sensitive about the topic, I didn't really want to talk to somebody who was not a Christian or who might not have that understanding of like—Because I feel like a lot of times, even with my pelvic floor physical therapist, she wasn't a Christian. And I felt like—not that she said anything negatively, but I kind of sensed that when I was telling her some of my background, it was like, "Oh, well, it was because you were a Christian, therefore, that causes it." … I mean, there's truth to that, but there's also the fact that I didn't want to blame it on my faith, you know what I mean? Because there's definitely flaws in my upbringing and things like that, but I didn't want anyone to get the wrong idea. And I think sometimes it is this balance of, yes, it was partially because of that, but then I also didn't want people to think, [*disparagingly*] "Oh, it's these Christians. They're always messing up their—" You know.

Like Isabella, almost every spouse or couple who sought counseling or psychotherapy indicated they specifically set out to find Christian counselors or therapists. Moreover, couples frequently mentioned unprompted whether their counselor, pelvic floor therapist, occupational therapist, or gynecologist was a Christian when asked about the support they had sought.

Current Partner as Only Reference Point. Finally, clinicians described the difficulty of treating patients or clients whose only sexual reference point was their current partner or

pornography. As Meredith mentioned, "I think the only kind of difference, big difference that I see is maybe the lack of other partners for comparison." From a clinical standpoint, the lack of experience and sexual exploration usually correlated with higher degrees of shame around masturbation and sexual exploration, which clinicians believed could be important parts of the healing process.

In the context of pelvic floor therapy, a few clinicians noted how they use prior sexual function—either in previous relationships or in the same relationship if sex was pain-free at first—to assess current function and develop a tailored treatment plan. As Piper explained,

> I tell a lot of my patients, especially if they've had an injury or they at one point didn't have pain with sex and now they *do*, a lot of what I say to them is, "This is a period where we get to kind of explore your body and find out what's on the menu again and almost like be a teenager and really explore what turns you on and all those things." But if someone doesn't have a background for what it was to be a teenager and to explore those things, that's *tough*. So much of what I do as a clinician is we base a lot of our prognosis on what your prior level of function was. … When there is no prior level, it can be—It's a totally different starting point.

Indeed, when PVI was possible but painful, the couples in the current study did not have a reference point, which was why some did not seek supportive resources for many months or years into marriage. However, it is noteworthy that several couples who had delayed PVI until marriage had been sexually intimate with each other in other ways. For instance, several women implied or explicitly mentioned engaging in oral sex with their partner before marriage. One wife stated part of why she was not concerned about sex going into marriage was because she knew she could orgasm. Also, many women experienced shame related to their premarital sexual

activity. It is possible women with sexual pain do have some degree of sexual function that can be assessed, but they may feel too ashamed to share with their clinician.

6 Implications, Limitations, & Future Directions

For couples who save penile-vaginal intercourse (PVI) for marriage, chronic sexual pain may be a "biopsychosocial puzzle" (Meana & Binik, 2022) they never expected they would have to solve (Azim et al., 2020; Gregoire et al., 2021; Happel-Parkins et al., 2020). This multilevel study sought to gain an in-depth understanding of how evangelical couples cope with women's persistent or chronic pain with PVI during the early days of marriage by exploring the messages and resources that facilitate or hinder coping. In this chapter, I describe this study's potential theoretical and practical implications, strengths and limitations, and future directions.

6.1 Potential Implications

6.1.1 Theoretical Implications

Social Context of Sexual Pain. The findings of this study extend interdisciplinary knowledge on communication and coping across multiple bodies of literature. First, extant scholarship on female sexual pain has called for greater attention to 1) male partners' experiences of coping and support (Lovell et al., 2023; Sadownik et al., 2017), 2) qualitative research on the perspective of partners within the same couple (Lovell et al., 2023), and 3) the social context of pain (i.e., cultural mores, medical invalidation; Meana & Binik, 2022; Rosen, Rancourt, et al., 2014; Rosen & Bergeron, 2019). By investigating how couples in a particular religious community cope with sexual pain by gathering qualitative from three different data points—wives, husbands, and clinicians—this study illuminates a more nuanced picture of the biopsychosocial experience of painful sex.

Previous research has explored the link between religion-induced sexual guilt and pain with intercourse in unmarried women (Azim et al., 2021), however few studies have examined the experiences of women who waited to have intercourse until marriage (Azim et al., 2020;

Happel-Parkins et al., 2020). By interviewing couples in which all women and most men had never attempted PVI prior to marriage and strongly valued abstinence before marriage, this study reveals how religious identity both aids in and complicates the coping and treatment process at the biological, psychological, and social levels. On one hand, couples found comfort and strength through prayer, recalling spiritual truths, and seeking emotional support from trusted network members (e.g., friends, pastors, small groups). Moreover, redefining sexual intimacy to include non-penetrative activities was critical for couples when sex was impossible or excruciatingly painful for women, mirroring previous findings (Bairstow et al., 2018; Hintz, 2019b). However, for some women, accepting that activities like oral sex or manual stimulation "counted" as sex created internal conflict, as they were caught between desperately wanting these activities to count and renegotiating what it would mean for their religious identities if they *did* count. If, for example, manual stimulation counts as sex, then does that mean women who engaged in manual stimulation before marriage had premarital sex?

Beyond the internalization of sexual guilt and shame that may contribute to painful intercourse for religious women (Azim et al., 2021), even women who seemed to experience less shame related to their bodies and sexuality still placed value on delaying sex until marriage (whether PVI, oral sex, or any sexual activity beyond kissing). All couples had "made it" to marriage without having PVI, and some had avoided crossing their sexual boundaries, largely because women had enforced boundaries, in line with the notion (in and outside of religious contexts) that women are expected to be the sexual gatekeepers (Estrada, 2022; Leonard et al., 2022; Leonard Hodges & Bevan, 2023). Yet, women had effectively trained their bodies to repeatedly repress their arousal response during sexual activity. Couples believed that this cycle, combined with the pressure and expectation they felt to have PVI on the wedding night or during

the honeymoon, contributed to women's pain (Estrada, 2022). Even couples who intentionally chose to *not* try PVI on the wedding night spent weeks and months trying to "figure it out" or push through the pain, which also reinforced the pain response for women and reduced the arousal response for men who were trying not to hurt their partners (Lovell et al., 2023).

Research on chronic (sexual) pain reveals how disenfranchising talk such as "It's all in your head" (Hintz & Venetis, 2019; Hintz, 2022) reflects medical invalidation in the form of psychogenic attributions, which strips patients of coping resources and delays care. Many wives in the current data set heard these messages repeatedly in medical contexts, primarily during gynecologic exams. However, almost every participant identified and emphasized religious messaging as a key factor contributing to the psychological aspect of sexual pain and attested to the importance of seeking treatment that bridges the mind and body, whether or not they actually sought such treatment.

Consequently, the findings reveal the need for researchers to continue examining the interplay between the biogenic and psychogenic factors that influence the sexual pain experience. Researchers have engaged in a long-standing debate about whether female sexual pain should be classified and treated as a sexual dysfunction or a chronic pain condition, as these approaches yield differing outcomes for women and their partners (Hintz & Venetis, 2019; Meana & Binik, 2022). The current study reveals how couples who attended to both dimensions of sexual pain through holistic treatment (i.e., treatment addressing physiological *and* psychosocial factors) experienced the greatest benefits in their romantic relationships. Women felt relief when their physical pain experience was validated and treated (see Azim et al., 2020; Hintz & Venetis, 2019; Kenny, 2004), yet most expressed that they needed aid for the mental

and emotional dimensions of sexual pain that reinforced patterns of avoidance and worsened pain symptomology. Clinicians in the current study confirmed the value of a holistic approach.

Theory of Memorable Messages. Scholars publishing in multiple areas of relationship research have voiced the need for greater attention to the identity-laden nature of romantic relationships (Ogolsky, 2023; Shrout et al., 2024), especially in the context of coping and support (Randall et al., 2023) and sexual communication (Rubinsky, 2021a; Rubinsky & Cooke-Jackson, 2018). The Theory of Memorable Messages (ToMM; Cooke-Jackson & Rubinsky, 2021, 2022) is a novel communication framework through which to explore the sociocultural context of romantic relationships and sexual intimacy and build on extant coping and support scholarship. Memorable messages received throughout the lifespan can serve as sensemaking devices that may offer individuals hope through difficult times (Lucas & Buzzanell, 2012; Merolla et al., 2017) but can also be cause for difficulty in health and coping contexts (Basinger et al., 2023; Gunning, 2023; Gunning & Taladay-Carter, 2023). Much of the memorable message research on sexual intimacy and sexual health documents the content and impact of memorable messages in people's sexual identity development (Rubinsky & Cooke-Jackson, 2018; Gunning et al., 2020). This study uses the context of painful intercourse in evangelical marriage as an opportunity to explore messages that may help or hinder coping around a stigmatized health issue. The model advanced in Figure 2 illuminates the ways that memorable messages may operate in the coping process for religious couples experiencing sexual pain or difficulty.

ToMM posits that memorable messages about intimate health function as a means of anticipatory socialization (Cooke-Jackson & Rubinsky, 2022), telling people what to expect and how to feel based on group norms or values. Many of the sexuality socialization messages this study documents mirror previous findings that sexual health messages are often incomprehensive

during adolescence (Coffelt, 2021a; Holman & Koenig Kellas, 2015, 2018), grounded in purity discourses (Manning, 2013, 2015), emphasize the “dangers” of sex (Manning, 2017; Rubinsky & Cooke-Jackson, 2018), and uphold unrealistic and hegemonic sexual norms pervasive in patriarchal societies and reinforced through media (Cooke-Jackson et al., 2021; Hintz, 2019a). The findings in the current study extend previous sexual communication research by revealing how messages that socialize evangelical couples in preparation for marital sex are decoded by couples: their understanding is that sex (especially PVI) shifts from being “the worst sin” if it occurs in a premarital context to the “best gift” upon completing the marriage ceremony.

Researchers have documented the effects and perceptions around this shift in Orthodox Jewish women (Frydman, 2022) and how evangelical religious leaders aim to facilitate the shift from the “sexual battleground” to the “sexual playground” during premarital education (Irby, 2019; Leonard Hodges & LaBelle, 2024). For some spouses, hearing that sex was meant to be beautiful, sacred, and fun served as a disruptive message that counteracted the negative messages they had received about sex in their youth. For far more spouses, the attempts of evangelical pastors, speakers, and authors to provide a redemptive and corrective lens (i.e., “sex is good”; “sex should bring pleasure to both partners, not just men”) to previous evangelical purity messaging became *part of* their anticipatory socialization, furthering the disappointment and confusion they felt when sex was painful or impossible. A few women noted that if they had heard this corrective message when they were younger it may have been positively formative, but that it was likely too late to shift the narrative. This speculation is confirmed across couples’ accounts of disappointment upon discovering WPP-PVI, as well as Fiona’s account of spending significant time and money on pelvic floor therapy and talk therapy to no avail.

Nonetheless, the findings indicate messages that both 1) emphasize the beauty of sex and also 2) reduce the pressure to have PVI on the wedding night may serve as intervening messages that buffer participants from confusion, facilitate their ability to define and redefine sexual intimacy, and reduce the shame that would otherwise prevent support-seeking. Thus, while intervening messages prior to marriage may not have been internalized such that women's pain was reduced (Azim et al., 2021), the timing of the message was critical for facilitating greater ease of reframing the sexual pain experience.

ToMM asserts the *impact* of memorable messages is more consequential than their content, form, or modality. Scholars have called for greater attention to the function and context of memorable messages (Cooke-Jackson & Rubinsky, 2021, 2022), which may help researchers better understand their impact. The findings of this study suggest that the *timing* of a message is an important aspect of the message context that would benefit from further exploration. Couples appreciated the messages they heard from pastors and Christian speakers that emphasized sex as positive and pleasurable, and many found these messages helpful in college or during premarital counseling. However, upon discovering WPP-PVI, these messages were reinterpreted as unhelpful. Cooke-Jackson and Rubinsky (2021) argue that memorable messages are made sense of retrospectively, and messages which were helpful at one time may be less helpful at other points in the lifespan. This research supports their contention.

Another aspect of the message context that may help scholars understand how MMs function in a ToMM framework is *message co-occurrence* or *message reinforcement*. Couples experienced greater distress when negative messages were reinforced from multiple sources, such as the prioritization of PVI in media *and* amongst friends *and* in the evangelical church, or dismissive responses to sexual pain from friends, family, *and* doctors. It is also possible that

intervening messages must be reinforced to be effective. For example, couples who described high degrees of teamwork and meaning-centered sexual communication seemed to have multiple sources of support that were reinforcing messages of validation, advocacy, and flexible sexual expectations. In other words, participants who heard empowering messages from a single source generally did describe positive benefits, however couples who heard these messages from a clinician, close friends, *and* each other (or heard the same message reinforced from one or more source) often described a greater ability to cope than those who only had one source of support conveying these messages.

Tucker and Hintz (2024) found that cisgender women who had difficulty orgasming sought therapy as a strategy for managing the stigma they felt due to dominant sexual discourses, and that over time therapy "transformed the status quo by changing the taken-for-granted beliefs invoked by the orgasmic imperative" (p. 14). It may be that messages become memorable or gain traction in a person's identity development and behavior formation when they are reinforced in therapeutic contexts. Examining memorable messages occurring in the context of therapeutic intervention may be a worthy avenue of attention for interdisciplinary scholars interested in developing interventions that capitalize on the use of memorable messages.

Multilevel Perspective on Dyadic Coping and Support. Data analyzed at the individual-level of each data point confirm and extend previous research on coping and support in the context of sexual pain (Ayling & Ussher, 2008; Happel-Parkins et al., 2020; Hintz, 2019a, 2019b, 2023; Lovell et al., 2023; Sadownik et al., 2017) and other sensitive health issues (Gunning, 2023; Gunning & Taladay-Carter, 2023; Horstman et al., 2023; Voorhees et al., 2023). However, a key contribution of the current study is the use of crystallization (Ellingson, 2009, 2014; Tracy, 2010), illuminating the phenomenon of coping with painful intercourse from a

variety of angles. Interviewing wives, husbands, and clinicians deepens scholarly understanding, as qualitative studies showcasing multiple perspectives are limited (Culley et al., 2013; Kenny, 2004; cf. Lovell et al., 2023).

Through flexible coding, I was able to conduct a more systematic analysis of dyadic data, which has been historically difficult and methodologically ambiguous, especially when conducting separate interviews with partners of the same couple (Collaço et al., 2021; Manning & Kunkel, 2015). Moreover, although clinicians are not ecologically linked to couples who participated (i.e., clinicians were not required to work with the couples in this sample), the fact that clinicians regularly worked with women and/or couples affected by sexual pain provides greater nuance and depth to the interplay between various social ecological systems that influence the biopsychosocial experience of sexual pain (Bronfenbrenner, 1977).

Data analyzed within couples (i.e., analyzing a wife's experience in relation to her husband's) indicated that couples occasionally held differing perceptions about the same memorable message. In other words, for one partner a message that was perceived as dismissive or hindering to the coping process may have been perceived as positive or intervening for the other partner. Memorable message research has found that the same message from two different message senders may be perceived differently (Voorhees et al., 2023), or that the same type of message may be perceived positively by certain participants and negatively by others (Horstman et al., 2023). Research has found that partners who process difficult events in similar ways may have less distress (Holman & Horstman, 2019) and that differing perceptions of an illness impact communication outcomes and treatment outcomes (Checton et al., 2012). Future research should consider how and whether similar or different perceptions of the same memorable message impact couples' *joint* identity development (i.e., as a couple) and behavior. Moreover, couples'

accounts revealed that an intervening memorable message received by one spouse may impact their action in such a way that their action (verbal or nonverbal) becomes an intervening message for the other spouse. Broadly, examining if and how memorable messages impact couples' *relational* identity formation and assessment (Hecht et al., 2005) may shed greater light on the function of memorable messages as well as dyadic coping.

Moreover, the clinician data clarifies and adds nuance to the couple-level findings, and consequently the coping and support literature. For example, when analyzing couple interviews, I began to sense that a wife having autonomy over her body and control during intercourse was an important part of the healing process. The clinician data revealed that women's feeling of *empowerment*—often first realized in pelvic floor therapy—may be the mechanism driving the positive impact of intervening messages (i.e., Validation, Advocacy, Flexible Sexual Expectations). Studies have examined how intervening or disruptive messages can function to enfranchise people with invisible illnesses (Gunning, 2023; Gunning & Taladay-Carter, 2023). Scholars should continue exploring the mechanisms that link memorable messages to identity formation and behavior.

The clinician data also revealed how chronic stress frequently presents in WPP-PVI, which may reduce the effectiveness of treatment. Many women voiced concurrent anxiety or depression. Also, every couple in the current data set explicitly or implicitly noted they began cohabiting when they got married, and many couples were in the process of graduating from college, switching jobs, or moving to a different city or state when they got married. Studies on stress and coping consistently suggest that social support (Jones & Koerner, 2015), relational maintenance (Afifi et al., 2016), and communal orientation (Afifi et al., 2016; cf. Afifi, Basinger, et al., 2020) can buffer the effects of stress on romantic relationships. Yet, relational change and

other transitions can set the stage for relational turbulence (Solomon et al., 2016). Couples who discover sexual pain while cohabiting for the first time may be under a tremendous amount of stress, which may be compounded by the perception of threat that is reinforced for a female partner if the couple continues to attempt PVI to "figure it out" and achieve the "coital imperative" (McPhillips et al., 2001). The findings of this study suggest that the engagement period may be a critical point of intervention for couples who abstained from PVI and other forms of sexual activity before marriage.

6.1.2 Practical Implications

Though the goal of this study is to provide a nuanced picture of how evangelical couples cope with WPP-PVI and precludes generalizable inferences, several possible implications exist for evangelical couples, practitioners, and pastors or lay church leaders. First, the findings may provide a sense of relief or hope to marital partners who have only experienced painful or impossible penetration for months or years into marriage. Couples in this study sought multiple forms of treatment, including pelvic floor therapy, psychotherapy or counseling, and mind-body programs designed specifically for women with vaginismus. Several women in the study were able to have completely or almost entirely pain-free intercourse with the right support. Moreover, couples were able to reframe the sexual pain experience to include non-penetrative acts and attribute the pain to something external to either partner (i.e., church messaging or disability). Couples who reframed sexual pain as an opportunity to grow in their communication and be a blessing to others felt encouraged, which they often attributed to spiritual truths they had learned through the Bible or trusted spiritual authorities.

The findings also provide reason for women who have abstained from premarital sex to consider seeking clinical intervention early if they wish to have PVI in their current or future

relationships. Most couples regretted not seeking help sooner, assuming the pain would resolve, and that they would "figure it out." However, these assumptions often intensified pain symptomology and created relational discord. Women who feel uncomfortable with seeking pelvic floor therapy or counseling prior to marriage (or during marriage) may find comfort knowing that the clinicians interviewed in this study were deeply passionate about helping women and couples find answers and meet their goals. Women or couples who have had negative medical encounters may benefit from continuing to search for a gynecologist who will validate them, listen to them, and refer them to the appropriate form of treatment. Given how important it was for both partners when women felt physically and psychologically safe, couples should partner together to continue looking for clinicians they feel comfortable with.

An estimated 90% of Americans lack average health literacy levels (Aldoory, 2017), so it is important for women with sexual pain to be cautious when reading about others' experiences on social media or comparing their experience to other women or couples they disclose their pain with. Comparison may not only lead to misdiagnoses but may also breed despair which can impede recovery. However, given that many misdiagnoses come from gynecologists and doctors (see Hintz & Venetis, 2019), women should also adhere to the advice of participants who advised couples going through similar experiences to keep searching for caring professionals who can provide answers, if they have been misdiagnosed or invalidated.

The findings also suggest the need for greater support for men partnered with women who have persistent sexual pain (Lovell et al., 2023; Sadownik et al., 2017). Most men in the current study had not sought support socially or professionally for their emotional experience of WPP-PVI, either because they wanted to honor their wives' privacy or felt like there was no one who would understand. A growing number of formal (e.g., facilitated by an organization) and

informal (e.g., Facebook groups) support groups exist for women with chronic genito-pelvic pain conditions like vaginismus, vulvodynia, and endometriosis, however support options available to male partners are much rarer. Practitioners, churches, and members of the public should consider how they may facilitate official or grassroots meetings in which men can explore and process their own emotional experiences.

All couples in the current study had access to health insurance but noted that it was difficult to find pelvic floor therapists or Christian counselors covered by their insurance. Evangelical couples who are unable to seek one or more forms of support that they desire they might benefit from finding a clinician who provides their most immediate support need but has training or experience in therapies that link the mental and physical, such as a psychotherapist who specializes in chronic pain or sensate focus, or a pelvic floor therapist who has some form of mental health training.

The findings also may benefit practitioners working with evangelical heterosexual couples experiencing sexual pain, or more generally heterosexual religious couples who waited to have PVI until marriage. This study may provide context for the emotional experience women and couples are walking through as they contend with the conflicting messages they received about sex while trying to maintain their religious identity. Moreover, counselors and sex therapists working with couples may wish to use the findings from the Emotional-Spiritual Labor or Analytical vs. Arousal Mindset codes as a way of facilitating empathy. In the current data set, husbands and wives overall deeply cared for one another and did not want to hurt each other emotionally (i.e., through rejecting a partner's advances) or physically (i.e., husbands not wanting to cause wives pain), and both partners were often hyper-attuned during sexual episodes. Empathy and teamwork have documented positive effects for both partners when a woman

experiences sexual pain (Rancourt et al., 2022), but may be especially important for a male partner whose primary source of support is his female partner.

The number of women who explicitly expressed they did not have previous sexual trauma reinforces the need for clinicians to avoid making this assumption when working with patients or clients who have sexual pain (Hintz & Venetis, 2019). One strategy for clinicians who may need to know this information (i.e., to ensure appropriate treatment) might involve asking the question later in a series of intake questions or within the medical interview script. At the same time, many women did describe how they needed intervention at the mental/emotional level to meet their medical and relational goals. Clinicians who suspect a primarily psychogenic cause should be sure to validate women's pain experience throughout the course of assessment and treatment.

Finally, the findings of this study implicate recommendations for evangelical church communities and perhaps conservative religious communities more broadly. The findings of this study and previous research (Leonard Hodges & LaBelle, 2024) indicate that pastors or lay church leaders facilitating premarital counseling or education may save discussions of "sex" until one of the final meetings, 1) to broach the subject after trust and rapport have been built between the counselor/teacher and couple, or 2) to avoid creating temptation in couples to have premarital sex. Given the long journey that may be ahead for couples experiencing a wife's sexual pain, premarital educators should consider revising their curriculum to include more explicit sexual health education material beyond the spiritual meaning of sex. This may be the first or only time a couple learns about specific sexual difficulties they may encounter. Many couples felt prepared for marriage emotionally and spiritually but were completely caught off guard by how difficult sex would be. Pastors might consider having a Christian sex therapist or pelvic floor therapist

give a presentation as part of the curriculum or gain training themselves (Leonard Hodges & LaBelle, 2024), so that they avoid outsourcing explicit discussions to marriage advice books or gynecologists, as these tended to be two of the most prominent sources of unhelpful messages for couples. A final suggestion for church communities is to consider how they might offer financial support to couples who desire but cannot afford clinical intervention.

6.2 Strengths, Limitations, and Future Directions

This study is one of only a few to my knowledge to interview both partners in couples experiencing women's persistent pain with intercourse (e.g., Culley et al., 2013). Moreover, the study addresses the need for empirical research on couples who waited until marriage to have intercourse (Azim et al., 2021). Women were not required to have a pain diagnosis, which was important for capturing a greater variety of experiences (Lovell et al., 2023). Moreover, Zoom interviews afforded me the ability to recruit nationally, which resulted in interviews with couples and clinicians living in multiple regions of the United States. This increased the ecological validity of claims made in reference to evangelical Christianity, which transcended geographical boundaries. However, several limitations of this study exist, creating ample opportunity for future research on sexual pain and coping.

First, despite my best efforts to recruit a diverse sample of couples, couples were mainly white, highly educated, and satisfied in their relationships, and the majority of couples made above the national median income. Interpersonal research continues to suffer from a lack of representativeness (Afifi & Cornejo, 2020). Although the goal was not to generalize results, it will be important for future studies to center the voices of low-income couples (Williamson et al., 2020), who may have fewer relational and financial coping resources, and BIPOC couples (Dogan et al., 2023), who may be disproportionately affected by sexual pain yet constrained by

cultural stereotypes and disenfranchising talk that impede care. Moreover, most of the couples in this study got married during the height of the COVID-19 pandemic. Given the link between stress and sexual pain, findings related to the stress couples experienced during early marriage should be taken with caution, as couples were under amplified COVID-related stress.

I strategically avoided the term “evangelical” during the bulk of my recruitment but rather used criteria in the interest survey (Appendix I) that allowed me to recruit Christians who held to tenets of evangelical Christianity (Russell et al., 2010) but were more diverse in their degree of religious conservatism. However, sexual pain affects religious and non-religious women alike (Azim et al., 2021). Future studies should examine how couples practicing other religions that promote premarital abstinence such as Catholicism, Mormonism, Islam, or Orthodox Judaism cope in their relationships. Quantitative researchers may wish to conduct cross-religious comparisons based on variables of interest such as coping strategy or sexual communication. Also, given that sexual communication research tends to draw participants who may be more open about sexual topics in general and that both partners were required to participate, open-ended surveys or analysis of Reddit forums may be valuable for gaining more honest disclosure. Future research could also examine retrospective accounts of couples who divorced (Lovell et al., 2023) or who no longer practice (evangelical) Christianity.

Furthermore, I was unable to recruit gynecologists despite my efforts. It may be that time constraints prevented gynecologist participation, or it is possible using the term “gynecologist” in my recruitment criteria (see Appendix J) may have excluded clinicians who could have qualified. Many couples mentioned that midwives, nurse practitioners, or other doctors had provided them gynecologic care. Future studies should expand recruiting efforts, such as partnering with health organizations to gain easier access to a wider variety of clinicians.

I specifically recruited female practitioners, as they are more likely to work with and support women experiencing sexual pain (Leusink et al., 2018, 2019; Willer, 2014), as well as their partners if they seek couples' therapy or if partners accompany women to pelvic floor appointments. However, a few husbands shared that they regularly sought talk therapy with male therapists. Future studies should not have gender in the exclusion criteria to capture a wider variety of perceptions about how men cope with a partner's sexual pain.

The current study was also guided by the assumptions of qualitative, interpretive research, and used ToMM as a sensitizing device throughout data collection and analysis. Moreover, the data were cross-sectional, accounts were retrospective, and upholding participants' confidentiality meant that I had to be selective in the findings I chose to represent and how I represented them (e.g., I did not share quotes from both participants about the same topic). The theorized links in Figure 2 between memorable messages and various support behaviors and coping strategies should be interpreted with caution.

Given the prominence of constructs such as disclosure, privacy, and stress in couples' accounts, researchers may also wish to use frameworks such as the Disclosure Decision-Making Model (Greene, 2009), Communication Privacy Management Theory (Petronio, 2002), Relational Turbulence Theory (Solomon et al., 2016), Communication Theory of Resilience (Buzzanell, 2010), or the extended Theoretical Model of Communal Coping (Afifi, Basinger, et al., 2020) to explore how religious couples cope with sexual pain or how memorable messages function. Critical theories such as the Theory of Communicative (Dis)enfranchisement (Hintz & Scharp, 2024) and Stigma Management Communication Theory (Tucker & Hintz, 2024) may be able to further illuminate the way that religious discourses constrain women's ability to cope with sexual pain. In fact, scholars using these theories may even wish to call into question the

notion of "coping" or "healing," as these terms may reify ideologies that uphold PVI as the truest form of sex (Hintz, 2019a; Tucker & Hintz, 2024;).

6.3 Conclusions

The findings of the current study capture a more in-depth, nuanced portrait of how evangelical couples cope with the biopsychosocial experience of painful intercourse. Figure 3 presents a framework that illustrates the crystallized data, guided by a social ecological systems lens (Bronfenbrenner, 1977). In doing so, this study takes up Randall et al.'s (2023) call to examine the interplay of various aspects of identity (e.g., gender, religion, health) in romantic couples' process of coping with stress. The model depicts factors at the *individual*, *relational*, and *systemic/sociocultural* levels that participants (i.e., wives, husbands, and clinicians) in the current multilevel study described.

At the *individual* level, each spouse brings factors into the sexual pain experience such as: their sense of self (e.g., gender, self-esteem, sense of autonomy or control); beliefs and knowledge about sex and sexual pain; prevailing emotions (e.g., shame, powerlessness); overlapping conditions such as concurrent health diagnoses; readiness to seek outside support; sexual history including past sexual abuse, sexual trauma, and sexual activity with each other or others prior to marriage; and religious identity (i.e., how they see themselves as a Christian and how they enact their faith; see Leonard et al., 2022).

At the *relational* level, spouses communicate with each other to make sense of and cope with sexual pain. Couples who 1) reframed the sexual pain experience, 2) communicated *about* sex and *during* sex, 3) felt supported by each other, and 4) engaged in teamwork appeared to be the least distressed by the sexual pain experience or at minimum, had the communicative resources to work through the difficulties that arose. Sometimes coping was facilitated when

partners communicated memorable messages to each other (some of which they had previously received from sources at the systemic or sociocultural levels). Couples engaged in emotional-spiritual labor to care for each other, which either reinforced closeness or reinforced patterns of avoidance (e.g., concealing pain or negative emotion).

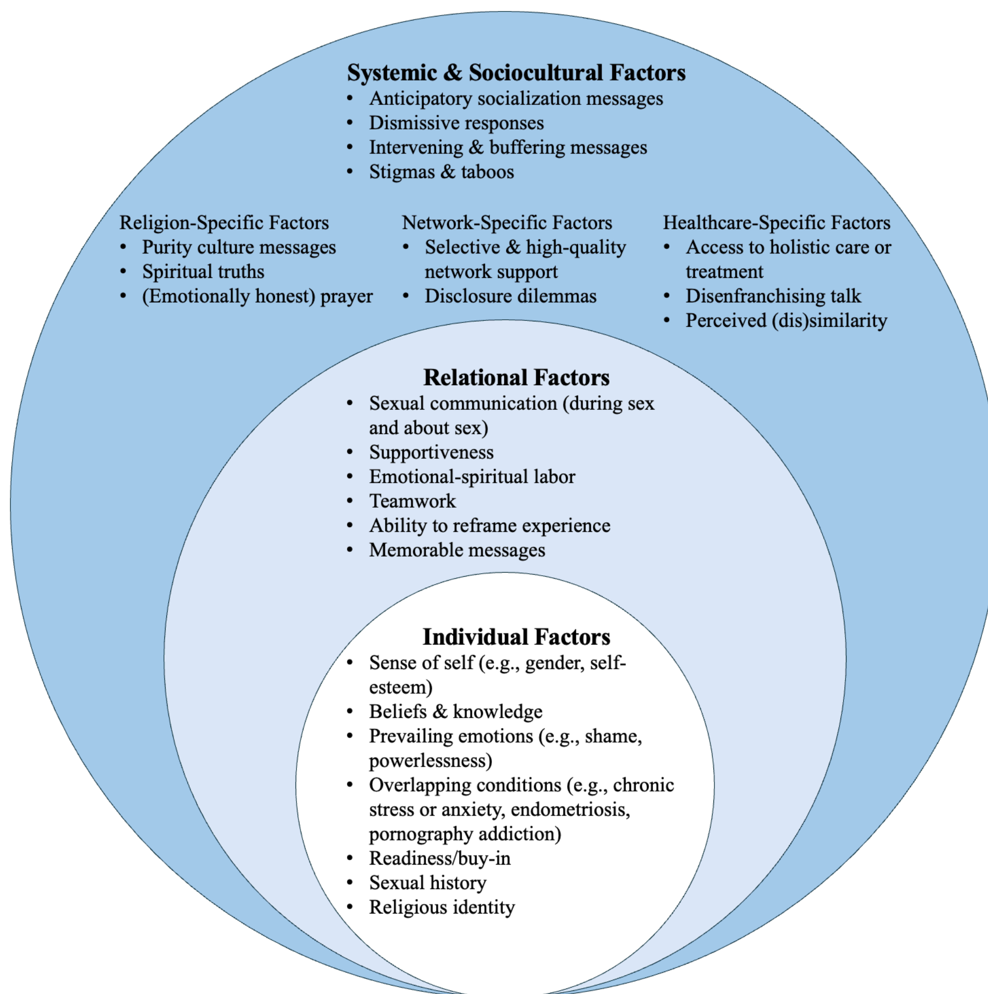
At the *systemic and sociocultural* levels, the findings illuminate ways in which factors across multiple message sources such as Christian and secular media, churches, social networks, and healthcare providers both reinforced and challenged narratives that impacted the coping process at the relational and individual levels. Memorable messages, stigmas, and taboos around sex and sexual pain transcended communication context, though several factors, positive and negative, were specific to religion, social networks, or healthcare. Couples individually or jointly received memorable messages throughout their lifespan and during early marriage that inhibited or empowered them (sometimes both, e.g., "Sex is God's gift") in the coping process. Couples in which one or both partners had high quality social support were afforded greater coping resources, though stigmas around sexual pain and the nature of the condition lying in the woman's body created disclosure dilemmas for husbands.

In all, an analysis of multiple qualitative data points elucidates the factors that may operate in evangelical couples' experience of coping with painful intercourse, extending interdisciplinary knowledge of sexual pain (Rosen & Bergeron, 2019; Meana & Binik, 2022) and building on interpersonal and health communication theory (Cooke-Jackson & Rubinsky, 2021, 2022). Though many couples believed their faith community was the reason they had pain in the first place, the couples who seemed to experience the least distress drew from spiritual resources, stumbled together through the confusion, frustration, and disappointment, and worked as a team, often aided by the empowering support of clinicians who validated their experience and

advocated for them. In the self-reflexive spirit of crystallization (Ellingson, 2014), I acknowledge that I often thought of my participants and the messages they heard when I felt defeated or weary from arduous process of qualitative research. Intervening memorable messages created a ripple effect of empowerment through couples' communicative systems; this project is a result of that ripple effect.

Figure 3

Social Ecological Framework of Painful Intercourse in Evangelical Couples



Note. The unit of analysis represented in this model is the specific partner (i.e., wife or husband).

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Appendix A

Final Couple Interview Guide

Guiding Questions

- RQ1: What helps couples cope with the biopsychosocial experience of sexual pain?
- RQ2: What factors motivate couples to seek or avoid support in managing or resolving their shared challenges with sexual pain?
- RQ3: What memorable messages do spouses perceive contribute to their individual and shared experiences of coping with sexual pain?

INTRODUCTIONS & RAPPORT-BUILDING

[*Introduce all parties; thank participant/s; share personal connection to topic; interviewers go to respective rooms/spaces*]

OVERVIEW OF STUDY AND TIMELINE

[Purpose] So, in our time together, I'd like to ask you about the communication you've had with [spouse's name] and with others as you've navigated the experience of marriage in general and painful sex specifically. I also want to hear what kinds of messages have "stuck" with you that you feel like have shaped your experience.

[Informed Consent] I know you signed a consent form already. Do you have any questions? *[answers questions if need be]*. Let me remind you that we will take steps to protect your anonymity; what this means is that we will not use your real names (or the names of anyone you mention) in any writeups. So, if we quote you, and your spouse or a friend was reading it, they couldn't be sure it was you.

[Timeline] The interview should take about an hour. Does that still work for you? There are no wrong answers, I really just want to hear your story. Again, your participation is completely voluntary; if any question is too difficult or you don't feel comfortable sharing, you don't have to answer. You can withdraw from the study at any time. Do you have any questions before we begin?

[*Informs participant when recording has begun.*]

INTRODUCTORY QUESTIONS ABOUT RELATIONSHIP & TOPIC

So the first few questions are just to get to know a little bit more about you and your relationship with [spouse's name].

- How long have you been married?
- How did you two meet?
    - When did you know you wanted to marry your spouse?
- How important was it to you that you marry someone with the same faith?

    - Did you grow up in a Christian home?
- What's been the best part of marriage so far?
- Did you have premarital counseling?
    - What kinds of things do you remember learning about during premarital? *(Probe for messages about sex)*
    - *(If they didn't do premarital counseling)* What made you decide not to do premarital counseling?
- Before we get to your experience with the topic of painful sex, I'd like to know, what were the kinds of things you heard about sex and intimacy growing up?
    - Did you have conversations with your parents? How did those go?
    - (*Depending on faith background*) What do you remember hearing about sex within religious contexts?
    - Did these messages influence the way you and your spouse developed your own physical relationship? *(e.g.*, *kissing*, *boundaries*, *etc.)*
    - What did you expect sex in marriage to be like?

SEXUAL PAIN EXPERIENCE

So I wanted to transition into hearing about your experiences with painful sex. Again, I just want to reassure you, there are no right or wrong answers here. This is just a space for you to share your story.

- So tell me your story of navigating sex with your partner. Feel free to be as explicit or not explicit as you want. *(Probe for wedding night experience)*
    - When did [you/your wife] first disclose the pain?
    - When did you first learn that intercourse was going to be difficult long-term?
    - Did [you/your wife] receive a diagnosis?
- What kinds of feelings have come up for you throughout this experience?
    - When you notice that feeling coming up, what usually happens next? How do you usually respond? *(probe for healthy and unhealthy coping strategies)*
    - What do you think your *partner* has felt throughout this experience?
- Have you or your spouse sought out any kind of support or treatment?
    - (*If so*) What prompted you to seek support or treatment?

- (*If not*) What has been the biggest barrier for you in getting help or support?
- Are there any resources or supports you would like to be able to access, but you aren't able to right now? *(Probe for details/constraints accordingly)*

- Of all the things that you have done, what do you think has helped you the most individually?
  - What has helped you the most as a couple?
- Some couples navigating sexual pain have said that communicating about it with their partner can be really challenging, while others have said that it brings them closer together. What has been your experience?
  - How would you describe your communication with your partner during the heat of the moment when [you/your wife] starts to have pain?
  - How do you usually respond? How does your partner usually respond? *(Probe for how the communication is in the bedroom*, *e.g.*, *empathy? Criticism/anger?)*
- How has this experience affected the way you see yourself? *(sexually*, *as a husband/wife*, *as a Christian.)*
  - Is this something you talk to your partner about?
  - How do you think this experience has affected the way your partner sees him/herself?
- How has your definition of sex changed over time, if at all?
  - What would you say it means to be a "virgin"?
- How would you rank the stress or difficulty of this experience compared with other things you have faced together? *(If sexual pain isn't the most stressful part*, *probe as to why.)*

MEMORABLE MESSAGES

- How much have you shared with others about your experience?
- How have others' responses to your experience of painful sex helped or hindered your coping process?
  - What was it about these messages that made them so impactful for you? *(For each message*, *probe for source*, *content*, *modality*, *context)*
  - How, if at all, have these messages affected the way you understand your sexual experience?

    - How have these messages impacted the choices you've made in relation to your experience of painful sex? *(e.g., who you share with, how much you share, how you interact with your spouse, the kinds of support you've gotten)*?

- What other memorable messages come to mind as you think about what has affected your experience? These might be things you've heard from pastors, church friends, media, or even your [husband/wife].
- This is a study about Christian couples. What has been your experience of God throughout this time? *(Probe about where they got that from based on their answer)*

CONCLUDING QUESTIONS

We've talked about a lot of things today–thank you so much! I have just a few more questions as we come to a close.

- What advice would you give to other couples experiencing what you have experienced?
    - What are the things you wish you would have heard?
- Is there anything you want to add to what we already talked about, or anything I should have asked you that I didn't think to ask?

I have just a few demographic questions for you and then we'll be done. [Move to demographic questionnaire.]

Appendix B

Initial Couple Interview Guide

Guiding Questions

- RQ1: What are the primary reasons couples believe they have been able to cope with sexual pain?
- RQ2: What factors motivate couples to seek or avoid support in managing or resolving their shared challenges with sexual pain?
- RQ3: What memorable messages do spouses perceive as contributing to their individual and shared experiences of coping with sexual pain?

INTRODUCTIONS & RAPPORT-BUILDING

[*Introduce all parties; thank participant/s; share personal connection to topic; interviewers go to respective rooms/spaces*]

OVERVIEW OF STUDY AND TIMELINE

[Purpose] So, in our time together, I'd like to ask you about the communication you've had with your spouse and with others as you've navigated the experience of sexual pain and your relationship in general. I also want to hear what kinds of messages have "stuck" with you that you feel like have shaped your experience.

[Informed Consent] Please take a few moments to read through this consent form and sign. *[Participant reads the consent form. Then, interviewer highlights key points.]* Let me remind you that we will take steps to protect your anonymity; what this means is that we will not use your real names (or the names of anyone you mention) in any writeups. So, if we quote you, and your spouse or a friend was reading it, they couldn't be sure it was you.

[Timeline] The interviews should take about an hour. Does that still work for you? Again, your participation is completely voluntary; if any question is too difficult or you don't feel comfortable sharing, you don't have to answer. You can withdraw from the study at any time. Do you have any questions before we begin?

[*Informs participant when recording has begun*.]

INTRODUCTORY QUESTIONS ABOUT RELATIONSHIP

So the first few questions are just to get to know a little bit more about you and your relationship with your partner.

- How did you two meet?
- How long have you been married?
- What has married life been like?

- What's been the best part of marriage so far?
- What has been the most stressful thing you've navigated? *(If sexual pain isn't the most stressful part, probe as to why.)*
- If you could describe your relationship in a single word, what would it be? Tell me more about that.

- Did you have premarital counseling? Tell me a little bit about that.
  - What kinds of things do you remember learning about during premarital? *(Probe for messages they heard about sex, and how to cope with difficulty in relationships.)*
  - If they didn't do premarital counseling, probe as to why.

BACKGROUND ON CHRISTIANITY & SEX

In these next few questions, I'd like to learn more about your faith and how that relates to your experiences with sex and sexuality.

- What is your faith background?
  - Did you grow up in a Christian home?
  - What was your view about the Bible as a kid? How does that compare with what you believe about the Bible now?
- How important was it to you that you marry someone with the same faith?
  - What do you believe God's role has been in your relationship?
- What were the kinds of things you learned about sex growing up?
  - Did you have conversations with your parents? How did those go?
  - (*Depending on faith background*) What do you remember hearing about sex within religious contexts?
  - What did you expect sex to be like? Where do you think you learned this?
- How did your physical intimacy with your spouse develop?
  - When was your first kiss?
  - What did physical intimacy look like in your relationship before you got married?

SEXUAL PAIN AND COPING

So tell me a little bit about [your/your wife's] experience with sexual pain.

- When did [you/your wife] first disclose the pain?
- When did you first learn that intercourse was going to be difficult to navigate?
    - What emotions did you experience during that time? How does that compare with what you feel now?
    - What does/did it mean to you to be experiencing sexual pain?
- How has your definition of sex changed over time, if at all?
- Some couples navigating sexual pain have said that it makes communication really challenging, while others have said that it brings them closer together. What has been your experience?
    - Probe for how the communication is in the bedroom (i.e., empathy? Criticism/anger?)
- How would you say have you coped with the experience of sexual pain?
    - Have you talked to others about your experience? Why or why not?
    - Have you or your spouse sought support or treatment?
        - (*If so*) What prompted you to seek support or treatment?
        - (*If not*) What has been the biggest barrier for you in getting help or support?
    - What do you think has helped you the most?
    - Are there any resources or supports you would like to be able to access, but you aren't able to right now? *(Probe for details/constraints accordingly)*
- What do you feel like has made it easy or difficult for your *partner* to cope with [your/her] sexual pain?
    - What do you feel most proud of in the way that you've supported your partner through these challenges?
    - What do you feel you could do better, if anything?
- How has this experience affected the way you see yourself? *(Probe for how it affects how they see themselves sexually*, *as a husband/wife*, *and as a Christian.)*
    - Is this something you talk to your partner about?
    - How do you think this experience has affected the way your partner sees him/herself?

MEMORABLE MESSAGES

One thing I'm interested in knowing is the kinds of things people hear when they're going through a hard time; these messages can be positive or negative. Take a minute to think about advice you've gotten or things people have said that have "stuck with you" as you've navigated this process.

- What is one message that comes to mind? (Probe participants to recall specific stories/interactions that stand out.)
  - What was it about this message that made it "stick" with you? *(Probe for source, content, modality, context)*
- What other messages come to mind when you think about the experience of navigating sexual pain? *(Probe for messages from spouses, doctors/therapists, and pastors/church members.)*
  - How do you feel these messages have impacted how you see yourself?
  - How do you feel these messages have impacted the way you have coped?
- What do you wish you'd been told before you got married that you think could have helped you navigate this process?
- How have your beliefs about sex shifted over time? What do you attribute that do?
  - Who do you think has been the most influential in shaping your beliefs about sex?

CONCLUDING QUESTIONS

We've talked about a lot of things today–thank you so much!

- Is there anything you want to add to what we already talked about?
- Is there anything I should have asked you that I didn't think to ask?

I have just a few demographic questions for you and then we'll be done [Move to demographic questionnaire, and provide resource sheet afterwards.]

Appendix C

Final Clinician Interview Guide

Guiding Questions

- RQ4a: What factors do clinicians believe contribute to women's/couples' ability to cope with, seek support for, and heal from sexual pain?
- RQ4b: How do clinicians account for religious identity when treating female sexual pain?

OVERVIEW OF STUDY AND TIMELINE

[Purpose] Thanks for taking the time to meet with me today! My name is Arielle, and I'm a Ph.D. student at Chapman University. I'm conducting a research study on how evangelical couples cope in their relationships when sex is painful or impossible. But I know that clinicians often have insight from working with women/couples about how they cope and the role of religiosity in their experience. So, in our time together, I'd like to ask you about the interactions you've had with patients/clients affected by female sexual pain, and religious patients/clients if applicable.

[Informed Consent] I know you signed a consent form already. Do you have any questions? *[answers questions if need be]*. Let me remind you that we will take steps to protect your anonymity; what this means is that we will not use your real names (or the names of anyone you mention) in any writeups. So, if we quote you and a colleague was reading it, they couldn't be sure it was you.

[Timeline] Does 30 minutes still work for you? Again, your participation is completely voluntary; you don't have to answer any questions that you do not feel comfortable answering. You can withdraw from the study at any time. Do you have any questions before we begin?

[*Informs participant when recording has begun*.]

QUESTIONS

- So tell be a little bit about your professional background.
    - What prompted you to go into this profession? *(Probe for religious or personal motivations)*
    - What do you believe your role to be as a provider?

- So I know you often treat [state whatever makes sense based on previous answers]. Talk to me about your typical [religious] painful sex patient/client. What are they like?
    - How similar or different are your religious painful sex patients from those who have not disclosed about their religion?
    - Do you notice any differences in patients'/clients' ability to heal or cope, based on their specific religious affiliation or denomination? *(Probe for how much they know about evangelicalism)*

- What are their hangups?
  - *(If therapist)* What do you think distinguishes the women/couples who cope more adaptively from those who cope less adaptively?

- What are your goals when treating these patients?
  - What do you hope the patient would know or do as a result of your treatment?
  - What kind of demeanor do you hope to portray?

- What do you feel could help you be more effective when treating these kinds of patients/clients? *(Probe about their own identity)*
  - To what extent did you cover topics related to sexual health in your training? *(Probe for training or preparation on sexual dysfunction*, *sexual satisfaction*, *relationship issues*, *and religious issues.)*

- We've talked about a lot of things today–thank you so much! Is there anything I should have asked you that I didn't think to ask, or anything you want to add to what we already talked about?

I have just a few demographic questions for you and then we'll be done [Move to demographic questionnaire.]

Appendix D.

Initial Clinician Interview Guide

Guiding Questions

- RQ4a: What factors do clinicians believe contribute to women's/couples' ability to cope with, seek support for, and heal from sexual pain?
- RQ4b: How do clinicians account for religious identity when treating female sexual pain?

OVERVIEW OF STUDY AND TIMELINE

[Purpose] Thanks for taking the time to meet with me today! My name is Arielle, and I'm a Ph.D. student at Chapman University. I'm conducting a research study on how evangelical couples cope in their relationships when sex is painful or impossible. But I know that clinicians often have insight from working with women/couples about how they cope and the role of religiosity in their experience. So, in our time together, I'd like to ask you about the interactions you've had with patients/clients affected by female sexual pain, and religious patients/clients if applicable.

[Informed Consent] I know you signed a consent form already. Do you have any questions? *[answers questions if need be]*. Let me remind you that we will take steps to protect your anonymity; what this means is that we will not use your real names (or the names of anyone you mention) in any writeups. So, if we quote you and a colleague was reading it, they couldn't be sure it was you.

[Timeline] The interview should take 30 minutes, but I actually have a full hour slotted just in case we go over. What is your timeframe today? Again, your participation is completely voluntary; if any question is too difficult or you don't feel comfortable sharing, you don't have to answer. You can withdraw from the study at any time. Do you have any questions before we begin?

[*Informs participant when recording has begun*.]

INTRODUCTORY QUESTIONS

- So tell be a little bit about your professional background.
  - What prompted you to go into this profession? *(Probe for religious or personal motivations)*
  - What do you believe your role to be as a provider?
  - What was your training like?

- How often do you treat women/couples affected by female sexual pain?
  - Are any of these women/couples religious?

- To what extent did you cover topics related to sexual health in your training? *(Probe for training or preparation on sexual dysfunction*, *sexual satisfaction*, *and relationship issues.)*

- Did your training ever go over what to do if a patient/client brought up their religion/faith? Tell me about that.

QUESTIONS ABOUT TREATING PAINFUL SEX PATIENTS

So I know you often treat [state whatever makes sense based on previous answers]. I want to hear about a typical patient.

- Walk me through the treatment process for your typical painful sex patient. If I was a fly on the wall, what would I see? What would I hear?
    - How do these interactions feel for you? *(Probe for comfort level*, *frustration*, *empathy*, *professional uncertainty*, *etc.)*

- What are your goals when treating these patients?
    - What do you hope the patient would know or do as a result of your treatment?
    - What kind of demeanor do you hope to portray?
    - How much do you disclose about yourself?

- How similar or different are your painful sex cases from each other?
    - What do you attribute these similarities or differences to?
    - What is your biggest success story?

- What do you feel would help you be more effective when treating these kinds of patients/clients?

- What do you think prevents individuals/couples from [reaching out for support/seeking treatment]?
    - *(If therapist)* What do you think is the biggest barrier that couples have when working through sexual pain?

QUESTIONS ABOUT RELIGION

- (If applicable) When does religion typically come up when treating patients affected by sexual difficulty?

- How do you feel when treating religious patients/clients?
    - What challenges do you run into? *(Probe about their own identity)*
    - Do you notice any differences in patients'/clients' ability to heal or cope, based on their specific religious affiliation or denomination? *(Probe for how much they know about evangelicalism)*

- What role do you think religion plays in the experience of sexual pain?

CONCLUDING QUESTIONS

We've talked about a lot of things today–thank you so much!

- Is there anything you want to add to what we already talked about, or anything I should have asked you that I didn't think to ask?

I have just a few demographic questions for you and then we'll be done [Move to demographic questionnaire.]

Appendix E

Couple Demographic Questionnaire

PARTNER INTERVIEWED

0	Wife	
1	Husband	

Remind me, how long have you been married?

[ENTER INTO DATASET IN MONTHS]

_____ Years _____ Months

During a typical month, how often would you say you and your spouse have engage in sexual activity together (intercourse, outercourse, oral sex, etc.)? **[SexFreqCurr]**

0	Never	
1	Less than once a month	
2	Once or twice a month	
2	Once a month	
2	2-3 times a month	
3	About weekly	
3	Weekly	
4	Several times a week	

On a scale from 1 to 5, with 5 being very satisfied, how would you rate your sexual satisfaction? How about your relationship satisfaction?

	[SexSat]	**[RelSat]**
1		
2		
3		
4		
5		

IF NO LONGER EXPERIENCING SEXUAL PAIN: When [your/your wife's] pain or difficulty with sex was at its peak, how often would you say you and your spouse engaged in sexual activity together (intercourse, outercourse, oral sex, etc.)? **[SexFreqPain]**

0	Never	
1	Less than once a month	
2	Once or twice a month	
2	Once a month	
2	2-3 times a month	
3	About weekly	
3	Weekly	
4	Several times a week	

How often would you say you and your spouse attend church or church-related activities together? Is this different than how often you attend on your own?

		SELF **[ChurAttSelf]**	COUPLE **[ChurAttCoup]**
0	Never		
1	Less than once a year		
1	Once or twice a year		
1	Several times a year		
2	Once a month		
2	2-3 times a month		
3	About weekly		
3	Weekly		
4	Several times a week		

How often would you say you engage in personal spiritual activities such as prayer, devotions, or reading the Bible? How often do you and your spouse do these types of activities together?

		SELF **[SpirActSelf]**	COUPLE **[SpirActCoup]**

0	Never		
1	Less than once a year		
1	Once or twice a year		
1	Several times a year		
2	Once a month		
2	2-3 times a month		
3	About weekly		
3	Weekly		
4	Several times a week		
4	Daily		

Including you, how many people live in your home? __________ **[HHSize]**

Who lives in your home in addition to you and your spouse? **[OthHH]**

0	No other adults live in my home	
1	Kid(s)	
2	Parent(s)	
2	Other adult relatives	
2	Other adult non-relatives	
3	Kid(s) and other adult(s)	

Which region of the country do you primarily reside in? **[Region]**

1	Midwest - IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI	
2	Northeast - CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT	
3	Southeast - AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV	
4	Southwest - AZ, NM, OK, TX	
5	West - AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY	
10	NOT APPLICABLE/REFUSED	

What is your highest level of education? **[EducLvl]**

1	Eighth grade or less	
2	Some high school	
3	High school grad/GED	
4	Some of an AA or Technical Degree	
5	Holds a 2-year degree	
6	Some 4-year college	
7	College graduate (BA)	
8	Some graduate school	
9	Graduate Degree	
10	Refused/Don't Know	

Which of the following best describes **YOUR** current work status? [**EmplStat]**

1	Employed full-time (40+ hours per week)	
2	Employed part-time (less than 40 hours per week)	
3	Self-employed	
4	Unemployed	
5	Retired / Disabled	
6	Full-time student	
7	Stay-at-home parent/ Housewife	
10	NOT APPLICABLE/REFUSED	

IF EMPLOYED: Do you or your partner receive any of the following benefits through work?

		Yes [1]
1	Health insurance	
2	Vacation days/paid time off	
3	Maternity/family leave (paid)	
OTH	Other **SPECIFY**	

For all the members of your household together, what is your best guess as to how much income the family had last year? Would you say it was… **READ OPTIONS, CHECK ONE [HHInc]**

1	Under $20,000	
2	$20,001 to $40,000	
3	$40,001 to $60,000	
4	$60,001 to $80,000	
5	$80,001 to $100,000	
6	$100,001 to $150,000	
7	Over $150,000	
OTH	SPECIFIC AMOUNT, IF MENTIONED:	

And which of the following do you feel best describes your race or ethnicity? **[RaceEth]**

READ OPTIONS AND CHECK ONE CATEGORY

1	White/Caucasian	
2	African American/Black	
3	Latino /Hispanic	
4	Asian/Pacific Islander	
5	Mixed race/ethnicity	
OTH	Other—**SPECIFY**	
10	REFUSED	

And can you tell me, how old are you? ____________ years [**Age]**

Are you willing to be contacted in the future for a follow-up interview?

Yes	
No	

Are you willing to be contacted in the next few months if I want to run the results by you to see if they resonate?

Yes	
No	

That's all I have for today! Anything I can tell you?

- SIGN CASH ACKNOWLEDGEMENT FORM
- THANK THEM FOR PARTICIPATING

Appendix F.

Clinician Demographic Questionnaire

What is your professional title? **[Write in; WorkDesc]**

____

How long [have you been practicing/did you practice] in this profession? **[YrsPrac]**

[ENTER INTO DATASET IN YEARS]

_____ Years _____ Months

Which region of the country do you primarily reside in? [**Region]**

1	Midwest - IA, IL, IN, KS, MI, MN, MO, ND, NE, OH, SD, WI	
2	Northeast - CT, DC, DE, MA, MD, ME, NH, NJ, NY, PA, RI, VT	
3	Southeast - AL, AR, FL, GA, KY, LA, MS, NC, SC, TN, VA, WV	
4	Southwest - AZ, NM, OK, TX	
5	West - AK, CA, CO, HI, ID, MT, NV, OR, UT, WA, WY	
10	NOT APPLICABLE/REFUSED	

Which of the following best describes your current work status? [**EmplStat]**

1	Employed full-time (40+ hours per week)	
2	Employed part-time (less than 40 hours per week)	
3	Self-employed	
4	Unemployed	
5	Retired / Disabled	
6	Full-time student	
7	Stay-at-home parent/ Housewife	
10	NOT APPLICABLE/REFUSED	

What is your highest level of education? **[EducLvl]**

1	Eighth grade or less	
2	Some high school	
3	High school grad/GED	
4	Some of an AA or Technical Degree	
5	Holds a 2-year degree	
6	Some 4-year college	
7	College graduate (BA)	
8	Some graduate school	
9	Graduate Degree	
10	Refused/Don't Know	

How would you describe your religious or spiritual affiliation? **[Write in; RelAff]**

____

How often would you say you attend religious services or activities? **[ChurAtt]**

0	Never	
1	Less than once a year	
1	Once or twice a year	
1	Several times a year	
2	Once a month	
2	2-3 times a month	
3	About weekly	
3	Weekly	
4	Several times a week	

How often would you say you engage in personal spiritual activities such as prayer, devotions, or reading religious texts? **[SpirAct]**

0	Never	

1	Less than once a year	
1	Once or twice a year	
1	Several times a year	
2	Once a month	
2	2-3 times a month	
3	About weekly	
3	Weekly	
4	Several times a week	
4	Daily	

For all the members of your household together, what is your best guess as to how much income the family had last year? Would you say it was… **READ OPTIONS, CHECK ONE [HHInc]**

1	Under $20,000	
2	$20,001 to $40,000	
3	$40,001 to $60,000	
4	$60,001 to $80,000	
5	$80,001 to $100,000	
6	Over $100,000	
OTH	SPECIFIC AMOUNT, IF MENTIONED:	

And which of the following do you feel best describes your race or ethnicity? **[RaceEth]**

READ OPTIONS AND CHECK ONE CATEGORY

1	White/Caucasian	
2	African American/Black	
3	Latino /Hispanic	
4	Asian/Pacific Islander	

5	Mixed race/ethnicity	
OTH	Other—**SPECIFY**	
10	REFUSED	

And can you tell me, how old are you? ___________ years **[Age]**

Are you willing to be contacted in the future for a follow-up interview or for future studies?

Yes	
No	

Are you willing to be contacted in the next few months if I want to run the results by you to see if they resonate?

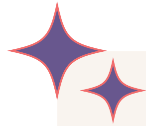
Yes	
No	

That's all I have for today! Anything I can tell you?

- SIGN CASH ACKNOWLEDGEMENT FORM
- THANK THEM FOR PARTICIPATING

Appendix G

Couple Recruitment Flyer



LET'S TALK ABOUT PAINFUL SEX.

WAS SEX PAINFUL (OR IMPOSSIBLE) YOUR FIRST TIME… AND EVERY TIME AFTER THAT? IF SO, THIS STUDY MAY BE FOR YOU AND YOUR SPOUSE.

We're interviewing Christian married couples about the challenges and opportunities they face when a wife is experiencing persistent pain with sex.

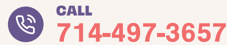
We know everyone's story is different, and we want to hear yours!

YOU AND YOUR PARTNER ARE INVITED TO PARTICIPATE IF YOU…

- Are 18 or older
- Are in a heterosexual, married relationship
- Practice the Christian faith
- Live in the US
- Are willing to participate in 1-hour long, separate, audio-recorded interviews

QUESTIONS?

CONTACT ARIELLE LEONARD HODGES



CALL
714-497-3657

EMAIL
arleonard@chapman.edu

TO EXPRESS YOUR INTEREST AND FIND OUT MORE INFORMATION, **SCAN THE QR CODE!**

Chapman University
IRB-23-319
Approved on 9-29-2023
Expires on 9-1-2024

Appendix H

Clinician Recruitment Flyer

Have you treated a patient or client for **painful intercourse?**

I am interviewing female mental health professionals, gynecologists, and pelvic floor therapists about their experiences treating patients or clients affected by painful sex. I am especially interested in talking with practitioners who have worked with religious patients/clients affected by sexual pain or dysfunction.

Am I eligible?

- 18 or older
- Live in the US
- Identify as female
- Current or former mental health professional (MFT, PsyD, etc.), gynecologist, or pelvic floor physical therapist

What would this require?

- Participation in an interview lasting approximately 30 minutes

Questions?

CONTACT ARIELLE LEONARD HODGES

CALL
714-497-3657

EMAIL
arleonard@chapman.edu

Each participant will receive a $50 visa gift card.

To confirm eligibility and sign up for an interview, scan the QR code.

Chapman University
IRB-23-319
Approved on 9-29-2023
Expires on 9-1-2024

Appendix I

Couple Interest Survey

Arielle Leonard Hodges of Chapman University is conducting a study with heterosexual married couples who practice the Christian faith and who are experiencing (or have experienced) a wife's persistent pain or difficulty with sexual intercourse during early marriage.

Arielle and a male research assistant will be conducting separate, simultaneous interviews with each spouse. If you are eligible and decide to participate in the study, your total participation time should be 1 hour. Each spouse will receive a $50 Visa gift card for their time.

Please click the box below. Then, click the arrow to begin the survey and see if you are eligible to participate.
[reCAPTCHA]

To make sure you're not a robot, please type “[name of color] (all lower case) in the text box below.

I am 18 years of age or older.
Yes
No – *ineligible*
I live in the United States.
Yes
No – ineligible
I am comfortable speaking in English.
Yes
No – *ineligible*
I am in a heterosexual married relationship, and my spouse and I share the same faith.
Yes
No – *ineligible*
I am
Male
Female
[If female is selected] I am currently experiencing (or have experienced within the past 5 years) persistent pain with penetrative intercourse that began the very first time I had/attempted sex with my husband, AND this pain has occurred (or did occur) each time we had/attempted sex for 3 or more months.
Yes
No – *ineligible*
I don't know
[If male is selected] My wife is currently experiencing (or has experienced within the past 5 years) persistent pain with penetrative intercourse that began the very first time she and I had/attempted sex, AND this pain has occurred (or did occur) each time we had/attempted sex for 3 or more months.

Yes
No – *ineligible*
I don't know
I believe that Jesus is my Lord and Savior, and my relationship with God is important to me.
Yes
No – *ineligible*
Don't know – *ineligible*
Which best describes your Christian denomination?
Protestant
Catholic – *ineligible*
Mormon – *ineligible*
Orthodox – *ineligible*
Mormon – *ineligible*
Jehovah's Witness – *ineligible*
Other (please describe): ________
Which one statement comes closest to your personal beliefs about the Bible? (Please check only one.)
The Bible means exactly what it says. It should be taken literally, word-for-word, on all subjects.
The Bible is perfectly true, but it should not be taken literally, word-for-word. We must interpret its meaning.
The Bible contains some human error. – *ineligible*
The Bible is an ancient book of history and legends. – *ineligible*
I don't know – *ineligible*
How often do you attend church or participate in church-related activities?
Never – ineligible
Less than once a year – *ineligible*
Once or twice a year – *ineligible*
Several times a year
Once a month
2-3 times a month
About weekly
Weekly
Several times a week

Based on the information you have provided, you and your spouse may be eligible to participate! Please provide your contact information below and a member of the research team will reach out to you within the next week to explain the study and schedule an interview. Also, at the end of this survey, you'll be provided with a link to send to your spouse so they can confirm their own interest.

Your name

____

Email

____

Phone

____

Preferred time to receive a call with more information about the study.

Between 6am and 8am (Pacific Standard Time)
Between 8am and 12pm (Pacific Standard Time)
Between 12pm and 7pm (Pacific Standard Time)
After 7pm (Pacific Standard Time)

If we try calling and you do not answer, do we have permission to leave you a voicemail with information about the study?

Yes
No

Thank you for indicating your interest. Please copy the link below and send it to your spouse so they can confirm their own interest, if they haven't already. Also, free to pass along the link to anyone else who you think might be interested or eligible.

[Qualtrics link]

[If ineligible, this message will appear]

I am sorry, but this study requires participants to be at least 18 years of age, live in the United States, hold to an evangelical worldview, be in a same-faith heterosexual married relationship, and be experiencing (or have experienced within the last 5 years) persistent pain with penetrative intercourse that began from the first time couples had/attempted sex and lasted for at least 3 months. While we cannot move forward at this time with your own participation, please feel free to pass along the link to this survey to anyone else who you think might be interested or eligible:

[Qualtrics link]

Thank you for your interest!

Appendix J

Clinician Interest Survey

Arielle Leonard Hodges of Chapman University is conducting a research study about how heterosexual couples who practice Christianity cope with painful sex during early marriage. As a part of this study, she is conducting interviews with female mental health professionals, gynecologists, and pelvic floor therapists about their experiences treating patients or clients affected by unwanted painful sex, especially religious patients or clients.

If you are eligible and decide to participate in the study, your total participation time should be 30 minutes on Zoom or face-to-face. You will receive a $50 Visa gift card for your time.

Please click the box below. Then, click the arrow to begin the survey and see if you are eligible to participate.
[reCAPTCHA]

To make sure you're not a robot, please type "[name of color] (all lower case) in the text box below.

I am 18 years of age or older.
    Yes
    No – *ineligible*
I am female.
    Yes
    No – *ineligible*
I live in the United States.
    Yes
    No – *ineligible*
I am comfortable speaking in English.
    Yes
    No – *ineligible*
I am a current or former gynecologist, pelvic floor physical therapist, or mental health professional (e.g., MFT, PsyD, etc.).
    Yes
    No – *ineligible*
I regularly treat or work with (select all that apply):
    Women who have persistent pain with intercourse.
    Heterosexual couples experiencing a female partner's pain with intercourse (e.g., during couples' therapy).
    Religious patients or clients experiencing sexual difficulties.

Based on the information you have provided, you are eligible to participate in an interview. Please provide your name and contact information below, and the researcher will call or email you to schedule an interview.

Your name

____

Phone or email

____

Best time(s) to reach you:

Between 6am and 8am (Pacific Standard Time)
Between 8am and 12pm (Pacific Standard Time)
Between 12pm and 7pm (Pacific Standard Time)
After 7pm (Pacific Standard Time)

Also, free to pass along the link below to anyone else who you think might be interested or eligible:

[Qualtrics link]

[If ineligible, this message will appear]

I am sorry, but this study requires participants to (a) be at least 18 years of age, (b) female, (c) living in the US, (d) comfortable speaking English, and a (e) a current or former gynecologist, pelvic floor physical therapist, or mental health professional (e.g., MFT, PsyD, etc.) who (f) regularly treats/treated women who have persistent pain with intercourse, heterosexual couples experiencing a female partner's pain with intercourse (e.g., during couples' therapy), and/or religious patients or clients experiencing sexual difficulties. While we cannot move forward at this time with your own participation, please feel free to pass along the link to this survey to anyone else who you think might be interested or eligible:

[Qualtrics link]

Thank you for your interest!

Appendix K

Couple Follow-Up Interview Guide for Member Reflections

OVERVIEW OF STUDY AND TIMELINE

[Purpose] It is great to see you again! The reason I wanted to chat with you two again is because [*insert reason based on the emergent nature of the study*]. In our time together, I'd like to hear share some of the findings with you to see if you think I'm on the right track.

[Informed Consent] You already filled out the consent form the last time we met, but let me remind you that I will take steps to protect your anonymity; what this means is that we will not use your real names (or the names of anyone you mention) in any writeups.

[Timeline] The interviews should not take more than an hour. Does that still work for you? Again, your participation is completely voluntary for both of you; if any question is too difficult or you don't feel comfortable sharing, you don't have to answer. You can withdraw from the study at any time. Do you have any questions before we begin? [*Informs participants when recording has begun*.]

FOLLOW-UP

Before we jump into some of the findings, I'd love to hear how things have been since I last saw you.

- If each of you could describe the last [X weeks/months] in one word, what would it be?
- *[If currently experiencing painful sex]* How is today similar or different than it was the last time we met, in terms of painful sex? (Probe for what they attribute that to.)

MEMBER REFLECTIONS

So far, what I'm finding is that [discuss summary of findings]. I'd love to hear what you think about my interpretations. [Provides summary sheet, if applicable].

- In what ways do you feel like I have accurately captured your experience with this topic? What do you resonate with?
- Where do you think I've misunderstood or misrepresented your experience, individually or as a couple?
- What advice would you give to other couples going through an experience similar to the one you've had?

CONCLUDING QUESTIONS

Thank you again for being willing to meet with me again. I appreciate it so much.

- Is there anything you want to add?