PAINFUL IDEALS

- Young Swedish women’s ideal sexual situations and experiences of pain during vaginal intercourse

Eva Elmerstig

Gender and Medicine
Division of Women and Child Health
Department of Clinical and Experimental Medicine,
Faculty of Health Sciences, Linköping University,
SE-581 83 Linköping, Sweden

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To my mother, Göran, Lovisa and Viktor
for all their love and endless support
Many young women today are concerned about their sexual health; an increasing number of them consult gynaecologists, youth centres (YCs) and general practitioners with vulvar problems such as painful sensations associated with vaginal intercourse (VIC). It is known that some women continue to have VIC despite pain. Theoretically, repeated painful VIC might elicit vaginistic reactions, which may increase the pain and induce vicious circles. Since many clinicians and researchers nowadays notice that pain during VIC often starts at young age, it is important to investigate how pain during VIC starts and is maintained in younger populations. The overall aim of this thesis was to investigate young women's experiences of ideal sexual situations and pain during VIC.

Women aged 13-22 years participated in our studies, which used both quantitative (study I and IV) and qualitative (study II and III) methods. For paper I, a questionnaire was developed and used in a YC sample (n=300); informants for paper II were selected from that sample to participate in qualitative interviews (n=16). Another qualitative interview study for paper III with a complimentary research question was conducted in a different YC sample (n=14). For paper IV, a questionnaire was developed based on the results from study I, II and III to test the hypotheses derived from study II in a sample of female high school students (n=1566).

The findings revealed that 65% of the women reported pain related to first VIC. Among those who reported VIC during the previous month, 49% had experienced pain and/or discomfort during VIC during that same period (paper I). In paper IV, 47% of the women reported experience of pain and/or discomfort during VIC, and among those, 47% continued to have VIC, 22% feigned enjoyment, and 33% omitted telling the partner about their pain. In paper II, the women's reasons for continuing to have VIC despite pain were: striving to reach their ideal image of a woman, characterized as always willing to have VIC; being perceptive of their partner’s sexual needs; and being able to satisfy their partner. In paper IV the hypotheses derived from study II were confirmed and showed, for example that a significantly higher proportion of women who continue to have VIC despite pain than women who did not had difficulty refusing sex when the partner wants it, felt inferior to the partner during sex, regarded the partner's satisfaction as more important than their own, felt dissatisfaction with their sex life, and feigned enjoyment despite pain. In a multivariate model, continuing to have VIC despite pain was associated with feelings of being inferior to the partner during sex (adjusted OR 1.82; CI 1.10-3.02), dissatisfaction with their own sex lives (adjusted OR 1.76; CI 1.14-2.72) and feigning enjoyment while having pain (adjusted OR 7.45; CI 4.37-12.69).

In conclusion, pain during VIC is a common complaint among young Swedish women, and a high proportion of them continue having VIC despite pain. The women's notion of prioritizing the partners' enjoyment before their own illustrates that unequal gender regimes affect young women's (hetero)sexuality negatively.
Supervisor
Barbro Wijma, MD, PhD, Professor
Gender and Medicine
Division of Women and Child Health
Department of Clinical and Experimental Medicine
Faculty of Health Sciences
Linköping University

Co-supervisors
Carina Berterö, RNT, PhD, Associate Professor
Division of Nursing Sciences
Department of Medicine and Health Sciences
Faculty of Health Sciences
Linköping University

Kerstin Sandell, PhD, Lecturer
Department of Gender Studies,
Lund University

Katarina Swahnberg, RN, PhD, Associate Professor
Gender and Medicine
Division of Women and Child Health
Department of Clinical and Experimental Medicine
Faculty of Health Sciences
Linköping University

Opponent
Bente Traeen, PhD, Professor
Department of Psychology
Tromsø University
Norway

Committee board
Gunilla Sydsjö, PhD, Professor (Chairman)
Obstetrics and Gynaecology
Division of Women and Child Health
Department of Clinical and Experimental Medicine
Faculty of Health Sciences
Linköping University

Bengt Fridlund, RNT, PhD, Professor
Department of Nursing
School of Health Sciences
Jönköping University

Preben Kjölhede, MD, PhD, Associate Professor
Obstetrics and Gynaecology
Division of Women and Child Health
Department of Clinical and Experimental Medicine
Faculty of Health Sciences
Linköping University
LIST OF ORIGINAL PAPERS

This thesis is based on the following papers, which will be referred to in the text by their Roman numerals I-IV.

I:  Elmerstig E, Wijma B, Swahnberg K.
    Young Swedish women’s experience of pain and discomfort during sexual intercourse.

II: Elmerstig E, Wijma B, Berterö C.
    Why do young women continue to have sexual intercourse despite pain?

III: Elmerstig E, Wijma B, Sandell K, Berterö C.
    “Sexual pleasure on equal terms”: Young women’s ideal sexual situations.
    Submitted.

IV: Elmerstig E, Wijma B, Swahnberg K.
    Why continue to have vaginal intercourse despite pain? Reasons and associated factors among young Swedish women.
    Submitted.

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PREFACE

This thesis began as a set of bothering questions while I was working as a midwife at a Youth Centre in Kalmar. There I met young people with different thoughts, questions and problems concerning sexuality. My attitude towards sexuality has always been that it is an important but complex part of life. After having studied sexology at Göteborg University I still had a lot of those intriguing questions that I had an urge to find answers to. I had realised that I met many young women who had pain during vaginal intercourse, and I wanted to know how common this problem was and how those young women handled their situation. So I contacted a professor in Linköping, Barbro Wijma, and it all began. We discussed our shared clinical experience of young women who continue to have vaginal intercourse despite pain, which made us ask: “why do they continue?” This was the starting point of the thesis; one study raised more questions and the research project developed.

Öland, Sweden
21 July 2009
# ABBREVIATIONS and DEFINITIONS

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<td>BW</td>
<td>Barbro Wijma</td>
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<td>CB</td>
<td>Carina Berterö</td>
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<tr>
<td>CI</td>
<td>Confidence interval</td>
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<tr>
<td>EE</td>
<td>Eva Elmerstig</td>
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<tr>
<td>OR</td>
<td>Odds ratio</td>
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<tr>
<td>STI</td>
<td>Sexually transmitted infection</td>
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<td>VIC</td>
<td>Vaginal intercourse</td>
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<td>YC</td>
<td>Youth centre</td>
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**Coital debut:** The first vaginal intercourse

**Coital pain:** Pain associated with VIC

**Discomfort:** I combine the concept discomfort with pain during VIC and define discomfort in this context as physical discomfort, such as itch, smarting pain, press, burning pain or a cutting feeling. When I use the term *pain* in the cover story, it is equivalent to pain and/or discomfort

**Dyspareunia:** In this thesis used as a general term for pain associated with VIC, and not as diagnostic classification

**Femininity:** A set of distinctive, culturally specific characteristics attributed to and prescribed for women

**Heterosexual practice:** Sexual interactions as acts between a man and a woman

**Ideal:** *Ideal* can have several meanings; a norm can become an ideal. In this thesis I define it as an image of something that is highly desirable
| **Masculinity:** | A set of distinctive, culturally specific characteristics attributed to and prescribed for men |
| **Norm:** | What is considered to be “normal”, “common” and/or “average” in a given society, culture or group |
| **Senior High School students:** | Students attending the Swedish gymnasieskola |
| **Sexual situation:** | Oral sex, petting, vaginal and/or anal intercourse |
| **Vaginal intercourse (VIC):** | Penetrative penile-vaginal intercourse. In the first two articles (I, II), we used two different terms to define VIC; sexual intercourse and coitus. In the last two articles (III, IV) we only used the term VIC. In the cover story I use the term VIC, whenever possible, even if it was referred to as intercourse, sexual intercourse, or coitus in our or other articles |
| **Young women:** | An overall term for female adolescents up to 21 years of age |
| **Youth centre (YC):** | A clinic offering counselling and health services for young people. In the literature, YCs may also be called Youth Clinics or Youth Health Centres |
INTRODUCTION

Several studies have been published about young people’s sexual behaviour and risk taking [1-6]. However, these studies often focus on the risk of STI and unwanted pregnancies and do not cover sexual dysfunction among young women. Many young women today are concerned about their sexual health and an increasing number of them consult gynaecologists, youth centres (YCs) and general practitioners with vulvar problems, such as painful sensations associated with vaginal intercourse (VIC) [7-9]. The cause of pain during VIC among young women is likely to be multifactorial, with physical as well as psychosocial components [10, 11]. It has been discussed that being able to have VIC is a dominant norm for heterosexual behaviour, which women feel obliged to fulfil. Treatment for sexual dysfunctions such as vaginismus, often focuses on increasing women’s ability to tolerate penetration [12]. It has been reported that young women make sexual investments to benefit (hetero)sexual relationships [13, 14]. Since many clinicians and researchers nowadays notice that pain during VIC often starts at young age, it is important to investigate how pain during VIC starts and is maintained in young women. Which expectations do young women have of themselves, and of (hetero)sexual situations? This thesis explores heterosexual practices; i.e., young women’s concepts of ideal heterosexual situations and their experiences of pain during VIC.

Prevention regarding youth sexual and reproductive health issues in Sweden

The Nordic countries are considered to have a permissive attitude towards sexual relationships between adolescents [15-18]. The Swedish government [19] has set up goals for the sexual and reproductive health of its citizens, since sexual health is regarded as an important dimension of general well-being. These goals accentuate safe sexuality as fundamental for the individual experience of health and well-being [19]. The Swedish National Institute of Public Health [20], a state agency under the Ministry of Health and Social Affairs, is responsible for health promotion and disease prevention. One of its main tasks is being a national centre of knowledge, which includes the planning and carrying out of sex information campaigns [20]. Health care for adolescents in Sweden mainly consists of school health services, sex education in schools, and family planning services primarily at YCs. Medical examinations and vaccination programs as part of the school health service have been an important part of health care for adolescents in Sweden for almost 200 years. During the previous decades, this program also has worked on preventing risky behaviour concerning drugs, alcohol, STIs and adolescent pregnancies [21].
Other preventive efforts concerning youth sexual and reproductive health in Sweden include free contraceptive counselling and testing of STIs and subsidized contraceptive methods. These services are also offered without requiring parental consent. Swedish midwives work as providers of preventive sexual and reproductive health care [22]. After having passed postgraduate training, they are allowed to prescribe hormonal contraception and to insert intrauterine contraceptive devices (IUDs) and subdermal contraception implants [23]. Legal abortion has been permitted by law since 1975, giving the woman the right to decide about an abortion until the end of the 18th gestation week [24].

School-provided sex education

Sweden was the first country in the world implementing sex education as a compulsory subject in public schools, in 1955 [23]. Elise Ottesen-Jensen was an advocate for sex education in school during the first half of the twentieth century and held the first chair of the Swedish Association for Sexuality Education (RFSU) [25]. She travelled around Sweden introducing birth control, thereby offering women the option of enjoying sex without fearing unwanted pregnancies [23]. The present sex education in Sweden begins with basic information about anatomy, physiology and reproduction in primary school; in secondary school students learn about contraception and STIs [23, 26]. School health care professionals play an important role in sex education in schools [22].

Youth centres

The first YC in Sweden started in 1970, founded by Gustav Högberg, a paediatrician who realised the need for a special clinic for young people, combining issues related to body, soul, sexuality and relationships [27]. The aim of the YCs was to support adolescents in developing responsible sexual behaviour and to minimise sexual and reproductive health problems. There are today approximately 200 YCs in Sweden spread over the country [27]. The YCs offer adolescents the opportunity to come for individual consultations, examinations and treatment, in order to prevent unwanted pregnancies, STIs and psychological/social problems. Counselling sessions also strive to help youth visualise different attitudes, strengthen self-esteem and influence behaviour.

The work at a YC varies from consultations by completely healthy individuals to treatment of certain psychological and medical conditions. The YCs have a holistic approach, built on a multi-professional structure with medical, social, psychological and educational competence. The youth make their appointments on their own, through their parents, or by referral from the health care staff at their school. The staff provides confidential care for adolescents, regulated by the Swedish secrecy
act. The confidentiality regulation protects sensitive personal data such as sexual and reproductive issues [22, 23, 27, 28]. The YCs provide support for young people of both sexes until they are 21 (in some cities up to 25) years old [22, 27].

Young women’s coital debut

During the past half century, age at first VIC has decreased in Britain [29] and the Nordic countries [23, 30, 31], but seems now to have stabilized [29, 31]. “Sex in Sweden”, a nationally representative population study conducted in 1996, found women’s median age at first VIC to be 16.5 years [30]. Another Swedish study, conducted in 1999 among high school students, found a median age for women at first VIC of 15 years [2]. The authors compared this median age with similar studies from 1979 [32] and 1989 [33] and concluded that age at first VIC had not decreased during these periods [2]. Female Swedish students attending practical/vocational programs seem to have their first VIC earlier than students attending general/economic programs [2, 16].

There are several studies assessing sexual risk taking behaviour and age at first VIC [16, 34-36] while there is a shortage of studies exploring pain at and emotional experience of first VIC. However, in one national study in Sweden [34] 17-year old women were asked to describe their emotional experience of VIC by choosing several positive or negative alternatives. The majority of the women expressed a positive emotional experience by choosing “loving” (60%), “exciting” (60%), “sexy” (40%) and “wonderful” (30%). Negative experiences of first VIC were described by using words as “embarrassing” and “failure” by 30 and 20 percent respectively. Edgardh [34] also found that women with coital debut <15 years of age experienced VIC more negatively than women ≥15 years of age at coital debut [34]. In a Swedish study from 2005 among high school students, 53% of the women reported their first VIC as a positive experience [37].

Prevalence studies assessing pain during first VIC are rare. However, one Swedish study from 1990 found that 54% of the women reported experience of pain during their first VIC [38]. The women’s ages ranged from 17-83 years, which explains why the time interval from coital debut until study participating varied widely [38]. It is unknown how an existing hymen affects the first VIC. The literature indicates a range of anatomical variation of the hymen [39-41], and there is at present a lack of knowledge concerning how hymenal elasticity changes during adolescents’ physical maturation. If the hymenal elasticity increases during adolescence, and the age at coital debut has decreased since the mid-twentieth century, you might expect that an increasing number of young women would experience pain during their first VIC due to an inelastic hymen.
Pain associated with VIC

Recently an increasing number of women seek professional help for genital pain associated with VIC [7], and the number of vulva clinics is also growing [8, 9]. However, pain during VIC is not a new phenomenon; descriptions can also be found in ancient history [42]. In the literature, pain during VIC is often classified as deep or superficial. This thesis focuses principally on superficial pain during VIC, which occurs frequently in young women [43].

Dyspareunia

There are different types of pain associated with VIC and the most commonly used general term in medical literature is dyspareunia. On the other hand, the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-TR) defines dyspareunia very strictly and in the following way: “(a) recurrent or persistent genital pain associated with sexual intercourse in either a male or a female; (b) the disturbance causes marked distress or interpersonal difficulty; (c) the disturbance is not caused exclusively by vaginismus or lack of lubrication, is not better accounted for by another Axis I disorder, and is not due exclusively to the direct physiological effects of a substance or a general medical condition” [44].

Many causes of dyspareunia are conceivable. For women in particular it is realistic to presume a multifactorial genesis [10, 11]. Nevertheless, dyspareunia is at present one of the most commonly reported sexual dysfunctions in women [11], and often leads to psychological, emotional and relational consequences, irrespective of the underlying cause [10, 11, 45-48]. Lack of treatment resources, as well as lack of adequate knowledge about the condition, may result in an increasing occurrence of dyspareunia with chronic elements when women finally reach specialized clinics. Dyspareunia is in general used more to describe a symptom than a diagnosis, and the DSM-IV definition of dyspareunia is far from clear. The nosology has been questioned, e.g., the fact that the pain label is related merely to VIC, and not to other sexual activities, or that the anatomical location of the pain is not specified. This is unlike definitions of other pain conditions, where location is primary [49-52]. The characteristics of the pain in dyspareunia do not differ from that of other pain disorders; the symptoms could fit into other, nonsexual, pain disorders [49-51].
Vulvodynia

Vulvodynia means chronic pain in the vulva and has earlier been described as “burning vulva syndrome” [53], and it often affects sexual activities. The International Society for the Study of Vulvovaginal Disease (ISSVD) defines vulvodynia as “vulvar discomfort, most often described as burning pain, occurring in the absence of relevant visible findings or a specific, clinically identifiable, neurologic disorder” [54]. Vulvodynia is classified according to the pain location, whether the pain is localized or generalized, and if it is provoked or unprovoked. The pain can also appear in a mixed form [54]. There is a lack of clear pathology of vulvodynia, and it also seems unclear if generalized and localized forms have different causes. The treatment regimes in diverse units worldwide differ, where combinations of different interventions are often used.

Provoked vestibulodynia

Provoked vestibulodynia, earlier called “vulvar vestibulitis syndrome”, is a subgroup of vulvodynia [53], considered the most common form of pain during VIC in women of fertile age [55]. Women with provoked vestibulodynia feel severe pain at any attempt at vaginal entry. Friedrich’s definition from 1987 [56], still commonly used, claims three criteria for a diagnosis of provoked vestibulodynia: (1) severe pain upon vaginal entry, (2) pain on pressure to the vestibular area and (3) vestibular erythema [56]. Women with provoked vestibulodynia also report other forms of discomfort, such as burning and stinging pain, related to VIC [11, 43, 57]. ISSVD defines provoked vestibulodynia as: “discomfort on intromission (introital dyspareunia), clothing pressure, tampon insertion, cotton-tipped applicator pressure, fingertip pressure, etc.” [58]. The symptoms usually arise during or after VIC but in some cases also during other activities such as running and sitting [11]. There are most likely several mechanisms contributing to the development of provoked vestibulodynia [10, 11, 49, 59, 60] and both biomedical and psychosocial factors have been discussed. Bohm-Starke et al. found a larger number of intraepithelial nerve endings [61, 62] and lower pain thresholds [63] for heat and cold stimuli in women with provoked vestibulodynia than in healthy women [8]. Combined oral contraceptives appear to induce a higher vestibular sensitivity and have been suggested to be a risk factor for developing provoked vestibulodynia [64]. Some studies have discussed recurrent candida infections as potential causative agents [65, 66]. High rates of depression and anxiety have been found in women with provoked vestibulodynia [45, 67-69], which may be interpreted as cause and/or consequence. It has also been found that women with provoked vestibulodynia differ from controls according to personality aspects such as harm avoidance, where the person has a tendency to react with increased anxiety and
pessimistic worry about problems in the future [60]. Danielsson et al. also showed that women with provoked vestibulodynia more often than controls suffer from somatic symptoms and complaints other than their genital pain, such as fatigue, muscular-skeletal pain, headache and gastrointestinal symptoms [59, 60]. Another recent study found that more women with provoked vestibulodynia suffer from chronic stress than do healthy controls [70], which may also be interpreted as both cause and/or consequence. Due to the cross-sectional design of most studies, it still remains unclear if the reported psychosocial factors, preceded or followed the appearance of pain during VIC [10].

Different treatment strategies for provoked vestibulodynia have been developed, such as vaginal EMG biofeedback, cognitive behavioural therapy, tricyclic antidepressants, vestibulectomy [11] and acupuncture [71]. However, there is still a lack of consensus concerning which interventions work.

**Vaginismus**

Vaginismus is a sexual pain disorder and defined in DSM-IV-TR as: “A. Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse. B. The disturbance causes marked distress or interpersonal difficulty. C. The disturbance is not better accounted for by another Axis 1 disorder (e.g., Somatization Disorder) and is not due exclusively to the direct physiological effects of a general medical condition” [44]. In the “diagnostic features” in DSM-IV-TR not only vaginal penetration by penis is included but also by finger, tampon or speculum [44]. Vaginismus has been subdivided into total/partial and further in primary/secondary vaginismus [72, 73] and can be classified as total primary vaginismus, total secondary vaginismus, partial primary vaginismus and partial secondary vaginismus [72]. Women with total vaginismus are unable to have VIC, whereas this is possible, however painful, for women with partial vaginismus. Women with total primary vaginismus have never been able to have VIC, whereas secondary vaginismus occurs in women who have had VIC. Total primary vaginismus has many similarities with phobic reactions, while partial secondary vaginismus is more of a pain disorder [74].

Research on vaginismus has earlier focused mostly on total primary vaginismus, while recent research also focuses on partial vaginismus [75-77]. Engman et al. found in a clinical sample that all women with provoked vestibulodynia also had vaginismus, and most of them partial vaginismus [75], which indicates a considerable overlap in these diagnoses [57, 75]. It is known that women with vaginismus experience pain and burning pain during VIC, even if pain is not necessary for diagnosis [44, 73]. Recently it has also been found that women with partial vaginismus report a sensation of burning pain, followed by itch sensations during a standardized penetration situation [76].
Burning and/or smarting pain during micturition after VIC has also been discussed as early symptoms of partial vaginismus [77]. The classification of vaginismus is also dependent on when the woman got the diagnosis. The symptoms develop in a process, where one form of vaginismus often turns into another [57, 72]. This is illustrated in a flowchart by Wijma et al. [72].

Figure 1. Forms of vaginismus [72 p.22], reprinted with permission from the publisher.

As this thesis focuses on pain during VIC, it is mainly partial vaginismus that is of relevance.

**Development of a vaginistic reaction**

There are diverse biological and psychological theories concerning the development of the vaginistic reaction. One explanation is that the vaginistic reaction initially is a defence mechanism that occurs automatically when the woman is exposed to something threatening or something she dislikes [73, 78, 79]. When women repeatedly are exposed to a threat, such as pain during VIC, this defence mechanism, the unconditioned reflex, becomes a conditioned reflex: a vaginistic reaction [73, 80]. A problem arises when this conditioned reflex then occurs as soon as the woman is exposed to the conditioned stimuli, such as sexual foreplay, a penetration situation or merely thoughts about penetration, even if the sexual situation is something she per se enjoys [73, 80]. When the woman is exposed to recurrent conditioned stimuli as times goes by, the vaginistic reactions may become aggravated and provoked by an increasing range of various stimuli. This description of how a vaginistic reaction develops seems to be valid for total as well as partial vaginismus.

It has been discussed whether the pain in vaginismus is secondary to some factor other than the vaginistic reaction, or if pain is merely the result of the spasm of the musculature [74, 81]. As the contraction of vaginal musculature causes pain in a
vaginistic woman, the pain sensation itself often elicits an even stronger muscle contraction, leading to a more intense pain reaction. A vicious circle is created [73]. The development of the vaginistic reaction is illustrated by Wijma et al. [73] in Figure 2.

When managing vaginismus, different treatment strategies are used separately, or combined, such as cognitive-behavioural therapy, sex educational therapy, desensitisation with vaginal dilators, electromyographic biofeedback, relaxation exercise, physiotherapy, surrogate therapy, local anaesthetic and benzodiazepines [12, 73, 80, 82].

**Prevalence of pain associated with VIC**

Prevalence estimates for pain associated with VIC, such as dyspareunia, provoked vestibulodynia and vaginismus, vary according to setting, selected populations, ages and definitions [83]. In a Swedish nonpatient population study (women aged 20-29 years), it was found that 19% of the women had ever had prolonged (≥ 6 months) and severe dyspareunia (“severe problems with pain or burning in genitals or pelvic region during or after intercourse”) and 13% had current complaints of prolonged and severe dyspareunia [84]. In a nationally representative population study [30, 46], women 18-65 years old were asked if they had experienced dyspareunia (intercourse...
associated with pain in genitals) and/or vaginismus (vaginal spasm, making it difficult or impossible to insert penis in vagina) during the previous 12 months, and to what extent. They were also asked if this had been a personal problem for them, where “quite often”, “nearly all the time”, and “all the time” were regarded as manifest distress, and the answers “hardly ever” and “quite rarely” as mild distress. Manifest distressing dyspareunia and vaginismus were reported by 5% and 0.8%, respectively, while mild distressing dyspareunia and vaginismus was reported by 23% and 4%, respectively [30, 46]. In the United States, a population-based study showed that 21% of the women aged 18-29 years had experienced “physical pain during intercourse” during the previous 12 months [85].

The prevalence of self-reports of vaginismus is most likely underestimated, as questions on partial vaginismus are usually not included in surveys and vaginismus passes undiagnosed in clinical samples [77]. Very little is known about the prevalence of pain associated with VIC in young women under 18 years of age. A Swedish study conducted at four YCs showed that 34% of the women (12-26 years) reported recurrent, and another 13% occasional experiences of pain/burning sensations during or after VIC [65]. A population survey in China with currently married, sexually active women found that 5% of the women aged 15-24 years reported that they had experienced pain in the abdomen or vagina at VIC during the previous 6 months [86]. Another 8% reported pain/burning sensation while urinating, but it is unclear if these complaints were related to VIC [86].
THEORETICAL FRAMEWORK

Qualitative versus quantitative research methods

There are different ways in the scientific world of getting close to the “true” understanding [87].
Medical research has traditionally used quantitative to a greater extent than qualitative methods, while in social sciences qualitative methods have traditionally been seen as more informative [88]. There are advantages as well as disadvantages with both qualitative and quantitative approaches; during the last decades, the two paradigms have more and more been regarded as complementary methods in medical research [89].
Which method is the most appropriate choice for a certain study depends on the research question [90]. Quantitative methods are, for example, useful for measuring a certain condition or well-described phenomenon in a population and could answer the questions “what”, “when” and “to which extent” [89], while a quantitative approach will be of limited value for explaining human phenomena [88]. Results from a quantitative study could raise the necessity for a qualitative approach to look more in depth into an issue. On the other hand, a qualitative study could raise ideas, theories and hypotheses, which can be tested in a quantitative study [90]. While the quantitative researcher often works with a large sample, the qualitative researcher explores a small sample size, for deriving detailed information about the participants’ thoughts, life stories and/or behaviours [89].
When using questionnaires the quantitative researcher obtains information merely as predetermined answers on the questions posed, which therefore directs the data collection very strictly. In qualitative interviews, new and unexpected information and subjects could arise during the interview.

Grounded theory

Grounded theory was developed in the 1960s by the American sociologists Barney Glaser, who had a quantitative background, and Anselm Strauss, who had a symbolic interaction background [91]. Later on the two founders split and went separate ways, and grounded theory methodology developed in different directions [92].
Grounded theory has been used in various disciplines such as sociology, health science, medicine, anthropology, business and management, as well as in diverse countries [92, 93]. Grounded theory is useful for discovering patterns and psychosocial processes in people’s reality [91, 93, 94], and is not a descriptive method [95]. According to Glaser, the purpose of grounded theory is to generate
concepts on an abstract level that describes psychosocial patterns of the participants’ main concerns and actions and not to give a description of the individuals [93, 95]. Instead, the descriptive parts of the results are there mainly to illustrate the conceptual level. A characteristic of the grounded theory method is the constant comparative analysing process, where data are collected and analysed simultaneously, and each code and category of the new data is compared with every code and category of the previously gathered data [91, 94]. This analysing process is the method for generating a theory that is grounded in the data [91, 94].

Gender perspective on youth sexuality

The existing gender regime

The concept of gender is often used as a social and cultural construction of differences in what the society defines as masculine and feminine, while sex is used as the biological classification of males and females [96, 97]. The existing gender regime, observed both in industrialized and developing societies, consists of unequal power relations between women and men with male dominance and female subordination [97, 98]. The unequal gender regime consists of two principles: dichotomy and hierarchy. The first principle, dichotomy, describes a segregation of a masculine and a feminine way, which are constructed as different [97, 99, 100]. The other principle, hierarchy, is based on a structure where the male is the norm and his position is valued higher than the female’s position. This unequal gender regime affects in different ways men’s and women’s life situations, e.g., in linguistic structures, where male forms are the norm in diverse words; education opportunities and school conditions; family structure; work conditions; economic situations; access to health care; sexuality; and domestic violence and abuse [99-101].

Young people learn how to “do gender” by adopting a gender identity, and then “do a gender performance” based on beliefs of what they think is natural and proper. Gender learning occurs in several situations in a youth’s everyday life. The process of doing gender continues throughout life with improvising, copying, creating and developing gender patterns [97].

The biological differences between sexes in anatomic and physiologic genital and reproductive structure, affect youth’s sexuality in one way [99], and the social and cultural constructions of gender affect sexuality in another way [102].
Femininity and masculinity norms connected to sexuality

In heterosexual relationships, the conventional gender norms differ between the sexes [102, 103] and influence sexuality, especially during the sensitive transition period from childhood to adolescence [104]. Several studies have examined these gender structures within the context of such issues as safer sex [1, 4, 6, 97, 101, 102] and have found the impact of power, influencing both masculinity and femininity norms and ideals [1, 4, 6, 101, 102, 105]. Holland et al. [102, 106] found in their research about social constructions of sexuality in young people that the masculinity power pressured both young women and young men to behave according to conventional gender norms. Women are often positioned in the notion of femininity as being passive, sensitive, responsible, satisfying, nurturant, suggestible, talkative, intuitive, emotional and sexually loyal [97]. On the contrary, characteristics associated with masculinity are being dominant, active, definite, independent, demanding, brave, tough-minded, rational, taciturn and analytic [97]. Young men and women learn to relate to these characteristics, which likely affect their identity and sexuality [99, 102, 107]. Holland et al. claims that the view of male power “male-in-the-head” regulates the heterosexual relationship, leading to an asymmetry between men and women. According to this theory, there are entirely the “male-in-the-head” and no “female-in-the head”, which affects the intimate heterosexual relationship in both women and men [102, 106].

Connell’s masculinity studies and research about hierarchical systems have resulted in the most often described cultural pattern of masculinity, “hegemonic masculinity” [99], which is a dominant form of masculinity, subordinating women as well as other masculinities [99]. Connell argues that all men have to position themselves in relation to this hierarchical system and are either supporting it or subordinated or marginalized by it. The hegemonic masculinity structure varies to some extent among different cultures, classes and generations [108]. Some researchers have argued for the existence of a diversity in masculinities with alternative, new patterns of masculine identities [108-110]. However, the concept of hegemonic masculinity has been useful for understanding the dynamics in such different social situations and behaviours as classrooms, crimes, violent behaviour, sexual risk taking and sport teams [108]. This hierarchical gender regime, which young men have to relate to, also maintains a young woman’s subordinated position.

Flood [111] has studied how young men’s male-to-male social bonds affect their sexual relations to women. He found that males’ sexual storytelling to one another gave them masculine status, and had a powerful influence on their sexual relations with women [111]. For a man, the first heterosexual sexual intercourse is the key for achieving manhood, while women have other markers of being a woman, such as puberty and menarche [106]. Male-to-male dynamics in sexual storytelling differ from that among women. Men gain masculine status when telling stories about their sexual conquests, experiences and performances, while female sexual
experiences told in peer groups could constitute a threat to the woman’s reputation [102, 111, 112]. Doing gender and getting masculinity affirmation by means of sexual storytelling have been seen particularly in male-centered environments, such as military camps, male colleges, male sport teams and male prisons [111]. Both young women and men are exposed to unequal gender norms in media. The sexual interactions are often portrayed as women holding a passive and men a dominant role, in commercial advertising, romance novels, diverse soap operas and magazines [102, 103].

While men during adolescence are learning masculinity norms in a hierarchal society, young women are at the same time learning to behave according to the demands of femininity norms. In the patriarchal world, young women have traditionally learnt to suppress their own needs and desires, e.g., by avoiding conflicts and behaving nicely [98, 113, 114].

VIC - normative heterosexual practice

VIC has been seen as an important part of heterosexual practice [102, 115]. Diverse activities, like petting and oral sex, are described as sexual, while VIC (penis penetrating vagina) is defined as “proper sex” and “real sex” [102, 115, 116]. To fulfill the hetero-normative role of being a woman and a man, there is a perceived societal pressure to have VIC [115, 116].

Empowerment

The concept of empowerment is widely used but with diverse definitions. Difficulties in defining power and empowerment are related to the wide variety of contexts in which the concepts have been used [117]. Due to the existing power imbalance between men and women, empowerment in youth sexuality has different meanings for women and men [101]. Young women have to relate to the conventional notion of femininity, where women are expected to suppress their own needs and desires. Here, empowerment for women is a process where young women have to resist the hegemonic masculinity and the unequal gender regime. In contrast to young women, young men have been taught that power is an important factor in masculinity. Resisting these norms might enable safer sexual practice, while they become disempowered according to the conventions of masculinity. From the perspective of women’s sexual health, intellectual empowerment can be seen as the women’s intention to act for safe and pleasurable sexual practice, and the experiential empowerment as the active part of managing to resist influences and take control over safe and pleasurable sexual practice [102].

The support for empowerment in young women’s sexuality differs worldwide [101]. Health care for adolescents in Sweden promotes young women’s empowerment in school health services and in sex education in school and family
planning services like those at YCs [23, 27]. Despite our society’s empowering approach for young women, the existing unequal gender regime affects young women’s sexual situations.
AIMS OF THE THESIS

The overall aim of the thesis was to investigate young women’s experiences of ideal sexual situations and pain during VIC.

More specifically the aims of each paper were:

- To investigate experience and prevalence of (1) pain related to first VIC; (2) pain and/or discomfort associated with VIC during the previous month; and (3) associations between these experiences. (Paper I)

- To explore why young women continue to have VIC despite pain. (Paper II)

- To identify young women’s ideal images of sexual situations and expectations of themselves in sexual situations. (Paper III)

- To estimate (1) the prevalence of women continuing to have VIC, feigning enjoyment, and omitting telling the partner despite pain during VIC; and (2) their reasons for those actions. (Paper IV)

In paper IV the following hypotheses were tested which had been derived from theories built in study II:

Hypothesis 1: A greater proportion of young women who experience pain and/or discomfort during VIC will, in comparison with those who do not:
   a) have difficulty refusing sex when the partner wants it, and
   b) feel inferior to the partner during sex.

Hypothesis 2: A greater proportion of young women who experience pain and/or discomfort during VIC will, in comparison with those who do not:
   a) regard the partner’s satisfaction as more important than their own, and
   b) feel dissatisfaction with their own sex life.

Hypothesis 3: A greater proportion of young women who continue to have VIC despite pain and/or discomfort will, in comparison with those who do not:
   a) have difficulty refusing sex when the partner wants it, and
   b) feel inferior to the partner during sex.
Hypothesis 4: A greater proportion of young women who continue to have VIC despite pain and/or discomfort will, in comparison with those who do not:
   a) regard the partner’s satisfaction as more important than their own, and
   b) feel dissatisfaction with their own sex life.

Hypothesis 5: A greater proportion of young women who continue to have VIC despite pain and/or discomfort will, in comparison with those who do not:
   a) feign enjoyment and
   b) omit telling the partner about their experiences of pain and/or discomfort.

Finally, we examined associations between continuing to have VIC despite pain and all the statistically significant variables from the univariate analyses in a multivariate model.
MATERIAL AND METHODS

Design

In the present thesis both quantitative (I, IV) and qualitative (II, III) approaches have been used. Methodological triangulation, when using different methods [118], increased our possibilities to get both broad and valid information about young women's experiences of ideal sexual situations and pain during VIC.

There are different ways of using both quantitative and qualitative methods in the same project [90]. In some cases it is appropriate to use qualitative findings for designing a quantitative study. Another way is to begin with a quantitative study and in a part of that sample also use the qualitative method to get more detailed information [90]. The design of this research project used both ways. In study I, a questionnaire was developed to use in a specific sample; in study II, informants from that sample were selected for in-depth qualitative interviews; in study III, another qualitative interview study was conducted with a complimentary research question in a different sample; and in study IV, a questionnaire was developed based on the results from study I, II and III in order to test in a large population the hypotheses derived from those theories that we had built in study II.

Table 1 gives an overview of the studies in the thesis.

<table>
<thead>
<tr>
<th>Paper</th>
<th>Methods</th>
<th>Sampling procedure</th>
<th>Study group/participants</th>
<th>Response rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Questionnaire study</td>
<td>Consecutive inclusion of patients</td>
<td>300 women, aged 13-21 years, visiting a YC</td>
<td>98%</td>
</tr>
<tr>
<td>II</td>
<td>Qualitative interview study, analysed with the Constant Comparative method, GT*</td>
<td>Purposive and theoretical sampling</td>
<td>16 women, aged 14-20 years, recruited at a YC and selected from participants in study I</td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Qualitative interview study, analysed with the Constant Comparative method, GT*</td>
<td>Purposive sampling</td>
<td>14 women, aged 14-20 years, recruited via two YCs</td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Questionnaire study</td>
<td>Total samples in classrooms</td>
<td>1566 female third-year high school students, aged 18-22 years</td>
<td>99.7%</td>
</tr>
</tbody>
</table>

* Grounded theory
Samples

In study I, a total of 307 women aged 13-21 years, who visited a YC in southeastern Sweden were asked to participate in a questionnaire study. Exclusion criteria were being unable to speak and understand Swedish. During the 2-month data collection period, 323 women attended the YC at least once and were eligible. Seven women declined participation, and 16 women were omitted for nonsystematic reasons (i.e. the staff at the YC did not have time to inform or forgot to ask). Thus 300 women participated, which gave a response rate of 98%.

Background characteristics of the participants are presented in Table 2.

<table>
<thead>
<tr>
<th>Age</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>13-14 years</td>
<td>8</td>
<td>2.6</td>
</tr>
<tr>
<td>15-16 years</td>
<td>63</td>
<td>21.0</td>
</tr>
<tr>
<td>17-18 years</td>
<td>107</td>
<td>35.7</td>
</tr>
<tr>
<td>19-21 years</td>
<td>122</td>
<td>40.7</td>
</tr>
</tbody>
</table>

Ethnicity

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Born in Sweden</td>
<td>284</td>
<td>95.0</td>
</tr>
<tr>
<td>Born in another Nordic country</td>
<td>1</td>
<td>0.3</td>
</tr>
<tr>
<td>Born in Europe; outside the Nordic countries</td>
<td>5</td>
<td>1.7</td>
</tr>
<tr>
<td>Born outside Europe</td>
<td>9</td>
<td>3.0</td>
</tr>
</tbody>
</table>

Have had VIC

<table>
<thead>
<tr>
<th>Have had VIC</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>292</td>
<td>97.3</td>
</tr>
<tr>
<td>No</td>
<td>8</td>
<td>2.7</td>
</tr>
</tbody>
</table>

Age at first VIC (n=288)

<table>
<thead>
<tr>
<th>Age at first VIC</th>
<th>n</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-12 years</td>
<td>8</td>
<td>2.8</td>
</tr>
<tr>
<td>13-14 years</td>
<td>84</td>
<td>29.2</td>
</tr>
<tr>
<td>15-16 years</td>
<td>138</td>
<td>47.9</td>
</tr>
<tr>
<td>17-20 years</td>
<td>58</td>
<td>20.1</td>
</tr>
</tbody>
</table>

Note: Internal dropout= (0.3-1.4%)

In study II, 16 women aged 14-20 years, recruited from the sample in study I, took part in a qualitative interview study. The inclusion criterion was having experienced pain during VIC during the previous month. Exclusion criteria were not being able to speak and understand Swedish. During the 2-month study period, 102 women had experienced pain during VIC the previous month, and 52 of them accepted to participate in an interview study. We used purposeful and theoretical sampling (further explained on p.30), in order to gather a heterogeneous sample. When contacted by telephone, 2 women declined participation and 7 women stated that they had not experienced pain during VIC during the previous month when asked again. Table 3 presents background characteristics of the participants.
Table 3. Characteristics of the 16 participants in study II

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Women (n=16)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Median years (range)</td>
<td>18 (14-20)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Born in Sweden</td>
<td>15</td>
</tr>
<tr>
<td>Adopted</td>
<td>1</td>
</tr>
<tr>
<td><strong>Present occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Student nine-year compulsory school</td>
<td>3</td>
</tr>
<tr>
<td>Student senior high school</td>
<td>9</td>
</tr>
<tr>
<td>University</td>
<td>3</td>
</tr>
<tr>
<td>Employed</td>
<td>1</td>
</tr>
<tr>
<td><strong>Housing conditions</strong></td>
<td></td>
</tr>
<tr>
<td>Living with both of their parents</td>
<td>8</td>
</tr>
<tr>
<td>Living with their mother</td>
<td>1</td>
</tr>
<tr>
<td>Living with their partner</td>
<td>2</td>
</tr>
<tr>
<td>Living with a friend</td>
<td>1</td>
</tr>
<tr>
<td>Living alone</td>
<td>4</td>
</tr>
<tr>
<td><strong>Age at coital debut</strong></td>
<td></td>
</tr>
<tr>
<td>Median years (range)</td>
<td>14.5 (11-16)</td>
</tr>
<tr>
<td><strong>Present contraceptive use</strong></td>
<td></td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>13</td>
</tr>
<tr>
<td>Gestagen implant</td>
<td>2</td>
</tr>
<tr>
<td>Condom</td>
<td>1</td>
</tr>
<tr>
<td><strong>Relationship/Single</strong></td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>12</td>
</tr>
<tr>
<td>Single</td>
<td>4</td>
</tr>
<tr>
<td><strong>Durations of symptoms</strong></td>
<td></td>
</tr>
<tr>
<td>Median months (range)</td>
<td>3 (1-36)</td>
</tr>
</tbody>
</table>

Note. Data registered at the time of the interview

In study III, we used purposive sampling in order to select a heterogeneous sample concerning age. A total of 14 women, aged 14-20 years, who consulted two YCs in two different cities in southern Sweden, participated in qualitative interviews. Inclusion criteria were: women under 21 years of age and having had VIC during the previous 6 months. Exclusion criteria were experience of pain during VIC and not being able to speak and understand Swedish.

Of those 37 women who initially agreed to participate, two no longer wished to participate when contacted, and another three women’s telephone calls were disconnected. Table 4 shows background characteristics of the participants.
<table>
<thead>
<tr>
<th>Characteristics</th>
<th>Women (n=14)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>Median years (range)</td>
<td>18 (14-20)</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
<td></td>
</tr>
<tr>
<td>Born in Sweden</td>
<td>13</td>
</tr>
<tr>
<td>Born in Europe; outside the Nordic countries</td>
<td>1</td>
</tr>
<tr>
<td><strong>Present occupation</strong></td>
<td></td>
</tr>
<tr>
<td>Student nine-year compulsory school</td>
<td>2</td>
</tr>
<tr>
<td>Student senior high school</td>
<td>8</td>
</tr>
<tr>
<td>University</td>
<td>2</td>
</tr>
<tr>
<td>Employed</td>
<td>2</td>
</tr>
<tr>
<td><strong>Age at coital debut</strong></td>
<td></td>
</tr>
<tr>
<td>Median years (range)</td>
<td>14.5 (13-17)</td>
</tr>
<tr>
<td><strong>Present contraceptive use</strong></td>
<td></td>
</tr>
<tr>
<td>Oral contraceptives</td>
<td>11</td>
</tr>
<tr>
<td>Gestagen implant</td>
<td>2</td>
</tr>
<tr>
<td>Condom</td>
<td>1</td>
</tr>
<tr>
<td><strong>Relationship/Single</strong></td>
<td></td>
</tr>
<tr>
<td>Partner</td>
<td>8</td>
</tr>
<tr>
<td>Single</td>
<td>6</td>
</tr>
<tr>
<td>Partner since median months (range)</td>
<td>6 (2-24)</td>
</tr>
</tbody>
</table>

*Note. Data registered at the time of the interview*

**In study IV,** 1566 female senior high schools students 18-22 years old representing the two counties of Östergötland and Skåne participated in a questionnaire study. The sample was a subsample from the project “Female and male third-year high school students’ experiences of and attitudes toward body and sexuality”. Östergötland and Skåne are situated in the south of Sweden and have small- and medium-sized cities as well as countryside areas, and university as well as industrial cities. In order to obtain two equivalent regions, Malmö, a large city situated in Skåne County, was excluded. Both private and public schools, as well as both general/economic and practical/vocational classes were included. In Östergötland County, all 34, and in Skåne County, 50/100 of the private and public senior high schools were contacted. Four school principals in Östergötland, and 27 in Skåne declined participation because of a shortage of available time on the students’ schedules. In Skåne, one school principal refused participation due to the study topic. The final target group consisted of 226 classes at 52 senior high schools in Östergötland and Skåne.

Inclusion criteria were being a woman ≥18 years of age, able to read and speak Swedish. Students not present in the classrooms at the time of data collection were 544, and the reasons given for their absence were illness, truancy, school trip, study tour, individual work, etc. At the time of data collection, 1616 women were present...
in the classrooms, but 45 women were excluded due to age <18 years. Thus 1571 female students were eligible, 4 women declined participation, 1 woman did not participate because of a handicap and 1566 participated in the study (response rate 99.7%). From general/economic classes there were 756 students and from practical/vocational classes 810 students; 911 students came from Östergötland County and 655 students from Skåne County. Background characteristics of the participants are displayed in Table 5. We found no differences in the prevalence of behaviour related to our outcome measures between the women representing the two counties; thus we treat the samples as one.

<table>
<thead>
<tr>
<th>Table 5. Background characteristics of participants in study IV (n=1566)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>n</strong></td>
</tr>
<tr>
<td><strong>Age</strong></td>
</tr>
<tr>
<td>18 years</td>
</tr>
<tr>
<td>19 years</td>
</tr>
<tr>
<td>20 years</td>
</tr>
<tr>
<td>21-22 years</td>
</tr>
<tr>
<td><strong>Study program</strong></td>
</tr>
<tr>
<td>Practical/vocational</td>
</tr>
<tr>
<td>General/economic</td>
</tr>
<tr>
<td><strong>Ethnicity</strong></td>
</tr>
<tr>
<td>Born in Sweden</td>
</tr>
<tr>
<td>Born in another Nordic country</td>
</tr>
<tr>
<td>Born in Europe; outside the Nordic countries</td>
</tr>
<tr>
<td>Born outside Europe</td>
</tr>
<tr>
<td><strong>School region</strong></td>
</tr>
<tr>
<td>Östergötland County</td>
</tr>
<tr>
<td>Skåne County</td>
</tr>
<tr>
<td><strong>Smoker</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Have had VIC</strong></td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
<tr>
<td><strong>Age at first VIC (n=1239)</strong></td>
</tr>
<tr>
<td>7-12 years</td>
</tr>
<tr>
<td>13-14 years</td>
</tr>
<tr>
<td>15-16 years</td>
</tr>
<tr>
<td>17-20 years</td>
</tr>
</tbody>
</table>

Note: Internal dropout= (0.3-1.6%)
Data collection

Study I

Study I had a cross-sectional design and was based on data retrieved from a questionnaire.

Procedure
Each woman who had consulted a physician, midwife, social worker or nurse at the YC received oral and written information about the study, its aim and voluntariness. The women, who gave oral informed consent to participate, filled in the questionnaire in a separate room at the YC. The participants returned the answered questionnaires in a sealed box.

Questionnaire
The questionnaire used in study I was developed by EE and BW and was based on review of the literature, clinical knowledge and observations. A pilot study was performed with 10 patients at the YC, where the understanding of each question was examined and evaluated. In addition, each question was discussed with midwives and research colleagues. Since all questions seemed appropriate, the questionnaire was regarded as useful in its original form. The questionnaire includes 19 questions covering age, ethnicity, first V1C, and experiences of pain and discomfort during V1C. The questionnaire, translated by two authorized translators “back-and-forth” (Swedish-English-Swedish), is shown in Appendix. The questionnaire consists of yes and no alternatives, and answers with four alternatives, where no dichotomizing was performed.

Study II and III

In study II and III, individual, qualitative, in-depth interviews were performed for data collection.

Procedure
In study II, women who had participated in study I, had reported experience of pain at V1C during the previous month, and answered yes on question 14 (Appendix), were contacted by EE. In study III, women who had visited midwives, social workers or nurses at two different YCs were invited to participate in a qualitative interview study. The women got oral and written information from the staff about the nature of the study, its voluntariness and the fact that a researcher (EE) would contact them.
During a 4-month (study III) and 5-month (study II) period, EE contacted potential informants by telephone. They received additional oral information about the study and an appointment was scheduled. Oral informed consent was obtained before each interview, where the participant also gave permission to audiotape the interview.

**Interviews**

The individual interviews in study II and III, carried out in a room at the YC, were all performed by EE and lasted 20-90 minutes. A minor sociodemographic questionnaire was completed; to establish a relaxed contact a small conversation took place before each interview. Two different interview guides [118, 119] had been constructed for collecting data in the two separate studies.

The guiding open-ended questions in study II were:

a) Describe a sexual situation typical of your sex life during the past month.

b) How does coital pain affect your life?

c) Why do you think women continue to have VIC despite pain?

The open-ended questions in study III were:

a) Can you tell me what a normal sexual situation is for you?

b) What is good sex for you?

c) Do you feel expectations about how to act as a woman in a sexual situation?

During the interview, participants were asked to enter into detail about the topics via probing questions like “Can you tell me more about it?” and “Can you explain how you think about that?” The interview guide was modified throughout study II, in response to emerging codes and categories according to grounded theory methodology [94, 120]. When the interview was finished, the participants’ feelings about being interviewed and their situation were discussed. The total time required was 60-180 minutes. Each woman participated in only one individual interview. Memos [93, 94] were written after each session. All interviews were transcribed verbatim, including pauses, interruptions, laughs, coughs, silences and intonation such as raised voice.

**In-depth interviews (study II and III)**

In-depth interviews are frequently used in qualitative studies and were used in study II and III in this thesis. Qualitative data from interviews consist of direct quotations from the informants about their opinions, experiences, feelings and knowledge [121]. It often takes the form of a conversation about daily life, but the professional conversation is a specific method for obtaining knowledge and understanding [119]. The interviewer has a specific approach and focus on
methodological issues such as the research questions, and on the dynamics between
the interviewer and the informant, but also pays attention to what the informants
really say and how they say it (i.e., body gestures and facial expressions) [119]. The
interviews generate a wealth of detailed information about a selected group of
people and cases [121], and give the researcher a possibility to get close to the
informants’ own conception of their lived daily world [119]. There is no substitute
for this raw data [121]. Important components in the interview situation are
building trust and respect and encouraging the informant to feel as comfortable as
possible [90, 119]

**Purposive and theoretical sampling (study II and III)**

Purposive sampling, performed in study III, means selecting informants who fulfil
the purpose of the study: i.e., typical cases, unusual cases, extreme cases or cases
contributing to a maximum range of variations [87].

In study II the initial stages of data collection consisted of purposive sampling
followed by theoretical sampling, when categories began to emerge.

Theoretical sampling according to the grounded theory method is an ongoing
process of data collection for receiving cases for theory development [94, 120, 122].
The selection of interviewees/sources is guided by the process of reaching the
emerging theory [123]. The interview guide is revised during this process to fill
conceptual holes and gaps [94, 120]. The sampling procedure continues until
saturation is attained, so there are no limits in the beginning of the study regarding
number of participants.

Theoretical saturation is the point during analysis when additional data information
does not substantially contribute to the categories [91, 94, 123]. In study II and III,
no new categories emerged by the time 13, respectively 11, interviews had been
analysed. Analysis of three additional interviews in both studies confirmed that
saturation had been achieved [91, 94].

Following Glaser’s grounded theory method of collecting data through theoretical
sampling simultaneously with the coding and analysing process [94] was not
possible all the way through study III due to logistical reasons. However, the
purpose of reaching theoretical saturation, was fulfilled.
Study IV

Study IV had a cross-sectional design and was based on data collected by means of a questionnaire.

Procedure
A preparatory meeting was held with the chief school-health physician and a school nurse in Östergötland for discussing the aim of the study and possible procedures. The contact with the schools was established by sending out an informational letter to the principals of the high schools about the background, aim and procedure of the study, followed up by a telephone call from EE. Additional information about the study was given during the telephone call, and practical issues were discussed. The principals, who gave permission for us to carry out the study at their school, informed the teachers. The nurses and/or social workers at the schools were personally informed by EE by telephone. During a 3-month period EE and three to six study assistants visited all the participating classes in Östergötland and Skåne County. The students received oral and written information about the study, including information about voluntariness and that they could discontinue participation whenever they wanted, without giving a reason. The questionnaire contained no identification information. Answering the questionnaires took place in the classrooms or lecture halls during a lesson included in the ordinary time plan of the week, and took 25-40 minutes. To maximize privacy and to minimize peer influence, the desks were separated if possible, and each participant received a screen produced for this study to place on the desk, which prevented neighbours from seeing the respondent's answers. The students put the completed questionnaire in a sealed box, which was collected after each session by EE. In order to meet the potential needs for counselling evoked by the study, all the students were given a card with a telephone number to the local YC, police, RFSU [25], and the nurse and social worker at the school.

Questionnaire
The questionnaire used in study IV was devised by the research team and based on clinical experience, an extended version of the questionnaire used in study I, results from study II and III, other research in the field, and scrutiny of existing questionnaires and instruments [30, 34, 124-126] that assess sexual issues. A pilot study was performed to test the questionnaire and procedure with three third-year high school classes in Vimmerby, Kalmar County. Statistics Sweden [127] scrutinized the questions to improve the quality of measurement technique and effectiveness [128]. Two different research groups discussed and evaluated the final version of the items. The questionnaire was finally revised according to the result from the pilot study, suggestions from Statistics Sweden and from the two research groups. The questionnaire contained 201 questions divided into eight parts: (1) Background variables, (2) Sexual experiences, (3) First VIC, (4) Sexual functions/dysfunctions, (5) Pain and/or discomfort during VIC, (6) Expectations
during sexual situations, (7) Experiences of sexual abuse, and (8) Attitudes to sexuality. In this thesis we have chosen to focus on variables about background characteristics, pain and/or discomfort during VIC, and expectations during sexual situations.

Introductory sections in all parts of the questionnaire pointed out that differences in young people’s sexual experiences are normal, and that the alternative “not relevant for me” was available to those who had no personal experience of an item.

As background variables we included age, ethnicity, school region, study program, smoking habits and age at first VIC. We divided all study programs into two groups, one representing the practical/vocational program and the other representing the general/economic program. Ethnicity was recoded into Born in Sweden, Born in another Nordic country, Born in Europe outside the Nordic countries and Born outside Europe.

Our dependent variables in this study were (1) experience of pain and/or discomfort during VIC and (2) continuing to have VIC despite pain and/or discomfort.

The first variable, “experience of pain and/or discomfort during VIC”, was based on the question “How often do you experience pain and/or physical discomfort as for example itch, smarting pain, press, burning or cutting feeling at the beginning, during and/or after VIC?”

If the women had experienced pain and/or discomfort during VIC they were asked to answer the questions for the second variable: “Does it happen that you continue to have VIC despite pain/discomfort?”, and the independent variable “Does it happen that you feign enjoyment despite pain/discomfort?” Answers were given on a six-grade scale: Never, Seldom, Sometimes, Fairly frequently, Almost every time and Every time. We dichotomized the answers into Yes and No, by regarding the answers Sometimes to Every time (3-6) as indicating Yes and Never to Seldom (1-2) as indicating No. The women were also asked if they had told their partners about their experience of pain/discomfort, with the answer alternatives Yes or No.

Participants, who had reported that they continued to have VIC, and/or feigned enjoyment despite pain and/or discomfort during VIC, were asked for their reasons for doing so. The women were given a range of preformulated options to select from, and an empty space was also provided to allow for other answers. The women were allowed to select one or more alternatives.

Participants were asked “Does it happen that you have difficulty refusing to have sex if your partner wants sex but you don’t?” “Does it happen that you feel inferior to your partner during sex?” and “Does it happen that you think that it is more important that your partner becomes satisfied than you, while having sex?” The answering alternatives (six-grade scale) consisted of Never, Seldom, Sometimes, Fairly frequently, Almost always and Always. We dichotomized the answers into Yes and No as before, after regarding the answers Sometimes to Always (3-6) as indicating Yes and Never to Seldom (1-2) as indicating No.
We also asked for estimates of the women’s satisfaction with their sex life, formulated as to what extent they were satisfied/dissatisfied on a six-grade scale from Very satisfied to Very dissatisfied, which we dichotomized into satisfied with sex life (1-3) and dissatisfied with sex life (4-6).

Data Analysis

Statistical analysis (study I and IV)

Statistical analysis was performed in SPSS (Statistical Package for the Social Sciences) for Windows, versions 14.0 (study I) and 16.0 (study IV). We used the Pearson Chi-square test both in study I and IV for comparisons between groups. In study I the Pearson Chi-square test was used to investigate differences in reported experiences in relation to pain during first VIC. Chi-square tests were also used to assess differences in reported pain and experience of first VIC, in relation to age at first VIC (<15 years or ≥15), and in relation to experience of pain during the previous month. In study IV we used the Pearson Chi-square test to investigate differences in reported experience of pain during VIC in relation to the partner’s and their own satisfaction. The Chi-square test was also used to investigate differences in continuing to have VIC despite pain, in relation to the partner’s and their own satisfaction, feigning enjoyment and omitting telling the partner about pain. Binary logistic regression was used in study IV to explore the relationship between continuing to have VIC despite pain and statistically significant factors in the univariate analyses. All observed differences with p-values at <0.05 were considered as statistically significant.

Constant comparative analysis (study II and III)

The in-depth interviews in study II and III were analysed using the principles of the Constant comparative method from grounded theory, advocated by Glaser and Strauss [91]. The Constant comparative method follows a systematic coding process, where indicators in the data are compared and similarities are identified. The process is circular, as the researcher continually goes back and forth among the data, emerging concepts, theory and participants [94]. To assure the accuracy of the transcriptions in study II and III, the tapes were replayed and the transcriptions were reread. Each transcript was coded manually and separately, beginning with examining the text with line-by-line analysis to find words or phrases that were meaningful for the research question [94, 129]. These meaningful words or phrases were extracted and substantive codes were generated,
which were given names derived from the data. Through the constant comparison process, substantive codes from the same and other interviews were compared to identify similarities and differences, which clarified patterns that were systematically developed into abstract categories. The relationships between the codes and the categories were clarified through comparing each category with other categories and codes, and regrouping, until full understanding was achieved. Theoretical memos, written during the data collection and analysis process, were used to create an understanding of the categories. According to Glaser, memo writing is an essential part of grounded theory methodology [93, 94]: “Memos are the theorizing write-up of ideas about substantive codes and their theoretically coded relationships as they emerge during coding, collecting and analyzing data and during memoing” [93 p. 177].

During the final stages in the constant comparison analyzing process, a central phenomenon, the core category arises, when the following questions is continually asked: “What is actually happening in the data? What is the basic social psychological process or social structural process that processes the problem to make life viable in the action scene?” [94 p. 57]. When theoretical saturation was obtained, the emerging theory, i.e. the core category, was considered “grounded in the data” [94].

To ensure the trustworthiness of the research process and findings [130], CB was involved in the coding and analyzing process. Similarities and differences in the emerging codes and categories were discussed until agreement between EE and CB was reached.

**Ethical considerations**

Ethical issues were repeatedly discussed during the work with this thesis, as sexology research in human beings inevitably raises ethical considerations.

All four studies were reviewed by the regional ethical review board at Linköping University. Study IV was also reviewed by the central ethical review board in Stockholm. Even if several ethical decisions are taken before a study is performed, ethical questions also continuously arise during the research process [119]. The researcher (EE) had experience in working with sensitive issues concerning youth sexuality, which had increased her capacity to handle those issues in the research process.

All the participants gave informed consent after receiving oral and written information about the studies, including information that participation was voluntary, and that they could withdraw their decision to participate at any time.

Study I, II and III were conducted at YCs, which necessitated informing the participants that declining or withdrawing participation would not affect their future contact with the YC.

In study I, II and III there were patients at the YC, women < 18 years of age, who participated without their parents’ permission, which is an ethical dilemma.
According to the Swedish law (2003:460) concerning ethical review of research of humans [131], parental consent is not needed when the participants are between 15 and 17 years of age, they understand the meaning of the research, and give consent. Informed consent from the parents for our studies might have caused more harm than good, when counselling sessions with young women <18 years of age, are held every day at YCs without parents’ knowledge. The minors’ data at the YC is protected by the secrecy act, when there is a risk that information to parents could harm the individual [23, 27, 28]. Even if an interview, as in study II and III, can evoke emotions of discomfort, it can also be a positive and enriching experience for the participants; someone is listening and is interested in their experiences [119]. The interview itself can influence behaviour in a positive direction. Furthermore, all the participants were offered further consultations at the YC if they wanted.

Confidentiality is important in this kind of studies. Thus each participant in the interview study was assigned a code number, which was the only means to identify all her data. Tapes and transcripts were stored separately in a locked box, according to standard research protocols.

In study IV, which was conducted in a school environment, other ethical concerns were raised. How could we reduce the risk of harming participants in our study at the school? As described earlier, the desks were separated if possible and each participant’s desk had a screen, produced for this study, to hide the answers from the other participants.

Sections in the questionnaires were introduced with a short text pointing out the normality of differences in young people’s sexual experiences; and the alternative “not relevant for me” was available for those who had no personal experience of what was asked for in specific questions. The questionnaire contained no identification information and the participants left the completed questionnaire in a box, which was closed and collected by EE.

In case anybody wanted personal counselling, all the participants received a card with a telephone number to the local YCs, police, RFSU [25], and the nurse and social worker at their own school.
RESULTS

Prevalence of reported experience of pain during VIC

The majority of the women (65%) reported pain related to their first VIC (I; Figure 2, p.100). The distribution of reported degree of pain was as follows: insignificant, 5%; some, 29%; strong, 23%; and very intense, 8% (I; Figure 3, p.100). There was a significantly higher proportion of women who reported pain during their first VIC among the women who had had a more negative experience of their first VIC, than among those with more positive experience (I; Table 1, p.101).

We found high prevalence rates of experiences of pain during VIC in both our samples (I, IV). In the YC sample (I), almost half (49%) of those who had had VIC during the previous month reported pain associated with VIC during that period (I; Figure 2, p.100). The women had often experienced more than one symptom; the three most commonly reported other symptoms were smarting pain (58%), other kinds of pain (23%), and dryness (19%) (I). Forty-seven percent of those women in the senior high school sample (IV) who had had VIC reported experiencing pain during VIC (IV; Table 2, p.8).

Continuing to have VIC despite pain

Almost half of the high school female students (47%), who experienced pain during VIC, reported that they continued to have VIC despite pain (IV; Table 2, p.8). We found similar reasons for continuing to have VIC despite pain in our two methodologically different studies (II, IV). In the interviews the women continued to have VIC despite pain because they were striving to be affirmed in their image of an ideal woman (II). The women’s perception of the characteristics of the ideal woman and the perfect girlfriend consisted of willingness to have VIC, being perceptive to the partner’s sexual needs, and being able to satisfy the partner (II). In the questionnaire study, the three most commonly reported reasons for continuing to have VIC despite pain were “I don’t want to destroy for the partner” (42%), “I feel foolish to interrupt” (41%), and “I don’t want to hurt the partner by interrupting intercourse” (39%) (IV; Table 3, p.8). We found that the women felt affirmed that they were “ideal women” when they had VIC, irrespective of pain (II). The striving to become the ideal woman was accompanied by processes such as resignation, sacrifice and feeling guilt (II). The women resigned because of the repeated experiences of pain, loss of sexual pleasure, and not knowing the cause or prognosis of their pain. Continuing to have VIC despite pain implied that pain became incorporated as a “normal” component of sex life (II). The women sacrificed their own pleasure to avoid being abandoned by the partner because of
sexual insufficiency (II). They felt guilt, since the pain appeared in their bodies, and since the ideal woman does not have sexual problems (II). Moreover, the partner could suspect them of faking pain (II). In study IV, continuing to have VIC despite pain was associated with feeling inferior to the partner during sex (adjusted OR 1.82, CI 1.10-3.02) (Table 6).

"...a guy should like to have sex often...in a way...and I think many guys are like that and...I think when you are a girl that you don't want to go against it, because then you are not a good girlfriend...you don't want to refuse too often, or you never want to refuse at all.../...but this feeling of not being a good enough girlfriend...and not being a good woman at all in a way...it feels like...that you are...less good than someone else...it is difficult to explain though...that you are not capable of something you should manage..."

A quotation from study II

**Feigning enjoyment despite pain**

In the interviews in study II, feigning enjoyment was part of the women’s striving to become an ideal woman (II). One-fifth of the women (22%) who experienced pain during VIC reported that they feigned enjoyment despite experiencing pain (IV; Table 2, p.8), and continuing to have VIC despite pain was strongly associated with feigning enjoyment (adjusted OR 7.45, CI 4.37-12.69) (Table 6). The women thought that pretending enjoyment prevented the partner from feeling sad, distressed, foolish, and inadequate or offended (II). The ideal, perfect woman should not provoke such feelings in the partner (II). The three most common reasons in study IV for feigning enjoyment despite pain were “The partner can be disappointed if I don’t enjoy VIC” (59%), “I don’t want to tell the partner that I don’t enjoy” (42%), and “I feel partner pressure to be able to enjoy VIC” (30%) (IV; Table 4, p.9).
Table 6. Adjusted odds ratios (OR) for associations between continuing to have VIC despite pain, in relation to having difficulty refusing sex, feel inferior to the partner, regard the partner’s satisfaction as more important, dissatisfaction with their sex life and feign enjoyment

<table>
<thead>
<tr>
<th>Variable</th>
<th>Continue to have VIC despite pain</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Adjusted OR</td>
</tr>
<tr>
<td>Difficulty refusing sex when the partner wants it</td>
<td>1.20</td>
</tr>
<tr>
<td>Feel inferior to the partner during sex</td>
<td>1.82*</td>
</tr>
<tr>
<td>Regard the partner’s satisfaction as more important than their own</td>
<td>1.10</td>
</tr>
<tr>
<td>Feel dissatisfaction with their sex life</td>
<td>1.76**</td>
</tr>
<tr>
<td>Feign enjoyment despite pain</td>
<td>7.45***</td>
</tr>
</tbody>
</table>

*p≤.05  **p≤.01  ***p≤.001.
Adjusted for age at first VIC and all included variables within the model.

Partner satisfaction

We found that regarding partner satisfaction as more important than own satisfaction was more commonly reported (p=0.022) among women who continued to have VIC despite pain than among those who did not (IV) (Table 7). Thirty-two percent of the women who experienced pain during VIC omitted telling their partners about their pain (IV; Table 2, p.8). According to our findings in study II, the reason was that they did not want to disturb the partner’s pleasure (II).

The women who did not experience pain during VIC described how influences of the social norm of women being in a subordinated position affected their ability to reach the ideal (hetero)sexual situation “sexual pleasure on equal terms”(III). On the other hand, women who continued to have VIC despite pain seemed to have incorporated being in a subordinated position while striving for their ideal image, and placed the partner’s sexual needs first in order not to make him disappointed (II). A significantly higher proportion (p=0.000) of women who continued to have VIC despite pain, than of those who did not, felt inferior to partner during sex (IV) (Table 7). Women without experience of pain during VIC described a partner’s “own race” as a sexual situation with a selfish partner who had an attitude that the woman should do everything for him (III). Difficulties reaching “sexual pleasure on equal terms” were influenced by experiences of the partner’s “own race” (III). Difficulties refusing sex when only the partner wants it, were more commonly reported among women who continued to have VIC despite pain than among those who did not (IV) (p=0.000) (Table 7).
The women prioritized the partner’s satisfaction higher than their own (II, IV). Women without pain during VIC also experienced the social norms and demands of what women should be like: obliging and always willing to satisfy everyone around them (III). The unequal gendered societal norms directing what a woman should be like were spread in various forms of media such as everyday commercial situations and films (III). The women who continued to have VIC despite pain (II), had the notion that the ideal woman they strived to become was perceptive of the partner’s sexual need and able to satisfy it (II).

"…from porn movies and everything, that you should be in a special way as a girl…that you are inferior in a way/ / That it is the woman’s task to satisfy the man… and the woman gets nothing back… in a way… / It is that image you get in the society… it is impressed in one’s mind… it is like that on the whole, the male-dominated society is everywhere… and that image is there also… yes in the society… the whole world… everywhere… on companies… in family life… everywhere… it is an image you learn from when you are young… you take part in those roles, that a man is more worth… than a woman…”

A quotation from study III

Women’s satisfaction

The women’s satisfaction was affected by their experience of pain during VIC (II, IV). The pain decreased their sexual desire and arousal, and the painful experience remained in their minds, forming a cognitive scheme of negative expectations (II). They could experience physical closeness and intimacy, but sexual pleasure was absent (II). However, their own pleasure was less important than their partner’s (II, IV). Continuing to have VIC despite pain was also associated with dissatisfaction with one’s own sex life (adjusted OR 1.76, CI 1.14-2.72) (IV) (Table 6). On the contrary, women who did not experience pain during VIC expressed an urge to experience the “source of pleasure” (III). Their ideal sexual situation “sexual pleasure on equal terms” was a sexual situation where no one dominates, the man and the woman satisfy each other, and both attain sexual pleasure (III). These women had experienced sexual pleasure and longed to experience it again (III).
Table 7. Continuing to have VIC despite pain in relation to difficulty to refuse sex, feel inferior to the partner, regard the partner satisfaction as more important than their own, dissatisfaction with their sex life, feign enjoyment and omit telling the partner about pain.

<table>
<thead>
<tr>
<th>Continue to have VIC despite pain</th>
<th>Yes</th>
<th>No</th>
<th>P</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>n=576*</td>
<td>n=270 (%)</td>
<td>n=306 (%)</td>
</tr>
<tr>
<td>Difficulty refusing sex when the partner wants it</td>
<td>92 (34.3)</td>
<td>63 (20.7)</td>
<td>0.000</td>
</tr>
<tr>
<td>Yes</td>
<td>176 (65.7)</td>
<td>242 (79.3)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feel inferior to the partner during sex</td>
<td>73 (27.2)</td>
<td>37 (12.2)</td>
<td>0.000</td>
</tr>
<tr>
<td>Yes</td>
<td>195 (72.8)</td>
<td>266 (87.8)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Regard the partner’s satisfaction as more important than their own</td>
<td>198 (74.4)</td>
<td>198 (65.6)</td>
<td>0.022</td>
</tr>
<tr>
<td>Yes</td>
<td>68 (25.6)</td>
<td>104 (34.4)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feel dissatisfaction with their sex life</td>
<td>97 (36.1)</td>
<td>60 (19.7)</td>
<td>0.000</td>
</tr>
<tr>
<td>Yes</td>
<td>172 (63.9)</td>
<td>244 (80.3)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Feign enjoyment despite pain</td>
<td>106 (39.8)</td>
<td>20 (6.7)</td>
<td>0.000</td>
</tr>
<tr>
<td>Yes</td>
<td>160 (60.2)</td>
<td>278 (93.3)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Omit telling the partner about pain</td>
<td>94 (34.8)</td>
<td>90 (29.6)</td>
<td>0.182</td>
</tr>
<tr>
<td>Yes</td>
<td>176 (65.2)</td>
<td>214 (70.4)</td>
<td></td>
</tr>
<tr>
<td>No</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Notes: Internal dropouts = (0.3-2.6%)
* Includes only women who have reported experience of pain during VIC.

Normal-Ideal sexual situations

The women defined a normal sexual situation as having VIC (II, III). For those women who continued to have VIC despite pain, the repeated experiences gradually incorporated pain as a “normal” component in the sexual situation (II). Their image of the ideal woman, willing to have VIC and being able to satisfy the partner, became an important cue to an ideal sexual situation (II). The normal sexual situation for the women who did not experience pain during VIC was influenced by social norms and demands and by the “partner’s own race” (III). These unequal gendered societal norms were stronger in the beginning of a relationship or in a one-night stand than in a relationship that had lasted for a while (III). In their ideal sexual situation, unequal gendered societal norms are absent; two people experience pleasure together without demands on fulfilling expectations (III).
Illustration of sexual situations for women with and without experience of pain during VIC

Women who continued to have VIC despite pain did not experience pleasure but had some intimacy, which, however, did not balance out the heaviness, which their striving to reach the ideal had created---implying resignation, sacrifice and feeling guilt.

The balance of sexual situations for women without pain during VIC was more positive, although social norms and demands and the partner's "own race" were heavier than the source of pleasure.
DISCUSSION

Discussion of findings

Our studies show a high prevalence of pain associated to VIC in young women, and a high prevalence of women continuing to have VIC despite pain. The reasons for the women's continuing to have VIC despite pain were: striving for their ideal image of being a woman, characterized as always willing to have VIC, not wanting to destroy for their partners, being able to satisfy the partner and feeling inferior to partner during sex. Women who continued to have VIC despite pain were in a vulnerable situation and seemed not to be able to resist the unequal gender norms. Women without pain during VIC also felt social norms and demands and had experience of the partner’s “own race”. However, they managed to some extent to resist these unequal gender norms because of their urge to experience own pleasure. For these women, a sexual situation could be associated with sexual pleasure, while on the contrary, women who continued to have VIC despite pain associated a sexual situation with pain.

Studies estimating prevalence of pain during first VIC are rare. We found that 65% of the young women in the series from the YC reported pain during their first VIC, which is a higher prevalence than Hagstad found in 1990 [38]. Despite the high prevalence of pain during first VIC, the majority (65%) of the women experienced the first VIC as more positive than negative, which has also been seen in other studies [34, 37]. One contributing factor to experiencing the first VIC positively despite pain might be that the women expected feeling pain instead of pleasure during their first VIC. Another aspect that could affect their experience, discussed in the literature, is that some young women regard losing their virginity as a gift they give to a partner [106].

Women have different motives for having their first VIC, which could affect their experience. In a Norwegian study among adolescents about motives for having their first VIC, 90% of the participants reported “being in love”; 77%, “curiosity/excitement”; 68%, “sexually aroused”; and 43% reported that “the partner wanted to” [17]. Another study, in Australia among adolescents, found the motives for having the first VIC to be “curiosity”, “peer pressure”, “felt ready” and “to keep him happy”[132]. In our study we have not assessed women’s motives for having first VIC. Therefore, we do not know if the women’s motive affected how they experienced VIC.
Our studies showed a high prevalence of pain during VIC in young women. Although there generally is a shortage of studies in this field, our result is in accordance with findings from a previous Swedish pilot study [65] assessing pain during VIC.

The rate of pain associated with VIC during the previous month in study I might in reality have been even higher. A weakness in our study is that we did not obtain any information about the women who did not have VIC during the previous month. Therefore, women who had pain at VIC, and had refrained from VIC during the previous month, or who could not have VIC due to a condition such as vaginismus, are missing in our study. Another Nordic study [7], found that women with longstanding (>3 months) entry dyspareunia (“pain at vestibular touch and vaginal entry, penile or upon tampon insertion”) more frequently abstained from VIC than women without such experiences, even if they had a steady partner [7].

It is well known that women continue to have VIC despite pain [116, 133], but we have not found any studies estimating the prevalence of this behaviour. Therefore, we find the high prevalence in our study noteworthy. Painful VIC could trigger a vaginistic reflex, initially as a defence mechanism and, when repeated, as a conditioned response [73, 78, 79]. Theoretically, such responses easily become firmly established reactions, which may become more entrenched as time goes by and the range of conditioned stimuli increases. Therefore, an unknown proportion of young women who continue to have VIC despite pain run the risk of developing chronic pain associated with VIC.

One mechanism for developing vaginismus could be previous attempts at VIC causing pain. On the other hand, the reflex contraction of the vaginal musculature in itself causes burning pain in patients with vaginismus [73]. If vaginismus could be a result of pain during VIC in young women, vaginismus may also maintain pain during VIC. However, it is still unclear when and why pain during VIC in some women becomes a chronic sexual problem. Thus vaginismus and pain sensations are often mutually reinforcing each other.

In our studies, the behaviour of those women who continue to have VIC despite pain illustrates the conventional gendered notion of femininity. They are striving to be an ideal woman who is always willing to have VIC and regards the partner's satisfaction as more important than their own. This is in line with other studies exploring gender issues and sexuality [102, 113, 115, 116]. Holland et al. [102] found in their studies about adolescents, gender and heterosexual practice, that women were expected to hold a passive position and be responsible for the partner’s desire [102]. The women wanted to make the partner happy and sacrificed their own desire [102]. Our findings also reveal that women are sacrificing themselves during VIC for the partner's pleasure; they continue to have VIC despite pain to make their partner happy. Approximately 40% of the women who continue to have VIC despite pain do so in order not to destroy for the partner, or hurt the partner by interrupting VIC. We also found that feigning enjoyment was
associated with continuing to have VIC despite pain, and the women gave similar reasons for this behaviour; i.e. preventing the partner from becoming disappointed. These expectations of femininity as “caring heterosexual partner” and being a “good” woman have also been found in other studies exploring older women who experience pain during VIC [116]. These women felt guilt and shame and positioned themselves as “inadequate sexual partner-woman” when they had difficulties in satisfying their partner by having VIC [116]. Other studies, assessing why women are faking orgasm, have found femininity notions being dominant, like the importance of being responsive to the partner and giving proof of the partner’s good technique [14, 134].

An important question is whether young women following femininity norms will internalize or resist the conventional notion of femininity when they become adults. Similar cognitions have been demonstrated in adult women with pain during VIC [115, 116]. Yet, studies with prospective designs are needed to answer this question.

The fact that VIC in our studies was defined as the “normal” sexual situation corresponds well with other studies assessing sexuality norms [102, 115, 116]. The women who experienced pain during VIC were afraid that if they did not manage to have VIC, the partner might leave them for someone else. Penile-vaginal intercourse has for long been regarded as “real sex” and “proper sex” and is discussed as one part of the hetero-normative gendering society [115, 116]. This notion of the importance of VIC in heterosexual practice makes it problematic when there is a sexual dysfunction involved; like pain during VIC in women, and erectile dysfunction or premature ejaculation in men. Feelings such as not being a “real” woman or man might arise when there are obstacles to taking part in the normative heterosexual act due to sexual dysfunction; i.e. inability to perform the “proper” man’s or woman’s role.

Hegemonic masculinity [97, 99, 108] is a widespread ideal and an image that affects the sexuality of many young men, and in a certain way also young women’s sex lives [97, 99, 108]. Young women and men have to relate to this hierarchical system, although only a minority of men adopt the hegemonic masculinity [108]. The women in our study without pain during VIC expressed their experience of the unequal gender regime as being in a subordinated position. It was difficult for them to reach their ideal “sexual pleasure on equal terms”, because of the existing femininity and masculinity norms. In the conventional notion of femininity, women learn to suppress their own needs and desires [113, 114]. This is in line with the women in our study, expressing societal demands about obliging and being able to satisfy everyone around them. The women’s experiences of hegemonic masculinity ideals were illustrated by their description of their partner’s “own race”; a selfish partner that just pushes on and gets cross if the woman does not want to do everything for him. Young men probably get masculinity affirmation in male-male relations [111] when telling sexual stories about their “own race”. It is
understandable that women have to struggle to resist both their own demands relating to femininity ideals and their partner's masculinity ideals. Other studies have argued that these unequal gender norms are stronger in the beginning of a relationship [102, 113], which was also the experience of the women in our study. Driving their “own race” might prevent men from “losing face” in the beginning of a relationship or in a one-night stand. Men have traditionally learned to hide weakness and vulnerability because it is a threat to the masculinity norm [107].

We found that continuing to have VIC despite pain was associated with feeling inferior to the partner during sex and feeling dissatisfaction with one's own sex life. Kiefer et al. [103] examined young women’s sexual submissiveness, and found that women at a non-conscious level associated sex with submission and not with dominance. This sex-submission association affected the women's sexual functioning negatively. Associating sex with submission predicted reduced subjective ability to become aroused, and reduced ability to achieve orgasm [103]. Considering Kiefer’s et al. [103] results, it is conceivable that the women in our study who continued to have VIC despite pain also decreased their possibility to reach orgasm both because of feeling inferior to their partners during sex, and because of a decreased sexual desire and arousal due to the experience of pain and their report of dissatisfaction with their sex lives. Another study assessing associations between gender norms and sexual satisfaction showed that college students who considered it important to be similar to gender norms based their self-esteem on others’ approval, reported lower sexual satisfaction and experienced undermined sexual autonomy [96]. These results are in line with our findings of women striving for being an ideal woman, having diminished sexual autonomy by having difficulties in refusing sex when the partner wants it and feeling dissatisfaction with their sex lives.

We found a higher proportion of women, who regarded partner satisfaction as more important than their own among women who continued to have VIC despite pain than among women who did not. Furthermore, the women who continued to have VIC despite pain did not express any critical reflections over their image of the ideal woman and the norms they thereby had incorporated. On the contrary, it was the women without pain during VIC who described an awareness of the unequal gender norms and tried to resist them; even if it was hard. Considering that exposure to traditional gender norms affects young women’s sexual function on a non-conscious level [103], non-conscious submissive behaviour might be more common in women who continue to have VIC despite pain than in women who do not.

Young women who internalise traditional notions of femininity might also be more likely to engage in risky, unpleasurable sexual practises that could increase the risk for unwanted pregnancies, STIs and sexual dysfunction.
Intellectual empowerment [102] can be seen in those women in our study who did not have pain during VIC. They were aware of the unequal gender norms and intended to act and move towards pleasurable sexual situations. However, the partner’s “own race”, influenced by hegemonic masculinity norms and the women’s subordinated position, affected their experiential empowerment [102]. The women with experience of pain during VIC were not aware of, or did not have the power to resist the conventional notion of femininity, nor that of hegemonic masculinity, so reports of empowering behaviour were absent.

A study about the mental health of adolescent girls aged 12-15 [114] found that internalizing conventional femininity ideologies, particularly concerning their body image, was associated with lower self-esteem [114]. It is possible that the women in our study who continue to have VIC despite pain have lower self-esteem than the women who do not continue. Because of the inability in our study to assess causal relationships, it is impossible to tell if a woman’s lower self-esteem could result in her continuing to have VIC despite pain, or if continuing to have VIC despite pain affected her self-esteem, or if both explanations are probable.

Our findings demonstrate that young women are trapped in conventional gender norms. We have only examined young women in this thesis. Studying the women’s partners would have given a complementary picture of gender norms and of the complexity of pain associated with sexual interactions. More knowledge about the structures linked to gender is needed for young people to be able to move towards gender equality.
Methodological considerations

There are both limitations and strengths of this thesis, which deserve comments.

Study I and IV

The two questionnaire studies (I, IV) had two kinds of samples, where different selection biases could arise and influence generalizations from the findings. The results from study I must be interpreted with some caution; it was a small sample and selected from a YC. Studies on youth who attend YCs in Sweden are few. However, one report from a Swedish YC showed that 95% of women born in 1976 had visited that center at least once when they were 17 to 20 years of age [23, 27]. Furthermore, there are other facts that speak for a breadth in attendance: there is an liberal attitude towards adolescent sexuality in Sweden, YCs are well known among adolescent groups since they get information about the local YC in school, and the visits are free of charge and confidential [23, 27]. The high response rate and the low internal dropout in study I further strengthen the generalizability of our results to other similar YC samples.

In study IV, it is difficult to say if our findings would have been different with a more representative sample, e.g., if big cities had been included. However, other Swedish studies assessing diverse questions about adolescents’ sexuality have not found any differences between urban and rural areas [15, 135-137]. In addition, our prevalence rate of women experiencing pain during VIC is in accordance with results from a study conducted in Stockholm, the biggest city in Sweden [65]. Furthermore, to obtain breadth in sociodemographic background factors, the participants in study IV came from both public and private schools, including both general/economic and practical/vocational classes.

Our choice of classroom or lecture hall setting for data collection has certain disadvantages, such as lack of privacy and the risk of peer pressure which might affect the validity of the collected data. However, to increase privacy each participant was provided with a screen produced for this study, and desks were separated when possible.

One ethical/methodological problem is that the response rate was very high, which raises the question of voluntariness. However, we emphasized that the study was voluntary and that the students could remain seated behind the screen even if they did not want to participate. This gave the opportunity for students to decline or withdraw participation without letting their classmates or EE and the assistants know. Despite these actions, the women might not have experienced the voluntariness even if we declared it. However, a considerable number of the participants wrote in the questionnaire that they found the research important and interesting.
On the other hand, our results must be interpreted with some caution because of the high absence rate in the classrooms at the time of data collection. In this group there were probably some students who did not want to participate. However, the high absence rate was independent of whether the investigation had been announced in advance or not. Other shortcomings are that the only information we could obtain about the non-attendants’ were sex and study program, and that we did not offer a second chance for participation for those who were absent. Having the teachers or school nurses distribute the questionnaires instead of EE and assistants, and in addition offering the students a second chance to participate, might have reduced the high amount of non-attendants. However, for ethical reasons we did not want to risk letting the participants feel that people they knew could read their answers. The problem of high numbers of non-attendants has been seen in other classroom studies conducted in Swedish senior high schools [2, 3, 37].

The questionnaires used in study I and IV were constructed by the authors. The information gathered totally depends on which questions were asked and how they were formulated. Other potentially important aspects might not have been asked for. A further validation process with validating key questions, such as continuing to have VIC despite pain and partner satisfaction, with an interview as gold standard, would have strengthened our results. This would have required a separate study.

Yet, in study I the understanding of each question was tested and evaluated among participants (in a pilot study), midwives and research colleagues.

The questionnaire used in study IV was more detailed and elaborated by different groups than the brief questionnaire used in Study I. In addition, a more extensive pilot study was performed, and Statistics Sweden tested out the questions to improve their quality.

Another strength of the questionnaire used in study IV is that it is an extended version of the questionnaire used in study I, based on our qualitative interviews (study II and III) with young women, with and without experience of pain during vaginal intercourse. This mainly theoretical knowledge was the basis of our hypotheses, which were operationalized as questions in study IV. On the other hand we only asked for such reasons for continuing to have VIC despite pain that arose in study II. There could be other conceivable reasons in this sample (IV) for continuing to have VIC despite pain, which we did not ask for, because they did not occur in study II. That is a limitation of a quantitative study design like this.

The answers in our questionnaire studies are dependent on the participants’ ability to recall events, which is a weakness in all retrospective studies. Recall bias might affect the validity in a negative way. However, memories of a certain event as, for example, a first VIC taking place rather recently, are probably clear, if the event did not take place under the influence of alcohol or other drugs.
This thesis did not aim to explore what kind of pain during VIC the women had experienced from a medical, diagnostic perspective. Such a research question would have required a totally different study design. Instead, the aim was to obtain the women’s subjective reports, i.e., the women’s perspective.

Due to the lack of information about what kind of pain during VIC the women had, it is not possible to find out (referring to the characteristics of the pain) which women continue to have VIC despite pain and which do not. For instance, we don’t know if women with longstanding entry pain during VIC more seldom continue to have VIC despite pain, as was seen in Edgardh’s et al. study [7].

Another weakness in our study as in all cross-sectional studies is that the direction of causality remains to be examined. It needs a prospective design to clarify whether continuing to have VIC despite pain causes women to adopt conventional norms of femininity, or if women who internalise conventional norms of femininity are more likely to engage in VIC despite pain.

**Study II and III**

We found that the grounded theory method was most appropriate for study II and III, as it is suitable for explaining psychosocial interactions [91, 94], which a sexual situation with a partner certainly is. Due to logistic reasons it was not possible all the way through study III to collect and analyse data simultaneously, as it should have been done according to grounded theory method [91, 94]. However, the intention was to reach theoretical saturation. Therefore, more interviews would have been conducted if saturation had not been fulfilled with the 14 interviews of study III.

The findings in study II and III are tied to a specific context that limits transferability to merely similar contexts. A specific limitation is that there was no ethnic diversity among the participants. Although the senior high school sample and the YC sample to some extent included women from different ethnic groups, they were absent in study II and III. Therefore, there might be important questions omitted in the questionnaire of study IV, of high relevance to other ethnic groups.

The content of a qualitative interview is influenced by the setting. It is therefore best to interview participants in their home, where the informants are more comfortable and at ease [138]. Although home interviews are desirable in some situations, they would not be suitable for adolescents living with their parents. We therefore chose the YC; representing a neutral setting the interviewees were familiar with, and where their stories could not be overheard by family members, which theoretically could have biased what they told the interviewer.
We used individual interviews for data collection in study II and III. Confidentiality would not have been the same if we had used focus group interviews, i.e., interviews with a small group of participants. On the other hand, focus group interviews might have given the participants an opportunity to reflect on the experiences and feelings of others [88, 94, 121, 129]. This might have added to their narratives, but might also have decreased the degree of truthfulness, due to the specific topic.

Reflexivity is the reflecting act on the researcher’s role and position, which might affect results of a study [120]. EE conducted the interviews with all the participants. She has earlier worked as a midwife at a YC and has a university education in sexology. This perspective and background might have influenced the results. Her knowledge concerning such sensitive issues as sexuality, the youth culture and its language may have encouraged the interaction between the informants and EE in the individual interviews. That the interviewer was a woman might affect the result. It is difficult to know if the participants would have told about the same experiences if the interviewer had been a man.

When exploring sensitive areas such as sexuality, it is important to be aware of the risk of social desirability; that the participants say what they think the researcher wants to hear or what is appropriate to say according to group norms [139]. This phenomenon is sometimes obvious in off-the-record statements, but it did not arise in this study, neither before nor after the audiotaped interviews. The participants got information about the importance of achieving a deeper understanding of young women’s thoughts and reflections on sexuality and sexual situations.

One way of reducing the risk of bias [140] and confirming the findings is triangulation; i.e., studying phenomena from different views [88, 120]. We used investigator triangulation [88, 120] with two researchers involved in the coding and analysing of the qualitative data, and methodological triangulation [88, 120] when using two methods (qualitative and quantitative) to study women who continue to have VIC despite pain.
GENERAL CONCLUSIONS

Pain during VIC is a common complaint among young Swedish women.

There is a high prevalence of women continuing to have VIC despite pain.

The reasons women reported for continuing to have VIC despite pain were: striving for their ideal image of a woman, characterized as always willing to have VIC, not wanting to destroy for partner, being able to satisfy the partner, and feeling inferior to partner during sex.

The findings illustrate how the unequal gender regimes can affect young women’s (hetero)sexuality negatively; a woman’s striving to fulfil femininity ideals may cost pain.

Women who do not experience pain during VIC also felt pressured by social norms and demands and experienced the “partner’s own race”. However, they tried to some extent to resist these unequal gender norms because of their urge to experience pleasure.

In quantitative studies about sexual dysfunction focus has often been on the occurrence or not of a certain sexual behaviour, e.g., frequency of VIC. Considering the results from this thesis, prevalence measures of VIC does not seem to be a sufficient indicator of sexual problems/health.
STUDY-SPECIFIC CONCLUSIONS

Study I:
• Almost two-thirds of the women who had had VIC reported pain during their first VIC.
• The majority of the women had experienced their first VIC more positively than negatively.
• Pain during first VIC was more commonly reported among women who had had a more negative than positive experience of their first VIC.
• Experience of pain during VIC the previous month, was reported by almost every second of those who report VIC during that period.
• We found no association between experience of pain during first VIC and pain experienced during the previous month.

Study II:
• Striving to be affirmed in their image of an ideal woman explains why the women continue to have VIC despite pain.
• The characteristics of the ideal woman are willingness to have VIC, perceiving their partner’s sexual needs, and being able to satisfy their partner.

Study III:
• Sexual pleasure on equal terms was the ideal sexual situation for women without experience of pain during VIC.
• Influences from social norms and demands, and experiences of the partner’s “own race” were obstacles to reaching the ideal sexual situation.
• An incentive to reach the ideal sexual situation was the wish to experience the source of pleasure.

Study IV:
• Experience of pain during VIC was reported by almost every second of those who have had VIC.
• Continuing to have VIC despite pain was reported by almost every second of those women who reported pain during VIC.
• Every fifth woman feigned enjoyment despite experiencing pain during VIC.
• Not letting the partner know about their pain was reported by one-third of women experiencing pain during VIC.
• The major reason for continuing to have VIC despite pain was prioritizing the partner’s enjoyment, before their own.
CLINICAL IMPLICATIONS

This thesis presents a model for understanding young women’s reasons for continuing to have VIC despite pain, after assessing this phenomenon with both qualitative and quantitative approaches. The knowledge derived can be used by educators, sexologists, physicians and counsellors working to promote sexual and reproductive health in young women.

Irrespective of the cause of pain during VIC, it probably involves psychological and relationship aspects. The cognitions associated with experiencing pain during VIC are important to take into consideration when meeting women with these problems; whether they are causative factors or a consequence of pain during VIC. Early counselling for young women with pain during VIC ought to ameliorate their problems.

The ways in which the unequal gender regime affects young women’s sexuality negatively should be explained in school-based sex education, school health services and YCs. It is important for professionals working with young women and men to constructively provide them with critical reflections about how to challenge these gender norms.
FUTURE RESEARCH

The results from this thesis raise more questions to be further explored with both quantitative and qualitative approaches.

Future research should explore:

- more details about pain during VIC in young women
- what characterises those young women with pain during VIC who in future will develop chronic vulvar pain
- causal links in prospective studies concerning the development of pain during VIC
- other sexual dysfunctions in young men and women from a gender perspective
- young heterosexual men’s ideal sexual situations and expectations of themselves, and the ways in which internalized hegemonic masculinity affects young men’s sexual experiences.

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Den forskning som bedrivs om ungdomars sexuella och reproduktiva hälsa fokuserar till stor del på frekvens av olika sexuella beteenden samt dess koppling till oönskade graviditeter och STI (sexuellt överförbara infektioner). Det finns bristfällig kunskap om kvinnors upplevelser av vaginalt samlag eller om deras förväntningar på sig själva vid en sexuell situation. Eftersom många behandlare och forskare har uppmärksammat att smärta vid vaginalt samlag ofta börjar i yngre åldrar, förefaller det viktigt att undersöka processer som bidrar till smärta vid vaginalt samlag i yngre populationer.

Det övergripande syftet med avhandlingen var att i fyra delstudier få kunskap om unga kvinnors erfarenheter av ideala sexuella situationer och smärta vid vaginalt samlag. ("Smärta" i denna sammanfattning inbegriper även fysiskt obehag såsom kläda, sveda, trängningar, brännande känsla och/eller skärande känsla). Kvinnor i åldern 13-22 år har deltagit i avhandlingen där både kvalitativa och kvantitativa metoder har använts. För studie I, utvecklades en enkät som användes i ett urval av unga kvinnor (n=300) som besökte en ungdomsmottagning. Sexton deltagare från studie I, deltog sedan i en kvalitativ intervjustudie för studie II. I ett
annat urval från två ungdomsmottagningar deltog 14 unga kvinnor i ytterligare en kvalitativ intervjustudie, studie III, med en annan forskningsfråga. För studie IV utvecklades ett frågeformulär som var baserat på resultat från studie I, II och III, och där hypoteser som formulerats på basen av resultat från studie II, testades i ett urval av 3:e årsstudenter (n=1566).

Studie I:
Syftet med denna studie var att undersöka erfarenhet och förekomst av (1) smärta vid första vaginala samlaget och (2) smärta vid vaginalt samlag den senaste månaden och (3) associationer mellan dessa erfarenheter.
Trehundra kvinnor i åldrarna 13-21 år, vilka besökt en ungdomsmottagning besvarade en enkät (svarsfrekvens 97%). Majoriteten (98%) av deltagarna hade haft vaginalt samlag, och av dem rapporterade 65% smärta vid första vaginala samlaget. Majoriteten hade upplevt första samlaget som mer positivt än negativt. Nästan hälften (99/203) av de kvinnor som haft vaginalt samlag under den senaste månaden hade erfarenhet av smärta vid vaginalt samlag under den perioden, och för nästan varannan av dem (46/99) utgjorde detta ett problem. Vi hittade ingen association mellan erfarenhet av smärta vid första vaginala samlaget och smärta vid vaginalt samlag under den senaste månaden.

Studie II:
I denna studie ville vi studera varför unga kvinnor fortsätter ha vaginalt samlag trots smärta.
Sexton kvinnor i åldern 14-20 år och med varierande grad av samlagssmärta valdes ut bland besökare vid en ungdomsmottagning, vilka besvarat enkäten i Studie I, att delta i en kvalitativ intervjustudie. Intervjuerna bandades och skrevs ut i sin helhet och analyserades med Constant Comparative Analysis enligt Grounded Theory. Resultatet visar att de unga kvinnorna ville bli bekräftade i sin bild av en idealkvinna. Resignation, uppfattning och skuldkänsla var komponenter som förklarade varför unga kvinnor fortsätter att ha vaginalt samlag trots att det gör ont. Karaktäriska hos idealkvinna var att alltid vilja ha samlag, ha kunskap om partnerns sexuella behov och möjlighet att tillfredsställa partnern. Upplevelsen av att inte vara en normal kvinna var tydlig, och kvinnorna kände skuldet att de hade svårigheter att leva upp till bilden av idealkvinna. Eftersom smärtproblematiken kvarstod, då kvinnorna fortsatte att ha vaginalt samlag, inkorporerades efter hand samlagssmärta i vad de definierade som normalt vid vaginalt samlag.
Studie III:
I denna studie ville vi studera unga kvinnors, som ej upplevt samlagssmärta, idealbild av sexuella situationer och förväntningar på sig själva vid sexuella situationer.
Fjorton kvinnor i åldern 14-20 år, vilka varit på mottagningsbesök vid två ungdomsmottagningar, haft samlag under det senaste halvåret och inte upplevt samlagssmärta deltog i en kvalitativ intervjustudie. Intervjuerna bandades och skrevs ut i sin helhet och analyserades med Constant Comparative Analysis, Grounded Theory.
Resultatet visade att kvinnornas ideala sexuella situation karaktäriserades av sexuell njutning på lika villkor, som inbegrep att ingen dominerade och att båda parter erhöll njutning. Kvinnorna upplevde hinder för att nå detta ideal så som sociala normer och krav, och erfarenheter av partners ” eget race”. Drivkraften att försöka nå den ideala sexuella situationen var långt efter att få tillgång till denna källa av njutning.

Studie IV:
Syftet med denna studie var att kartlägga (1) hur ofta det förekommer att unga kvinnor trots smärta fortsätter att ha vaginalt samlag, lätsas njuta, och inte berättar för partnern om smärtan, samt (2) anledningar till dessa handlingar.
Totalt 1566 kvinnliga årskurs tre gymnasiestudenter från 226 klasser vid 52 kommunala- och fritstående gymnasiesskolor i Östergötland och Skåne besvarade en enkät. Deltagarna fördelade sig på 810 kvinnor från praktiskt program och 756 från teoretiskt program (svarsfrekvens 99.7%). Bortfallet (n=5) i klassrummet bestod av: 4 som avböjde deltagandet samt 1 som hade en synskada. 544 kvinnliga elever var ej närvarande i klassrummen vid datainsamlingen. Deras frånvaro berodde på sjukdom, skolkr, individuellt val, studiebesök, skolresa, eget arbete osv.
Av de kvinnor som haft samlag rapporterade 47% (591/1259) att de upplevde smärta vid vaginalt samlag. Fyrtiosju procent (207/576) av de som rapporterade smärta vid vaginalt samlag fortsatte ha samlag trots smärta. De vanligaste anledningarna som kvinnorna rapporterade var att de inte ville förstöra för partnern, eller såra partnern med att avbryta vaginalt samlag. Låtsas njuta och att inte berätta för partnern trots att de upplevde smärta rapporterades av 22% respektive 32%. Att fortsätta ha vaginalt samlag trots smärta var associerat med att känna sig underlägsen partnern i sexuella situationer, vara missnöjd med sitt sexliv och låtsas njuta av sex trots smärta vid vaginalt samlag.

Slutsatserna av denna avhandling är att smärta vid vaginalt samlag är vanligt förekommande hos unga svenska kvinnor, samt att en stor andel av unga kvinnor fortsätter att ha vaginalt samlag trots att de upplever smärta. Kvinnornas anledningar till att fortsätta ha vaginalt samlag trots smärta visade sig vara: strävan efter att uppfylla en ideal bild av att vara kvinna, karakteriserad av att altid vilja ha vaginalt samlag, inte förstöra för partnern, kunna tillfredsställa partnern vid sexuella
situationer. Kvinnorna kände sig också i underläge mot partnern vid sexuella situationer. Fynden illustrerar att det ojämlika genussystemet påverkar unga kvinnors (hetero)sexualitet negativt; en kvinnas strävan att uppfylla femininitets ideal sker ibland till priset av samlagssmärta.

För att undersöka sexuella dysfunktioner hos kvinnor används ofta samlagsfrekvens som ett mått. På basen av resultatet från vår intervjustudie (studie II) samt populationsstudien (studie IV) förefaller detta synsätt orimligt.

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“I want to understand the world from your point of view. I want to know what you know in the way you know it.”
[Spradley 1979][141]

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APPENDIX.

RESEARCH QUESTIONNAIRE  STUDY I

1. How old are you?__________________

2. Were you born in Sweden?
   - No
   - Yes
   If you answered no, which country?_________________________________

3. Was either of your parents born in another country?
   - No
   - Yes

4. Do you regard yourself as an immigrant?
   - No
   - Yes

5. Have you had sexual intercourse?
   - No
   - Yes

If you have not had sexual intercourse, you don’t need to answer any more questions.

6. How old were you at the time you first had sexual intercourse?__________________

7. Did the first sexual intercourse you had cause you pain?
   - No
   - Yes
   If you answered yes, to what extent?
   - Very intense
   - Strong
   - Some
   - Insignificant

8. Did you bleed when you first had sexual intercourse?
   - No
   - Yes
   If you answered yes, to what extent did you bleed?
   - A tremendous amount
   - A lot
   - A little
   - Insignificant
9. How did you experience your first sexual intercourse?
   - Only negative
   - Mostly negative and a little positive
   - Mostly positive and a little negative
   - Only positive

10. Have you ever experienced discomfort and/or pain during or after sexual intercourse? For example, a feeling of smarting pain during sexual intercourse, smarting pain after sexual intercourse, itching, pain at contact, burning feeling, a need to pee, a feeling that you might tear or a feeling of dryness.
   - No
   - Yes

   If You answered yes, what did you experience? ___________________________________________________
   _______________________________________________________________________________________

11. Have you had sexual intercourse during the previous month?
   - No
   - Yes

   If you answered yes to question 10, continue with question 11. If you answered no, you don’t need to answer any more questions!

12. During the previous month, have you experienced discomfort and/or pain during or after sexual intercourse? For example, a feeling of smarting pain during sexual intercourse, smarting pain after sexual intercourse, itching, pain at contact, burning feeling, a need to pee, a feeling that you might tear or a feeling of dryness.
   - No
   - Yes

   If you answered yes to question 12, continue with question 13 and 14. If you answered no, you don’t need to answer any more questions!

13. Is pain or other discomfort during or after sexual intercourse a problem for you?
   - No
   - Yes

14. Would you consider meeting me for an interview, where we would talk about the above questions in a little more detail?
   - No
   - Yes

   If you would consider a conversation about this, write your name, mobile number or other telephone number where I can reach you, and a convenient time for me to call.