RESEARCH SUMMARY

INVESTIGATING THE EXPERIENCES OF EVANGELICAL COUPLES COPING WITH PAINFUL INTERCOURSE DURING EARLY MARRIAGE

2023 / 2024 ARIELLE L. LEONARD HODGES, PH.D.

Website: arielleleonardhodges.com
Instagram: @convoswith.drari

BACKGROUND

Pain with sexual intercourse is quite common, affecting about 1 in 5 reproductive-aged women. Pelvic pain can be **primary** or **secondary**, so, it can occur from the first time a woman inserts anything vaginally—including tampons—or after a period of pain-free insertion. Pain can also be constant or only when provoked with insertion. Causes of pelvic pain

TABLE OF CONTENTS

are extremely wide-ranging and can be physical (e.g., vaginal birth, injury, or endometriosis), psychological (e.g., chronic stress or fear of pain), or some combination of factors. As a result, painful sex is referred to as a **"biopsychosocial puzzle,"** often requiring integrative or multidisciplinary assessment and treatment.

THE GOAL:

A COMMUNICATION FOCUS

As with many other health issues, communication plays a central role in the sexual pain experience. Researchers know that verbal and nonverbal messages about sex, purity, gender, and religion/spirituality may be part of the cause of pain in the first place. We know less about how religious partners' communication with each other and with others impacts their ability to **cope and seek support**.

THE RESEARCH

INTERVIEWS WITH:

20 HETEROSEXUAL MARRIED COUPLES

- churchgoing evangelical Christians
- PIV (penis-in-vagina sex, or intercourse) was chronically painful or impossible for women from first attempt
- partners were interviewed separately
- ranged in age from 22-38 (average: 28)
- married 4 months to 14 years (average: 4 years)
- 82.5% White (17.5% mixed race/ethnicity, African American/Black, or Latino/Hispanic)

16 CLINICIANS

- 11 pelvic floor physical therapists, 5 mental health professionals (e.g., LPC, LMFT, clinical psychologist)
- age range: 22-55 (average: 35)
- regularly work with women/couples affected by painful intercourse
- Practicing 3 months to 30 years (average: 7 years)
- 67% White/Caucasian (33% Asian/Pacific Islander, African American/Black)

WHY STUDY EVANGELICAL CHRISTIANS?

Forty-one percent (41%) of U.S. adults identify as "born-again or evangelical," and 1 in 2 evangelical Christians believe premarital sex is a sin, even in committed relationships. This belief is not unique to evangelical Christianity, but the Evangelical Purity Movement of the 1990s and 2000s forged a purity culture that strongly shaped the sexual expectations of many young people, promising sacred and mutually satisfying sex to those who wait for marriage in obedience to God. **The result?** Countless couples discovered only after making a lifelong marital commitment that sex was chronically painful or even impossible. But unless there's abuse or infidelity, painful sex isn't really a reason to divorce, leaving couples no choice but to cope—not only with the pain, but also with the fact that they may have made things worse by trying to do the right thing.

SUMMARY OF RESEARCH FINDINGS

WHAT HELPED COUPLES COPE?

(RE)FRAMING THE SEXUAL PAIN EXPERIENCE

For example...

- Defining and re-defining intimacy to include non-sexual activity, and re-defining sex to include non-penetrative activity like oral sex or manual stimulation. (Note: This strategy backfired for some women who felt shame around premarital sexual activity, leaving them wondering, "If sex is more than PIV [penis-in-vagina intercourse], does that mean I had premarital sex?")
- Blaming external factors such as physical injury or evangelical purity culture, which helped both spouses feel less like the pain was because of something inherently wrong with them or their marriage.
- Framing the experience as a long and non-linear journey to healing.
- Finding opportunity in the pain, such as being an encouragement to others going through something similar or seeing God use the situation to bring them closer together.

STUMBLING THROUGH IT TOGETHER

For example...

- Cultivating teamwork (e.g., troubleshooting during sex, attending medical appointments together), which helped couples feel like they were "in it together." (Note: problem-solving could put couples into an "analytical mindset," which reduced sexual arousal and desire for both partners.)
- Engaging in emotional and spiritual labor to cope and care for each other, which often looked like husbands concealing their feelings of disappointment, frustration, and powerlessness to remain positive and encouraging for their wives, and wives concealing their pain or low libido to prevent their husbands from feeling unwanted or rejected. (Note: both partners often viewed husbands' concealment of negative emotion positively, but wives' concealment of pain and negative emotion negatively.)
- Discussing the emotional meaning of the sexual experience to each of them, which was one of the most valuable coping strategies.

OUTSIDE SUPPORT

For example...

- While some couples seemed to be fine without any formal intervention, most sought a range of treatment (individually or together), with treatment that bridged the mental and physical being most helpful, especially pelvic floor physical therapy.
- Selective and high-quality social support from friends, family, and mentors.
- Emotionally honest prayer to God, which included expressing anger and disappointment, and asking for wisdom, protection from "the enemy," and spiritual virtues (like patience or strength) that would help them cope and lead them on the right path to healing.

WHY DID COUPLES AVOID, DELAY, OR WITHDRAW PROFESSIONAL AND/OR SOCIAL SUPPORT?

THINKING IT WILL RESOLVE

At first, most couples believed that over time, the pain would resolve on its own or they would be able to figure it out.

NO (PERCEIVED) NEED OR BENEFIT

Either the pain was manageable with couples' current approach, or one or both partners did not see any benefit in seeking treatment or sharing with others outside the relationship.

SHAME AND STIGMA

People outside the relationship often did not know how to respond or help, which reinforced feelings of shame and stigma around painful sex.

DISCLOSURE DILEMMAS

How much to share and whom to share it with, since the issue felt very private and was usually seen as the wife's information to share. (Note: many husbands hadn't shared their experience with a single person outside of their spouse.)

DISENFRANCHISING TALK

Constant questioning and stereotyping women experienced when trying to describe their pain, especially from doctors.

INACCESSIBILITY

Certain treatment(s) were not covered by insurance, or the location was too far away.

WHY DID COUPLES SEEK PROFESSIONAL AND/OR SOCIAL

NO CHANGE OR WORSE WITH CURRENT APPROACH

For most couples, repeated attempts at intercourse made the pain worse and decreased arousal

NEED FOR EMOTIONAL SUPPORT

Many couples reached a breaking point and were desperate for support.

KEY FINDING:

Learning to relate to each other sexually and navigating the relational challenges associated with painful sex were Usually more distressing than the pain itself.

DIFFERENT VALID REASON

Some had sought support for a different overlapping physical or relational health issue that seemed like a more valid reason than the pain, which ended up giving them the opportunity to focus on the pain or the distress the pain was causing in the marriage

REFERRAL OR RECOMMENDATION

Some referrals were game changers; others were unhelpful.

MEDIATED SEXUAL HEALTH INFORMATION

Learning from a podcast, blog, or social media post that persistent pain isn't normal or that treatment exists.

WHAT MEMORABLE MESSAGES IMPACTED COUPLES' EXPERIENCE OF COPING AND SUPPORT?

	Typical Message Content [1]	Possible Impact[2]
SOCIALIZING MESSAGES ABOUT SEX		
PURITY CULTURE MESSAGES	"Premarital sex is a sin."[3] "Men want, need, or are entitled to sex in marriage." "Women and girls are responsible for men's sexual purity." "Men will be tempted to use pornography or have an affair if women do not give them sex."	» Difficulty re-defining intimacy (i.e., contending with premarital sexual activity; negotiating meaning and definition of "sex") » Wife's distrust in husband » Wife's steep drop in libido after getting married » Hyper-fixation on figuring out PIV and not hurting wife » Catalyst for (Re)framing the Sexual Pain Experience and Stumbling Through it Together
UNREALISTIC OR ROMANTICIZED IDEAL	"Sex (in marriage) is fun, easy, and pleasurable for both partners." "Sex is beautiful, sacred, and God's design." "Sex is sexy." Messages romanticizing wedding night and honeymoon	» Range of negative emotions (confusion, shock, frustration, anger) » Cognitive dissonance regarding faith » Catalyst for (Re)framing the Sexual Pain Experience and Stumbling Through it Together » Delayed support (Disclosure Dilemmas, Shame and Stigma)
INCOMPLETE, INACCURATE, AND VAGUE SEXUAL HEALTH INFORMATION	Focus on dangers of premarital sex (e.g., pregnancy, STDs) "Sex will be painful (at first)." "You'll figure it out." "Sex will be great if the relationship is healthy."	» Delayed support (Thinking it Will Resolve, No [Perceived] Need or Benefit, Shame and Stigma) » Range of negative emotions (frustration, anger, confusion)

1 These examples are not meant to be read in a particular order or linked to the possible impact in any particular way.

2 Participants' accounts indicate many possible positive and negative impacts of memorable messages, but establishing cause and effect was beyond the scope of this qualitative analysis.

3 Quotation marks are added around typical message content illustratively and may not reflect exact messages participants heard. Message sources included friends, family (parents, siblings, extended family members), clinicians (pelvic floor therapists, gynecologists, mental health professionals), Christian media (books by evangelical authors, Christian podcasts, social media influencers), secular media (movies, TV shows, podcasts, books), coworkers, church contexts (pastors, lay church leaders, youth group, sermons), and educational contexts (teachers, professors, lectures).

(MEMORABLE MESSAGES CONTINUED)

	Typical Message Content	Possible Impact
DISMISSIVE RESPONSES TO PAIN DISCLOSURE		
HASTY SENSEMAKING	Unhelpful questions and assumptions about cause of pain (e.g., sexual trauma, relationship problems) Misdiagnoses Reference to message source's own experience	» Dismissed one or more aspects of the sexual pain experience » Delayed or withdrawn social support or intervention » Sadness and grief when the pain did not resolve
SIMPLE SOLUTIONS	"Sex will be easy and less painful in a different atmosphere (i.e., with a loving partner)." "Drink wine." "Just relax." "Use more/different lube." "Read the Bible or pray more." Disenfranchising Talk	» Delayed or withdrawn social support or intervention » Reinforced feelings of brokenness, failure, and insecurity » Assumed a quick fix to sexual pain that couples had not already tried » Range of negative emotions (frustration, shame, anger) » Difficulty assigning blame to external factors » Catalyzed selective and high-quality network support (i.e., to avoid hearing more simple solutions) » Some reduction of pain and discomfort
INSENSITIVITY AND DISMISSAL	Silence/no response Asking when couple wants to have children Greater concern with how husband is doing Responses of shock and confusion Clinician not reading medical chart Clinician using Disenfranchising Talk (e.g., questioning pain or saying they can do nothing else since they have tried everything)	» Strong negative emotion (anger, frustration) » Medical mistrust » Avoided, delayed, or withdrawn support from social networks and clinicians due to Shame and Stigma and Disclosure Dilemmas » Hyper-awareness during sex (husbands do not want to reinforce previous traumatic medical experiences)

(MEMORABLE MESSAGES CONTINUED)

	Typical Message Content	Possible Impact
INTERVENING AND BUFFERING MESSAGES		
VALIDATION	Passive validation (i.e., legitimizing pain experience) Mediated Sexual Health Information Nonverbal presence ("sitting with" or "grieving with") Empathic responses Asking thoughtful questions cautiously	» Feeling less broken, less alone, and less like it was their fault » Reduction of pain and discomfort » Catalyst for reframing and teamwork behaviors » Grieving the messages and events leading to sexual pain » Support-seeking
ADVOCACY	Going above and beyond to find a solution Husband halting PIV (Psycho)ducation about anatomy and sexual health	» Energizing emotions (empowerment, hope, relief, validation) » Wife feeling like her needs mattered » Reduction in husbands' feelings of powerlessness and frustration » Catalyst for teamwork and sexual communication » Support-seeking (especially holistic treatment)
FLEXIBLE SEXUAL EXPECTATIONS	"Sex is more than PIV." "You can take it slow and don't have to have sex on the wedding night." Debunking romanticized ideals about sex in media and the church New form of Unrealistic or Romanticized Ideal (e.g., "Sex can still be AMAZING!")	» Easier time reframing the sexual pain experience » Less distress on wedding night and throughout early marriage » Increased frustration when PIV is still painful or impossible
SPIRITUAL TRUTHS	Bible verses/stories (e.g., Job, Jonah, David) Corrective teachings or interpretations of Bible verses/stories "Suffering is normal and purposeful." "A husband should be sacrificial and prioritize his wife's pleasure." "God is gracious and merciful."	» Reduction of shame related to premarital sexual activity. » Aided in reframing the sexual pain experience » Normalization of emotionally honest prayer » Range of positive and negative emotions (e.g., anger at church culture)

WHAT FACTORS DO CLINICIANS BELIEVE IMPACT WOMEN'S/COUPLES' ABILITY TO COPE, SEEK SUPPORT, AND HEAL?

Factor	Clinicians sought to manage this by...
SYSTEMIC FACTORS	
KNOWLEDGE LEVELS ABOUT SEXUALITY AND TREATMENT OPTIONS	Debunking misconceptions, providing psychoeducation, and emphasizing that pelvic pain is "common, but not normal" (i.e., should not be normalized, since it is treatable).
MULTIPLE LAYERS OF SHAME AND STIGMA	Minimizing patients' or clients' shame by affirming their courage to seek treatment, validating their pain, and creating a trusting environment; destigmatizing and normalizing sexual health by personifying anatomy and using humor to neutralize perceptions of sexuality.
MORAL, MEDICAL, AND MEDIA MESSAGES	Helping women/couples revise their sexual scripts, though this could be more complicated for couples who attach spiritual meaning to PIV.
INDIVIDUAL FACTORS	
ACCESS TO HOLISTIC CARE	Seeking out supplemental training or partnerships related to sexual health, mental health, or pain science, to provide more holistic support for their patients or clients.
SENSE OF SELF	Instilling hope for healing by validating women's pain and celebrating small wins with them during appointments, which was helpful for women with low self-esteem or self-defeating behaviors.
OVERLAPPING CONDITIONS	Validating women's courage to seek support, since oftentimes women discovered painful sex is not normal when they came in for different concerns. Notably, overlapping conditions (e.g., complex PTSD, chronic stress or anxiety, endometriosis, IBS) could prolong treatment, but also created the opportunity to treat sexual pain.
BUY-IN (I.E., READINESS OR WILLINGNESS)	Suggesting patients pause certain forms of treatment (e.g., pelvic floor therapy) to seek other forms of treatment (e.g., psychotherapy) that may render care more effective.
AUTONOMY AND CONTROL	Empowering women to have autonomy and control in their treatment, bodies, and romantic relationships through (a) being clear about each step in the treatment process, (b) providing space for women's authentic expression of their needs and values, and (c) reminding women healing was for them and not (just) their partners.

CLINICIAN PERCEPTIONS CONTINUED

Factor	Clinicians sought to manage this by...
RELATIONAL FACTORS	
SEXUAL COMMUNICATION DURING AND ABOUT SEXUAL ACTIVITY	Asking patients/clients what their goals are and what sex means to them; referring patients/clients to blogs or books; providing pelvic health education to male partners.
PARTNER SUPPORT	Offering to involve male partners in the treatment process; suggesting couples' or sex therapy if the woman with sexual pain is plateauing in her treatment.
RELIGIOUS CONSIDERATIONS	
LONG JOURNEY	Acknowledging the healing process may take time for women who are unraveling years of sexual messaging and multiple layers of shame.
RELIGIOUS IDENTITY NEGOTIATION	Understanding what a patient's or client's faith means to them and what they perceive the relationship is between their religion and their sexual pain, before presuming a specific relationship or meaning. Also, providing space for clients to express grief, anger, and resentment towards God and their religious community and to aid them in "deprogramming" the messages they had heard growing up (only to the degree clients are comfortable with, since religion could be women's or couples' primary source of support).
PERCEIVED PATIENT-PROVIDER (DIS)SIMILARITY	Drawing on shared identity when appropriate to build trust, and being mindful that identity difference may impact clients' openness in treatment.
CURRENT PARTNER AS ONLY REFERENCE POINT	Creating a safe space for religious client/patient to share about previous sexual experiences (which women may feel reluctant to share due to shame), which may aid in assessing prior sexual function.[1]

1 No clinicians explicilty described this strategy, but this suggestion is offered here based on clinicians' accounts and prior literature.

KEY FINDING:

Clinicians believed coping differences were less about religion than other factors such as moral conservativism, parental upbringing, education level, and societal messages about sex. However, they believed religion was often intertwined with these factors.

RECOMMENDATIONS

FOR...

The two most helpful points of communication intervention for couples were:

(1) Before the wedding night and

(2) When the female partner or the couple first seeks support for painful intercourse.

COUPLES

-Work as a team to seek professional support early, including a trusted mentor or therapist for male partner to process with.

-Look for clinician who meets the most immediate support need and has supplemental training in other therapies (for example, a counselor who has knowledge of pelvic pain, or a pelvic floor therapist who has a certification in mental health).

-Work toward communicating the emotional meaning of the pain experience.

CHURCHES

-Revise premarital education curriculum to involve Christian sex therapists or pelvic floor therapists.

-Avoid outsourcing explicit discussions of sex to gynecologists or Christian marriage books.

-Emphasize that intercourse does not need to happen on the wedding night.

CLINICIANS

-Don't assume history of sexual trauma or abuse.

-If you think there are psychogenic factors at play, be sure to repeatedly validate women's physical pain experience.

-If facilitating couples therapy, use the fact that both partners are often walking on eggshells during sex to facilitate empathy between them.

FOR FURTHER READING

KEY READINGS ARE BOLDED

As-Sanie, S., Till, S. R., Schrepf, A. D., Griffith, K. C., Tsodikov, A., Missmer, S. A., Clauw, D. J., & Brummett, C. M. (2021). Incidence and predictors of persistent pelvic pain following hysterectomy in women with chronic pelvic pain. American Journal of Obstetrics and Gynecology, 225(5), 568.e1-568.e11. https://doi.org/10.1016/j.ajog.2021.08.038

Azim, K. A., Happel-Parkins, A., Moses, A., & Haardoerfer, R. (2021). Exploring relationships between genito-pelvic pain/penetration disorder, sex guilt, and religiosity among college women in the U.S. The Journal of Sexual Medicine, 18(4), 770-782. https://doi.org/10.1016/j.jsxm.2021.02.003

Bairstow, A. M., Pillai-Friedman, S., Crane, B., & Milhausen, R. R. (2018). Holy Grail or nice option: The meaning of penile-vaginal intercourse in "unconsummated" relationships. The Canadian Journal of Human Sexuality, 27(2), 171–179. https://doi.org/10.3138/cjhs.2018-0015

Blass, D. M., & Fagan, P. J. (2001). The treatment of Orthodox Jewish patients in sex therapy. Journal of Sex Education and Therapy, 26(4), 267-271. https://doi.org/10.1080/01614576.2001.11074432

Cooke-Jackson, A., & Rubinsky, V. (2021). Theory of Memorable Messages: Theorizing message disruption. In A. Cooke-Jackson & V. Rubinsky (Eds.), Communicating intimate health (pp. 89-98). Rowman & Littlefield.

Dimiant, J. (2020, August 31). Half of U.S. Christians say casual sex between consenting adults is sometimes or always acceptable. Pew Research Center. https://www.pewresearch.org/fact-tank/2020/08/31/half-of-u-s-christians-say-casual-sex-between-consenting-adults-is-sometimes-or-always-acceptable/

Estrada, L. L. (2022). Clinical considerations of the Evangelical Purity Movement's impact on female sexuality. Journal of Sex & Marital Therapy, 48(2), 121-132. https://doi.org/10.1080/0092623X.2021.1977445

Frydman, S. D. (2022). The quick shift: Orthodox Jewish women's early marital sexual experience. Sexual and Relationship Therapy, 37(3), 360-376. https://doi.org/10.1080/14681994.2022.2027361

Gregoire, S. W. Gregoire Lindenbach, R., & Sawatsky, J. (2021). The great sex rescue: The lies you've been taught and how to recover what God intended. Baker Books.

Hintz, E. A. (2022). "It's all in your head": A meta-synthesis of qualitative research about disenfranchising talk experienced by female patients with chronic overlapping pain conditions. Health Communication, 38(11), 2501-2515. https://doi.org/10.1080/10410236.2022.2081046

Hintz, E. A. & Venetis, M. K. (2019). Exploring the effects of patient-provider communication on the lives of women with vulvodynia. In P. Kellett (Ed.), Narrating patienthood: Engaging diverse voices on health, communication, and the patient experience (pp. 99-116). Rowman & Littlefield.

Holman, A. (2021). "Why don't all parents talk about this stuff": Informational, emotional, and cultural barriers to meaningful parent-child conversations about sex. In A. Cooke-Jackson & V. Rubinsky (Eds.), Communicating intimate health (pp. 19-32). Rowman & Littlefield.

Irby, C. A. (2019). Instructions for God's gift: Emotional management in the cultural transmission of evangelical sexuality. Journal of Contemporary Ethnography, 48(5), 645-673. https://doi.org/10.1177/0891241618808353

Kemble, J., Köhler, T., Helo, S., Warner, J. N., & Ziegelmann, M. (2023). (216) Insufficient medical school sexual health curriculum leads to inadequately prepared trainees. The Journal of Sexual Medicine, 20(1), i133-i134. https://doi.org/10.1093/jsxmed/qdad060.207

Kenny, D. T. (2004). Constructions of chronic pain in doctor–patient relationships: Bridging the communication chasm. Patient Education and Counseling, 52(3), 297-305. https://doi.org/10.1016/S0738-3991(03)00105-8

Leonard Hodges, A., & Bevan, J. L. (2023). "Some days are much holier than others": Relational uncertainty and partner influence in Christian dating couples' sexual intimacy negotiation. Personal Relationships, 30(3), 980-999. https://doi.org/10.1111/pere.12494

Leonard Hodges, A., & LaBelle, S. (2023). Teaching God's design: Exploring the rhetorical and relational goals of evangelical leaders during premarital education about sex. Communication Education, 73(1), 64-83. https://doi.org/10.1080/03634523.2023.2275772

Lovell, D., Hayfield, N., & Thomas, Z. (2023). "No one has ever asked me and I'm grateful that you have" men's experiences of their partner's female sexual pain. Sexual and Relationship Therapy, 1-24. https://doi.org/10.1080/14681994.2023.2293766

Meana, M., & Binik, Y. M. (2022). The biopsychosocial puzzle of painful sex. Annual Review of Clinical Psychology, 18, 471-495. https://doi.org/10.1146/annurev-clinpsy-072720-014549

Nagoski, E. (2015). Come as you are: The surprising new science that will transform your sex life. Simon and Schuster.

Reissing, E. D. (2021). Inability to experience penetrative vaginal intercourse: Evaluation and management. In A. T. Goldstein, C. F. Pukall, I. Goldstein, J. M. Krapf, S. W. Goldstein, & G. Goldstein (Eds.), Female sexual pain disorders: Evaluation and management (2nd ed., pp. 367-374). Wiley-Blackwell.

Rosen, N. O., & Bergeron, S. (2019). Genito-pelvic pain through a dyadic lens: Moving toward an interpersonal emotion regulation model of women's sexual dysfunction. The Journal of Sex Research, 56(4–5), 440-461. https://doi.org/10.1080/00224499.2018.1513987

Russell, M., Yeh, A. L., Sanchez, M., Friesen, D. J., & Stearns, C. (2010). Routes & radishes: And other things to talk about at the evangelical crossroads. Zondervan.

TO ALL WHO PARTICIPATED AND ANYONE READING,

THANK YOU!

Questions? Contact Dr. Leonard Hodges at:

WEBSITE
arielleleonardhodges.com

LINKEDIN
https://www.linkedin.com/in/arielleleonardhodges/

INSTAGRAM
@convoswith.drari

FULL REFERENCE:

Leonard Hodges, A. L. (2024). Investigating the experiences of evangelical couples coping with painful intercourse during early marriage [Doctoral dissertation, Chapman University]. Chapman University Digital Commons. https://doi.org/10.36837/chapman.000533