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**The sharper end of love: When sex is painful, how is intimate love navigated?
Reflections from a qualitative study in England and France**

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PART 2

Intimate bodies



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The sharper end of love: When sex is painful, how is intimate love navigated? Reflections from a qualitative study in England and France

Hannah Loret



Introduction

The discourses around sexual pain are complex, multidisciplinary and constantly evolving. Studies of sexual pain experienced by women range from self-labelled feminist criticism,¹ to medical recommendations written by healthcare professionals in diverse specialities,² to works which bring together women's own written and spoken experiences and interpretations of concepts including sexual 'dysfunction'.³ Genital sexual pain, understood here as pain in the genitals felt during sexual activity, whether partnered or not, is described in multiple ways by many different people. Treatment outcomes can be bleak for the women experiencing pain, and classifications of the pain have been repeatedly problematized within health services without standardized remedies always being agreed, often 'exacerbating patient distress'.⁴ This piece is drawn from doctoral research undertaken between 2017 and 2020 with self-identifying women who were experiencing or had experienced sexual pain and with healthcare professionals involved

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in its treatment.⁵ Diagnostic categories, commonly cited issues in accessing healthcare and women's descriptions of their own pain and experiences were examined in this research, which defined and critically appraised conceptualizations of women's sexual pain in England and France, creating policy recommendations and encouraging increased awareness of sexual pain experiences in healthcare settings. France and England were chosen for this comparative study due to their similarity in terms of treatment options for women's sexual pain issues despite their differing healthcare system structures, with France operating a healthcare system with both mainstream public and private elements and England operating with a largely public healthcare system, where private healthcare exists but in less mainstream ways. For the participants of the study, then, experiencing sexual pain meant navigating not just the potentially life-altering pain felt but also the complex national systems of care and the relational, financial and social complications of this.

It is for this reason that this study also considered sexual pain experiences within a sociopolitical frame, using selected readings of Foucault to analyse semi-structured interview data, in particular the concepts within the History of Sexuality series and conceptualizations of structural and fluid power dynamics. Taylor additionally suggests that Foucault wrote the History of Sexuality series because 'sex is a privileged site through which power works in biopolitical times, and cultivating different relations to sex might undo some of the effects of this power'.⁶ Biopolitics, meaning the utilization of 'numerous and diverse techniques for achieving the subjugation of bodies and the control of populations',⁷ features heavily in the series and is interwoven with the consideration for constantly evolving and complex 'relations of power'.⁸ Foucault's concept of the 'genealogy', suggesting a 'focus on discontinuities, contingencies and power struggles in order to demonstrate that the past was different from the present, the present could have been otherwise and thus the future may also be otherwise',⁹ was borne in mind while undertaking this research and in situating the research in question within the context of a specific, contingent relationship with its own inherent power dynamics. The link between power and pain is explicit in Foucault's writing, Foucault reminding readers in 'The Birth of the Clinic'¹⁰ that the 'figures of pain are not conjured away by means of a body of neutralized knowledge', rather 'redistributed in the space in which bodies and eyes meet'. Though this piece will not closely examine the link between Foucault and this cross-national sexual pain research, it is nonetheless significant that the research study conducted maintained that all discourse, including scientific and healthcare discourse, is constructed, historically specific and shaped by the structural and subjective experiences of power. When participants spoke about sexual relationships, their bodies and their experiences of love and self-love, it was in the context of these power dynamics, many of which were openly acknowledged by participants when discussing them.

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Working alongside an analysis informed by readings of Foucault was the theoretical tool of intersectionality, that is to say ‘the ‘analytic tool’ which recognizes that ‘major axes of social divisions in a given society at a given time ... operate not as discrete and mutually exclusive entities, but build on each other and work together’.¹¹ Care was taken in the choice of intersectionality as a theoretical and analytical tool for this project, and it was borne in mind throughout the research that intersectionality is rooted in ‘Black feminism and Critical Race Theory’ and was originally coined ‘to address the marginalization of Black women within not only antidiscrimination law but also in feminist and antiracist theory and politics’.¹² Though the impact of the project and the professional practice of the researcher reflected a practical and personal commitment to challenge multiple and coexisting inequalities, the context of the use of intersectionality here is nevertheless removed from the specific and important context in which it was first coined. The lens of race here is seen as a significant possible axis of social division in the societies in which the participants interviewed live or lived and as a potential way in which some participants may have had no choice but to renegotiate structural healthcare opportunities differently to others in systems where ‘race, class, gender, sexuality, age, disability, ethnicity, nation, and religion, among others, constitute interlocking, mutually constructing or intersecting systems of power’.¹³ Recognizing that this project was anchored in a commitment to try and understand and academically represent participant experiences in as faithful a way as possible, intersectionality was particularly appropriate for this methodology as a tool and ‘a way of understanding the complexity in the world, in people, and in human experiences’,¹⁴ where ‘intersectional frameworks understand power relations through a lens of mutual construction’.¹⁵

Methodology

The writers and researchers involved in *Troubling the Angels: Women Living with HIV/AIDS*¹⁶ noted that in the work they felt they were walking ‘a fine line between making a spectacle of these women’s struggles and a wanting to speak quietly with respect for all that it means to tell the stories of people willing to put their lives on public display in the hope that it will make it better for others’. This ‘fine line’ is very much at the heart of the current study, though the interviews had a different social context. Grappling with how best to represent participant voices during the process of recruitment, data collection, analysis and writing echoed with what Lather and Smithies describe¹⁷ in *Troubling the Angels* as the ‘responsibility’ born to the women who shared their stories. Smithies further comments of this responsibility¹⁸ that during her own decision-making process in writing with and about women affected by HIV and AIDS, she was ‘overwhelmed with the

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responsibility of getting it right' and of 'misrepresent[ing] or dishonour[ing] the women' she 'greatly admire[d] and love[d]'. Lather and Smithies hoped their book was¹⁹ 'a breakdown of clear interpretation and confidence of the ability/warrant to tell such stories in uncomplicated, non-messy ways', and the present study also embraces the complicated nature of telling stories where there is a clear responsibility to respondents to produce a study where their experiences can be shared with a wider audience without overly reducing or skewing their voices. This was incorporated into the study design and the engagement of the study with theory and healthcare practice.

This piece will focus on selected analyses of the interviews conducted in England and France with women who have experienced sexual pain. The women interviewed for the study often spoke about love and the embodiment of love for themselves and for their sexual partners; and though the analysis conducted following the interviews with healthcare professionals in England and France also provided rich and fascinating information about how love is conceptualized in their professional environments, the current piece focuses on some of the experiences discussed by women who participated in the study. This permits a closer reading of selected quotations from the study rather than a broader exploration of how intimate love, embodiment and sex were discussed as part of the qualitative work. The quotations which follow are taken from semi-structured interviews conducted between summer 2018 and December 2019 with anonymous participants who responded to social media calls for participants to the PhD study. Calls were made to interview self-identifying women residing in England or France who experience, or had experienced, genital pain during sexual acts, and interviews were conducted in English or French, in person or via telephone or video call, as agreed with the participant prior to the interview. Interviews were conducted in the language preferred by the participants, with several of them completing the interview in a non-native language, and the option to speak in either English or French was made clear as part of the participant recruitment process to proactively ensure that participants who spoke more than one language would be as comfortable as possible in their choice. The interviews were transcribed verbatim and analysed in English using a reflexive thematic analysis approach,²⁰ chosen due to its flexible nature which nevertheless allows for nuance and a rigorous inductive approach within study results. This transcription was carried out in the language of the interview by the lead researcher and was only translated into English at the point of analysis, where it was key to remember that the translations were specific to a research context and constructed by the researcher. This cross-national design, allowing for data analysis, research questions and relationships with the theory around sexual pain to be driven by participant data and priorities, was intended to be as faithful as possible to 'the responsibility of getting it right' when representing the voices of participants.²¹ The research from which this piece is drawn examined and challenged the conceptualization

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of sexual pain in England and France using an intersectional lens with a particular focus on the axis of gender. This was understood with reference to how gender can form part of other marginalizing factors in healthcare experiences, and love and intimacy were at the forefront of how participants described their experiences of sexual pain.

Power and empowerment

Many of the study participants explicitly spoke about the power dynamics they had experienced or were experiencing as part of their sexual pain. WA-EN-001 conveyed the power of being believed for the first time by a healthcare professional and how this felt:

It's the 'yes, we believe you, yes, I hear you', umm, and 'you're not a freak' [pauses at length], you know, 'we believe you', that's 'we believe you; I believe you'. Three words, it's like three of the most powerful words in the English language.

WA-FR-003 spoke about power in a different way, explaining that the experience that she had been through before the pain resolved was linked to what she saw as a misunderstanding about what real love was. She spoke of only knowing real love after the pain had resolved:

And then, you know, well, so, umm, I think that there's some misunderstanding in what, uhh, in what we want, in what we really actually want. And even perhaps ... even perhaps some misunderstanding of what real love feels like. Because ... personally I only knew that after [the pain experience].

WA-EN-001 was not in a relationship at the time of interview. She discussed how she felt that not being in a relationship had hindered her treatment-seeking, with healthcare professionals seeming to provide care tailored more towards women in heterosexual relationships than towards women who did not have a regular sexual partner. Being heard and being taken seriously was momentous for her, and hearing the words 'I believe you' after many consultations during which she had not been believed was a powerful and emotional experience. WA-FR-003 spoke about an empowering experience of a different kind. Finding out what love really meant to her, in this case with a change of sexual partner and appropriate treatment after many years of being unable to name what she was experiencing, was a positive, affirming experience. Though, for both participants, having repeated encounters with healthcare professionals who were unable to help them resolve the pain was a disempowering, frustrating and distressing

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experience, they reported feeling powerful moments of clarity about their own experiencing and the love they felt towards others. Though these two interview quotations do not reveal the complex marginalizing factors that these women were a part of, the notion that power dynamics are mutually constructed and fluid, and the intersectional concern of seeing ‘power relations through a lens of mutual construction’,²² is clearly present here. These two excerpts demonstrate that when these participants spoke about the experience of ‘real love’ and the process of being heard, power was not an abstract concept, taken away from the experience of pain. The power of being heard and believed, and of understanding and experiencing what ‘real love’ was, was liberating – and though these power dynamics were nevertheless mutually constructed, they had profound effects on the embodied experiences of both these participants.

This potentially liberating conceptualization of power was not present in all interviews, however. WA-EN-004 spoke of frustration with a medical professional who had told her that therapy tailored to her needs was not available for free through NHS services, only for her to subsequently find out that the therapy was indeed available free of charge:

I just feel so like ... kind of powerless in the whole situation to be honest. Cause they’re ... they’re kind of saying it’s your f—, you know, your responsibility, to deal with this, you can ... employ techniques to get around it ... But then, the, I just don’t have the money to get the, the kind of guidance on that.

The description of a feeling of powerlessness was seen repeatedly in the interviews with women who participated in this study. The onus described above by WA-EN-004 to take ‘responsibility’ and ‘employ techniques’ to ‘get around’ the pain was also described repeatedly by women in the interviews in both England and France, and this applied in many of the descriptions of treatment-seeking, where responsibility was placed back on the women experiencing the pain if a possible treatment had not relieved their symptoms, or if repeatedly trying different treatments had had no positive effect. The women interviewed who consulted health professionals for their sexual pain may have contributed to the power dynamics which formed part of their experience of pain, but the power dynamics here were described as largely unequal. In WA-EN-004’s description of her lack of appropriate guidance and available funds to deal with the problem, and the reversal of responsibility from the healthcare professional back onto her, the potentially marginalizing factors which shaped her experience of pain do not seem to have been considered by those who were in a position of power over her. Factors including her sexuality, gender, age, financial status, race and class do not appear to have been taken into account in this experience of advice from a healthcare professional. Rather, her experiences

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of sexuality and love are shaped by a feeling of powerlessness ‘in the whole situation’, where factors which might make access to treatment and support easier have seemingly not been adequately considered by the healthcare professionals she consulted.

Other participants did speak of the same frustration with healthcare providers that their situations were not heard or understood, but WA-EN-010 did speak of how, despite navigating the complex systems of care and national healthcare structures, she had been able to adjust elements of her life to reflect her wishes, despite disempowering and negative experiences with healthcare providers and previous sexual partners. She spoke about how self-pleasuring worked for her, despite experiences of this activity being profoundly negative with other people:

Manual stimu-, stimulation by another person ... dreadful ... I’m fine with masturbation, I know what to do.

She also spoke positively of her queer identity and how she hoped that ‘within that’ she could find ‘a space’ for herself, and how this had helped her feel ‘the most hopeful’ that she’d felt ‘for a while’ in trying to ‘make an account of’ herself. Reflecting, then, the fluid and mutually constructing nature of the power dynamics involved in conceptualizing sexual pain, WA-EN-010 spoke of reappropriating intimate practices through focused sexual activity and through making an ‘account’ of herself on her own terms. WA-EN-010 spoke of insensitive and frustrating encounters with healthcare professionals, but her descriptions of finding ‘space’ for herself were hopeful ones. It seems from her descriptions of interactions with healthcare professionals that, though her individual material and personal circumstances were not at the forefront of considerations about her care, she had nevertheless forged a space of power to reappropriate her intimate life and the embodiment of the intimate power dynamics she was a part of.

Alongside disruptive experiences of genital pain felt during sexual acts, many of the participants in both England and France spoke of feeling that their pain felt like it needed to be legitimized, sometimes in terms of a clear diagnosis, and that this affected their own understandings and experiences of their pain. WA-FR-009 spoke about seeking a diagnosis and how she felt this would help her understand her pain and to feel more legitimate:

I would finally have a diagnosis to confirm what I’ve been saying, you know, quite simply, and so I would finally feel legitimate.

WA-FR-004 spoke about her diagnosis of vaginismus, which involves the muscles of the vagina contracting in a painful way, and how this diagnosis had helped her come to terms with her issue and to speak about it openly in a way that was fearless about the reactions of others:

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To be able to accept and to be able to, umm, treat the thing, I think you have to dare to give it a name, and to clearly say ‘yes I have vaginismus, yes I’m “vaginique”, so what?’

WA-FR-004 described herself as ‘vaginique’, an adjective specific to the French-language interviews, meaning ‘a person who has vaginismus’. The power dynamics reported in these two quotations are very different, despite both being taken from interviews with women in France. The first quote speaks of a desire for legitimacy, without a clear statement of who this legitimacy is regarded by, and a desire to give different, and perhaps more medical, language to her experience. The second openly speaks of a feeling of possession of the problem and frankly declares that vaginismus is a problem affecting her. Just as is seen in the quotations above from WA-EN-010 and the description of the power of being heard given by WA-EN-001, reappropriation of certain elements of the experience of sexual pain can be empowering, despite being framed within frustrating, potentially distressing and profoundly disempowering situations. This could be seen as a form of liberating and powerful renegotiation, which changes how participants have come to regard themselves and others.

Vulnerability was, however, a common experience in the narratives of many of the women interviewed. Wilson²³ proposes a definition of vulnerable research participants as ‘peopl[e] whose strengths and positive attributes are generally overlooked, and who are confronted with differential risks and health burdens in comparison to others living in their community or country’. Part of the reflexive process in creating the methodology for this project was a commitment not to further marginalize participants or increase the ‘risk’ or ‘health burden’ they were experiencing but to recognize that the participants for the study may have been structurally and culturally marginalized in the complex neoliberal systems within which they live. Dealing with pain and its emotional and relational consequences, and also the stigma and vulnerability attached to long-term suffering, sometimes without a name, was reported by many participants as having taken a huge toll on their lives. WA-EN-001 felt like she was the problem, and that she was in fact stigmatized by the medical professionals she was consulting. This is how she described it:

For me, I still struggle at times, like I feel, I think I’m the problem. Because, if you’re told you’re a problem often enough, you begin to believe it. So, something that could help me on a personal level is just ... let’s get rid of the stigma.

For some of the participants, genital pain was not just experienced during sexual acts, but was experienced continuously or in many other areas of their life. Sexual pain was cited in the interviews as a direct cause of one



participant leaving her job, as it became too painful to sit down, to ‘go the cinema’, ‘go see friends’, ‘sit down in front of the TV’, with this participant describing her pain at the time – which forced her to lie down rather than sit upright when not in a standing position – as ‘awful’. WA-FR-008 spoke about her relationship with her own body following a sudden onset of pain:

It’s a bit of a double bind, you know, but ... uhh, but actually, ... for me, it’s very much linked to sex, right, or to sexual relations anyway, uhh, well, it’s not just during sex that it’s painful, for example, if I put a finger in my vagina, it’s going to hurt.

Not being able to touch an area of her body without pain had a notable effect for this participant, and she spoke of the frustration of not having a clear diagnosis for the problem despite wanting one. Though she spoke of renegotiating her relationship with her long-term partner in a positive way and how she had found other ways to express intimacy, the ‘double bind’ she spoke of clearly echoes the description of WA-EN-001 of feeling that there was a stigma around her experiences. The way that these participants might experience their own intimate lives – or their positioning within social divisions operating ‘not as discrete and mutually exclusive entities’ but as complex asymmetries of power building ‘on each other’ and working ‘together’²⁴ – is complex, often difficult and can affect all aspects of women’s lives. Where love is concerned here, it seems secondary to practical considerations, including employment status and healthcare opportunities, and it appears as part of intricate power dynamics which can stigmatize and complicate.

Reappropriation of intimacy in England and France

Preliminary analyses of the study data suggest that healthcare services providing assistance to people experiencing sexual pain can encompass numerous specialities in both England and France and can be staffed by diverse professionals with different backgrounds. The analyses undertaken from the semi-structured interviews in France show that navigating complex national systems of care relies on many factors, including the knowledge and inclination of the healthcare professional who is consulted, the way this information is communicated by the woman who is affected and the financial and structural constraints on the healthcare professional making referrals. Sadly, the interview findings also reveal that, for the women interviewed for this study, discounting of their symptoms as ‘women’s problems’ further pathologized their entire being; suggestions that symptoms of treatable illnesses were being exaggerated or faked were common; and misuse of power, including

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non-consensual examination and touching, also took place. Sexual pain was felt by many participants to affect their whole being and self-perception, as ‘one of the factors that kind of forecloses a lot of the interactions ... with other people’ (WA-EN-010). In France, slightly more choice was reported by participants than in England, in that the healthcare professional consulted could often be chosen rather than allocated as part of the referral process, as was largely the case in England. In France, some participants reported that the treatments or specialist appointments they had sought or were seeking were not reimbursed by the state social security system, and that this added an extra layer of financial consideration and stress on their treatment options. Both private and public elements of healthcare services were evoked by the participants in England, yet the need to find healthcare professionals who are ‘interested in finding out why’ the pain was happening ‘as opposed to going “oh well, could be this, could be that”’ (WA-EN-002) was an integral part of accessing appropriate healthcare. Participants in both England and France reported the potential importance of knowing that ‘other women go through the same thing as you’ (WA-EN-007), and in contrast to France, English data reflected the predominant use of state-funded services, with only one participant speaking openly about using private services to confirm an issue she suspected was present after NHS services were ‘quite dismissive’ about it. Playing a part in the ‘interlocking, mutually constructing or intersecting systems of power’²⁵ in both England and France was complex, with sexual pain experiences seen by many participants as flowing through many elements of their life, including the social, the intimate and the financial. Participants’ embodiment of intimate power dynamics then, in England and in France, was at times reported as a conscious, powerful process which they took control of, and at other times as an arduous undertaking which forced them to establish a new way of being with themselves and with potential or current sexual partners. Love and both positive and negative affective relationships with individuals close to the participants were reported as another complex layer of the sexual pain experience of women in both England and France, but one which could bring comfort and reassurance at times.

The conclusions drawn from the analyses undertaken as part of this study bring an enlightening insight into how sexual pain, love and intimacy can be experienced in England and France and how they were lived by the women interviewed for this project. The results of this study are transferable in several different ways, including raising awareness of the issues around sexual pain to provide information for policy-making decisions and for commissioning groups involved in allocating resources to health services. Further research into this neglected area, especially where this research is collaborative and listens actively to structurally underserved groups, is crucial moving forward. The design of the study has prioritized involving participants and potential audiences from many different backgrounds, from frontline healthcare staff, to commissioners, to academics. The cross-national design of the study



brought many advantages as well as an enlightening comparative element, and it has given exciting opportunities for further research into this area with non-academic professionals in both England and France. Non-heterosexual and non-monogamous experiences of sexual pain must be prioritized in further qualitative research into this topic as much of the existing research focuses on the experiences of heterosexual women in long-term relationships. The way that fluid intimate power dynamics are enacted by and upon bodies is complex, and this complexity is further manifested when genital sexual pain is experienced. This piece reveals only a snapshot of the data from this study, but it finds that coming to terms with sexual pain experiences, reappropriating sexual encounters and modifying these intimate power dynamics are formidable acts. To be part of the complex sociopolitical, relational and social systems in which we live, and to potentially embody the complexities of intimate acts, can be challenging. To adjust the ways of living and to renegotiate and reappropriate their own intimate lives following or during experiences of sexual pain is an act of power demonstrated by the participants of this study. Renegotiating intimate love is not always easy, but this study shows that taking small steps to challenge and dismantle the ‘interlocking, mutually constructing or intersecting systems of power’ is possible and, more than this, can be liberating.

Notes

- 1 See, for example, Chloë Taylor, ‘Female Sexual Dysfunction, Feminist Sexology, and the Psychiatry of the Normal’, *Feminist Studies* 41, no. 2 (2015): 259–92.
- 2 For example, Rosemary Basson et al., ‘Report of the International Consensus Development Conference on Female Sexual Dysfunction: Definitions and Classifications’, *Journal of Urology* 163 (2000): 888–93, and Micheline Byrne and Paula Christmas, ‘Psychological Management of Pain Syndromes in a Sexual Health Setting’, in *Psychological Management of Pain Syndromes in a Sexual Health Setting*, ed. David Miller and John Green (Oxford: Blackwell Science, 2002), 282–91.
- 3 Shere Hite, *The Hite Report on Female Sexuality* (London: Pandora, 1992), 60.
- 4 K. R. Mitchell et al., ‘Painful Sex (Dyspareunia) in Women: Prevalence and Associated Factors in a British Population Probability Survey’, *BJOG: An International Journal of Obstetrics and Gynaecology* (January 2017): 1.
- 5 This research was funded by the Vice Chancellor’s Gender Equality in Europe Studentship at Nottingham Trent University from 2017 to 2020. Ethical approval for the semi-structured interviews was granted by the Joint Inter College Ethics Committee at Nottingham Trent University on 20 December 2017. I would like to gratefully acknowledge the support of Jonny Hatfull, and special thanks are due to Professor Gill Allwood of Nottingham Trent University.

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- 6 Chloë Taylor, *The Routledge Guide to Foucault's History of Sexuality* (Oxon: Routledge, 2017), 109.
- 7 Michel Foucault, *The History of Sexuality, Volume I: The Will to Knowledge*, trans. Robert Hurley (London: Penguin, 1998), 140.
- 8 *Ibid.*, 103.
- 9 Taylor, *The Routledge Guide to Foucault's History of Sexuality*, 12.
- 10 Michel Foucault, *The Birth of the Clinic: An Archaeology of Medical Perception*, trans. A. M. Sheridan (London: Routledge, 2012), xi.
- 11 Patricia Hill Collins and Sirma Bilge, *Intersectionality* (Cambridge: Polity, 2016), 13.
- 12 Devon W. Carbado et al., 'Intersectionality: Mapping the Movements of a Theory', *Du Bois Review* 10, no. 2 (2013): 303.
- 13 Hill Collins and Bilge, *Intersectionality*, 1.
- 14 *Ibid.*, 1.
- 15 *Ibid.*, 26–7.
- 16 Patti Lather and Chris Smithies, *Troubling the Angels: Women Living with HIV/AIDS* (New York: Routledge, 1997), xiii.
- 17 *Ibid.*, xvi.
- 18 *Ibid.*, 215.
- 19 *Ibid.*, xvi.
- 20 Virginia Braun and Victoria Clarke, 'Using Thematic Analysis in Psychology', *Qualitative Research in Psychology* 3, no. 2 (2006): 77–101; Victoria Clarke and Virginia Braun, 'Using Thematic Analysis in Counselling and Psychotherapy Research: A Critical Reflection', *Counselling and Psychotherapy Research* 18, no. 2 (2018): 107–10; Virginia Braun and Victoria Clarke, 'Reflecting on Reflexive Thematic Analysis', *Qualitative Research in Sport, Exercise and Health* 11, no. 4 (2019): 589–97.
- 21 Lather and Smithies, *Troubling the Angels: Women Living with HIV/AIDS*, xvi.
- 22 Hill Collins and Bilge, *Intersectionality*, 26–7.
- 23 Denise Wilson, 'Culturally Safe Research with Vulnerable Populations (Māori)', in *Handbook of Research Methods in Health Social Sciences*, ed. Pranee Liamputtong (Singapore: Springer, 2019), 1526.
- 24 Hill Collins and Bilge, *Intersectionality*, 13.
- 25 *Ibid.*, 26–7.

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