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Where does the problem lie? Focus of evaluation in Marital Sex Therapy: A Case Report of Vaginismus

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Abstract

Often a therapist treating sexual dysfunction in a couple with marital distress is faced with the dilemma of deciding what or whom to focus in therapy. With the increasing recognition of the need for an integrated systemic approach, therapist is expected to simultaneously address individual, couple and family systems. The challenge is eliciting, organising and understanding complex information from multiple domains. This article, through a case report, illustrates how a couple with vaginismus could be conceptualised and treated in an integrated fashion using Marital Sex Therapy. The intricacies involved in the process are elucidated with an emphasis on a thorough systemic evaluation.

Keywords: Marital therapy, Sex therapy, Vaginismus.

Introduction

Sexual and marital relationship are inextricably interwoven, they not only interact with each other but with a host of other factors. The relationship forces such as marital quality, intimacy, communication are known to affect the sexual functioning. On the other hand sexual dysfunction is usually a complicated individual and relationship problem that undermines personal and relationship happiness. A comprehensive and multidimensional assessment of all the relevant variables is required to enhance the treatment outcome of couples facing sexual dysfunction and marital distress.[1,2,3] This will not only facilitate the decision making process of when and what component of sex or marital therapy needs to be emphasized, but also help the therapist to anticipate and be prepared for the potential problems or challenges that might erupt during the course of the therapy. At times, information on relationship variables such as extreme hostility will not only be contra-indicators for sex therapy but may need to be effectively addressed to pave the way for execution of sex therapy.

Therapists trained in individual therapy formats as well as beginner couple therapists often find it challenging to give up linear understanding of problems and deal with two people without an identified patient. It is overwhelming to simultaneously hold multiple perspectives and embrace circular understanding of relationship problems.[4] Complexity of the situation is further increased when the presenting complaints lie in different domains such as individual psychopathology, sexual functioning as well as marital relationship. Through this paper we aim to aid practitioners in this area by illustrating the process of assessment and therapy in a couple who presented with Vaginimus in wife, Depressive disorder in husband and Marital distress. The Integrative Problem Centered Metaframeworks model (IPCM), embraces a transtheoretical, common factors, integrative and problem centered perspective that provides a method for organizing and processing complex couple data. For the case study we follow four session evaluation nested in IPCM model as illustrated by Chambers.[5] Pointers for addressing depression in couple therapy in the context of marital distress was obtained from the format provided by Whisman and Beach.[6]

Case Illustration

Newly married, educated, dual careered couple in their late twenties with a courtship of 5 years in a long distance relationship sought help for non consummation of marriage owing to Vaginismus in wife. During their occasional meeting during courtship they were physically intimate but avoided penetrative sex. They were emotionally connected, could communicate openly, and manage general differences without great difficulty. Husband was found to have signs of clinical depression with history of two episodes in the past. Individual sessions revealed that husband came from a highly educated family which had liberal attitude towards sexuality and provided permissive environment for expression of views. Wife came from a more conservative family; sex as a topic was avoided and she was found to historically have misconceptions about menstruation, external genitalia and pain during sex. Tracking of their relationship behaviours revealed an interesting interaction pattern. After adequate foreplay, on every attempt at penetration wife tensed up and pushed the husband away. Husband was offended and hurt as he attributed it to her lack of trust and inability to get vulnerable with him. In response wife was apologetic and immensely guilty for not being able to fulfil her duty as a wife. Later they both were distressed and avoided general interactions for fear of showing

these negative emotions. With each effort at consummation of marriage these behaviours escalated resulting in complete avoidance of sexual interactions for fear of ensuing another cycle of hurt, anger, resentment and avoidance of general interactions. Wife dreaded sexual initiations from the husband for the fear of deepening the sense of hurt in him. However, she was clueless as to how to solve the problem. Husband would catastrophize the situation and dreaded the future of the marriage. His daily routine and performance at work were impaired. Thus they maintained the problem by the way they responded to each other despite the best of their intentions to improve the state of affairs. Both felt inadequate as they could not consummate the marriage and also fulfil the expectation of the extended family. The couple then decided to seek help. Initial sessions focussed on evaluating depression in the husband, making appropriate referrals for pharmacotherapy and assessing the effect of depression on the relationship. Tracking of the interaction pattern, reframing the problem in a shared perspective, emphasizing on the strengths in the marriage helped them feel hopeful and optimistic about the outcome. Following evaluation the targets set for the therapy were: addressing depressive symptoms, misconceptions about sex, maladaptive sexual and marital interaction as well as training in communication and problem solving skills.

Therapy: Through feedback of systemic hypothesis, covering individual (biological and psychological), couple and family systems, the role of each partner in maintaining and escalating avoidance behaviour in the other partner was explained. Six weekly conjoint sessions (excluding 4 assessment sessions) were held over 2 months' time. Psycho-education on symptoms of depression and behavioural activation were provided to the husband. Sex education addressed doubts and misconceptions about female genitalia and misattribution of sexual dysfunction. The couple gradually learnt to use non-hurtful productive ways of sexual communication.[7] Couple were encouraged to express their vulnerable emotions to each other in the safe environment of therapy resulting in each feeling validated and understood by the other. Sex therapy included sensate focus, graded exposure to sexual stimuli, fingering/dilatation technique, wife's genital exploration in the presence of the husband and focus on pleasure in the here and now. The couple showed quick improvement in terms of better communication, not avoiding sexual interaction and mindfully changing their way of responding to each other. Therapist reinforced their efforts and encouraged each one to be appreciative of the others' efforts. The couple consummated the marriage in the second month of therapy. Relapse prevention through normalising occasional inability to penetrate, use of alternative modes of sexual satisfaction was discussed. Identification of early warning signs of depression, and addressing the same was also discussed. During one year follow-up, the couple maintained the improvement in their relationship behaviours.

Discussion

Evaluation through IPCM format involves two individual sessions, one with each spouse, sandwiched between two conjoint sessions, carried out through clinical interviews.[5] Conjoint sessions are useful in observing and tracking dyadic and family patterns while individual sessions facilitate eliciting individual psychological, sexual developmental issues. In the initial conjoint session, despite couple presenting with the assumption that wife was the one with the problem, therapist constantly focused on the relationship and not on either partner. It is through such focus, depression in the husband was discovered although it was not the presenting complaint. Defocusing from individual, de-pathologising, non-judgemental neutral stance, reflexive and circular questioning of the therapist put the couple at ease as they could distance themselves from the problem and not see themselves to be the problem.[1] Evaluation is basically done for the couple and with the couple such that it enables them to gain insights into their problems, diminishes anxiety, enhances hope, induces a sense of power and increases responsibility in each spouse for change. Subsequent individual sessions revealed individual psychopathology issues in each spouse, as well as the interrelationship of each with the other. Exploring the family of origin issues revealed the origin of wife's fear of penetration, fear of pain during sex, her misconceptions regarding female genitalia and pregnancy. Similarly husband's family of origin emphasising on emotional intimacy in a sexual relationship might have lead him to misattribute wife's non cooperation in sex to her lack of trust or inability to get vulnerable with him. Furthermore, as in most cases, the couple showed avoidance behaviour and a shared fear towards sexual activity.[8] The systemic hypothesis that was generated by the therapist in the first three sessions could then be verified in the fourth (conjoint) session followed by feedback of systemic hypothesis and setting of therapy goals. Following the IPCM model also ensured that the therapist explored all the relevant areas ranging from individual biology to societal expectations from the newlywed couple.[5]

Given the reliable association between depression and marital distress in literature, treating depression in husband within the context of his or her marital relationship was a logical choice.[6] Depression in the husband, Vaginismus in wife and avoidance of sexual behaviour in the couple were all closely connected to and maintained each other. Addressing vaginismus and improving the quality of marital relationship was a source of strength and an asset to husband's recovery from depression. Improvement in his mood also

reflected in increased positive interactions between the couple.

Thus, using theoretical base of systemic and cognitive behavioural therapies and skills building approach the therapist could integrate marital therapy, sex therapy and cognitive behaviour therapy for depression. The techniques of psychoeducation, cognitive restructuring, communication skills and problem solving skills training were used to address multiple complaints at different levels that were related to each other. This was facilitated by IPCM model of evaluation that provided transtheoretical template for eliciting, organising and processing complex data from multiple systems.

Conclusions

The case illustrates a systemic, integrative and transtheoretical approach to evaluation and therapy in a couple with Vaginismus. A comprehensive, multidimensional and detailed evaluation is a prerequisite in setting focussed, realistic goals and smooth progress of therapy. The case also illustrates how such approaches are open for simultaneous intervention for multiple presenting complaints that are related to one another.

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