Piero Porcelli

A Case of Vaginismus: Case Presentation

Summary:

The psychotherapy process of a 28-years-old woman, Anna, is reported. The patient was referred to psychological consultation from the gynecologist with a diagnosis of primary vaginismus. Because of clinical and hospital policy-based considerations, the patient was given a short-term psychotherapy planned for lasting 16 sessions, which were however prolonged for further 8 sessions. The psychotherapeutic process went through 3 consecutive phases of rapid symptomatic improvement, therapeutic stalemate, and final resolution of symptoms. Some classic techniques of cognitive-behavioral therapy were utilized, primarily progressive relaxation and in vivo exposition. However, the whole psychotherapeutic process was interpreted and is discussed in the paper through a psychodynamic perspective. In particular, some relevant key points are discussed within the theoretical framework of Weiss and Sampson's Control Master Theory. One major issue was raised at the end of the treatment, i.e. what kind of treatment has been carried out with Anna, whether a cognitive-behavioral therapy (if treatment is identified with the technique) or a psychoanalytic psychotherapy (if treatment is identified with the analysis of the meanings shared by the therapist and the patient within the therapeutic relationship).

Anna is a 28-year-old, she has been married for a few years and has no children. She and her husband had been sent for consultations at the day hospital of the Obstetrics and Gynecology department where she was diagnosed with functional vaginismus. She had consulted a gynecologist, for the first time in her life, to find out why she was unable have children. During the gynecological examination she discovered that "she was practically still a virgin": the gynecologist didn't succeed in his exploration because of the terrible pains the patient felt as soon as the lips were opened. After several examinations, carried out with enormous difficulties, the gynecologist gave a diagnosis of primary vaginismus of a functional nature. From that day it was as if the world had collapsed on her shoulders. Now she feels very confused, she is miserable with the frustration of her failure to become a mother and with the profound sense of having failed her family too, who constantly put pressure on her with the question: "when are you going to have a baby?" She is also angry with her husband, who she feels has disappointed and betrayed her. She always believed they'd had normal sexual intercourse, but now she was discovering, after her husband's confession, that he had never penetrated her. Except once, their first wedding night, and even then only superficially, because of the intense pain she felt.

Anna's parents, who are around 50, come from a provincial country background. She has a slightly older sister, who was always bright and sensible and did very well at school. This sister has also been married for some time and she too is childless. She left her place of birth and is continuing her university studies. For Anna this sister represents a kind of ideal; the one who managed to achieve the teenage ambitions they had both once shared and for which Anna had also always striven, but with the feeling of just trudging along. Burdened with the limits set by an authoritarian old-fashioned father, both girls had always been determined to achieve what they wanted. For example, their father didn't want them to go to school, so in the summer they both worked on the land to save up enough money to buy school books. Anna's sister turned into a

rebel, tenacious, with a fighting spirit. Anna, on the other hand, clenched her teeth, more indulgent towards others, incapable of rebelling against paternal authority. Still today her sister isn't bothered by the pressure her parents put on her about having a baby, while Anna feels guilty. They took different paths: Anna is now proud of her sister, of her job, of her determination in continuing her studies. Anna has given up ever realizing the dreams she had of going to university and adapts to seasonal jobs in the country or with food transformation companies. She and her husband first met when she was in her early teens, the first and, so far, only man in her life. As a personal choice they never had sexual intercourse before marriage and she has always been the one to manage their married life, from important choices to small everyday details, with great leadership, convinced that her husband is more immature and therefore can't be trusted. She works from seven in the morning to the early evening, weekends included. So, she has to wake up before dawn and goes to bed very late to see to all the household chores, sleeping no more than four or five hours per night. On top of all this she looks after her little orchard and helps her mother with her household chores. Basically, she is the one to see to any problem, faces it, attacks it and solves it. She says that "she grew up alone and precociously": her mother began suffering from a bipolar disorder, she never showed much fondness for her children and, as early as at the age of five, Anna was always the one who made up for her mother's functional "deficiencies."

Her husband is the same age and with a very similar background. He is the youngest brother, he has a slave of a mother who contributed to fuelling in him the cultural stereotype that the male is to be served in the home. His brothers slowly set up small crafts enterprises like their father's. He tried to gain independence from his father too, but failed. His ambitions, like Anna's, were frustrated and today he is forced to do subordinate labor. He describes himself as touchy and introverted, very irritable and practically totally dependent on his wife, who is the one who really deals with problems in the home. Even for the problem in question, she was the one to take the initiative, first forcing him to see a gynecologist and then me. Anna is the first and only woman of his life. He immediately noticed his wife's problem, as early as the first wedding night, but never did anything about it, never even talked to her about it. He was content with having partial intercourse: scant and rapid preliminaries, genital contact with no penetration, to avoid his wife any pain, precocious ejaculation. His wife believed this was what sexual intercourse was all about and before seeing the gynecologist hadn't realized anything was wrong. He doesn't quite know why he never said anything, probably just to avoid problems, to avoid his wife any suffering and avoid wounding his own male pride. Neither family is aware of Anna's problems.

After five preliminary interviews (two with the couple – one at the beginning and one at the end, one just with the husband and two with Anna alone), in the last all three of us discuss the possibility of starting a psychotherapy. The husband immediately declares his unavailability: he has no time and cannot constantly ask for leave from work. Anna, on the other hand, is determined to solve the problem and says she has no problem organizing her work schedule, making up for time off for sessions in the late morning. In formulating the therapeutic contract I make it clear to Anna that she can use a single Public Health Service authorization prescription written by her family doctor for a total of eight sessions, therefore with minimum costs. For management reasons and the logistic limits of the Service it is not possible to carry out long-term therapy, therefore therapy has a duration fixed at eight sessions, corresponding to the maximum a family doctor may prescribe under the Local Health Authority, these may be prolonged to a maximum of another eight sessions with a second prescription. Before accepting Anna asks me if I think I can solve her problem. I say I'm confident, but Anna chills me by saying she is highly skeptical and can't understand where my optimism comes from, but says that nevertheless she is willing to start. During the whole period of the psychotherapy her husband took part in a total of five sessions.

Phase One: Rapid Symptomatologic Evolution

Anna's personality is very strong, she is very down-to-earth and her behavior is directed at maximizing efficiency. Her self-esteem is high, she is absolutely convinced she knows the essentials of everything and

that she knows how to do what is most appropriate under all circumstances. She has a strong need for success and cannot tolerate failure, complaints, recriminations, rebukes. She is actually a very able and intelligent woman and concentrates on the fundamentals for any decision. At work too her colleagues turn to her when they have a problem, while she never mentions hers to anyone, as she knows she's the only one who can solve them. This high efficiency of her adaptation functions is unconsciously useful to her both for increasing her self-esteem and cultivating her fantasy that she is extremely appreciated by others. Therefore, because of the nature of the symptom and particularly to help our therapeutic alliance, I decide to adopt the classic behaviorist technique of systematic desensitization via gradual exposure to an anxiety-inducing stimulus. Beyond the proved effectiveness of this technique in treating vaginismus, it also seems to me the one that best corresponds to Anna's need to have control not only on the therapeutic process but on its results too, therefore the one with the highest probability of both guaranteeing a good working alliance and sustaining her motivation.

During the first sessions she brings out all her resistance: the problem is too big and cannot be overcome. She is angry with her husband who has hidden everything from her with his superficial immature attitude. As for me, I take the situation too lightly and have no idea how serious it is. She knows what her problems are and there's nothing I can teach her that she doesn't already know. Besides, she doesn't know how to justify the weekly two-hour leave from her job to her employer. I basically suggest she begin to work on the problem and verify the various difficulties. Anna begins her relaxation exercises at home but, as was quite predictable, has huge difficulties. Her organization is extremely efficient (she's managed to find some time at home when her husband is away, she's finished her various chores, she can switch her phone off, she's bought a *new age* CD to create some atmosphere), but she just can't relax. It takes her about two hours to relax with her mind, but her body doesn't respond, it's stiff. When she finally does relax, however, and starts to touch herself, she immediately has very intense acute reactions: sense of panic, fear, crying, strong pelvic pains, pains in her legs, which drag on for the whole of the following day (the job she does requires her to stand a lot). A few days after the third session I receive an anxious frightened phone call from her husband. Anna finished her relaxation exercises one hour ago, but now her legs are paralyzed, she can't move them, they're numb. He asks me what could have happened, if he should take her to emergency. I talk to her on the phone for a while and reassure her, she calms down and starts to feel better. She would then tell me that, after the conversion episode, the inside of her thighs hurt for the whole week.

At the next session she is very depressed. She feels ill, she no longer knows whether she should continue with therapy, nothing is changing, things seem only to be getting worse. But that's not the point. Anna has realized that this is her problem, that the problem is her. She had always blamed everything on her husband and was angry with him, but now she realizes that she can't have sexual intercourse because it is her who cannot relax, and she cannot relax because there is something wrong with her. What happened was proof enough: she had become frightened because she thought I was harming her and had ordered her husband to call me to tell me she felt paralyzed, her legs straight and as stiff as dried cod. Then she was distressed by the fact that she calmed down when I spoke to her on the phone, proof that there is a problem somewhere inside her. I consider these episodes (the hysteric and the depressive) a "test for the therapist", according to the principles of Weiss and Sampson's *San Francisco Psychotherapy Research Group*, a challenge against *pathogenic belief*, according to which "if I'm not good, you won't want me anymore". So, I tell her that she had flunked herself and that now she was unhappy with herself; but that I know what a smart individual she is and I'm positive that together we'll be able to disentangle the whole matter. This is a kind of summary of my general attitude towards her: we analyze the results of her relaxation exercises, but at the same time I pay a great deal of attention to the signals Anna subtly uses to communicate to me that she's letting go of her resistance and beginning to trust me.

After this episode the clinical situation evolves very quickly. To begin with, for the first time Anna turns up to the next session wearing make-up, her hair carefully brushed, wearing very smart clothes; in other words with a decisively more feminine look. Her exercises are also going much better. It takes her less and less to relax (from two hours down to 20-30 minutes), but she has difficulties of *reverie*: initially she cannot visualize anything, an empty black screen; then she can visualize a scenery, sea, beach, lawn; finally she can

visualize a person (an actor she's very fond of or her husband), but not including herself, as if she were seeing a film without entering the scene. She then starts masturbating, but just when she's getting aroused has to interrupt and run to the bathroom to pee.

As time goes by improvements become more and more significant. Anna decides to dedicate the whole day when she has sessions to herself: she gets up late, has a long breakfast, goes to the hairdresser's, does her exercises calmly. During the session we talk a lot about how difficult it's always been for her to put her own pleasure first in the list of priorities, how she only devoted herself to herself when and if she had any time to spare. Now she can visualize people directly, without the preliminary steps of the "black screen" and the "scenery". During masturbation she can almost reach an orgasm (something she's never experienced) but has to stop immediately before because of feelings of intense anxiety and tremors in her legs, which carry on hurting for several hours afterwards. She also begins to gradually insert first one then two fingers in her vagina, also asking her husband to do so with his fingers. Together they try gradual penetration (non-exigential coitus), which Anna can control by blocking her husband's movements at will. For the first time she feels no pain (but no pleasure either) when penetrated. Nevertheless, Anna's general attitude to intercourse is still rather stiff. While she recognizes that she is making some progress she still thinks that things aren't going as they should, that the problem will never be solved, that she can't understand how I can see things differently, that nobody understands her, helps her or wants to come to terms with her, that her husband doesn't co-operate at all (for example, the penetration exercises are vain because of his premature ejaculation). At every session this sort of role playing game repeats itself: with her as the destructive and pessimistic woman and with me optimistic about the results reached, comparing them with the situation the previous week or at the beginning of therapy, underlining each time my trust in her capabilities and commitment.

Phase Two: Therapeutic Stalemate

During an exercise at home strangely enough Anna succeeds in relaxing, deeply, her mind wandering without a precise direction and images overlapping. At a certain point she sees the country lane of the house of her birth, she approaches a tool shed where she perceives some shadows, at that point she wakes up again in a panic. She is sure she already lived through that scene as a child, she saw in it some details of the place that she had completely forgotten and that are no longer there, and even asked her parents for confirmation. She can't remember what took place or what she saw near that shed as a child. She can only remember it being a scorching summer afternoon with the adults taking their afternoon nap and herself, probably with a cousin or her sister (but today her sister has no memory of this episode), approaching the shed. At this point her memory fails her. This frightens her, she wonders what could have happened there. I am perplexed myself. The hypothesis that she was scared because she saw someone having sexual intercourse there is plausible. It is also possible, however, that this was a form of transferential communication to me, telling me how she felt traumatically seduced by me – considering the detailed accounts she gave me of her masturbation and attempts at coition with her husband – making me feel a voyeur spying in her bedroom. Or a retrospective causal relation may have begun. As a child she was afraid of that shed, she doesn't know whether she had ever been locked up in there in the dark, scared stiff. It is therefore possible that Anna is scared of the deep and has never experienced relaxation (I won't forget that, in general, loosening her grip and control over situations causes her a great deal of anxiety) and that she has unconsciously associated this current fear of hers to the one felt as a child, merging images and memories. I'm not sure what meaning to give this episode. It is an image that never came up again during treatment and until the end I continued having doubts about how to interpret it.

Shortly afterwards, about three months after the beginning of therapy, half way through the second eight session cycle, the positive evolution of treatment suddenly comes to halt, and in fact decisively regresses. The occasion presents itself with her mother having an episode of acute maniacal agitation, one like she hadn't had for at least fifteen years. Her mother is taken to a psychiatric clinic for a fortnight, after which

she is cared for at the day hospital of a private clinic. As usual it is she who spontaneously offers to help the family deal with the problem: look after her mother, wash her underwear, wash her father's clothes, make the food, manage her parents' house. All this in addition to her job and her own housework. She is tired and worried. At the same time her husband is jealous of the time Anna dedicates to her family of origin, upsetting their habitual household rhythms. She also has an argument with her sister who accuses her of always wanting to be the star of the show, acting as a little mother for their father, who could easily look after himself.

The situation regresses to the early stages. Anna does her exercises at home distractedly, when she finds the time, but her mind is elsewhere. She doesn't relax, on the contrary, she starts feeling vaginal pains again and the tremors in her legs return, she can't go beyond the "black screen" in her visualizations. One evening, during yet another quarrel, her husband grabs her, shouts at her saying he's tired of waiting, of the exercises, of being considered a half-witted child by her and penetrates her causing the same pains she felt at the beginning of the therapy. During sessions she no longer co-operates. She doesn't put up a deliberate resistance but now thoroughly lacks any motivation: she doesn't protest, nor accuses me of anything; it's simply that nothing works, she says, everything is lost, everything is pointless; after all, she knew from the very start that nothing could come of the situation. I feel a bit like her too: what was working before isn't anymore, what I thought I could control during the therapeutic process is now completely out of control. Anna has other issues on her mind, she hardly co-operates at all, environmental stress is high. However, some signals are still important. For example, Anna continues to attend sessions regularly, even when she doesn't do her exercises or has had a very heavy week dealing with a thousand other things. And she also starts giving me small gifts: seasonal fruit and vegetables hand-picked in her kitchen garden or bread made by her and her mother after her discharge. It seems to me that the important point is not so much her presenting me with gifts, but the fact that these gifts are things grown or made by her, while she is no longer producing anything as far as symptomatologic improvement is concerned. I could interpret these gifts as a transferential phenomenon, but with her I don't. I'm afraid of overlapping my language to hers, of giving her the impression that I'm defending myself from my feeling of impotence as a therapist rather than catching the substance of her entirely unintentional communication. I decide to leave her a large space for maneuver within our relationship, and so even to allow her to control me with her own communication code.

I accept her gifts and tell her again and again how optimistic I feel about the progress she had made, which at the moment is simply blocked. In a way I want to communicate to her that I don't think anything is lost, that we must stick together to face this new situation, which is undoubtedly very critical.

But at the same time I want to recover her productive abilities of control over events, force her to work with the functions of the ego on a more adaptive level, share the responsibilities of the process and its results. As we're at the end of the second cycle of sessions available on prescription, I firmly and resolutely remind her of the terms of the initial therapeutic contract (two eight session cycles) and inform her that I've arranged to exceptionally extend the therapy by another cycle of eight sessions. This means that we still have approximately another two months to solve the situation: in or out. I won't abandon her (for another two months) but I put a realistic time limit within which each must take one's responsibilities. I see by her expression that she's somewhat struck by my words: she doesn't reply, just nods in the affirmative, but I can clearly see her state of confusion.

Phase Three: Solution to the Therapy

At the following session she turns up in a foul mood, wearing a strange hat and dark glasses, which she doesn't take off. She accuses me of wanting to abandon her, of playing dirty with her, of having given her the illusion I could solve her problem, of being a liar, she threatens to report me to the health authorities. She's had a serious quarrel with her husband and this time it's over for good: she's left home to live with a much older man, a very rich widower who has been wooing her for ages, but she'd never told anyone. She

won't take her glasses off because she's been crying so much that her eyes are swollen and one is black from her husband beating her. She will no longer be coming to therapy but felt she needed to tell me how much I hurt her with my behavior and above all to know why I said I would abandon her.

I am frankly overwhelmed by the tone of her voice and the situation I'm suddenly confronted with. I start wondering if I got everything absolutely wrong, but can't seem to find any serious mistakes in anything I had said or done. I apologize to her for having given her the impression that I wanted to abandon her and for not being clear enough on the terms of the contract. I tell her that I'm truly sorry and that yes, it's true I've been a bit tough on her, but only because I believe in her and had to take action after the situation of stalemate our therapy has reached. Her expression suddenly changes, she takes off her glasses and smiles. She says she was joking, putting on an act in order to understand whether mine was a provocative attitude to shake off her block of recent months or whether I really wanted to quit her. After the last session she felt awful for days, brooding over the reasons for my harsh and resolute behavior, and she also considered putting a stop to treatment. She thought over the fact that she was putting her trust in me to the test and that this could also be the reason why she can't relax with her husband: he doesn't place any trust in her, he's a child, she doesn't feel he's a real man who protects her and gives her security. She was suddenly relieved: these considerations about her husband did not disturb or frighten her anymore. She felt light, happy, everything seemed so simple. A few hours later, in the country with her husband to see to some minor pruning work, she felt a very strong and never felt before physical attraction towards him. She drew close to him and asked him to embrace her, to hold her. They both let themselves go, they made love on the grass with near to complete penetration, without worrying whether anyone was watching. Now she is obviously ready to carry on with the therapy, happy with the results reached so far.

I thought over this session for a long time afterwards. Never before had a patient of mine acted during a session to verify a doubt about me. I'm not sure how to put Anna's behavior into focus: she wasn't in bad faith and her behavior couldn't be defined either as a hysterical scene nor as *acting-in*, because it was carefully planned, it was completely conscious, it had nothing of the "drive". And, most important of all, her acting was consequent to an emotional impulse of intimacy with her husband, which in turn was the consequence of a deep awareness of herself, drawing very close to what is usually defined as insight. I think that the basic motivation for Anna's behavior was finalized towards a further macroscopic "test for the therapist", to verify once and for all if she could trust her trust in me even if she was displaying the exact opposite of what you might expect from a smart efficient person. It was, therefore, the scenic dramatization of a test carried out separately, in solitude, thanks to which Anna was able to accept her husband and let herself be carried away by feelings of tenderness towards him.

After this session the painful symptoms were progressively and significantly reduced. Her exercises have made it possible for her to have normal sexual intercourse, with only a slight degree of pain during deepest penetration. During sessions Anna reflects a lot about her relationship with her husband, about herself, her past. She says that now she is fully aware that her sexual symptom was only the most obvious aspect of something more important inside her, that she has other more serious psychological problems and that she would like to face them more appropriately when she has enough financial security for a longer and more thorough psychotherapy. The issue is not urgent and so she doesn't pose it as a problem in the short term. But she knows that she'll have to face these problems when she feels ready. Her relationship with her husband is changing too. They devote more time to themselves, in the evening they go on romantic walks by the seaside, she has become more tender and cuddles him. Now, however, it's her husband who's intimidated by his wife's *advances*, he's awkward and shy about them. Anna thinks over all the occasions when he proved to have a block: for example the decision not to go to the U.S.A. for their honeymoon, as she had wanted, because he was afraid of going to a big foreign country all alone, without even knowing the language. Now, however, she cares more for what she wants, what counts most for her: the time dedicated to herself rather than to work or to her mother or to anyone else. She's no longer angry with her husband but only a little bitter about having set up a relationship whereby she's the factotum mother (suffice it to say that she chooses all his clothes) while he is still the usual demanding whimsical child, exactly the same kind of relationship he has with his mother.

In the final sessions, which include her husband (as earlier on, for certain periods, with the consent of both), I try to be as clear as possible about separating the problem in respect to the beginning of the therapy. Technically the symptom has been dealt with: the two have normal sexual intercourse and, if they wish, can try to have a child. This aspect has become completely different from other fundamental ones: Anna's personality and her husband's difficulty in becoming independent of the need to feel an external guaranteeing guide behind him. The quality of their relationship as a couple will now depend on how they continue to grow, each with their own individual problems or together as a couple or as a future family of three. An awareness has been reached by which vaginismus no longer represents an obstacle, one which had made it possible for them to avoid facing their problems of intimacy.

At the last session, Anna, after thanking me together with her husband, hands me a letter that I will later find extremely beautiful and moving. About a year after the end of treatment the situation remains very positive for Anna, who still phones me from time to time. The painful symptom has disappeared altogether, she feels fine and is going through positive and pleasant experiences. Her relationship with her husband has also improved somewhat. She doesn't become pregnant, despite repeated attempts. But she's not too concerned: they are a normal couple who have trouble having children, like so many others.

I still keep asking myself what type of therapy I have done with Anna, and this is the reason why I felt I should publish this case. My training is analytical, but the techniques used in this case are much closer to the cognitive-behaviorist. If psychoanalysis is identified with the *technique* used it certainly hasn't been a therapy of the psycho-dynamic variety. I'm not entirely sure, however, that it is correct to formulate the issue in this way. If psychoanalysis is meant not as a set of techniques, but as the analysis of meanings within the therapeutic relationship, then I believe that this has been an analytic psychotherapy. I am therefore grateful to Anna for making me reflect upon my professional identity as a psychotherapist.

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