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Confessions

Structural mechanisms for regulation, interpretation and
knowledge of vulvar pain

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Abstract

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Problem/background: Vulvar pain has been known of for thousands of years but the general knowledge of vulvar pain is limited and the condition receives less medical attention than other disorders. Previous research focus on physical and/or psychological causes, treatment strategies and problematizing female sexuality due to women's inability to engage in sexual intercourse.

Objective: This master thesis attempt to understand vulvar pain and the process of pain management by using the concept of confessions as a theoretical framework. Foucault (1990) and Plummer's (1995) are mainly used for capture the individual and organizational dimensions of vulvar pain and pain management.

Summary: Research material consists of nine interviews with three women and reviews of 41 letters. Pain is an individual and abstract feeling of hurt and reaching awareness of pain is necessary in order to seek treatment. Institutional pain management teach women understand their pain by applying confessional techniques, simultaneously; by gaining knowledge of pain women also access tools to control the social and emotional impact of pain even if the physical pain remains.

Conclusion: Confessional techniques are necessary to reach knowledge of vulvar pain. Pain management is performed institutionally as well as individually. Institutional pain management teach women techniques to organize experiences of pain in order to reach control. The institutional facilities offer social space for exploring and experiencing pain while individual pain management focus on controlling and relocating pain.

Keywords: Confessions, Pain management, Vulvar pain, Provoked vestibulodynia, Vaginismus, Chronic pain, Female, Women, Diagnosis, Pain, Sexuality, Coital pain

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1. Introduction

Vulvar pain is not a new phenomena that has evolved and grown in pace with modernity, psychoanalysis and sexual liberation. Instead, vulvar pain has been described and known of for thousands of years (Engman, 2007:1). In similarity with other diseases has vulvar pain been processed and understood through cultural, geographical, ideological, material and social contexts (see Engman, 2007; Hallerstedt, 2006; Kärffve, 2006; Johannisson, 2006). The knowledge of vulvar pain depends on interpretational domains such as modernity, psychoanalysis and sexual liberation. This master thesis is an attempt to understand vulvar pain and pain management through the theoretical concept of confession.

Pain is an abstract experience of physical hurt; the intensity, occurrence and existence is unpredictable. A confession is the result of self-observations and organizing those observations into patterns and knowledge. My own experience of dealing with vulvar pain was helpful, if not crucial, in order to find and interview women with vulvar pain and understand the processes of pain management. The research material on women's experiences of vulvar pain consists of nine interviews with three women and 41 letters. In the interviews and the letters are experiences of neglect, mistrust and mistreatment common and the abstract feeling of pain is difficult to explain.

This master thesis will elaborate the processes of pain management concerning vulvar pain. By using the theoretical concept of confessions this master thesis connect the individual experiences of vulvar pain with the social organization of heterosexuality, the body in pain and society. In short, the master thesis explores the social organization of pain by highlighting how society has designed social space for pain to exist as well as categorized pain as inconvenient and deviant.

Disposition

In *Research question*, I state the research question that has guided this master thesis but also argue for the relevance of the research approach. Most research regarding vulvar pain have been conducted within medical and psychological research, to understand the dominant perspectives, approaches and critiques in vulvar pain research I give a brief overview in chapter 2, *Previous research*. Vulvar pain consists of several conditions and descriptions of those are specified in chapter 3, *Conceptualization and overview of vulvar pain*. Chapter 3 also contains historical background and estimates the prevalence of vulvar pain.

The theoretical concept of confession is discussed in chapter 4, *Theory*. Descriptions of confessional techniques, discussions of the relation between confessions, development of knowledge and implement of power are discusses in the chapter. Apart from discussing the purpose of confessions and its relations to society the chapter contains an example of how societal norms subjectify bodies.

In chapter 5, *Method and methodology*, I reflect upon the use of method and implementation of ethical values and scientific research. The chapter contains full descriptions of the selection procedures, choice of method, coding the material and the research material. I also discuss my own experiences and impact on the research material. The *Analysis*, in chapter 6, is divided into two major themes; *Pain* and *The subject in pain*. The theme *Pain* highlights the experience of pain and making pain concrete, while the theme *the subject in pain* address how women become subjects to pain by outer and inner ideals. Confessional techniques, confessions and pain management are evident in both themes but occur in different manors since the circumstances shift. Concluding remarks and results are given in chapter 7, *Conclusion*. Research significance and need for future research are stated in chapter 8, *Further research*. Literature sources, Internet sources and links to the letters are found in chapter 9, *Bibliography*. *Endnotes* are found in chapter 10.

Research question

In this master thesis I will explore the intertwinement of vulvar pain and confession, to do so I ask:

How are women with vulvar pain able to transform the principles of confessions into strategies of pain management?

The underpinning of vulvar pain and confession will be an attempt to address how the experience of vulvar pain and pain management can be related to societal values and norms. I also wish to explore how women use the techniques of confessions to develop knowledge and manage vulvar pain. Exploring issues of vulvar pain and pain management hopefully contributes to the shared knowledge and understanding of vulvar pain as well as emphasize how vulvar pain first of all is a physical pain disorder and secondly a socially painful illness.

The decision to explore vulvar pain and pain management through the concept of confession developed under a long time and lasted almost to the very end of this master thesis. This thesis will not show every twist, turn and revision that has been made but it is necessary to understand the unorthodoxy of this thesis's approach to vulvar pain and pain management. In chapter 2, *Previous Research*, I will show that previous knowledge of vulvar pain has forgot to connected women's individual pain history with an institutional organization of pain management. Instead, as chapter 2 will show, the domains of knowledge concerning vulvar pain either address the medical condition or the individual experiences of pain in relation to femininity and sexuality. This master thesis is an attempt to add a bridge between the institutional organization of pain management and the individual experiences in order to conceptualize women's history of dealing with vulvar pain.

2. Previous research

Vulvar pain is a collection of several painful vaginal and vulvar conditions, *provoked vestibulodynia* and *vaginismus* are two of those conditions. The general consensus regarding vulvar pain is uncertainty since the borders and definitions of diagnosis, cause and treatments are unclear and still under debate (see Bohm-Starke & Rylander, 2000; Borgefeldt et al., 2010; Engman, 2007). Testimonies of vulvar pain have been around for thousands of years and the syndrome has primarily interested medical experts and practitioners (See Bohm-Starke & Rylander, 2000; Engman, 2007; Elmerstig, 2009; Sörensdotter, 2013). Most research regarding vulvar pain is conducted in medical research but it is important to highlight that vulvar pain receives less medical and scientific attention compared to other medical disorders. Medical researcher Nina Bohm-Starke concludes in a medical overview that there are about 500 publications concerning vulvar pain in the international database PubMed (2010:1504,1508). A quick search in PubMed's database shows that *vulvar pain* receives 925 hits, while another non-life threatening condition, *erectile dysfunction*¹ show 18.341 hits (PubMed search, 2013-05-15). Although men with erectile dysfunction experience emotional pain, presence of physical pain is rare.

The majority of vulvar pain research projects focus on the physical condition in order to diagnose, treat and develop measurements to grasp processes of recovery. Vulvar pain is a cross-disciplinary experience that circulates the borders of body and psyche. The condition has primarily been scrutinized within the fields of medicine and psychology. Vulvar pain as a field of research has also interested sociologist and social anthropologist whom examine aspects of femininity and sexuality, however this master thesis's focus on the pain and the management in relation to the individual experience and the institutional organization of vulvar pain. In this section I will give an overview of the dominant approaches in vulvar pain research.

In *Physical evidence and treatment strategies* I describe medical approaches to the physical body and their focus on cause and possible treatments. In *Psychological explanations* I describe psychological explanations to vulvar pain. Women's sexual

development and critiques of dominant western perspectives in previous vulvar pain research is discussed in *Critiques of cultural blindness*. In the last section, *In Sweden*, I give a brief overview of research conducted in Sweden.

Physical evidence and treatment strategies

Medical studies focus on cause and localizing physical evidence of vulvar pain (see Engman, 2007; Bohm-Starke, 2010; Metts, 1999). For example, provoked vestibulodynia was assumed to be an inflammation, whereas recent clinical studies have found a larger number of nerve endings, which can and have been mistaken for a rash (Elmerstig, 2009:9). Vaginismus on the other hand, has primarily been categorized as a psychosomatic condition, however, careful studies of vaginismus suggest that there is a difference between *total primary* and *partial secondary vaginismus* (see Engman, 2007). The phobic reaction of *total primary vaginismus* has traditionally been under the lens whereas recent studies tend to focus on *partial secondary vaginismus* and pain management (Elmerstig, 2009:10-11; *ibid*:5-6).

Medical studies also focus on treatments and explore possible recovery strategies. Medical doctor, Ulrika Heddini claims that "[t]here is no standardized treatment for PVD [provoked vestibulodynia], and management differs between care providers. Very few randomized, placebo-controlled trials have been performed, and the level of evidence is generally low" (Heddini et al., 2012:1401). Dilators, cognitive behavioural therapy, low amount of tricyclic antidepressants, Botox injections, surgery, vaginal EMG biofeedback and acupuncture are some of the treatments available (Heddini et al., 2012; Kleinplatz, 1998). Treatment outcomes are under process and studies attempt to establish successful methods for recovery and pain management (see Bohm-Starke & Rylander, 2000; Engman, 2007; Fugl-Meyer, 2013; Heddini et al., 2012; Kleinplatz, 1998). "However, there is no consensus regarding the definition of successful treatment outcome and methods for evaluation of outcome vary between studies as well as follow-up time" (Heddini et al., 2012:1401).

Psychological explanations

Psychological researchers has also been interested in vulvar pain and the attempts to find psychological causes have focused explaining the phobic reactions and lack of sexual lust by connecting pain with sexual abuse and sexual assault (Borgefeldt et al., 2010; Kleinplatz, 1998). Opinions regarding causes are divided among researchers, some studies rule out correlation between sexual abuse/assault and pain, while other studies show that experiences of sexual abuse and assault are higher among women with vaginismus (see Borgefeldt et al., 2010; Engman, 2007; Fugle-Meyer et al., 2013; Swedish National Institute of Public Health, 2012).

Critiques of cultural blindness

Publications concerning affects in social life mainly address sexuality and sexual development but also how vulvar pain can be localized within gendered structures (see Ayling & Ussher, 2008; Elmerstig, 2010; Sörensdotter, 2013). Psychologist and sexologist Peggy Kleinplatz (1998) suggest that research on vulvar pain have been phallogentric as well as westernized.

Regardless of theoretical orientation, throughout the sex therapy literature, the goal of treatment of vaginismus is reversal of the symptom, thereby enabling vaginal containment.[...] “When the patient can tolerate a phallus size object, she is cured” (Kaplan, 1987, p. 99). There is a strong emphasis on engaging in sexual intercourse [...] rather than other sexual acts, for example mutual masturbation [...] or the “pervasion” of oral sex [...] (Kleinplatz, 1998:54).

The fact that most research has been done in the West contributes to infuse knowledge with contextual blindness. Chinese sexologist Man-Lun Ng propose that vulvar pain, in this case vaginismus, need to be reconceptualized as a “[...] culturally-bound syndrome (meaning a medical disease due to a cultural problem” (1999:13). Ng wishes to reconceptualize vaginismus so that it becomes possible to address the disease from a culturally elastic and more accommodating way since sexual relationships, sexuality and perceptions of the body are rooted in specific cultural

contexts. Turkish researchers Kabakci and Batur agree that cultural contexts become evident in treatments and states that psychotherapeutic frameworks might not be suitable for clients from non-Western cultures (Engman, 2007:7).

In Sweden

Medical research projects based in Sweden have taken it upon themselves to critically review previous research with the attempt of clarifying and develop the diagnosis, and evaluate previous research and treatments (see Bohm-Starke, 2010; Bohm-Starke & Rylander, 2000; Elmerstig, 2009; Engman, 2007; Fugl-Meyer et al., 2013; Heddini, 2012; Olsson & Örjes Svensson, 2006; Swedish National Institute of Public Health, 2012).

Social anthropologist Renita Sörensdotter (2013) explores provoked vestibulodynia in a currently on-going research project where she investigates women's sexual practices in relation to gender structures. She proposes that female sexuality becomes restricted within heterosexual sexual practices and that non-penetrating sexual relations have a wider space for sexual negation (Sörensdotter, 2013; also see Sörensdotter, 2012). Studies using social scientific perspectives are rare, but studies influenced by feminist perspectives² and analysis of power contributes to discuss cause, treatment and impacts in human life (see Bohm-Starke & Rylander, 2000; Elmerstig 2009; Engman 2007).

3. Conceptualization and overview of vulvar pain

Vulvar pain, as I mentioned above, consists of several conditions all located in the vaginal area. The definitions and borders between the vulvar pain conditions are unclear. Due to the explanations of the interviewees I mainly focus on two vulvar pain conditions, namely *provoked vestibulodynia* and *vaginismus*. In this chapter I offer a

three-dimensioned understanding of these conditions starting with diagnosis, historical background and prevalence. In the following chapters I will refer to the conditions as *vulvar pain* if nothing else is noted.

In the first section, *Diagnosis*, I explain the medical diagnoses and describe the physical pain. In *History of the medical condition*, I give an historical and cultural overview. The last section, *Prevalence of vulvar pain*, is rooted in contemporary society and approximates the amount of women experiencing vulvar pain.

Diagnosis

In this master thesis *vulvar pain* is the concept to illustrate pain in the vulvar and vaginal area since the interviewees and authors mostly talk non-specific about their genital pain. Vulvar pain includes women in all ages, stages in life and circumstances. The condition lack a clear medical definition and researchers struggle with establishing causes and treatments (Bohm-Starke, 2010). This section is designed to guide you to understand the conditions of *provoked vestibulodynia* and *vaginismus* in terms of pain sensations but also as a debated field of knowledge concerning cause, overlaps and treatments.

Provoked vestibulodynia

Vestibulitis, *Vulvar Vestibulitis*, *Vulvar Vestibulitis Syndrome*, *Vulvodynia* and *Provoked Vestibulodynia* are synonyms. Vulvodynia is a chronic pain syndrome that occurs in the genital area. It is sometimes considered to be a synonym to vestibulitis whereas others use vulvodynia as a generic to several genital conditions (see Bohm-Starke, 2000: 4832; Borgfeldt et al., 2010:319). Vulvodynia “[...] can be either generalized, affecting major parts of the vulva, or localized. The most common form is localized provoked vulvodynia, formerly known as vulvar vestibulitis syndrome” (Fugl-Meyer, 2013:84). However, the concepts: vestibulitis, vulvar vestibulitis and vulvar vestibulitis syndrome, was recently replaced with the term *Provoked vestibulodynia* (Sörensdotter, 2013:70). Reason for change is that the **itis** in

vestibulitis indicate inflammation, but clinical trials show conflicting results regarding inflammation in the vaginal area (Vulvar Pain Society; Bohm-Starke & Rylander, 2000:4833-48334). Patients sometimes show redness in their tender areas and therefore it might have been confused with inflammations, infections and skin problems but tissue samples cannot give any guidance, instead diagnosis are established through careful anamnesis, examinations and pain reactions (Borgefeldt et al., 2010:320; Gottlieb & von Schoultz, 2004:197).

Provoked vestibulodynia is a chronic³ pain disorder. Pain is triggered by the lightest touch and pain is commonly explained as a stinging, stabbing, itching or burning sensation in the external vulvar area (see Ayling & Ussher, 2008:294; Bohm-Starke & Rylander, 2000:4833; Elmerstig, 2010:2, 10-11). Provocations such as bike rides, sitting down, wearing tight clothes and sexual intercourse can trigger pain but pressure from gynaecological examinations, inserting tampons or touches are also painful (Bohm-Starke & Rylander, 2000:ibid; Sörensdotter, 2013; Borgefeldt et al., 2010:319-320). Studies have found that vulvar pain patients have more pain receptors than a healthy control group (Bohm-Starke & Rylander, 2000; Borgfeldt et al., 2010). There are no solid explanations for why the condition occurs but experts suggest that a range of casual mechanisms cause the painful state. For example, malpractice of antibiotics cause yeast infections, to treat yeast infections cortisol are prescribed making the skin thinner and therefore more sensitive (Borgefeldt et al., 2010:320).

Vaginismus

Vaginismus is an involuntary muscular spasm that makes it more or less impossible to insert any item. Penetration and thinking of penetration can trigger the muscular spasms, which make it almost impossible for women to insert tampons, fingers, go through with gynaecological examination or have penetrating sex (see Borgfeldt et al., 2010: 326-327; Engman, 2007:2; Elmerstig, 2009:10). Penetration can be possible but the muscular contractions are followed by pain and discomfort. Pain sensations are described as itching, stinging and burning. Gynaecologist Maria Engman concludes that “[p]ain after intercourse [...] lasted for several hours and was described with

words like burning and/or smarting, while pain during penetration was described as brief and with words like sharp/incisive/bursting” (Engman, 2007:64).

Researchers suggest that the involuntary muscular spasms derives from a psychological condition “[...] caused by unresolved psychosexual conflicts from early childhood” or is a “[...] protective symptom and a defence against a perceived fearful violation” (Engman, 2007:6). The term vaginismus was coined about 150 years ago and from the beginning it has been characterized by the closing reflex and later on it has become associated with sexual dysfunctions, lack of interest in sex, desire, arousal and orgasm (Fugle-Meyer et al., 2013:86; Swedish National Institute of Public Health, 2012:54). Today, vaginismus is categorized as *total primary vaginismus* and *secondary vaginismus*. Practitioners distinguish between the two states since *total primary vaginismus* is considered to be a phobic reaction whereas *secondary vaginismus* a pain disorder (Elmerstig, 2009:10). Pain related to intercourse is in medical terms described as *dyspareunia* and indicate a symptom rather than a diagnosis, whereas *vaginismus* is a diagnosis that include pain symptoms (Engman, 2007:39).

Overlaps

Provoked vestibulodynia and vaginismus occurs in different genital areas but Engman (2007) argues in her dissertation *Partial vaginismus - definition, symptoms and treatment* that many women diagnosed with provoked vestibulodynia also have vaginismus but that women with vaginismus not always have provoked vestibulodynia. Comparative studies show no evidence of difference regarding age, sexual debut, number of pregnancies, number of partners, experiences of sexual abuse or underlying genital infections (except for suspected HPV infections) between women with provoked vestibulodynia and a healthy control group (Borgfeldt et al., 2010:320).

History of the medical condition

Provoked vestibulodynia and vaginismus have different historical origin. Diseases are understood within a specific cultural context, allowing conditions to appear and others to disappear (see Hallerstedt, 2006:11-21; Kärffve, 2006). Vulvar pain is sometimes considered to be a new condition but medical and historical records show that vaginismus have been known for thousands of years while provoked vestibulodynia is a more contemporary innovation. In this section I contextualize vulvar pain historically and finish with a discussion of how diagnoses are dependent of the social perception of the body.

Vaginal pain in Medieval Europe and Ancient Egypt

In 1862 American gynaecologist Dr. J. Marion Sims conceptualized and published an article using the term vaginismus to define muscular spasms and hypersensitivity in the female genitals (Engman, 2007:1). French medical specialists had identified key elements of the symptom around the same time as Dr. Sims, but others suggest that Dr. Sims recognition, as the founding father, depended on his publishing skills (Cryle, 2012:71).

Vaginismus can easily be interpreted as a modern phenomenon rising with psychoanalytical scrutiny and development of the frigid woman but according to Engman:

Painful coitus has been described as far back as in ancient Egypt in the Ramesseum Papyri Scrolls (Costa Talens and Colorado Vicente 1971). The first known written description of vaginismus is nearly a thousand years old. Trotula of Salerno described in “The Diseases of Women” “a tightening of the vulva so that even a woman who has been seduced may appear a virgin” (Trotula 1547/1940) (Engman, 2007:1).

It is important to keep in mind that historical documents are translated and interpreted through a specific civilization’s lens. The sequence described in the papyri scrolls

from Egypt, descriptions of vaginismus in Trotula or today's publications are all historical documentations of societal understandings of the female body, sex, penetration, virginity and pain.

Popularity or discovery during the 1980's

American gynaecologist Edward Friedrich conceptualized provoked vestibulodynia in 1987. He described a group of women that experienced severe pain and discomfort in the area where vulva and vagina meet (also called vestibule area) (see Bohm-Starke & Rylander, 2000:4832; Vulvar Pain Society). Friedrich's description contained three criteria that are the basis for diagnostic assessments today. The criteria are "(1) severe pain upon vaginal entry, (2) pain on pressure to the vestibular area and (3) vestibular erythema" (Elmerstig, 2009:9).

Researchers agree that Friedrich first described and conceptualized the syndrome but medical doctor Julius F. Metts suggests that Friedrich along with Lynch and McKay renewed interest for vulvar pain in the 1980's, and add that very little was written about vulvodynia before 1980 (Metts, 1999). Although medical doctors Nina Bohm-Starke and Eva Rylander (2000) agrees with Metts, they also emphasize that others before Friedrich have documented aspects of the condition. Bohm-Starke and Rylander emphasize that gynaecologist Alexander Skene described vaginal hypersensitivity and redness in the vulvar area in 1928 (Bohm-Starke & Rylander, 2000:4832).

A Cultural Phenomena Rooted in History

Vulvar pain is sometimes assumed to be a new condition and is categorized as cultural diseases together with fibromyalgia and whiplash (see Johannisson, 2006; Sjöberg, 2001). Gynaecologist Inga Sjöberg suggest that vulvar pain is stress-related and that some people have a tendency to respond with their bodies (Sjöberg, 2001:423).

Physical pain is sometimes the consequence of the cultural environment. Karin

Johannisson, historian of ideas and science, mentions that vulvar pain threatens to tear the daughter of emancipation apart (Johannisson, 2006:35). Meaning that vulvar pain counteracts and threatens the emancipatory ideals of the sexually liberated woman. Diagnoses and diseases are culturally rooted and have the possibility to reflect social organisation and social understandings of phenomenon. Contemporary cultural understanding of vulvar pain associates it with stress and inability to participate in contemporary female ideals (Elmerstig et al. 2008; Sjöberg, 2001; Ayling & Ussher, 2008; Sörensdotter, 2013), however, the inability to participate in sexual practices have lined the story of vulvar pain for thousands of years (Engman, 2007:1). Instead of responding to current events, vulvar pain reveals a phallogentric gender order that have been situated in human civilization for a very long time.

Prevalence of vulvar pain

There are no sufficient statistics on how many women experiencing vulvar pain. Attempts have been made but unclear definitions of diagnosis and symptoms obscures the calculations. This section highlight the prevalence of vulvar pain and data collected.

Insufficient data and unclear definitions

Provoked vestibulodynia and vaginismus are primarily found among young women (Borgefeldt et al., 2010; Engman, 2007). Engman stresses that if practitioners make appropriate diagnostic efforts vaginismus is often found among women seeking help for coital pain (Engman, 2007:4). Since both vaginismus and provoked vestibulodynia have been debated, it is likely that both conditions demand careful and knowledgeable examinations to be discovered. Engman highlights that the prevalence of vaginismus depend on how the condition is defined and that it is unknown how many women are affected (ibid).

In 1996 and 2012 the Swedish National Institute of Public Health released publications estimating that 1% of the Swedish female population have experienced

vaginismus during the last 12 months (Swedish National institute for Public Health, 2012:54; also see Fugl-Meyer & Lewin, 2000, Engman, 2007). Midwife Inga-Lill Olsson and counsellor Britta Örjes Svensson (2006) estimates that 13% of all women have vaginismus. Engman argues that vaginismus is one of the most common female psychosexual dysfunctions and that Sexual Dysfunction Clinics report prevalence between 5-17% but that it is unknown how common vaginismus is in the whole population (Engman, 2007:4).

Other studies suggest that vulvar pain (vaginismus and/or provoked vestibulodynia) occurs among 1-15% of all women (Olsson & Örjes Svensson, 2006), while others suggest that 13-15% of all women are affected (*En handbok i vestibulit*). Other studies estimate that prevalence⁴ among women between 20-30 years old is 2-5% (Borgfeldt et al., 2010:327; Gottlieb & von Schoultz, 2004:197), while others suggest that 5-7% of all women have provoked vestibulodynia (*En handbok i vestibulit*). Translating these percentages into numbers, 1 % equals almost 48.000 of the female Swedish population whereas 15 % roughly affect 718.000 (Calculation based on population 2012, Population 2012).

4. Theory

The concept of *confession* is necessary to understand dimensions of vulvar pain. By using philosopher Michael Foucault's view on *confessions* I aim to organize women's (research material: 3 interviews and 41 letters) experiences and reflections of vulvar pain into patterns of pain management. Through the principles of confession it is possible to leave the issues of shame and instead address the organization of pain. In *The history of Sexuality vol.1*, Foucault investigates societal movements of sexuality and describes how confessions enabled sexuality to become scrutinized within intuitions of power. Confessional techniques brought out men's, women's and children's sexual behaviour and sexual desire with the purpose of regulation of behaviour, body, society and knowledge. Foucault's analysis of desire and sex is central to approach vulvar pain in terms of pain management since it shows how 'the

unknown' becomes organized internally, socially and institutional. By using confession as a theoretical concept I aim to understand vulvar pain on an individual as well as institutional level of organization.

Instead of focusing on confession and vulvar pain as a tool for outing one's experiences, the theoretical framework is designed to emphasize socialization and organization of human experiences and knowledge. The moment of confession is the end product of self-observations and reflections as it is the beginning of social organization. It is an instrument to induce accountability for one's actions and organize one's past into history⁵.

In the first section, *Purpose of confession*, I explain techniques and aims of confessions. The second section, *Regulation and organization*, emphasize how confessions becomes subjects of investigation, organization and knowledge. To discuss power and organization I use the female body as an example in the sub-chapter *Bodies and borders*. By doing so I aim to exemplify how the body and knowledge are rooted in contexts and accounts of truth and power. Overall, confessions are collected knowledge that appear on different levels and disappear into different slippery slopes, however, knowledge should not be mistaken for power; power is the producing force in knowledge (Ramazanoğlu & Holland, 2002:95). Foucault states:

If I had said, or meant, that knowledge was power I would have said so, and having said so, I would have had nothing more to say, since, having made them identical, I don't see why I would have taken the trouble to show the different relations between them (Ramazanoğlu & Holland, 2002:95).

The purpose of confession

As I mentioned above, confessions are crucial for understanding development of knowledge, for Foucault it is a matter of development in a contextual sense. According to Foucault, every epoch reflects a paradigm of thinking, a social

organisation of knowledge. Knowledge and the order of things signify a society in a specific time and place rather than a linear development of logic order of things (Miegel & Johansson, 2002:206).

Since the European Middle Ages, confessions have been the tool for reaching the truth in legal and religious contexts (Foucault, 1990:58). Truth is elastic, socially negotiated and follows an epoch's guiding principles, Foucault suggests that the truth was regulated and controlled by one's peers but by following paths of individualization the truthful confession became available to individual acts of vouching for one's own truth (ibid:58-59). The principle of confessions challenges the individual's ability to manage self-control and regulation. Confession is a process of self-observing every movement to finally reach into one's authentic self (Barsley & Peters, 2007:22). During the 17th century, questions formulated in confessional manuals became less prominent, importance of articulation and penance increased and so self-examination became rule to everyone (Foucault, 1990:17-21). Telling everything was a matter of revealing and summoning transparency, anything and everything that could relate the body and soul with sex was told. Nothing was insignificant or trivial; thoughts, actions, dreams, sensations, and arousals needed to be orally captured in order to reach control of sex (ibid:19-21).

Regardless of time, confessions are defined by the act of telling what is most difficult to say. It is not an easy and accessible story of truth but a piece of narrative that has been hidden in the corners of the soul (ibid:59). Detailed descriptions signify the confessor's story as if every detail count and as if every confessor has the position of being interrogated (ibid). Using a confession to share a state of being becomes a parameter to bring truth into a relationship but also to organize knowledge around specific matters. The method of confession is applied in everyday acts of life and "[...] plays part in justice, medicine, education, family relationships, and love relations [...]" (ibid).

In Foucault's analysis of sex and desire, confessions are a matter of reaching control and establishing discourses of sex (ibid:21, 61). The 19th century bourgeois continued

the previous era's oral fascination of sex with the goal of reaching the true nature of sex or at least creating a standardized truth of sex (ibid:69). Foucault suggests that it is "[a]s if it was essential that sex be inscribed not only in an economy of pleasure but in an ordered system of knowledge" (ibid). Sex became an object for science and a person's relation to sex was the fundament for categorization (ibid:68). Psychologists Kathryn Ayling and Jane M. Ussher suggest that not being able to perform sexual acts disrupts the social order of (hetero)sexual relationships (Ayling & Ussher, 2006:295-296). Following Foucault's line of thought, it becomes necessary to orally express and investigate the threat to make it manageable (Foucault, 1990:68). During the second half of the nineteenth century eugenics and the medicine of pervasion were two innovations in the techniques of sex, bodies became disciplined by sex and sexual relations were governed to suit the social body as a whole (ibid:118, 120-121). The medicalization of sex and re-location to the marital bed captures the heterosexual relationship within a social order of society (ibid:3). Distinction and categorization of bodies emerged as an effect of endless confessions of sex and desire, dissecting every hidden thought that appears in the bedroom, the private and the public (ibid:44-47).

Confessions are techniques designed to conform to relations of power. To associate confessions and truth with freedom is a mistake, instead, confessions of any truth is a product of power relations (ibid:60). For Foucault, confessions are means for subjectification. Confessing turns the inner, the personal, the singular and the private experiences into material foundations that allow processes of interpretation to localize and categorize the human experience within a societal framework.

Regulation, organization and knowledge

Foucault suggests that principles of the Victorian era remain in modern⁶ days. Logics of heteronormativity and monogamy are traces of Victorian organization of sexuality and desire (Foucault, 1990:3). Normalization processes of the sexual 'other' remains under the spell of confessions. Through the process of diagnosing the disease becomes real and it becomes possible to manage, categorize and investigate (Johannisson, 2006:30). Medicalization of the sexual peculiar was the instrument to

establish a natural order of disorder (Foucault, 1990:44). During the nineteenth century the concept of confession was transformed into being interpretable rather than a test, through these changes, confessional techniques was adapted to a scientific discourse on sex (ibid:67). Yet, the aim to control, relocate, displace and modify desire remained (ibid:23). Post-structuralist philosopher Judith Butler used the concept of the heterosexual matrix to explain how heterosexual practices reaffirm heterosexual behaviour as normative in terms of gender and sexuality (Butler, 1993:239). Disruption in these practices appears as deviant behaviour. Deviance can be explained as a consequence of pathological processes during the 19th century, in this time, the body was ground for specification of individuals and the body and bodily practices was organized as being natural (Foucault, 1990:47, 68). Not having or not being able to have penetrating vaginal sex are deviant actions, and having vulvar pain becomes problematic because these women are unable to perform standardized heterosexual behaviour (Sörensdotter, 2012; ibid, 2013).

Regulations concerning sex cannot be explained through one discourse of sex, it has to be viewed as several discourses that operate in several institutions and infuses areas of economy, politics, medicine, justice and pedagogy with these sexual discourses. Western societies' fascination of sex can merely be explained through the stubbornness of people's minds of revealing secrets (Foucault, 1990:33, 35). Sociologist Kenneth Plummer (1994) suggests in *Telling sexual stories* that techniques of confession and the demand to know everything linger and that storytelling is central in our symbolic interactions since it is a joint action among several practitioners (Plummer, 1994:20). Confessions are central elements to harvest knowledge. Like Foucault (1990) showed in his analysis of sex and desire, the regulations of sexual behaviour was constructed on notions of sexual practices. Sex became socially regulated but also regulated through institutions. Professions such as therapists, lawyers, doctors and scholars sought it out to be the ones reaching after the truth: the unveiled and the hidden, and by doing so they also claimed primacy of knowing (Plummer, 1994:21; Foucault, 1990:53-54).

Sexual stories reflect social organizations around specific matters, meaning that the

content and interpretation of sexualized stories shifts in accordance with societal changes (Plummer, 1994:26-27). Plummer exemplifies by re-telling a story about sexual harassment and points out that only a few decades ago it was told as a humorous story, placing the main character as a vibrant and potent male and the female as a non-negative receiver of this potent message, 20 years later the story is a crystal clear case of sexual assault and sexism (ibid:147-170). Plummer points out that stories, sexist or not, can reflect dominant ideologies of the moment of interpretation. It is not an attempt to reduce pain, suffering and injustice to discourses but a reminder that discourses are expressions of power. Similar to Foucault, Plummer focuses on the boundaries of society and how they are negotiated through relations of power and order of things. In the introduction to *the History of Sexuality, vol. 2*, Foucault explains that the analysis in *the History of Sexuality vol.1* is set out to investigate the games of truth and the pedagogy of truth which makes the truth an instrument of teaching, learning and revelation of knowledge (Foucault, 1990b:6-7). “[T]he games of truth and error through which being is historically constituted as experience; that is, as something that can and must be thought” (ibid). Illness and pain becomes a consequence of the knowing, it is processes of socialization and power that teach our bodies vocabularies of experiences.

I continue to convey the task of showing how material is moulded in accordance with society’s dominant perception of truth. Using the female body as an example, I will connect the techniques and logics of confessions to the machinery of knowledge production.

Bodies and borders

Entering the knowledge of body, Foucault acknowledges that the task of philosophers was replaced with the knowing of medicine. Apart from curing the ill and operating the broken, medicine also set out to “[...] propose, in the form of regimen, a voluntary and rational structure of conduct” (Foucault, 1986:100). Medicine began to define the way of living by establishing rules of relating to oneself, one’s body and the surrounding (Foucault, 1986:100-101). The body we recognize as female today has

not always been obviously female because of ovaries and vagina. Before the 18th century ovaries shared name with today's male genitals since it was believed that the female genital was the same as men's but carried inside the body instead of on the outside (Laqueur, 1994:15-18). Men and women carried different genders but their bodies were versions of one and the same. Women were men turned inside out because they lacked the vital heat men possessed and therefore less complete than men (ibid:17-18, 40). During this time, any body, male or female, had the ability to create vital fluids and convert them into other vital fluids and the power of the body also allowed women to turn into men (Laqueur, 1987:8). In the article "Orgasm, Generation, and the Politics of Reproductive Biology" Thomas Laqueur (1987) describes how sexual climax for both men and women were understood to be necessary for reproduction. But after the late 17th century, the view on physical abilities changed and the female body became a mystery: -a different other. Female sexuality and ability to lust was centralized in her clitoris and so the pleasures of sex became disconnected from experience and relocated in the body as a biological causal event of stimuli. Foucault's (1990) analysis in *The Will to Knowledge* show that the redefinition of desire to reproduction also moved sexuality into the marital bed, his analysis also shows that ideological shifts like these appear as epochs enter new sets of conduct. The individualization of sexuality and the individualization act of confessions develops in accordance with society (Foucault, 1990:114). That gender schemes over male and female practices evolve and organize abilities in accordance with biologically separated bodies are logical paths based on the notion and rise of two separate bodies. Butler suggests that gender and sexuality are two domains of power that are monitored and regulated in terms of theoretical apparatuses of heterosexual sexual behaviour (Butler, 1993:238).

The gendering and regulation of bodies implies that a body is more than flesh and blood, to separate the body from systems of gender, class and race would be an ontological mistake since they are the domains that shape and interpret the body. Sociologist Pierre Bourdieu used the concept of habitus⁷ to locate individuals within structures of power and show how structures are part of the physical body as collective and individual memories (Broady, 1991:41-67). The habitus is inscribed in

the body and affect a person's perception, actions and possibilities in life. Sociologist Annick Prieur puts it more eloquently:

Habitus denotes a socialized body, a structuralized body, a body that has adopted the structures of the world it lives within. The outer structures has become the inner structures, they form of mental schemes of perception and categorization of the world of perception and classification" (Prieur et al., 2006:39) (my translation).

A habitus is neither stable, static or temporarily, instead it is an on-going process of accumulation. The idea of habitus locates the body in history and denies the body to be the beginning, as well as the end, but rather a part of an on-going narrative creation. The consequences of the body depends on where the body is located, in sociologist Diana Mulinari's (2013) analysis of a Swedish hospital's birth clinic it was evident that the mother's skin color and cultural belonging settled the ground for perception. By analysing the staff's interactions and actions it became visible that the staff created different narratives based on the patient's origin due to skin color and cultural heritage. In these narratives, fair-skinned, western women was fragile and needed to be encouraged throughout the birthing process while giving birth was 'natural' for dark-skinned women from development countries. As a consequence, women from development countries were given less emotional support and fewer painkillers to ease the pain of giving birth.

Feminist methodologies make it possible to address the specificity of the body's historical descents. Standpoint feminists'⁸ emphasize the relation between power and knowledge, claiming that knowledge and experience are rooted in gendered structures that organize bodies due to their relation to power (Ramazanoğlu & Holland, 2002:60-65). In "Why has the sex/gender system become visible only now?" philosopher Sandra Harding (1983) points out that sex and gender systems are a fundament upon which societies organize. This notion does not deny any relevance of class and race analysis but emphasize that a body's sex and gender is rooted in structural organization of power. Following this logic, experiences of being a woman cannot be explained as a coincidence due to her biological sex but rather a

consequence of a social organization of sex. Experiences of structural oppression and discrimination due to gender are, according to standpoint feminists, products of knowledge and power relations that ultimately manifest in a shared material reality (Ramazanoğlu & Holland, 2002:73). This means that experiences are not individual and separate consequences of one person's life but rather a result of power relations. The borders of the body: one's sex, gender, sexuality, skin color, cultural belonging, and age, regulates access to fields and domains of power but also regulate access to emotions, experiences and knowledge.

5. Method and methodology

Finding interviewees proved to be a more comprehending task than I first imagined. My own experiences of vulvar pain became crucial to gain access to women and their personal stories of pain. To position the interviewees' stories of pain I have incorporated letters from 41 women. This chapter describes methods for interviews and the letters. The chapter also discusses methodological issues of power, knowledge and subjectivity. In the section *Selection procedure*, I describe how the interviewees and the letters were found and selected. In the section *Choice of method and ethical considerations*, I describe how the interviews were executed by applying a three-step model to enhance the interviewees' control of participation. My experiences of vulvar pain and impact on the material are particularly discussed in the final section, *Material and bias*, this section also introduces the research material.

Selection procedure

This master thesis does not attempt to generalize women's experiences of vulvar pain but rather to understand how women develop understandings of pain and how they manage pain. To reach this knowledge, in-depth interviews with three women were conducted and 41 letters to the editor (henceforth referred to as *the letters*) in a Swedish daily newspaper was reviewed. The first section, *The interviewees*, describes how women were found using a snowball effect and the second section, *The Letters*,

give an overview of material published in Swedish media and describes selection criteria.

The interviewees

In Sweden approximately 1-15 % of all women has vulvar pain (Borgfeldt et al., 2010:327; *En handbok i vestibulit*; Gottlieb & von Schoultz, 2004:197; Olsson & Örjes Svensson, 2006). Restricted access to patients developed into an ad hoc approach. To find women I launched a social snowball effect, questioning everyone in my social surrounding if they knew someone with vulvar pain and after a while three names appeared.

The three women I interviewed have experienced vulvar pain since their early teens. They started to approach the health care facilities when they were between 17 and 18 years old and has continuously tried to get help. Today they are 25, 26 and 27 years old and have received proper medical care during the last 2-5 years. All of the interviewees are brought up in Sweden with Swedish as their mother tongue and all interviews were executed in Swedish.

The letters

Searching Swedish media archives, *Retriever Research*⁹ and *Svensk Mediedatabas*, for produced and published material that mention provoked vestibulodynia or vaginismus. The search result was 390 articles in *Retriever Research* and 21 television and radio shows in *Svensk Mediedatabas* (*Retriever Research(a)*; *Retriever Research(b)*; *Svensk Mediedatabas(a)*; *Svensk Mediedatabas(b)*). The table below show an overview of search results regarding provoked vestibulodynia and vaginismus.

Retriever Research		Svensk Mediedatabas	
<i>Keyword*</i>	<i>Result</i>	<i>Keyword*</i>	<i>Result</i>
Provoked vestibulodynia	315	Provoked vestibulodynia	21
Vaginismus	76	Vaginismus	0

*Keywords were used in Swedish. *Vestibulit* (in english *provoked vestibulodynia*) and *Vaginism* (in english *vaginismus*)

Table 1. Media search. Swedish produced and published material concerning provoked vestibulodynia and vaginismus (Retriever Research(a); Retriever Research(b); Svensk Mediedatabas(a); Svensk Mediedatabas(b)).

In the material two major themes appeared; one regarding sex and relations, and the other focus on critique of the health care system and their knowledge of vulvar pain. The themes are either reflected through women's experiences of vulvar pain or through professional statements. Most of the articles emphasize the author's voice by using quotes and paraphrases from women with vulvar pain or experts.

Criteria of selection is that the material must be:

- published by a Swedish daily magazine
- a reflection of the woman's own experience of vulvar pain (provoked vestibulodynia or vaginismus)
- written by herself
- and that she identifies her pain to be provoked vestibulodynia and/or vaginismus.

The documented research material that met the selection criteria above consists of 41 letters published in *Svenska Dagbladet*. In 2005 the Swedish daily newspaper asked for letters regarding provoked vestibulodynia (see Lundbäck, 2005). 51 responses arrived and were published in their online magazine while 12 of them were selected for publication in print. Out of 51 responses one man responded and 9 women focused on other kinds of vulvar pain or commented in general, remaining was 41 letters (see Letters, part 1-7). Henceforth the women will be referred to as *the authors*.

Choice of method and ethical considerations

The interview method applied is a result of ethical considerations and strive to reach transparency in the interview process. In two separate sections I will describe the method for interviews and the method for coding the letters and interviews. In the first section, *Interview techniques*, I explain how I have used a three-step model to ensure the interviewees' power over their story as well as assure that stories are understood correctly. In the second section, *Coding the interviews and the letters*, I describe how letters has been coded in order to contextualize the interviews.

Interview technique

Qualitative research approaches demand different interview techniques depending on what the project is set out to investigate or answer (Kvale & Brinkmann, 2009:30). In this case, I want to understand women's experiences of vulvar pain and how they manage pain. Not knowing much about the interviewees' lives I decided to aim for an open dialogue. After explaining the interview procedure to one of the interviewees she decided to take part on two conditions: 1, no recording and 2, being anonymous. To meet her demands I decided to develop a three-step model that is influenced by feministic and participatory research methods to protect the interviewees integrity and maintain their control of their contribution (see Kvale & Brinkmann, 2009:48-49; O'Reilly, 2010; Borland, 1991).

The first step has an explorative approach to allow the woman to speak freely. When people talk from their own point of view the researcher becomes exposed to new themes and angles (Widerberg, 2002:99-100). In the second step selected themes and stories are secured by explaining how I understood their story so that the interviewee can give me feedback on how I understood it. Even if I understood the content in general, contexts went missing in the first session so by retelling and asking for details the story becomes more accurate and contextualized. The last step is designed to reach full understanding from the woman by describing how selected stories are used and analyzed. By explaining how the stories are processed and analyzed I

attempt to make the analytical process transparent. Even if the analytical process is executed in their absence the participatory element allow the interviewees to be part and comment on the process. Sociologist and ethnographer Karen O'Reilly describes that this way of localizing the interviewee in relation to the material procedure is to think of the interviewee as research participants instead of being passive informants or subjects. She claims that a technique to overcome material realities is to allow the researched to become part of the research process (O'Reilly, 2009:58-59).

The three-step model is an interview process where each step contributes to ground the research material. It is also an interview model that offer the interviewees space for reflection and control of their story. Every step equals one interview session so that the interviewees will have time to process and reflect over the last session. In this way the method creates opportunity to correct, withdraw or add statements from the previous session. Even if the three-step model is designed to be adaptable to the interviewees' preferences and open to new information from the interviewees it also continuously reproduce power asymmetry between the researcher and the interviewees. Psychologists Steinar Kvale and Svend Brinkmann emphasise that an interview is something else than a conversation between equal partners since the researcher always has primacy over the situation. For example, the researcher steer the conversation with questions to collect a rich material (Kvale & Brinkmann, 2009:49). The three-step model disturbs power asymmetry by sharing analytical thoughts and creates space for the interviewees to control and have impact on the research process, however, as Kvale and Brinkmann points out, the researcher and researched is not equal partners even if attempts are being made (ibid).

Interview sessions last between 60-180 minutes and the women I interview are aware that they control the story they share but that the analysis of the material belongs to me. Ethnographer Katherine Borland stress that interpretive conflicts may arise as a consequence of sharing ideas with the interviewee since perspectives collide (Borland, 2004:522-524). Borland's suggest that there is a difference between interpreting in relation to the analysis and interpret the situation in itself (ibid, 1991:64, 73). A story may need to be interpreted, contextualized and clarified so that the researcher receives

a detailed story but the interviewees cannot claim primacy of the analysis. For example, Borland's interviewee refuses to identify herself as a feminist but in the analysis it was clear that the interviewee conducted several feminist acts in relation to her societal context (ibid, 2004:532-533).

The three-step model is the result of one woman's refusal to be recorded. After she spoke up I told the other two that it is possible to do the interview without recordings. All of them were relieved and told me that they preferred to do the interviews without recordings. Researchers ethical responsibility is wider than just protecting people's anonymity, it also involves making the interviewee feel safe and being able to speak freely and not being forced or to feel judged (Kvale & Brinkmann, 2009:32-33). This set back made me aware that the interviewees might need time to actually tell me what they wanted and what they thought. Borland states that

The fieldwork exchange has a tendency to downplay differences, as both investigator and source seek to establish a footing with one another and find a common ground to from which to proceed to the work of collecting and recording oral materials (Borland, 1991:72).

Boreland points out that the interviewee and the researcher attempt to find a common ground overshadow the actual material the researcher is set out to collect. The fact that the interviewees waited to speak up until I presented an option is a sign that they tried to accommodate my research project. By applying the three-step model I attempt to reduce the tendency to downplay and enhance the possibilities of collecting women's experiences. During three moments the interviewees tried to express a decade of experiences and throughout the process the interviewees were able to change, add or specify their stories. The women were also able to follow the analytical process as well as point out analytical mistakes and help me bring the thesis forward; a full description on how the women helped me is described in the section, *Material and bias impact*.

Coding interviews and the letters

Qualitative research consists of different coding techniques but as O'Reilly describes the process of coding “[t]here is no formula for coding ethnographic data” (O'Reilly 2009:35). Coding is a technique to make the research material accessible (see Kvale & Brinkmann, 2009:217-221; O'Reilly, 2009:34; Winther Jørgensen & Philips, 2000:122).

The research material consists of 9 interviews and 41 letters, each material was coded into themes. Every theme had different subgroups that connected statements to the theme. For example, in the interviews women told me their medical history, apart from telling a linear story about how they reached professional care they also described feelings of neglect and powerlessness. Each part of their story was categorised and coded into keywords.

The themes that appeared during the interviews became guidelines for coding the letters. By strictly looking for material that aligned with the themes it was possible to cull information and avoid accuse of over-rapport¹⁰. The aim of highlighting themes in both sources is to show gaps and correlations with the interviewees' statements in relation to the letters. Codes can be both thematic and descriptive as long as they suit the study's requirements (O'Reilly, 2009:35).

Material and bias

In this section I describe material from nine interview sessions (three women times three interview sessions) and 41 letters as well as discuss bias and my impact on the material. In *Research material*, I describe and discuss the research material and briefly discuss how my experiences of vulvar pain helped me to access research material. In *Balancing act of involvement and accessing data* I continue to discuss how my experiences of vulvar pain affect the research material.

Research material

Research material consists of two sources; 9 interviews (and one text message) and 41 letters. The interview material is based on in-depth interviews with three women, approximately 17 hours of interview material. The interview material consists of notes and summaries that were written down during and after every interview session (research material presented in this thesis is translated from Swedish to English). Sociologist Karin Widerberg states that summaries display the researcher's interpretation but also offer an overview and a vivid picture of the interview session that might be lost in transcriptions (Widerberg, 2002:115). In the analysis, material from the interview sessions and letters are translated into English, the interviews are paraphrased in italics while the letters are quotes. People and places are unnamed in the analysis in order to protect the interviewees from recognition; this is done accordingly to recommendations from the Swedish Research Council report *Good Research Practice* (2011) and the International Sociological Association (2001).

Previous research on vulvar pain, using qualitative methods, has primarily recruited participants through clinics or hospitals (for example see Ayling & Ussher, 2006; Engman, 2007; Elmerstig, 2009; Sörensdotter, 2013; Sörensdotter, 2012). In Sörensdotter's study she reached out to find participants in online communities, blogs, vulvar pain societies and private contacts (Sörensdotter, 2012; *ibid*, 2013). Instead of turning to hospitals, blogs and online communities I applied a snowball effect and the women participating in this study identified themselves to be suitable. By doing so I was able to reach a group of women that have not yet been studied. The women I interview have managed their pain almost alone, none of the interviewees have read any significant amount of literature about the condition or actively reached out to others with similar problems. The women's stories have developed through self-reflection rather than processing experiences among peers (in writing, face-to-face or receiving others ideas), however influences from healthcare professionals has likely occurred.

The interview material consists of stories of how they have tried to get help, how pain

is present in their everyday life and decisions regarding pain. Sex and sexuality was discussed but the interviewees found this subject to be less important compared to pain, pain management, neglect and how pain affects social relations.

The 41 letters are responses to a request that the Swedish daily newspaper, *Svenska Dagbladet*, made to their readers in 2005 after publishing an article, “Smärtsamma samlag förbryllar forskarna” (my translation: “Painful intercourse perplex scientists”), interviewing researchers and midwives about vulvar pain. The editor asked readers to share their experiences or share ideas about causes (Lundbäck, 2005). Even if the article and the letters mainly concern provoked vestibulodynia it is likely that many of them also experience vaginismus. Engman’s study indicates that many women with provoked vestibulodynia can be diagnosed with vaginismus since she found that none of her participants had provoked vestibulodynia without having vaginismus (Engman, 2007:22).

The letters are likely affected by the editor’s request and the articles outline. After coding, eight themes appeared. The themes are: age when they started to seek professional care, amount of years with pain, sex and sexuality, amount of gynaecologists they visited, cause and treatments, best practice¹¹, and personality types. To exemplify how the article affected the readers’ response letters I quote the article’s introduction. This introduction summarizes the article and shows the themes I found in the letters.

More and more young women seem to suffer from painful intercourse. Nearly one in eight women between 20 and 29 years suffer. Several doctors have noted that many of them are high-performing and stressed. Other scientists believe that personality type does not play a role and that the relationship with repeated yeast infections is clearer. No doctor knows for sure. Therefore, treatment methods also tentative (Lundbäck, 2005) (my translation).

All of the eight themes can be traced in the example. Even if the letters are affected by the request and outline they describe 41 women’s reflections of vulvar pain and path to recovery. The letters has capacity to position the three women’s stories so that correlations between the interviewees’ stories and the letters appear but also to see

how the interviews differ in themes and details.

Balancing act of involvement and accessing data

Using my own experience to access the field and finding interviewees was helpful but using the same tacit knowledge to relate to interviewees and process interviewees and the letters puts me in danger of *being* native rather than *going* native. The concept of 'going native' refers to the colonial traces in anthropological studies, the term highlights how researchers became socialized into the community they were set out to research (O'Reilly, 2009:87-88). Even if 'going native' has an 'othering' dimension it also emphasizes how researchers lose sense of objectivity and distance (ibid:87). According to O'Reilly "it is recognised that complete physical and emotional distance is neither possible nor even desirable" (ibid:88). However, it is important to discuss how emotional and physical distances are beneficial or intrusive (ibid:89).

My own experience of dealing with vaginismus and provoked vestibulodynia for several years was crucial for accessing other women with vulvar pain; all participants agreed to be interviewed because they knew my history of pain. By sharing my own personal experiences of vulvar pain other women felt safe to talk about theirs. Sociologist Val Colic-Peisker describes in "Doing Ethnography in 'Ones' Own Ethnic Community. The experience of an awkward insider" that an insider status demand reflection of one's own experience and the biases shared with the interviewees as well as avoiding navel gazing (Colic-Peisker, 2004:91). Colic-Peisker proposes "a kind of self-awareness that recognizes the subtle important difference between constantly reflecting on one's limitations and responsibility, and being paralyzed by them" (ibid:93). Sharing, bonding and relating are not the same as *sharing an experience* or *feeling the same way* or *experiencing the same reality and demands from life*. Instead sharing is an instrument to grasp the relational habitat of the condition and the women in pain. Theoretical philosopher and phenomenologist Lisa Folkmarson Käll suggest that it is possible to share the experience of being in pain through the experiences of isolation and singularity that conceptualize pain (Folkmarson Käll, 2013:5-6). To distance my own experiences and to avoid making assumptions the interviewees

spoke freely and were only interrupted to clarify certain events. Widerberg suggest that it is possible to restrict personal impact over the material by collecting detailed stories even if the subject is familiar as well as allow themes and perspectives to appear without interference (Widerberg, 2002:99-100, 109).

The concept of objectivity within qualitative research can be strived for through different means. Kvale and Brinkmann (2009) make objectivity manageable by conceptualizing objectivity in relation to being 'free from bias'. They suggest that research material needs to be reflected upon and controlled in order to prevent bias to occur (Kvale & Brinkmann, 2009:260). After the reflexive turn during the 1980's, researchers began to think critically about how research had been conducted and under which conditions it had been produced, in this way the researcher became visible and power relations between researcher and researched became acknowledged (O'Reilly, 2009:187). During the interviews the women and I were able to address topics from a place of normality rather than deviance since I also experience vulvar pain. Talking about pain, pain management, sex, sexuality, relationships, and everyday practices was never entered to convince a listener but to reach detailed descriptions and prevent me from making assumptions based on my own experience. Occasionally I used my experience to exemplify so that the interviewee could position her experience to something. Locating oneself in the ethnographic writing is a technique to "confront your relationship with others, it means conveying the context and your place in it" (ibid:191).

Kvale and Brinkmann suggest that by 'allowing the object to object' objectivity is achieved in similar terms as the natural sciences since the object is given the power to prove the experiment wrong (Kvale & Brinkmann, 2009:261-262). The three-step model used for interviews is designed to create opportunity for the women to retell, change, and withdraw statements and thereby control their material but it was not designed for full participation in the analytical process. Instead of striving for objectivity in this sense, objectivity was rather strived for by openness to the women's stories, ideas and reflections but also through critical reflection of my impact and how to restrict my influence.

6. Analysis

Three years ago I, almost by mistake, discovered that my body were in pain. Behaviour that I earlier had interpreted as bad tempers; rage, anger, irritable, and passive aggressiveness, was actually connected to pain - pain that I had taken for granted and thought was normal. I never struck me that vulvar pain could affect the whole me and be apart of my everyday life. Most research regarding vulvar pain concern medical assessment, treatments and causes (Bohm-Starke, 2010:1504,1508). This analysis focuses on medicalization of the female body by investigating discovery processes and paradigms of knowledge.

The analysis is divided in two sections, each subchapter consisting of three subchapters. All sections reflect aspects of how confessional techniques are used in relation to understanding and management of vulvar pain. The first section *Pain* discusses what pain is and focus on discovery process. In *Pain and making sense of the unknown*, the analysis begins by discussing pain and the pedagogics of pain that medical institutions use as a strategy to develop women's knowledge of vulvar pain. Pain can be an abstract experience but in relation to certain actions pain becomes less abstract, in *Disrupted heterosexual acts* I discuss how vulvar pain abrupt heterosexual acts of vaginal intercourse and that this abruption becomes cause for women to seek medical treatment. In *Communicating pain and persistently seeking treatment* I emphasize women's efforts of reaching proper medical treatment but also discuss how women are mistreated, misunderstood and educated by medical professionals.

In the second section *The subject in pain* I discuss the medicalization of the body and how women manage vulvar pain. In *Resist and Challenge. Re-contextualizing vulvar pain and the women behind the condition* I discuss how women with vulvar pain have been identified with specific personal traits but that these traits can be viewed as an effect of a sifting medical system. In *Appearing to be "normal"* I highlight society's obsession with truth telling and categorization. In order for women to maintain a position of normality they refuse to reveal pain. The refusal can be viewed as an act of control, in *Controlling pain* I emphasize that society has established space for pain to

thrive while in other places pain becomes inconvenient. Women's desire to control pain also drives them to take charge of pain physically and emotionally.

Pain

About 1-15 % of all women in Sweden are estimated to have vulvar pain (see Borgefeldt et al., 2010; Olsson & Örjes Svensson, 2006; Gottlieb & von Schoultz, 2004; Fugl-Meyer, 2000; Swedish National institute for Public Health, 2012:54). As I explained in previous chapter 3, subchapter *Prevalence of vulvar pain*, opinions regarding prevalence of vulvar pain are divided and diagnostic assessments are debated. Unclear definitions make it difficult to estimate the prevalence of vulvar pain but it also affect women's possibilities to get treatment. After reviewing the 41 letters and interviews I realized that neglect, mistreatments and mistrust lined the women's interaction with health care institutions. This section focus and explores the concept of pain: pain as individual awareness and how pain is taught by institutional care facilities.

In the first subchapter, *Pain and making sense of the unknown*, I describe the how the confessional techniques of self-observations are necessary in order to become aware of pain and being able to organize the experiences of pain by associate pain with situations and emotions. In *Disrupted heterosexual acts* I explain how vulvar pain becomes a concrete feeling of hurt since it abrupt the 'natural' act of penetrating vaginal sex. Pain during sex makes it possible for women to confess pain, however, the significance of pain during sex is less critical compared to other painful situations. In *Communicating pain and persistently seeking treatment* I discusses the clash between an institutional view of vulvar pain and the individual's experience of pain. This part describes women's attempts to find proper medical care and how they try to convince medical practitioners of their pain.

Pain and making sense of the unknown

In the HBO produced TV-show called *Sex and the City*¹², one of the female characters,

Charlotte, finds out that her vagina is depressed. The doctor explains that she has vulvodynia (another name for provoked vestibulodynia or generic for vulvar pain). After the appointment she meets and tells two of her friends.

Friend 1 asks: *How do you know your vagina is depressed?*
Charlotte replies: *There are symptoms* (Charlotte's doctor explained the symptoms: stinging, itching and burning)
Friend 2 comments: *Like what, it can't reach its deadlines?*
[...] Everyone laughs (Sex and the City, 2001).

In the episode, vulvodynia is thought of as a minor condition, however, the TV-show pinpoint that women are unaware of the existence of vulvar pain.

One of the interviewees had heard about the condition before realizing that she also had it while health care professionals introduced the other two to the condition (Interviewee, 1; Interviewee, 2; Interviewee, 3) (my translation).

In the letters, women testify that they realized that they had vulvar pain after seeking treatment for other conditions such as yeast infections. One of the authors write "Everything looked normal and nothing helped.[...] I also believe that my experience of pain got worse since no one seemed to know about the condition" (Letter 3:1) (my translation). Unawareness of vulvar pain appears in the social circle among friends, in medical institutions and in the mind of women with pain.

Stinging, stabbing, itching and burning are commonly used to describe pain in the vulvar area (see *Handbok i Vestibulit*; Olsson & Örjes Svensson, 2006). These descriptions also appear in the letters but pain is mostly referred to in terms of degrees of pain. I asked the three interviewees to explain their pain, all of them found it difficult to explain. Folkmarson Käll suggests that pain is an individual experience but that it becomes sharable through the collective conception that pain is individual suffering. She claims that pain is a self-referential experience that is sharable through the experience of isolation and singularity that conceptualize the experience of pain (Folkmarson Käll, 2013:5-6). Poststructuralist and philosopher Jacques Derrida

suggests that pain for example occurs in relation to the absence of pain and that the concept of pain is collectively rooted in systems of difference (Miegel & Johansson, 2002:204-205). Based on Folkmarson Käll and Derridas concepts, being in pain are the relation of not being in pain as well as the absence of collective.

Being in pain is a shared notion of an individual emotion and even if emotions are abstract, I continue to ask the interviewees to explain their pain so that I can understand their concept of vulvar pain.

One of them said that it simply hurts, I asked her to develop her answer, she explains that she never spend much time thinking about how it hurts, she just notices it and try to move on regardless of if it occurs in her vulvar, arm, jaws or head (Interviewee, 2) (my translation). The other two answered that it has become easier to explain pain since they started their rehabilitation two years ago. Rehabilitation activities at the clinic, between 3 times a week to once every other week, has helped them to attach words with the kind of pain they are feeling (Interviewee, 1; Interviewee, 3) (my translation).

Foucault suggests that confession is pedagogy of self-observations with the aim to transform desire into discourse (Foucault, 1990:19, 21). During the 17th century it was rule for everyone to “[...]telling oneself and another, as often as possible, everything that might concern the interplay of innumerable pleasures, sensations, and thoughts which, through the body and the soul had some affinity with sex” (ibid:20). One of the authors was encouraged by the vulvar clinic to write a pain journal and through the documentation she realized that her pain got worse when she was stressed (Letter, 3:1). The other authors also describe how they reached pain awareness through careful self-observations.

The three interviewee’s rehabilitation consists of meetings with a team of physiotherapists, sexologists, gynaecologists and midwives. The interviewees began their current treatment 2-5 years ago, during this time they have tried several treatment strategies such as: acupuncture, body awareness through physical exercises,

verbal awareness, pelvic floor exercises, ligaments massage, dilators, analgesic gel and bio-feedback. Through the rehabilitation processes the women has gained more knowledge of which state their bodies are in and recognize when pain will fade away. Associating words with pain sensations has helped the women to organize pain experiences (Interviewee, 1; Interviewee, 3) (my translation).

In similarity to Foucault's (1990) analysis of desire, abstract elements such as pain and desire are contextualized for the benefit of control and regulation. Self-observations to identifying pain sensations and situations that trigger pain are pedagogic strategies to control pain through discourses. The rehabilitation pedagogics has helped the interviewees to reach bodily awareness, knowledge of different states of pain, and provided the interviewees with words to describe different pain sensations.

Two of the interviewees explain that vulvar pain consists of different types of pains: it can sting or be itching and irritating and last for a long while but it can also be short and intense and feel like being stabbed with a knife (Interviewee, 1; Interviewee, 3) (my translation). One of them explains that her vulva feels uncomfortable; as if her underwear is misplaced. Her pelvic contractions are more or less constant and says that it is almost as if her body tries to suck her vulva inside (Interviewee 2) (my translation). Another explains that it is almost as if her mucous are fragile: wearing tight jeans or being in a swimming pool irritates her vulva and pain can last for a long while afterwards (Interviewee, 3) (my translation). The third one says that she is not in constant pain but that she finds it difficult to sit for a long time and that it can hurt for a couple of days after having penetrating sex (Interviewee, 1) (my translation).

In similarity to the authors, the interviewees mostly describe pain in areas or in relation to degrees of pain but they refrain to explain pain in relation to other experiences or emotions. In this sense, the research material supports Folkmarson Käll's conclusion that pain is self-referential (Folkmarson Käll, 2013:5-6). The pedagogy of pain awareness is reached through self-observations and documentation

of pain sensations. Every moment, every situation is organized in patterns to detect when pain is triggered, increasing or easing. Through pain awareness pain becomes less abstract and it becomes possible to evaluate recovery strategies, organize the experience of pain and take calculated risks.

Disrupted heterosexual actions

According to previous research vulvar pain occurs among women between 20-60 years old but it is primarily found among young women, the average age is 25 years (Bohm-Starke & Rylander, 2000:4832; Borgfeldt et al., 2010; Engman, 2007; Metts, 1999:2). Comparative studies between women with vulvar pain and a healthy control group shows no differences regarding first intercourse, pregnancies, sexual partners, experience of sexual abuse or sexual transmitted diseases (Borgfeldt et al., 2010:320). Based on the previous chapter I suggest that vulvar pain is something women realize and by having a language to explain pain it is also possible to become aware of how long one has been in pain.

I ask the interviewees for how long they have had vulvar pain and all of them answers that they probably have been in pain since their early teens but that they started to seek help when they were 16-18 years old (Interviewee, 1; Interviewee, 3) (my translation).

The act of seeking help signifies acknowledgement of vulvar pain as a case of institutional pain. In the letters, 23 women writes about how old they were when they first experiences vulvar pain or states how many years they have been in pain (see table below for full data overview). Seeking treatment for vulvar pain is preceded by gynaecological visits for prescriptions of birth control pills, yeast infections and pain during intercourse, none of the authors have approached health care institutions for general vulvar pain.

Current age	28	30	30	30	32	33	39	40	?	50	63	?	?	?	?	?	?	?	?	?	?	?	?	?
Age first time feeling pain	18	29	22	15	30	26	24	20	40	?	4	?	16	?	?	?	?	?	?	?	?	17	13	22
Years in pain	?	?	?	?	2	?	?	10	4	50	?	18	?	5	5	25	7	2	3	>	14	6	?	?

Table 2. Pain. Overview of 23 authors current age, age for the first time feeling pain and years they have been in pain. The upper row show the authors current age, the second row shows when she first experienced vulvar pain and the third row show how many years she has had vulvar pain. The question mark (?) indicates unknown data.

For the interviewees and authors, vulvar pain becomes concrete or at least less abstract in relation to penetrating sex.

All of the interviewees began to seek help at youth clinics. One of them tells me that when she was 16 or 17 she visited a youth clinic because it hurt when she had sex. She knew that sex could hurt in the beginning but in comparison to others it seemed to be worse. At the youth clinic she explain that having sex feels like if she is dying. The staff responds by telling her that sex hurts in the beginning and recommended her to relax (Interviewee, 1) (my translation).

Elmerstig’s study shows that many women with vulvar pain agree to have sex even if it hurts, her research display how sexual practices of vaginal intercourse are infused with ideas about femininity and pleasure that affect not only women with vaginal pain (Elmerstig, 2009:5). However, I believe that age is crucial. In Elmerstig’s (2009) study, the women were between 13-22 years old whereas my interviewees are in their mid twenties.

None of the interviewees have felt pressured to have sex. Two of them have ignored pain and had sex even if it hurt. None of the two were afraid to deny their partners penetrating sex but they lacked an explanation to why they were in pain and thereby reasons for being in pain (Interviewee, 1; Interviewee, 3) (my translation). One of the two says that it feels as if she has let herself down and that she is ashamed over how she used to ignore the fact that she was in pain. She is also ashamed that she lets her current boyfriend hurt her because she knows that he would never hurt her intentionally (Interviewee, 3) (my translation).

Before I continue I would like to emphasize that it is important to see that gender patterns strike on both men and women and that the 'natural' act of sex and the dominance of heteronormative behaviour affect people regardless of sexual belonging (Butler, 1993:329). I will continue to discuss heteronormativity and how penetrating vaginal sex has become 'normal' but also emphasize how the women becomes motivated to seek institutional care treatment.

Based on Butler's notion that the body becomes material through normative regulated discourses that affect perception of biological sex, gender and actions, Sörensdotter suggest that sexual practices constitute humans as subjects (Sörensdotter, 2012). Sörensdotter claim that women with vulvar pain are unable or find it difficult to fulfil the ideal of the natural sexuality that is manifested through the act of vaginal penetrating sex (ibid). Correlations between inability to have penetrating sex and seeking health care assistance are not coincidental but could be the casual effect of disruption in sexual acts.

The conception that sex hurts in the beginning is also part of the sexual scripts. In the letters, sex and sexuality are central for detecting pain but the discrepancy between sex and desire is also ventilated. Both the interviewees and the authors testify that they have sexual lust and desire but that penetrating sex is more or less impossible due to pain and spasms. 9 of the authors claim that they actively avoided sex and 14 of them have continued to have sex even if it hurts (Letters, 1-7).

Sexual scripts are maintained by the act of sex but also within the discourse. The organization of sex is socially and culturally rooted in the system of economics, politics, culture and mind. Foucault suggests that in the West during the 19th century two logics of sex were conveyed: the biological reproduction of sex and the medicine of sex (Foucault, 1990:54). Sexuality embodies the truth of sex and sexual pleasures that has been harvested through scientific confessions (ibid:68). The *scientia sexualis* deploy the notion of normal as heterosexual and reproductive sex (ibid:3, 68-69). Disruption in these practices appears as deviant behavior. Deviance can be explained as a consequence of pathological processes during the 19th century, in this time, the

body was ground for specification of individuals and the body and bodily practices was organized as being natural (ibid:47, 68).

Sörensdotter's sexual scripts of vaginal penetration confirm the reproductive 'natural' act of sex but also the logic of heterosexual medical sexuality (Sörensdotter, 2012; Foucault, 1990:55). The focus on previous research that incorporates social aspects of vulvar pain primarily process aspects of sex and sexuality. The disruption of sex is problematic for women since it challenges their femininity (see Sörensdotter, 2013; Sörensdotter 2012; Ayling & Ussher, 2008). Ayling and Ussher noticed that 6 out of 7 women claimed positions of being inadequate women, thinking that they were failures for experiencing pain during sex and feeling shame that their pain affect their ability to satisfy their partners sexually (Ayling & Ussher, 2008:294). However, the inability to perform vaginal sex and disruption in women's acts of femininity has to be understood as cultural. Critiques of cultural blindness, phallocentrism and a westernized view on women, sex, sexuality and femininity has been raised in previous research (see Ng, 1999:13; Engman, 2007:7). These critiques are necessary to take into account when approaching vulvar pain. That vulvar pain becomes problematic due to sex and sexuality is a matter of the social organization around sex and sexuality that constitutes us as subjects (Sörensdotter, 2012). Ayling and Ussher suggests that women are motivated to engage in painful coitus in order to maintain their status as desirable women, heterosexual and sexual partners (Ayling & Ussher, 2008:296).

Women's tendency to seek help for vulvar pain correlated with the emergence of pain during and after sex, Engman claims that vulvar pain syndromes are often found among women seeking help for coital pain and that pain after intercourse can last for several hours (Engman, 2007:4, 64). Women seeking help for vaginal pain in relation to sex indicates a disruption in the heterosexual act of the natural vaginal penetrating sex. Vulvar pain becomes visible through the disruption and legitimizes the act of seeking help to become 'normal' again. According to Ayling and Ussher, coitus is the organizing feature of hetero-sex and "heterosexual women's experience of vulvodinia might be understood to emerge within her simultaneous negotiation of dominant

discourses of femininity and heterosexuality [...]” (Ayling & Ussher, 2008:296). Even if sex is central for women to realize vulvar pain and seek treatment the dominance of vulvar pain as a sexual disorder is overshadowing the fact that vulvar pain is primarily a pain syndrome. Ayling & Ussher emphasize that vulvodynia (vulvar pain) and dyspareunia (coital pain) are similar to other pain syndromes and meets all the criteria’s for pain disorders according to standardized diagnostic assessment, DSM-IV, as it also occurs during other activities that involves pressure and penetration (ibid:295).

The interviewees speak about sex in relation to seeking pain treatments but vulvar pain as a disruption in their heterosexual scripts seems to be less significant.

All of the interviewees state that they feel secure in their sexuality and that it has been reached through sexual development similar to their peers. For the interviewees, sex has a restricted impact in their concept of vulvar pain. For them sex is not the act of penetration, instead sex can be executed in other ways (Interviewee, 1; Interviewee, 2; Interviewee, 3) (my translation).

Development of other sexual solutions has helped them to control pain in relation to sex but also to renegotiate the demands of vulvar pain. Sex and sexual desire is not absent in their lives but performed to accommodate the pain and dominance of heterosexual practices, in this way sex becomes less problematic in terms of pain. Instead, other situations that triggers or reveals pain are more significant.

Taking the bus instead of cycling, sitting for too long, leaving early to meet the doctor, engaging in physical activities, wearing jeans or tight clothes, using tampons, standing for too long, being stressed, and not being able to tell your friends are all situations that are more important than having sex (Interviewee, 1; Interviewee, 3) (my translation).

The situations mentioned above are more important than having sex because the situations impact the everyday life and identity of the interviewees. I will continue to

discuss the impact of pain in everyday life in chapter *The subject in pain* (the last two sections; *Appearing to be “normal”* and *Controlling pain*). But first I will discuss women’s contact with institutional health care in the next chapter, *Communicating pain and persistently seeking treatment*. In this chapter you will discover that the women visits several doctors in order to get heard and find treatment. You will also discover that heterosexual and normative values continue to organize perceptions of women’s bodies, desires, sexual- and biological abilities.

Communicating pain and persistently seeking treatment

Records of mistreatments regarding vulvar pain are evident in medical literature (Ayling & Ussher, 2008:295) and careful medical assessments are recommended (Engman, 2007:4). The authors suggest that repeated treatments for yeast infections and birth control pills have caused vulvar pain. Many of them have visited several doctors without diagnosis and getting help. Two of them state:

After going several times I have stopped going to the gynaecologist, I cannot stand the thought of being poked and examined without being helped (Letter, 7:4) (my translation).

Autumn 1997 was the turnaround, after meeting about 20 gynaecologists, I got an appointment at the XX-hospital, and the first thing I said to the doctor was that I wanted a diagnosis or I would not leave (Letter, 6.3) (my translation).

Both the interviewees and the authors have experiences of persistently seeking help and trying to get through. The interviewees’ stories of how they found professional care stretches over a few years and all of them have experiences of neglect, mistreatment and mistrust. Two of the interviewees have been tested for herpes whereas one of them went through two treatment procedures even if she was tested negative for herpes twice (Interviewee 1, Interviewee 3). Both the interviewees and 13 of the authors have been treated for several yeast infections. Previous research acknowledges that these errors commonly occur (see Engman, 2007; Ayling & Ussher, 2008). Meetings with health care professionals are lined with mistreatment, mistrust

and discrimination but also heterosexual normative ideas about sex, sexuality and how women should behave are evident in the interviews.

One of the interviewees tells me that she always had a positive and relaxed relationship to health care but that it has changed due to all nightmare doctors and gynaecologist she met during her quest for help (Interviewee, 2) (my translation).

I will continue to retell the story of one of the interviewees but before doing so I would like to emphasize that the three interviewees and the authors of the letters have experiences of visiting several doctors without getting proper medical attention. Instead, they become lectured, ignored, mistreated and mistrusted. Metts claims that “patients with vulvodynia have been diagnosed with a psychological problem because of the lack of physical findings” (Metts, 1999:10). Lack of physical findings can be one explanation to why women with vulvar pain are being ignored, lectured and mistreated but after the story I will also discuss the impact of gender structures and normative heterosexual practices.

When the interviewee was 18 she contacted a midwife to find out the cause of her vulvar pain. The midwife could not find anything wrong and recommended her to visit a gynaecologist but the midwife never remitted her to a gynaecologist. A year passed and she moved to another city and made an appointment with a youth clinic. The employees at the youth clinic were tentative to her needs and took her pain seriously. When she requested a female sexologist they respected her request and while she waited they arranged for her to see a counsellor. After a while she got an appointment at a women’s clinic. This is the story of the interviewee’s efforts to communicate her story vulvar pain after being remitted to the gynaecologist for vulvar pain (Interviewee, 2) (my translation).

The interviewee says (this section is written in ad verbatim during the interview):

At the women’s clinic, I met the biggest bitch ever. This woman was a nightmare gynaecologist, completely lacking competence, empathy and humility. She was

terrible and judgemental but apparently one of the best. After meeting her I cried for six hours. Before I met her I was nervous and she clearly saw that I was upset so she told me that I should be happy (read: thankful) to see her. It was clear that she ignored my story of pain and it felt as if she overlooked important parts of my medical history. For example, she completely ignored that sex didn't hurt and wrote in my remittance (to another clinic) that it did. When I told her that I just started to have sex with men I could see her delight. That I had left the dark side (read: women), she assumed that I would continue to see men and that my sexual experiment was a crisis. It never seemed to occur to her that it is possible to have sex with both men and women. She wanted me to tell her about my feelings and if I was in love. When I told her that it is not necessary for me to love in order to have sex, she was offended and told me that Mr Right had not showed up yet. I was 19 years old and my only explanation for pain, so far, was that I haven't met Mr Right. After the education in sex and emotions she said that she wanted to take a look to rule out any physical condition. After one glance she said, "oh my God, it's not strange you're in pain with all those tensions". I felt angry because it seemed as if she wouldn't do anything about my pain so I told her that I know that this pain isn't normal because I have talked about this with my friends. As a favour to my friends, she booked me an appointment with a sexologist because according to her: your friends don't want to listen to your troubles anyway (Interviewee, 2) (my translation).

Being in pain is never just about the pain itself but rather about who has it and how it deviates. It is easy to interpret actions as isolated events but according to the other interviewees and the letters it is common that vulvar pain patients are ignored or object to heteronormative discourses. Ayling and Ussher states that practitioners and gynaecologists misunderstand and fail to recognize vulvodynia (vulvar pain), resulting in misdiagnoses and mismanagement for many years even if one in ten women are affected (Ayling & Ussher, 2008:295). Lack of knowledge concerning vulvar pain is not coincidental but an effect of resource distribution. Bohm-Starke concludes that vulvar pain has received more medical attention during the last 30 years but compared to other medical disorders studies are few and the studies has low scientific basis (Bohm-Starke, 2010:1507-1508). The lack of knowledge in vulvar

pain cannot be explained by its rarity, it is not classified as rare pain disorder¹³, instead we have to turn to the fact that vulvar pain commonly occurs among young women. Disorders that affect young women are not coincidental but an effect of gendered structures that negotiate the terms of women's conditions of life. Analysis of women's position in relation to men shows that gender is an organizing factor in relation to power and access to resources (Ramazanoğlu & Holland, 2002:60-65; Harding, 1983).

Foucault suggests that medical knowledge concerning sex and sexuality regarding the female body are designed to endure women's reproductive skills within the family space to accommodate the social body (Foucault, 1990:104). The clinical listening methods of confessions are tools to establish and govern the discourses of sex (ibid:68). I will not go into detail and dissect every sentence of the interviewees' statement but the conversation illustrates how women's vulvar pain becomes problematic in relation to sex and how women's sexual relations are objects for subjection. Sörensdotter claim that vulvar pain disrupts the heterosexual act of 'normal' vaginal sex (Sörensdotter, 2012). The gynaecologist's attempts of reconnecting sex with love and redefine pain with sex can statue examples of how vulvar pain interrupts the 'normal' act of sex between two lovers rather than between strangers. The reconnection of sex and monogamy can also be viewed as an attempt to govern the act of sex. Disruption in the heterosexual and sexual actions are transformed into deviance but the state of pain remains unsolved.

For the interviewees, presence of vulvar pain occurs more or less every day. Coital pains are one aspect of vulvar pain but cannot explain the whole gravity and impacts of pain. In the following chapters I will discuss how vulvar pain affects women. In the first chapter I discuss how the persona behind the condition, namely that women with vulvar pain, are considered to have common personal traits that makes them ill. In the second chapter I discuss how women manage vulvar pain by creating spaces of existence and the game of hiding pain by appearing 'normal' and in the last chapter I discuss how women use the strategies of confession to control pain.

The subject in pain

The previous chapter *Pain* discusses how women with vulvar pain realize that they are in pain and how their pain becomes problematic in relation to heterosexual practices. The previous chapter also highlights how women try to convince practitioners of their pain but become ignored, mistreated and subjects for heterosexual education. This chapter discuss the subject in pain and focus on how women becomes subjectified but also how women use the techniques of confession to understand their pain and thereby resist subjectification and attempt to control pain socially.

In the first section, *Resist and challenge. Re-contextualizing vulvar pain and the women behind the condition*, I show how medical publications attempt to conceptualize bodily features: personal traits, behaviour, skin color, class belonging and body type, while, the women and I suggest that the medical characteristics are an effect of difficulty to access proper medical care. The section also highlights how women resist and reflect upon the medical conceptualizations by using the knowledge gained through confessional techniques. In *Appearing to be "normal"* I discuss society's obsession of confessions and how the women hide their pain in everyday situations to avoid telling or revealing pain. The last section, *Controlling pain*, continues to focus on how women manage pain by controlling the impact of pain and restricting acknowledgement of pain to specific situations.

Resist and challenge. Re-contextualizing vulvar pain and the women behind the condition

Who is the woman with vulvar pain? Psychologist and sexologist Peggy Kleinplatz has summarized knowledge concerning vaginismus. In her overview she show that vaginismus is believed to be a psychosomatic illness, that women with vulvar pain are afraid of sex due to fear of painful intercourse (Kleinplatz, 1998:52). It is also believed that vulvar pain is the result of sexual assault or abuse or has a negative attitude towards their bodies and sex (ibid:52:53). Psychodynamic perspectives

explain the origin of vaginismus to be a protective mechanism for ‘good girls’ who are unable to say no and has tendency to passive aggressiveness. Women with vaginismus are girls who are unwilling or unable to verbalize anger and have a need to please and have unresolved problems with dependence and gaining control (ibid:53-54). Other explanations are that these women strive for perfection, are depressed, have an immature psychosexual development and “unconscious partial masculine identifications deriving from fantasy introjects of a stern sadistic father” (ibid:53; Özdel et al. 2012).

Midwife and Sexologist Eva Elmerstig (2009) states in her dissertation *Painful Ideals* that women with provoked vestibulodynia have a tendency to avoid harm and that depression and anxiety are common personal traits among women with provoked vestibulodynia. Chronic stress and general body pain (such as headache, fatigue, stomach ache, muscular-skeletal pain) are more common among women with provoked vestibulodynia than a healthy control group (ibid:9-10). Metts suggest that provoked vestibulodynia almost exclusively affect white women (Metts, 1992:2). After reviewing women remitted to a vulvar clinic¹⁴, Bohm-Starke and Rylander concluded that 97% of the patients were white but states that women with provoked vestibulodynia shows no medical, psychological or sexual difference from a healthy control group or have been more exposed to sexual abuse and sexual assault (Bohm-Starke & Rylander, 2000:4832, 4834-4835). Metts also suggest that risk-taking sexual behaviour is rare among women with vulvar pain and that few have had sexually transmitted diseases (Metts, 1999:2).

The letters was preceded by the article “Smärtsamma samlag förbryllar forskarna” (English title, my translation: “Painful intercourse perplex scientists”), the article contains quotes from medical researchers (Lundbäck, 2005). Sjöberg claims that women with vulvar pain are almost exclusively intellectual women with limited childhood years and that stress has been inherited from their parent’s lifestyles. She states that:

They are beautiful and thin with many projects running. The

condition is common in university areas. If a round and happy girl from Västerbottens15 midlands visits me and says that her vaginal area hurts, I know that it cannot be provoked vestibulodynia but something else (Lundbäck, 2005) (my translation).

Vulvar pain has an unclear origin and this can explain the shifting ideas concerning causes (see Borgfeldt et al., 2010:320; Bohm-Starke & Rylander, 2000). Not all medical researchers agree with Sjöbergs statement and Medical doctor Ingela Danielsson responds that there is no research support for Sjöbergs statement (Lundbäck, 2005). Ayling and Ussher emphasize that:

Psychosocial etiological pathways, such as personality characteristics, psychopathology, history of sexual abuse, and sexual and relationship adjustment have also been suggested; however, the correlational and cross-sectional nature of this research has resulted in debate as to whether these are causal factors or consequences of vulvodynia (Ayling & Ussher, 2008:295).

Elmerstig supports Ayling's and Usshers notion and emphasize that it is unclear whether the psychosomatic symptoms of vulvar pain appears as a matter of cause or consequence (Elmerstig, 2009:9-10). The authors have their own view on the personality types and tendencies described above. 7 authors comment on the article's subject of personality and 4 of them are critical of the correlation between personality and vulvar pain. One of the three interviewees can relate to the status of overachievement whereas the other two have chosen to ignore those correlations.

*The one interviewee that identifies herself with overachievement is the only one of the interviewees that has spent any significant time reading about the condition. The interviewee tells me that the overachieving girl is a common characteristic to portray women with vulvar pain. I ask her how she relates to that image. She says that she doesn't see herself as an overachiever today and adds that her pain isn't as severe today as it used to be. The interviewee continues and tells me that she used to be more of an achiever when she was younger; that she had good grades and studied hard. She is puzzled over the word **overachiever** and discusses the gravity of achievement necessary to rank as an overachiever. She theorizes whether or not is a matter of*

upholding a constant level of quality, doing a lot and handling several projects or perhaps to push oneself to study even if you're tired (Interviewee, 3) (my translation).

I ask if she thinks that her friends can be thought of as overachievers as well. She respond that it is possible given that they, just like her, have studied hard and been highly motivated in general. I ask if they also have vulvar pain and she tells me that they don't or at least not that she knows of (Interviewee, 3) (my translation).

Later that evening I receive a text message from the interviewee:

I just thought of something regarding overachieving women. Given how hard it is to get help and how much you have to work to get past those incompetent and disrespectful people in the health care it might not be so odd that the ones who remain are the so called overachievers [...]
(Interviewee 3, text message) (my translation).

The interviewee's conclusion that the overachieving girl is an effect of medical unavailability is shared with one of the authors. The remaining three authors also question the legitimacy of personality regarding vulvar pain. I wish to emphasize that two of the other interviewees also discussed similarities and differences between them and their friends concerning stress, achievement, goals, ambitions and the life they live. None of the interviewees regard themselves to be exceptionally ambitious or pressure themselves more than others; instead they feel as if they are just like their peers.

I would like to suggest that terms such as overachievement, ambition, perfection and stress could be a shared approach to life and not a significant trait to women with vulvar pain. I believe that Elmerstig's (2009) and Ayling and Ussher's (2008) raise important issues of the medicalization of vulvar pain by questioning the order of cause and patients' personality. Johannisson suggests that diagnoses are results from a collectively negotiated approach to the human body and societal and structural circumstances (Johannisson, 2006: 33-36). The collective acceptance and agreements of medical conditions are processed by the doctors who confirm a patient's state of

being, the bureaucracy that shows acceptances by for example developing health-insuring incitements (ibid:30-31, 37-39).

The stereotype of vulvar pain patients reflect a medical system that systematically demands a level of persistence and knowledge that allow these women to continue to seek and demand help. I also would like to emphasize that this notion also calls for attention to the importance of women's tacit knowledge of the Swedish health care system to consistently seek help in order to get help. Knowing where to turn, who to speak with, have time to visit several doctors, afford to buy treatments and make clinical appointments and knowing when it is possible to resist and push are aspects of getting help. Bourdieu's theory of habitus and capitals connect these every day practices with women's possibilities to get medical attention. Sociologist Donald Broady suggests that Bourdieu's theoretical framework make it possible to scrutinize immaterial and material states of being since the capitals are social relationships, which powers and existence only appears within a field. (Broady, 1991:70-71). Roughly put, the colour of one's skin, geographical location, economic recourse, level of education, and family's relation to the Swedish health care system affect women's access to institutional pain management and the medical portrayals of women are the effects of possibilities to medical attention.

Appearing to be "normal"

Earlier, in chapter 6, *Analysis*, I briefly mentioned Derridas view of pain. In his concept the matter of pain occurs in relation to the absence of pain (Miegel & Johansson, 2002:204-205). Using this notion I suggest that normality is the absence of deviance. Normality is the taken for granted - the original of how things should be. For Foucault, normality is the effect of societal organization power (Ramazanoğlu & Holland, 2002:95). "He traces particular examples of how power is produced, exercised and made legitimate at particular historical moments, looking at how different forms of knowledge can run through similar institutional structures" (ibid:96). Normality is power put into practise; therefore normality becomes important and relevant in society.

I already described how women feel abnormal, unfeminine and broken because they are unable to perform the ‘normal’ act of vaginal intercourse (see chapter 6, “Disrupted heterosexual actions”). Not being able to take part in heterosexual scripts reveals deviance but situations that possibly reveal deviance also appears in everyday situations. This chapter highlights how women refuse to admit pain in order to appear ‘normal’. The chapter also discuss why women feel it necessary to hide their pain and the norm of confessing and sexual availability.

One of the interviewees has told her friends about vulvar pain but the other two remain silent. It is difficult to estimate how many of the authors that speak openly of vulvar pain. Previous research claims has recorded that women with vulvar pain feel isolated (Ayling & Ussher, 2008:295). None of the authors state that they are lonely. When browsing through blogs, articles, radio-and television shows it seems as if many women choose to be silent because vulvar pain is too private, embarrassing or abstract to talk about (see for example Fitt for fight (a); Fitt for fight (b); Levin, 2012; *Sveriges Radio*). Each of the two interviewees has examples of when they proclaim normality instead of revealing vulvar pain to their surrounding.

One of the interviewees used to work as a cashier. Sitting down for several hours caused her pain and to ease her pain she used to stand up. The company required working uniforms and to avoid pain she always wore loosely fitted trousers. After a while new uniforms were ordered and she received a pair of trousers with regular fit, it was very uncomfortable but requesting a new pair would be noticed, instead she kept it together as if everything was normal (Interviewee, 1) (my translation).

The other interviewee also exemplify with a work scenario

Once every other month the interviewee goes to her rehabilitation activities. According to her employment contract its possible to extend the amount of sick days to accommodate long-term sickness. Instead of informing her employer of her condition she works overtime to cover the days she visits the health clinic. The interviewee knows that no one would treat her bad if she announced her vulvar pain

but she is uncomfortable with the idea of colleagues knowing and thinking about her vulva. I get the impression that the co-workers age or gender is problematic but that the image she projects to them becomes compromised by introducing vulvar pain (Interviewee, 3) (my translation).

Approaching normality and the reasons for avoiding deviance draws attention to Sociologist Erving Goffman's work *Stigma: notes on the management of spoiled identity* since his work discuss the processes of group dynamics and negotiations of normality and the place of shame in relation to physical and social deviance (Goffman, 1990). However, vulvar pain and the strategy to appear normal are more suitably discussed through the work of Plummer, *Telling Sexual Stories*. This book address how stories account for something in a specific time and place, meaning that stories reflect social organizations around specific matters (Plummer, 1995). Media scholar Anja Hirdman's dissertation *Tilltalande bilder*, (English title, my translation: *Appealing Images*) (2001) show how sexual relationships in Sweden shifted by analyzing and comparing a male pornographic magazine and women's lifestyle magazine between 1960 and 1990. She suggests that society's view on sex and femininity reflects in both magazines. In the dissertation Hirdman claims that magazines teach women to be sexually available and the male magazines' sexualization of women during the 1960 and 1970's also became evident in women's magazines during the 1990's.

Being physically and mentally sexual available seems to be a core element of women's identity today. Plummer emphasizes that sexual stories have been told for centuries but that the content of those stories shift in accordance with public opinions (Plummer, 1995:26-27). If sexual availability have intensified in the last three decades this could also explain the recent rediscovered interest in vulvar pain. As I explained in previous section, *Disrupted heterosexual acts*, vulvar pain contradicts sexual availability and thus cause abruption in the sexual script society is set out to maintain.

Plummer suggests "[...] the truth of our lives lies in better communication – in telling all. There should be no 'sexual secrets'" (ibid:4). However, Foucault traces the

West's obsession of revealing the truth through confessions back to the Middle Ages (Foucault, 1990:58).

We have since become a singularly confessing society. The confession has spread its effects far and wide. It plays a part in justice, medicine, education, family relationships, and love relations, in the most ordinary affairs of everyday life, and in the most solemn rites: one confesses one's crimes, one's sins, one's thoughts and desires, one's illnesses and troubles; one goes about telling, with the greatest precision, whatever is most difficult to tell (Foucault, 1990:59).

Telling one's surrounding about vulvar pain becomes important because it is customary. Revealing oneself is acquired in order to establish and maintain social relations. The rite of confessing and telling is a procedure possible by the individualization of power (ibid:58-59). According to Plummer, "[w]e have become the sexual story tellers in a sexual story telling society" (Plummer, 1995:5).

For the interviewees, revealing vulvar pain and proclaiming sexual availability are juxtapositions. A public display of vulvar pain means to publicly share a condition that is potentially threatening to collective agreements. Not telling is a secret veiling the interviewees and their surrounding. Silence becomes an option in order to control their surroundings knowledge and allowing them to precede their life under the banner of normality.

Controlling pain

When writing about vulvar pain it becomes necessary to ask oneself in which way pain is significant. It is easy to assume that pain is significant by the mere experience of hurting, however, this section is set out to explore the presence of pain in women's everyday life.

In subchapter *Pain and making sense of the unknown* I explained how the interviewees tried to describe pain. One of them said that she notices the pain and moves on whereas the other two found it more difficult to describe. All three interviewees notice pain but two of them actively work to avoid pain while the other

one manage pain when it appears but does not work to prevent it. After asking about pain, all of the interviewees advice me that I should not let vulvar pain get the upper hand of me.

One of the interviewees and I discussed the presence of vulvar pain in everyday life, after two hours she tells me that we shouldn't allow vulvar pain to take over our lives. Because if we do, what is then left? Who are we and how does it actually help us? (Interviewee, 1) (my translation).

I found myself agreeing with the interviewee. Earlier in subchapter *Pain and making sense of the unknown* I discussed the pedagogics of pain management that teaches the subject to recognize and organize experiences of pain. Foucault suggested that the aim to take charge of sex and desires focused on self-observing and confessing everything and “[t]oward the beginning of the eighteenth century, there emerged a political, economic, and technical incitement to talk about sex” (Foucault, 1990:23). Foucault’s analysis highlights that ideas and speech are attached and organized in economical and political structures. The location of pain in one’s everyday life extends one’s personal life; pain also appears and has a place in economical and political spheres. Philosopher and sociologist Herbert Marcuse proposes that everyday life consumes of technical rationality that promote a simplistic mode of living and thinking with shallow desires dictated by capitalism and human needs; speech and thoughts are suppressed by the capitalist ideals (Miegel & Johansson, 2002:228). Sociologists Fredrik Miegel and Thomas Johansson exemplify and state that in Marcuse’s theory:

Human beings are no longer allowed to express psychic pain hence pain suffocates with psychiatric techniques. Pain, ambivalence and guilt do not exist in the one-dimensional society. Figures such as Hamlet and Don Juan are unimaginable in such a community (ibid) (my translation).

Based on Marcuse’s notion on not letting pain taking over one’s life or fully affirm pain is guided and organized in patterns of productivity. Foucault showed how political decisions influence and shape citizens’ behaviour and perception of right and

wrong. Declaring that power constitutes the subject in a two-folded movement where the individual is a subject in relation to an external control and dependence but also to its own self-control and self-awareness (Wright-Nielsen, 2009:50, 67-68). The interviewees' desire to restrict the impact of pain in their everyday life can be understood as a causal effect of societies organization around healthy bodies.

I ask the interviewees about the relation between pain and the practices of everyday life, two of the interviewees wish that they were less aware of pain as they used to be. One of them elaborates and she tells me that it used to be easier to do daring things, nowadays she try not to hesitate but sometimes she does. She worries if it is going to hurt and sometimes avoid things that usually induce pain (Interviewee, 1) (my translation). However, both of them agree that it is better to be aware so that they can predict the outcome of their actions or just to stay calm when pain occurs (Interviewee, 1; Interviewee, 3) (my translation).

Wishing to be less aware of pain highlights that knowledge of vulvar pain is gained. In subchapter *Pain and making sense of the unknown*, the confessional techniques of self-observing are designed to reach an organized knowledge of one's pains, simultaneously the increased knowledge of pain have also made them more cautious of pain. The organized knowledge of pain guides the interviewees to anticipate pain and make calculated risks. Previous subchapter *Appear to be "normal"* highlights how women with vulvar pain hide their pain in order to appear 'normal' but the restricting pain to take over their life is different. Restricting pain is different in the sense that the interviewees' desires to control the impact of pain rather than just hide the pain. One of the interviewee says:

Once in a while I go out drinking, dancing and wearing tight jeans even if I know that it will hurt the next following days (Interviewee, 1) (my translation).

The authors' rarely describe everyday situations but discuss sex in a time line. The authors describe the occurrence of pain and how they managed pain. One of the

authors describes:

The acute intercourse pain eased after a year and my boyfriend and I could try gently again. [...] For me it was not a disaster to abstain from sexual intercourse for some time. I think it was worse for my boyfriend even though he seemed to take it well. But as I said, today, several years later, it works again (Letter, 5:5) (my translation).

Another states:

Painkillers that facilitate intercourse allowed me to relax enough and after a while cramps did not appear in the same way anymore. Since then it has just gone better (Letter, 6:6) (my translation).

The quotes can seem to be random but they reflect women's ambition to take charge of pain. The authors' descriptions of painful sex contain the revelation of pain during sex, the abstinence of sex and the persistent attempt to have sex despite of pain. The interviewees and authors' reasons for exposing themselves to pain can be explained through the dominance of heterosexual practices. But I suggest that these acts need to be explored as act of control but also see that confessions of vulvar pain are restricted to certain relationships; primarily: institutional health care facilities and secondary: to friends.

All of the interviewees' claim that it is enough to be in pain, they don't want to think about pain when they're not in pain (Interviewee, 1; Interviewee, 2; Interviewee, 3) (my translation). When I ask them if they discuss their pain with anyone all of them says that they primarily turn to a team of vulvar pain experts (Interviewee, 1; Interviewee, 2; Interviewee, 3) (my translation). One of them also discusses vulvar pain with her friends. (Interviewee, 2) (my translation).

Sharing their condition in a broader sense can liberate and create space for painful experiences; however, all of them regularly confess their pains to practitioners. The establishment of codes and manors concerning the confession can explain that women

turn to institutional care facilities to talk about vulvar pain. Foucault claims that the organization of sex also applied to concerning children and adolescents. He suggests that the school system operates as a pedagogical institution to implement the coded contents and speakers of sex (Foucault, 1990:29-30).

Speaking about children's sex, inducing educators, physicians, administrators, and parents to speak of it, or speaking to them about it, causing children themselves to talk about it and enclosing them in a web of discourses [...] The sex of children and adolescents has become, since the eighteenth century, an important area of contention around which innumerable institutional devices and discursive strategies have been deployed (Foucault, 1990:29-30).

Formal (e.g. in schools) and informal (e.g. television shows) sexual education and the establishment of health care institutions have created spaces of talking about the vulva, sex and pain. Foucault concludes that “[p]leasure and power do not cancel or turn back against another; they seek out, overlap, and reinforce one another. They are linked together by complex mechanism and devices of excitation and incitement (ibid:48). The restriction of vulvar pain to institutional domains can be viewed as an effect of an organization of social, political and economical organization of speaking of vulvar pain. Similar to the establishment of discourse with the goal to control sex, the women have restricted the existence of pain to the health care institution (see ibid:3, 20-21). Making calculated risks, not sharing their condition and not allowing pain to appear and act ‘normal’ can be viewed as acts of restricting confessions of pain.

7. Conclusion

This master thesis attempt to understand vulvar pain by using the concept of confessions by addressing the research question: *how are women with vulvar pain able to transform principles of confession into strategies of pain management?*

By using the principles of confession I have managed to explain how women with

vulvar pain manage their pain in relation to society. The analytical conclusions can be organized into three categories: *confessional techniques*, *institutional pain management* and *individual pain management*. Confessional techniques are applied in both the institutional pain management and in the individual pain management, see picture below for clarity.

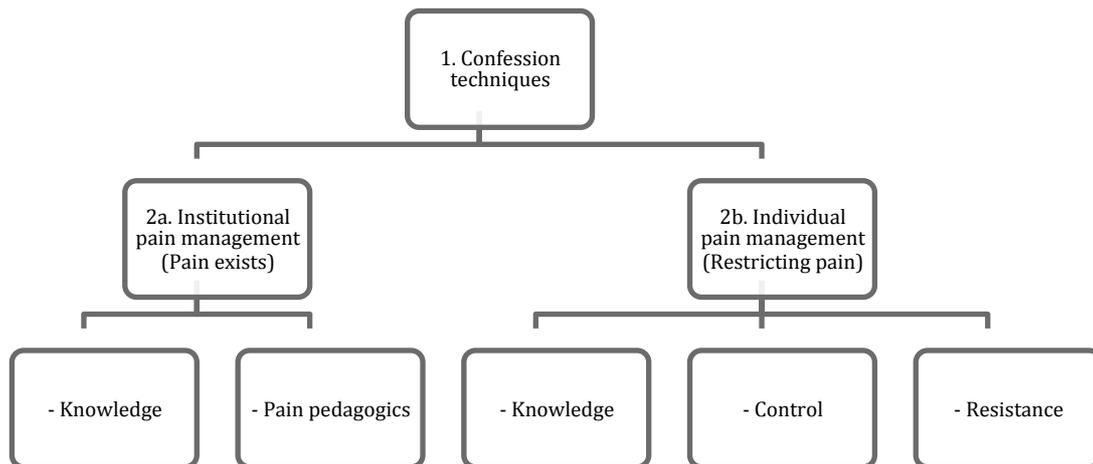


Table 3. Confessions and pain management. *Illustration of confessional techniques and types of pain management (institutional and individual).*

Foucault showed in *The Will to Knowledge. The history of Sexuality, vol.1* that confession was tool to harvest knowledge of people’s inner desires, actions and thought. Desire to control sex and desire resulted in discourses of sex and sexuality that regulated the premises and existence of sex and sexuality. The confessional techniques of self-observations, telling and organizing of knowledge are exercised to capture the abstract experiences of vulvar pain. But before reaching awareness of pain, the women lack ability to acknowledge vulvar pain. Previous research supports the notion that women tend to seek treatment for vulvar pain in relation to sex (see Engman, 2007:4). I suggest that vulvar pain becomes ‘real’ or less abstract in relations to vaginal intercourse because vulvar pain makes the ‘normal’ vaginal penetration almost impossible. The interviews emphasize that vulvar pain is problematic in other situations than sex and that pain during sex is a minor problem compared to the everyday pain. However, pain during sex help women to concretize their everyday experience of pain.

The institutional pain management use the confessional technique of organizing pain

experiences; by encourage vulvar pain patients to associate words with experiences. The interviewees' claims that their knowledge has increased and that they have developed knowledge to anticipate and address pain. However, before developing knowledge concerning pain, the women are subjected by institutional pedagogics that educate and neglect their abstract experiences of pain. Uncertainty of diagnosis among practitioners affects women's possibilities to treatment and the interviewees and authors' quest to get proper medical attention lasts for several years. Experiences of being mistreated and ignored are evident in the women's stories and previous research supports the interviewees and the authors' statements of difficulties to get proper medical attention (see Engman, 2007; Ayling & Ussher, 2008).

I suggest that the troubles of accessing medical care single out women with particular personal traits; that women with vulvar pain are considered to be ambitious, intellectual, white etc. are an effect of the health care system and not a characteristic shared by all women with vulvar pain. Instead it is a matter of women's possibilities due to geographical location and resources. However, this suggestion call for further research but it is necessary to consider these effects since the interviewees and at least 4 of the authors resist the correlation between personal traits and vulvar pain.

To understand the interviewees' and authors' critical voices to institutional pain management it is necessary to separate pain into two categories. The concept of individual pain management emphasizes women's ability to use the confessional techniques and knowledge of pain to perform acts of resistance and control. By organizing their experiences of pain the women are able, as I mentioned above, to anticipate pain and make calculated risks. This allow women to enter situations of pain for their own benefit but also make them aware and socially equipped to talk about pain on their own terms. The physical pain remains but instead of dealing with an abstract feeling of hurt they are able to transform the notion pain into actions and restrict the presence of pain in their everyday life. However, the institutional pain management offers space to women where they are able to fully affirm the existence of pain rather than restricting it. This master thesis shows how women are able to

control, relocate and restrict the emotional and social presence of pain by applying the confessional techniques into practice.

8. Further research

Confession and pain management are until now mostly explored in terms of confessions of neglect or mistreatments (see Koehler, 1971; Marx, 2011). As this thesis have shown, a theoretical understanding of confessions enable pain management to be accessed and understood as a process of knowledge production. The concept of confessions allows us to investigate how vulvar pain is connected to domains of knowledge and power. Pain is an individual experience but it is also shared in several levels. Treating pain becomes a matter for the individual as well as the practitioner but knowledge and relevance of pain are collectively regulated and affect our organization that manage and identify and categorize different pains.

I believe that it is not a misfortunate coincidence that women with vulvar pain becomes minimized, ignored and mocked in their experiences of pain. Feminist influenced research and intersectional analysis have shown that neglect, oppression and uneven distributions of power are systemically structured rather than unfortunate individual misfortunes. Addressing pain is a matter of resources and belonging. Geographical location, economical resources, class, level of education, tacit knowledge, skin colour, cultural belonging, gender and age determine a person's access to pain management.

I also believe that vulvar pain is difficult to express since it oppose prevailing western norms concerning femininity, heterosexuality and vaginal intercourse. The lack of language to express pain is connected to unawareness of vulvar pain and inexperience of addressing pain unrelated to sex. The dominance of healthy bodies contributes to make pain abstract. By applying sociological and feminist perspectives on pain management it becomes possible to address pain as individual as well as a systemically organized sensation.

Instead of restricting confessions to the act of telling, the confession can be used for developing a theoretical framework that allow the process of self-observing, telling and organizing knowledge to address how these actions are foundations to control, regulate, reaffirm, establish and maintain social organization of power. I strongly suggest that continued research on pain management within social sciences is necessary to critically examine how gender, age, class, skin color, economical resources, sex, geographical location and cultural belonging structures knowledge and treatment.

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10. Endnotes

¹ *Erectile dysfunction* is, just like vulvar pain, associated to be a sexual dysfunction in the reproductive organs and concern the inability to maintain or develop erection.

² Maria Engman claim that feminist theories applied to vaginismus emphasis male standpoints in regard to sex and myths about femininity and masculinity. Most literature is written in Dutch and summarized by Drenth (Enmang, 2007:7).

³ *Chronic* is based on an assumption that pain and the physical state have been occurring during at least six months (Gottlieb & von Scholutz, 2004:197).

⁴ Prevalence indicates how many women are affected at every moment.

⁵ *The past* is individual time elapsed whereas *history* is a shared narrative of a common the past.

⁶ Foucault first published *the History of Sexuality vol.1-3* in 1976-1984. *Modern days* include present day as well as during the time Foucault developed his ideas.

⁷ Habitus is the accumulated history of four capitals: social capital, symbolic capital and economic capital.

⁸ Using Dorothy Smith's (1997) explanation in her article "Comment on Hekman's 'Truth and method: feminist standpoint theory revisited'", Caroline Ramazanoğlu & Janet Holland (2002) contextualize standpoint theory as a classification, created by feminist scholar Sandra Harding, to pin point several feminist scholar's common attempt to investigate women's standpoint or women's experiences or locating knowledge. Standpoint theory is theoretically fragmented since its assumed scholars came from different epistemological fields (2002:64-65).

⁹ Retriever Research was formerly called *Mediearkivet*.

¹⁰ *Over-rapport* is similar to 'going native' since it is an accusation of being too close to the researched that distance and scientific research is no longer applied (O'Reilly, 2009:91).

¹¹ *Best practice* is a method or technique for a standard way of doing things in an effective or superior way. It is commonly used within management theory to describe developments of ideas in practice.

¹² *Sex and the City* is an HBO produced television series that portray four women's life in New York City.

¹³ The European Commission has established a disease as rare if it affects less than 5 in 10.000 (European Commission).

¹⁴ The vulvar clinic specializes on vulvar related conditions. Bohm-Starke and Rylander (2000) reviewed the 295 patients, including 81 patients with provoked vestibulodynia that were remitted to the vulvar clinic at two Swedish hospitals.

¹⁵ Västerbotten is a region in the north of Sweden.