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A Desire to be 'Normal'? A Discursive and Intersectional Analysis of 'Penetration Disorder'

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Abstract

Psychiatry's problematic framing of femininity, women's bodies, and sexuality has attracted much condemnation (Caplan & Cosgrove, 2004; Frith, 2013; Ussher, 2011). The intersection of sanism and sexism is particularly overt in the psy-complex's (Rose, 1979) response to violence. While psychiatry acknowledges that many of those diagnosed with 'female sexual dysfunction' have experienced sexual abuse, addressing the problems of violence against women is starkly absent within psychiatric discourse. The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* combined 'vaginismus' and 'dyspareunia' to produce a new diagnostic classification: 'genito-pelvic pain/penetration disorder.' The diagnostic criteria included difficulties, pain, or fear regarding penetrative heterosexual sex (American Psychiatric Association, 2013). Using discourse analysis (Burman, 2004; Parker, 2013) and critical intersectional analysis (Cole, 2009; Crenshaw, 1991; Hill-Collins, 1998, 2003)**,** this paper analyzes psychiatric discourse to illuminate the violence inherent in procedures and treatments that perpetuate sanism and (hetero)sexism within psychiatry. We argue that psychiatry's positioning of penetrative heterosexual intercourse as 'normal,' necessary, and 'healthy' pathologizes experiences of sexual violence as well as other forms of sexual identity (e.g., asexuality and homosexuality). Psychiatry needs to promote and accept sexual diversity, including the choice not to have penetrative sex at all.

Keywords: sanism, rape, discourse analysis, penetration disorder, dyspareunia

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Psychiatry has a longstanding interest in the study of sex; however, it has also been heavily criticized for its conceptualization and intervention in issues related to sexuality (Tiefer, 2005; Tosh, 2011a). In this paper, we trace how women's[1]

[1] Our definition of women includes trans women and non-binary or gender nonconforming individuals who identify as women. While psychiatric discourse regarding these diagnoses typically applies to cisgender women (i.e., those who identify as the gender that was assumed or assigned at their birth), please note that a body with a vagina is not necessarily female. Men with vaginas, or genitalia that is typically considered "feminine" by medical professionals, may also experience pain or difficulty during penetrative intercourse, or choose not to participate in penetrative intercourse for a wide range of reasons.

avoidance of or refusal to engage in penetrative intercourse has been framed as a 'mental illness' within psychiatric discourse. This includes a range of diagnostic terms such as: *frigidity*, *female sexual dysfunction*, *arousal disorder*, *vaginismus*, *dyspareunia*, and the latest diagnosis, *penetration disorder*. We draw on discursive psychology (Burman, 2004; Burman & Parker, n.d.; Parker, 2013) in a critique and genealogical tracing of the discursive object, that is, the concept of a disorder based on women's abstinence from penetrative sex, and the discursive subject of women who do not participate in penetrative sex (due to fear, pain, or lack of interest). We do this via an analysis of archival medical and psychiatric texts from the 19th century until the latest *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-5*; American Psychiatric Association, 2013); we describe and interrogate these discourses in relation to their construction of gender and sexuality, as well as how they intersect with a range of oppressions. Our analysis, therefore, includes critical intersectionality theory (Cole, 2009; Crenshaw, 1991; Hill-Collins, 1998, 2003; LeFrançois, 2013), as we examine the intersecting oppressions operating within this space where women are pathologized, sexualized, victimized, and shamed, as well as coerced, disbelieved, silenced, and further victimized through their label as 'mentally ill'. This represents an intersection of sexism and sanism (Birnbaum, 1960; Perlin, 1992) with the latter referring to

> the systemic discrimination, the individualised prejudice, the structural barriers, as well as the fear, hatred, and distrust directed toward psychiatrised people. Sanism impacts negatively on their entire world—socially, politically, economically, physically, personally, intellectually and emotionally. Generally, the impact of sanism is far-reaching and devastating, more devastating than the experiences that bring us into contact with psychiatry in the first place. (LeFrançois, 2012, p. 7)

This is in addition to the intrinsic heterosexism of the diagnosis, which assumes penis-in-vagina sex is 'normal.' Like others have done (e.g., Barker & Richards, 2013), we analyze influential texts in their construction of sexuality through diagnoses and treatment recommendations. Through our analysis, we show that women's right to refuse sexual intercourse, particularly penetrative intercourse, is framed as problematic and in need of "correction" through a range of invasive treatment options. The professions of psychiatry and medicine also potentially standardize coercion through invasive interventions that focus on further unwanted, painful, or distressing penetration. These treatments are carried out or supported by partners and medical professionals, both of whom have vested interests in the continued penetration of the woman, either through their desire to maintain accepted gender norms regarding sexuality, or through access to a women's body that has previously been denied to them.

Perversion and "Whiteness"

It is important when tracing the historical constructions of a psychiatric concept to first examine the context and narratives that proliferated prior to the introduction and predominance of biomedical discourse. Providing this historical context can begin to unpick the dense and influential ways that biomedical discourse frames

sexuality, that can then be assumed to be universal and timeless (Burr, 2014; Gergen, 2007). For example, the scientific study of sexuality developed out of analyses of Indigenous people as a part of colonial race science. This was the basis of, and stemmed from, the underlying assumption that "exotic" women and sexualities could be a threat to "white" and European women, as well as sexual (and racial) "purity" (Stoler, 1995). Examinations and analyses of the genitals of colonized people represented the initial sexual separation of 'normal' and 'abnormal' (i.e., "perverse") categorizations that developed within a context of violence, slavery, and colonial oppression (Nurka & Jones, 2013). The example of Sara Baartman, also known as Hottentot[2] Venus, who toured the world on display for the entertainment of colonists in the 18th and 19th centuries, shows not only the colonial gaze of the bodies of black women, but also the coercion involved for the purposes of "research"; Baartman refused to have her genitals examined for research, but her bodily autonomy was denied when after her death scientists removed her genitalia and kept them on display in a jar for over two centuries (Noss, 2010).

In relation to pain during intercourse or the avoidance of penetrative intercourse, this can include a reflection on what is absent as well as what is present. For example, as critics of the profession's lack of engagement with "race" have highlighted (e.g., Adams and Salter, 2011; Guthrie, 1998; Richards, 2012), those who are different from the 'norm' are often positioned as 'abnormal' or problematic (Phoenix, 1987, 1994). Phoenix explained:

> It has so far been more common for black than for white psychologists to highlight the normalized absence/pathologized presence of black people in psychological research. Not surprisingly, members of devalued groups are more likely to question negative constructions of their group as a whole and to redefine formulations which treat blackness as automatically problematic. This illustrates the fact that those who define social problems tend to be socially distant from the problems they define and that their definitions tend to reflect only their own viewpoint (Seidman and Rappaport, 1986, p. 2). (Phoenix, 1990, p. 93)

As we analyze the psychiatric constructions from the late 19th century onward, it is important to note the pathologizing absence and lack of research that examines these diagnoses and experiences in relation to race. Consequently, the psychiatric concepts of 'normal' sexuality often refer to a "white," Western, and Eurocentric view of women's sexuality that reaffirms and promotes a kind of "delicate" feminine sexuality based on passivity as universal, "natural" and 'normal'.

'Frigidity'

The framing of women who abstain from penetrative sex as being 'frigid' has a long history. While the term and concept has much earlier beginnings, the 19th century saw a proliferation of discourses regarding sex and 'perversion' (Foucault,

[2] A term used by colonial race scientists to refer to Indigenous women, sometimes used interchangeably with *bushwomen* (Nurka & Jones, 2013).

1990), including 'frigidity', which began to be described as psychologically 'abnormal' (Cryle & Moore, 2010). Krafft-Ebing, in *Psychopathia Sexualis* (1892) hypothesized that sexual avoidance was due to genital insensitivity ("genital anaesthesia"; p. 376). In France the term was applied to women who did not experience sexual desire and/or pleasure, regardless of whether the cause was considered moral or physical (Gupta, 2013). Pain during penetrative intercourse, and women's avoidance of such activities, has also been theorized about for centuries. As Binik (2010) described, vaginal pain during penetrative sex has historically been tied to menstruation, the vulva, and "mismatched anatomies." The blurring of frigidity as a result of pain, or pain as a result of frigidity led to a range of overlapping diagnoses and theories regarding difficulty and avoidance of penetrative intercourse.

A lack of interest in sexual activity had numerous labels applied to it, including *sexual coldness*, *naturae frigidas*, *hyphedonia*, *anaphrodism*, *erotic blindness*, and *anaesthesia sexualis* (Ellis, 1913; Krafft-Ebing, 1892), with a frequent conflation between a lack of desire and a lack of participation in sexual activity. In relation to sexual pain, Barnes (1873) coined the term *dyspareunia*, which referred to "difficulty mating" (Binik, 2010). In addition to sexually inactive wives, a mental illness based on the avoidance of heterosexual activity was associated with homosexual and intersex individuals (Krafft-Ebing, 1892). This was due to difficulties in developing relationships when both were considered 'abnormal' at this time. Interventions that aimed to stop individuals from pursuing homosexuality led to their trying to engage in heterosexual relationships; but when these were unsuccessful, their lack of desire was labeled as 'frigidity' (e.g., Krafft-Ebing, 1892). Therefore, homosexual[3] individuals were pathologized both for their attraction to others of the same gender (i.e., 'homosexuality') and for their lack of attraction to those of a different gender (i.e., 'frigidity'). However, the predominant population of focus was women:

> They are met more frequently among women than among men. The characteristic signs of this anomaly are: slight inclination to sexual intercourse, or pronounced disinclination to coitus without sexual equivalent, and failure of corresponding psychical, pleasurable excitation during coitus, which is indulged in simply from a sense of duty. I have often had occasion to hear complaints from husbands about this. In such cases the wives have always proved to be neuropathic *ab origine*. Some were at the same time hysterical. (Krafft-Ebing, 1892, pp. 46–47)

While the 'condition' of not participating in sexual intercourse was pathologized, there were also accounts that framed women's sexual desire as 'normally' absent, such as Lombroso and Ferrero's (n.d.; cited in Ellis, 1913) statement, "Woman is naturally and organically frigid" (p. 195). This led to theories that women's desire needed to be "awakened" by a man (Adler, 1912, cited in Ellis, 1913), and thus led to myths that when women declined sex they needed to be

[3] As intersexuality was often conflated with homosexuality in early psychiatric literature, intersex individuals were pathologized in a similar way depending on their gender and sexual identity.

"seduced," and that there was a tension between masculine sexuality and feminine passivity. This latter myth required women to "submit" in their role (or "duty") as woman/wife even though they did not want to, or did not enjoy the experience. This is illustrated in the writings of Ellis, who stated,

> In a very large number of women the sexual impulse remains latent until aroused by a lover's caresses. The youth spontaneously becomes a man; but the maiden—as it has been said—"must be kissed into a woman." (1913, p. 241)

Recommended treatments were either "through the husband" (i.e., intercourse) or hypnosis that aimed to reduce "disgust," "fear" and "involuntary resistance" (Ellis, 1913, p. 240). Clitoridectomy (the surgical removal of the clitoris), ovariectomy (removal of the ovaries), and pregnancy have also been "treatments" for female 'frigidity' (Potts, 2002).

The 19th century also brought pronounced differentiation in hegemonic femininity and masculinity, which largely impacted what was viewed as sexual pathology or as sexual normalcy (Cryle & Downing, 2009). In this context, the discourse surrounding sexuality was largely gendered and operated on tacit essentialist assumptions (Ussher, 2003). These assumptions were often disadvantageous to women, who were pathologized for experiencing too little desire or pleasure, just as they were for experiencing too much. Similarly, there was a mixing of scientific, pseudo-scientific, and popular discourses that crept into what was accepted as knowledge (Cryle & Moore, 2010; Shields, 2007); inevitably this would have a trickle-down effect on later beliefs about gender and sexuality.[4]

The early 20th century brought with it the professionalization of the field of psychiatry, and women's sexual difficulties were further consolidated as a mental 'illness' (Angel, 2012). Freudian and neo-Freudian theoretical and clinical research were developing in parallel to psychiatric perspectives in the study of sexuality. Bonaparte's notable, if somewhat divisive, contributions and writings on women's sexuality, which were to some extent influenced by Freud, would reconceptualize frigidity in psychoanalytic terms (Gupta, 2013). By the late 20th century the term '*frigid'* was less frequently used (Angel, 2012); however, it is evident that the underlying assumptions embedded in the frigidity discourse were still present, which speaks to a broader existence of a social and cultural construction of femininity, women's bodies, and sexual behaviours as inadequate and 'abnormal'. Interestingly, many feminist researchers would argue it is these very social and cultural limitations that can play a role in women's ability to experience sexual desire and pleasure (Blackledge, 2004; see also Kaschak & Tiefer, 2001).

[4] This blurring of lines between scientific and popular discourse is still a concern when examining information on women's sexual difficulties. For example, Angel (2012) addressed how this discursive "cross-pollinat(ion)" precipitated 'female sexual dysfunction' switching from a mere descriptor, to the name of an actual condition (pp. 10–11).

The *DSM* and 'Sexual Dysfunction'

Revisions for the third edition of the *Diagnostic and Statistical Manual of Mental Disorders* (*DSM-III*) were produced by the APA in the 1980s, a key time in the construction of sexuality and pathologized identities. This was the time that saw major changes to the diagnostic text, from excluding homosexuality as a diagnosis, to the inclusion of an entirely new section on 'sexual dysfunctions' that was based on the popular (but since heavily criticized; see Tiefer, 2004) work of Masters and Johnson (1966). Frigidity became renamed 'inhibited female orgasm' (APA, 1980) and centred around an inability to orgasm during penetrative sex, despite women being able to orgasm during other sexual activities (Canner, 2008). It was also the time that 'sexual pain disorder' was introduced (APA, 1987), with dyspareunia and vaginismus as subcategories (Binik, 2010), and thus became the predominant way of describing women who experienced pain during intercourse.

The term '*dyspareunia'* was mainly defined by its "interference with intercourse" (Binik, 2010), highlighting that the central concern was not pain, but its prevention of penetration. The diagnosis has always been vague or over-inclusive, with the *DSM-IV-TR* (APA, 2000) framing any kind of pain during penetrative sex that wasn't associated with a medical condition as dyspareunia (Binik, 2010). Over time, the *DSM* has included medically caused vaginal pain, as dyspareunia can be associated with a wide range of conditions including: endometriosis, pelvic congestion syndrome, levator ani muscle myalgia, uterine retroversion, uterine myomas, adenomyosis, ovarian remnant syndrome, and irritable bowel syndrome (Binik, 2010). As Binik (2010) observed, this diagnostic category contained a widely diverse range of women experiencing vastly different problems and pain with intercourse: "A woman who experiences a shooting pain over one ovary during thrusting and one who experiences a burning pain at the introitus[5] during penetration could both be classified as suffering from dyspareunia" (p. 4). Diagnosis is predominantly based on self-reports of pain during sexual intercourse and gynecological examinations (Binik, 2010).

Within the context of a diverse and multifaceted feminist movement, much of the concern over the discourse surrounding women's sexual difficulties spurred feminist scholarship and activism specifically regarding the promotion of these problematic constructions (Angel, 2012). Feminists responded to these gynaecological-related psychiatric diagnoses (e.g., Canner, 2008; Tiefer, 1988, 2004; Ussher, 1993), and the indelible pathologization and subsequent medicalization of women's sexuality inherent in this, with a purpose to instead broaden the framework through which sexuality is viewed. Some feminists regard the APA's methods for defining and classifying women's sexual difficulties as misguided. One major criticism is that there have been significant inconsistencies in the classification and diagnoses of these disorders in previous versions of the *DSM* (Angel, 2012; Payne et al., 2008). For example, despite being pain conditions, dyspareunia and vaginismus were categorized as sexual

[5] Meaning an entrance to an organ that can be penetrated (i.e., the vagina).

dysfunctions instead of pain disorders, and are the only pain conditions to be categorized with this type of irregularity (Payne et al., 2008). Some researchers also maintain that the *DSM*'s approach to rectifying the sexual hindrance was prioritized above the woman's chronic genital pain, which was treated as something psychological/psychosomatic. Consequently, their pain is viewed as less "real" and less of a priority for effective treatment; due to the perceived *sexual* nature of the diagnoses, the main symptom of pain gets ignored (Angel, 2012; Payne et al., 2008).

Aside from the ambiguity and inconsistencies in the definitions and criteria for these sexual difficulties, the diagnoses perpetuated a limited view of women's sexuality. First, these diagnoses have been criticized for the inherent biological reductionism, which is still prevalent in much of the discourse and theory surrounding women's sexual functioning (Ussher, 2003). Similarly, Tiefer (2004) critiqued the Masters and Johnson (1966) study on the human sexual response cycle, which largely influences and makes up the foundation for the *DSM* criteria for sexual disorders (see also Angel, 2012; Ussher, 2003), for its methodology as well as for its oversimplification and compartmentalization of sex into distinct categories, thus removing it from its broader context (Tiefer, 2004). The result of this is not only limiting, but also damaging, as it undermines women's socialization and experiences of inequality; Tiefer (2004) stated that "to speak merely of desire, arousal, and orgasm as constitutive of sexuality and ignore relationships and women's psychosocial development is to ignore women's experiences of exploitation, harassment, and abuse and to deny women's social limitations" (p. 62). In psychiatry's search for quantifiable evidence of dysfunction the focus is on mere symptom reversal. This disregards other key factors that make up the highly contextual and subjective nature of sexuality (Tiefer, 2004); therefore, psychiatry may be looking for a pharmacological or medical cure for what can often be the outcome of a social or cultural problem.

Penetration Disorder

In 2013 a new edition of the *DSM* was produced, the *DSM-5* (APA, 2013). It included "penetration disorder" (PD), a new conceptualization of dyspareunia and vaginismus, or genital/vaginal pain during intercourse. This was due to many factors, including that there was relative disagreement within the profession regarding the cause of the pain, effective treatment approaches, whether it should be a pain disorder or a sexual dysfunction, and a notable absence of research on the psychological aspects of the diagnosis (Bergeron, Morin, & Lord, 2010; Binik, 2010). Therefore, the production of a new edition of the *DSM* was a key time for the profession in relation to its sexual diagnoses, as, like many other times in the publication's history, it was marred with criticism and uncertainty (Balon & Wise, 2011). There was a recognition that the diagnostic system in place was flawed and "outmoded" (Binik, 2010) and that significant change was needed (Balon & Wise, 2011). The lack of professional consensus regarding the concept was further exacerbated by the *DSM-5* Sexual and Gender Identity Workgroup decision to not to complete field trials on the proposed sexual 'disorders' (Balon & Wise, 2011).

The newly named 'penetration disorder' aimed to subsume both dyspareunia and vaginimus, due to the difficulty in distinguishing between the two conditions (Payne et al., 2008; Reissing et al., 2014). Binik (2010) proposed 'genito-pelvic pain/penetration disorder' as the alternative diagnostic term. However, the new term expanded the category even further by including not only pain, but also fear of penetrative intercourse as criteria. Thus, it would be possible to be diagnosed as mentally ill based on fear and distress alone. In its entirety, the criteria include at least one criterion from: an inability to have penetrative sex, pain during attempts at penetrative sex,[6] fear or anxiety about such pain or about penetration, or tensing of pelvic floor muscles when penetration is attempted (APA, 2013; Balon & Wise, 2011; Bergeron, Rosen & Morin, 2011). As with all *DSM* diagnoses, distress or impairment is needed for a diagnosis, but an inability to have sex is considered sexual 'impairment.' So, not participating in penetrative sex qualifies as both a criterion from group A and group B. The 'symptoms' also need to be present for a minimum of six months.

Changes to diagnoses related to sexuality would end up being one of the most heatedly debated areas during revisions for the *DSM-5*, such as Frances' (2013) unrelenting criticism of the revision process and final publication, in addition to feminist critique and protest (Tosh, 2011a, 2011b). The difficulty in defining sexual 'abnormality' often centres around the pathologization of a wide range of sexual orientations and behaviours, as "there is no consensual basis for a normative sexual behavior that could provide a useful boundary to constitute what is a mental disorder and what is not" (Balon & Wise, 2011, p. 2). More generally, there is a discursive tendency in psychology and medicine to focus on pathology and perversion, with less attention given to the supposedly difficult-to-attain "normalcy" (Cryle & Downing, 2009). Perhaps the only area of consensus is that while the prevalence of pain during penetrative intercourse is high,[7] understanding regarding the issue is not (Bergeron et al., 2011). It is also important to note that while diagnoses are most often applied to young women, research into women's experiences of pain during intercourse is lacking. As Donaldson and Meana (2011) observed, "Largely missing from the debate [on the *DSM-5* changes] and from the empirical research on pain with intercourse is women's subjective experience of this problem" (p. 814).

Compulsory Sexuality and Gender 'Norms'

The psychiatric diagnoses applied to women's sexual pain work within the same heterosexist framework that positions penile-vaginal penetration as the 'norm', such as Masters and Johnson's (1966) sexual response cycle model. This positions other forms of sexual activity (including homosexuality) as "less than" penetration

[6] There is also increasing acknowledgement that pain can occur during non-sexual events, such as tampon insertion and smear tests (Binik, 2010).

[7] Research using community samples found that between 12% and 21% of women experience pain during penetrative intercourse (Bergeron et al., 2011), rising to 34% in clinical samples (Donaldson & Meana, 2011).

or, at worst, 'abnormal' (Barker & Richards, 2013). It assumes that penetrative sex is 'normal', 'healthy', and the desired endpoint of sexual activity[8] (McPhillips, Braun, & Gavey, 2001). This is seen explicitly in psychiatric texts, in which treatment aims to 'normalize' vaginal responses to penetration (e.g., Bergeron et al., 2010). Despite the recognition that pain and fear during intercourse can be the 'norm' (i.e., "This 'normal' reaction may lead to avoidance of sexual/intimate situations," APA, 2013, p. 438), women labeled with 'penetration disorder' are further pathologized as they become associated with a wide range of 'disorders', for example:

> Variables that have discriminated between healthy controls and women with dyspareunia include vulnerability factors, such as the personality trait neuroticism (e.g., Van Lankveld, Brewaeys, ter Kuile, & Weijenborg, 1995), mood disruptions (e.g., Gates & Galask, 2001), underlying psychopathology, such as obsessive-compulsive traits and phobias (e.g., Meana et al., 1997; Van Lankveld et al., 1995), and individual difference factors like catastrophizing and hypervigilance (Payne et al., 2004; Pukall, Binik, Khalifé, Amsel, & Abbott, 2002). (Farmer & Meston, 2007, p. 3)

This pathologization includes the framing of women's descriptions and experiences of pain and fear as untrustworthy accounts, either through positioning them as psychosomatic or a phobia. When attempts to find the physical cause of the pain fail, professionals can frame women's pain as psychosomatic. This undermines or invalidates women's experiences of sexual pain, as well as questioning (the validity of) her refusal or avoidance of penetration. This is a well documented consequence of psychiatrization, or sanism, in which individuals' experiences become discredited and questioned. By framing the pain as "not real," women's experiences of pain are reframed as a psychological disorder that prevents 'normal' intercourse. Similarly, the woman's fear is described as a "phobia" in psychiatric literature (e.g., Steege & Zolnoun, 2009, cited in Binik, 2010), in other words, an irrational fear. This can be despite feelings of pain and distress, which would arguably be rational reasons to avoid intercourse.

In addition to framing penetration as 'normal', PD (and the other prior terms used for women's pain during sex) construct norms of sexuality in gendered terms. This is due to the diagnoses being applied most often to women. While some researchers have acknowledged that a range of issues and conditions can result in painful penetration for the penis (e.g., Edmonds et al., 2012; Gyftopoulos, 2009; Mohr, Kuhn, Mueller, & Kuhn, 2011), it remains a separate issue to penetration disorder, which is "by definition… only given to women"[9] (APA, 2013, p. 439); and "[there is] no discussion of male dyspareunia in the *DSM-IV-TR*" (Binik, 2010, p. 9), nor in the *DSM-5* (APA, 2013). Not only does this exclude and fail to consider a greater range of gender identities and sexed bodies (such as intersex, trans, and non-binary individuals), but it also highlights how women's inability to be to penetrated (through

[8] Also referred to as the 'coital imperative', see McPhillips, Braun, and Gavey (2001).

[9] Note the intrinsic cisgenderist assumptions (Ansara & Hegarty, 2012) so deeply embedded in the *DSM*, beyond constructions of 'gender dysphoria' and 'transvestism'.

pain and fear) is perceived to be a particular problem, in need of medical treatment, classification, and study. It shows that when women do not engage in sex, when women are active in the sexual decision-making process, it is viewed as a problem.

These gendered roles can be seen from qualitative analyses of women's experiences of sexual pain. Distress from experiencing such pain included feelings of inadequacy when they were not able to "do it on call" (Donaldson & Meana, 2011, p. 818), in addition to a "fear of losing their partner/s, and the desire to please others more broadly" (Barker, 2011, cited in Barker & Richards, 2013, p. 248), illustrating how feelings of needing to "perform" at a partner's request were tied to conceptions of their role in relationships. The *DSM* notes that women "also report that the symptoms significantly diminish their feelings of femininity" (APA, 2013, p. 438), showing how being penetrated is tied to conceptualizations of femininity, which further reinforces heterosexual norms (Ayling & Ussher, 2008).

Another notable tension within the interviews conducted by Donaldson and Meana (2011) was that the women did not describe (or feel comfortable with) their experiences being framed as a mental illness or an abnormality. Researchers showed how participants were resistant to framing their experience in medical terms, and had never viewed their own experience in this way:

> Some participants lumped sexual and relational problems together and defined these outside of the realm of medicine. They did not believe the medical profession would be able to assist them because they did not believe themselves to have a medical problem. (Donaldson & Meana, 2011, p. 820)

This is troubling for two reasons: (a) It appears that professionals aim to reframe women's experiences of sexual pain specifically in medical and psychiatric discourse despite this feeling inaccurate or inappropriate for women; and (b) it is also concerning that women viewed pain during sex as 'normal'. This parallels how sexual violence is 'normal' in the sense that it occurs frequently and it can be embedded in gendered norms of heterosexuality (Gavey, 2005), but also not 'normal' in that it is behaviour that needs to be challenged, condemned, and stopped. Similarly, while pain during intercourse may be frequent and therefore a 'normal' experience for many women, it should not be accepted as a necessary occurrence within women's sexual lives.

Like other areas within medicine and psychiatry, such as gynecologic cancer (e.g., Cairns & Valentich, 1986; Hyde, 2007; Schover, 2005; Ussher, Perz, Gilbert, Wong, & Hobbs, 2013) and intersexuality (Tosh, 2013), these gendered norms regarding sexuality and the assumption that penile-vaginal penetration is desired lead to the primary aim of most treatment and intervention: to enable penetrative sex. While there are some within the profession who offer alternative approaches, the predominant perspective of vaginal penetration as the 'norm' can close down avenues for other kinds of assistance, such as supporting couples as they adjust to sexual intercourse with a changed body (in the case of genital surgery) or alternative forms of sexual activity. Cairns and Valentich (1986) argued that this is a consequence of a health care system being dominated by traditional male or masculine values. They conclude that "critical attention must focus on examining

and challenging medical practices that prevent women from 'exercising full and informed choice in reproductive [and sexual] decisions' (Norman & Mancuso, p. 185)" (Cairns & Valentich, 1986, p. 334). In light of such insights, feminist research often calls for reflexivity, for the critical and personal reflection on the research process, outcomes, and their role in the analysis. Similarly, others have called on psychiatrists to be more transparent in their work; rather than claiming the impossibility of objectivity (particularly in the context of research on sexuality), they ask for declarations of a "conflict of interest," whereby those involved in the *DSM* revisions outline their own theories and research, as well as their personal ideology (Balon & Wise, 2011).

Sexual Coercion

For those who research sexual violence, a number of red flags may be raised while reading through psychiatric literature on PD, such as "hypervigilence," "fear," pressure to "do it on call," and a marked and longstanding difficulty in the participation of sexual activity with a partner. These areas of concern are further pronounced when analyzing such literature with the specific focus on constructions of sexual violence. While the *DSM-5* (APA, 2013) does state that the 'dysfunction' should not be explained by "severe relationship distress (e.g., partner violence)" (p. 437), this disclaimer in the diagnostic criteria is too little, too late. Due to the known difficulties of disclosure of sexual violence (Ahrens, 2006), professionals may not be aware that this is an issue for women diagnosed as having a 'sexual dysfunction' even if they enquire. There is also the admittance that psychiatrists do not know the causes of sexual pain, in addition to psychiatry's poor track record in ignoring violence and pathologizing victims (Reavey & Warner, 2003; Tosh, 2013, 2015).

Women diagnosed with PD and those who have experienced sexual violence are not mutually exclusive groups. Despite acknowledging the controversy of the relationship, the APA (2013) stated that "sexual or emotional abuse" can be a "vulnerability factor" (p. 348), making victims more susceptible to PD. This continues the longstanding association of 'disordered' vaginal pain with abuse victims. The *DSM-IV* (APA, 1994) stated that vaginismus "is more often found in younger than in older females, in females with negative attitudes toward sex, and in females who have a history of being sexually abused or traumatized" and that "acquired Vaginismus also may occur suddenly in response to a sexual trauma or a general medical condition" (p. 514). Bergeron et al. (2011) noted that "In a study involving over 1400 adolescent girls, those complaining of dyspareunia of at least 6 months' duration were more likely to report past sexual abuse, [and] fear of physical abuse"; and "the first study focusing on victimization in a general population adult sample showed that severe physical or sexual childhood abuse was linked to a 4- to 6-fold risk of reporting genital pain in adulthood" (p. 1224). Qualitative interviews with women have also drawn out this connection between past sexual abuse and present sexual pain (Donaldson & Meana, 2011).

The APA (2013) admitted the difficulty in distinguishing between cases in which abuse caused the avoidance, pain, or fear of sex, and those in which abuse or distress is a result of such avoidance:

> Comorbidity with relationship distress is also common. This is not surprising, since in Western cultures the inability to have (pain-free) intercourse with a desired partner and the avoidance of sexual opportunities may be either a contributing factor to or the result of sexual or relationship problems. (APA, 2013, p. 440)

Moreover, women who experience sexual pain describe fear of their partner's response when they try to refuse penetrative intercourse. Interviews conducted by Donaldson and Meana (2011) found that "partner dissatisfaction was another recurrent theme. Some partners became angry and frustrated when their girlfriends turned down sex or stopped half-way through" (p. 10). Therefore, fear of penetration could include a fear of their partner's reaction if they fail to live up to unreasonable or idealistic expectations of women's sexual availability. This also brings into question women's ability to refuse sex, and the risk of participation in "unwanted" sex (Walker, 1997) as a means of avoiding conflict or hostility. Donaldson and Meana's interviews included declarations from women who did not want sex with their partner, but who also described engaging in penetrative intercourse:

> I just can't, I don't want to do it. I never come home and just want to have sex anymore. I'll never want to go have sex.
>
> I *never* want to have sex now. There is never a time when I initiate it. Never. It's always him coming to me, and *half of the time* when he comes to me, I have to turn him down. (Donaldson & Meana, 2011, p. 10, emphasis added)

Donaldson & Meana (2011) fail to consider or comment on the coercive assumptions of "necessary" sex, with participants frequently acknowledging pressure to participate in unwanted sex and anger at sexual refusals. There are numerous other examples of psychiatry describing women with a diagnosis of PD participating in "unwanted sex," but failing to address issues of consent and coercion, such as "women with genital pain have reported engaging in sexual intercourse without wanting to do so" (Farmer & Meston, 2007, p. 27); and

> it would be useful to understand what motivations underlie the sexual activity reported by women with genital pain (Hill & Preston, 1996). Regardless of sexual motivation, it is clear that the experience of pain does not appear to prevent young adult women from engaging in sexual activity. (Farmer & Meston, 2007, p. 27)

While there will be some who are distressed by experiences of pain who want to pursue penetrative intercourse, and there can be a wide range of situations that can lead to pain during intercourse, the professional sanitization of coercion as "unwanted" sex and as the result of "unknown" motivations functions to remove focus away from the prevention of sexual violence and onto pathologized women's bodies. Advising psychiatrists not to diagnose based on partner abuse or relationship distress, without any clear way of knowing the cause of the pain or of identifying abuse victims, is unlikely to have an impact on the lived realities of victims visiting psychiatric and psychological departments for support.

Treatment for PD

Another area of particular concern is the advice for what the psychiatric and medical literature refers to as 'normal/guarding' reactions in relation to vaginal muscle contractions and tension. Guarding reactions are a "protective-like defence consisting of an over-contraction of the pelvic floor muscles during intercourse" (Bergeron et al., 2010, p. 293). The *DSM* describes this as, "'normal/voluntary' muscle guarding in response to the anticipated or the repeated experience of pain or fear or anxiety. In the case of 'normal/guarding' reactions, penetration may be possible under circumstances of relaxation" (APA, 2013, p. 438). Here we can see how the body is framed as producing a productive and protective function—in anticipation of pain or distress, making penetration difficult or impossible. What is concerning is how the *DSM* promotes continued penetration despite acknowledging that the individual in question is demonstrating a bodily reaction indicating that penetration is not wanted and is painful and/or distressing. As Barker and Richards (2013) noted from the analysis of Bancroft's (2009) key text, practitioners are "at risk of perpetuating the problem of encouraging women to be penetrated even when they are not aroused (which writers from all perspectives agree is a key part of the reinforcement of vaginismus and related difficulties" (p. 248). Advising women to "relax" to enable penetration under these circumstances, without addressing why there is fear or pain, or whether the intercourse is wanted (within a context of gendered norms and sexual pressure, even possible abuse), reads like the problematic advice given to rape victims to "lie back and enjoy it" (Brownmiller, 1971). This is further supported by accounts of women describing their experiences of sexual pain and penetrative intercourse:

> Most participants reported using cognitive distraction to divert attention from the pain. They repeated to themselves that the pain would be over soon or that it did not hurt that much. Others focused on their partners' pleasure, while yet others tried to think of anything but sex: I wouldn't think about it. I would think about going to the mall or what I had been watching on TV—anything to get me out of the situation and thinking about something else. (Donaldson & Meana, 2011, p. 12)

Such descriptions resemble those of rape victims describing strategies of survival and dissociation (Haaken, 1994). Yet psychiatry promotes "facilitative responses, in which the partner encourages the patient's efforts at coping with the pain" (Bergeron et al., 2011, p. 1224). Encouraging women to "cope" with pain for the duration of penetration while their partner experiences pleasure reads similar to accounts of rapists who are sympathetic to their victims during assault, who also describe how women's predominant concern prior to an attack is a fear of pain (Lea & Auburn, 2001). Much like men ignoring sexual refusals (Kitzinger & Frith, 1999; O'Byrne, Hansen, & Rapley, 2008), this approach appears to be encouraging men to ignore signs that their partner is not enjoying the experience, or does not want to participate. This individualized approach, which frames the problem as an internal (either physical or psychological) issue within the woman, ignores the complex issue of sexual consent within a context of gendered and sanist oppression.

While it is acknowledged that the role of a partner can impact the experience of sexual pain (e.g., technique, lack of foreplay, APA, 2013, p. 440), "relationship variables have been widely neglected in dyspareunia and vaginismus" (Bergeron et al., 2011, p. 1224), and consequently interventions focus on adjusting the women's body to accept penile penetration, rather than changing the sexual relationship. Therefore, instead of changing the sexual activities that would reduce pain and increase pleasure, women can be encouraged to continue participating in an activity that causes pain and distress. This is further evidenced by research that shows women who experience pain state that their pleasure is increased when they engage in oral sex or other sexual activities; however, treatment approaches can fail to address this by focusing solely on the frequency of penetrative intercourse, and base "success" of treatment on increases in frequency (Farmer & Meston, 2007).

In addition to the promotion of continued penetration, other treatments recommended for PD include the manual insertion of fingers or dilators that increase in size (Barker & Richards 2013), "electro-therapeutic methods" (e.g., the electrical stimulation of nerves inside the vagina; Bergeron et al., 2011; Morin & Bergeron, 2009), intravaginal botox injections, and genital surgery (Pacik, 2011). This is in addition to genital examinations that can use swabs or a variety of instruments (e.g., the vaginal algometer, vulvodolorimeter, and algesiometer; Binik, 2010) that aim to replicate the pain experienced during intercourse. In other words, on reporting pain during penetration with a partner, women can experience further pain during penetration by medical professionals. Others have described an "intensive exposure therapy" based on therapies intended for phobias:

> The actual exposure therapy consisted of a maximum of three 2-hr sessions within 1 week, in which the participant was exposed to the feared penetration objects. The purpose of these exposure sessions was to enable the woman to penetrate herself with an object (including fingers or a dilator) that was just a little bit larger than the circumference of the erect penis of the partner (10–14 cm). The exposure therapy at the hospital was self-controlled, that is, the participant did the exercises involving vaginal penetration herself. All the exercises were conducted with the use of lubricants. The female therapist (psychologist or gynecologist) gave directions and encouragement to stay in the fearful penetration situation as long as necessary. The exposure tasks were ordered hierarchically from low anxiety to high anxiety. For each step in the hierarchy, the circumference of the object was measured. The participant started with the exercises sitting in a gynecological examination chair (in the lithotomy position). The therapist and the partner were standing or sitting beside and/or behind the participant. The three of them observed all of the vaginal penetration exercises with a handheld mirror (held by the therapist). (Kuile et al., 2009, p. 151)

This therapy overlooks sexual arousal, the increase in sexual pressure and monitoring, as well as the problem of consent within a context where an individual has been labeled as mentally ill. It underestimates the impact of the diagnostic label on how the individual perceives and experiences their own sexuality, body, and identity: "I went into this thinking like, I am abnormal. I am different. Like,

something's wrong. I'm just not normal like everyone else" (Donaldson & Meana, 2011, p. 7). Consequently, women may repeatedly insert painful objects that generate fear in the belief that it will make them 'normal', and to please the desires (or demands) of a partner. Moreover, as women have described a fear of losing a partner (Barker & Richards, 2013) and a fear of hostility in response to a refusal (Donaldson & Meana, 2011), the involvement of partners in this system of "compulsory penetration" is concerning:

> After each session, the participant and her partner were given a number of exposure homework assignments. During the first week, they were asked to practice, with the use of lubricants, two to three times daily. The therapist took care to convey the message that these penetration activities should be performed in a safe (harmless) way. The role of the partner was to motivate the participant to do these exercises and to help her confront new, feared penetration objects. As soon as possible, the partner was also actively involved in the home exercises (e.g., by vaginal insertion of one, two, or—if necessary—three or four of his fingers; touching the vaginal entry with his erect penis without penetration; vaginal insertion of his erect penis; and finally making bodily movements with his erect penis). (Kuile et al., 2009, p. 151)

Daily penetration by/with a partner numerous times a day complicates the issue of consent, as it makes it more difficult for an individual to refuse. A 'patient's' refusal can be viewed as non-compliance with treatment or as a failure to complete treatment, rather than being viewed as non-consent to a sexual act. Encouraging partners to confront the 'patient's' feared objects, when they may be impatient, frustrated, and even hostile toward the issue, is placing women in a situation where their refusals and bodily autonomy are at risk of being ignored. A women's ability to say *no* or to stop a sexual encounter is reduced or potentially impeded, as her discomfort and pain are overridden as evidence of her 'mental illness' (more so if her pain is framed as psychosomatic). Thus, she can be encouraged to continue when she does not want to, with aims of being considered sexually 'normal'.

Beyond Penetration: Alternative Sexualities

This is a broader problem within medicine—where attitudes and assumptions of physicians can include that it is 'normal' or acceptable for women to continue painful intercourse with the long-term goal of being able to participate in penetrative intercourse with a partner (Cairns & Valentich, 1986)—which coincides with discourses regarding women's sexuality as "naturally" absent, passive, or in need of masculine "awakening."[10] For psychiatrists to be encouraging women to "cope" with pain and distress during intercourse, and to continue in participating in "unwanted" sex, colludes with gendered discourses of sexuality that remove women's bodily autonomy in a patriarchal, sanist, rape culture. Framing vaginal penetrative sex (and

[10] This is in addition to psychiatric discourses that promote 'normal' women as "naturally" sexual, and that therefore pathologize the absence of sexual desire, which results in an impossible tension whereby to be 'normal', women are expected to be both passive *and* sexual.

orgasm) as 'normal' not only positions homosexuality and asexuality as Other and potentially pathologizes them: It can also result in women tolerating pain in the hopes of achieving orgasm, and thus normalcy. As one interviewee stated, "I just want this to end because it hurts—then I want it to keep going so I can reach orgasm" (Donaldson & Meana, 2011, p. 7). As Barker and Richards (2013) stated, "Perhaps a move toward the language of diversity rather than dysfunction/problem would be appropriate as it would remove the implication that being non-sexual, non-orgasmic, non-erectile or non-penetratable are necessarily problems" (pp. 246–247).

With diagnoses related to sexuality framing intercourse as 'normal' and necessary, and with "disgust" being listed as a reason for the avoidance of penetration (Farmer & Meston, 2007), it is of concern that those of other sexual orientations may be undergoing such therapies within a context of relative invisibility (such as bisexuality) and possible pathologization, or that it may not feel like other options are possible (such as asexuality, or a heterosexual or homosexual relationship that does not involve penetration). For example, Kim (2014) talked about asexual individuals being one group that got "left behind" in the sexual revolution, and as a result remains marginalized within a context where medical discourse predominates:

> Even as it was becoming evident to the medical establishment that women with insufficient sex drive had a medical problem that needed to be treated with therapy or pharmaceuticals, a social perspective that viewed asexual women as a socially and historically oppressed group was emerging. (Kim, 2014, p. 268)

Rather than framing vaginal penetration as necessary for a successful heterosexual relationship and as 'normal' sexual behaviour, psychology and psychiatry should examine gendered norms of sexuality and should include recommendations for mutually pleasurable sexual activity even if this includes no penetration at all.

Conclusions

While medical and scientific discourse can bring a sense of validity or "realness" to distress, it simultaneously reifies psychiatry's role in defining what is, and what is not 'normal' or valid. This newly named diagnosis, 'penetration disorder', which combines two prior diagnostic terms, is yet another example of how psychiatry excludes or neglects the consequences of coercion, and instead seeks to reinstate norms of gender and sexuality on individuals who have veered from such rigid norms. It is extremely important for mental health professionals and those who work with victims of sexual violence to say to women who are experiencing pain and fear regarding penetrative intercourse, that not participating in penetrative intercourse is an option. Those who describe participating in unwanted sexual intercourse with a partner need discussion about how they do not need to participate in penetrative intercourse to be 'normal', to be loved, to be a good partner, or to be a woman. There are other options—other sexual activities and other ways of being sexual and feminine. It is in this spirit of diversity and multiplicity that the voices of those who experience pain, fear, or a lack of interest in vaginal penetration should be prominent, as they will not experience sex, sexuality, or therapeutic interventions in

the same way. Therefore, while we have discussed the potential of such interventions to be coercive, it should not be assumed that they will be experienced this way by women diagnosed with PD. Instead we argue that professions that draw on psychological and psychiatric diagnoses and discourse should examine the complex interweaving of desires, pressures, choices, and oppressions, and consider whether they are helping those with a desire to experience sexual pleasure, or being complicit in the promotion of and desire for 'normalcy'.

References

Ahrens, C. (2006). Being silenced: The impact of negative social reactions on the disclosure of rape. *American Journal of Community Psychology, 38*(3)*,* p. 263–274.

American Psychiatric Association. (1980). *Diagnostic and statistical manual of mental disorders* (3rd ed.; *DSM-III*). Washington, DC: Author.

American Psychiatric Association. (1987). *Diagnostic and statistical manual of mental disorders* (3rd ed., revised; *DSM-III-R*). Washington, DC: Author.

American Psychiatric Assocation. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.; *DSM-IV*). Washington, DC: Author.

American Psychiatric Asssociation. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.; *DSM-IV-TR*). Washington, DC: Author.

American Psychiatric Association. (2013). *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM-5*). Washington, DC: Author.

Angel, K. (2012). Contested psychiatric ontology and feminist critique: "Female sexual dysfunction" and the *Diagnostic and Statistical Manual*. *History of the Human Sciences*, *25*(4), 3–24. doi:10.1177/0952695112456949

Ansara, Y. G., & Hegarty, P. (2012). Cisgenderism in psychology: Pathologising and misgendering children from 1999 to 2008. *Psychology & Sexuality*, *3*(2), 137–160. doi:10.1080/19419899.2011.576696

Ayling, K., & Ussher, J. M. (2008). "If sex hurts, am I still a woman?" The subjective experience of vulvodynia in hetero-sexual women. *Archives of Sexual Behavior, 37*(2), 294–304. doi:10.1007/s10508-007-9204-1

Balon, R., & Wise, T. N. (2011). Update on diagnoses of sexual dysfunctions: Controversies surrounding the proposed revisions of existing diagnostic entities and proposed new diagnoses. *Advances in Psychosomatic Medicine, 31*, 1–15. doi:10.1159/000330670

Bancroft, J. (2009). *Human sexuality and its problems*. London, UK: Churchill Livingston Elsevier.

Barker, M., & Richards, C. (2013). What does Bancroft's *Human Sexuality and its Problems* tell us about current understandings of sexuality? *Feminism & Psychology*, *23*(2), 243–251. doi:10.1177/0959353511434664

Barnes, R. (1873). *A clinical history of the medical and surgical diseases of women.* Philadelphia, PA: Henry C. Lea.

Bergeron, S., Morin, M., & Lord, M.-J. (2010). Integrating pelvic floor rehabilitation and cognitive-behavioural therapy for sexual pain: What have we learned and were do we go from here? *Sexual and Relationship Therapy*, *25*(3), 289–298. doi:10.1080/14681994.2010.486398

Bergeron, S., Rosen, N. O., & Morin, M. (2011). Genital pain in women: Beyond interference with intercourse. *PAIN*, *152*(6), 1223–1225. doi:10.1016 /j.pain.2011.01.035

Binik, Y. M. (2010). The DSM diagnostic criteria for dyspareunia. *Archives of Sexual Behavior*, *39*(2), 292–303. doi:10.1007/s10508-009-9563-x

Birnbaum, M. (1960). The right to treatment. *American Bar Association Journal*, *46*(5), 499–505.

Blackledge, C. (2013). The function of the orgasm. In A. L. Ferber, K. Holcomb, & T. Wentling (Eds.) *Sex, gender, and sexuality* (2nd ed.; pp. 235–246). Oxford, UK: Oxford University Press.

Brownmiller, S. (1971). *Against our will: Men, women, and rape.* New York, NY: Bantam Books.

Burman, E. (2004). Discourse analysis means analysing discourse: Some comments on Antaki, Billig, Edwards and Potter "Discourse analysis means doing analysis: A critique of six analytic shortcomings." *Discourse Analysis Online*, *1*(2). Retrieved from http://extra.shu.ac.uk/daol/articles/open/2003/003 /burman2003003-paper.html

Burman, E., & Parker, I. (1993). Introduction—discourse analysis: The turn to the text. In E. Burman & I. Parker (Eds.), *Discourse analytic research: Repertoires and readings of text in action* (pp. 1–13). London, UK: Routledge.

Cairns, K. V., & Valentich, M. (1986). Vaginal reconstruction in gynecologic cancer: A feminist perspective. *Journal of Sex Research*, *22*(3), 333–346. doi:10.1080/00224498609551313

Canner, E. (2008). Sex, lies and pharmaceuticals: The making of an investigative documentary about 'female sexual dysfunction'. *Feminism & Psychology*, *18*(4), 488–494. doi:10.1177/0959353508095531

Caplan, P. J., & Cosgrove, L. (2004). *Bias in psychiatric diagnosis*. Lanham, MD: Rowman & Littlefield.

Cole, E. R. (2009). Intersectionality and research in psychology. *American Psychologist*, *64*(3), 170–180. doi:10.1037/a0014564

Crenshaw, K. (1991). Mapping the margins: Intersectionality, identity politics, and violence against women of color. *Stanford Law Review*, *43*(6), 1241–1299.

Cryle, P., & Downing, L. (2009). Feminine sexual pathologies. *Journal of the History of Sexuality, 18(1),* 1–7.

Cryle, P., & Moore, A. (2010). Frigidity at the fin de siècle in France: A slippery and capacious concept. *Journal of the History of Sexuality, 19(2),* 243–261.

Donaldson, R. L., & Meana, M. (2011). Early dyspareunia experience in young women: Confusion, consequences, and help-seeking barriers. *The Journal of Sexual Medicine*, *8*(3), 814–823. doi:10.1111/j.1743-6109.2010.02150.x

Edmonds, E., Hunt, S., Hawkins, D., Dinneen, M., Francis, N., & Bunker, C. (2012). Clinical parameters in male genital lichen scierosus: A case series of 329 patients. *Journal of the European Academy of Dermatology and Venereology, 26*(6), 730–737.

Ellis, H. (1913). *Studies in the psychology of sex volume III: Analysis of the sexual impulse; Love and pain; The sexual impulse in women*. Philadelphia, PA: Davis Company.

Farmer, M. A., & Meston, C. M. (2007). Predictors of genital pain in young women. *Archives of Sexual Behavior*, *36*(6), 831–843. doi:10.1007/s10508-007-9199-7

Foucault, M. (1990). *The history of sexuality: The use of pleasure*. New York, NY: Vintage Books.

Frances, A. (2013). *Saving normal: An insider's revolt against out-of-control psychiatric diagnosis, DSM-5, Big Pharma, and the medicalization of ordinary life.* New York, NY: Harper Collins.

Frith, H. (2013). Accounting for orgasmic absence: Exploring heterosex using the story completion method. *Psychology and Sexuality*, *4*(3), 310–322. doi:10.1080/19419899.2012.760172

Gavey, N. (2005). *Just sex? The cultural scaffolding of rape*. London, UK: Routledge.

Gupta, K. (2013). Frigidity: An intellectual history. *Psychology and Sexuality*, 1–4. doi:10.1080/19419899.2013.858644

Gyftopoulos, K. (2009). Male dyspareunia due to short frenulum: The suture-free 'pull and burn' method. *Journal of Sexual Medicine, 6(9),* 2611–2614.

Haaken, J. (1994). Sexual abuse, recovered memory, and therapeutic practice. *Social Text*, *40*, 115–145.

Hill-Collins, P. (1998). The tie that binds: Race, gender and US violence. *Ethnic & Racial Studies, 21(5),* 917–938.

Hill-Collins, P. (2003). Some group matters: Intersectionality, situated standpoints, and Black feminist thought. In T. Lott & J. Pittman (Eds.), *A companion to African-American philosophy* (pp. 205–229). Blackwell Publishing.

Hyde, A. (2007). The politics of heterosexuality—A missing discourse in cancer nursing literature on sexuality: A discussion paper. *International Journal of Nursing Studies, 44*(2), 315–325. doi: 10.1016/j.ijnurstu.2006.03.020

Kaschak, E., & Tiefer, L. (Eds.). (2001). *A new view of women's sexual problems.* New York, NY: Haworth Press.

Kim, E. (2014). Asexualities and disabilities in constructing sexual normalcy. In K. Cerankowski & M. Milks (Eds.), *Asexualities: Feminist and queer perspectives* (pp. 249–282). London, UK: Routledge.

Kitzinger, C., & Frith, H. (1999). Just say no? The use of conversation analysis in developing a feminist perspective on sexual refusal. *Discourse & Society*, *10*(3), 293–316.

Krafft-Ebing, R. (1892). Psychopathia sexualis *with especial reference to contrary sexual instinct: A medico-legal study*. Philadelphia, PA: Davis Company.

Lea, S., & Auburn, T. (2001). The social construction of rape in the talk of a convicted rapist. *Feminism & Psychology*, *11*(1), 11–33.

LeFrançois, B. A. (2012). And we are still being psychiatrised. *Asylum*, *19*(1), 7–8.

LeFrançois, B. A. (2013). Queering child and adolescent mental health services: The subversion of heteronormativity in practice. *Children & Society*, *27*(1), 1–12. doi:10.1111/j.1099-0860.2011.00371.x

Masters, H. W., & Johnson, V. E. (1966). *Human sexual response.* Boston, MA: Little, Brown.

McPhillips, K., Braun, V., & Gavey, N. (2001). Defining (hetero)sex: How imperative is the "coital imperative"? *Women's Studies International Forum*, *24*(2), 229–240. doi:10.1016/S0277-5395(01)00160-1

Mohr, S., Kuhn, P., Mueller, M., & Kuhn, A. (2011). Painful love—"hispareunia" after sling erosion of the female partner. *Journal of Sexual Medicine, 8*(6), 1740–1746.

Morin, M., & Bergeron, S. (2009). La rééducation périnéale dans le traitement de la dyspareunie chez la femme. *Sexologies*, *18*(2), 134–140. doi:10.1016 /j.sexol.2009.01.004

Noss, K. (2010). *Knowledge is made for cutting: Genealogies of race and gender in female circumcision* (Unpublished master's thesis). University of Toronto, Toronto, ON.

Nurka, C., & Jones, B. (2013). Labiaplasty, race and the colonial imagination. *Australian Feminist Studies, 28(78),* 417–442.

O'Byrne, R., Hansen, S., & Rapley, M. (2008). "If a girl doesn't say 'no'…": Young men, rape and claims of "insufficient knowledge." *Journal of Community & Applied Social Psychology*, *18*(3), 168–193. doi:10.1002/casp.922

Pacik, P. T. (2011). Vaginismus: Review of current concepts and treatment using botox injections, bupivacaine injections, and progressive dilation with the patient under anesthesia. *Aesthetic Plastic Surgery*, *35*(6), 1160–1164. doi:10.1007/s00266-011-9737-5

Parker, I. (2013). Discourse analysis: Dimensions of critique in psychology. *Qualitative Research in Psychology*, *10*(3), 223–239.

Payne, K., Reissing, E., Lahaie, M., Binik, Y., Amsel, R., & Khalifé, S. (2008). What is sexual pain? A critique of DSM's classification of dyspareunia and vaginismus. *Journal of Psychology & Human Sexuality, 17*(3–4), 141–154, doi:10/1300/J056v17n03_10

Perlin, M. L. (1992). On sanism. *SMU Law Review*, *46*, 373–407.

Phoenix, A. (1987). Theories of gender and black families. In G. Weiner & M. Arnot (Eds.), *Gender under scrutiny* (pp. 50–63). London, UK: Hutchinson.

Phoenix, A. (1990). Social research in the context of feminist psychology. In E. Burman (Ed.), *Feminists and psychological practice* (pp. 89–103). London, UK: Sage.

Phoenix, A. (1994). Practicing feminist research: The intersection of gender and 'race' in the research process. In M. Maynard & J. Purvis (Eds.), *Researching women's lives from a feminist perspective* (pp. 49–71). London, UK: Taylor & Francis.

Potts, A. (2002). *The science/fiction of sex: Feminist deconstruction and the vocabularies of heterosex*. Hove, UK: Routledge.

Reavey, P., & Warner, S. (2003). *New feminist stories of child sexual abuse: Sexual scripts and dangerous dialogue*. Hove, UK: Routledge.

Reissing, E., Borg, C., Spoelstra, S., Kuile, M., Both, S., Jong, P., … Schultz, W. (2014). "Throwing the baby out with the bathwater": The demise of vaginismus in favor of genito-pelvic pain/penetration disorder. *Archives of Sexual Behavior*, 43(7), 1209–1213.

Rose, N. (1979). The psychological complex: Mental measurement and social administration. *Ideology & Consciousness*, *5*, 5–68.

Schover, L. (2005). Sexuality and fertility after cancer. *ASH Education Book, 1,* 253–257.

Shields, S. A. (2007). Passionate men, emotional women: Psychology constructs gender difference in the late 19th century. *History of Psychology, 10*, 92–110.

Stoler, A. L. (1995). *Race and the education of desire: Foucault's history of sexuality and the colonial order of things*. Durham, NC: Duke University Press.

Tiefer, L. (1988). A feminist critique of the sexual dysfunction nomenclature. *Women & Therapy, 7*, 5–21.

Tiefer, L. (2004). Historical, scientific, clinical, and feminist criticisms of "The Human Sexual Response Cycle" model. In M. S. Kimmel & R. F. Plante (Eds.), *Sexualities: Identities, behaviors, and society* (pp. 52–63). Oxford, UK: Oxford University Press.

Tiefer, L. (2005). *Sex is not a natural act and other essays* (2nd ed.). Boulder, CO: Westview Press.

Tosh, J. (2011a). The medicalization of rape? A discursive analysis of "paraphilic coercive disorder" and the psychiatrization of sexuality. *Psychology of Women Section Review, 13*(2), 2–12.

Tosh, J. (2011b). Professor Zucker's invitation as a keynote speaker to the Division of Clinical Psychology Annual Conference: A response. *Psychology of Sexualities Review, 2*, 62–67.

Tosh, J. (2013). The (in)visibility of childhood sexual abuse: Psychiatric theorizing of transgenderism and intersexuality. *Intersectionalities: A Global Journal of Social Work Analysis, Research, Polity and Practice, 2*, 71–87.

Tosh, J. (2015). *Perverse psychology: The pathologization of sexual violence and transgenderism*. London, UK: Routledge.

Ussher, J. (1993). The construction of female sexual problems: Regulating sex, regulating women. In J. Ussher & C. Baker (Eds.), *Psychological perspectives on sexual problems: New directions in theory and practice* (pp. 9–40). London, UK: Routledge.

Ussher, J. (2003). Biology as destiny: The legacy of Victorian gynaecology in the 21st century. *Feminism & Psychology, 13*(1), 17–22. doi:10.1177 /0959353503013001003

Ussher, J. M. (2011). *The madness of women: Myth and experience*. London, UK: Routledge.

Ussher, J., Perz, J., Gilbert, E., Wong, W., & Hobbs, K. (2013). Renegotiating sex after cancer: Resisting the coital imperative. *Cancer Nursing, 36*(6), 454–462. doi:10.1097/NCC.0b013e3182759e21

Walker, S. J. (1997). When "no" becomes "yes": Why girls and women consent to unwanted sex. *Applied and Preventive Psychology*, *6*(3), 157–166. doi:10.1016/S0962-1849(97)80003-0

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