PHENOMENOLOGICAL ANALYSIS OF FREQUENT AND DISRUPTIVE SEXUAL DISCOMFORT IN MARRIED WOMEN

by

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ABSTRACT

This qualitative study aimed to deeply explore and understand the lived experiences of married women who suffer from frequent and disruptive sexual discomfort of a physical and/or emotional nature. Pre-conditions or facilitating events, coping strategies, and after-effects of the experience were also examined. The study purposed to expand theoretical and empirical knowledge in the currently under-researched area of female sexual dysfunction. Moreover, it intended to provide a detailed description and thus enhance understanding of the subjective experience of female sexual discomfort in its profundity and complexity, an account unavailable to date. Finally, the study, having as a focus the psychological aspects of human existence, compensated for the trend towards biological reductionism in the study of sexual dysfunction.

A phenomenological research design was used to collect and analyze the data derived from in-depth interviews conducted with nine married women. Forty-two common themes gradually emerged and were woven into a common story—or a fundamental structure—of the experience, its pre-conditions, coping strategies, and after-effects. Both the common themes and the common story of the experience were confirmed by the participants and two outside raters in brief follow-up interviews. The study findings were interpreted in light of existing research on female sexual dysfunction. The limitations of the study and suggestions regarding future research and counselling practice were discussed.

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CHAPTER I: INTRODUCTION

You fit into me
Like a hook into an eye

A fish hook
An open eye

Margaret Atwood (1971)

Although there is significant disagreement among estimates of the prevalence of sexual dysfunctions in the general population of North America (American Psychiatric Association [APA], 2000), the typical proportion of women who experience sexual difficulties is currently estimated at 40% (Laumann, Paik, & Rosen, 1999). The National Health and Social Life Survey (Laumann et al.) finds that 42% of women experience one or more types of sexual dysfunction. Rosen, Taylor, Leiblum, and Baumann (1993) demonstrated that 38% of a non-clinical sample of 329 women regularly exhibit anxiety or inhibition during sexual activity. In addition to the wide prevalence of female sexual dysfunctions, women today seem to experience more severe and chronic forms of sexual difficulties than in previous generations (Beck, 1995).

Sexual dysfunction tremendously impacts the quality of life for many women, including their view of themselves and their interpersonal relationships. As Basson, Berman, Burnett, Derogatis, Ferguson, & Foucroy (2001) state, "[female] sexual dysfunction [is] … physically disconcerting, emotionally distressing and socially disruptive" (p. 83). Yet, in spite of its wide prevalence, increasing severity, and various negative effects on women's lives, sexual dysfunction is poorly understood and under-researched (Basson et al.).

Purpose of the Study

The purpose of the current study was to compensate for this deficiency in research in the area of female sexual dysfunction by investigating the nature of such experience. For methodological purposes sexual dysfunction in this study was defined as emotional and/or physical sexual discomfort (see the beginning of the Literature Review section). Nine women

were interviewed for the purpose of gathering descriptions of the experience of sexual discomfort. The discomfort tends to occur *more often than not* and prevents women from obtaining satisfaction and enjoyment as they engage in sexual encounters with their spouse.

In particular, the research participants were asked, “Please think back to a time or times when you, after beginning to engage in sexual activity with your spouse, found yourself experiencing discomfort. Please describe this experience as fully as you can.” The participants were also asked, “What happened that brought about that experience? What were the effects of such experience on you and your relationships? How did you cope with the discomfort?” Phenomenological methodology (Colaizzi, 1978; Osborne, 1990; Polkinghorne, 1989) was used to collect and analyze the obtained data.

Rationale for the Study

There are several reasons why this study was important to conduct. First, as mentioned above, the phenomenon of female sexual dysfunction has been under-researched (Andersen & Gyranowski, 1995; Basson et al., 2001). Female sexual dysfunction has been investigated to a lesser extent than male sexual dysfunction (Kohn & Kaplan, 2000; Read, 1995) and is understood even less than basic aspects of "healthy" sexuality (Levine, 1984, 1987). Hence, this study was intended to advance empirical and theoretical knowledge in the area of female sexuality and sexual dysfunction and serve as a basis for further research and theory development.

Second, the current study was an attempt to more fully grasp the phenomenon of female sexual dysfunction. Although the focus of the study lies in the experience of sexual dysfunction, and it would therefore probably be more logical to explore the experience of those who are diagnosed with some form of sexual dysfunction, it was decided to draw the sample from the general, rather than the clinical, population for the following reasons:

1. The lack of empirical evidence regarding the nature of female sexual dysfunction (Hoch, Safir, Peres, & Shepher, 1981; Wiedermann, 1998) and the subsequent absence of widely

accepted and well-defined diagnostic classification of female sexual dysfunction (Basson et al., 2001; Beck, 1995) make questionable the appropriateness of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) or other classification systems as a basis for sample selection.

2. According to the survey conducted by Laumann et al. (1999), only 20% of women who had one or more types of sexual dysfunction (40% of the general population) sought medical consultation, indicating that the experiences of the remaining 80% are apparently overlooked by the scientific community. The samples consisting exclusively of women who seek medical assistance seem to be biased, and thus the knowledge obtained from such studies is incomplete and potentially inaccurate. The current study aimed to understand the phenomenon of sexual "dysfunction" (in this context meaning sexual discomfort or distress) in its entirety and as it was represented in the general population.

A third reason for the importance of the study was that, until now, it has been generally assumed within the field of sexology that women's subjective experience was a highly important factor in the formation and maintenance of sexual dysfunction (Barlow, 1986; Kaplan, 1977; Walen, 1980). Yet, this researcher discovered only a few studies (e.g., Birnbaum, Glaubman, & Mikulincer, 2001; Clifford, 1978; Daniluk, 1993) which systematically explored the subjective experience of sexuality and sexual difficulties in adult women. Thus, this research project aimed to obtain women's subjective accounts of their sexual distress, because such in-depth descriptive studies have been unavailable to the scholarly community to this date.

Fourth, the study was expected to provide meaningful, profound, and complex data on the subjective experience of female sexual dysfunctions. Kring (2000) notes the existence of tension in the sexological literature between the empirical or biological approach, which emphasizes human sexual behaviour, and the theoretical or psychological approach, which focuses on the quality of the subjective experience of the sexual encounter. As already mentioned, a review of the literature found few studies that explored the subjective experience of female sexual

dysfunction or discomfort. Further, most of these studies utilized some form of quantitative scientific paradigm. One of the limitations of such quantitative designs as applied to the sexual phenomena is that they overlook the complexity of those phenomena. Such restriction is asserted, for instance, by Maney (1988; cited in Wiedermann, 1998, p. 95) as follows: "for the most part [sex research] still follows the experiential design of classical physics and celestial mechanics, and searches for univariate cause and effect, whereas the phenomena of sex research are, virtually without exception, multivariately determined." The current study obtained subjective descriptions of the experience of sexual dysfunction and thus considers this dysfunction in more fullness and complexity than previous quantitative research.

Fifth, although multiple biogenic and psychogenic factors seem to underlie female sexual dysfunctions (Levine, 1995; cited in Wiedermann, 1998), a trend has emerged within recent years to reduce such phenomena to purely biological correlates (Kring, 2000). Consequently, much current research resists the consideration of psychological dimensions—which was, in fact, the focus of this study.

Finally, the study may assist clinicians to enhance their understanding of female clients with sexual dysfunctions, which, in turn, may lead to more effective therapeutic interventions. The findings obtained in the study could also be used by clients to understand themselves and their experiences more fully, as well as to realize that they are not alone in their experiences.

To summarize, this study intended to reveal the fundamental structure (or a single description) of the experience of sexual discomfort in married women, whether physical or psychological. Further, the pre-conditions, after-effects, and coping mechanisms of such experiences were explored. The results obtained were expected to advance theoretical and empirical knowledge in the areas of psychology and sexology, to capture the subjective experience of female sexual dysfunction in more fullness and complexity, to assist professionals in understanding their clients better, and to develop more effective treatment strategies. In

addition, the findings were available to be used by women with sexual dysfunctions to expand their understanding of themselves in order to promote growth, happiness, and life satisfaction.

Chapter 2 will overview various theories and related research findings on such topics as female sexual dysfunctions, anxiety, and sexual anxiety. Some phenomenological studies conducted on anxiety and female sexuality will be presented here, followed by the researcher's own theoretical view of the concept of sexual dysfunction. Chapter 3 will describe phenomenological methodology, the rationale for its use in the present study, and the procedure for data collection and analysis. Such issues as ethical considerations, reliability, validity, and generalizability of the findings will also be covered in this chapter. Chapter 4 will present the findings of this study, which will be followed by discussion of these findings in light of existing theories and previous research in Chapter 5. An overview of limitations of the study, implications for research and counselling practice will conclude this chapter and this work.

CHAPTER II: LITERATURE REVIEW

This chapter will provide an overview of various theories and research findings on such subjects as female sexual dysfunctions, anxiety, and sexual anxiety. Some qualitative studies conducted on anxiety and female sexual functioning will be summarized here. The researcher's own theoretical view of the concept of sexual dysfunction will conclude this chapter.

Female Sexual Dysfunction

Definition

The contemporary definition applicable to all forms of sexual dysfunction widely used by clinicians and researchers is reflected in the *DSM-IV-TR* (APA, 2000); it describes sexual dysfunction as "a disturbance in the process that characterizes the sexual response cycle [desire, excitement, orgasm, and resolution] or … pain associated with sexual intercourse" (p. 535). Furthermore, such disturbance must cause marked distress and interpersonal difficulty. Some researchers (e.g., Walen, 1980) consider emotional distress and the inhibition or absence of sexual desire or excitement during intercourse to be sufficient indicators of the presence of sexual dysfunction. Others (e.g., Daniluk, 1998), insist that sexual concerns should not be limited strictly to intercourse. Daniluk, a proponent of social constructionism, believes that "[female] sexuality may be highly personal or interactive, it may be profoundly physical, relational, emotional or spiritual, and it may include a woman's body, mind, or soul" (p. 7). She insists that the meaning a woman attaches to her experience is of more importance than whether we, as outside observers, characterize that experience as functional or dysfunctional.

Many researchers and clinicians (e.g., Kaplan, 1977; Masters & Johnson, 1970) consider anxiety to be the underpinning of all types of sexual dysfunction, although this concept is not incorporated into the current definition of sexual concerns found in the *DSM-IV-TR* (APA, 2000) due to this manual's atheoretical orientation. Conceptualization of sexual dysfunction for the purposes of this study also includes anxiety as a crucial component. However, directing the focus

of investigation to the concept of sexual anxiety would contradict the basic assumption of phenomenological methodology chosen for the study. A phenomenologist must allow the phenomenon "to speak for itself" and avoid approaching it with various pre-conceived notions (e.g., the experience must be anxiety) (Giorgi, 1985). In order to allow the experience to speak for itself the phenomenon of sexual dysfunction was labelled rather broadly as " discomfort" experienced by women during sexual encounters. Such discomfort can be psychological or physical and is up to the meaning attributed by the participants.

For the purpose of this study, the researcher specifies sexual dysfunction as the discomfort women experience during sexual encounters. Assuming that all women experience sexual discomfort on occasion, it was deemed important to limit the focus of the investigation to women whose experience is rather frequent. To date no data have been uncovered by this researcher regarding the frequency of sexual discomfort in a non-clinical population. Consequently, to exclude from participation in the study women who experience occasional sexual discomfort, it was decided to select for participation only those women who, *more often than not,* find themselves experiencing sexual discomfort.

Historical Background

Unfortunately, there is no evidence available regarding the existence of female sexual dysfunction prior to the 19th century. The few accounts and documents of the Victorian era (1817-1901) that did survive primarily reflect the women's attitudes of general satisfaction with sex. An example is a recently discovered sexual satisfaction questionnaire administered to 45 married women in 1892 (Mosher, 1980; cited in King, 1996). As opposed to descriptions of sexually satisfied Victorian wives (which have possibly undergone some revisions from the women's original accounts), the letters, articles, and pamphlets written by sexual radicals known as "Free Lovers," provide rather convincing evidence that many married women of the 19th century experienced sexual discomfort, dread, and indifference to their husbands (Battan, 1999). Battan refers to Mattie Hursen, one of the "Free Lovers" writers, who conveyed the implications

of the non-egalitarian ideology of that time for the sexual interactions between wives and husbands. According to Hursen, most of the women she encountered described their sexual intercourse as "unpleasant," "nasty," "dirty," "vulgar," or "vile." As a source of their dissatisfaction they indicated selfish attitudes and behaviours of their husbands, who used wives as objects and tools for their own sexual pleasure.

Contemporary Background

In contrast to the previous centuries with their rare references to female sexual distress, the present era can be characterized by more frequent empirical and theoretical advances within various disciplines in regard to female sexual dysfunction. Terman (1938), focusing on couples' sexual relationships, was the first researcher who attempted to estimate the frequency of intercourse, presence of passion in sexual activity, refusal of intercourse, the wife's lack of desire, and other complaints. Kinsey, Pomeroy, and Martin (1948, 1953; cited in Andersen & Cyranowski, 1995) explored similar issues, but considered them from a developmental perspective. Various psychological views and related research findings, which focused on the phenomenon of sexual dysfunction, are described below. Some scholars speculated on the topic as it applies to both genders, while others focused on female sexual dysfunction.

Psychoanalysis. The clinical and theoretical contributions of Freud (1964) solidly established the psychodynamic framework as the major approach to understanding and treatment of sexual dysfunction for the first half of the 20th century. According to Freud's psychoanalytic theory, sexual dysfunctions are psychobiological phenomena rooted in the inappropriate resolution of childhood sexual development. Although Freudian concepts of sexual dysfunctions are not widely shared today, the assumption that childhood intrapsychic conflict is a major etiological factor of sexual dysfunction is still prevalent among clinicians and researchers (Stuart, Hammond, & Pett, 1986).

Object relations theory. The object relations model, stressing the importance of an infant-primary caregiver relationship, conceptualizes sexual dysfunction as one's inability to

transfer the sexual excitement developed during the experience of being held and touched as an infant to a specific object (e.g., a partner) in the adult life (Kernberg, 1994; cited in Kring, 2000). Unfortunately, no empirical evidence of the impact of specific developmental processes on sexual functioning has been discovered (Beck, 1995).

Attachment theory. According to attachment theory (Bowlby, 1973), sexual dysfunction seems to be rooted in an attachment injury (i.e., abandonment or betrayal of trust during a crucial moment of need)—whether in the original child-caregiver attachment bond and/or in an adult attachment bond. Such attachment injury may cause "seemingly irreparable damage to close relationships" (Johnson, Makinen, & Millikin, 2001, p. 145). Insecure attachment developed as a result of attachment injury(-ies) often leads to negative internal working models of self and others (Bartholomew, 1990; Lyddon & Sherry, 2001) which could supposedly interfere with one's ability to be intimate with the partner. The only related study found (Macphee, 1996) investigated the efficacy of the emotionally focused therapy (EFT, Greenberg & Johnson, 1988) as applied to the treatment of low sexual desire in women. EFT is an approach which is partly based on the attachment theory premises. The results suggested a moderate improvement in female sexual desire after treatment. Further application of the theory to female sexual concerns, as well as research conducted from this perspective, is yet to come within the field of psychology.

Behaviourism. Advocates of Behaviourism (e.g., Lazarus, 1971; Wolpe, 1958) apply its concepts of learning to the understanding and treatment of sexual concerns. According to this theory, through a variety of learning experiences people acquire a series of sexual fears, anxieties, and other inhibitors (Wolpe & Lazarus, 1966). Specifically, sexual difficulty is a result of unconditioned stimuli and negative reinforcement contingent upon such stimuli. In the case of sexual assault, sexual behaviour became associated with punishment, which conditioned people with sexual dysfunctions to subsequently react to sexual stimuli with fear, anxiety, and/or avoidance.

If sexual difficulties are learned responses, these responses can be relearned. Nemetz, Craig, and Reith (1978) used behavioural modification techniques to treat sexual dysfunctions. Wolpe (1958) employed *conditioning* (e.g., systematic desensitization) to replace negative responses to sexual stimuli (fear or anxiety) with positive ones (relaxation or sexual arousal). They used *aversive conditioning* (e.g., systematic sensitization) to associate negative responses with erotic cues. Moreover, Masters and Johnson (1970), major contributors to the field of sex therapy, used behavioural techniques to treat sexual dysfunctions. They viewed such concerns as having stemmed from sexual restrictions in individuals' upbringing and lack of emotional intimacy among partners. Masters and Johnson's therapeutic efforts were directed to the anxiety associated with performance, the improvement of partners' communication, and education regarding sexuality and related issues. Their approach was elaborated by LoPiccolo and Lobitz (1972), who used stimulated awareness of pleasurable responses during masturbation to treat orgasmic dysfunction in women.

Social learning theory. Social learning theory (Bandura, 1977) incorporated the ideas of operant conditioning and social cognition, thereby stressing the significance of both external (environmental) and internal (intrapsychic) stimuli in the development of sexual difficulties. The major concepts of this theory are vicarious learning (modeling), expectations of rewards (e.g., sexual pleasure), internal and external control of reinforcement, and the emotional, cognitive, and behavioural consequences of rewards and punishments. According to Hovell et al. (1994), such reinforcements as sexual pleasure and the expectancies of sexual pleasure constitute the most potent reinforcements.

Social scripting theory. Similarly, the perspective of social scripting (Gagnon, 1990) pays special attention to the role of cognitive expectancies in the formation and maintenance of sexual dysfunction. The main assumption of the theory is that sexual difficulties originate in past learning experiences and are maintained by current problematic cognitions that often interrupt the present pleasurable sexual experiences (Barlow, 1986). Walen (1980), describing the disruptions

in the process of sexual stimuli perception, states, "inability to detect sexual stimuli, incorrect labeling, or misattribution of them may significantly impede sexual performance" (p. 88).

The cognitive-behavioural theories described above seem to have solid empirical support. Demonstrating the environmental impact on female sexual functioning, Burgess and Holmstrom (1979) found that 71% of adult rape victims experienced subsequent decline in sexual activity. Likewise, Feldman-Summers, Gordon, and Meagher (1979) showed a substantial decrease in sexual satisfaction after rape. Kilpatrick, Best, Saunders, and Veronen (1988) found that victims of sexual abuse were 2.5 times more likely to experience sexual dysfunction than were nonvictims. It was also discovered that sexual distress (i.e., inhibited sexual interest, decreased sexual pleasure, and fear of sex), anxiety/fear, and depression were some of the after-effects of sexual assault (Siegel, Golding, Stein, Burnam, & Sorneson, 1990).

Bartoi and Kinder (1998) found that women who were abused as adults were significantly more sexually dissatisfied and less sensual (e.g., not as likely to caress the partner during sex) than women in the control group. Sexually abused women, however, did not differ from nonabused women on physiological variables (e.g., vaginismus, anorgasmia). Bartoi and Kinder suggested that sexual abuse leads to women losing insight into their own sexuality. They can no longer differentiate between what is satisfying or unsatisfying. Because they feel that they have lost control over their sexuality as a result of the traumatic incident(s), they may be cautious rather than sensual with their partners. Van Berlo and Ensink (2000) discovered that emotions women felt during, immediately, and a year after sexual assault (anger towards self, shame, and guilt) were strong predictors of lasting sexual dysfunctions.

Moreover, Becker, Skinner, Abel, and Tracy (1982) demonstrated that out of a sample of 83 women who had experienced rape and incest, 57% had at least one sexual dysfunction. The majority of sexual dysfunctions were fear of sexual interaction, arousal dysfunction, and desire inhibition (i.e., Hypoactive Sexual Desire Disorder). Interestingly, Becker et al. discovered that physiological responses to sexual stimuli are less affected by the incident of rape and more by

women's perception of sexual stimuli. Those who perceive sexual stimuli as threatening and anxiety provoking tend to experience inhibition and a reduction of sexual desire. Furthermore, Laan, Everaerd, van Aanhold, and Rebel (1993) found cognitive and attentional processes to be primary mediators of the effects of anxiety on female sexual dysfunction (cited in Rosen & Leiblum, 1995). In addition, women's beliefs about sexual activity, more than their genital cues, were found to affect their reports of the extent of their sexual arousal (Schreiner-Engel, Schiavi, & Smith, 1981). Lastly, sexual fantasies (i.e., cognitive skills used to enhance sexual arousal) were shown to be less frequent in "dysfunctional" women compared to those without such dysfunctions (Nutter & Condrov, 1983). Frequency of such fantasies was found to be negatively associated with sexual guilt and anxiety and positively correlated with positive orientation towards sexuality (Fisher, Byrne, White, & Kelly, 1988).

Systems theory. The systems theory (e.g., LoPiccolo, 1991; cited in Jurich & Myers-Bowman, 1998) stresses the importance of interpersonal determinants in the formation and maintenance of sexual dysfunction. According to the systems theory, sexual dysfunction occurs in order to maintain homeostasis within the system and/or to manifest unresolved relational issues. Such sexual difficulties can also be reinforced by the environment, especially by the experiences acquired within one's family-of-origin. Hulbert, Apt, and Rabehl (1993), stressing the significance of the interpersonal dimension for adequate sexual functioning of women, state, "The role… of relationship variables such as sexual assertiveness, erotophilia, and recreational closeness may be more important in understanding female sexual satisfaction than sexual variables such as frequency of sexual activity, number of orgasms, sexual excitability, and sexual desire" (p. 162).

Sui-Ming Pan (1993; cited in Jurich & Myers-Bowman, 1998) conceptualizes sexual functioning as being composed of three interconnected subsystems: biosexual, psychosexual, and sociosexual. A breakdown in any of these three subsystems may subsequently lead to sexual dysfunction. Two major contributors to the field of sexology, Masters and Johnson (1970), claim

that emotional connectedness and intimacy should underlie sexual interaction. Summarizing sexual difficulties, these authors state, “The real issue isn’t making love; it’s feeling loved” (p. 42). Other researchers and clinicians (e.g., Heiman, Epps, & Ellis, 1995; LoPiccolo, 1991; Roughan & Jenkins, 1990; Talmadge & Talmadge, 1986; cited in Jurich & Myers-Bowman) also successfully applied systems theory to the treatment of sexual dysfunctions.

Although the systems theory is criticized for being too general and abstract and for being difficult to verify empirically (Jurich & Myers-Bowman, 1998), much research has been conducted that gives evidence of the impact of interpersonal variables on adequate sexual functioning—though not necessarily conducted from the systems perspective. A number of studies have demonstrated a positive correlation between such variables as couples’ marital satisfaction and sexual functioning (e.g., Woody & D’Souza, 1997). A similarly positive correlation was established between emotional intimacy and sexual satisfaction (McCabe, 1997; Witkin, 1980) and between marital intimacy and the degree of sexual fulfillment (Patton & Waring, 1985). In the latter study, wives’ sexual fulfillment was more associated with marital intimacy than was the sexual fulfillment of husbands. Dermer and Pyszczynski (1978) discovered that sexual arousal often contributes to enhanced feelings of love toward the sexual partner.

Stuart et al. (1986) also specified that the quality of the marital relationship was a major factor influencing the wife's sexual desire–the poorer its quality, the greater the dissatisfaction. Buss (1989) found that the strongest correlate of sexual dissatisfaction for women is a partner’s sexual aggressiveness. Lack of assertiveness in women was found to be associated with low desire and orgasmic difficulties (Hulbert et al., 1993). Nonsexual conflict was demonstrated to have a negative impact on couples' sexual functioning (Bograrozzi, 1987). Finally, Wallace (1981) showed that supportive, encouraging, and accepting parenting in one’s family-of-origin is related to the positive experience of adult sexual expression.

Existential theory. Yalom’s (1981) concept of psychopathology can also be applied to

female sexual dysfunction. According to Yalom, humans experience at least partially unconscious psychodynamic conflict between:

1. *Life* (possibility of possibilities) and *death* (complete absence of possibilities);
2. *Structure* (a sense of being in control) and *nothingness* (we create our own selves and our own worlds; there is no ground beneath us);
3. *Belonging* (being-a-part-of-a-group) and *isolation* (being-apart-from-a-group; we die alone);
4. *Meaningfulness* (need to construct meanings to fit the situation into a recognizable pattern) and *meaninglessness* (no meaning in the universe; we live alone, we die alone).

When confronted with one or more of the above stated conflicts, people tend to experience primary anxiety (i.e., anxiety originating from confrontation with such ontological givens as death, isolation, meaninglessness, and/or freedom). Such anxiety is too overwhelming to handle and so people defend themselves against it. Two primary defence mechanisms used by most human beings are the belief in the ultimate saviour (e.g., a partner) and the belief in one's uniqueness (Yalom, 1981). If one of these universal mechanisms fails, then additional mechanisms are required. Such defences help to reduce the primary anxiety but they also prevent people from growth and subsequently produce secondary anxiety. Secondary anxiety is anxiety about some object/situation (e.g., sexual activity), onto which the primary anxiety is displaced. It is more tolerable than the primary anxiety as a result of its being less frightening, more concrete and simpler to deal with (see Table 1 for graphical representation of the Existential Model of Psychopathology, p. 164).

Hence, according to Yalom's (1981) existential theory, sexual dysfunction can be viewed as an additional defence mechanism used to cope with the primary anxiety of death, isolation, meaninglessness, and/or nothingness. Sexual anxiety that leads one to avoid sexual activity is more concrete and simple to handle than the overwhelming primary anxiety.

Medical model. Another perspective on sexual dysfunction is the medical model, which assumes that behind such difficulties lies some physical abnormality (some neurological damage, untreated sexually transmitted disease). According to the medical model, pharmacological therapy is beneficial for assisting women in achieving healthy sexual functioning. To date, little empirical attention has been given to the role of organic factors in female sexual dysfunction (Rosen & Leiblum, 1995). Although some attempts have been made to investigate biological or hormonal accounts of Hypoactive Sexual Desire Disorder (HSDD) (Schreiner-Engel, Schiavi, & Smith, 1988; cited in Rosen & Leiblum), more evidence is needed in order to indicate hormonal influence on sexual desire in women (Beck, 1995).

A medical model serves as the basis for the current classification of female sexual dysfunctions found in the *DSM-IV-TR* (APA, 2000). This classification categorizes sexual dysfunctions into desire disorders, sexual arousal disorders, orgasmic disorders, and sexual pain disorders. Criticism of this system has focused on its subjectivity and lack of empirical support, its dichotomous view on sexual health as functional or dysfunctional, and its either-or tendency toward psychogenic and organic aetiology (Rosen & Leiblum, 1995).

The classification is also based on the triphasic model of the sexual response cycle (desire, excitement, and orgasm) proposed by Kaplan (1977). Therapeutically Kaplan combined the ideas of psychodynamic and behavioural approaches and promoted the so-called "new sex therapy" which serves as a model for the practice of contemporary sex therapy. She differentiated between those sexual disorders with underlying intrapsychic conflict and those without such conflict. The former disorders, according to Kaplan (1979), are used as psychological defences (e.g., sexual dysfunction in a woman can be seen as her longing for the father whose love can repair her self-esteem) and require long-term in-depth therapeutic interventions. In contrast, the latter difficulties originate in more superficial sources of anxiety (e.g., fear of failing to perform sexually) and can therefore be treated with relative efficiency and success with behavioural modification techniques.

Considering these various theories of female sexual dysfunction, each emphasizing a particular class of determinants, it is important to note that many of the proponents of these theories (e.g., Kaplan, 1977; Masters & Johnson, 1970; Wolpe & Wolpe, 1988) dedicate special attention to the phenomenon of anxiety and emphasize its crucial role in the formation of sexual difficulties. To explore theories and research data on the specific effects anxiety has on female sexual functioning, it is important to review various conceptualizations of the phenomenon of anxiety.

Anxiety

The term "anxiety" has been used in its broader sense to signify the drive activated by a signal of potential psychological or physical pain (Gregory & Underwood, 2002). Such pain can be viewed as deriving from the person's experience of being confronted by the inevitability of death (existentialism), being excluded from a social group (exclusion theory), being overwhelmed, disintegrated, or punished (psychoanalysis), having lost a significant other (object relations theory, self-psychology, ego-psychology, and attachment or separation theory), or having lost security and certainty (neo-Freudism, perception of uncertainty theory). Thus, it can be said that anxiety arises when one is faced with a conflict between the potential of experiencing these negative consequences and desires for positive consequences (e.g., to live, to be a part of a social group, to satisfy sexual or aggressive drives, to be loved and nurtured by a significant other, and to have protection, security, and confidence in life). It is important to consider in detail the nature of such conflicts and the mechanisms used to form and preserve anxiety.

Psychoanalysis. The concept of anxiety is central to Freud's (1936) theory of psychoanalysis. Before the development of the structural model of the psyche (id, ego, superego), Freud conceptualized anxiety as an infant's experience of being unable to discharge libidinal energies in the temporary absence of the object for discharge. Psychoanalytic theory assumes the existence of a weakly-structured ego at birth and views anxiety as having the

potential to overstimulate the ego, thereby causing a so-called “falling apart” experience or “self-disintegration” (Pollio, Henley, & Thompson, 1997, p. 271).

The invention of this structural model caused Freud (1936) to reconsider his view of the role of anxiety and to interpret the phenomenon as a cause as well as consequence of a conflict between the components of the human psyche, id, ego, and superego. Specifically, when the innate sexual drive contained in the id seeks expression and gratification, it is confronted by the superego’s moral standards. Subsequently, intrapsychic conflict develops between drives and social reality.

The conflict between wishes and restrictions, along with its associated affects (guilt, shame, and fear) has a potential to overwhelm the ego. Anxiety, serving as a warning sign of the possibility for the ego to be overwhelmed, causes the ego to repress the conflict with its associated affects (including anxiety) out of the sphere of consciousness. Sexual wishes, being part of the conflict, are now located in the unconscious and are seeking to return to the conscious in order to be objectified and gratified. The wishes often fail to find direct expression due to the defence mechanisms created and utilized by the ego to protect itself. Accidental errors of speech or writing, sudden failure of memory, various symptoms (including chronic anxiety) are examples of how the conflict manages to overcome the defence mechanisms and express itself (Freud, 1953). The ego uses some defence mechanisms (e.g., sublimation, projection, and displacement) to decrease anxiety through allowing transformed or symbolic expression of the wishes.

Object relations theory/self-psychology/attachment theory. Psychologists of the British school of object relations (A. Freud, 1946; Winnicot, 1958), along with advocates of self-psychology (e.g., Kohut, 1971) combined both principles of Freud (1936), these being: anxiety as an overstimulated state of ego, and anxiety as a cause and consequence of the conflict between drives and social restrictions. They therefore stressed the importance of both intrapsychic and interpersonal factors for mental health. According to these theorists, anxiety is an experience of self-fragmentation due to the lack of an intimate relationship with a significant other. Such a

significant other is needed by an infant, not to discharge libidinal energy as claimed by Freud, but "to maintain [his or her developing] self . . . as a self in relation to others" (Pollio et al., 1997, pp. 271-273).

Self-psychologists (e.g., Rangel, 1955, 1968; cited in Pollio et al., 1997), speculating in somewhat similar terms, differentiated between annihilation anxiety (based upon fear of self-fragmentation) and structural anxiety (based upon conflict in a self-other relationship). If structural anxiety is low (i.e., no conflict in the interpersonal sphere), the environment (object) provides stability and cohesion for the self, which consequently decreases annihilation anxiety.

Transgenerational model. Bowen (1978) perceived anxiety as a biological phenomenon, which is both chronic and omnipresent in lives of people. Such anxiety is aroused when a family experiences struggles with pressures concerning togetherness and individuation. Typically, the more restricted the individual autonomy of the family members, the higher the anxiety levels within the individuals and the family as the whole. Such anxiety then produces various psychopathological symptoms. The more one is differentiated (i.e., the degree to which he/she is able to avoid having the behaviour automatically driven by emotions), the less anxiety this individual experiences, and, consequently the less he/she struggles with psychological difficulties.

Neo-Freudism/uncertainty theory. Neo-Freudians (e.g., Fromm, 1970; Sullivan, 1953) theorized that anxiety originates in the conflict between an individual's desire to grow autonomously, and his or her need for security and protection (Yalom, 1981). Similarly, Barlow (1988), the founder of the perception-of-uncertainty theory, conceptualized anxiety as a diffused pattern of response to various environmental threats. Both of these theories seem to imply that when people experience lack of safety and control within some environment, they tend to feel anxious.

Exclusion theory. Baumeister and Tice (1990), the originators of the exclusion theory, argued that behind anxiety is the anticipation of being excluded from a social group. Based on

separation theory and evolutionary theory, exclusion theory assumes the existence of a tendency to feel distress upon separation or exclusion from a social group, which would decrease a person's chances to survive, especially under primitive conditions. According to Baumeister and Tice, people might be biologically prepared to experience anxiety in response to the threat of exclusion or social rejection and some might, more easily than others, make certain conditioned associations. For example, someone's angry face may cause anxiety in one individual more than in another. Moreover, even in the case where a direct threat or danger is absent, a person may still experience anxiety in the anticipation of rejection. Anxiety is described by the authors as deriving from one's internalization of the significant other and the anticipation of how such another might react to the person's behaviour.

Simon (1967), describing the avoidant function of anxiety, insists that such anxiety, being ingrained in the cognitive system, interrupts the completion of behaviour that may potentially lead to social exclusion. It redirects one's attention from the task to the assessment. While making a speech in front of an audience, if one realizes that the consequence of expression of a particular argument means possible exclusion from the group, he or she then experiences anxiety, which, in its turn, leads the person to interrupt that self-expression (cited in Baumeister & Tice, 1990).

Existentialism. The advocates of existentialism (e.g., Heidegger, 1962; Kierkegaard, 1944), emphasizing human existence, saw anxiety as a state of being confronted by the ontological (existential) "givens" of life, such as death, meaninglessness, isolation, and freedom. Kierkegaard characterized anxiety as a state of facing unknown possibilities and new ways of living. Heidegger dedicated special attention to such a "given" as death and described anxiety as the dread of facing the inevitability of "being-into-dying". May, Angel, and Ellenberg (1958) defined anxiety as a "diffuse apprehension cued by a threat to some value that the individual holds essential to being, who it is he or she has chosen to be" (cited in Pollio et al., 1997, p. 273).

Lastly, Fingarette (1963; cited in Pollio et al.) conceptualized anxiety as a failure of the self to produce or synthesize the meanings of life.

Having reviewed a number of perspectives on the phenomenon of anxiety, it is important to engage in the exploration of this concept as it applies to a specific behavioural domain, namely, human sexuality.

Sexual Anxiety

Viewed as a major cause of sexual dysfunctions in both men and women (Kaplan, 1974; Masters & Johnson, 1970; Palace & Gorzalka, 1990) anxiety and the subsequent chronic avoidance of sexual encounters "can have deleterious effect on one's happiness and personal adjustment and pave the way for subsequent social, romantic, and marital problems" (Leary & Dobbins, 1983, p. 1348). Women are subject to these detrimental effects more than men, for, as research shows (Fredrickson & Roberts, 1997; Katz, Frazer, & Wilson, 1993), they experience sexual anxiety and sexual avoidance more than men. Theoretical and empirical material on the subject of sexual anxiety (i.e., anxiety experienced during sexual encounter) is presented below.

Freud (1966; cited in White, Fichtenbaum, & Dollard, 1967) saw anxiety as a cause and consequence of the repression of a conflict between sexual drives and social restrictions. He asserted that the connection between sexual restraint and anxiety is indubitable. Lief (1979), elaborating on Freud's ideas separated a more chronic type of anxiety (with an underlying intrapsychic conflict) from that anxiety which is caused by anticipation of failures in various situations (with no such conflict). According to Lief, either or both types of anxiety are present in sexual dysfunctions.

Lief's (1979) other contribution to the area of sexuality lies in his distinction between two subsystems of the autonomic nervous system: sympathetic (providing a neurological basis for anxiety) and parasympathetic (providing a basis for sexual arousal). According to him, adequate sexual functioning requires an equal and balanced operation of both subsystems. Some

individuals, however, experience the dominance of one of these two subsystems. In the case of frequent excessive discharge of the sympathetic system, a subsequent inhibition of the parasympathetic system occurs, and a person is apt to experience chronic anxiety and inhibited sexual arousal. Whereas a moderate amount of anxiety is beneficial for various life situations (possibly due to the stimulation of the reticular activating system), too much of it appears to be counterproductive.

Lief's (1979) theory seems to have some empirical support. Specifically, a number of studies (e.g., Barlow, Sakheim, & Beck, 1983; Cranston-Cubas & Barlow, 1990; Rosen & Leiblum, 1995) have shown that anxiety seems to increase sexual arousal in the case of "functional" men and women, while being problematic for sexually "dysfunctional" individuals. The study of Palace and Gorzalka (1990) demonstrated that anxiety decreases sexual arousal as reported subjectively for both "functional" and "dysfunctional" women, while increasing sexual arousal in both groups of women, as measured physiologically—in the "functional" group significantly more than in "dysfunctional."

Palace and Gorzalka (1990), on the basis of their findings, proposed a theory according to which anxiety serves physiologically as a "jump start" for sexual arousal in both "functional" and "dysfunctional" women. However, the physiological predisposition for lower sexual arousal and supposed subsequent negative expectancies regarding sexual performance lead "dysfunctional" women to experience various sexual difficulties. Hence, the researchers suggest that cognitive expectancies concerning sexual performance may impact the development of sexual dysfunctions in women.

Gagnon (1990), the founder of the social script theory, conceptualized the role of cognitions in the sexual functioning of "dysfunctional" individuals. According to him, performance demand leads to anxiety about such performance and a consequent decrease in sexual arousal (and other sexual concerns). This is due to a shift in focus from "sensations" to "performance" and performance anxiety. Gargon (cited in Wiedermann, 1998) argues,

"interfering cognitions as a result of increasing anxiety during sexual performance are believed to underlie various forms of sexual dysfunction" (p. 91). This assertion was empirically verified by a number of studies (see Rosen & Leiblum, 1995), which insisted that cognition serves as a mediator of the effects of anxiety on sexual dysfunction.

Whereas cognitive theories stress the crucial role of cognition as a mediator of the inhibiting effects of anxiety on sexual functioning, behaviourists (e.g., Wolpe & Lazarus, 1966), perceiving anxiety as a learned response, insisted that a number of sexual fears, inhibitions, and avoidant behaviours may develop through various learning experiences. Nemetz et al. (1978), supporting this perspective, proposed, "as anxiety, whether defined or measured affectively, is a highly learnable pattern of response, aversive sexual incidents would be sufficient to generate female sexual dysfunction" (p. 62). A series of studies on sexual assault (e.g., Burgess & Holmstrom, 1979; Feldman-Summers et al., 1979) seem to witness to the validity of the theory (see the section "Female Sexual Dysfunction" for more details).

Drawing ideas from social-learning theories, the following thinkers and researchers emphasize the role of society in the development of sexual anxiety. Janda and O'Grady (1980) define sexual anxiety as "generalized expectancy for the non-specific external punishment for the violation of perceived normative sexual standards" (p. 169). Similarly, Reiss (1970; cited in Jurich & Polson, 1985) argues that an approach-avoidance reaction, typical for people who experience sexual anxiety, is rooted in the sexual double standard of Western society. According to Reiss, women more than men have been subjected to ambiguous labelling of many sexual behaviours. Such behaviours are not entirely prohibited for women by the society, neither are they considered acceptable. In case of men their acceptability is rarely even considered.

Some research that has been undertaken supports the idea stated above. In their study conducted on university students, Jurich and Polson (1985) discovered great increase in participants' anxiety when they were asked questions associated with premarital sex. Their anxiety increased as the questions became more intimate. Sigush, Schmidt, Reinfeld, and

Wiedermann-Sutor (1970; cited in Jurich & Polson, 1985) reported that women became extremely emotionally defensive over their sexual arousal as a result of sexually explicit, visual stimuli. Also a positive relationship between constructive sexual motivation (i.e., desire to date, marry, engage in sexual interaction, etc.) and the expression of conscious anxiety about sexual matters was found in the qualitative analysis of the units of the interview units (White et al., 1967). It is this researcher's perception that perhaps women's negative sexual value systems regarding sexuality (Masters & Johnson, 1970) and negative sexual self-concepts (Longmore, 1998) could be at least partially attributed to the societal double standard mentioned above.

Schnarch (1991), in his "Sexual Crucible" approach, argued that in order for a person to experience sexual intimacy, he/she has to first confront his or her own anxiety. Intense desire and satisfaction are not secure until the person is able to deal with his or her own disappointments and fears. Drawing from the Bowen's (1978) transgenerational model, Schnarch proposed that people pursue self-differentiation in order to eventually be able to relinquish their insecurities and self-doubts and fully reveal themselves in the presence of their sexual partner, exactly as they are. The self-differentiated person is the one who maintains a clear sense of identity, is able to regulate his or her own anxieties, is non-reactive to others' anxieties, and is willing to tolerate discomfort in order to experience growth. He/she does not seek their partner for the purposes of reassurance, but rather to share what he/she already feels (fullness and meaning). Sexual desire derives from such fullness, rather than from a biological drive for sex.

Although there is a tendency to view sexual dysfunctions as originating in some biophysical abnormality, current research provides no substantial evidence to support such a presupposition (Wiedermann, 1998). Often a biophysical basis for a specific difficulty is assumed solely on the basis of successful pharmacological treatment. However, in the case of sexual dysfunctions, such treatment is complicated by the fact that one of the side effects of many antidepressant drugs used to decrease anxiety is inhibition of sexual desire. Klein (1980) claims that drugs that block panic anxiety in most phobic and anxious individuals still produce no effect

on the anticipatory dread and avoidance typically found in individuals suffering from some form of sexual dysfunction.

Qualitative Studies on Anxiety and Female Sexual Functioning

Although much of the research that exists in the area of female sexuality and anxiety is quantitative, some qualitative studies have been done on these topics. Fisher (1970, 1978, 1989; cited in Pollio et al., 1997) has completed a series of phenomenological studies with the aim of exploring the human experience of anxiety. Fisher stresses the importance of differentiating between two concepts: “other-being-anxious” and “anxious experiencing." He collected written reports from college students, on which had been described their experiences of being anxious. The study’s primary discovery was that the experiential structure of anxiety consists of two ingredients: “in-the-face-of-which” one is anxious (event) and “about-which” of such anxiety (attitude). The “event” ingredient was defined by Fisher as “the possibility of losing a chosen, lived, and/or planned-for world." The “attitude” component was described as a fear of the failure to become the person “one has chosen to be or had to be” (p. 272).

The purpose of another phenomenological study done by Pollio et al. (1997) was to describe the human experience of “falling apart,” or anxiety. Eight females and four males were interviewed and the results disclosed four themes of the focal experience of falling apart: (1) Crying/pain (body related experience); (2) Loss or losing (feeling of being lost or losing a sense of the familiar; feelings of meaninglessness and isolation); (3) Alterations of time (an inability to perceive time in a conventional manner; losing future and past); and (4) Being out of control (not being in control of one’s life, behaviour, and/or emotions; being extremely vulnerable and hopeless).

This idea of “falling apart” relates to the topic of female sexuality; however, only a few qualitative studies, one of which utilized phenomenological research design, have been conducted that explored the meaning and experience of female sexuality and sexual difficulties (Birnbaum et al., 2001; Clifford, 1978; Daniluk, 1993). In Daniluk’s study ten women were interviewed in a

group setting once a week for ten weeks. Participants created collages which related their sexual and reproductive histories, and which served as stimuli for participants to share their stories during interviews. Colaizzi's (1978) phenomenological method was employed to analyze the transcribed data. Results revealed eight themes related to the experience of women's sexuality:

1. Women's power, agency, and dignity have been undermined due to their experiences with medicine and medical professionals.
2. Women have been viewed as "undeveloped men—defective and deficient" due to the impact of traditional religious attitudes.
3. They have been victimized physically and sexually.
4. They have been objectified and marginalized due to the influence of media.
5. Women's selves and their bodies have been invalidated due to their early sexual desires and adventures having been characterized by secrecy, isolation, and ignorance.
6. They have experienced the connection, mutuality, and pleasure associated with and received in a mutual relationship of respect and care.
7. Women have also had the experience of powerlessness and negation of dignity connected with the aspects of a women's reproductive cycle (e.g., menstruation, pregnancy, breast-feeding, etc.).
8. They have experienced themselves as inadequate due to a negative body image produced and encouraged by media, which have defined female beauty in typically unattainable ways.

In spite of limited generalizability due to sample selection, and possibly restricted depth of descriptions that are associated with a group format for interviewing, the results revealed multiple socio-cultural factors that might have influenced women's sexual self-concepts and sexual value systems. From the results obtained it seems that such a sexual self-concept would be more likely negative as a result of women having gone through experiences which resulted in their feelings of powerlessness, deficiency, victimization, objectification, marginalization,

invalidation, negation, and insufficiency. It is not surprising that, as a result of these experiences, many women find themselves unable to experience pleasurable and anxiety-free sexual interactions with their partners.

Byrne, Fisher, Lamberth, Mitchell (1974) and Weis (1983, 1985) explored adolescent girls' reactions toward initial sexual intercourse. Among positive and neutral emotional responses the participants revealed the following negative reactions: sadness, guilt, exploitation, nervousness, tension, embarrassment, fear, pain, disgust, anger, and depression. Moreover, Thompson (1990) discovered themes related to a negative experience of sexual interaction by adolescent girls. These included alienation from the body, physical and romantic disappointment, and coercion. Because these studies targeted the sexual experiences of single adolescent girls, the results might be difficult to transfer to adult women's experience of sexual interaction due to their psyche, and possibly other factors, such as loss of virginity, lack of commitment, and age.

Clifford (1978) interviewed adult women and discovered a frequent sense of anticipation and desire to cuddle during sexual activities. Sadness, nervousness, performance anxiety, judgmental thoughts were reported to be experienced to a lesser degree. A few scales have been created that incorporated specific components of women's sexual experience and sexual dysfunction. These included "Sexual Arousal Inventory" (Hoon, Hoon, & Wincze, 1976), "Sexual Arousability Inventory-Expanded" (Chambless & Lipshitz, 1984), "Revised Mosher Guilt Inventory" (Mosher, 1988), and "Sex Anxiety Inventory" (Janda & O'Grady, 1980). The scales identified arousal, anxiety, and guilt as important experiential components of sexual dysfunctions. Although these scales appear to query the discrete emotional reactions women experience during sexual encounters, they seem unable to capture the female experience of sexual distress in its profundity and complexity.

Finally, Birnbaum et al. (2001) examined emotional, cognitive, and motivational components of women's heterosexual intercourse and developed a self-reported scale for the

purpose of assessing this kind of sexual experience. One hundred and twenty-four sexually "functional" and 15 sexually "dysfunctional" Israeli women communicated their feelings, thoughts, and wishes involved in the experience of intercourse. The results yield three global themes: (a) The Relationship-Centered Sexual Experience; (b) The Pleasure-Centred Sexual Experience; and (c) The Worry-Centred Sexual Experience. A confirmatory factor analysis revealed that the Relationship-Centred theme (61.4% of the total variance) included such factors as the feeling of being loved by a partner (32.5% of the explained variance); focus on the partner's state (12.8%); feelings of love toward partner (5.8%); desire for partner's involvement (5.5); and a sense of interdependence (4.8%). The Pleasure-Centred Sexual Experience (53.9% of the total variance) confirmed the following factors: pleasure related feelings (30.6% of the explained variance); a letting go state (10.5%); strength of feelings (7.4%); and focus on one's sexual needs (5.4%).

The Worry-Centred Sexual Experience (Birnbaum et al., 2001)–60.3% of the total variance–included such factors as a sense of estrangement and vulnerability (36.2% of the explained variance); negative feelings (6.7%); disappointment from partner's sexual behaviour (4.8%); sexual "burnout" (4.6%); a sense of sexual inadequacy (4.2%); and interfering thoughts (3.8%). The specific components of this domain are presented below:

1. Sense of estrangement and vulnerability. This factor incorporated such elements as feelings of emptiness, anger, self-pity, loneliness, sadness, vulnerability, and alienation.
2. Negative feelings. These included feelings of fear, disgust, and guilt related to the negative and immoral possibilities in sexual activity.
3. Disappointment from partner's sexual behaviour. This element consisted of feelings of frustration, dissatisfaction, resentment, complaints, and difficulties in experiencing pleasure.

4. Sexual burnout: This factor included feelings of indifference, impatience, tiredness, boredom, desire for ending and escaping from the situation, and decrease of sexual interest during intercourse.
5. Sense of sexual inadequacy. Worry, tension, and shame were presented within this factor.
6. Interfering thoughts. This aspect included disturbing thoughts, lack of concentration, and mind wondering.

Furthermore, MANOVA was conducted to compare the experiences of heterosexual intercourse of women with and without anorgasmia (Birnbaum et al., 2001). The results revealed that those women who experienced orgasmic difficulties, reported lower levels of loving feelings toward the partner, pleasure-related feelings and ability to "let go". They also were found to have higher levels of disappointment with the partner's behaviours and a sense of estrangement and vulnerability during intercourse.

As indicated above, a few qualitative studies have been conducted on the subjects of sexuality and anxiety. Although Birnbaum et al. (2001) were able to uncover the worry component of the experience of sexual intercourse, having a relatively large number of the participants in the study (N=129) possibly prevented the researchers from obtaining detailed descriptions of complex and profound experience. To date no one has explored the experience of anxiety during sexual interaction in its profoundness and complexity. The present study was an attempt to fill this gap. An in-depth interview was conducted with nine women, asking them to describe their experience of sexual discomfort, in whose cases such discomfort occurs more often than not. Also explored were facilitating events, coping mechanisms, and after-effects of the experience of discomfort.

Theoretical Framework for the Study

This study was approached from a cognitive-behavioural-existential perspective. However, it is noteworthy that there are other perspectives on the phenomenon which were not

included in the Literature Review section (e.g., feminist, evolutionary psychology, various religious views on distressing sexual functioning, etc.). The perspective from which this study was approached is based upon the ideas of such scholars as Wolpe (1958), Barlow (1986), and Yalom (1981). According to the theory of this researcher, as a result of certain learning experiences, women's fundamental fears (e.g., of death, meaninglessness, isolation, and/or freedom) become associated with particular sexual stimuli (e.g., a man's gaze, petting, intercourse, etc.). When such stimuli are sensed/perceived (detected, labelled, and attributed), an association with anticipated negative consequence (i.e., the potential of being confronted by some existential given) is activated and anxiety is subsequently (or simultaneously) aroused. One of two responses to anxiety can be identified: on the one hand is control over the situation/sexual stimuli, leading to some form(s) of sexual dysfunction; on the other hand is the experience of "letting go of control," which is associated with resulting sexual pleasure and enjoyment.

An example of this model is a woman who, after having experienced sexual objectification in the past (i.e., was perceived and used by others as an object), is now afraid of losing herself (or dying) in the sexual encounter with her potentially loving partner. She has a need to be consciously present in the interaction and be a spectator of herself—that is when she knows she exists. Whenever her partner approaches her sexually she feels anxious and finds it difficult, if not impossible, to let go of the control she feels she needs to have over her responses, partner's behaviours, and the situation in general. To let go of control for her means to be swept away by sexual pleasure and to simultaneously "die." It is noteworthy in this context that the French equivalent of the word "orgasm" is *"la petite morte,"* (i.e., "small death") (MacKnee, 1997). It means that it is only through facing her own death that this woman can experience orgasm and sexual intimacy with her partner.

The type of sexual dysfunction that manifests itself often depends upon the nature of association between sexual stimuli and ontological fear. If a woman, being unable to handle overwhelming anxiety before sexual activity even begins, interrupts sexual or even pre-sexual

interaction, she displays sexual desire disorder; if she withdraws from the sexual interaction after it has begun, this can be classified as sexual arousal disorder; if before orgasm—orgasmic disorder; and if before or during intercourse—sexual pain disorder. This researcher's theory requires further elaboration regarding the following; (a) The difference between "functional" and "dysfunctional" women in their experiences of ontological givens; (b) The nature of cognitive expectancies about being confronted by such givens; (c) The experience of anxiety; and (d) The differences in responses to such anxiety.

CHAPTER III: METHOD

Phenomenological Methodology

Phenomenology, as a study of consciousness (Stewart & Mickunas, 1974), was founded by German philosopher Edmund Husserl. The term "phenomenology" derives from two words: "phenomenon" (from the Greek *phainomai* "that which shows itself in itself, the manifestation") and "logos" (Greek, “word, reason,” i.e., "discourse" or "letting something be seen") (Heidegger, 1962, pp. 29-33). According to Husserl (1970), the world transcends the consciousness of an individual, meaning that it goes beyond what a human mind can capture. However, both consciousness and the world meet in the "intentionality" of consciousness — the concept implying that the consciousness does not exist independently, but is always of something (either of some objective correlate or of itself). Consequently, consciousness can be said to have direction or intention ("noetic") and some object to which it is directed ("noematic"). Traditionally, psychology has focused upon the "noematic" and, thus, limited itself to observable and measurable aspects of human existence (Stewart & Mickunas). Phenomenologists, however, direct their scientific inquiry to the "noetic," asking *how* something appears in consciousness. According to Heidegger, the key of phenomenology is not its theme, but its method (the life of consciousness).

A phenomenon can be understood in two ways: *phenomenally* (a simple account of a person's experience of some phenomenon, e.g., a pencil in its concreteness) and *phenomenologically* (the essential aspects of the experience of the phenomenon or its meaning, e.g., “pencilness” as a category). To understand a particular phenomenon a researcher would first obtain its phenomenological description. Fuller (1990) defines such a description as "an attempt to bring the phenomena to rigorous and systematic expression as they themselves (Husserlian motto—‘back to the things themselves’) show themselves to be, without the blinding intervention of conventional presuppositions" (p. 28). After the phenomenon is described, one would need to

conduct a so-called "eidetic seeing" or “eidetic reduction” (i.e., grasping the inner necessities of the structure) in order to get to the essence of some phenomenon. It is noteworthy that in phenomenology, the phrase “to reduce” does not mean to decrease in size, but rather to make clearer (Hermann, 1988). In the example of the pencil, one could experiment in the imagination, attempting to change various attributes of the pencil—its shape, colour, size, etc. If all changeable characteristics are subtracted, then what remains is its essence or the pencil’s meaning, namely, something that all pencils share. To summarize, the goal of phenomenology is the unbiased scientific exploration of the concrete or self-evident phenomenon as it appears in the consciousness without any preconceived perspectives (Hermann).

Some researchers (e.g., Colaizzi, 1978; Giorgi, 1985) applied the philosophical insights of phenomenology to psychological research, as Husserl did not make such an application. Phenomenological psychology is a rigorous and systematic study of structures that produce meaning in consciousness or, in other words, "lived" experiences that are typical for groups of people. "Experience" is defined as resulting from "the openness of human awareness to the world, and it cannot be reduced to either the sphere of the mental or the sphere of the physical" (Polkinghorne, 1989, p. 42).

Phenomenological psychology aims at developing a single theory of experience to capture its richness, and focuses on pre-reflective nature of such experience (Giorgi, 1999). The term "pre-reflective" means the immediately-sensed perception of lived experience (Prouty, 1994). Ricoeur (1981) calls such experience "preunderstanding" or "interpretation as appropriation," while Gendlin (1962; cited in Shapiro, 1986) defines it as an explicit thought or a description of what is felt, or "the explication of the bodily felt-meaning" (p. 174).

Some thinkers (e.g., Derrida, 1976) deny the existence of any experience prior to language, whereas others, realizing the cultural and historical determination of language (Heidegger, 1962) along with the inevitable gap between language and experience (Osborne, 1990), still accept the idea of primordial, pre-reflective, or bodily felt experience (e.g., a non-

verbal memory while in infancy). The focus of phenomenological psychologists is descriptions of people's experiences and the meanings attached to them, rather than the interpretations, rationalizations, and speculations about the causes of their experiences. In this sense, such experiences can be called pre-reflective, but it does not imply that the descriptions cannot be expressed linguistically.

According to phenomenological methodology, the contributors or the participants of a study who have experienced some psychological phenomenon provide descriptions of their experiences. Participants are also referred to as co-researchers because they work in collaboration with the primary researcher in the process of collection and analysis of the data (Osborne, 1990). The interpretations (or the determination of the essential structures) are conducted by the researcher, but still verified with co-researchers. Throughout the process of interpretation the researcher allows the obtained data to speak for itself, while putting aside as much as possible her preconceptions and assumptions about the phenomenon. The descriptions are interpreted from a particular theoretical perspective, but the essential structure of the described experience goes beyond these particular interpretations (Osborne, 1990). Other sources for descriptions of experiences considered by the researcher were her self-reflection on the phenomenon (see "Bracketing" section) and the reflections upon the phenomenon of interest taken from outside of the context of the study (e.g., previous research, poetry, paintings, etc.).

Rationale for Research Approach

Because the purpose of the study was to investigate and understand the co-researchers' experience as it manifested itself, rather than to control or predict it, the qualitative method seemed to be the most suitable approach to take. A phenomenological design was preferred over other qualitative designs due to the former's focus on pre-reflective experience (The principal researcher was more interested in the experience per se, rather than co-researchers' conceptualizations or speculations about such experience). This method also allowed one to obtain a single essential or fundamental structure of people's experiences through the

means of eidetic reduction (i.e., intuitive capturing of the essential elements of some phenomenon; Polkinghorne, 1989). Moreover, as a result of conducting rather lengthy interviews with the co-researchers, the researcher was able to capture the richness of their experiences. And finally, phenomenological research, being a holistic enterprise (Giorgi, 1997) described the rules of operation or essences of the complex phenomenon without losing any individual characteristics (Pollio et al., 1997) and permitted one to capture the phenomenon in its wholeness, including compound interactions of constituents within it.

Procedure

Steps for the present phenomenological research were borrowed from Colaizzi (1978), Osborne (1990), and Polkinghorne (1989). These steps, described below, include: (1) Framing the Question; (2) Bracketing; (3) Selection of Co-Researchers; (4) Data Collection; and (5) Data Analysis.

Framing the Question

According to the phenomenological method, the overall process of the research is guided by the research question (Osborne, 1990). Therefore, framing the question becomes a crucial part of the research project. The main research question was formulated on the basis of the research problem presented as follows: There are married women who, after beginning to engage in sexual activity with their spouse, find themselves experiencing discomfort. What is the meaning and description of such experience?

The co-researchers were asked to respond to the following questions: "Please think back to a time or times when you, after beginning to engage in some sexual activity with your spouse, found yourself experiencing discomfort of some nature. Please describe this experience as fully as you can." Furthermore, co-researchers were asked: "What happened that brought about the experience of sexual discomfort? What specific events led to the moments of such experiences?" In addition, co-researchers were encouraged to respond to the questions: "What were the effects of such experience on you personally? What were the effects of such experience on your

relationships? How did you cope with the discomfort? What have you learned or how have you grown as a result of having sexual discomfort?" This particular sequence (experience, pre-conditions, coping, and after-effects) was chosen over a chronological one to collect the data on the assumption that "exploring the intensity of the … [experience] first would elicit stronger associations with participants' prior experience and subsequent experience" (MacKnee, 1997, p. 80).

Bracketing

Heidegger (1962) states, "every inquiry is a seeking. Every seeking gets guided beforehand by what is sought" (p. 5). A researcher brings personal biases about the subject matter into various stages of the investigation: formulation of the question, identifying, collecting, and interpreting the data. Osborne (1990) calls it "the inevitable presence of the researcher" (p. 81). Husserl (1970; cited in Giorgi, 1997) devised a method that would allow the researcher to "put aside" and temporarily avoid using his or her biases in order to conduct a rigorous and objective examination of the phenomenon. He called this method phenomenological reduction or bracketing. Husserl promoted an attitude of universal doubt in which every aspect of the phenomenon and its appearance in human consciousness is not taken for granted but questioned by the researcher.

Thus, rather than trying to avoid biases, the researcher of a phenomenological tradition attempts to articulate such biases in a systematic and rigorous manner through the process of bracketing (Osborne, 1990). Whereas Husserl thought that complete bracketing is possible and should be aimed for, many researchers have expressed scepticism in this regard. Those who favour constructionism claim that the human consciousness is idiosyncratic, streaming out from a person's interaction with the world, and is thus shaped by the particular culture (Heppner, Kivligham, & Wampold, 1999). The glasses symbolizing the researcher's presuppositions about a certain phenomenon cannot be taken off during the investigation, as claimed by Husserl, but are the researcher's eyes through which he or she illuminates the phenomenon. Karlsson (1993)

expresses this point as follows, "[bracketing] does not change anything [e.g., allows for the transition from being biased to being unbiased]. It merely brings to light or discloses that which was concealed in the actual living [the researcher's perspective]" (p. 52).

To summarize, phenomenological research, being a perspective-based enterprise, through the process of bracketing reveals the researcher's conceptual biases and personal experience of the phenomenon in question, so that the reader can judge whether this phenomenon has been elucidated from this particular perspective (Valle & King, 1978).

Bracketing is an opportunity for the researcher of this present study and for the reader to become aware of her personal conceptions concerning the experience under investigation in the attempt to suspend or put them aside as much as possible. These conceptions would have as origins personal experience of the phenomenon, through such means as reading about it, and discussing it previously with people who had such experiences. Some of this researcher's ideas and insights about the phenomenon in question, gained through the process of bracketing, are presented in Appendix A.

Recruitment of Co-Researchers

Phenomenological research is characterized by the partnership between the researcher and the co-researcher. Both work toward a common goal—the precise and complete description of the structure of the experience. Hence, co-researchers are fully informed about the research and are considered to be involved in the process (Heppner et al., 1999). The role and responsibility of co-researchers is the sharing of their experiences with the researcher as fully and accurately as possible (Giorgi, 1985).

Nine co-researchers participated in the current study. Wertz (1984), describing the number of co-researchers required for phenomenological research, claims that the researcher needs as many co-researchers as it takes to illuminate the phenomenon of interest. It was the goal of the researcher to "generate a fund of possible elements and relationships that can be used in determining the essential structure of the phenomenon" (Giorgi, 1985, p. 48). Having conducted

in-depth interviewing of the co-researchers (1-2 hours in length on average), this researcher obtained a large range of variation in the set of descriptions (variety of specific experiences related to the topic).

The recruitment of co-researchers was conducted in the following ways. An information letter describing the researcher, the purpose of the study, and the criteria for selection into the study was sent to practitioners who specialized in the fields of sexuality and sexual dysfunctions and resided in the Lower Mainland of British Columbia (see Appendix B). A poster advertising the study was sent via mail or e-mail and/or displayed in various counselling agencies, university campuses, and community services organizations (see Appendix C). Also personal acquaintances and colleagues of the researcher were informed about the study.

When co-researchers contacted the researcher they were screened to determine whether they met the criteria for selection into the study. There were three criteria for participation: first, co-researchers had to experience sexual discomfort more often than not; second, they had to be able "to function as informants by providing rich descriptions of the experience being investigated" (Giorgi, 1985, p. 47); finally, co-researchers had to be female and married for at least six months. This last criterion helped to ensure the persistent, rather than temporary, nature of the experience. It also helped to avoid the experiential aspects (e.g., loss of virginity, physical pain) associated with an initial sexual encounter.

Data Collection

"Dialogue" has been described as one of the most useful and utilized methods for gathering and interpreting descriptions in phenomenological research (Osborne, 1990; Pollio et al., 1997). The phenomenological interview is "conceived of a discourse or conversation" and involved "interpersonal engagement" in which the co-researchers would share their experiences with the researcher (Polkinghorne, 1989, p. 49). The goal of such an interview is to describe and grasp the meaning of the fundamental themes of the experience. As mentioned earlier, the pre-reflective experience is emphasized, rather than the interpretations of such experience by the co-

researcher. Specific situations and action sequences that are representative of the phenomenon under investigation serve as the centre of attention of the experience, so that its structure would eventually be able to emerge and reveal itself (Polkinghorne, 1989). The questions asked by the researcher are framed in a way that allowed co-researchers to focus on their experiences and report them, rather than provide wordy descriptions of the situation (Colaizzi, 1979).

Osborne (1990) identified three stages of the interview process: establishing rapport, gathering data, and “respiralling”, or further reflection upon the phenomenon. Rapport between the researcher and co-researcher is probably the most fundamental "given," not only for the data collection stage, but for the study overall. If good rapport is absent then the descriptions will lack depth and accuracy and the final product of the study—the fundamental structure of the phenomenon—will be neither valid nor reliable. Even though a single interview is a rather short period of time for a working alliance and trust to be established, the researcher, by acquiring certain attitudes, will likely increase the safety and comfort of the atmosphere for a participant during the interview. Such attitudes include empathy, positive regard, and genuineness and are communicated through the listening/reflecting technique, the strategy characterized by accurate restating the participant's description of the experience (Rogers, 1980).

The second stage of the interview is concerned with the actual gathering of data. The dialectics (i.e., the interaction between the researcher and co-researcher) occur face-to-face, are rather unstructured, and the questions asked are open-ended. Co-researchers are encouraged to use their own words to describe their experiences. The researcher "goes with the [participant’s] pace and in accordance with the [participant’s] unique way of being" (Bozarth, 1996, p. 242). The researcher tries to remain open to unexpected aspects in the co-researcher's descriptions (Polkinghorne, 1989). Such activities as leading questions, interruptions, and reinforcing some of the interviewees’ responses are avoided (Schamberger, 1997; Heppner et al., 1999).

The respiralling effect occurs when the researcher asks the co-researcher to further reflect upon the phenomenon. This process allows the researcher and co-researcher to achieve a pre-

reflective depth of the experience and to reach towards its core. A lengthy interview would very possibly lead to this stage of respiralling.

Heppner et al. (1999) described three levels in the interviewer/interviewee dialectic through which the individuals' meanings or constructions become understood by one another and subsequently become transformed. The first level is characterized by the understanding of the constructions through word exchange and interpretations of the other's language. At the second level a discussion of constructions occurs in which the researcher shares with the co-researcher his or her interpretations of the co-researcher's constructions. The last level is the essence of the dialectic and is described by changing constructions in the process of interpretations. Here the co-researcher's meanings undergo transformations and new meanings emerge. Many counsellors aim for the transformations or changes that happen at this level. The primary task as researcher, however, is not to facilitate change in the co-researcher, but to obtain accurate descriptions of his or her experiences. However, if obtaining such descriptions requires certain transformations in the co-researcher's meanings then that is what the researcher should aim for.

The interviews. Osborne (1990) suggests the following sequence of data collection: brief preliminary telephone interview, in-depth face-to-face interview, and at least one follow-up interview. The purpose of the initial interview of the current study was to assess potential co-researchers for the study as well as to give them details about the study. If the co-researcher met the criteria for selection into the study (for criteria see Selection of Co-Researchers section), the time for the in-depth interviews was set. The cover letter (see Appendix D) and a consent form (see Appendix E) were given to each co-researcher prior to the in-depth interview.

The in-depth interview took place in a location chosen by the co-researcher. Each interview lasted from 60 to 120 minutes each. All interviews were audio recorded and transcribed verbatim. The interviewing process started in January 2002 and terminated in April 2002. The information that was conveyed to the co-researcher during the orientation stage of the in-depth interview and the examples of the questions asked are presented in Appendix F.

The follow-up interview was conducted over the telephone or face-to-face whenever possible and was about 15-30 minutes in length. Prior to this final interview, co-researchers received the list of the common themes and the common story (or fundamental structure) of the experience of sexual discomfort. The co-researchers were encouraged to share how the researcher's descriptions compared with their experience as well as whether any aspects of their experience had been omitted or were missing (Colaizzi, 1978). Corrections were made and additions were incorporated into the revised version of the report.

Data Analysis

Osborne (1990) asserts that there is no universally acceptable way to analyze the data and that the choice depends primarily upon the purpose of the research. The purpose of this study was to obtain the essential features of the co-researchers' experience. The best way to achieve this was to conduct an inductive analysis in which categories are defined as they emerge (Pope & Ziebland, 2000). The analysis of the data obtained in the current study was composed of the steps borrowed from Giorgi (1997), Colaizzi (1978), and Karlsson (1993). These steps are outlined below:

Step 1. In order to obtain a global or holistic sense of data or to grasp the data in its entirety, the researcher read through all protocols or transcribed interviews completely. The researcher attempted as much as possible to remain open to the text and avoided imposing presuppositions or fitting the description into some theoretical explanation. Sufficient understanding of the phenomenon was already reached at this stage of the data analysis.

Step 2. This step was dedicated to the discrimination of the meaning units or self-contained meaning blocks that directly pertained to the experience. The assumption behind this step was that experiences are not chaotic, but are structured and organized by certain processes in the consciousness. Such experiences manifest themselves as meaningful, clear, and discriminatory (Polkinghorne, 1989). The task of the researcher was to explicate such meanings. “Meaning" does not refer to the co-researcher's speculations or conceptualizations of the

experience, but rather the explication of her "lived relation" to such experience (Shapiro, 1986). In discriminating meaning units the researcher read the descriptions and marked the text each time that there was transition in meaning (the end of the meaning unit). The final product of such a process was a number of meaning blocks (Giorgi, 1997) within each individual transcript.

Step 3. This step involved the reduction and linguistic transformation of the meaning units within individual transcripts into more precise descriptive terms. The descriptions, expressed in colloquial language with its "multiple and blended references" (Polkinghorne, 1989) were restated in psychological terms. This process allowed the researcher to narrow a more general everyday life perspective to a more specific psychological perspective. Although a standard psychological language has not yet been created (different theories within the discipline utilize different languages), the researcher was aware that she could use the language grounded in the phenomenological tradition (Giorgi, 1997).

In this stage the researcher focused on the experience to which the language referred, and, namely, on the meaning of the experience rather than on the surface linguistic structure (Osborne, 1990). The researcher used two processes: reflection (what is truly being described in the unit?) and imaginative variation ("type of mental experimentation in which the researcher intentionally alters through imagination, various aspects of the experience, either subtracting from or adding to the proposed transformation" [Polkinghorne, 1989, p. 55]). Wertz (1984) suggested that successful transformation should result in about 80% of inter-subjective agreement, meaning that the transformation conducted on the same protocol by different individuals produces agreeable results (see the Reliability section for the reliability coefficient obtained in this study).

Step 4. Once meaning units had been transformed into psychological terms, the researcher started working on synthesizing them into consistent and systematic general themes that were common to all protocols. The process is described by Polkinghorne (1989) as "the eidetic seeing of the whole"("*eidos*"— Latin, “essence”) or the "intuitive 'grasping' of the essential psychological elements that incorporate the redescribed psychological meanings" (p.

56). Giorgi (1997) conveys two characteristics of this process—wholeness and reduction. The outcome of the analysis was the “common themes”—the various manifestations of the essential structure of the experience. The common themes were confirmed with the co-researchers on the matter of accuracy (see Validity section). Participants were sent a copy of the common themes prior to the telephone follow-up interview. During the follow-up interview the participants were asked to compare the description received with their own experience, add any aspect of the experience that has been omitted, and point to the experiential elements that were incorporated but did not represent their experience.

Step 5. Here the researcher created an "exhaustive description" (i.e., a detailed description of the experience with the incorporation of the participants’ original quotations) of the themes, in which the experience was presented in its chronological order—facilitating events, actual experience, coping mechanisms, and after-effects. Direct quotations from the original transcripts were incorporated into the exhaustive description.

Step 6. The final step of the data analysis was the formation of the "fundamental structure" or a “common story” of the experience (i.e., a description of the essential components or elements of the experience common to all or many of the participants). It was made up of the elements that were essential for an experience to accurately manifest or present itself (Polkinghorne, 1989). The fundamental structure of the experience, after being formulated, was also verified with co-researchers in a way similar to that described in Step 5. Verification of the common themes and the common story of the experience of sexual discomfort occurred in the follow-up telephone or face-to-face interview.

Ethical Considerations

To ensure the ethical treatment of co-researchers, several precautions were taken. First, co-researchers were fully informed as to the purpose and nature of the study and of their right to withdraw from it at any time. This was done in a variety of ways—during the initial interview,

through the cover letter given to the co-researchers prior to the in-depth interview (see Appendix D), and, finally, in the orientation stage of the in-depth interview.

Second, the issues associated with confidentiality were communicated to the co-researchers at the beginning of the initial and in-depth interviews. The participants were asked to sign a copy of the Informed Consent (see Appendix E) at the beginning of the in-depth interview. Third, the co-researchers were encouraged to ask questions regarding the research in order for them to make an informed decision concerning participation. Fourth, audiotapes will be destroyed upon completion of the researcher's Master's degree. The participants were notified that the protocols will be securely locked on the researcher's laptop. If participants express preference to withdraw their data from indefinite retention, such data would be erased permanently two years after the study was completed. Fifth, only the researcher had access to participants' true identities. The research team (Thesis Supervisor, Second Reader, and Thesis Coordinator) and the transcriber of the tapes were familiar only with the first-name pseudonyms chosen by the participants and assigned to the tapes. Each co-researcher was given a $20 honorarium at the beginning of the in-depth interview.

Reliability and Validity

Some researchers (e.g., Smith, 1984; cited in Burke, 1997) consider quantitative criteria of reliability and validity as irrelevant to qualitative research, due to the incompatibility of the assumptions behind quantitative and qualitative methods. Qualitative research, including the studies that utilize the phenomenological design, conceptualizes reliability and validity in the way described below.

Reliability

Reliability refers to the consistency in the description, analysis, and interpretation of the data across time and/or persons. Qualitative research places emphasis on the importance of the results obtained, rather than on their correspondence to reality (Heppner et al., 1999). Various perspectives on the same phenomenon may exist, but it is still possible that common conclusions

can be drawn from the variables within human perception. Phenomenological research assumes that the fundamental structure or the essence of an experience may transcend various perspectives and interpretations and, thus, be viewed as reliable in an inter-rater manner. Of course, there is no absolutely reliable interpretation. Therefore, the researcher should argue his or her particular interpretation as well as he or she can and leave the judgment regarding such interpretation to the audience (Osborne, 1990).

Reliability in this study was evaluated in Step 3 (see Data Analysis section). All common themes were presented to two outside judges (i.e., individuals who had expertise in the area of psychology) to match with the 15% of all meaning units identified in Step 2 of the data analysis. The main purpose was to ensure that the categories or themes reliably represent the meanings of the co-researchers' experiences. The level of agreement between the researcher and the external judges achieved was 80%. A higher level of agreement was not achieved—possibly due to the following reasons:

1. The external judges matched a particular meaning unit with a theme without consideration for the context from which such a unit was derived.
2. The primary researcher chose to make categories or themes fairly specific in order to reveal the phenomenon in its profundity and complexity. The downside of this decision was the ambiguity experienced by the external judges when matching a unit with a category. The judges were faced with an expectation to place meaning units in accordance with the four phases of the experience (pre-conditions, experience itself, coping mechanisms, and after-effects). They also had to match units within the experience of sexual discomfort according to the four psychological domains—emotional, cognitive, behavioural, and physical (physiological). If the categories or themes were made more inclusive and less distinct, it is possible that the external judges would not have experienced as much difficulty matching the meaning units with the themes.

Validity

Validity refers to the extent to which the results of the study accurately represent the participants' experiences (Schamberger, 1997). One task of the researcher is to persuade the reader that the transformation of raw data into psychological terms, as well as synthesis of such transformed meaning units into a general structural description, are valid (Polkinghorne, 1989). Validity of the results corresponds to their quality or to whether the results are conceptually understandable, reasonable, sensible, and informative (Heppner et al., 1999).

Validity of the current study was increased in a number of ways: (1) Through conducting interviews of a considerable length—the longer the dialogue is the more opportunity is there for a person to "exhaust" the phenomenon; (2) Checking results with co-researchers and two colleagues familiar with the topic of study; (3) Debriefing and verifying results with two women who had the experience of sexual discomfort but whose data was excluded from the analysis; (4) Checking results against the existing literature; and (5) Bracketing. Participants were sent a copy of the common themes and the fundamental structure of the experience. A convenient time was arranged for a telephone or face-to-face follow-up interview, where participants were asked to compare their experience with the researcher's description of it, add any omitted aspect of the experience, and note experiential components which did not pertain to their experience.

Verification by co-researchers, peers, and the two women external to the study was based upon the experiential criterion described as follows. A verifier's response was of principal importance. "Response" means "an immediately given judgment of the description," or "a comparison between formulation and phenomenon" (Shapiro, 1986, p. 175). A response such as "Yes, that's it!" was an example of experiential verification that the phenomenon was interpreted accurately.

Generalizability of the Results

Similarly to reliability and validity, criteria for determining generalizability differ from those of the quantitative research (Morse, 1999). Osborne (1990) characterizes

phenomenological inquiry as descriptive rather than explanatory. Because the focus of the phenomenological research is the description and understanding of the co-researchers' experience, the more accurately the experience is understood (empathic generalizability), the more generalizable or applicable the findings are to other people with similar experiences. Osborne points out: "the interpreted structure obtained from one person should be found in the experience of the other person if it has empathic generalizability. Generalizability was established as a posteriori rather than by a priori procedures based upon sampling theory" (p. 82). Thus, the compatibility of the phenomenon and the knowledge obtained is not limited to demographic characteristics of the people in the study (Morse). Accuracy of the results obtained in this study, confirmed in a numerous ways (see Validity section), ensures the generalizable potential of such results to married women with the experience of sexual discomfort. Still, those who have experienced sexual dysfunction will ultimately determine the generalizability or applicability of the results.

CHAPTER IV: RESULTS

This chapter includes brief descriptions of the nine co-researchers, common themes of the experience of sexual discomfort that emerged from descriptions provided by these married women, exhaustive descriptions of each theme, and finally the fundamental structure or a common story of the experience under investigation.

The Participants

Nine married women participated in this study. Their ages at the time of the in-depth interview ranged from 24 to 51 years with a mean age of 35.33. All of the participants were married for an average of 11.68 years and the experiences described took place within their marriage. Seven out of nine women have children. All women were Caucasian. Eight resided in Lower Mainland of British Columbia, and one lived in the United States. Seven out of nine women were religiously inclined. In terms of education, the participants ranged from having completed grade ten to having finished their undergraduate degree. The following is a short introduction of the participants in order of the interviews:

"Tara": Choreographer, age 33, married 10 years with 2 children, atheist.

Having experienced a date rape as an initial sexual encounter, Tara for the last ten years has felt lack of sexual desire and has displayed a tendency to avoid sexual intimacy with her spouse. Her emotional reactions towards sexual contact with her partner included feeling vulnerable, trapped, out of control, unsafe, betrayed, and invaded. Tara explained that she was constantly "worrying" about sex. She felt as though every day she has to make a choice as to whether this is going to be a "yes" or "no" day in regard to her sexual involvement. Although Tara appeared to accept the presence of sexual difficulty in her life, she still felt hope for remedying this, and achieving an ultimately satisfactory sexual functioning.

"Jenny": Artist, age 44, married for 10 years with one child, Unitarian.

Jenny has been suffering from some medical conditions (infertility, fibromyalgia). Partly due to the feelings of loss, pain, and fatigue of these conditions, partly to the history of childhood

and adult sexual abuse and neglect, Jenny now experiences sexual difficulties. She creatively described the process of engaging in sexual interaction and her need to pass through the layers of worrisome and disturbing thoughts and feelings with the hope of eventually reaching sexual enjoyment and pleasure—a process, which she called an "archaeological dig." Jenny has learned to enjoy life in spite of all the struggles she has faced. She finds meaning in painting, being compassionate towards others, and sharing her experiences with others.

"Lisa": Student, age 41, married for 19 years with three children, Evangelical Christian.

Lisa shared her experience of stress, pressure, physical tension, and anxiety while engaged in a sexual encounter with her spouse. Lisa felt feelings of guilt and shame over having sexual relationships prior to marriage and also for having current sexual difficulties. She also felt resentment, anger, and a desire to withdraw psychologically when feeling exhausted from meeting the needs of others (including those of her spouse). Lisa discovered within herself a tendency to avoid intimacy and noticed that this relational pattern occurred in various areas of her life (e.g., spiritual). When Lisa feels liberated from sexual discomfort, she experiences freedom from any concerns and doubts, and can appreciate relaxation, surprise, and arousal. She has found that her sexual struggles have inhibited her certainty about how to best parent her children around the topics of sexuality, and have also contributed to a lack of spontaneity in non-sexual areas of life. Finally, despite the deteriorating and damaging effects of sexual discomfort, Lisa conveyed having learned the positive effects of the commitment she and her spouse have for each other.

"Lauren": Physiotherapist, age 24, married for 5 years with 1 child, Christian Baptist.

Lauren experienced anticipation of forthcoming and mutual sexual enjoyment prior to marriage and frustration and disappointment with sexual interaction after marriage. Her initial sexual interaction was unpleasant and painful. Having learned throughout her upbringing that sexual interaction and being sexual are inappropriate or bad, she felt "sexually repressed." Lauren expressed a belief that a woman must have control to generate the response of excitement;

for her, the degree of sexual enjoyment and pleasure depended on the supremacy of the self's mind-control. According to Lauren, one way to do this is to anticipate pleasure and enjoyment.

"Colette": Massage therapist, age 51, married for 30 years with three children, Mennonite.

Collette expressed having had a sense of obligation to engage in sexual interaction with her spouse without a clear sense of her own self, her desires, and needs within the marriage. She reported having experienced frustration, anger, and depression associated with getting married without having a definitive sense of her own identity. Her sexual interaction has improved significantly as she has been able to let go of some anger associated with having made choices prior to fully knowing who she was and what she wanted. This "letting go" experience created spiritual, psychological, relational, and sexual transformation within Colette. In her experience of sexual discomfort Colette felt objectified (i.e., valued exclusively for her body), invaded, and used. She felt anxious, angry, hurt, and frustrated over having to meet the needs of others, including her spouse's needs. Colette experienced a lack of control and frustration with herself when choosing to participate in sexual encounters without having desire, or a sense of being in control, but guilt when choosing not to engage in sexual interaction.

"Claris": Student and server, age 25, married for 2.5 years with no children, atheist.

Having had multiple sexual encounters prior to marriage, Claris consequently experienced shame, guilt, and a perception of herself as bad and dirty. Sex prior to marriage seemed to serve as a means of attracting men's attention. As Claris got married and found an ultimate partner, she reported a loss of motivation to perform sexually. Claris has felt a sense of obligation to engage in sexual acts with her spouse, fearing that she will be rejected and unwanted if she refuses to participate in sexual interaction. She has been feeling tired and exhausted from constantly looking for proof that she is loved for who she is and not for her ability to satisfy her spouse sexually. Claris also conveyed the experience of unity, deep pleasure, and mutual satisfaction in the absence of discomfort.

"Morgan": Financial planner, age 38, married for 18 years with two children, Lutheran Christian.

Morgan has experienced intense guilt over having been sexually active with her spouse prior to marriage. She indicated that non-sexual interaction with her spouse directly affects sexual interaction. In her case, having felt unloved, unwanted, abused (sexually exploited), and unsupported by her spouse, Morgan felt unsafe to connect with him sexually. She withdrew from her husband psychologically and sexually. Morgan's experience of sexual discomfort was characterized as emotional, rather than physical pain. As a result of having relational and sexual struggles, Morgan experienced strengthened faith in her own potential and in God.

"Roxanna": Teacher, age 26, married for 8 months with no children, Evangelical Christian.

Roxanna suggested that birth control pills and being on antidepressant medication has negatively impacted her sexual life. Other factors that Roxanna felt contributed to the emergence and maintenance of sexual difficulties were being sexually active prior to marriage (to a greater degree than she thought was right) and also the painful initial sexual interaction with her spouse. Roxanna experienced inner pressure to engage in sexual encounters and guilt over a lack of genuine desire to satisfy her spouse sexually. She expressed a tendency to assume responsibility for her spouse's feelings and emotional reactions. Roxanna shared feelings of intense physical pain and being detached both from the experience and from her spouse while engaged in a sexual act.

"Sally": Health professional, age 37, married for 11 years with three children, Christian (non-denominational).

Sally had a positive perception of herself as a sexual being, her body, and the sexual act prior to marriage. After having engaged in the initial sexual interaction with her spouse, she has experienced a tremendous amount of guilt and shame about herself and her desires, which are rooted in her spouse's discomfort associated with sex. Sexual activity has consequently been perceived as dirty and disgusting. Sally also shared having unpleasant sensations or lack of sensations due to the detachment from the experience. Journaling, communication with others (including counsellors), and attempts to create a relaxing and peaceful atmosphere during sexual

encounters were some of the ways in which Sally tried to resolve and better cope with the sexual discomfort.

The Themes

The following forty-two themes emerged from the descriptions of the experience of sexual discomfort provided by the nine married women above. Though many of the co-researchers experienced numbers of these themes simultaneously, they also occurred in varying orders and amounts. A variance in articulation and salience of themes for different co-researchers was noted. Nevertheless, the final list of thematic meanings was created containing the themes common to many and validated by all of the participants.

Clusters of Themes

It should be noted that the imposition of any structure on the experience reduces the accuracy of such experience. Hence, it was the task of the primary researcher to balance the clarity and simplicity of the presentation of thematic descriptions with its accuracy and profoundness. The categorization system described below seems to be the most appropriate way to achieve such balance.

The themes were categorized within four sections: (a) Pre-conditions and facilitating events, (b) The experience of sexual discomfort, (c) Coping mechanisms used to reduce the discomfort, and (d) The after-effects of the experience. Further, to present the themes in a more comprehensible and structured manner the section “Experience of Sexual Discomfort” was divided into “General Description” of the experience and its “Specific Components.” The former allowed incorporating the descriptions of the experience that reflected the phenomenon in its wholeness and profoundness, whereas the latter focused on more specific manifestations of the experience. The themes within the “Specific Components” subsection were grouped in accordance with the four interdependent psychic domains (i.e., emotional, cognitive, physical, and behavioural), which have traditionally been used within the field of psychology to conceptualize people’s intropsychic experiences (Cains, 1979). The categorization described

above is consistent with the interview format used in this study to query the experience of sexual discomfort. During the interview participants were first encouraged to reflect on their experience in broad terms (e.g., "What was the experience like for you?"). As such general descriptions were exhausted, the participants were invited to reflect on what they were feeling, thinking, doing, and experiencing physiologically.

The initial phase, themes 1-8, included pre-conditions or specific events that set the stage for the experience of sexual discomfort to take place. The middle phase, themes 9-30, incorporated the descriptive categories of the experience of sexual discomfort followed by the coping mechanisms used by women to minimize and better deal with the discomfort (themes 31-39). The final phase, themes 40-42, represented the categories that describe the after-effects or the impact of the experience on women, their relationships (with a spouse, others, higher power), and life in general. The number in the first bracket specifies the ratio of the participants who reported having the indicated experience; the second set of numbers shows the ratio of the additional two women who were not participants, but who validated the themes.

Four Phases of the Experience of Sexual Discomfort

Phase I: Pre-conditions and Facilitating Events

1. Child/adult sexual, physical, and emotional abuse (6:9) (1:2)
2. Unpleasant/painful initial encounter (7:9) (1:2)
3. Being sexually active prior to marriage (6:9) (1:2)
4. Belief that sexual interaction and being sexual is something negative (8:9) (1:2)
5. Sense of obligation to perform sexually (9:9) (1:2)
6. Feeling psychologically/physically unprepared to engage in sexual interaction (8:9) (2:2)
7. Deficit in emotional intimacy with the spouse (7:9) (1:2)
8. Some physical condition or being on medication (7:9) (2:2)

Phase II: Descriptive Themes of the Experience of Sexual Discomfort

Emotional

9. Feeling anxious and vulnerable (9:9) (2:2)
10. Feeling betrayed, invaded, and used; resistance (7:9) (1:2)
11. Guilt and inner pressure to engage in sexual interaction (9:9) (1:2)
12. Shame, feeling of inadequacy, and fear of rejection (9:9) (2:2)
13. Feeling exhausted, hurt, and angry over meeting others' needs while not having own needs met (8:9) (2:2)

14. Discouragement and hopelessness (8:9) (2:2)
15. Loneliness and isolation (8:9) (2:2)
16. Emotional detachment from the experience and the spouse while engaged in sexual interaction (9:9) (2:2)
17. Disgust (7:9) (1:2)
18. Relief following sexual interaction, i.e., being relieved that it is over (8:9) (2:2)

Cognitive

19. Encouraging and/or negative self-talk (9:9) (2:2)
20. Sense of obligation to engage in sexual interaction (9:9) (2:2)
21. Negative perception of self, spouse, and the sexual act (8:9) (2:2)
22. Lack of control/choices (6:9) (1:2)
23. Mental detachment from the experience (9:9) (1:2)

Physical

24. Pain (5:9) (2:2)
25. Tension and resistance (9:9) (2:2)
26. Physical manifestations of anxiety (e.g., heart rate and breathing) (7:9) (1:2)
27. Numbness and lack of sensations (4:9) (1:2)

Behavioural

28. Avoidance of sexual interaction/intimacy (9:9) (2:2)
29. Engaging in sexual encounter despite discomfort/pain (8:9) (2:2)
30. Motionlessness during sexual interaction (7:9) (2:2)

Phase III: The Mechanisms Used to Cope With the Discomfort

31. Acknowledging and trying to resolve sexual struggles (9:9) (2:2)
32. Avoiding sexual encounters (9:9) (2:2)
33. Tending to engage in compensatory behaviours and rituals (7:9) (1:2)
34. Co-operating with unexpected experiences of openness and freedom during sexual encounters (7:9) (2:2)
35. Accepting the situation; keeping up hope (9:9) (2:2)
36. Releasing shame, guilt, and anger (9:9) (1:2)
37. Engaging in self-caring activities (9:9) (2:2)
38. Placing mental focus on a spouse and the couple's unity (8:9) (2:2)
39. Having a predictable and stable pattern of sexual interaction (6:9) (2:2)

Phase IV: After-effects

40. Overall negative effects counterbalanced by enhanced faith in sexual and/or spiritual healing (9:9) (2:2)
41. Individual difficulties counterbalanced by individual benefits (9:9) (2:2)
42. Relational discord counterbalanced by enhanced dedication to marriage (9:9) (2:2)

Detailed Description of Themes

Phase I: Pre-conditions and Facilitating Events

Themes 1-8 represent the conditions that contributed to participants having the experience of sexual discomfort. These included specific events or incidents, whether of isolated occurrence, or continuous (e.g., child/adult sexual, physical, and emotional abuse; an unpleasant/painful initial encounter; and being sexually active prior to marriage), and more general conditions or experiences (e.g., a sense of obligation to perform sexually; feeling psychologically/physically unprepared to engage in sexual interaction; a deficit in emotional intimacy with the spouse negatively effects sexual interaction; some physical condition or being on medication; and belief that sexual interaction and being sexual is something negative).

1. Child/adult sexual, physical, and emotional abuse. Morgan described herself as a "sexual abuse survivor." Similarly, Colette also shared an incident of being sexually assaulted by her brother. She said:

> I was very young, one of my brothers did actually, I would have to say now, in retrospect, it was sexual abuse when I was about five. I don't think that it was really bad. It didn't make me hate men, it didn't even make me hate him, but I know that that was there. I don't know why I ever even brought that up now, but that might have been some factor, I don't think it was a huge factor, maybe I'm not giving enough weight to it…

Jenny experienced sexual assault incidents throughout her life. She disclosed a number of situations when she was sexually abused as a child:

> I'm not the kind to go blow the whistle on my father, but I'm pretty sure there were some things that went on when I was younger, I don't know exactly but, he's somebody who says, "Oh, it's perfectly normal for adults to sexually explore children," and he says and does things that are just sick, I mean he's just a sick man, ha, ha. Then I was sexually assaulted in the school system, at a time when there wasn't anybody that did anything about it. They just put the man in front of you and the principal, and sat you down, and

> you had to talk to the Principal and tell him in front of the man that did it, what happened, right, so. So, there's a guarding, even though I know that my husband isn't abusive. He's the gentlest man around.

Jenny did not experience protection and support within her family-of-origin. She said, "If I talk to my mother, she just doesn't remember any of it. It's like God. I mean you love your parents. My dad, I don't really care for him, but it's like she doesn't have a clue what I went through. It's like it didn't even happen." She further shared another experience of sexual abuse:

> So, when I was at this program, I sort of mentioned the rape very nonchalantly, "I was raped,"— that's how I referenced the rape for a long time after it happened. I mean right after it happened I was extremely angry. I was in a room full of people, so I was thinking, maybe I could have just screamed. Why didn't I? So it almost becomes my fault cause I didn't do anything about it, right, cause I didn't want to make a scene.

As a consequence of these and other traumatic experiences Jenny had felt unsafe and endangered. She put it this way:

> I guess the word *tormented individual* comes up. It feels like a tormenting. I would like to be a relaxed, sexually active being who paints and who can get myself out in the world. I'm very scared of being out in the world, because when I go out in the world and start living in it, bad things have happened, consistently.

Finally, Tara described how a man, with whom she decided to connect sexually, eventually raped her. She felt as though she had lost control over the situation and was ashamed and embarrassed to share with others what happened and thus, was unable to stop rape incidents from happening. She revealed:

> I've never liked it. Like I can go back to the first experiences, when you meet boys, you're experimenting, etc. I didn't want to have sex. I was like 20 and I still didn't want to, they'd want to and say, yes you're going to do it, and I'd say no I'm not and I'd leave, and I'd be very in control, and I'd say no, and I never did it just because I had to do it.

> Then I met a boy and he said yes it's time and I'll be gentle, and I'll show you, and I was like 20. So I would say no, and he would say, you are anyway, and that's where the tension started . . . I said no, and he didn't care, and he was 200 pounds, and he pinned me down and made me do it anyway so the whole time in my head I was saying no, I said no, why is no not no, and that sort of thing. So, now what do I do? I said no, what's going to happen next time? Well I can't tell my parents that basically I said no, and he did it, so I better keep going out with this guy so nobody finds out what happened that I lost control, and I let him do this, because now it's my fault. I said no, I should have left, I should have been able to get out of there somehow and said no but I didn't so, now it's my fault, so now I have to put up with the situation, and I have to keep dating this guy because otherwise people find out that I was not in control, and I didn't control my situation.

2. Unpleasant/painful initial encounter. Lauren committed herself to not engage in sexual interaction prior to marriage and anticipated forthcoming mutual sexual enjoyment. However, she experienced frustration and disappointment with the initial sexual interaction, as it ended up being very unpleasant and painful. She described it like this, “The honeymoon was like the first time and nothing even happened that night because nothing could.” Similarly, Roxanna recalled having pain and discomfort during initial sexual intimacy experience:

> I think the first time we had sex was fairly traumatic. I don't know if I'd use the word traumatic actually, but it was very, very uncomfortable to the point where I was in tears and that was our wedding night, and it was just, like so much anxiety building up to this thing that we've been waiting for 20 years and we didn't really prepare ourselves mentally. I was anxious about it, we didn't really prepare for it physically at all and so it was really, really hard and hurt a lot. So since that time, I kept thinking well we've just got to keep trying and like it will just get better, and it wasn't really getting better and the more and more we tried, I'd just get so much more anxiety about it.

Tara also felt disappointed with the initial experience of sexual interaction. She said:

> The fact that I never liked it didn't help. Like even before I said no, even when I said yes, and I wanted to, I was ready, I was so prepared, I studied for it, you know I was ready, it still wasn't that great. I guess it was just a disappointment. I was expecting this huge great, oh fireworks, it was going to be so wonderful, but it was just an act like wrestling. I never, in my first few times had this huge emotional thing that I wanted to have it and I'm a very emotional person. I love emotion, I love feeling emotion, I love that and I don't get to have that. I don't feel emotion, I love being in love, I love my husband, I love my children, but I don't get to feel that when I have sex.

For Sally, the initial sexual interaction experience was also unpleasant. Her spouse felt uncomfortable connecting with Sally sexually and as a result she felt dirty and ashamed of herself. She portrayed these feelings in this way:

> So on our honeymoon, I remember this specific experience, the first night or the first couple of days I had brought along the *Joy of Sex* book thinking that we'll just start basic, because he was uncomfortable with anything, like oral sex was just like he could hardly say the word. So I brought the book out and his face just fell, and he looked totally uncomfortable and he just, sort of, shut down and made some remark about it or something, and I felt really dirty. Like it made me feel like I must be so dirty to be in possession of this book and wanting him to look at this with me and engage and try to explore and in my mind it was this beautiful thing that was part of our relationship, but right away when I saw that facial expression and that reaction from him, I could just feel myself, just turning in my head, this must be disgusting, this must be not right.

Lastly, Claris disclosed, “Well my very first sexual experience was with a man, almost the age of my dad, and I got pregnant and I got a venereal disease… I think from that point in time, I started feeling dirty.”

3. <u>Being sexually active prior to marriage.</u> Roxanna experienced guilt associated with being sexually involved prior to marriage. She said, “I was always a very sexual person before I

got married, more than I probably should have been, but never having sex, but just very in touch with that part of my body." Morgan also had been sexually active prior to getting married. Although her partner was her future spouse and they finally did get married, she still experienced a tremendous amount of guilt and anger at herself for not waiting until marriage to connect with her spouse sexually. She stated:

> We had sex before we were married and that really bothered me, I had a hard time with that. So that was my discomfort because I had the guilt, and I knew it was wrong, and I was so glad that we got married so that it could, kind of, cover it up, but it still ate at me.

Claris used to be sexually active prior to marriage. She consequently experienced shame and guilt and perceived herself as bad and dirty. Having had a sense that she might have misused sex, she stated, "I used my body for so long that now I don't want to do that." Claris described that the interactions she had with her mother might have contributed to the formation of the self-concept as dirty and bad. She described it like this:

> If my mom knew I was with a lot of men, I don't think she would [approve]. One time she used a word "slut" when I would came home really late, like three or four o'clock, she came out and said, "Look at yourself, you dirty slut. Go where you came from and lay down under the person you came from, I don't want you in my house." Yes, in her opinion, it would be really inappropriate to have as many sexual contacts as I had.

Lastly, Claris reported feeling unmotivated to perform sexually any longer. She used to engage in sex in order to have a sense of belonging; when she gained this sense within her marriage, she no longer felt a need to perform sexually:

> When we first got married I continued to do what I was doing previously. I tried so hard, I tried my best, I tried to prove how good I am, and he is showing that he did a good choice, and he wouldn't be sorry about our sexual life, and now it's like slowing down. And lately, basically, he is wondering why I can't do it like I used to do it. Why before I

> could do that and now I can't? What changed? I understand him, but there is also, like, what's the point of having sex with him if I'm already in a relationship?

Lisa shared taking on the responsibility for past sexual experiences. She confessed:

> Voluntarily… It was my choice, so I had to look at the connection between having a lack of boundaries of having someone take advantage of you sexually before you're ready, as a little girl, and that there's a connection, then between not having the boundaries when you're 17, and then also not talking to your parents about such things. So there's some further victimization there, but I have a hard time having the same sense of victimization when it was of my own free will. Well I say it's my free will.

According to Lisa, it is not the event itself but her perception of it that leads to the experience of discomfort. She argued:

> I would say that people have had these experiences in the past because, and I don't think that's struggle for me, it's the way I have interpreted it and used it against myself, and have had trouble letting go of the guilt and the shame… forgive myself, not keep holding that against me for the rest of my life.

4. <u>Belief that sexual interaction and being sexual is something negative.</u> Lisa was taught within her family-of-origin that sexuality and sexual interaction is something negative and sinful. She said:

> Maybe . . . my sexual heritage and upbringing in my family. The way my parents didn't talk about it and when they did, how negative it was. My mom gave me negative messages about the approaching sexual time. A verbal, overt, this is what it's going to be like, you're going to have to do it, so the way I've figured out with dad, the way to keep things content in your marriage is just to do it more often than you want, because he'll want it more often and that will be the best way for you. I call it, like a, really crummy sexual heritage. I think I got that and it's tied up with rigid religious stuff which I'm sorry

> to say is truth, because God created sex so why would the God-fearing people make it sound so bad.

Lauren, having had no model of positive sexual interaction to imitate, said, “I don't think, I ever had an example of what a healthy sexual marriage relationship was.” She also conveyed having learned through upbringing that sexual interaction and being sexual are inappropriate or bad. She put it in the following manner:

> There are people out there whose parents are not teaching them that, they maybe don't feel repressed, don't say comments about stuff on T.V. or comments about clothes that people wear. I know that my mom did. She always flicked the channel if there were scantly clad women on there, she would talk badly about women who had been around, things like that. So I knew that being sexy was bad. Yah, like I didn't know how, I would find a comfortable place for me, because being repressed didn't feel comfortable either but it felt like if I went over that boundary that I would be bad, but again I didn't necessarily like where I was. It was that I truly believed in it, but it was more ingrained in me.

5. <u>Sense of obligation to perform sexually.</u> Colette got married prior to having gone through the process of individuation. Consequently, she found herself experiencing a sense of obligation to engage in sexual interaction with her spouse without a clear sense of her own self, her desires, and needs. She put it this way:

> I think it even related to the whole, all the dynamics of my own struggle and psychological development and everything like that as well in terms of not knowing, of having a sense of my own self… before I could even be in touch with my own wants, I was being initiated upon, all the time. So I think that created some of the discomfort so that I came to the point of not wanting to even have sex because it was like I don't have the choice, and I'm not in touch with where my wants and desires are, and so I want to close off because I feel as I am being [initiated upon]…

As Lisa reflected back on her adolescence and young adulthood, she discovered that she would ignore personal sexual desires and preferences and focus on the sexual needs of her partners. She developed a belief that she needed to perform sexually in order to belong. She described it in the following way:

> Without even knowing, at such a young age that, like I remember wanting to be with them and there was some one-night stands but then there was also, like a, one and a half year relationship where I would miss the guy if I wasn't with him and I thought I loved him, and I would have sex with him regularly, but even then, I didn't have orgasms regularly and I didn't sort of take the time to explore all that, and of course in an immature relationship, I faked it, actually, quite a bit with one guy. So there was some funny stuff going on even when I was 20. I think that really, subconsciously I thought it was more about their pleasure without ever talking to anyone about what it could be like for me.

Likewise Claris felt a need to perform sexually and experienced difficulty to achieve orgasm prior to marriage. She conveyed:

> Lately it's not like that, but before I got married, I would try to look as sexy as possible, to talk as sexy as possible and to participate in what's sexy, but when I actually would engage in intercourse, I can't remember myself ever having an orgasm. I never did have orgasms before I got married… I did try to please so many men that I didn't really feel any pleasure. I just tried to please them.

6. <u>Feeling psychologically/physically unprepared to engage in sexual interaction.</u>

Lauren emphasized the supremacy of the mindset in the control of the degree of both sexual enjoyment and sexual discomfort. She said:

> And so much of it it's mostly in the mind for women, whether it's going to be good or bad or whether you're going to be interested or not, or whether you feel good about yourself and you feel sexy. Whether you are attracted to your husband, whether you're talking

> yourself into it, or whether you really are distracted. Whether you are going to let the distractions go, or whether you are going to just nit pick about nothing's right, like my feet are cold or something, you know, it's all in the mind. You know, distractions like that, your feet are cold can totally ruin the experience. It's all in the mind. It felt good to have those words in the mind, "You're in control, you can make the response happen." It changes everything, so that you are not bound to your thoughts.

Roxanna also believed in the important role mindset plays in determining the process and outcome of sexual interaction. She stated: “I'm realizing sex has a lot to do with your mindset and what you are thinking about and where your mind is and whether or not you're into it, and so when I'm not into it I'm just kind of thinking about other things.”

The participants reported that when they found themselves being mentally unprepared to engage in a sexual encounter with their spouse, those were the times when these women were most likely to experience sexual discomfort. Tara conveyed:

> Just on the days when there is no foreplay and we just do it, I just go okay, whatever, and I just sit there and it's done, it's over. So there's nothing, but at least during foreplay it gives me a chance to get my mind organized to try and enjoy it more.

Similarly, Colette revealed feeling not ready to engage in a sexual act with her spouse. She described it like this:

> I'm going past where I am, and I'm not ready to go there. Or it's going past where I feel emotionally right. To go there is something really I'm just not prepared to do. I'm able to express that, whereas in the past I'd feel guilty for expressing that.

7. <u>Deficit in emotional intimacy with the spouse.</u> For Sally, emotional connectedness between her and her spouse enhanced her desire to experience sexual intimacy:

> Obviously times in your marriage when I'm feeling closer to him emotionally, to see him do something very sensitive with the children or an interaction that he'll have with me that increases my desire to want to be with him physically. So when we're having our

> marriage like this, when we're having our times, when he's just ticking me off about things and not helping with anything or whatever, that physical desire wouldn't obviously, so that's a factor which I think is pretty normal with any woman. That's what they say, if you want to go to bed with your wife in the evening, you better start working on doing nice things all day long.

Likewise, Tara emphasized the importance of emotional attachment and feeling genuinely cared for by her spouse. She shared:

> Whether it will be good or, yes, yes, in my mind [depends on] what's happening before, like…if he was there for me, did something caring that would make me more, as long as I didn't get my mind to think that he's doing it for sex…. I know the day after we had it, I'll never do it two days in a row and he knows that. So I always know the day after, whatever he does is genuinely affectionate. So I always love that day, because everything he did on that day was totally for affection because he knows he's not going to have sex. I don't do it two days in a row. So I always love that day, because I always feel very emotionally attached to him. So, he's doing everything today just because he loves me.

Jenny wished that she could spend more time with her spouse. She conveyed, "The other thing is that my husband's working fulltime and studying all the time. It gets so there's hardly any time together. I think that most women need to have time to relate." Moreover, Morgan linked a non-sexual interaction with her husband with the consequential enjoyable sexual experience. She said, "The feeling of love, being in love. The feeling that we're getting along really good, we're having fun together. Those all lead up to a great time and that just seems like the sex is the end of it." She further expressed feelings of resentment and anger toward her spouse for not providing her with a caring, loving, and supportive environment. As a result she experienced a lack of safety to connect with him sexually. She put it this way:

> Because for me, anyways, it's a showing that you love somebody. It's showing and it's exposing you as the most open person that you are, and I guess when you harbour resentments or you've had a fight for the day, or the week, or the month, or the year, you just don't feel like expressing it that way. You just don't have the desire for that person, on both sides.

Similarly, Lisa needed to protect herself against the anger of her spouse, even though such anger has decreased significantly. She also felt that her husband was not there for her emotionally when she needed him. She expressed it like this:

> One of the dynamics between my husband and I are that we've been married 18 years and during our marriage, he struggled a lot with anger, and I think part of the wall that I put up was probably early in our relationship in that we would never talk about the physical or sexual abuse against me, but it was living with someone that was very volatile with anger, and I grew up in a family where we really had sort of peace at all costs kind of family. So with an explosive temper that sometimes you didn't know what had affected him during the day and whether or not he might take that out on you, I think might have contributed to me feeling defensive. Feeling a need to safeguard myself and protect myself because I couldn't predict how he would always be and I needed to guard myself from that.

8. Some physical condition or being on medication. The co-researchers shared a number of medical conditions or procedures and types of medication that they felt contributed to the onset of sexual discomfort. These included: birth control pills, fibromyalgia, feeling physically exhausted, abortion, venereal disease, infertility, and psychotropic medication. Roxanna found that having gone on the birth control pill after marriage, she experienced a decrease in sexual drive:

> A lot of it I attribute to the pill that I was on and since I've been on a new one for about a month and a half, I've noticed a big change, and I will have initiated sex and enjoyed it

> though not necessarily the intercourse part of it. We're still working on that, but just the leading up to that part and that's a big change but it's still not right, it's not fitting right.

Jenny suggested that fibromyalgia might be contributing to the deficit in sexual desire she experiences. She put it this way, ”Right now I'm going through a period when I can't feel pleasure, libido is sort of not happening and I think that's got to do with the fibril.” She also thought that infertility might have affected how she perceives herself as a woman and sexual being, and consequently led to the reduction of the libido. She stated:

> So the infertility thing is just a pain in the ass, literally. You know pregnant women, they keep on being around. So, even now I think, having a newborn would be exhausting. I think it would be not necessarily something I'd want to do now, but then if I have a baby then I wouldn't be a mutant [laughter]. And that's got a lot to do with my self-concept of the sexual being.

She also added that the experience of sexual intercourse had been at times both mechanical and unnatural, because it was engaged in frequently, for the purpose of becoming pregnant. She pointed out:

> Um, well it probably has to do with infertility. So, first of all, trying to have a child and not being able to have a child. The sort of automated intercourse prescribed by a doctor, and ah, that went on for about four or five years... Umm, at one point we had to have intercourse every other day, and we'd go for the post-coital test and there you go up and have intercourse and then ten minutes later you're in the doctor's office and there's a room full of people waiting and they're saying, "Oh, are you here for your post-coital”. So do you have to tell everybody? So that was a big part.

Jenny expressed having difficulty to let herself have a rest and relax. As a result she recurrently felt exhausted physically. This affected her sexual intimacy with her partner:

> I think another factor is that usually it would be at night, but because I'm in so much pain I'm exhausted at night, cause I have this huge house, and I'm trying to do things… [like]

> painting the house. You know fixing things, but because I'm in so much pain, by the time night-time comes around I'm in so much pain I'm just exhausted. I mean cause when you're dealing with constant pain it takes a lot of energy so I'm usually pushing through it all the time… at the end of the day, if I want to have a sexual relationship, I have to somehow get the energy to get to it.

Claris underwent an abortion and had a venereal disease prior to marriage. She felt these incidents might have facilitated her current sexual difficulties. She revealed:

> Well my very first sexual experience was with a man, almost the age of my dad, and I got pregnant and I got a venereal disease but it wasn't a venereal disease of the genitalia it was from oral things. I got it in my glands. So, basically, from the very, very first time, even my mom had told me that, she knew I was pregnant, we never talked about this, never, ever. She called one of her friends, she was there with me and she told me if anything like this every happened that I shouldn't wait for so long because it really affected my health and opportunities to have a baby later on, and it was kind of forgotten, but I think from that point in time, I start feeling dirty.

Finally, Roxanna found psychotropic medication to contribute to the reduction in her sexual drive. She stated:

> I'm by nature a very anxious person and I've taken um, I ended up taking, kind of, an anti-anxiety, anti-depressant for about three years which is another thing that also won't really help my libido all that well so, um, that's the other thing that I've started, this is totally an aside, but I've started to come off that um drug as well which is also probably part of the reason why my sex drive is a little bit better. So those are two pretty major things with the pill and the *Paxil*.

Phase II: Experience of Sexual Discomfort: General Description

Overview of the experience. It appears that women experience a multitude of emotions, cognitions, and physical reactions simultaneously. The participants reported feeling trapped,

pressured, anxious, betrayed, and tense. Describing her experience of discomfort during sexual interaction with the spouse Lisa stated:

> The discomfort already happens before and during the engagement leading up to sexual intercourse. I feel like it is stress and pressure, physical tension, and a little bit of, well, dread is too strong of a word, but anxiety.

Tara summarized her thought process during the experience of sexual discomfort. It seems like she might approach the encounter with the stance of being open to the possibility of sexual contact, which, as interaction progresses, transforms into the feeling of betrayal and a need to resist. Tara conveyed:

> I have a little process when at first I'm like, oh yah, I want to and then he'll try a little more. He'll rub my leg or hold my hand and my mind will be going like, oh right, now I know what's going on here and then I'll get my wall up and say no, I don't want to do this and I'll get very, my body will tense up and I won't relax at all, it would be a very tense situation before we can get into that. I even try to get my mind to stop those thoughts, but it's just in my mind that it's not the best thing for me.

It is interesting that the majority of the women tended to experience a lack of emotional connectedness with their spouses during sexual interaction, in spite of experiencing such intimacy in other, non-sexual areas of life. Furthermore, the participants reported feeling unprotected, unsafe, and betrayed by their spouse during sexual encounters. Tara expressed it in the following metaphor:

> I wish I could feel that he is helping me, but I don't. I feel like I'm just there. I feel like I'm in a burning building and no one's coming to rescue me and I'm just there, and I just have to let the flames kill me because there's no one to rescue me, and I can't get myself out of there because I don't know the way to escape, and I feel like I'm just trapped in this building, and that I can't get out and he's not my rescuer, and he's not my fireman coming, he's the flames…

Distinction between emotional and physical discomfort. The women distinguished between two types of discomfort: emotional and physical. Some found themselves experiencing emotional discomfort as more frequent and disturbing than physical discomfort, while others found the opposite to be true for them. Claris expressed such distinction as follows:

> Well, most likely there are two types of discomfort. There's discomfort that I could describe shortly as "I don't want to do that" and another discomfort is the physical nature and could be described as pain inside genitalia. Physical discomfort bothers me a lot more than emotional, because now I'm thinking, it comes more often than emotional discomfort.

Roxanna reported that "the discomfort usually is the physical pain, um, I don't ever feel, I feel good when there's not pain, like this is actually working. I don't ever feel, like emotionally scared." Morgan, however, found sexual interaction highly pleasant physically, while being extremely painful emotionally. She stated:

> It would take him a long time of working on me to open up, and then, okay then we would have sex, um, and it was always great, it was just like we were in the beginning where, he's so good at it, he's really good at it, but then the next day he would become a real jerk to me again. … So, it's very painful. I find it painful on the emotional level. I would love to have, I would love to have it all the time, but I don't like it afterwards. So, physical discomfort, none whatsoever, it's great

Lack of sexual desire/arousal. Some women seemed to experience lack of sexual desire and/or arousal at times when they did not feel like being a part of sexual interaction. Claris stated, "When I do have discomfort, it is when I don't want to have intercourse." Others found that such desire was foreign to them and they experienced difficulty coming up with positive moments, free from uncomfortable sexual interactions with their partners. Tara described the constant deficit of sexual desire in the following way, "I don't know why I don't desire, but I don't want it, I don't think I could. I think I could go my entire life without having sex and it wouldn't bother me at

all." She indicated, "I don't know what such desire would feel like." Sally portrayed such lack of sexual desire as an "emotional shut down." She conveyed:

> Basically my husband and I have had a lack of intimacy for a few years now and so it's not a physical discomfort at all, it's an emotional, sort of, shut down for me, and it's not just a lack of desire, it's like completely no desire and almost like turned to the point where it's almost repulsive.

Feeling connected, joyful, and surprised in the absence of the discomfort. Describing the difference between uncomfortable and enjoyable sexual encounters, Tara emphasized the presence of emotional closeness in the latter. She asserted:

> When I'm enjoying it, I can relax, I'm not preoccupied with the sex thing, my body's not thinking physical, physical, the whole time, it's more of an emotional connection, that I feel when I like it. When I don't want to have sex, this wall is up, and I'm trying to enjoy it, or when I can enjoy it, it's a relaxing, it's a loving, a way more comforting feeling, it's a secure, safe feeling, whereas the other one isn't. I'm feeling the exact opposite, I'm feeling trapped like I can't get out. Why do I have to do this, why is this me, and the other one's like, oh this is me, this is the relaxed time, this is nice. They are like opposites to each other.

Lauren, emphasizing the significance of emotional intimacy, portrayed the difference between pleasant and uncomfortable sexual interaction as follows:

> Well the main difference was that we were both at the same point all the way along, we could both enjoy our bodies and so there was much more unity and we could experience something together. That's what feels like the oneness that you're supposed to feel like. Like intimacy is supposed to create this oneness and so, when one of you is just wishing it would end, you don't feel like you have that, and yet, when it does go right, you realize what it's all about. Like it is really an oneness. You never really want to get apart. It's totally different.

Claris described such unity between spouses in this way:

> A couple of times I really did have a feeling that I've been so close to my husband during making love that in some point in time, I got the feeling that it's one body and everything that's going on there's only one body. I was so into his body, like my chest was inside of his chest and it was like one big body. It was almost scary… We would not necessarily both come. [The enjoyment] happened for that reason, that transfusion. It would be taking an energy, like two energy bugs they would start sparkling all around going buzz buzz and using so much energy that there was actually not much energy to have an orgasm, but the pleasure of this feeling is really, really overwhelming.

Lisa experienced an unexpected and amazing sexual encounter free from any concerns and doubts—an event where she felt fully relaxed, and greatly surprised to find herself enjoying the experience and being sexually aroused. She described the occasion this way:

> I felt, happy to be with my partner, instead of the nagging doubts with the choice of partner. I felt very fulfilled about being with him and good that I had made a good choice and what a great guy he was. I felt happier and fulfilled about my viewpoint towards him. I also felt relaxed, and carefree. Relaxed from the everyday commitments, I felt freer. I was sort of surprised about the letting go part. I felt aroused that I was thinking about sex. It had to do with feeling freer and then not planning to be like that, it was just kind of a spontaneous part of what was coming out in me.

Such freedom to let go of doubts and concerns is described by Claris in the following fashion, "There is not any shame, there is not any doubt. Basically, not any negative emotions…. [there is] accepting the fact of what's going on then."

Colette conveyed the extraordinary experience of tremendous enjoyment and openness to pleasure in the absence of the discomfort:

> Well obviously lots of pleasure, when I didn't have [discomfort]. Lots of pleasure and a kind of out of body experience…[The union] takes you somewhere where that's

> completely pleasurable. It's a feeling not just a union either, you could almost construe it of being selfish to be delighting and to take, to take, and not just to give. In my own receiving, I'm somehow giving, because I am also creating pleasure for myself. When I'm giving, I'm also receiving…

For Claris the pleasure of freedom from discomfort in sexual interaction is holistic and experienced on different levels. She describes such experience as "being satisfied all the way around, physically and emotionally altogether." Jenny described the pleasurable experience of sexual interaction as spiritual. She said, "when it's a positive experience, it's quite a spiritual, it can be spiritual or good."

Phase II: Experience of Sexual Discomfort: Specific Components (Emotional)

9. Feeling anxious and vulnerable. The participants shared that both prior to engaging in sexual interaction and in the midst of it, they found themselves experiencing a variety of emotions that are usually felt in a situation of actual or imagined danger or threat. The women seemed to mainly experience panic, dread, fear, anxiety, and worry (e.g., sexual contact, pain, pleasure, uncertainty, and closeness/intimacy). The co-researchers reported such emotional experiences as vulnerability and lack of safety and protection. In addition, the participants communicated that they felt trapped, lost, and out of control.

Sharing her experience of engaging in a sexual encounter with her husband, Tara said: "When my husband and I want to engage in sexual activity, I feel a panic over me." Sally described a similar experience in which she felt dread and fear associated with the anticipation of upcoming sexual interaction with her partner. She put it this way:

> I've made this agreement that it's at least once a week and so it often ends up on the weekend, and when the weekend comes, it's just a dreading, "Oh no, God it's going to have to happen before the end of the weekend," and so the emotions are dread and also a bit of anger at John. Like I just feel like, I just wish he'd–if he just didn't, if his desire just

> went to zero too, then we would be fine, so I feel a little tidbit angry at him that he's still initiating it.

Lisa portrayed her feelings of dread in the following way:

> So it's been a busy day, and then I know that we haven't had sex for about a week and that this is the night that Tim will expect we're going to have sex. So, what's going on for me leading up to that, is like, even already, driving home and I feel uptight, and I feel a little bit of dread, like oh I'm not, so I'm a little anxious and maybe even a little bit resentful. I have to now do this for you yet, and I've already had the kind of day I've had.

She further suggested that she might be feeling anxious over facing the dilemma, which has to do with having to engage in sex in the complete absence of sexual desire. She conveyed her conflict like this:

> I feel the anxiety. That's an emotional thing going on. I feel a little bit of dread. If I dread something, and I dread having to do it because it feels like a chore, and it feels a little bit unauthentic. Um, so I feel a bit trapped. I'm trapped into this thing that I feel that I should do, but I don't really feel that willing to do, and I feel a bit guilty, anxious trapped, guilty that I am like that. That I'd be disappointing someone if I told him that was the truth about me. I wouldn't tell him that. I wouldn't tell him.

Tara reported a similar experience of feeling trapped. She expressed it in the following image: “I can't get myself out of there because I don't know the way to escape, and I feel like I'm just trapped in this building, and that I can't get out.” She further expressed her feeing of being constantly worried prior to the times of sexual contact with her spouse. Describing such mental preoccupation with sexual involvement, she stated, “I don't like it because I worry about it all day long, like if I'm at work is it going to be a yes day or a no day.” Colette experienced frustration with herself when choosing, in the absence of desire, to participate in sexual encounter

anyhow. She felt in control, but also guilty when choosing not to engage in sexual interaction. She said:

> Well in choosing not to go on, it would leave me with tending to be more in the driver's seat in a sense, and yet it would make me feel like I had been a disappointment again. It would make me feel like I had operated out a sense of where I was at that moment, but there was maybe something good or positive there, but at the same time, it would be, like I was a disappointment. But if I would go through with it, there would come a feeling afterwards that I would feel frustrated with that, that I had actually done it. I guess it was a matter of feeling like I don't want to continue and give something that I don't have to give, but I did it again.

The participants also informed the primary researcher about having anxiety or fear of intimacy and closeness with their partners. Describing such experience, Tara articulated:

> If we sit next to each other it affects how I'm feeling, like the sex or no sex thing. As soon as we get a foot from each other, my brain goes, okay, it's starting…I will do nice things for him. But if he asks for a massage or something, to me that's a sexual activity, even if it's not. Or if he says come sit here, why are your sitting over there. Because it's a sexual thing so from a distance, love him, but as soon as we get close I feel, he wants sex.

Jenny reported feeling scared, unsafe, and out of control when experiencing physical and emotional intimacy. She said, “If someone approaches me sexually, it's very upsetting to me… that's somehow threatening to me.” She went on to describe such experience:

> Usually if John approaches me, intellectually I know he's not a threat to me. There's just this automatic …not so much fear, [but] an emotional resistance. I guess letting someone that close is quite– it's like when I was at … they said that trust is very hard for you, and I guess it is. I guess there's a control thing. There's letting somebody into my physical

> psychic space. It's probably just safer not to let yourself get too close to people, because things can happen if you let them get close to you. I mean that's the undercurrent.

Lauren conveyed her experience of fear and anticipation of pain. She stated:

> So every time the fear would sort of settle in before things happened. I guess because of the first few times, like on the honeymoon, it was very painful so every time after that, is this going to be a painful time or a not painful time. I guess it's just a deep-seated kind of thought that you just kind of crawl back to.

Roxanna described such anticipatory anxiety:

> It still hurts so I know that it's going to hurt each time, so there's going to be anxiety behind that as well. Just like going to the dentist, you know, this is not going to be fun, I'm not enjoying this, but you do it because you have to, or because you must do it.

She further illustrated it in greater detail:

> In any of those times [when] Kevin was really trying to initiate sex, I would get really anxious. I've had this anxiety, probably, from the first week of our honeymoon and just how painful it was and hard it was. And it's not that every time I think back to the first time and go, "Oh no, it's going to be like the first time," but it's just that the first time led to the second time which led to the third time and so then it, then it was like every time. So I associate sex with a painful, unwilling experience. I think that's probably what was going on, not consciously really, but I think that's what was happening.

Tara underwent the fear of allowing herself to experience pleasure. She said, “I'd rather jump out of an airplane, than want to enjoy sex, because it's not something that I think is a necessity in my life so I don't really want to enjoy it.” Reflecting further on the nature of such fear, she argued: “Maybe I'm scared of what will happen if I want to. If I wanted to have sex, yah, because I don't know what that would be like, and I like to know what's going to happen in my life, and maybe I don't know what that is, so I'm scared of what I don't know.”

The women shared feeling vulnerable, unsafe, and unprotected prior to or in the process of sexual intimacy. Tara conveyed, “I would not feel safe, I would not feel protected.” She further stated, “I feel like I'm just there. I feel like I'm in a burning building and no one's coming to rescue me and I'm just there. I just have to let the flames kill me because there's no one to rescue me.” Lisa expressed a need to guard and protect herself against becoming vulnerable and intimate with someone. She put it this way:

> That's just hugging and then there's kissing which is very intimate, and I remember how I used to kiss when I was totally engaged, and I don't allow myself that kind of kissing anymore either. I don't allow myself, it sounds funny but it's like I don't do it. I think that all has to do with just feeling very guarded about being vulnerable and needing someone, wanting someone I'm just really guarded, even with my own husband.

Lisa added:

> Inside my head I would probably just, maybe, even not want to undress in front of my husband, but come in the bathroom to undress. I don't know why cause I already know I'm going to have to have sex, but maybe I just don't even want to be as vulnerable as to undress in front of him, because then I know he's looking at me, and it's like I, so don't want to be involved.

Tara stated her feelings of vulnerability like this, “I feel very vulnerable if I am relaxed when I have a massage. I'll feel like, uh-oh, I'm in a vulnerable situation here.”

Jenny also expressed a need to defend herself this time against traumatic and painful experiences of the past. She stated:

> I was saying the other day that it's like, I could feel there were tears, I wanted to cry but I don't cry. I come from a lot of abuse in my background and I had to survive, so I didn't cry, because I had to be watching where I was and so. So the same veil is sort of there. Right now, I've got a lot of pain in my spine, so I'm in constant pain all the time and, it

> takes up a lot of energy so there's just a block. It's just that I can't get through; it's really weird, like I don't know, like, "go away," [laughter].

Lastly, the co-researchers shared that they felt lost and out of control. Colette experienced not having a sense of control prior to or during sexual interaction. She put it this way: ”I am feeling like I'm not in the driver's seat.” Tara, in describing what would it be like for her if, just when she needed her husband’s emotional support he suggested connecting sexually, said, “I would lose it.”

10. Feeling betrayed, invaded, and used; resistance. The interviewees shared that they felt betrayed, deceived, and used as they engaged in sexual interaction with their partner. They felt angry, disappointed, and resentful over being invaded. Interestingly, the majority of the women described their spouses as utterly carrying and supportive. They experienced lack of support, protection, and care exclusively in the sexual area of life. Other women shared experiences when their spouses did something hurtful to them. Such wounds seemed to remain, serving as barriers to intimacy and pleasurable sexual interaction between the spouses. Morgan felt betrayed, deceived, and used by her spouse:

> That's mainly what it is and it's his reaction prior to all of it, or then now he becomes a real jerk, the morning after. You know, it makes you hesitant to, oh well, if he's in a good mood, let's see if we can delay this a little bit longer so we can get another week out of him being nice to me. It's really quite a treat. Then, you know, once you've had the sex, it's like, oh no, he's going to be a jerk again and then I'm going to go another four or five weeks before he's nice again so …the next morning, he becomes the grumpy old man again and then I feel the hurt and the betrayal. That's a good word, yah I definitely feel betrayed.

Moreover, Morgan experienced hurt, anger, disgust, guilt, and shame associated with being exploited sexually by her spouse. She felt fully betrayed and experienced a need to completely shut off from her spouse when this occurred. She described this experience as follows:

> It's not right. Sex is between a man and a women, and a husband and wife, and there shouldn't be anybody else involved in it. If I'm going to have a fantasy about somebody, I should be having it with my husband. You know a fantasy about him. Not of another woman, or another man or whatever. That's to me, that's too dangerous. No he would want me to talk about it, and he was getting to the point where he wanted me to engage in it, and that we were going to set up something to engage, and I shut it all down, it was getting too much at that point. I didn't enjoy at all, but I allowed them [fantasies] to go on for about ten years…. [I felt] betrayed that he would need that. That's, for those sex times, I felt totally betrayed, because I felt that he needed that in order to have sex with me. That bothered me a lot. He wasn't satisfied unless he saw me with a couple of other men or a couple of other women. Then it would be interesting, so that bothered me. That hurt me a lot. That was betraying. I felt really dirty too. I knew it was wrong, very disgusting. I did finally went out, I thought, okay, I'll please him. I'll go out and do it, and I found somebody and did have an affair with a guy for one night, and I came home, I was just so mad at myself. That's when I renewed my faith and everything. I just felt so disgusting and so icky and I told him about it, and he was all excited. He thought it was great. He's not upset that I've betrayed our marriage vows. He wanted to know all the bloody details. Here I'm feeling just sick to my stomach that I'd even gone this route. I'm confessing to my pastor about it and he's excited about it. That was it, shut down, gone, we're finished. This is it. Went too far.

Claris felt bitter and found that she had not forgiven her spouse for some past transgression. She said:

> I think that the year that we spent apart when I went back to school didn't do any good for our sexual relationship. I miss everything and I want that special relationship to get back to what it used to be before… If he did behave the way he was supposed to behave and unconsciously I didn't forgive him. Maybe that's what it is. Something has changed in the relationship. Not as much in our daily life as in our sexual relationship. I trust him less and basically, I think this is the only thing I could punish him with, I could have control over.

Tara felt betrayed when she was involved in a sexual encounter with her spouse. She needed his emotional support and protection in the midst of the terrifying experience of being engaged in sexual interaction. Not only did she feel unprotected, but also, in a way, she perceived her spouse as causing such discomfort. She portrayed the experience of feeling betrayed like this, “And he's not my rescuer, and he's not my fireman coming, he's the flames.” She continued describing such feeling of betrayal:

> I felt betrayed in a way, even angry, not even just nervous or anxious, because knowing that that's what he wants. So the whole reason you brought me all the way out here, paying $400 for a one night thing was so we could have sex.

Tara further said that she associated any kind of act of service on the part of the spouse as a means for getting her to interact with him sexually. She stated:

> He really tries. He'll ask, okay what can I do? Obviously flowers doesn't work. What would work? You know taking you out for dinner. Like he makes dinner everyday, he's the cook of our house. So it's not like he makes dinner, it's something special, because he does that everyday, or something, like he makes my favourite meal. Well that helps, like he tries, he's asking, but it doesn't because then I feel like he's asking so that he can get results back. Basically he's asking me what he can do to get the act, so now nothing. Now even something that used to be nice, is no longer nice, because now I've associated that every time you make that food, guess what I know I'm going to have to do.

Claris experienced disappointment with the spouse for engaging with her in sexual encounters despite her lack of desire. She said, "[I feel] disappointment that he took a chance and did it, even though understanding that I don't want to do that." Claris also felt guilt over allowing her body to be used sexually. She conveyed:

> Emotionally I could say, could you please be done with this as soon as possible, and when it's done, I never turn around and blame him saying that you probably shouldn't do what you've done, because I don't think it's right, because in this case, I would confuse him, that I let him do it and right after that, I would try to blame everything on him. I don't think it's right. It was my choice that I let him use my body. You know, I would say, could you please do it as quick as possible.

Jenny expressed how she felt when focused on the act of sex, rather than on the emotional connection with her spouse. She compared such an experience with rape and illustrated it in this way, "If it's just the mechanical focus, then that [caring] part isn't there and it doesn't feel as safe to me. I guess the word depository; I don't want to just be a little depository cup. Well it's a rape, right? I mean that's what rape is like…"

For Colette the experience of being used sexually felt like this, "It would be, like to have my own life sucked out of me into him so that he could have energy, he could have sex." She reported experiencing the feeling of hurt over being objectified (valued only for her body), invaded, used, and considered unimportant. She illustrated this experience: "I guess that comes with a sense of being run over, you know, a truck is running over you. I kind of feel squashed flat. [It's] hurtful…" Claris commented, "Yes that's what it is. Why should he, I can't understand in full, what is so important about that that you are willing to go through with it, if I don't want it."

Lastly, the women interviewed reported feeling angry, resentful, and resistant over being invaded. Tara shared the feeling of being invaded like this:

> If I came home and say I hit a car, a different car, and it's my fault, and I come home, and I'm all sad, and I start crying, and I say I need you, and he'll hold me. If he ever wanted sex at that time, I would never want to do that again, but he doesn't, so he knows that that's just a holding time and that's fine. If he ruined that by saying okay she's very emotional, she's attached to me, lets go have sex. I would never, I would totally lose contact with my husband. I would lose it, I would not feel safe, I would not feel protected, I would feel that they came into the wrong territory. That was my territory and you've ruined my sad moment, as I was expressing to you. So I would not feel comfortable. Like the same feelings, like you are invading me and my territory. I was asking you for one thing and I got something different.

Tara felt resistance, which she expressed in the following way, “I just feel that, I didn't give you that choice, this is my body, not yours, you know, you don't own this. If he tries to move a leg over, I'll be like no and I'll put it right back. Like this is me, this is my body; and just says no throughout the whole body.”

Lisa articulates such resistance over feeling invaded in this manner:

> At that point in time when I'm feeling that uptight and that anxious, I can't say I feel repulsed, but I don't like in those sensitive areas, like on your breasts, on your nipples, to have them kissed. It's almost like I repel from it, because that's a sensitive area and it's like, it's too soon, too much, I don't want it. So what feeling is that. So that's a bit of an invasive feeling. It's a bit of an invasion to have someone go to kiss your nipples when you're so not there. That when it starts, it's like you're not ready for it.

11. Guilt and inner pressure to engage in sexual interaction. Participants reported feeling pressured to engage in a sexual activity with their spouses. They also expressed feeling responsible and guilty for sexual difficulties and for their spouse’s emotional reactions. Roxanna shared her inner pressure to engage in sexual interaction and her feeling of guilt over a lack of desire to satisfy her husband sexually. She stated:

> I would feel way too guilty [if I] said no, because I just thought he would shrivel up and die, if I did, and he won't, but that's how I feel is that it would just hurt him physically way too much and emotionally way too much if we didn't.

Sally feels guilty for having no sexual desire. She put it this way, "Even though he takes responsibility and that he hasn't put the responsibility solely on me, I'm very guilty and very hard on myself, because I'm the one with no desire." Tara expressed it as follows: "I do feel guilty. I feel bad that I don't have these desires that he has or that normal married couples are supposed to have." Describing a sense of responsibility to satisfy her spouse sexually, Roxanna added:

> [I] definitely [feel] responsible, I think it's my role, I feel like it's my role as a wife to do that, to give that to him. That it's a responsibility not just an option but it's a responsibility and it's hard when you really don't feel like it, and I had a hard day, and you just don't want to, and I have a headache and all those things, which is bad.

Tara, sharing similar a feeling of pressure said, "Even though he's not forcing me to, but he still is in a way, because I'm married and I feel like I'm being forced to do it."

> Claris expressed a need to take on the responsibility for spouse's feelings. She conveyed: Sometimes I don't want to [have sex] because I'm afraid that I'm not going to come and that would disappoint him or he would feel rejected, or he would be disappointed and he would be upset and it would hurt me, and I would feel that it is my guilt that he is not in a good mood but there is a time when I understand that he is a man, and he needs to have an outcome and he tries to do as much as possible masturbate, when I choose not to engage in intercourse with him, but it's also, sometimes I feel guilty because I'm rejecting him.

12. <u>Shame, feeling of inadequacy, and fear of rejection.</u> The co-researchers shared feelings of shame and embarrassment, connected with the perception of themselves as abnormal, dirty, bad, inadequate, and unworthy of love and attention. Tara described her view of self in the following way:

> I don't think of myself highly. I think I'm a prostitute. I do. I think I'm a very dirty, bad. I'll take a shower after. I think of myself as a bad person because I'm doing it, not for love. I'm doing it because I have to. So in other words, I need to have money on the table, like why prostitutes have sex, because they have to have money. So I always feel like I'm just, I don't like myself, and I actually dislike myself more when I have to do it because, no, I felt like, okay I've lost control, I had no control of myself so I feel bad that I lost control, because I gave in when I don't want to, and then I feel bad that I actually did the act, because I don't like it.

Colette felt "like there was something wrong with [her]." Similarly, Claris questioned, "Why is it me, why is it not somebody else? Why am I experiencing it, like what did I do wrong?" Lisa shared feeling ashamed and embarrassed over struggling with sexual issues:

> I think of the word frigid and I go, do I qualify for that? I hope not, because that's a terrible word that people use to describe some unfeeling, cold non-sexual women. So, I don't want to be that. So, to think that I might be in that category, just seems so, it seems shameful or embarrassing. I wouldn't want people to know this. So, yah you sort of hide the extent of it from people. I don't tell anyone what I'm telling you.

Claris attributes the shame she presently feels to the past negative experiences. She said, "I don't want to get in touch with shame, but I think all of the shame came from my past." Jenny reported feeling unimportant and unworthy of attention and love. She asserted:

> I feel, I mean, the impact on the relationship I'm constantly feeling guilty, I'm feeling like I'm not being a good wife. That I'm, um, you know, that John would want to spend more time with me if I'm more sexual and that, it's just he wants to study or go and see his friends, but I take it as he's just not interested in spending time with me cause there's nothing worth spending time with me about, because I don't do that, right.

Likewise, Morgan felt insecure about herself, as she was aware that her spouse worked in an office with many attractive female workers. She said, "That made me a very insecure person.

That made me feel, that I had to please all the time, that the only way to get liked was to please." Claris expressed a fear of being rejected as a person by the spouse. She said:

> I'm afraid … if I didn't do it, I would be rejected. I would be unwanted…I don't want to acknowledge fear, I don't want to acknowledge that I can't, that I'm not good enough. I don't want to acknowledge that he'll reject me, he will reject me sooner or later, because having sex is bad and a girl shouldn't have sex until she is married. So guys look at these girls as prostitutes. As somebody that he would go out with, but he would eventually get [rid of] them.

Claris further talked about a "test" she felt she needed to give to her spouse, as she was constantly looking for proof that she is loved for who she is and not for her ability to satisfy the partner sexually, and this testing was the means for ensuring that love. She conveyed, "Again that's what I'm trying to come to a conclusion about. Is it really, would he still love me and be with me in a relationship with a smaller amount of sex, or should he have the sex object? The one he got married to." She then elaborated on the topic:

> I'm really unconsciously trying to check if I'll really be accepted, even if I don't want sex. Is it true feelings from him towards me, or is he just faking it? Some kind of test of him. Or a test for me, can I really get away with doing this each night and how many times can I get away with it? Is it really, do you feel what you felt, because there's no other way to check? He would be nice to me and just unclear, like do you really love me, just because of me or do you just want to have sex with me, that's what it is. So if you just want to have sex with me, why did you marry? You could have sex as many times as you want with anybody else.

13. <u>Feeling exhausted, hurt, and angry over meeting others' needs while not having her needs met.</u> Lauren reported experiencing anger associated with giving (e.g., taking on the pain) and not receiving (e.g., sexual pleasure, orgasm). She stated:

> Sometimes I was mad that I was the one who had to bear the brunt of the pain and even I was trying harder and I had to be in pain, and I wasn't ultimately as interested as he was and in the end, I wasn't getting much out of it… After, because you put in so much effort, you're willing to take the pain and for what result, ultimately. I sort of thought if I sacrifice and am willing to take pain, I should at least get a result.

Likewise, Roxanna felt that she had been giving sexually while not receiving back. "I'm also feeling like it's not fair because I'm always giving this, and he probably doesn't understand how painful it is," she said. Morgan suggested that her spouse had no insight into her feelings regarding her needs not being met by him. She said:

> Giving and giving and don't get it back, so you kind of lose interest. You want somebody to fill your cup and he just has to give a little bit and I'm like filled right back up again, and I can go off and do a ton of things, and after 20 years, he still hasn't figured it out.

Colette shared that she maintains the belief that others' needs are more important than her own. She conveyed:

> Yah probably in a lot of times, always having my sensors, my sensors are always out. My antennas are out to, oh, that's how that person's doing, oh, that's how that person's feeling. So to facilitate how to appease that person. Like that person so that they're not angry with me. So you're always aware of what other people could be thinking or not. Other people are always more valuable than yourself, other people's wants or needs come before my own and living in a state of not having any wants is probably preferable…

She further expressed feeling tired over meeting her spouse's needs, including sexual ones: "Yah and that's tiring. It feels like I nurture my children, I'm always being wanted and here's another person who needs nurturing. I almost feel on that level that I have to nurture him."

Lisa reported experiencing emotional "shut-down", or retrieval from the environment, having no energy left to meet the needs of people around. She put it in the following way:

> It feels grouchy. It just feels like I'm a bitchy kind of person, not warm, but I'm cold and I'm cranky and bitchy. I don't have anything to give someone else. I'm kind of recoiling into my own little ball. It's the time of the night when my kids ask me one more question, and I just say I can't deal with you anymore. I'm going in my room, I have to go to bed, and I'm exhausted. So no more. I think of that in regards to my marriage and anticipating sex with that feeling, it's like I want to have a wall right up. It's either half way up or it's up and I don't want to let someone through.

14. Discouragement and hopelessness. Although the theme of discouragement was persistent and explicit throughout the participants' protocols, the feeling of hope for an ultimate improvement of sexual intimacy seemed to run alongside the discouragement. Sharing her experience of hopelessness and discouragement, Lisa stated, "And it feels a little bit hopeless, or I'm resigned to being that way, in a way. So then I think well I guess all I can do is get through it and look for little improvements." She further suggested, "I am not going to be one of the lucky people in life who can boast about how great sex is. That's not going to be for me. I am not going to be one of the lucky ones."

Similarly, Lauren felt discouraged, the likes of which she expressed as follows: "Am I ever going to want it the way a man does? I don't think so. At that point, you think, I'm never going to want it. I guess I'll just roll over and let it happen." Tara also felt pessimistic about gaining sexual desire at some point of her life. She conveyed, "I would love to say, when I want sex, come, but I don't think that would ever come. I mean, we've gone months and there's been nothing, and I would say, okay now I'm ready, it's been a month and nothing's happened so we've got to do it. I really believe that I wouldn't want it."

Roxanna, though feeling discouraged in the midst of sexual contact, still felt hopeful as she reflected on her and her spouse's sexual relationship. She said, "I do see some hope at the end of the tunnel, because I do see it evolving to a better place, but it's still not during sexual intercourse at all that we are feeling that way." Lauren had similar experiences, when she would

experience hope in the presence of discomfort. It was expressed like this, “Yah, don't be selfish, but I was hoping that somewhere along the line I would enjoy it.”

Likewise, Jenny hoped to enjoy sexual interaction, as she was approaching it:

> I guess the initial thing is hoping that it's not going to be the weird, hard work, tedious, struggle with all my emotional crap. Hoping that it will just be okay and we can just do this and have fun.

Lisa described the hope that has kept her going in spite of discouraging struggles in the sexual aspect of her life. She stated:

> That commitment is a very powerful thing and probably that, um, we are always growing and changing and that it's never too late and now is the time to keep healing to be set free, um, to keep pursuing your dreams, to keep growing, like you should never stop. Like both of us are close to retirement. You never want to stop growing and changing and serving and being parents. My husband hopes he lives to see 135, because he loves life and loves the fact that God, you know, you can be a Christian and you can go to heaven and it can all be over or you can really find fulfilment when we're here. So it makes him want to never retire, and live long, and yah, just being on that journey is very exciting. You know, like I find hope in it all.

15. Loneliness and isolation. Tara shared her experience of feeling lonely. Even though her spouse generally supported her, she did not sense such support and care from him in the sexual area of life. She put it this way:

> Lonely because I feel like making love should be such a beautiful thing and I feel so alone. I feel like my husband's not there, I feel like I'm not there, I feel like it's just trapped there and I'm all by myself. I just feel, you know that I am alone, I still think I'm alone. Even though my husband's there, he's not there because, at that time, he's not my husband, he's somebody that wants sex, you know, the love, the other 23 hours of the day that I have for him, is not there during that one hour because he's the enemy at that time.

> I don't even want to love him at that time, because if I do love him, at that time, because if I do love, I think that I'll want to have sex and I don't even, in my mind, want to have sex.

Lauren similarly reported feeling isolated, especially when she experienced pain after sexual interaction. She said, "There was the isolation, if you work together at something and he goes to sleep and you're lying there in pain. Is this really what it's supposed to be like?" Morgan sensed the lack of insight or concern on the part of her spouse in regards to her emotional pain, "Where you feel like your heart's being ripped out, that's the pain. In my perspective, and yet he doesn't see it."

16. Emotional detachment from the experience and the spouse while engaged in sexual interaction. The participants reported feeling disconnected from their spouse and the experience of sexual interaction. Tara stated, "I feel withdrawn from him." For her, sexual encounter felt like something mechanical, an act where she did not feel intimate or connected with her spouse. She conveyed, " It's like surface sex. I do it but it's just kind of on the surface, emotionally. I don't have relationships with my husband that way." Claris described her lack of connectedness like this: "[There] wouldn't be any connection, except that he would be inside of my body. I wouldn't feel that my desires have been met. I'm not connected to the process [of sexual interaction]…now sex just makes me detach myself from the situation." Likewise, Sally experienced detachment from the sexual encounter. She portrayed it in this way:

> Quite often I feel that feeling where I'm not in my body, like I'm watching and when I'm watching the act, it just looks disgusting to me. It looks like, oh there's my big bum and I'm outside of my body watching this thing, and it looks disgusting and repulsive.

She expressed Roxanna's experience of not being a part of sexual interaction psychologically as follows:

> I would say that pretty much since I've been married, I don't really see myself as a sexual being. I felt very disconnected. Almost like I wasn't even really there. It wasn't like …

> out of body experience where I'm watching from above, but not even really watching just not really there, not really a part of it. So, I did not feel like a sexual person or being at all.

17. Disgust. The participants reported feeling disgusted over the act of sexual interaction. Sally expressed this feeling in the following manner:

> It's more like, okay [let's get] over with. Quick get cleaned off, get, because it just still feels so dirty and everything, it's like, okay it's finished, I want to get showered and don't want to be even intimate by just holding each other. It's like, okay it's done, it's finished, I did my thing here, even afterwards I don't even get enjoyment out of that any more.

Tara described such feeling like this, "I just don't like the act, like after I throw up, because I'm disgusted. I think it's gross, I don't like it." Claris said, "Disgust, like I'm disgusted over the situation. I would say mainly disgust."

18. Relief following sexual interaction. Tara experienced a sense of relief as sexual interaction was finished. She stated, "Then afterwards [I'd] go, oh good it's over; I [would] feel relieved because I actually did it and I'm happy I finally did it."

Phase II: Experience of Sexual Discomfort: Specific Components (Cognitive)

19. Encouraging and/or negative self-talk. The women interviewed stated that they often had to talk themselves into engaging or partaking in a sexual activity with their spouse. Tara described such motivational self-talk, which she would have during intercourse:

> I would be, like, you said you were going to do it today, come on you promised yourself today you were going to do this, today you were going to do it. I would say, okay let's go, and I would just go back into my mode again. Then I'd be, like okay, here I go and then I'd be like, tomorrow, and I'd start planning and that's when the planning started. I'd either be relaxed or I'd be I don't want to do that. Stop rolling your eyes, I can't do that, and then he'd say fine and we won't and we'd either go to sleep, and we wouldn't do anything or else it would be, we would and he'd be like, oh okay.

Lisa also reported, “The thought might be, what's your problem, this is fine, this is okay. Or I might be thinking, you know just a little longer I'll be in the world. The dialogue is almost like encouraging myself.” Likewise, Sally attempted to convince herself to engage in a sexual encounter with her partner. She described this process in the following manner:

> It's like, in my mind, um, before I can tell myself, I can self talk and say, even though the emotional feelings aren't there, just go through the actions, at least please him, at least make him feel that he's important, and that I want to make him feel good, and self talk, and I tell myself those things.

Lastly, Lauren described her motivational self-talk like this:

> Grin and bear it. Get it over with. Do it for him, get it over with, it's all going to be fine as soon as it happens, try to be into it, pretend you're into it, yep. Most often it would end happily. Yah, do this for your husband, you'll both be happier and you can act happier. Don’t be selfish. Tons of women have probably done this year after year, century after century.

The co-researchers detected various negative thoughts during the experience of sexual discomfort. Jenny, describing her negative self-talk, stated, “When I go to that place in my mind … I'll talk myself down. I'll say bad things about my body. I call it garbage, piece of trash, useless, mutant, gimp, [laughter] and John doesn't like that, I mean it's a total turn off for him…” Tara shared her cognitive experience like this:

> In my mind there's no good thoughts, there's no, I love my husband, there's none of that. It's all, no don't bring me back to those feelings of pain that I feel when he initiates sex. Once things are happening it's not so bad, but once it starts, it's totally, no I can't clear my mind of bad thoughts to make it a good thing.

Lisa described the internal dialogue, in which she would engage prior to getting into sexual interaction and experiencing pleasure. She put it this way:

> Why I wouldn't look forward to having sex and want to, why I would consider it more like a duty or a chore, and so I'm sort of having some internal, I'm not saying all those things to myself but it's habitual now. It's kind of the way I approach it and that's sort of discouraging.

Tara similarly illustrated the inner conflict or dialogue between two parts of her—Tara, who feels obliged to have a sexual contact with her spouse talking, clashing with Tara, who dreads sexual interaction and experiences a lack of sexual desire. She said, “I'd either be relaxed or I'd be I don't want to do that. Stop rolling your eyes, I can't do that”

Another interesting phenomenon revealed by the participants was the process of “uncovering” layers of disturbing thoughts and pain in order to hopefully experience sexual pleasure. Jenny called this method an “archaeological dig” through the “layers of tension.” She described this process saying, “I have to get through that pushing away to get to it. You know, I feel safe with John but there's multiple hurdles to jump over.” She further elaborated:

> If I don't have desire, then I call it an archaeological dig, right, you've got to go digging for, and sometimes [the desire] can be found and sometimes it can't be. Dig under all those layers. It's a digging down to all, to the essence or the core, the possibility that I can get to this place of enjoyment and digging through all the layers of infertility and all the rest of the crap, right. … it's hard for me to separate the infertility from the rape and all the other stuff from the pain, the fatigue. It just, it feels like a loaded deck and whatever card, take your pick.

Sally also expressed that to experience pleasure one needs to pass through layers of negative self-messages and worrisome thoughts. She put it like this:

> I don't know if it's a big part of it and this is so common from what I've read about with other women is that women's arousal time is so much longer and you're caught up in your day-to-day things and you're busy and you're thinking about kids in your mind and stuff. It's hard for me to totally turn off that busy mind and just lie back on a bed and relax and

> forget about everything out there and just be there for the moment. That part is hard, but if I'm even able to get to that point, just getting away from all those other messages is two fold on top of it all.

These layers of negative thoughts were also described by other women as "garbage," "block," and "wall." Lauren expressed the desire to be free from obstacles to satisfactory sexual functioning: "I often wish I could just leave all my garbage behind and just try and be somebody else." Sally named the obstacles to the experience of sexual pleasure a "block" and said:

> I have to start just feeling comfortable with my own body and that even just feels uncomfortable and repulsive. Yet, in my mind and when I'm sleeping I can often have dreams of sexual encounters and they're pleasant [and] orgasmic. So it's there but there's a big block there…

Tara experienced resistance against something uncomfortable and deeply disturbing, which she described as a "wall." She said, "I feel like I wish I wanted to make love to him but for some reason in my mind, I keep saying no, no, no, I don't want to." She continued, revealing:

> I get a wall up, I will curl into a ball. It's basically a wall that comes up and it makes me feel that I won't go past this position and in my mind I say no, I'm not going to, I'm not going to let myself go past where I am right now. I don't want to. I don't have any desire to move on and so I just kind of get a wall up.

20. <u>Sense of obligation to engage in sexual interaction.</u> The data obtained from the interviews revealed a sense of obligation, experienced by the women, to be a part of sexual interaction in spite of their lack of desire to do so. Claris said, "I don't want it and you do want, then I am obliged to let you do that." Lisa described such a mindset like this, "It's going to happen, and just once I wish I didn't have to do it." Similarly, Tara conveyed, "I can't remember once in my entire life wanting to have sex. I've only had sex because I felt like I needed to." She further stated, "Then when actually sex is occurring, I kind of feel like it's just my duty and I just

have to do it, so I just go, okay, and do it… I don't have the desire so it's not like I'm doing it for me, I'm doing it for him."

The participants reported a number of reasons for feeling strongly obliged to engage in a sexual encounter despite having no sexual desire. First, each woman interviewed expressed care for her spouse and a deep desire to please him. It seems they perceived their spouses' needs as more important than their own. They also tended to feel responsible for their spouses' emotional reactions (e.g., frustration, disappointment, anger). Second, the women seemed to experience a fear of punishment or of some negative consequence, which they might have to face in the case of their refusal to connect sexually. Last, the participants felt pressured by society to engage in an act of sex. They viewed it as their role as a woman and a wife.

Tara believed that it would be unfair towards her spouse if she were to refuse participating in sexual interaction with him. She expressed:

> I understand I don't have to, I could never [engage in sex], and we would still be married forever if I never, ever had sex, and we'd probably be very happy, but it's not fair to him, because that's an important thing to him.

She went on to assert that the sexual interaction in which she engages is motivated by love for her spouse and a desire to please him, rather than by a personal desire for sex. She conveyed:

> If I didn't love him, I wouldn't do it, because personally, I believe, I could go the rest of my life without. I don't think I have to have it like he does. You think that it's a part of his natural being and that's something that is. I just feel that, I'm just doing it as a duty to my husband that it's something that will please him, not me. I wish it would please me because I know it can be pleasing, and um, friends in their relationships are very pleased and they love it and it's a very important part of their relationship. So I would like it to please me, but it doesn't.

Colette expressed that she typically places a priority on meeting the needs of others, including her spouse, rather than addressing her own. She explained:

> Other people are always more valuable than yourself, other people's wants or needs come before my own and living in a state of not having any wants is probably preferable and ah, you know the whole sense of me being the one unclear and hopefully you get some enjoyment in the process, but that's really what life is all about. That's what God expects from me.

Likewise Roxanna shared taking on responsibility for her spouse's feelings. She revealed:

> I feel bad for him. I feel badly of, I just feel not like I'm a bad wife, but I just feel like, oh poor thing, you know, I mean like, here he's 25 years old, you know, but I just, kind of, see him as a little boy who just needs somebody to go play with him or something. Like I just, kind of, feel sorry for him.

Lastly, she talked about the need to protect her spouse psychologically by not disclosing to him what the experience of sexual discomfort is really like for her. She put it this way:

> I'm always giving this, and he probably doesn't understand how painful it is. I try to tell him but I don't want him to feel too guilty because it will start to affect him, and I don't want him to feel like he's hurting me all the time…So, I mean, it's not any resentment towards him, or anger because it's my own trying to protect him from really knowing what it's like.

Lisa, feeling afraid of the consequences of a long-term refusal to engage in sex, stated:

> There's a cost to saying that I don't want to have sex, because, like logically, if he's not wanting to have sex two or three times a week, but he's quite patient with my low desire. So then it's not logically, or it's not even kind for me, at that point, to say I don't want to have it again. So it's like, I'm not going to do that, and I know it.

Lauren felt obliged to engage in sexual interaction with her spouse in spite of discomfort/pain, because that's what she thought her responsibility as a wife was. She said, "There's definitely that, in the beginning there was that thought that I just have to put up with it,

because this is what marriage is about." Claris shared her recognition that the spouse's need to engage in sexual interaction is healthy and normal:

> I would feel disappointed, but there is also he has needs to make love. It's part of healthy family relationships as man and wife, and I understand that I have really less need for that, but he's a normal man and I can't blame him that wants to make love to me. He loves me. He loves my body.

Lauren expressed her opinion that there is gender difference in sexual desire and that it is not untypical for a woman to engage in sex with a spouse in spite of the absence of desire. She said:

> There's definitely that, in the beginning there was that thought that I just have to put up with it, because this is what marriage is about. You have to mutually satisfy each other and yet it wasn't mutual. Even if it was a thought for him it was going to be mutual, you know, it's a lot harder once the man has completed for the women to continue. It's sort of like, you're done, okay I'll just roll over and be quiet, and yet if the woman is finished first, it's very easy for the man to keep going until he's done. So that's a different kind of situation for them.

She added:

> Probably many women throughout the ages did this. You know, men like sex more than women. That seems to be the general consensus of the population at large and my husband. So I thought that many women have done this, probably my mother, my grandmother, her mother, probably at times didn't enjoy sex but did it for him.

21. Negative perception of self, spouse, and the sexual act. The theme of being bad, dirty, and abnormal remained persistent throughout the protocols of the participants. Describing herself, Jenny said, "I'm not attractive because I'm not very easily sexual." Roxanna shared, "I would say that pretty much since I've been married, I don't really see myself as a sexual being." Tara conveyed, "I don't think I'm a woman that deserves." Moreover, Claris mentioned, "When

my husband asks me for this amount of frequency in my relationship with him, that unconsciously is connected with me being dirty."

The co-researchers conveyed a sense of wrongness with themselves as women and persons. Sally expressed this in the following way:

> There's something wrong with me, because I just can't even comprehend anymore what it feels like to have desire, like I just think, a woman who's horny or desires, I just think, how do they feel like that? Like it's just so normal but I can't even comprehend how that would be anymore.

Tara put it this way:

> Maybe I'm the only one in the entire world who feels this way and every other married couple happily has sex, so they're not thinking of it as a, oh, I can't believe society's making us do this, they're wanting to do it. So, maybe it's just me and I think I'm the bad guy. There's something wrong with me– there is something wrong with me, I know that. It's not like I don't know that something is wrong. How do you get a desire, how do you like chocolate if you don't like it? Like how do you get yourself to like something that you don't like? So that's just how I feel about that.

Likewise, Lisa shared her belief that she was as abnormal. She put it like this:

> I am abnormal, something's wrong, I am not going to be one of the lucky people in life who can boast about how great sex is. That's not going to be for me. I am not going to be one of the lucky ones.

She further conveyed:

> I'm bad. I did bad things and now I'm paying. I'm guilty and there's consequences to what you've done that's bad and now you're destined to live it out. Things that happened to me, and I was innocent and then things I chose to do as an older woman that were bad, and when you throw all that together, there's a result and that is a person who is a bit messed up sexually.

Claris described perceiving herself as a prostitute. She said:

> I don't want to acknowledge that he'll reject me, he will reject me sooner or later… because having sex is bad and a girl shouldn't have sex until she is married. So guys look at these girls as prostitutes. As somebody that he would go out with, but he would eventually get [rid of] them …

Tara similarly revealed:

> I don't think of myself highly. I think I'm a prostitute. I do. I think I'm a very dirty, bad. I'll take a shower after, I will, I think of myself as a bad person because I'm doing it, not for love. I'm doing it because I have to. So in other words, I need to have money on the table, like why prostitutes have sex, because they have to have money. So I always feel like I'm just, I don't like myself, and I actually dislike myself more when I have to do it because, no, I felt like, okay I've lost control, I had no control of myself so I feel bad that I lost control, because I gave in when I don't want to, and then I feel bad that I actually did the act, because I don't like it.

Lisa in particular expressed the doubts about her ability for intimacy with the spouse. She articulated such doubts in this manner:

> It's too much sharing of myself; I just want to have myself to myself. I feel safer with myself than continuing to be with someone else, and I feel more secure and more comfortable just to be with myself…. Sort of rewarding myself with a little bit of time for myself and that's why I feel something is weird about me, because why wouldn't I look forward to my togetherness with him when the responsibilities of the day could be set aside so I could connect with him? I don't seem to desire that as much. So all of that makes me, sort of, just wonder about my capacity for intimacy, and it's hard because I'm thinking about becoming– I'm becoming a counsellor, and I realize that you would have to go to intimate places with your clients, and if don't I understand my fear of going to

> intimate places with my spouse, with God, and my kids, then what would make me think that I'm capable of walking through that fear to go there with other people.

Furthermore, she expressed her realization that the relational patterns she uses to connect with the spouse are also applicable to her relationship with the supreme power, who is, for Lisa—God. She asserted:

> Why don't I feel intimate to my spouse, why don't I feel very intimate with God, because we talked about the connection between spirituality and sexuality? That when one of them is really kind of on fire, sometimes that correlates with the other one being on fire and also the opposite is true. I would normally find myself in the opposite category, unfortunately…

The women interviewed reported viewing their spouse as abnormal and questioning their husbands' choice. Colette shared:

> My feelings were there was something wrong with him for him to need me so much. It was not like that was normal that this person needed to feel whole and I didn't like that. I wanted this person to feel whole on his own without needing me so much, and so I felt like he couldn't just be a whole person without having to depend on me so much.

Likewise, Morgan expressed doubts about her choice for a partner, "Well I didn't pick the right man, maybe if I had dated a little bit longer, um, maybe, but I'm second-guessing it, it's the past." Lastly, Lisa shared:

> You say, okay, I must have married the wrong person that I'm not really attracted to, because maybe that's what it is. I married him on the re-bound, and I would have made a better friend than a lover with him, and those are way in the background, scary questions.

The participants reported a negative perception of a sexual act. Tara explained her perception like this:

> Yah, not necessarily negative thoughts of our relationship or negative thoughts of him, it's negative thoughts of the act of sex. It's the whole thing, or it's a bad thing that I'm

> going to be doing. I'm actually not even thinking of him at that time or me, I'm just thinking of what I'm going to have to do… if I actually think that we are having sex, it would be no. My mind would never, like if I think about what we are doing, and see him, and open my eyes, and look and see what he was doing, I would not like that at all.

Claris faced the difficulty to recognize fully that sexual interaction can be a positive and intimate experience. She said:

> It's difficult for me to come to a conclusion. It's difficult for me to realize that …it could be really enjoyable, it's not just satisfying your hunger, it also satisfies your aesthetical needs, because you can eat from the pot with soup or you could serve yourself on nice china and have an extended really nice dinner. Well this is almost the same. It's something that people need to do. It's something that people need to do as a couple, not by themselves that's maybe the only difference. To be connected during eating times and let each other know that they enjoy the time of eating together.

22. Lack of control/choices. Tara felt out of control during sexual interaction with her spouse: "I have 100 percent control of who I am, and at that point, I don't have control…Mentally I feel like it is because I don't want to and he does and he's winning, so basically, he wins control of the situation." She linked these thoughts with another experience she underwent, in which she felt a similar lack of control–sexual assault. She stated:

> I just feel, no, no, because I've said no then that's it. Like I did on that day [sexual assault], I said no and you're making me do it anyway, but, I mean, after years of– I talked about it to my husband, I explained exactly what happened, feeling out of control. I feel like you don't give me control, and he'll say 'okay you take control' and 'you tell me what you want to do in our relationship'– *goodnight*, that's what I want to do, I want to go to sleep, I don't want to do it. He'll be like, 'oh, okay, that didn't work'. If he leaves me in control, nothing will happen. Like if I actually get control and I say, okay,

> today I'm going to have sex but it's all up to me, I'll just say no. I'll try, but it won't really happen.

Tara further connected lack of control with a physiological response of tension. She described it this way:

> When I go into my little foetal position that's my control of my body, that's my area and you can't go. If I relax, I feel like I'm not in control and that he's in control and that's not what it should be. We should both be in control; I don't need to be in more control than him. I think I need to be in control of me and he needs to be in control of him, and if I relax, I'm out of control of the situation because he knows that's a good time to come in, and so I don't let myself relax. And he knows that because if I relax, he knows it's okay to come in, because even if we're lying on the couch together and I relax, he's like, okay she's relaxed, this is a good time. So I'm always tense so that he doesn't do that.

Finally, she stated, "I would, right away, think oh, oh, he's going to want to have sex, and I'm out of control at that point, because I think, now what will I do. Do I say no?" Making a choice whether to engage in a sexual act in the absence of sexual desire appears to be a typical process these women go through. Again Tara portrayed such decision-making experiences like this, "I like to be strong, I like to make my choices and that's not a choice I get to make. It's a choice I have to do… at least it's a choice I get to make it a yes day, or a no day. At least I have the choice." She moreover described:

> And I always make my choice. Okay today is it going to be a no day or is it going to be a give in day. So I do no, for about 4 or 5 of them, and then I think I've said no too many times so I better do a give in day here. Even, like, I try to set it up, like I said no, like, ten times to the poor guy, today I'm going to do it, when he tries and then I'll like stay up really late so I won't have to, he'll go to bed before me and I'll crawl in bed, so he'll move his hand on me, so I said I would, no I can't, I can't. So I say no again. I try to think all

> day long that today will be a yes day, but it doesn't help me. As soon as that situation comes, it's no again, in my body.

When speaking about their sexual struggles, some of the participants believed they could change the situation, while others gave the impression of being more sceptical and attributed pleasure/orgasm to factors they felt they had no control over. Tara attributed pleasure to physiological factors, as opposed to an emotional connection between spouses during sexual interaction. She stated:

> I don't have control…[over pleasure or orgasm]…I mean I have reached orgasm many times so it's not that my body isn't there, but my mind is still, like 'lets do this' and then all of a sudden I'll be like, 'oh, this isn't so bad, well wait a minute it's okay' and then it will be over maybe three or four seconds and that's about it, and I think that's just a physical thing that he can figure out. I don't think it's an emotional attachment.

Lauren expressed a belief about having some level of control over sexual difficulty. She put it like this, "It's like, you're not bound by some unknown chemical changes in your body. It's a response that you can generate, if you feel [like]."

23. Mental detachment from the experience. The participants experienced cognitive removal from the situation. They found themselves thinking about things other than the sexual act and intimacy. Tara stated, "There is [orgasm], that's probably the best moment. I mean that is a good moment, but leading up to that moment is just me thinking about groceries." She further described such experience of detachment like this:

> I just kind of remove myself from the situation and I just feel like it's not really me, it's just my body, it's not my mind, and I take my mind away from what I'm doing and think of other things, or think of things other than what I'm now having to do. In my mind, even though I want to do it, and I bring my mind to different things, my work or planning things I could do, so that way my mind doesn't have to be on what I'm doing at that time.

Roxanna put it this way:

> I think the thing I think about this the most is that I just think about other things. That I'm totally distracted, and so, and it's kind of a worldwide joke between men and women is that often women will be thinking about the grocery list and what they are going to make for dinner and all those things but it's true and you'll all of a sudden start asking questions right in the middle of things and he'll just be going, "How can you be thinking about these things?" So there are times when I'm not into it that I'm thinking about whatever and not focusing on the task.

Phase II: Experience of Sexual Discomfort: Specific Components (Physical)

24. Pain. The participants used such expressions as “sharp as a knife,” “very excruciating,” “weird sensation,” “really unpleasant,” “annoying,” “hurtful,” and “tense” in their effort to describe the physical pain. The pain seems to be located in both the vagina and clitoris. It would usually occur during penetration. Jenny described the pain like this, “I can be going along just fine and then when we have intercourse, then, I mean, the pain is quite excruciating; sometimes I can push through the pain and I can be okay, but sometimes the pain is too excruciating. So it's just like, game over.” Claris paralleled the pain with friction against tight muscles. She stated:

> Like someone having a really tense muscle and somebody trying to make a movement against this tense muscle. That's basically what kind of pain. Really unpleasant and it's not sharp, it's kind of really long and smooth and annoying. So, basically I could overcome this thing and most likely wouldn't stop my husband. I deal with this type of pain; it's just really unpleasant.

To illustrate this pain Roxanna used the following description:

> Just pain, a lot of pain, even though from the beginning we've always tried to use a lot of lubricant. It seems like it's still very, frictiony, and painful, and so it's pretty much been that way since the beginning. If we try different positions, it will also be painful for me in a different way. It feels like, "I've never felt that before," and it feels really like a sharp

> pain but it also, I'll feel mostly like a weird sensation that I haven't felt before, like in my uterus, like I'm going, "I don't feel right." It's a painful, like it feels like it's painful.

It seemed from the information shared by the participants that the pain would be especially strong when the woman is not aroused, during deep penetration, and after the experience of orgasm.

25. Tension and resistance. The co-researchers conveyed feeling tense prior to or during sexual interaction with their spouse. Tara described such tension in the following way:

> I don't feel pain, like, I feel tense. If he tries to move a leg over, I'll be like no and I'll put it right back. Like this is me, this is my body. and [I] just say 'no' throughout the whole body, it's just very tense and it doesn't relax. I'm fine when I'm there, but if sex comes into play then I'll tense up. So if I'm all relaxed, and we're lying on the couch, and we're just sitting there and watching a movie, as soon as, if he moves his hand, even if he moves it to get a drink and be, and I'd tense up, 'oh shoot, what's he want', and 'oh, he's just getting a drink', you know that would come right into play, like I would tense up right away if he moved. If he moved, one muscle because he's uncomfortable, I'd go huh, and so that's what would come into play and I'd tense up. I couldn't stay in that relaxed state.

Such tension may serve a function of resistance against pain and discomfort. As Claris stated it, "When my husband penetrates me, it seems like all my muscles are getting really tight and I would say, in a joking way, my vagina doesn't want you and the muscles just feel really tight and it's kind of protecting, not letting anything go there." Roxanna added, "When I'm tense, the sex is going to be more uncomfortable because then I'm closed up.

The women detected that tension could be located in various places including shoulders, arms, neck, chest, stomach, and in the body as a whole. Lisa said, "Probably if I would stop and examine my tension, I would notice that my shoulders feel tight, my muscles feel, sort of constricted, it's in my body as well as in my mind." Colette, tracing the path of her tension, stated, " [it] would be through my whole body in a way but eventually in my chest." Colette

remarked, “Physically my arm muscles would get really tight. Almost like a feeling when you're pushing something away and there is tightness in the muscle [of the arms] and shoulders and you're pushing something with your legs.”

In addition, Lauren suggested that the physical response, like tension, occurs in spite of efforts to avoid negative thinking. She put it this way, “Even if you're trying to not conjure up the thoughts, somehow your body knows.”

26. Physical manifestations of anxiety. Roxanna expressed that she would experience distinctly physical anxiety. She stated, “I would get really anxious in my breathing and in my stomach. I'd feel it in my chest, and I'd feel it in my stomach. That's where the source of anxiety manifests itself.” Claris’ “heart rate” and “breathing” patterns also change as she engages in sexual interaction with her partner.

27. Numbness and lack of sensations. Claris described this experience as “a really, really cold feeling in your body.” Jenny portrayed this feeling like this, “It’s a physiological shut off. I can be totally interested and it can just shut down. Pain or just sort of numbness. She called such physiological shut off– “being dead.” She stated, “I say to John, I'm dead down there, dead. I'm like a piece of dead wood and he gets very angry with me but it's like that's what it feels like. It's dead, it's useless.” For Sally numbness is experienced along with irritating sensations

> There's no physical discomfort in that episode, but nothing feels good. Like if my husband is to caress me or kiss my breasts or something like that, it just feels numb and sort of irritating.

Phase II: Experience of Sexual Discomfort: Specific Components (Behavioural)

28. Avoidance of sexual interaction/intimacy. This study’s results determined that the women attempted to avoid sexual interaction that brings about discomfort and pain. Some do it by not engaging in sexual interaction for some relatively extended period of time, while others participate in the sexual encounter but are not fully present psychologically. Jenny wondered whether her reluctance to engage in sexual interaction due to discomfort might be interpreted as

deliberate and purposeful avoidance. She said, “It feels as though it could be misconstrued as avoidance things, or whatever, and I sometimes wonder if John thinks I'm just making it up to avoid it, or whatever, but it's like that's my reality right now.”

Lisa described her experience of avoiding sexual contact in this way:

> So I will sometimes turn my face, I won't kiss mouth-to-mouth. My body actually turns away from it. Or I'll lay on my stomach and ask him to get on top of me for awhile, and again, I think that's about turning my face into the pillow instead of turning my face to his face. Face him, kiss with an open mouth, open my eyes and look at him. It's that feeling of avoidance. Avoiding the closeness of the encounter, and so you can actually get through the encounter without doing that a lot. You know you can turn your head, you can be a different direction, you can close your eyes and it prevents you from making a really close connection.

She went on generalizing about those behaviours that avoided any kind of intimate or affectionate activity between her and her spouse. She stated:

> Besides even sex. I've just come to realize that hugging is intimate and kissing is intimate, and he will complain that I come to hug you and you're stiff, and I'm not after you for sex just then, but you don't reach out and touch me and grab me and hold me. You seem to say I should be more affectionate with you and not just when I want to have sex with you, but during the week if I go to make those moves towards you, you seem stiff or you pull away, or you look away, or you walk away.

29. <u>Engaging in sexual encounter despite discomfort/pain.</u> Interestingly, the participants reported that although they tended to avoid sexual contacts with their spouses, they still on some occasions engaged in sex, bearing the pain and discomfort, out of a sense of obligation to connect sexually and a desire to please their partners, as well as a hope to eventually experience pleasure. Lauren conveyed, “Even if it hurts, often we would just go through with it.” Roxanna expressed it this way, “Sometimes, I don't want to go there for myself because I know it's going to be

painful when we eventually have sex, but then, obviously he wants me to enjoy it and so it's a hard problem, and usually I just endure it anyways." Claris revealed her experience of giving in to her spouse's sexual needs.

> So, I would say, okay, let's do it. Most of the time he would say no, he would say I'm not going to do it, but sometimes he will say 'okay'. He would go like, 'Okay, it has been so long, we didn't make love for so long.' It would make me feel even guiltier. Then I would say okay, let's do it, just don't try to make me come, just, whatever, basically use my body. I will let you do that and at this point, I always think I'd rather not let him do that, but it's not rape because I say, yes, you can do it. Without my permission he wouldn't do it. Maybe because he knows what buttons to push and when it's really hard for him to hold, he would probably push those buttons of making sure there was a time to do it. I would let him do it.

Jenny expressed it as follows:

> Sometimes I'll engage with John because I want to please him, because I want to do that and even though I know, my body is so tired, it's just not going to go for it. Then I just get frustrated and for John it's not fair. It's not what he was looking for either, right. Other times, I can be really tired and it can work. I kind of just say to John, well you know, you'll have to go through this archaeological dig to see if you can find me, because I don't know where I am. That's what I say. It's like I don't know. I have no idea where it is but if you can, help me find it.

She also reported having a sense of whether or not she would be able to enjoy the sexual interaction. She stated:

> He doesn't like to push me through that, and I'm the one who decides to push through, and there's times when I will just say, no this isn't going to work. You know I can sometimes feel, okay, I can push through it and then it will be fine, but other times it's like, no, this is too deep and it's not going to work.

30. Motionlessness during sexual interaction. Finally, the participants mentioned that they might be completely motionless in the process of sexual interaction. Sally put it this way: "The only other thing is, I'm not moving. I'm, kind of, just frozen… When it's initiated and it starts, it's almost like I freeze. I just, my arms won't even stroke his back."

Phase III: The Mechanisms Used to Cope With the Discomfort

Themes 31-39 represent coping mechanisms used by women to deal with sexual discomfort and pain. Some mechanisms shared by the participants provided constructive solutions to the sexual struggles, while others could be seen as less constructive and even harmful.

31. Acknowledging and trying to resolve sexual struggles. Women reported coping with sexual discomfort by acknowledging, expressing, and trying to resolve sexual difficulties through journaling, therapy, or other means. Colette, for instance, emphasized the importance of her acknowledgement of the difficulties (whether depression or sexual struggles) and her expression of them. She stated:

> I think it would make me pay attention to this [problem], like don't just let it go, don't just cover it up, don't just deny it, don't try to make out that it's nothing. But we need to learn to express what's there so we can move in the psychological flow of ups and downs, and so I realize that, so even though that was a long period of down and I had a lot of struggle in coming to the expression of myself and I think it's caused me to trust in that process. That there can be, um, you know, even if I'm down now, I will, it's important to express what's there, and hope.

Other co-researchers' experiences were similar to Colette's in regards to the importance of communication about sexual discomfort with others, whether with the spouse or a counsellor. Roxanna suggested that communication with her spouse about the discomfort seemed to reduce her frustration. She said:

> In the last few months it has changed somewhat. It's in a process of changing so I think, I'm thinking back to how it was and how it is now. Before I probably would have tried to hide more from him and try to protect him, and at that time, it would have been harder but as things are changing more it's not as painful all the time. I think I can share that more with him. So I'm moving to a place of a lot less frustration.

Sally found that self-talk through journaling has been helpful to her:

> Journaling, I do a lot of journaling. Coping by self-talk, just trying to tell myself that it's not all my issue that it's a combination of both of us and, you know, I often wonder if it just, you know, if John would have married somebody that wouldn't have had this baggage and these body image issues and someone that was very comfortable with body image or their sexuality and would be able to just push him along and get him over that, his hump, and then if I would have married someone like my previous boyfriend.

Lauren found therapy to be helpful, “the therapy really helps for me.” Conversely, Tara has not found it helpful. She conveyed:

> I see a therapist to try to help me through this, and I sit down, and I go through my bad experiences thinking that maybe I've blocked something and I'm not going through. So I've tried to do that. I've tried to explain more to my husband what, maybe, will work for me but it hasn't worked.

Claris expressed her simultaneous desire and fear to share more about her sexual struggles with her spouse:

> At this point of my life what I need to do is talk openly to my husband and involve him in the much deeper roots of the situation, of the discomfort. So we can try to solve it together, but there is also a fear of, what if he's not going to understand me, what if he's going to get upset, what if it's not rational blame? That it's partially his mistake. So I don't know.

Sally conveyed that communication about sexual difficulty with her spouse did not seem to resolve such difficulty. She stated:

> One counsellor has said to us that a good place to start then, because John's not so keen to come to counselling, would be just for us to start talking and trying to get that intimacy on a level where we are able to talk about it and tell each other how it makes us feel. Not the actual experience but as you're doing it… so, and I've come home from counselling and suggested that kind of thing to him and, you know, and he tries, and he makes the effort, but he's still so uncomfortable and so, you know, about even talking about things that nothing ever changes, like it just stays the same. So it's very frustrating.

Tara had a similar experience where she felt that communication did not seem to change the situation. She shared:

> I try, like you know, I see a therapist or something to try and, um, help me through this, and I sit down, and I go through my bad experiences thinking that maybe I've blocked something and I'm not going through. So I've tried to do that. I've tried to explain more to my husband what, maybe, will work for me but it hasn't worked.

Other participants also communicated a feeling of frustration originating in having made multiple attempts to improve sexual interaction but not experiencing any significant change. Lauren described it in the following way:

> Well I can remember one time trying so hard to make it happen. You know like I got some nice clothes a little nighty and put a blanket out on the floor. We thought we'd try somewhere other than the bed, and so the anticipation was there but the fear was so deeply rooted that I knew that nothing was going to be right. Even though, here we are trying to make it all happen, candles and everything and trying to do a little bit of foreplay and things like that, and I was kind of wishing that that was all that was going happen and then go to bed. But, knowing that I had perform, so I would try, and I think my husband could tell when I'm into it and when I'm not. So for him, he can try a little

> bit, but if I'm in pain he knows and nothing happens, really, right way. He might get frustrated and I'm to the point where I say, I just can't do it anymore, and then we both kind of go to bed. We had so much anticipation of something happening I invited him unclear all the way along. I think that happened many times where, we kind of got a bit frustrated.

Tara similarly experienced that their mutual efforts to reduce discomfort were not helpful and only led to frustration. She described it this way: "I try really hard to get my mind, you know I set up candles, I try the whole thing to try and get my mood to where it has to be. We take a bath, we try that, but that doesn't change it." Sally experienced sadness and frustration as a result of not being able to eliminate sexual difficulty. She stated:

> I feel really saddened, especially that it's the way it is and also just so frustrated at myself that I can't seem to make it change, you know, like I just feel like I should be able to, you know, I read one book once that talked about if you just go through the motions that the emotional part will eventually kick in. Like if you force yourself to caress him and force yourself to physically do the movements and the motions that eventually, maybe you'll get to the point where you can get, and I don't, I just I feel frustrated at myself that I can't make that happen because, I've tried to make that happen.

32. Avoiding sexual encounters. This theme differs from the Theme 27 in the *intentional* nature of such avoidance, i.e., the participants deliberately stayed away from sexual encounters to decrease the amount of discomfort. The co-researchers informed the primary researcher that they tended to avoid engaging in sexual interaction with their spouses. Some reported simply staying away from the spouse or sexual contact. Morgan offers an example: "I would try and go to bed early, I would try to go to bed later than him. I just didn't want him to touch me, come near me." Tara did not want to engage in a sexual interaction with her spouse and, in order to avoid feeling guilty and uncomfortable, she tried to look unattractive or come across as irritable. She stated it this way:

> I don't know. I just think if I block, if I say no, he'll stop. If I make him feel like I'm not desirable, like I'll wear three pairs of jogging pants and turtleneck sweaters to bed so that I'm not desirable, so that I won't have to go through these bad experiences, so then it's not always my fault that I'm making him not want to. So then it's not always me being the bad guy. So I feel like if I put my wall up, say be this grouchy old person that doesn't want to, well then it's not me not wanting to. I make it more that, it's more that, okay he doesn't want to today so that's good, so I don't have to, that sort of thing.

Others made individual attempts to speed up the process of sexual interaction after having engaged in it. Tara stated it this way, “I am thinking of how to do this as quick as I can to get this over with, so my body does what it needs to do. I try to enjoy it but I'm at the point now, where it's just, yah okay, let’s finish it off and then okay I'm done.”

Roxanna shared that self-distraction was her method of avoiding being fully present during sexual contact– she would attempt to distract herself in order to detach from the experience of discomfort or pain when it occurs. This is her way of avoiding or not being fully present during sexual contact. Roxanna conveyed:

> I try to just look away or try to like pinch myself so I, kind of, defer the pain, and during the time I'm just trying to think of other things to try and distract my mind or just try to do things to make him hurry up. Like pretend that I'm really enjoying it or something like that.

Colette revealed detaching herself from the experience of sexual discomfort by placing her mental focus on things other than sexual interaction. “I would try to have my mind somewhere else,” she stated. Similarly, Claris shared that she would detach herself from the experience of sexual interaction to avoid feeling ashamed of herself. She stated, “I don't want to get in touch with shame, but I think all of the shame came from my past. It's not part of my relationship, my private relationship. And so I would say that, in order not to feel that, I am detaching myself.” To avoid getting in touch with sadness associated with the presence of discomfort in her life Morgan

reported engaging in various projects and activities that took place outside of marriage context. She said, "[I] try not to think about it, because it makes you sad if you think about it. Um, you just get busy with other things, like I just put more things on my plate."

33. Tending to engage in compensatory rituals or behaviours. Some women found that drinking wine helps to decrease anxiety and tension and makes sex a more pleasurable activity. Lisa stated:

> Yep and that's probably why I drink on the weekends, because I find that I'm quite uptight and so drinking wine just, it helps my up-tightness and my tension just chill a little bit. I drink for the same reasons lots of people drink, which is to unwind from the tension on the weekends. So I drink on Friday and Saturday and those are, probably most often, the nights that I have sex and I think that that helps a little bit, because of the tension I feel inside. It just lowers it a bit, and to me that's helpful, actually. It's helpful to just lower my anxiety level a bit, so that I can relax a bit, and then I have good sex on the weekend.

Sally also found that alcohol facilitates relaxation and feeling more sexual and comfortable. She expressed:

> We've tried things too, like alcohol, but my personality is so black and white and I've had issues in the past with not being able to handle alcohol well and not knowing when to stop and so I haven't touched alcohol for many years. So when we were going through all this intimacy thing, one of the counsellors we had seen said, well just try it. One glass of wine or something, just to relax, and that one glass of wine ended up the whole bottle, and I was very comfortable and sexy, and John was repulsed by it, but he says he wasn't, like I came on too strong again for him. That's how I felt, that was the message that I got, but I don't know.

Sally coped with lack of emotional intimacy by consuming food. She pointed out:

> I've coped that way, and I've probably coped with that ghost of the eating disorder coming back once in awhile to haunt me. Coped by emotional eating, filling that void and that hole. You know, if I can't get that intimacy there, I'm going to eat that sweet piece of pie or ice cream to make me feel better, probably that's my coping.

34. Co-operating with unexpected experiences of openness and freedom during sexual encounters. Lauren anticipated pleasure as she went off the birth control pill, hoping that somehow the subsequent sexual interaction would be less painful. She said: "There were some times when I went off the pill, all of a sudden I thought, oh this is going to be better. Psychologically I made myself realize that it's going to be better, maybe physically as well. Then…it wasn't as painful." Lisa discovered that in the midst of sexual contact she makes a decision whether to let herself be open to pleasure and enjoyment. If she does, the sexual interaction seems to become more satisfactory. She described it in this way: "The last couple of times was good, and I don't know if it was because, again, I feel, well I'm going to have sex, sort of obligation type of sex, but very early on, I think I make that decision in my mind to feel enjoyment and pleasure. To let myself feel it." Lisa further illustrated how such openness to pleasure is experienced:

> It's not unenjoyable while my face might be in the pillow. Okay, so lets say he's on top of me and he's doing things to me from behind. He's rubbing, I might actually feel enjoyment. It feels nice but it's on my terms, and maybe that might be a moment when something about that will feel really good and that will be that changing moment that I was talking about. And he'll say, "Do you want me to do something to you," and if I felt the arousal, I might get into it, and say, "Oh, okay." Then I feel the arousal and I'll keep going. Why it has to be so torturous to allow yourself to be aroused, I don't know.

35. Accepting the situation; keeping up hope. Although some women accepted that the sexual struggles they experience might last forever, there still seemed to be some hope for improvement and enhanced sexual satisfaction. "Hope keeps me going," stated Morgan who, in

spite of the neglect and emotional abuse from her spouse, made a conscious decision to stay in the marriage and trust that the husband and consequently their sexual interaction would eventually change. She further asserted, “I ask God for more patience, and I ask God to fill me with the love so I can love Bill, because he's still one of God's creations. God loves him too, and he's just a little stupid right now. He'll come around.”

Tara, having had sexual difficulty for many years, reported that she coped with its presence by accepting the situation. At the same time, Tara continues making efforts to decrease the feeling of discomfort whenever sexual interaction takes place. She stated:

> I just learned to live with the fact that I won't enjoy it. I try to get myself to think nice thoughts, to try to get myself to want to. So I cope with it by trying to get myself to keep going. I don't cope with it, I just deal with it. This is who I am and you know, some people are blind in one eye and some people have one arm and this is my thing that I have.

Lisa reported feeling discouraged about the struggles in the sexual area of life, along with her wish to be able to better accept the situation. She said:

> So I think I could do myself a favour by being more open about the way things are for me and just accepting that that's part of my struggle, and that small improvements are a step in the right direction and that sometimes the way that I look at people's sex life in magazines, I need to tone that down a bit and realize that reality for everyone is what it is. You know, like holding up that ideal, does me harm, because I think of it being so different of what reality is, that that causes me pain because of the gap between what I maybe think you should be like. [I feel] discouraged about the gap [between ideal and reality].

Colette recognized people’s tendency to avoid unpleasant experiences and suggested that facing them, grieving, even crying, was a healthier alternative. Having these painful and discouraging experiences is, for Colette, a way of experiencing God’s comfort and care. Without her having

this difficulty, there would be no need for her to seek for God, and, more specifically, God's love and comfort. She described it in the following way:

> And not just hoping for the better times, but when the time is there, when it is down, or whatever, to stay there and not try to make it go away, try to actually go to where it really is painful and say yes, and to actually grieve that things are not ideal. Things are not the way I wish they were, even allow the tears to flow so that is kind of a cleansing, in a way. Then in those tears coming to the actual spiritual side that I can be comforted there and try to find comfort and know it's not perfect and feel actually God's comfort.

36. Releasing shame, guilt, and anger. The participants conveyed that letting go of self-doubt and associated effects contributed the enhanced sexual satisfaction. Lisa, commenting on the infrequent experience of sexual freedom and satisfaction, said:

> Well I could tell you about an incident when I had just finished six months of therapy and Tim and I went to Hawaii. Like we had good sex on that trip, and I don't usually initiate sex and I even initiated a bit. We can say one or two times in 12 months compared to never…What made me suddenly get more passionate right then, I think it had to do with feeling kind of free from some of the past stuff that in my mind, I would use to hold myself down or punish myself, or cause me to realize that, you know, maybe this great sexual thing is not for me. Like I wasn't buying into that as much when I was working on the topics in therapy, and I was feeling freedom from the past and I felt lighter and freer and I was, all of a sudden, into sex more.

Colette's sexual interaction improved after she was able to discharge bitterness and anger associated with having made choices without fully knowing either herself or her desires. She had an experience of spiritual, psychological, and sexual transformation where she was able to learn to receive care and pleasure. She described such experience as follows:

> I did undergo quite a dramatic change when I actually was able to let go of and it took so long to let go of some of my bitterness for [making] a lot of choices that I've made. My

> educational training and those sorts of things, and now I'm coming to something that's more spiritual… God is saying that you have to show me who you are and that you have my blessing. If you truly have my blessing, then you have to show me, and in those kinds of dealings I actually show my personal care. So it was, at first, I think maybe, coming to a readiness to receive psychologically, and then it was coming to [receive sexually] after that. I'm not saying our sexual relationship is perfect, but I'll try to tell you it was like honeymoon city after this happened, and I was able to learn to love again, of course, the whole sexual experience was incredible.

37. Engaging in self-caring activities. The women found themselves feeling more alive and sexual when they were conscious of self-care. Colette had discovered that her needs were important and valuable. She stated:

> That it's okay for me to have needs, and I guess, in that end in meeting my own needs ultimately, I am fulfilling who I am created to be and [fulfilling] who I am created to be, I do meet the needs of other people in that way, but I kind of resist the terminology…

The participants reported taking care of themselves in various ways, including exercising, eating properly, getting in touch with personal interests and passions, and in general doing pleasant and enjoyable things. Lisa communicated it this way: “I would take time, take a nap, read an autobiography of someone, do things for myself that were just pleasing, and then all of those things seemed to, I don't know help, contribute to a little bit of an awakening of the sexual part.” She continued claiming that her sense of self, including her view of self as a sexual being, has improved since engaging in self-caring and nurturing activities. Lisa said:

> [I was] surprised by that. I felt sexier about myself. You know so for a year there, after I was working on some of my own emotional issues, I started taking better care of my body and exercising more regularly. I was in the sun. I was drinking lots of water, eating right. All of that was combining in me feeling really good about myself, which included the sensual part. It was like looking after myself emotionally had a trade off, a positive

> trade off in wanting to care for myself more physically, care for my body, and the overall effect of that was that I felt sexier, sensual.

Similarly, Jenny found power walking to be beneficial for her feeling better about herself and subsequently for feeling more romantic and connected with her spouse. She alleged:

> I met John, and we had the romance period and everything else. I don't know if it was associated with [power walking], maybe it was last year. Like when I go out power walking I stand tall and receive life. That's my kind of way of trying to bring life into me.

Colette described her identifying her own needs and obtaining a clearer sense of self as a natural developmental process. Search for self-actualization and the fulfillment of the self seemed to be a by-product of this personal journey of self-discovery. Colette connected such process with reduction in the sense of obligation to satisfy her husband's needs, including sexual ones. She conveyed:

> I think there's less need for me to have all my needs met and my husband's when I'm aware of my own, have more of my own sense of myself. Not that there's still not disappointment and stuff like that, but I can, because there are places where I have passions and desires that I wasn't in touch with before, I can go there and I can relate in different ways and with different people and with different places, and I started to have courage to go to those places and not just feel like a victim, not just feel like, um, oh something was done to me in my past and somehow I have to live with it, poor me, kind of thing that, some kind of intrinsic motivation for me has been restored.

38. <u>Placing mental focus on a spouse and the couple's unity.</u> The participants reflected upon their mental focus during the process of sexual interaction. They suggested that the discomfort is decreased when they recalled their emotional connection to their husband, their feelings towards their spouse, and their partners' care for them. Jenny found that focusing on her spouse, rather than on the sexual interaction itself, or her body and/or herself as sexual being,

decreased the pain. She stated, “If I mentally orient myself more towards him and how much I care about him, instead of thinking about my own body and my own sexuality, that helps sometimes.” She further suggested that orienting herself towards loving as opposed to sexual energy helped her to experience a decrease in discomfort. She communicated it this way: “We just change the focus and stop focusing on sexual energy as on loving energy. I find that's really important.”

Similarly, Tara experienced that pleasure and orgasm is possible when mental focus is placed on the spouse, daily tasks, or something relaxing, as opposed to the sexual act. She pointed out, “I actually have to experience something beautiful in my mind to experience [something] beautiful with my body.” She added:

> If I'm in my mind and do my grocery list or whatever, I feel like I'm more relaxed than if I'm going, no, no, I don't like this, it's bad, so I really try to get my mind somewhere else because that actually relaxes me more. Or else I try to think of me on a beach, a nice beach so at least he thinks that I'm enjoying what we're doing.

Tara found it extremely uncomfortable to think of the sexual activity itself, while in the midst of it. She described it in the following way, “If I actually think that we are having sex, it would be no…If I see him, and open my eyes, and look and see what he was doing, I would not like that at all.” Thus, she discovered that she had to be focused on the spouse and not the act of sex to be able to feel enjoyment. Tara shared, “Basically it's hard for me to get to that point [of orgasm]. I mean there have been times where I can, but my mind has to totally be on him and focused on him rather than on the situation.”

39. <u>Having a predictable and stable pattern of sexual interaction.</u> From the information provided by the co-researchers it became apparent that a predicable pattern of sexual interaction decreased the women’s discomfort. For some participants such stability and predictability derived from following established routines. For others it required having a relaxing atmosphere that was free from distractions. Still others needed to please their spouse non-sexually in order to

prevent criticism and rejection, so that they would feel safer to engage in sexual interaction. Lisa, describing her need for sexual contact to be predictable, said:

> Like it's a big cost. So I slip back into my predictable comfortable way of being which is the patterns that we've been in together. Which is, yah, we're going to have sex about once a week, and so you know if it's the weekend and I have a glass or two of wine, and I know, maybe we talk about the fact we are going to have sex that day, great, I'll probably prepare myself a bit to, sort of say, okay this is the night we are going to have sex, that's okay, and then, you know, maybe we'll have sex for 15 or 20 minutes, and I get an orgasm and then, so it's kind of okay.

Sally found that a relaxing and distraction-free environment decreased but did not eliminate her discomfort. She expressed it in the following fashion:

> Like I said, just a time that would be set aside that we'd have time to have that intimacy together without any distractions. To just have a little quickie in the morning when you're running and the kids are knocking on the door and everything like that would definitely be a factor. I would need some time to, in the evening it's quiet with music. Like I said, that's all those layers, because then John will say, okay, I'll do all that for you, and he will pour the bubble bath and [turn on] relaxing the music, like 'let's work up to this' and then still it's so [uncomfortable]….

Morgan tried to please her spouse in various non-sexual ways, to feel safer to engage in sexual encounters. She said: "I would … find ways to please him, so then he wouldn't have reason to be cranky at me, or whatever and ruin the evening then I would feel like I wouldn't want to please him…. I would try [to] find ways, so it would be easier for me… to give myself to him."

Finally, Roxanna felt the need to be prepared physically prior to getting involved in sexual contact. She stated:

> I tried to relax my body, like really just totally stop, and sometimes he'll just go, "Relax," because I'm just "eeee," and breath deeply and try to focus. During sex I don't really try

> to focus my mind on sexual things because it doesn't really matter anyways, it's too late. If it wasn't already there, it's too late. I mean previously yes, like previous to sex, yes, but not during sex.

Phase IV: After-effects

The themes 40-42 represent the consequences or after-effects of sexual discomfort on women, their relationships (whether with the spouse, others, or God/higher power), and life in general.

40. Overall negative effects counterbalanced by enhanced faith in sexual and/or spiritual healing. The participants reported that sexual difficulty has, in Colette's words "affected every area" of their lives. Morgan's comment was similar: "It affects everything, it affects your whole life…" Specific effects of sexual discomfort on women's lives in general were expressed during the study. These included: uncertainty in regards to how best to parent children, financial difficulties, and a deficit in spontaneity in areas other than the sexual aspect of life.

Lisa experienced difficulty in parenting and educating her children about sexual issues. She explained:

> It may have an effect on the way I parent, it may set me up to be a little bit more worried what messages to try to convey to my children. You see, I think I don't want my kids to be screwed up, so I have to, so if my husband wants to talk about I love mom and doesn't she look great, and mom and I are la la la and the kids go, "Oh, don't tell us." I'm a little bit concerned that okay, Tim and I have to make sure that we give our kids healthy sexual messages so that they end up anticipating sex in a healthier way than I was brought up to.

She also suggested that predictability and a lack of spontaneity in the sexual area of life is transferred into other life domains. "Spontaneous," she shared, "That's a big effect, because it causes me to hold back in little ways. Hold back something I might do spontaneously." Sally experienced financial stress due to the payment of counselling fees, "It's affected us in that we are

spending money with counselling and things to try and fix the problem that's not so easily fixed, and so the financial stress of it."

Although the women who were interviewed revealed multiple harmful and hurtful effects that sexual struggles have had on their lives, a strengthened faith in God or in another higher power and/or in ultimate satisfactory sexual functioning were themes confirmed by all of the participants. Morgan shared feeling more connected with God as a result of the presence of sexual problems in her life. She disclosed, "It keeps me close to the Lord, it keeps me very close to him, because I'm always at his feet– 'What do I do now?' and he knows when I can't take it and he seems to give me a reprieve for a while..." Lauren conveyed that she came to a recognition of the potential for sexual intimacy and for an ability to connect with her partner sexually. She stated, "It's just a realization that the unity could be there and painless, and you know that."

41. Individual difficulties counterbalanced by individual benefits. Various individual effects, generally classified as positive and negative, of the presence of sexual discomfort on the participants and their lives have been noted. The negative after-effects are comprised of frustration, anger, guilt, sadness, discouragement, hurt, depression, loneliness, insecurity, uncertainty, anxiety, fear and physical pain. The positive consequences of having the experience of sexual discomfort include enhanced self-awareness and an ability to cope with discomfort, recognition of one's own strengths, and a willingness to offer help to other women, who suffer from sexual discomfort, by sharing one's experiences.

Concerning the negative aspects, Lisa experienced resentment, disappointment, and anger after she had felt invaded sexually. She shared:

> Resentful, sometimes that would result in me even acting kind of a little bit angry or standoffish for not a good reason. Almost as if I could pick a fight, but at the time I'm thinking about I'm not doing that. I'm just, I have a, the sense that, like that it's inevitable

> and that I can't think of the work I'm trying to think of. It's just that I've accepted that that's going to happen, but I'm not happy about it.

Jenny revealed anger, frustration, and sadness associated with not having as fulfilling and satisfactory life (including sexual) as she might have hoped for:

> That I'm not attractive because I'm not very easily sexual, and I talk about it in frustration and mainly I talk about it on a level and index as frustration. When I feel, talk about these tears that are behind the veil, I feel sad about it. I mean there's sadness there, there's sadness about the loss of a lot of dreams right now… I'm feeling quite sad that I'm not living the life I could be living.

She further expressed feelings of guilt and perceptions of her self as an inadequate wife, unworthy of attention and love:

> The impact on the relationship I'm constantly feeling guilty, I'm feeling like I'm not being a good wife. That John would want to spend more time with me if I'm more sexual and that it's just he wants to study or go and see his friends, but I take it as he's just not interested in spending time with me cause there's nothing worth spending time with me about, because I don't do that.

Jenny continued, describing feelings of insecurity, sadness, and fear of being abandoned by her spouse. She asserted, “then I start feeling insecure that he's going to find some young psychologist that's got a degree and working, and out there in the world, and he's going to fall in love with her. So that's very, very threatening.”

Claris’ experience of having sexual difficulty in her life is characterized by frustration, anger, uncertainty, and depression. She disclosed, “maybe a frustration over the year and feeling anger. I do want to have the same feelings that I used to have about making love.” She added, “[sexual difficulty] affects me personally, it makes me feel unsure… Unsure about, is it me or is it my partner, or is it something between us, or is it normal?” Finally, Claris conveyed, “It's

affected my mood… it seems like at home I would be always depressed and don't want to do anything. Just, like, waiting unconsciously, how am I going to get through tonight?"

Sally felt sadness and discouragement about having sexual difficulty and feeling abnormal. She explained it like this, "I just know it's not normal and it's affected me, it's saddened me that it's got to this point." She shared a fear of losing the spouse as a result of sexual difficulty, "My greatest fear is that I'm going to ruin this marriage because of this problem that we have. That he'll go and somebody else will be interested and show him some interest and he'll be gone…" Tara described the emotional hurt associated with the presence of sexual discomfort. She said, "I'm not feeling pain in my body, but I'm feeling pain, because I don't like it and I want to like it." She further expressed feeling worried and mentally preoccupied with sexual discomfort, "I worry about it all day long, like if I'm at work is it going to be a yes day or a no day. I just wish I wouldn't have to worry about that all the time, I just wish it would be a desirable thing."

For Lisa sexual discomfort contributed to reluctance in her to be affectionate, fearing that expressions of affection may lead to a sexual interaction. She stated:

> I'd say the effect is in the affectionate levels that I will allow. So what happens is sex becomes more of an engagement that we have this quiet, unspoken agreement about, so I'm afraid, deep down that if I am more affectionate or I say I love you more, or I kiss him better that then that might get into that scary territory where he might think that's a come on for more sex, which is not what I'm thinking. So if I feel it, I actually would stuff it sometimes and not do it.

Lisa expressed feeling resentful, insecure, disappointed, and lonely. She said, "Sometimes I feel the resentment before, because I don't want to do it beforehand, so I think, why can't I just say I'm tired, and this is a bad time, and I don't want to do it and why do you expect it?" She added:

> Just a lack of confidence, lack of sexual confidence, feeling of insecurity, maybe I'm frigid and maybe I'm abnormal. Disappointment in that. A bit of loneliness. Like I like

> being alone, and I like spending time alone, but when I say loneliness I mean that once in a while, I'm aware that I don't feel that closely connected. So it's enjoying solitude, but that's not what I'm talking about, I'm talking about when I feel lonely.

Lauren developed a tendency to avoid engagement in sexual activity with her spouse. She pointed out, "I was really the one who was avoiding it."

Alongside the negative, the participants' transcripts revealed a number of positive effects, which were related to their experiences of sexual discomfort. Lauren described one of them, an enhanced self-awareness, like this. "And you're closer to yourself. I think I'm closer to myself…" Sally also stated, "The only thing I can see is just the fact that I'm still analysing myself, just trying to learn about myself." Another outcome of the experience of sexual discomfort is the increased ability to cope with this type of trauma. Tara, for instance, stated:

> I've grown to realize what I need to do to get the end result. I've learned that it's okay, it's not a bad thing. I've learned ways that I can do it without torturing myself so much, even though it's so discomforting. I've not learned a lot too, like it's still uncomfortable, so my learning process has to continue and you know mentally I know how to prepare more than I used to and try to relax when I think like that.

In addition, she realized that she could refuse to participate in sexual interaction with her spouse if she did not feel the desire. She conveyed it like this:

> And also that no is okay. I know I can say no, like with my husband I can say no and he's not going to make me. So through my bad experiences, when I felt guilty for not saying no, now I will say no and I know he will not harm me if I say no whereas before I didn't know that. I was fearful that I could get harmed if I said no, whereas, now I'm strong enough to say no…

Jenny learned to enjoy life in spite of all her struggles:

> I mean, in my quiet time I feel frustration and anger sometimes about my inability to have kids and the mutant thing the dead tree thing. It's interesting in an art therapy when

> I've been asked to draw a tree. To me it's very alive but it's been pointed out to me numerous times on different occasions that this tree has no roots and there's no foliage. But I mean that says something, it says a lot, because it's dead wood, but I mean I'm alive in that deadness. I haven't, I mean, I'm not going to give into it.

An additional after-effect, resulting directly from the presence of sexual discomfort in their lives, is the participants' recognition of their personal strengths as a result of the presence of sexual discomfort in their lives. Lauren discovered that she could be selfless and willing to sacrifice for her spouse: "The selflessness, knowing that you would be willing to sacrifice for your husband's sake, and that he truly does care." Morgan noted her strength to be committed and dedicated to marriage: "I'm a tough, old bag," she said. "I can handle anything, and I wouldn't be able handle it if I didn't have God. I probably wouldn't handle it. I wouldn't be in this marriage, if I didn't have God. I would have been long gone, long gone." Moreover, Jenny noted, "I don't judge people very quickly because everybody has a struggle, and I think I'm somebody who has quite a bit of compassion. Yah, because I've been through a lot of struggle I'm quite compassionate."

A final quality that was mentioned repeatedly in the study was that the women noticed they had developed a willingness to assist others Finally, it was mentioned that a willingness to assist others as they struggled with their own sexual difficulties. Jenny expressed a motivation to share her experiences with others: "Because I have these problems but I'm willing to be open about them because there's probably other people that, anyway. There's a lot that I have to say…." Lauren expressed that other women with the experience of sexual discomfort could benefit from her sharing her own sexual struggles. She expressed, "I hope that I can help other, like my sister-in-law who just got married. You know, I hope that I can give them the real truth, or a few tips that might help. Like I feel like I've been there, let me coach you."

42. <u>Relational discord counterbalanced by enhanced dedication to marriage.</u> This study revealed, in a number of forms, relational discord and other negative effects of the discomfort on

the spousal relationship. Lauren asserted that, the pleasurable or uncomfortable nature of sexual interaction affects non-sexual aspects of her partners' relationship. She conveyed it like this:

> It really impacts the whole dynamic of your relationship for days to come. When it happens successfully you can totally tell that we were way more of a team, we were bonding. [At times when] the sexual relationship was in trouble everything revolves around it, it's very weird… it's so difficult when you haven't had sex you don't call each other honey and sweetie as much. You don't hug in the kitchen.

Lack of an emotional bond was one form of the negative effect that sexual discomfort had on a couple's relationship. Roxanna stated, "Well I think it affects our every day relationship, because it does have something to do with how connected we are…" She further indicated that sexual difficulty also seems to have an impact on her spouse's mood and emotional condition. She said:

> I can see him getting a little bit more grumpy if he doesn't get it for a while. If we don't have sex for a few days, he just gets more frustrated with things and grumpy, and little comments back and forth, like making some kind of comment about never getting, never really having sex, and I'll be making comments about how he always wants it, and I think, somewhere along the line that's affecting both of us in the way that we poke at each other… it just affects our relationship in the obvious ways of just being disconnected with each other.

Similarly, Sally suggested that her partner might be experiencing resentment and other negative emotions towards her. She stated, "I'm sure he's, even though he doesn't say it to me, I'm sure he feels resentment towards me, and as well as, a whole bunch of emotions."

Another form of negative effect on the couples' relationship is the wife's doubts about the sincerity of her feelings for her spouse. Claris expressed these doubts in the following way, "Is something wrong with him? Do I not love him anymore? Why have I sexually slowed down so much? What's going on?" Still one more negative outcome of the presence of discomfort is marital discord and conflict. Claris stated:

> Like one question I would misinterpret and he would start yelling at me. Sometimes I would take it like, whoa, like what's going on, and sometimes I'm already irritated from my internal conflict, I would like fight back and it's like a fight, and we are going to fight again, and maybe just turn around and not talk to each other. It's really put a lot of stress on the family relationship. Like this energy could be used for something more important than that.

A small number of positive effects on the participants' marital relationship have been specified. Expressing hope for ultimate enjoyable sexual intimacy, Roxanna perceived her and her spouse as a team who have joined forces to face and fight the sexual distress. She said, "This is what *we* have to deal with and this is how *we're* going to work it out. It's just acknowledging that it's not the ideal situation, but *we* can do things to improve it." Roxanna also reported that their difficulties have enhanced their communication, in the midst of the sexual act, about mutual preferences and experiences. She explained it this way, "The two of us have had to work together on this and figure out what works and what doesn't, and be patient with each other, and be giving to each other. And just learning about each other and how each other work."

The last positive effect of the existence of sexual discomfort on the couples' relationship, mentioned by the participants, was the partners' mutual commitment. Lisa shared:

> Well I think I've learned the positive effects of commitment to each other. You know like someone cares so much about me to put up with tough things, and to encourage me through my struggle. Um, that's a commitment of him to me, and then I also feel proud of myself for staying committed and not going to the greener pasture thinking that must be where for talking myself into staying and realizing that for our family and for myself, I think the best healing has come from walking it through.

Similarly, Sally in a similar way disclosed the realization of the mutual commitment for each other and to the marriage, which she expressed like this:

> Well obviously it's affected our relationship on some level, but I think our relationship is strong enough, like I said that we are committed enough and like he's told me that he's there for the long-haul and that we'll work through this together, but definitely, how can it not affect your relationship.

Lauren also discovered her dedication and commitment to the marriage:

> I knew that it wasn't going to affect my marriage, ultimately. I knew that if I was a non-believer and was just dating that I probably would have given up because it wasn't worth it, but in a marriage where you know your ultimate goal is to be together, forever, and to work through problems together, I knew that I was going to keep on trying. But you realize in the dating scene, that people would give up on something like that and would try somebody else, but it would be them that was the problem, but they would probably keep trying to find somebody who was a better fit for them sexually. You know working through it has being the best thing ever, because now I think we've found each other. So yah, I think what you learn, you know, your dedication to the marriage, ultimately, is not based on one part, one problem, really.

The Fundamental Structure

The "Fundamental Structure" section provides readers with an opportunity to grasp the core of the experience that is under investigation. Here, the principal researcher attempts to capture the richness of the experience of sexual discomfort experienced by married women in the most concise and succinct manner possible. A description of the core elements of the phenomenon proceeds in the sequence described below:

The beginning phase of the common story is centred on the conditions and facilitating events, in this case, sexual discomfort. These conditions and events create the context in which the phenomenon can arise and be experienced. The second phase of the common account represents the central part of the investigation—thematic descriptions that help researchers to understand the profoundness of the sexual distress experienced by the women interviewed. This

part is followed by the third phase representing the coping mechanisms discovered by the participants to better deal with their unpleasant experiences. The final phase summarizes the effects of the experience on the women, their relationships, and their lives in general. It is noteworthy that the thematic descriptions specified within each of the four phases may occur concurrently and have a circular or reciprocal, as opposed to linear, impact on each other.

Common Story

The initial phase of this common account of the experience of sexual discomfort in married women describes the general pre-conditions and specific facilitating events that contribute to the emergence of such experiences. Effort has been made to present facilitating events in a chronological order; despite efforts, this was difficult to implement, as the order of the thematic descriptions varied significantly within the participants' original accounts.

A common condition that preceded the experience of sexual discomfort was abuse of different types experienced by women throughout their lives. This abuse took a number of forms, varying from parental neglect and lack of support or protection to continuous and severe experiences of rape in adult life. One of the participants used the word "tormented," to describe how she viewed herself, as a victim of repeated sexual persecution. The consequences of such traumatic experiences included the women feeling unsafe and endangered in their present relationships.

An unpleasant and painful initial sexual encounter, whether with their spouse or another partner, was also a fairly "traumatic" episode experienced by the participants. The women felt intense pain and discomfort as they engaged in the initial intercourse. Having anticipated forthcoming pleasure prior to the moment when a sexual encounter took place, the participants experienced disappointment and frustration with the incident after it had occurred. The sexual act was depicted with such expressions as "disgusting" and "this must be not right, " and was also compared to "an act [of] wrestling." Some cried from the extreme amount of pain, others felt "really dirty," still others thought that they had "let [their spouse] down."

Many of the contributors to this study were sexually active to various extents prior to marriage. They consequently experienced shame and guilt, some perceiving themselves as bad and dirty. Some participants lost their motivation to perform sexually (a performance used previously to keep their partners close to them) when they found belonging and acceptance within their marriages. Others saw their pre-marital sexual involvement and acting out as having had a particular function or having being manifested for a particular purpose (e.g., to dissolve parents' marital discord, to attract attention from a parent/partner) that seemed less relevant to their married lives.

These and other factors contributed to women developing the belief that sexual interaction and being sexual is something negative, inappropriate, disgusting, or sinful. Such views were "ingrained" in their minds through the observations made and interactions experienced in their family-of-origin. In addition, the women gradually developed a feeling of obligation to perform sexually. Colette, one of the participants, reported having acquired such a perception even prior to the development of a clear sense of self, desires, and needs. "Before I could even be in touch with my own wants, I was being initiated upon, all the time," she conveyed. The participants appeared to desire to please their partners and displayed a tendency to ignore their own sexual preferences and wants.

When the women did not feel ready or prepared, whether mentally, emotionally, or physically, they were more likely to experience sexual discomfort. Expression of this theme related to a lack of mental preparation—not having the mindset placed on things that would enhance and facilitate sexual arousal and pleasure. When the participants did not have an opportunity to organize their minds, discomfort was present, interfering with satisfactory sexual functioning. The participants also felt emotionally unprepared to engage in sexual contact. It was expressed like this, "I'm going past where I am, and I'm not ready to go there. It's going past where I feel emotionally right."

The participants' willingness to partake in a sexual encounter was hindered by a lack of or a deficit in non-sexual interaction and connection between the spouses. The participants stressed in a variety of ways the significance of such emotional intimacy for satisfactory sexual functioning. As the emotional bond undergoes some damage (e.g., a spouse being angry and unsupportive), sexual interaction also deteriorates.

Finally, the interviews made apparent that having some medical condition or being on medication seemed to be a predisposing factor to the experience of sexual difficulty. Such medical pre-conditions included birth control pills, fibromyalgia, feeling physically exhausted, abortion, venereal disease, infertility, and psychotropic medication.

The second phase of the story illustrates the core or the essence of the experience of sexual discomfort in married women. General and specific components of the description are presented here. A number of themes capture the profoundness and complexity of the experience. It is noteworthy that many of the themes occurred for individual participants simultaneously and that these themes varied significantly among the participants.

The general description of the experience embraced a multitude of different feelings, cognitions, and physical reactions. Such description captured the issue in its fullness and complexity. An example is a meaningful narrative shared by one of the participants. The woman metaphorically illustrated that, in her experience of sexual discomfort, she had to submit herself to pain and suffering, as she knew no way out. Her partner was not a sympathetic co-sufferer, but was rather the one who was causing the agony. She conveyed:

> I wish I could feel that he is helping me, but I don't. I feel like I'm just there. I feel like I'm in a burning building and no one's coming to rescue me. I just have to let the flames kill me because there's no one to rescue me, and I can't get myself out of there because I don't know the way to escape. I feel like I'm just trapped in this building, and that I can't get out and he's not my rescuer, and he's not my fireman coming, he's the flames…

Other general characteristics of the experience included the distinction made by the women between the physical and emotional natures of the discomfort, the lack or deficit of sexual desire and ability to get aroused, and finally the feeling of being connected, joyful, and surprised in the absence of the discomfort.

The specific elements of the experience were identified to describe the experience of sexual discomfort in a detailed, thorough, and exhaustive manner. Such precise components of the story were sorted in accordance with the emotional, cognitive, physical, or behavioural domain of human functioning.

On the emotional level, the participants reported feeling anxious and vulnerable. Such anxiety manifested itself in a variety of ways, ranging from slight worry to the experience of severe and intense panic. The feelings of worry, anxiety, fear, dread, and panic seemed to pertain to a real or imagined threat or danger of an act of sex, eventual pain and/or pleasure, uncertainty, and closeness/intimacy with the spouse. The women felt vulnerable, unsafe, endangered, and unprotected. They felt trapped, lost, and out of control.

The participants also felt betrayed, invaded, and used as they were involved in a sexual interaction with their spouses. They felt a need to resist such participation and resented their spouse for encouraging their involvement in a painful and uncomfortable sexual act, as opposed to preventing it from happening. The feeling of being used during marital sexual contact was paralleled with “being a depository cup,” and “rape.” Such experience was also compared with “my own life being sucked out of me into him so that he could have energy, he could have sex” and described as “a truck is running over me, and I feel squashed flat.” Feeling invaded was expressed as those who have come “into the wrong territory,” “This is my body, not yours, you don’t own this.” The resistance to such invasion was described in a variety of ways: “Saying 'no’ throughout the whole body,” “[feeling] repulsive,” and “[wanting] to repel from it.” Some women also felt emotionally hurt by the fact that their spouses committed some transgression against them in the past, an event that now prevented them from connecting with them sexually.

Guilt and inner pressure to engage in sexual interaction with a partner was a common theme in all the interview transcripts. The women experienced feelings of guilt and tended to assume the responsibility for sexual difficulty and for a spouse's emotional reactions. Shame, feelings of inadequacy, and fear of rejection were also experienced by the participants. The women felt ashamed and embarrassed, feelings associated with their perceptions of selves as abnormal, dirty, bad, inadequate, and unworthy of love and attention. Some participants felt insecure about themselves and thought that the only way to keep their spouses was to please them in various ways, including sexually. Others acknowledged that the function of sexual difficulties was to find out the genuineness of their spouses' feelings for them. They described it as "a test" they believed they needed their spouses to pass, prior to the women being able to become fully and unconditionally intimate with them.

Moreover, the women felt exhausted, hurt, and angry over meeting others' needs while not having their own needs met. One woman used the term "empty cup" to describe her inner state, which she believed had no remaining energy for meeting others' needs. Another woman noticed that her "antennas" or "sensors" are constantly raised to detect how the other person is doing or feeling. Still a third one described how she felt emotionally shut-off from the environment when she was exhausted, and consequently how she felt no longer able to gratify someone else's needs. She called it "having a wall up" and refusing "to let someone in."

Sharing the feelings of deep discouragement and hopelessness, the women described themselves as "resigned to being that way" and "not the lucky one." Furthermore, the participants shared their experience of loneliness and isolation in regards to their sexual experiences. It was conveyed:

> He is not there because, at that time, he's not my husband, he's somebody that wants sex. The love, the other 23 hours of the day that I have for him, is not there during that one hour, because he is the enemy at that time.

The contributors to this study also described feeling emotionally detached from the experience and from their spouse. Women recalled, "not being a part of sexual interaction" and "[not having] relationships with [the] husband that [sexual] way." As a sexual contact was finished, the women typically experienced a sense of relief.

Cognitively, women reported the tendency to engage in encouraging and/or negative self-talk in the midst of a sexual act. The following is an example of a revealed motivational self-talk, "Grin and bear it. Get it over with. Do it for him, it's all going to be fine as soon as it happens, try to be into it, pretend you are into it." Some descriptors the women used to characterize their own body in the process of a sexual encounter were "garbage," "trash," "useless," "mutant," "gimp." The act of sex was characterized by many participants as a "chore" or "duty." Another interesting phenomenon revealed by women interviewed was the process of "uncovering layers" of disturbing thoughts and uncomfortable experiences (e.g., pain). This mental procedure was called an "archaeological dig" through the layers of tension (past or present triggering experiences or negative/worrisome thoughts) or "jumping over multiple hurdles," hoping to eventually get to a place of enjoyment. Layers of negative thoughts such as these were described as "garbage," "block," and "wall."

The women experienced a strong sense of obligation to engage in the process of sexual interaction in spite of a lack of sexual desire, or even the presence of pain. Their shared rationale for such obligatory engagement in an act of sex was as follows: (a) The women felt a deep caring for their spouse and a strong desire to please him. Spouses' needs were viewed as more important than their own, and the responsibility for the spouse's emotional reactions (e.g., frustration, disappointment, anger) was assumed; (b) The co-researchers seemed to experience fear of punishment or some negative consequences which they might have to face in the case of a refusal to connect sexually; and (c) The participants felt pressured by society to engage in acts of sex. They viewed it as their role as a woman and wife.

Negative perceptions of self, one's spouse, and the act of sex were revealed. Women described themselves as " prostitutes," "bad," "dirty," and "abnormal." One participant stated, "I don't think I'm the woman that deserves [love and sexual pleasure]." The spouse was also portrayed as abnormal and needy. Many women questioned their choice of partner. Finally, the sexual act was portrayed as "disgusting" and "dirty." In addition, the participants experienced lack of control and choices in regard to their sexual involvement. Furthermore, the participants reported undergoing mental detachment in the midst of a sexual encounter. They seemed to think about things other than sexual interaction and intimacy and were apt to engage in planning grocery shopping lists, or other activities.

Physically, women experienced pain, which was described as "sharp as a knife," "very excruciating," "weird sensation," "really unpleasant," "annoying," "hurtful," and "tense." Tension and resistance were other sensations felt by the women while engaged in sexual contact. There were physical manifestations of anxiety (e.g., enhanced heart rate and accelerated breathing) and numbness or lack of physical sensations noted by the participants.

On the behavioural level, the participants noticed a tendency to avoid sexual interaction and intimacy. Some women chose not to engage in sexual interaction for extended periods of time, while others participated in sexual encounters, but were not fully present psychologically throughout the process of sexual contact. Interestingly, the participants reported that, although they tended to avoid sexual encounters with their spouses, they still engaged in sex and, tolerating pain and discomfort on some occasions. This was accomplished out of a sense of obligation to connect sexually and a desire to please their partners, as well as their hope to eventually experience pleasure themselves. Finally, the women interviewed mentioned that they might be completely motionless in the process of sex.

The coping mechanisms used by the participants to deal with sexual discomfort and pain included acknowledging, expressing, and trying to resolve sexual difficulty through journaling, therapy, and other methods. Avoidance of sexual encounters was also practiced to reduce the

uncomfortable and unpleasant experiences. Some did this by not engaging in sexual interaction for some relatively extended periods of time, while others participated in sexual encounters but were not fully present psychologically. Engaging in compensatory behaviours or rituals (e.g., alcohol, compulsive eating, overwork, household activities) was another way of dealing with sexual difficulties.

The participants also found it helpful to "let themselves go", i.e., to liberate themselves by permitting themselves to have unexpected experiences of openness and freedom during sexual encounters; to let go of shame, guilt, and anger; to place mental focus on a spouse and the partners' unity, as opposed to the act of sex or herself as a sexual being; and to have a predictable and stable pattern of sexual interaction. Lastly, the acceptance of the presence of sexual struggles in the women's lives was revealed; acceptance, however, does not indicate the women gave up feeling hopeful that the situation would eventually improve.

The following themes capture the effects of the experience of sexual discomfort on the women, their relationships, and their lives in general. Overall negative effects were found to be counterbalanced by enhanced faith in sexual and/or spiritual healing. Although the women interviewed revealed multiple harmful effects that sexual struggles have had on their life (e.g., uncertainty about how to best parent children, financial difficulties, deficiency of spontaneity (in non-sexual areas of life), all of the participants validated certain themes, including: strengthened faith in God or some other higher power, and/or in ultimately satisfactory sexual functioning.

Individual difficulties turned out to be counterbalanced by individual benefits. The negative after-effects included feelings of frustration, anger, guilt, sadness, hurt, depression, loneliness, insecurity, uncertainty, anxiety, fear, and physical pain. The theme of hope in the eventual improvement of a sexual situation consistently mirrored the feelings of deep discouragement and hopelessness throughout the protocols. Other positive outcomes of having an experience of sexual discomfort were comprised of enhanced self-awareness and ability to

cope with the discomfort, recognition of the participants' own strengths, and a willingness to help other women who suffered from sexual discomfort, by sharing the participants' own experiences.

Relational discord was counterbalanced by enhanced dedication and commitment to marriage. Such relational distress and other negative effects of the discomfort on the spousal relationships were revealed in a number of forms. It was discovered that the degree of discomfort or pleasure of the sexual interaction determined the nature of the non-sexual aspects of the partners' relationship. The husband's perceived resentment toward a wife was mentioned as another negative after-effect. Another form of negative effect on the couples' relationship was the wife's doubts about the sincerity of her feelings towards her spouse. Positive effects included the perception by the woman of her and her spouse as a team formed to face and fight the sexual distress; enhanced communication with the spouse in the midst of the sexual act about mutual preferences and experiences; and the partners' mutual commitment.

CHAPTER V: DISCUSSION

Summary of Purpose and Results

The vast majority of psychological phenomena have been approached scientifically from a perspective of modernism with its assumption concerning the existence of object-subject dualism. The accounts of those who "possess" an experience have been considered "subjective," being synonymous with "inaccurate." Phenomenological psychology denies an object-subject dichotomy and the ability of the researcher to remain completely unbiased, and proposes subjective accounts of an experience as the most legitimate source of knowledge about human existence.

This current study, utilizing the phenomenological design (Colaizzi, 1978; Osborne, 1990; Polkinghorne, 1989), aimed to explore and understand the lived experience of married women who suffer from sexual discomfort. The methodology used allowed a preliminary grasp of the phenomenon in its fullness and complexity. Additionally, explored in the study were the pre-conditions and facilitating events, coping mechanisms, and after-effects of this experience on the women, their relationships, and their lives in general. Nine women were interviewed regarding their experience of sexual discomfort and the analysis of the data obtained revealed 42 themes (a detailed description of these themes is presented in the Results section) and a common story of the experience, its pre-conditions, coping mechanisms, and after-effects. Thematic descriptions were arranged in accordance with four phases outlined immediately below.

Phase I (Pre-conditions and Facilitating Events) includes eight themes, which are: (1) Child/adult sexual, physical, and emotional abuse; (2) An unpleasant/painful initial encounter; (3) Being sexually active prior to marriage; (4) A belief that sexual interaction and being sexual is something negative; (5) A sense of obligation to perform sexually; (6) Feeling psychologically/physically unprepared to engage in sexual interaction; (7) A deficit in emotional spousal intimacy negatively affecting sexual interaction; and (8) Some physical condition or being on medication.

Phase II (Descriptive Themes of the Experience of Sexual Discomfort) contains themes nine to thirty. These are: (9) Feeling anxious and vulnerable; (10) Feeling betrayed, invaded, and used; resistance; (11) Guilt and inner pressure to engage in sexual interaction; (12) Shame, feelings of inadequacy, and fear of rejection: (13) Feeling exhausted, hurt, and angry over meeting others' needs while not having own needs met; (14) Discouragement and hopelessness; (15) Loneliness and isolation; (16) Emotional detachment from the experience and the spouse while engaged in sexual interaction; (17) Disgust; (18) Relief following sexual interaction; (19) Encouraging and/or negative self-talk; (20) A sense of obligation to engage in sexual interaction; (21) Negative perception of self, spouse, and the sexual act; (22) Lack of control/choices; (23) Mental detachment from the experience; (24) Pain; (25) Tension and resistance; (26) Physical manifestations of anxiety; (27) Numbness and lack of sensations; (28) Avoidance of sexual interaction/intimacy; (29) Engaging in sexual encounter despite discomfort/pain; and (30) Motionlessness during sexual interaction.

Phase III (The Mechanisms Used to Cope With the Discomfort) incorporates themes 31 to 39, which include: (31) Acknowledging and trying to resolve sexual struggles; (32) Avoiding sexual encounters; (33) Tending to engage in compensatory rituals or behaviours; (34) Co-operating with unexpected experiences of openness and freedom during sexual encounters; (35) Accepting the situation; there is still hope; (36) Releasing of shame, guilt, and anger; (37) Engaging in self-caring activities; (38) Placing a mental focus on the spouse and the spousal unity; (39) Having a predictable and stable pattern of sexual interaction.

Phase IV, the final phase (After-effects) is comprised of themes 40 to 42. These themes are: (40) Overall negative effects counterbalanced by enhanced faith in sexual and/or spiritual healing; (41) Individual deficits counterbalanced by individual strengths; and (42) Relational discord counterbalanced by enhanced dedication to marriage.

The current chapter examines the results specified above in light of previous research and existing theory presented in the Literature Review section. This is followed by a discussion of

the limitations of the current research study and its implications for further research and the practice of counselling.

The Relation of Results to Existing Theory and Research

In this subsection the findings of the present study are explored based on research and various theories previously undertaken by other researchers. Thematic descriptions consistent with, and validated by, earlier research findings and existing theoretical suppositions are followed by the themes that seem to represent unique aspects of the experience of sexual dysfunction. The researcher determined the benefit of discussing the results in accordance with the four phases (pre-conditions, the experience of sexual discomfort, coping mechanisms, and after-effects).

Common Themes Consistent With Previous Research and Existing Theory

Pre-conditions and Facilitation Events. Theme 1 (Child/adult sexual, physical, and emotional abuse) was found to be consistent with the view held by advocates of Behaviourism (e.g., Lazarus, 1971; Nemetz et al., 1978; Wolpe, 1958; Wolpe & Lazarus, 1966) stating that sexual dysfunction is rooted in the association of the unconditioned stimuli (sexual cues) with punishment (a violent, aggressive, hurtful act), followed by the negative reinforcement (avoidance of the sexual act). Empirically, this theme was supported by a number of studies (e.g., Bartoi & Kinder, 1998; Burgess & Holmstrom, 1979; Feldman-Summers et al., 1979; Van Berlo & Ensink, 2000) demonstrating that sexual abuse contributes to the development and maintenance of sexual dysfunction. Daniluk (1993) found that one component of women's experience of their sexuality was them having been victimized sexually and physically. Finally, Wallace's (1981) findings confirmed the results of the present study suggesting that the deficit of support and affection within one's family-of-origin was likely to contribute to sexual difficulties in adult life.

Theme 2 (Unpleasant/painful initial sexual encounter) was similarly found to match the behaviourist conceptualization of sexual dysfunction. Studies (Byrne et al., 1974; Weis, 1983,

1985), which investigated the experience of initial intercourse in adolescent girls, found a variety of negative emotional responses these girls experienced while engaged in a sexual act. Such responses included pain, fear, and disgust—the emotions also reported by the women in this study. Thompson (1990), examining adolescent girls' experience of sexual interaction (not necessarily initial), discovered physical and romantic disappointment, an experience shared by the participants of the present study.

Theme 3 (Being sexually active prior to marriage) was found to be consistent with the double standard of Western society, according to which it is simultaneously acceptable and unacceptable for women who are unmarried, to engage in some sexual activity. The women in the study conducted by Daniluk (1993), describing their experience of sexuality, shared that their selves and bodies had been invalidated due to early sexual experiences and adventures distinguishable by secrecy, isolation, and ignorance. Supporting this, Jurich and Polson (1985) found that the level of anxiety increased as women were asked questions regarding their premarital sexual involvement. The more intimate the questions were, the higher was the anxiety experienced by the participants in the study. Additionally, Gibson (1999), having interviewed celibate, divorced, middle-aged, Christian women, found negative emotional and spiritual effects as a result of premarital and extramarital sexual relationships. Cobliner (1988) found that if premarital sexual relationships lacked intimacy and commitment, it is more difficult to experience sexual intimacy in marital life. However, if premarital sexual contacts were not solely physical in nature, but based upon commitment, subsequent marital sexual life did not suffer.

The emphasis of Behaviourism on learning as the major method of acquiring behaviours and Bandura's (1977) concept of vicarious observation seem to verify Theme 4 (Belief that sexual interaction and being sexual is something negative). The co-researchers of this study conveyed that negative attitudes and beliefs they have held regarding the sexual act and themselves as sexual beings were attained through hearing their parents' comments about sex and witnessing their marital interaction. Additionally, the findings of Birnbaum et al. (2001)

corresponded with this thematic category, revealing that one element of a women's experience of sexual intercourse is the negative and immoral meanings connected to sexual activity.

Theme 5 (Sense of obligation to perform sexually) resonated with the finding that women have been viewed by society as underdeveloped men due to the impact of traditional religious values (Daniluk, 1993). One aspect of Theme 6 (Feeling psychologically and physically unprepared to engage in sexual interaction) is women's need to prepare mentally prior to engaging in a sexual act. The participants emphasized the crucial role of this mindset in their degree of sexual discomfort/enjoyment. This finding was found to be consistent with the results of studies that stressed the major impact of the attentional and cognitive processes on sexual functioning (e.g., Becker et al., 1982; Schreiner-Engel et al., 1981).

Theme 7 (Deficit in emotional intimacy with the spouse) was supported by the ideas of Masters and Johnson (1970) and the tenets of systems theories (e.g., LaPiccolo, 1991; cited in Jurich & Myers-Bowman, 1998). It was also congruent with the results of multiple studies (e.g., McCabe, 1997; Patton & Waring, 1985; Stuart et al., 1986; Woody & D'Sonza, 1997), which claimed the existence of a positive correlation between marital intimacy and sexual functioning. Theme 8 (Some physical condition or being on medication) seemed to support the assumption of the Medical Model, according to which sexual difficulty is a result of some physical abnormality. Previous research (Schreiner-Engel et al., 1988) demonstrated the existence of hormonal and biological effects on Hypoactive Sexual Desire Disorder in women. In addition, the studies of Wincze and Cairg (1976) and Palace and Gorzalka (1990) found that "dysfunctional" women had lower levels of vaginal blood volume (VBV) as compared to women without sexual dysfunctions.

Experience of Sexual Discomfort. Theme 9 (Feeling anxious and vulnerable) demonstrated that anxiety indeed was one of the major experiential components of married women's experiences of sexual distress. This theme thoroughly permeated the co-researchers' protocols. It seems to correspond with Freud's (1964) concept of an inner conflict (in the case of the participants of this study such conflict is between the obligation to engage in sex and a lack of

desire for such engagement). Behaviourists (e.g., Wolpe, 1958) also saw anxiety and fear as symptoms of sexual dysfunction. Bowen (1978) and Schnarch (1991) insisted that anxiety is a natural by-product of the process of becoming more differentiated (i.e., emotionally non-reactive to others, including a sexual partner). Lastly, uncertainty, existential, and exclusion theories emphasize anxiety as a reaction to the unknown, isolation/lack of structure/meaninglessness/potential for death, and exclusion from a social group.

A number of studies validated the theme of anxiety and vulnerability. Barlow et al. (1983), Cranston-Cubas and Barlow (1990), and Rosen and Leiblum (1995) found that anxiety seemed to increase sexual arousal in the case of sexually "functional" women, while being problematic for sexually "dysfunctional" women. Palace and Gorzalka (1990) discovered that anxiety subjectively decreased sexual arousal in both sexually "functional" and sexually "dysfunctional" women, whereas physiologically it increased sexual arousal in both groups—in the "functional" group significantly more than in the "dysfunctional" group. Furthermore, Fisher (1970, 1978, 1989; cited in Pollio et al., 1997), having phenomenologically explored the experience of anxiety, suggested the presence of two components of this experience: "in-the-face-of-which" one is anxious, during which one is, by and large, fearful of, the possibility of losing a planned-for world (e.g., not having pleasurable sexual interaction with the spouse). The second component is that part "about-which" one is anxious; this indicates a fear of failing to become the person "one has chosen to be or had to be" (e.g., not being an active sexual being).

Moreover, Byrne et al. (1974), Thompson (1990), and Weis (1983, 1985) observed that fear and nervousness were emotional reactions, in adolescent girls, to the experience of sexual interaction—feelings shared by the participants of this study. Clifford (1978) also discovered feelings of nervousness and performance anxiety as components of the experience of adult women. In addition, a number of scales and inventories assessing women's sexual functioning (e.g., Janda & O'Grady, 1980) found anxiety to be one of the experiential components. Birnbaum

et al. (2001) found that vulnerability and fear were the elements of women's experience of sexual intercourse. Finally, such themes as "loss/losing" and "being out of control" were uncovered by Pollio et al. (1997) as constituents of the ordeal of being anxious, experiences expressed by the women in their study.

Theme 10 (Feeling betrayed, invaded, and used; resistance) was confirmed by the results obtained by Birnbaum et al. (2001), who discovered the theme of "disappointment in a partner's behaviour," which included such elements as frustration, dissatisfaction, resentment, and complaints, feelings gathered within this study. Daniluk (1993) found that women's experience of their sexuality was characterized by objectification (i.e., being valued exclusively for their body). Additionally, some women in the present study indicated having been "let down" by their spouse at some point in their marriage (the spouse was not present psychologically for the wife during a crucial moment of need). This type of "let down" was defined as an "attachment injury" by Johnson et al. (2001).

Themes 11 and 12 (Guilt and inner pressure to engage in sexual interaction; shame, a feeling of inadequacy, and fear of rejection) were also found to have some theoretical and empirical support. Theme 12 seemed to match the assumptions of exclusion, existential, and attachment theories, according to which people are fearful of dying as a consequence of being alienated and excluded. Daniluk (1993) emphasized the importance of self-esteem and self-acceptance for woman's satisfactory sexual functioning. Similarly, Helminiak (1989; cited in Johnson, 2001) stated that to transcend (i.e., to go beyond the self and connect with the other) a woman must first know and accept herself.

Empirically, Van Berlo and Ensink (2000) found that such emotions as anger towards self, shame, and guilt (experienced by women during, immediately after, and a year after sexual assault) seemed to be strong predictors of a lasting sexual dysfunction. The principal researcher of this study wonders whether women sexually assaulted in the past might still experience these emotional reactions when engaged in sexual interaction with a non-abusive partner. Oliver and

Hyde (1993; cited in Fredrickson & Roberts, 1997) found that women experience more shame and guilt about sex than men. Lastly, Birnbaum et al. (2001) identified shame, guilt, and feelings of inadequacy as experiential components of women's intercourse.

Theme 13 (Feeling exhausted, hurt, and angry over meeting others' needs while not having one's own needs met) was supported by the results obtained in a study conducted by Hulbert et al. (1993), who discovered that a lack of assertiveness in women (part of which is one's ability to identify and express one's own needs to others) was associated with low sexual desire and orgasmic difficulties. The study of Birnbaum et al. (2001) claimed two thematic descriptions related to this topic: "focus on one's sexual needs" and "focus on the partner's state." The researcher in this study speculates that women who experience sexual difficulties tend to ignore their own needs, but also feel obliged to focus on the partner's needs (as opposed to having a genuine desire to satisfy the partner sexually).

According to the participants of this study, Theme 15 (Loneliness and isolation) related primarily to the sexual area of life. Women seemed to feel intimate with their spouse and not otherwise lonely. In her study McCabe (1997) found that total, social, sexual, and recreational intimacy of the partners was low in the "dysfunctional" group, whereas the levels of emotional and intellectual intimacy were not different from those of the "functional" group. Unfortunately, McCabe did not provide an operational definition for emotional intimacy, which complicated the comparison of the results of her study with these findings. It could be that the co-researchers in this study referred to the overall or total intimacy when describing emotional closeness and connectedness. If this is the case, then the results of McCabe's study validate the findings of this investigation.

Theme 16 (Emotional detachment from the experience and the spouse while engaged in sexual interaction) seemed congruent the concept of dissociation. The only study confirming this experience as related to sexual interaction was the study performed by Thompson (1990), who discovered a feeling of alienation from one's body in adolescent girls in the midst of the sexual

act. Theme 17 (Disgust) was supported by Byrne et al. (1974) and Weis (1983, 1985), who observed this feeling to be an experiential component of adolescent girls' experience of initial intercourse.

Themes 19-23 (Encouraging and/or negative self-talk; A sense of obligation to engage in sexual interaction; Negative perception of self, spouse, and the sexual act; Lack of control/choices; Mental detachment from the experience) seemed evidently supported by the theoretical speculations of Gagnon (1990), who emphasized the significance of cognitive processes in the development of sexual dysfunction. Some research data provided evidence to the validity of themes 19-23. Becker et al. (1982) and Schreiner-Engel et al. (1989) found a significant impact had by cognitive and attentional processes on women's sexual functioning. The women interviewed by Clifford (1978) expressed having judgmental thoughts while engaged in sexual interaction with their partner. Finally, Birnbaum et al. (2001) found interfering thoughts and mental wandering to be experiential components of women's experience of sexual intercourse.

Themes 24-27 (Pain; Tension and resistance; Physical manifestations of anxiety; Numbness and lack of sensations) were supported by Pollio et al. (1997), who found pain to be an element in the experience of anxiety. Byrne et al. (1974) and Weis (1983, 1985) found pain, tension, and alienation from the body to be physiological reactions to initial intercourse in adolescent girls. Birnbaum et al. (2001) also mentioned tension as a theme revealed by the participants in their study. Theme 28 (Avoidance of sexual interaction/intimacy) could be explained by the behaviourist concept of negative reinforcement and was confirmed by the studies on sexual assault (e.g., Burgess & Holmstrom, 1979), according to which women experienced subsequent decline in sexual activity after rape.

Coping Strategies. The comparison of theme 32 (Avoiding sexual encounters) with the previous research was expressed under Theme 28 of this section. Themes 31 and 37 (Acknowledging and trying to resolve sexual struggles; Engaging in self-caring activities) are

consistent with ideas of Daniluk (1993), who suggested that self-awareness, self-knowledge, and self-care are essential to a woman's construction of her sexuality. Themes 34 and 36 (Co-operating with unexpected experiences of openness and freedom during sexual encounters; Releasing shame, guilt, and anger) were confirmed by the experiential component labelled "letting go", an aspect mentioned within the "pleasure-centred" theme that was obtained in the study conducted by Birnbaum et al. (2001).

After-effects. Themes 40-42 (Overall negative effects counterbalanced by enhanced faith in sexual and/or spiritual healing; Individual difficulties counterbalanced by individual benefits; Relational discord counterbalanced by enhanced dedication to marriage) were found to be congruent with the results of the study conducted by Stiller (2000). She found that self-transcendence was one way of coping with suffering. People in her study reported looking beyond their individual suffering and participating in others' lives. This theme corresponded with the coping mechanism disclosed by the women in the present study, who wanted to share their experiences with other women suffering from sexual difficulties to help them feel they were not alone. Other themes identified by Stiller congruent with the findings of this study were: (a) Meaning in paid/volunteer work; (b) Creative power or discovering resourceful solutions to problems; (c) Autonomy or a sense of control a person has over his or her life and also the choices that are available to this person; and (d) Spiritual values/faith or the strength and comfort provided through religious belief in a higher power.

Novel Components of the Experience

The results of this study revealed aspects of the experience of sexual discomfort that have not been previously mentioned, and therefore possible never explored, in the relevant literature. These results seem to complement the existing understanding of the phenomenon and provide useful insights into specific nuances of the experience. The unique themes are listed here: (a) Discouragement and hopelessness; (b) Relief following sexual interaction; (c) Engaging in sexual

encounter despite discomfort/pain; (d) Motionlessness during sexual interaction; (e) Tending to engage in compensatory rituals or behaviours; (f) Accepting the situation, keeping up hope; (g) Placing mental focus on a spouse and on the couple's unity; and (h) Having a predictable and stable pattern of sexual interaction.

Discouragement and hopelessness; Accepting the situation, keeping up hope. Having taken a number of steps to eliminate their sexual problems, the participants of this study became discouraged and hopeless about reaching a point in their lives where they would enjoy sexual interaction with their spouses. Some were able to accept, for the time being or perhaps even forever, that they would not be able to experience intimacy with their partners and gave up fighting sexual problems. Others could not accept the situation and worked hard hoping to eventually achieve some positive results. Women in the study reported that they would find themselves constantly moving along the continuum of "*discouragement–hope.*" One day they would feel somewhat hopeful, the next day—highly discouraged. Although the themes of discouragement and hope do not seem to be validated by previous research, they seem to represent actual and vital elements of the women's experience of sexual discomfort.

Engaging in sexual encounter despite discomfort/pain; Motionlessness during sexual interaction; Relief following sexual interaction. These themes seem to demonstrate the intense nature of the discomfort. The principle researcher of this study was unable to identify any previous research findings on these experiential components. The "Engaging in sexual encounter despite discomfort/pain" Theme seems to relate to the themes containing an "obligation" element of women's unpleasant sexual experiences. The "Motionless during sexual interaction" Theme appears to relate to the themes representing "detachment" or "dissociative" experiences of he participants.

Tending to engage in compensatory rituals or behaviours; Placing mental focus on a spouse and on the couple's unity; Having a predictable and stable pattern of sexual interaction. These themes present innovative ways to decrease sexual discomfort and to facilitate sexual and

psychological healing. These behaviours and the themes described in the preceding paragraphs seem to be the unique contribution of this study to the fields of psychology and counselling.

These original themes have been validated by the participants in this study and are considered by the principle researcher to be significant because of their impact on the lives and relationships of the co-researchers. As to why themes of this nature have not been identified or raised in previous research is uncertain. Perhaps the unique nature of this present study facilitated the disclosure of information that led to discovery of these themes, while previous researchers may have overlooked or failed to encounter information that would have highlighted these important elements of the experience.

Limitations of the Study

Some of the limitations of the present study are listed below. The majority of the participants were Caucasian, heterosexual, married women, who reside in Canada. Such homogeneity may potentially place some restrictions in terms of applicability of the results to women of other cultural/ethnic backgrounds, marital status, and sexual orientations. It is important to note, however, that in the phenomenological research design the generalizibility of the findings is not determined a priori (by the procedures based upon the sampling theory), but a posteriori (empathically, i.e., can a reader, adopting the perspective articulated by the researcher, see what the researcher was able to see? Kvale, 1994). The experience was understood accurately by the researcher, which was confirmed by various validity and reliability verifications. This implies that the findings obtained in the study are most likely generalizable to married women not in the study who experience sexual discomfort; although this will only be concluded by such women after they acquaint themselves with the thematic descriptions obtained in this investigation.

Another possible limitation of this study is the self-reported format of the data collection. Such format may restrict the accuracy of the findings (potential threats include an inability of the

participants to remember or articulate certain aspects of the experience). This limitation was minimized by various validity checks (see Method section).

Finally, the sensitive nature of the topic may have led to some participants feeling hesitant to share the important aspects of the experience. However, the researcher, being a woman herself, might have helped these women to feel more comfortable to describe their experience as fully as they could, thus minimizing this limitation.

Recommendations for Future Research

A number of suggestions that can be made in light of the findings obtained in this study. First, an extension of the current study could be conducted. Women of other ethnic, cultural, religious, and educational backgrounds, as well as those who are homosexual and non-married, could be queried about their experiences of sexual discomfort. Such studies may provide additional unique elements of the experience, which were not captured in this study. Second, proponents of the systems theory (e.g., LoPiccolo, 1991; cited in Jurich & Myers-Bowman, 1998) would argue that a sexual problem is the product of the partners' reciprocal interaction. Drawing on this premise, it becomes essential to explore the husband's experience of his wife having sexual difficulties, as each is affected by the other's behaviours and reactions.

Third, further research could be undertaken that would investigate specific components or thematic descriptions (e.g., painful and unpleasant initial sexual interaction) of the experience of sexual discomfort obtained in this study (e.g., an in-depth understanding of such element). Finally, present research findings may serve as a basis for the development of a theory of female sexual distress/dysfunction, assessment tools exploring the presence (extend) of such distress, and treatment strategies to deal with these disruptive experiences.

Implications for Counselling Practice

The findings of this study provide counsellors with a framework that enables them to see the core elements of the experience, in light of which they can then consider idiosyncratic constituents of such experience. Clinicians may be more aware of which particular experimental

components to look for and tap when working with women who suffer from some type of sexual dysfunction. The results allow counsellors to conduct an informal assessment of the presence of sexual dysfunction and consult clients concerning which experiential components are especially relevant and important to address.

In addition, the results may be used by counsellors to enhance their understanding and consequently their ability to empathize and validate clients and their experiences. Furthermore, counsellors can normalize women's experiences by pointing to the results of this study. Practitioners may develop further assessment and treatment strategies to facilitate their clients' sexual and psychological healing. Moreover, participants in the study indicated that one way in which they coped with the experience of sexual discomfort was to share their experiences with others (counsellors, spouse, friends, etc.). Thus, it is suggested that counsellors would promote and encourage such disclosures, whether one-on-one with a counsellor or in a group setting.

Lastly, the findings may be used by women with the experience of sexual discomfort to promote self-awareness and the realization that they are not alone. This might contribute to healing and enhanced satisfaction with sexual functioning and life in general. Specific suggestions for counsellors who work with women with sexual dysfunction are described below.

A counsellor might keep in mind that it is possible that a woman suffering from sexual distress and discomfort has undergone some type of abuse—sexual, physical, emotional—or has witnessed such abuse. Therefore, it might be necessary to therapeutically address such past traumatic experiences prior to assessing the client's present triggers and anticipatory or future anxieties. Also it might be helpful to explore the nature of the client's initial sexual interaction and associated affect. Unpleasant and painful initial sexual experience might have brought about the experience of discomfort in later sexual encounters. Additionally, a counsellor might consider querying the client's developmental history but being sure to identify the nature of her premarital sexual experiences. Particular attention should be given to beliefs and attitudes

derived by the clients from such early interaction with others, including caregivers and previous partners.

Couples counseling might be beneficial to address a lack or deficit in intimacy as experienced by both partners. Although a counsellor might get the perception that partners are fairly close and connected emotionally, it is important to identify whether a woman feels heard, understood, and supported by the spouse in the sexual area of their relationship. The results of this study demonstrated that, even though women felt connected and intimate with their partners in general, they still felt unprotected and misunderstood by them in the sexual area of life.

It might be deemed important to refer the client to a physician or gynecologist for physical examination prior to engaging in the therapeutic process. A medical condition or being on medication might be a barrier to the client's satisfactory sexual functioning. If this is the case, then the medical condition should be addressed first before implementing psychotherapeutic measures.

A counsellor might consider addressing such issues as safety, responsibility, and control/choices and associated affect (guilt, shame, fear/anxiety, helplessness, etc.) when working with a client suffering from sexual dysfunction. When addressing these issues a counsellor might explore their aetiology (contributing factors), phenomenology (what and how the client experiences an issue), and cognitive and environmental variables (e.g., current triggers). Which aspect will be focused upon will depend on the counsellor's theoretical orientation and the characteristics of the client and presenting concern. It might be beneficial to help a client to explore possible irrationality behind her fear/anxiety, guilt, and shame. To achieve this a counsellor might consider utilizing cognitive-behavioural interventions.

Assertiveness training (Wolpe, 1958; Wolpe & Lazarus, 1966) and self-esteem enhancement interventions might be beneficial for women with sexual dysfunction. The findings of this study showed that the majority of women prioritized others' needs and desires and found their own desires insignificant and unimportant. The women felt responsible for others'

emotional conditions and general well–being, and consequently felt guilty and inadequate if others displayed negative emotional reactions (e.g., anger, frustration, anxiety, disappointment). The women tended to interpret such reaction as their own failure to keep others feeling satisfied and pleased. This researcher wonders whether this "pleasing tendency" might have originated as a conditioned response in the early developmental stages, when a child's survival and acceptance might have depended upon how "good" the child and her behaviour was as evaluated by caregivers.

It appeared that many of the participants in this study developed a tendency to dissociate from the experience of sexual interaction with the spouse. It might be worthwhile to assess the extent of such dissociation (using e.g., Dissociative Experiences Scale–DES; Wright & Loftus, 1999) prior to the implementation of a therapeutic intervention. The results derived from this or other similar scales might also indicate the extent to which clients have undergone trauma.

Furthermore, teaching the client relaxation exercises might bring about a reduction in tension, pain and thus discomfort overall. The client might practice such exercises prior to or even in the process of sexual interaction.

Having discovered that the participants in this study tended to engage in the act of sex despite discomfort/pain, but also simultaneously avoided sexual interaction when possible, the primary researcher wondered if it might be helpful to first encourage the client to experience the safety of saying "No" to sexual involvement for as long as the client needed. It is crucial for a counsellor to provide emotional support for the spouse during this phase of abstinence from sexual contact—who, in turn, is encouraged to support his wife and make her feel accepted and loved. After the client has experienced that she has choices and control, a counsellor might gradually facilitate sensitization of the client to erotic and sexual stimuli, such as holding, rocking, touching, touching erotic zones, and so on (Sensate Focus procedures could be utilized for this purpose).

Journaling experiences and sharing sexual struggles with close friends and other women who have similar experiences was found by the participants of this study to be beneficial. Thus, a counsellor might encourage these activities in order to facilitate healing in those clients who suffer from some form of sexual dysfunction. A counsellor can recommend other coping strategies shared by the participants of this study to his/her clients (e.g., placing mental focus on the spouse and the couple's unity, self-caring activities).

Finally, a counsellor may want to explore beneficial outcomes of having sexual difficulties, whether on the client herself, on her relationships, or her spiritual life. This may help the client to see the problem from a more positive, growth-oriented perspective.

Conclusions

The present study explored experience of sexual discomfort in married women, its pre-conditions and after-effects, as well as coping mechanisms used to deal with or minimize such discomfort. Forty-two descriptive themes were identified through phenomenological methodology. These themes revealed a multitude of emotional, cognitive, physical, and behavioural responses that women experience while engaged in sexual interaction with their spouses. Some responses demonstrated the detrimental and distressing nature of such experience, its pre-conditions and after-effects. Others illuminated the creativity of women (and of their bodies) in diminishing unpleasant feelings and sensations, their perseverance, and faith in ultimate sexual, relational, and spiritual healing.

The results of this investigation have advanced theoretical and empirical knowledge in the areas of psychology and sexology. They have offered professionals an opportunity to understand their clients better and to develop more effective assessment tools and treatment strategies. In addition, women experiencing sexual distress may now expand their understanding of themselves, which in turn can contribute to personal growth, happiness, and satisfaction in life.

Women in this study shared how terribly disruptive and detrimental can be the effects of sexual distress personally, interpersonally, and spiritually. Yet, one cannot help but be amazed at

the strengths and determination of these women, who in the midst of their sorrow and pain are able to lead highly productive lives and have meaningful marital relationships.

REFERENCES

American Psychiatric Association. (2000). Diagnostic and statistical manual of mental disorders. Washington, DC: Author.

Andersen, B. L., & Cyranowski, J. M. (1995). Women's sexuality: Behaviours, responses, and individual differences. Journal of Consulting and Clinical Psychology, 63(3), 891-906.

Atwood, M. (1971). You fit into me. In M. Meyer (Ed.). The Bedford introduction to literature: Reading, thinking, writing. (p. 674). Boston: Bedford Books of St. Martin's Press.

Bandura, A. (1977). Social learning theory. Englewood Cliffs, NJ: Prentice Hall.

Barlow, D. H. (1986). Causes of sexual dysfunction: The role of anxiety and cognitive interference. Journal of Consulting and Clinical Psychology, 54, 140-148.

Barlow, D. H. (1988). Anxiety and its disorders. New York: Guilford.

Barlow, D. H., Sakheim, D. K., & Beck, J. G. (1983). Anxiety increase sexual arousal. Journal of Abnormal Psychology, 92, 49-54.

Bartholomew, K. (1990). Avoidance of intimacy: An attachment perspective. Journal of Social and Personal Relationships, 7, 147-178.

Bartoi, M. G., & Kinder, B. N. (1998). Effects of child and adult sexual abuse on adult sexuality. Journal of Sex & Marital Therapy, 24, 75-90.

Basson, R., Berman, J., Burnett, A., Derogatis, J., Ferguson, D., & Foucroy, J. (2001). Report of the international consensus development conference on female sexual dysfunction: Definitions and classifications. Journal of Sex & Marital Therapy, 27, 83-94.

Battan, J. F. (1999). The 'rights' of husbands and the 'duties' of wives: Power and desire in the American bedroom, 1850-1910. Journal of Family History, 24(2), 165-187.

Baumeister, R. F., & Tice, D. M. (1990). Anxiety and social exclusion. Journal of Social and Clinical Psychology, 9(2), 165-195.

Beck, J. G. (1995). Hypoactive sexual desire disorder: An overview. Journal of Consulting and Clinical Psychology, 63(6), 919-927.

Becker, J. V., Skinner, L. J., Abel, G. G., & Treacy, E. C. (1982). Incidence and types of sexual dysfunctions in rape and incest victims. Journal of Sex and Marital Therapy, 8(1), 65-74.

Birnbaum, G., Glaubman, H., & Mikulincer, M. (2001). Women's experience of heterosexual intercourse–scale construction, factor structure, and relations to orgasmic disorder. Journal of Sex Research, 38(3), 191-204.

Bogarozzi, D. A. (1987). Marital/family developmental theory as a context for understanding and treating inhibited sexual desire. Journal of Sex & Marital Therapy, 13, 276-285.

Bowen, M. (1978). Family therapy in clinical practice. New York: Aronson.

Bowlby, J. (1973). Attachment and loss: Separation, anxiety, and anger. New York: Basic Books.

Bozarth, J. D. (1996). A silent young man: The case of Jim Brown. In B. A. Farber, B. A., Brink, D. C., & Raskin, P. M. (Eds.), The psychotherapy of Carl Rogers: Cases and commentaries (pp. 240-250). New York: Guilford Press.

Burgess, A. W., & Holmstrom, L. L. (1979). Rape: Sexual description and recovery. American Journal of Orthopsychiatry, 49(4), 648-657.

Burke, J, R. (1997). Examining the validity structure of qualitative research. Education, 118(2), 282-293.

Buss, D. M. (1989). Conflict between the sexes: Strategic interference and the evocation of anger and upset. Journal of Personality and Social Psychology, 56, 735-747.

Buss, D. M. (1998). Sexual strategies theory: Historical origins and current status. The Journal of Sex Research, 35(1), 19-31.

Byrne, D., Fisher, J. D., Lamberth, J., & Mitchell, H. E. (1974). Evaluation of erotica: Facts or feelings? Journal of Personality and Social Psychology, 29, 111-116.

Chambless, D. L., & Lipshitz, J. L. (1984). Self-reported sexual anxiety and arousal: The Expanded Sexual Arousability Inventory. The Journal of Sex Research, 20, 241-254.

Clifford, R. E. (1978). Subjective sexual experience in college women. Archives of Sexual Behavor, 7, 183-197.

Cobliner, W. G. (1988). The exclusion of intimacy in the sexuality of contemporary college-age population. Adolescence, 23, 99-113.

Colaizzi, P. F. (1978). Psychological research as the phenomenologist views it. In R. S. Valley, & M. King (Eds.), Existential–phenomenological alternatives for psychology (pp. 47-71). New York: Oxford University Press.

Cranston-Cuebas, M. A., & Barlow, D. H. (1990). Cognitive and affective contributions to sexual functioning. Annual Review of Sex Research, 1, 119-161.

Daniluk, J. C. (1993). The meaning and experience of female sexuality: A phenomenological analysis. Psychology of Women Quarterly, 17, 53-69.

Daniluk, J. C. (1998). Women's sexuality across the life span: Challenging myths, creating meanings. New York: Guilford Press.

Dermer, M., & Pyszczynski, T. (1978). Effects of erotica upon men's loving and liking responses to women they love. Journal of Personality and Social Psychology, 36, 1302-1309.

Derrida, J. (1976). Of grammatology. New York: Norton.

Feldman-Summers, S., Gordon, D., & Meagher, I. (1979). The impact of rape of sexual satisfaction. Journal of Abnormal Psychology, 88(1), 101-105.

Fisher, W. A., Byrne, D., White, L.A., & Kelly, K. (1988). Erotophobia-erotophilia as a dimension of personality. Journal of Sex Research, 25, 123-151.

Fisher, W. F. (1978). An empirical–phenomenological investigation of being–anxious: An example of the meanings of being-emotional. In R. S. Valley & S. Halling (Eds.), Existential–phenomenological perspective in psychology (pp. 166-180). New York: Plenum Press.

Fredrickson, B. L., & Roberts, T. (1997). Objectification theory: Toward understanding women's lived experiences and mental health risks. Psychology of Women Quarterly, 2, 173-206.

Freud, A. (1946). The psych-analytic treatment of children. London: Imago.

Freud, S. (1936). The problem of anxiety. New York: Norton.

Freud, S. (1953). Psychopathology of everyday life. New York: Mentor Books.

Freud, S. (1964). The complete psychological works of Sigmund Freud, (Vols. 1-24). London: Hogarth Press.

Fromm, E. (1970). The crisis of psychoanalysis. New York: Holt, Rinehart & Winston.

Fuller, A. R. (1990). Insight into value: An exploration of the promises of a phenomenological psychology. New York: State University Press.

Gagnon, J. H. (1990). The explicit and implicit use of the scripting perspective in sex research. Annual Review of Sex Research, 1, 1-43.

Gendlin, E. T. (1962). Experiencing and the creation of meaning. New York: Free Press.

Gibson, C. (1999). The experience of sexuality in the celibate, divorced, middle-aged Christian women. Unpublished master's thesis, Trinity Western University, Langley, British Columbia, Canada.

Giorgi, A. (1985). Toward a phenomenologically based unified paradigm for psychology. In D. Kruger (Ed.), The changing reality of modern man: Essays in honor of J. H. von Berg (pp. 20-34). Pittsburgh: Duquesne University Press.

Giorgi, A. (1997). The theory, practice, and evolution of phenomenological method as a qualitative research. Journal of Phenomenological Psychology, 28(2), 235-261.

Giorgi, A. (1999). A phenomenological perspective on some phenomenological results on learning. Journal of Phenomenological Psychology, 30(2), 68-94.

Greenberg, L. S., & Johnson, S. M. (1988). Emotionally focused therapy for couples. New York: Guilford.

Gregory, R. L., & Underwood, G. D. (2001). The Oxford guide to the mind. New York: Oxford Press.

Heidegger, M. (1962). Being and time. New York: Harper and Row.

Heppner, P. P., Kivligham, D. M., & Wampold, B. E. (1999). Research design in counseling (2nd Ed.). New York: Brooks/Cole.

Herrmann, F. W. (1988). Der Begrief der Phänomenologie bei Heidegger und Husserl [The concept of phenomenology by Heidegger and Husserl]. Frankfurt am Mein: Vittorio Klostermann.

Hoch, Z., Safir, M. P., Peres, Y., & Shepher, J. (1981). An evaluation of sexual performance – comparison between sexually dysfunctional and functional couples. Journal of Sex & Marital Therapy, 7(3), 195-206.

Hogben, M., & Byrne, D. (1998). Using social learning theory to explain individual differences in human sexuality. The Journal of Sex Research, 35(1), 58-71.

Hoon, E. F., Hoon, P. W., & Wincze, J. P. (1976). An inventory for the measurement of female sexual arousability: The SAI. Archives of Sexual Behavior, 5, 291-300.

Hovell, M. F., Hillman, E. R., Blumberg, E., Sipan, C., Atkins, C., Hofsteller, C. F., & Myers, C. A. (1994). A behavioral-ecological model of adolescent sexual development: A template for AIDS prevention. The Journal of Sex Research, 31, 267-281.

Hurlbert, D. F., Apt, C., & Rabehl, S. M. (1993). Key variables to understanding female sexual satisfaction: An examination of women in nondistressed marriages. Journal of Sex & Marital Therapy, 19(2), 154-165.

Husserl, E. (1970). The crisis of European sciences and transcendental phenomenology: An introduction to phenomenological philosophy. Evanston, IL: Northwestern University Press.

Johnson, C. M. (2001). Connections between sexual self-esteem and spiritual orientation. Unpublished master's thesis. Trinity Western University, Langley, British Columbia, Canada.

Janda, L. H., & O'Grady, K. E. (1980). Development of sex anxiety inventory. Journal of Consulting and Clinical Psychology, 48(2), 169-175.

Johnson, S. M., Makinen, J. A., & Millikin, J. W. (2001). Attachment injuries in couple relationship: A new perspective on impasses in couples therapy. Journal of Marital and Family Therapy, 27(2), 145-155.

Jurich, A. P., & Polson, C. J. (1985). Nonverbal assessment of anxiety as a function of intimacy of sexual attitude questions. Psychological Reports, 57, 1247-1253.

Jurich, J. A., & Myers-Bowman, K. S. (1998). Systems theory and its application to research on human sexuality. The Journal of Sex Research, 35(1), 72-85.

Kaplan, H. S. (1974). The new sex therapy. New York: Brunner/Mazel.

Kaplan, H. S. (1977). Hypoactive sexual desire. Journal of Sex & Marital Therapy, 3(1), 3-10.

Kaplan, H. S. (1979). Disorders of sexual desire. New York: Brunner/Mazel.

Kaplan, H. S., Fuer, A. J., & Novick, A. (1982). The treatment of sexual phobias: The combined use of antipanic medication and sex therapy. Journal of Sex & Marital Therapy, 8(1), 3-28.

Karlsson, G. (1993). Psychological qualitative research from a phenomenological perspective. Stockholm: Almquist & Wilsell.

Katz, R. C., Frazer, N., & Wilson, L. (1993). Sexual fears are increasing. Psychological Reports, 73, 476-478.

Kierkegaard, S. A. (1944). The concept of dread (2 vols.). Princeton, NJ: Princeton University Press.

Kilpatrick, D. G., Best, C. L., Sanders, B. E., & Veronen, L. J. (1988). Rape in marriage and in dating relationships: How bad is it for mental health? In R. A. Prentsky & V. L. Quinsey (Eds.), Human sexual aggression: Current perspectives (pp. 335-344). New York: New York Academy of Science.

King, B. M. (1996). Human sexuality today (2nd ed.). Upper Saddle River, NJ: Prentice Hall.

Klein, D. F. (1980). Anxiety reconceptualized. In D. F. Klein & J. G. Rabkin (Eds.), Anxiety: New research and changing concepts (pp. 235-241). New York: Raven Press.

Kring, B. (2000). Psychotherapy of sexual dysfunction. American Journal of Psychotherapy, 54(1), 97-102.

Kohn, I. J., & Kaplan, S. A. (1999, September). Female sexual dysfunction: What is known and what remains to be determined. Contemporary Urology, 54-71.

Kohut, H. (1971). The analysis of the self. New York: International Universities Press.

Laumann, E. O., & Paik, R. C. (1999). Sexual dysfunction in the United States: Prevalence and predictors. Journal of American Medical Association, 281, 537-544.

Lazarus, A. A. (1971). Behavior therapy and beyond. New York: McGraw-Hill.

Leary, M. R., & Dobbins, S. E. (1983). Social anxiety, sexual behavior, and contraceptive use. Journal of Personality and Social Psychology, 45(6), 1347-1354.

Levine, S. B. (1984). An essay on the nature of sexual desire. Journal of Sex & Marital Therapy, 10(2), 83-96.

Levine, S. B. (1987). More on the nature of sexual desire. Journal of Sex & Marital Therapy, 13(1), 35-44.

Lief, H. I. (1979). Anxiety, sexual dysfunction, and therapy. In W. E. Fann, I. Karacan, A. D. Polkorny, & R. L. Williams (Eds.), Phenomenology and treatment of anxiety (pp. 311-324). London: Spectrum.

Longmore, M. A. (1998). Symbolic interactionism and the study of sexuality. The Journal of Sex Research, 35(1), 44-57.

LoPiccolo, J., & Lobitz, W. C. (1972). The role of masturbation in the treatment of orgasmic dysfunction. Archives of Sexual Behavior, 2, 163-171.

Lyddon, W. J. & Sherry, A. (2001). Developmental personality styles: An attachment theory conceptualization of personality disorders. Journal of Counseling and Development, 79, 405-414.

MacKnee, C. (1997). A description of practicing Christians' experience of profound sexual and spiritual encounters. Unpublished doctoral dissertation, University of British Columbia, British Columbia, Canada.

Macphee, D. C. (1996). The effects of marital therapy on inhibited sexual desire: An outcome study. Dissertation Abstracts International, 56, 11B. (US Microfilm International).

Masters, W. H., & Johnson, V. E. (1970). Human sexual inadequacy. Boston: Little, Brown.

May, R., Angel, E., & Ellenberger, H. F. (1958). Existence: A new dimension in psychiatry and psychology. New York: Basic Books.

McCabe, M. P. (1997). Intimacy and quality of life among sexually dysfunctional men and women. Journal of Sex & Marital Therapy, 23(4), 276-292.

Meyer, M. (1996). The Bedford introduction to literature: Reading, thinking, writing. (4th ed.). Boston: Bedford Books of St. Martin's Press.

Morse, J. M. (1999). Qualitative generalizability. Qualitative Health Research, 9(1), 5-7.

Mosher, D. L. (1988). Revised Mosher Guilt Inventory. In C. M. Davis, W. C. Yarber, & R. S. L. Davis (Eds.), Sexuality-related measures (pp. 75-88). Lake Mills, IA: Davis.

Nemetz, G. H., Craig, K. D., & Reith, G. (1978). Treatment of female sexual dysfunction. Journal of Consulting and Clinical Psychology, 46(1), 62-73.

Nutter, D. E., & Condron, M. K. (1983). Sexual fantasy and active patterns of females with inhibited sexual desire versus normal controls. Journal of Sex & Marital Therapy, 9(4), 276-282.

Osborne, J. W. (1990). Some basic existential-phenomenological research methodology for counsellors. Canadian Journal of Counselling, 24(22), 79-91.

Palace, E. M., & Gorzalka, B. B. (1990). The enhancing effects of anxiety on arousal in sexually dysfunctional and functional women. Journal of Abnormal Psychology, 99(4), 403-411.

Patton, D., & Waring, E. M. (1985). Sex and marital intimacy. Journal of Sex & Marital Therapy, 11(3), 176-184.

Polkinghorne, D. E. (1989). Phenomenological research methods. In R. S. Valley & S. Halling (Eds.), Existential-phenomenological perspective in psychology (pp. 41-60). New York: Plenum Press.

Pollio, H. R., Henley, T. R., & Thompson, C. J. (1997). The phenomenology of everyday life. Cambridge: University Press.

Pope, C. E., & Ziebland, S. (2000). Analysing qualitative data. British Medical Journal, 7227, 114-117.

Prouty, G. (1994). Theoretical evolutions in person-centered/experiential therapy. London: Westport Preager.

Read, J. (1995). Female sexual dysfunction. International Review of Psychiatry, 7(2), 175-183.

Rogers, C. R. (1980). Foundations of the person-centered approach. Boston: Houghton Mifflin.

Rosen, R. C., & Leiblum, S. R. (1995). Treatment of sexual disorders in 1990s: An integrated approach. Journal of Consulting and Clinical Psychology, 63(3), 877-890.

Rosen, R. C., Taylor, J. F., Leiblum, S. R., & Bachmann, G. A. (1993). Prevalence of sexual dysfunction in women: Results of a survey study of 329 women in an outpatient gynecological clinic. Journal of Sex & Marital Therapy, 19(3), 171-188.

Schamberger, M. M. (1997). Elements of quality in a qualitative research interview. South African Archives Journal, 39, 25-35.

Schnarch, D. M. (1991). Constructing the sexual crucible: An integration of sexual and marital therapy. New York: Norton.

Schreiner-Engel, P., Schiavi, R. C., & Smith, H. (1981). Female sexual arousal: Relation between cognitive and genital assessments. Journal of Sex & Marital Therapy, 7(4), 256-266.

Shapiro, K. J. (1986). Verification: Validity or understanding. Journal of Phenomenological Psychology, 17, 167-179.

Sigel, J. M., Golding, J. M., Stein, J. A., Burnam, M. A., & Sorenson, S. B. (1990). Reactions to sexual assault: A community study. Journal of Interpersonal Violence, 5(2), 229-246.

Stewart, D., & Mickunas, A. (1974). Exploring phenomenology: A guide to the field and its literature. Chicago: American Library Association.

Stiller, C. J. A. (2000). Coping with suffering: How individuals find meaning in life while experiencing pain, disease, and disability. Unpublished master's thesis, Trinity Western University, Langley, British Columbia, Canada.

Stuart, F. M., Hammond, D. C., & Pett, M. A. (1986). Psychological characteristics of women with inhibited sexual desire. Journal of Sex & Marital Therapy, 12(2), 108-116.

Sullivan, H. S. (1953). The interpersonal theory of psychiatry. New York: Norton.

Thompson, S. (1990). Putting a big thing into a little hole: Teenage girls' accounts of sexual initiation. The Journal of Sex Research, 27, 341-361.

Valle, R. C., & King, M. (Eds.). (1978). Existential-phenomenological alternatives for psychology. New York: Oxford University Press.

Van Berlo, W., & Ensink, B. (2000). Sexual functioning after adult sexual assault: Which factors predict persistent sexual problems. Manuscript submitted for publication.

Walen, S. R. (1980). Cognitive factors in sexual behavior. Journal of Sex & Marital Therapy, 6(2), 87-101.

Wallace, D. H. (1981). Affectional climate in the family of origin and the experience of subsequent sexual-affectional behaviors. Journal of Sex & Marital Therapy, 7(4), 296-306.

Weis, D. L. (1983). Affective reactions of women to their initial experience of coitus. The Journal of Sex Research, 19, 209-237.

Weis, D. L. (1985). The experience of pain during women's first intercourse: Cultural mythology about female sexual initiation. Archives of Sexual Behavior, 14, 421-438.

Witkin, M. H. (1980). Sex therapy: A holistic approach. In B. B. Wolman & J. Money (Eds.), Handbook of human sexuality (pp. 335-353). Englewood Cliffs, NJ: Prentice-Hall.

Wertz, F. J. (1984). Procedures in phenomenological research and the question of validity. In C. M. Aanstoos (Ed.), Exploring the lived world: Explorations in phenomenological psychology (pp. 29-48). (West Georgia College Studies in the Social Services, 23). Carrollton: West Georgia College.

White, A. M., Fichtenbaum, L., & Dollard, J. (1967). Measured relationships between sexual motivation and anxiety. Journal of Counseling Psychology, 14(6), 544-549.

Wiedermann, M. W. (1998). The state of theory in sex therapy. The Journal of Sex Research, 35(1), 88-99.

Wincze, J. P., & Cairg, W. K. (1976). The effects of systematic desensitization and video desensitization in the treatment of essential sexual dysfunction in women. Behavior Therapy, 7, 335-342.

Winnicott, D. W. (1958). Collected Papers. London: Tavistock.

Wolpe, J. (1958). Psychotherapy by reciprocal inhibition. Stanford: Stanford Press.

Wolpe, J., & Lazarus, A. A. (1966). Behavioral therapy techniques. New York: Pergamon Press.

Wolpe, J., & Wolpe, D. (1988). Life without fear. Oakland, CA: New Harbinger.

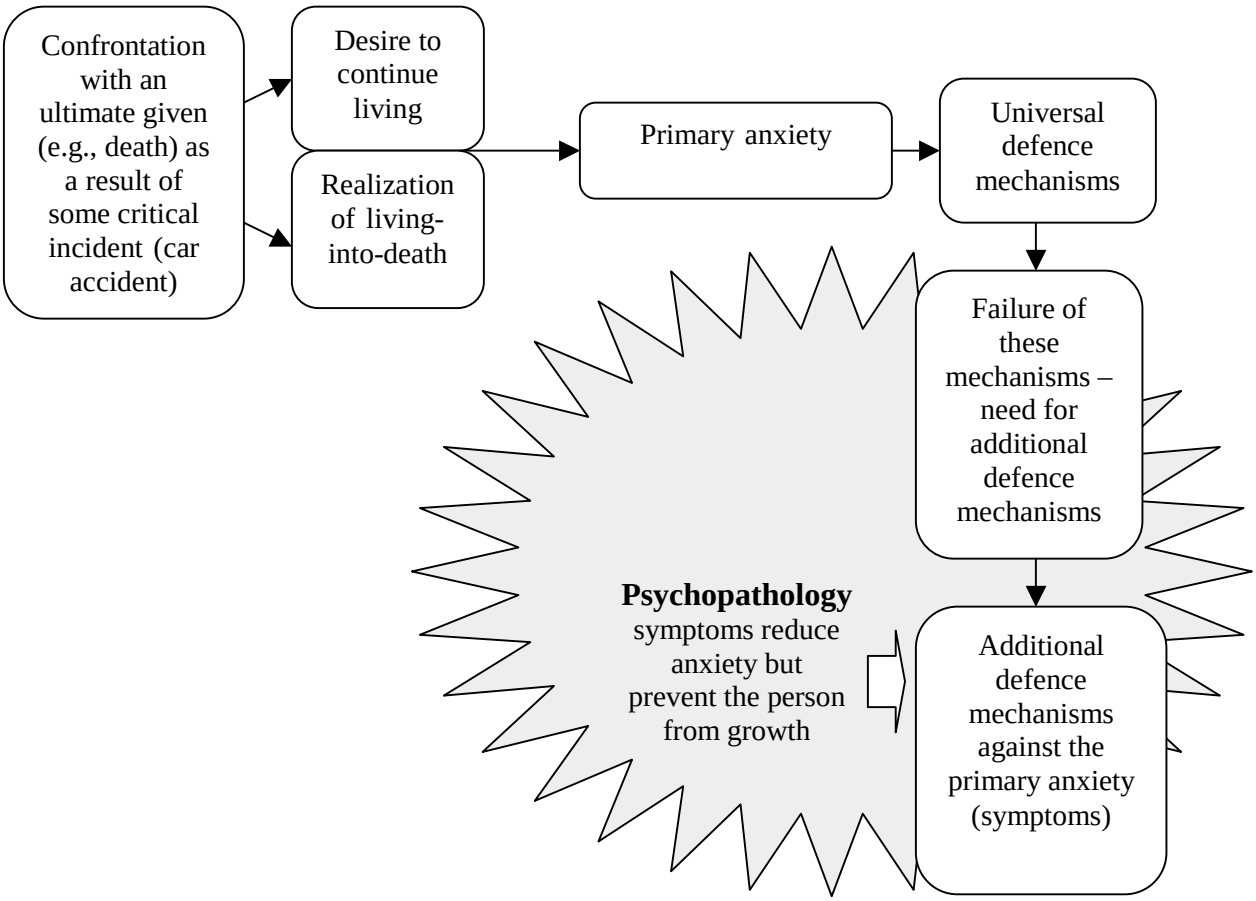
Woody, J. D., & D'Souza, H. J. (1997). Sexual interaction in nonclinical couples. Family Journal, 5(3), 224-231.

Wright, D. B., & Loftus, E. F. (1999). Measuring dissociation: Comparison of alternative forms of the dissociative experiences scale. American Journal of Psychology, 112(4), 497-520.

Yalom, I. (1981). Existential psychotherapy. New York: Basic Books.

TABLE 1

Yalom's (1981) Existential Model of Psychopathology



APPENDIX A

Personal Bracketing

In this section I will describe my own experience of sexual discomfort. Such a description can be beneficial to readers who acquaint themselves with the results of this study, as it could provide them with an idea regarding possible pre-conceptions and assumptions I have held about the phenomenon while collecting and analyzing the data.

I am a 26-year-old Slavic woman, born and raised in Belarus (part of the former Soviet Union). Having lacked essential information regarding sexuality and having experienced sexual abuse and in my childhood and early adolescence, I underwent confusion, guilt, and shame trying to independently discover my sexual identity. As a consequence of this process, I now, in spite of being in a loving and committed marital relationship, experience frequent sexual discomfort and inhibition.

Specifically, I experience fear, anxiety, and worry about potential rejection and abandonment by my spouse. Subconsciously, I seem to believe that such abandonment is likely to occur if I either engage in sexual interaction or choose to abstain from such interaction for a relatively long period of time. This conflict produces feelings of confusion and entrapment. It also leads me to question my own adequacy (What did I do wrong that now I have to go through this? What is wrong with me?). Occasionally, I tend to question my spouse, wondering what is wrong with him if he chooses to engage in sexual interaction knowing how uncomfortable I might find it. I was gradually able to identify the cycle in which we as a couple seem to engage.

When my spouse wonders if I want to connect with him sexually, I feel unsafe (due to my fear of abandonment) and am likely to refuse this participation. I feel lonely in my experience and want my spouse to be there for me when I am scared, but instead I feel that I have to support him when he experiences disappointment over the deficit of sexual intimacy in our marriage. I consequently feel resentment, anger, and frustration towards my spouse, whom I love deeply. He, in turn, exhibits behaviours of rejection and being hurt. He expresses his need for comfort

and emotional support from me, which I tend to interpret as pressure to engage in sexual contact. I withdraw, which he seems to experience as further rejection. The more rejected he feels (with me sensing negative affect and being responsible for such), the more pressured and obliged I feel to participate in sex, and the more I don't want to be a part of sexual interaction (realizing that fear, guilt, and obligation are not the right basis for sexual intimacy). Hence, we get stuck in this cycle. Being able to empathize with and comfort my spouse in non-sexual areas of life, I struggle with "being there for him" as we work through sexual difficulties.

I feel discouraged but simultaneously hopeful. Our mutual commitment and love keep us motivated to attempt to resolve the sexual problems we experience. Although sexual difficulty produces mutual resentment, bitterness, and other negative effects, it also facilitates growth in both of us (individually and as a couple)—we grow towards each other and God. In spite of mutual frustration, stress, resentment, fear, and hurt we are gradually getting to the place where we are able to consistently experience sexual intimacy and pleasure.

Having described my own experience of sexual discomfort, I will mention other encounters I have had with this phenomenon. As I began to research the literature on the subject of female sexual dysfunction in attempts to understand my difficulty, I discovered that the phenomenon of female sexual discomfort has been under-researched. Being an existentially-oriented student/counsellor, I believe that the core existential concerns of humans underlie many psychological difficulties. Thus, the natural choice of methodology for my study was phenomenological, for it seemed to be the best way to reach the core of human experience and existence. I join many clinicians and researchers in the conceptualization of sexual discomfort as being rooted in anxiety. I, however, extend my beliefs further, assuming there is some existential concern (e.g., fear of death or isolation) that underlies such sexual difficulties. While conducting my study I attempted to keep in mind the biases and personal experiences stated above.

APPENDIX B

Information Letter Sent to Practitioners/Clinicians

Dear Sir/Madam,

My name is Olga Sutherland. I am a Graduate Counselling Psychology Student at Trinity Western University and am currently doing research for my thesis that explores the phenomenon of sexual discomfort during sexual encounters in married women. I am using an interview format of data collection, with interviews being audiotaped.

The purpose of this study is to allow women to communicate their troubling experience of sexual discomfort (whether physical or emotional), along with facilitating events or pre-conditions, coping mechanisms, and after-effects.

It is hoped that the study results will provide information useful to practitioners with female clients who express having experienced discomfort in marital relationships. Ultimately, this may help in the development of more accurate assessment and effective treatment strategies. In addition, the findings might allow women with such experience to become more self-aware and learn that there are others who go through similar difficulties. It is possible that participation in this study might affect women's experience and coping with other psychological issues.

I am enclosing a poster that describes the research and calls for participants. I would appreciate your assistance in posting it (if it is possible to do so) and in directing any women who have an experience of sexual discomfort (occurring more often than not) to contact me.

Confidentiality is guaranteed and participants will be offered a $20 honorarium. If you have any questions please do not hesitate to contact me.

Thank you for your help.

Sincerely,

Olga Sutherland.

Tel: (604) 323-41-93
Email: discomfort_study@mac.com
Supervisor of Research: Dr. Chuck MacKnee (Tel: 888-7511)

APPENDIX C

Poster Advertising Study

If you are a married woman and suffer from physical and/or emotional discomfort during sexual encounters

here is an opportunity to contribute to research exploring this experience.

Our present societal view is that marital sexual relations are a mutually satisfying and enjoyable experience. Yet many women experience some measure of discomfort at least occasionally throughout a lifetime of sexual encounters.

In this study you will be asked to reflect upon occasions during which you have experienced discomfort associated with sexual interaction. Such discomfort continues to occur more often than not. The study is composed of one interview and one follow-up telephone call. **Confidentiality is guaranteed.** Participants will be offered a $20 honorarium.

If you are willing to dedicate time and have the courage to share such private aspects of your life, please contact Olga Sutherland (a Graduate Counselling Psychology Student at Trinity Western University) at (604) 323-4193 or discomfort_study@mac.com. Further information will be forwarded to you.

APPENDIX D

Cover Letter Describing Study Sent to Participants

Dear_____,

Thank you for your expressed interest in participation in my research. Our present societal view is that marital sexual relations are seen as a mutually satisfying and enjoyable experience. Yet many women experience some measure of discomfort with sexual relations as least occasionally over their lifetime of sexual experiences. You will be asked to reflect on occasions in which you have experienced discomfort associated with a sexual interaction. The purpose of this study is to obtain the descriptions of the experience of sexual discomfort from a number of married women, its pre-conditions, coping mechanisms, and after-effects. The participation in the study may be beneficial for you as it might enhance your self-awareness and increase your understanding of the experience. Such changes may improve sexual functioning and promote growth, happiness, and life satisfaction. You will be offered a $20 honorarium in appreciation for your participation.

Participation will involve about 60-120 minute interview and a brief follow-up telephone interview. During the interview you will be asked to recall the experience of sexual discomfort (physical and/or emotional) that occurred more often than not. You will be asked to describe in details such experience, factors that led to it, coping ways, and its effects. Interviews will be tape-recorded and transcribed. First-name pseudonyms will be assigned to the audiotapes to ensure confidentiality. Only I will be able to match your actual identity with the information obtained during the in-depth interview. Even for the research team (Supervisor, Second Reader, and Thesis Coordinator) and a person(s) transcribing the interview your name will remain anonymous. Should you feel the need to debrief your participation in the study, a therapist will be available for one counselling session free of charge.

Audiotapes will be stored in a secure office and the protocols—securely locked on my laptop. Audiotapes will be destroyed through breaking after the successful thesis defence and the protocols will be securely kept on my laptop indefinitely for the purposes of further research or potential publication of the study. You will be asked permission if there is a need for the use of your data in the future. You have a right to withdraw your permission for the indefinite retention of your data. In the case of such withdrawal your data will be completely and permanently erased from the laptop in two years after I receive my Master's degree. Upon the completion of the study you will receive the copies of findings (unless you express your preference not to receive them). The information regarding post-research access to the results will be included in the debriefing letter mailed to you after the study is completed.

Your involvement is voluntary and you will be able to withdraw from the study at any time without being penalized in any way. I will contact you to arrange a suitable interview time. Thank you for your help.

Sincerely,

Olga Sutherland,
Graduate Counselling Psychology Student, TWU.

APPENDIX E

Consent Form

STUDY: EXPERIENCE OF SEXUAL DISCOMFORT IN MARRIED WOMEN
INVESTIGATOR: Olga Sutherland (Tel: 323-4193)
SUPERVISOR OF RESEARCH: Dr. Chuck MacKnee (Tel: 888-7511)

The purpose of the study is to explore descriptive themes, facilitating events, coping mechanisms, and after-effects of the experience of sexual discomfort in married women. You will be asked in a 60-90 minute interview to recall an experience of sexual discomfort and identify facilitating events and after-effects of such experience.

Interviews will be audiotaped, transcribed, and assigned a first name pseudonym to ensure confidentiality. The tapes will be erased upon the completion of the researcher's degree and the transcripts will be securely saved on the researcher's laptop indefinitely, unless you withdraw your permission for such indefinite retention of your data. In the latter case, your transcripts will be permanently erased from the laptop in two years upon the completion of the study. A brief follow-up interview will be scheduled. You can withdraw from the study at any moment without any prejudice and all your data will be destroyed. If you have any questions, you can ask them at any time before or after the interview. You will be offered a $20 honorarium prior to the interview.

I HAVE READ AND UNDERSTOOD THE COVER LETTER AND THIS CONSENT FORM AND CONSENT TO BE A PARTICIPANT IN THIS RESEARCH.

I ACKNOWLEDGE RECEIPT OF A COPY OF THIS CONSENT FORM.

Name of Participant:_____

Address:_____

Telephone #:_____

Signature:_____ Date:_____

Researcher: Olga Sutherland, phone: (604) 323-4193.

APPENDIX F

Interview Protocol

Orientation Speech

"Thank you for agreeing to participate in this study and to share your experience of discomfort. I recognize that the nature of this subject is extremely private and, therefore, respect your courage to volunteer and be a part of this study.

The purpose of the study is to allow married women to describe, in a very detailed manner, the actual experience of sexual discomfort, the events that led to the experience, the coping mechanisms used, and the after-effects of such experience. It is hoped that the study results will provide information useful to women who express having experienced discomfort in married relationships and to practitioners who care for them.

The information shared will remain confidential. The first-name pseudonym will be assigned to the tape and only I will have the access to your identity. You have a right to withdraw from the study at any moment without being penalized in any way. Please do not hesitate to ask questions."

Questioning

To explore the experience:

- Please think back to a time or times when you, after beginning to engage in sexual activity with your spouse, you found yourself experiencing discomfort of some nature. (Pause) Please describe this experience as fully as you can.
- What was that experience like for you? How did you experience such discomfort? What were you feeling? Where did you feel the discomfort in your body? What were your thoughts? How did you respond to the emergence of the experience (What did you do as you started experiencing discomfort)? How was this experience different from the experience when you enjoyed and wanted to proceed with sexual activity?

To explore coping mechanisms:

- How did you cope with the discomfort?

To explore pre-conditions of the experience:

- What happened that brought about that experience of wishing to discontinue engaging in sexual activity? What specific events led up to the moments of such experiences?

To explore the after-effects:

- What were the effects of such experience for you? What were the effects of such experience for your relationships?

APPENDIX G

Debriefing Letter Sent to Participants

Dear _____,

Thank you for contributing to the study that explored the experience of sexual discomfort in married women. You, along with eight other women, made it possible to understand what such experience is like, its pre-conditions, methods used to cope with it, and its after-affects. I hope that your participation in the study was one of the steps you took in the process of moving toward satisfactory, fulfilling, and anxiety-free sexual functioning.

The experience of being an investigator of the study was also beneficial for me, both personally and professionally. Personally, I experienced a combination of emotions (e.g., sadness, hurt, anger, helplessness, but also joy, and excitement, and hope) as I first read through the transcripts and attempted to capture what is it like for you to have this experience in your life. I remember crying from feeling your pain and despair and at the same time laughing from witnessing your humor, creativity, or irony of your life situation. At times I was amazed by the personal and/or spiritual transformations that occurred in your life, by your perseverance, and your life journey overall. I have grown personally as I learned more about how you experience and deal with such troubling and distressful experiences. I started noticing some aspects in my own sexual interaction with my spouse that I did not perceive before. I have significantly expanded my own self-awareness in regards to my own sexual struggles and relational patterns. You made it possible and I am thankful to you for this. I hope that our work will also be helpful to other women who suffer from sexual difficulties and to the professionals who assist these women.

I am attaching the copy of my analysis of your transcript for your interest. If you wish to obtain additional copies in the future, such copies will be provided to you within a five-year period from the completion of the study. There will be no guarantee for the release of the findings after this time.

I hope that the experience of the participation was beneficial for you. If you have any questions or concerns please contact me.

Sincerely,

Olga Sutherland.

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