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SEXUAL DYSFUNCTION AND COUPLE PROBLEMS. CIRCULAR CAUSALITY

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Abstract

The work verifies the hypothesis if there is a circular causal relationship between sexual inhibition and couple problems. Couple relationships are, for many researchers, the closest relationships that an adult develops during his life. The interest in the dyadic relationship is increased by the possible repercussions of the dysfunctions in the intimate space. When the couple does not develop or maintain an expected degree of intimacy, its dissolution is likely, as lack of closeness has been identified as the most common reason for divorce and separation. Two case studies, couple partners in the process of systemic psychotherapy and 20 responding subjects in the evaluation by: Questionnaire for mutual appreciation of sexual-affective needs and attitudes, adapted by I. Mitrofan, 1984 after the Inventory of attitudes towards sexuality – Eysenck, Scale for measuring marital satisfaction, Spanier. Satisfaction in the relationship is positively and moderately correlated with the level of sexual-affective satisfaction of the couple ($r = 0.39$; $p \leq 0.001$), thus confirming the working hypothesis. From the answers given, it can also be seen that in couples where communication is authentic on a digital and analog level, the degree of trust between partners is higher, the level of sexual inhibition is lower and respectively the quality of life as a couple is better. The research within the work confirms the formulated hypothesis - sexual dysfunction and couple problems influence each other, in a circular causality.

Key words: family, systemic, couple, sexology.

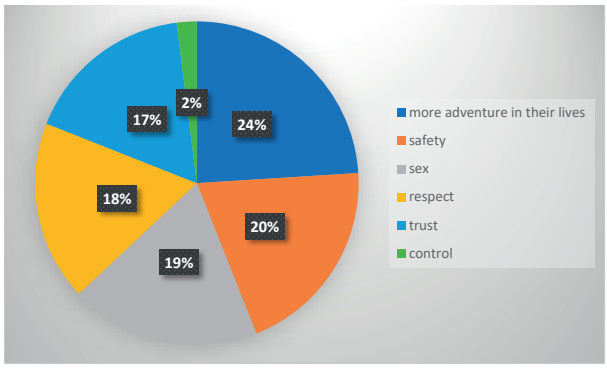
INTRODUCTION

The work starts from the idea that the sexuality of the couple needs to be perceived, aware and accepted beyond the generic approach in a list of factors that support or affect the balance of the relationship. When we ask ourselves about the couple's sexuality, we evaluate and answer questions regarding aspects related to functionality and dysfunctionality. Even from this stage, it can be observed that the approach will provide consistent references related to the level of marital satisfaction.

The correlation between sexuality and dyadic satisfaction was found in few of the studies with application to groups of subjects from Romania. A larger study is the one applied before the arrival in Romania of John Gray, the author of the book „Men are from Mars, Women are from Venus". Between 01.07.2015 and 01.09.2015, Extrem Training carried out probably the most extensive research on the satisfaction of the couple's relationship, both online and through direct interviews - 1369 questionnaires. The obtained data bring attention

to topics such as: sexuality, unsatisfied needs, level of satisfaction (Psychology magazine 1, 2016).

The results showed that the percentage of satisfied/very satisfied women in the couple's relationship is lower (57%), compared to men's responses regarding marital satisfaction (67%). The reference study established that Romanians feel the need for more adventure in their lives (24%), safety (20%), sex (19%), respect (18%), trust (17%), control (2%).



As can be seen, the 2015 research showed significant percentage correlations between satisfaction in the relationship and the predictor indicators for the increase or decrease in the degree of satisfaction. If the reference study identified the factors and the percentage with which they influence the level of satisfaction in the relationship, the present work aims to verify a hypothesis that provides information about how sexual dysfunction is integrated and felt and how it is expressed digitally and analogically in interaction patterns between partners.

In the verification of the working hypothesis, it started from an analysis regarding the role of the patterns with which the partners are involved in building the couple relationship. We consider this aspect to be an important one, because the observed relationship model has a major influence on the way the individual builds his own pattern of interaction (Godeanu, 2011). During systemic psychotherapy sessions, the question is often asked - „what does the couple relationship between your parents and your own relationship have in common?". The answer brings important notes about how he perceives the frames of a relationship, about what it means differently between the observed relationship and his own values that he considers functional in the relationship he maintains.

Compared to the age criteria and the parenting style in which it developed, it can be said that requests for psychotherapy come from three categories of couples:

- with **partners aged 20-35**, who come from a family where parenting developed in the post-communist period, had at least a minimum of access to sexual education through information from written materials or through the mass media. Of course, here comes the flexibility with which each of the individuals could break the inherited patterns and the capacity with which they selected and integrated the new information. We can appreciate an obvious aspect regarding the transition to another form of acceptance of sexuality - the appearance of the consensual couple and the beginning of a married life without legalization through marriage;

- with **partners of 35-50 years**, where parenthood was especially restrictive in terms of sexual education. We can say that in that period, the topics discussed regarding sexuality summarized data regarding the period of menstruation and the prohibitions regarding the beginning of sexual life before marriage;

- with **partners aged 50-65**, a category in which sexual education was an almost taboo concept, parents „protected" children from such information - and we can consider this alternative as a more beneficial attitude than the situation in which sexuality was defined as the worst/shameful thing that can happen to you.

Working with the three categories of clients brings a generous lens, with which we can observe how and if there is a correlation between the two dysfunctions - sexual inhibition and the instability of couple relationships. The patterns highlight the limits in which the partners designed and expressed their needs as a couple, right from the zero point in the formation of dyadic relationships.

From practical experience, it can be appreciated that specialized support is requested

with difficulty, when sexual dysfunctions are present. The problem is explained as a normal one, it becomes a „secret of the house" and it is not natural to want an improvement in the sex life. The person suffering from a sexual dysfunction often prefers to use a series of dysfunctional adaptation mechanisms, in order not to confirm a problem and thus be forced to look for solutions. A homeostasis is formed in which the relationship becomes a series of frustrations and disappointments, in a background that predicts psychopathologies. The symptom related to the general mood becomes the reason for which the client requests specialized support.

Among the observed dysfunctional defense mechanisms are:

- self-isolation,
- avoiding intimate connection,
- designing the problem in partner behaviors.

An inauthentic communication at the digital and analog level has consequences that lead to a deterioration of the relationship. Thus, a long period of time passes until they decide to ask for help, the relationship loses considerable consistency - emotional sterility in transfers, poorly motivated/assumed roles, self-isolation, feelings of guilt and self-blame, feelings of loneliness and mistrust, rigid boundaries, infidelity, emotional divorce or physical separations. Most of the time, requests are formulated from the perspective of affecting communication and connection between partners. A carefully chosen intervention model and an interval of 5-6 sessions are needed to be able to secure the clients' willingness to talk openly about sexuality.

For the partner who exhibits sexual inhibition, it is very difficult, because he received from the other partner, the label of culprit/cause/problem. Careful support is needed for the differentiation of the self, the reframing of patterns and the recovery of the image of one's own person. As a rule, the following particularities are identified:

- the person generally had no interest in sex;
- the person had an interest, but lost it;
- the person manifests a sexual desire towards a person other than the relationship partner;
- the person presents the sexual desire but represses it because during her training, various educators/factors „taught" her that expressing desire or initiating steps to satisfy it are inappropriate.

From psychotherapeutic practice, it has been observed that often, the person not only does not feel the sexual desire, but also shows a repulsion towards sexual contact. There are situations where there may be a discrepancy between the levels of sexual desire of the two parties. One of the partners is accused of sexual hypoactivity, without the one who puts the label realizing that he actually suffers from sexual hyperactivity (a very high sexual desire).

RESEARCH METHODOLOGY

The previously mentioned aspects often become therapeutic hypotheses that support the need to answer the question - „there is a circular causality between sexual dysfunction and couple problems; is the process one-sided or where there is sexual inhibition, couple problems also appear?".

The answers gain more veracity, using cross-sectional and longitudinal research techniques. Along with the two applied questionnaires, to support and verify the hypothesis, two case studies are brought to attention that contain important aspects for verifying the working hypothesis.

THE QUALITATIVE METHOD

Case study 1

Established legal couple, with a marital relationship of approximately 17 years; they have a 16-year-old daughter, they live together in a privately owned building. They describe themselves as a family that should have no problems, because financial comfort is ensured.

The husband (40 years old) is the one who requested the psychotherapy services, formulating the problem in the following terms:

„My wife is most often conflicted, I feel misunderstood and unappreciated, I get involved in household activities and bring a consistent income to the family. 3 years ago I went through a difficult period, I was diagnosed with a reactive episode of depression, I received psychiatric treatment and after about 6 months I was cured. The daughter is distant, we talk very little, I don't know anything about what her life means now - school, friends, relationships, aspirations, etc. She prefers to talk to her mother about everything that concerns her, there are many situations in which if I want to ask about something, she tells me that she talked to her mother. The wife has decided not to sleep together for about 1 year, she accepts with difficulty that we do certain activities together, as before. At my slightest mistake, she gets angry and becomes aggressive in language, sometimes physically. I don't like the time I stay at home anymore, I feel like a stranger, we talk more and more often about divorce".

With the client's consent, the wife (38 years old) was also invited to the second psychotherapy session. In order to respect the balance in the intervention, it was proposed to the partner that an individual session could be scheduled with her, but she considered that it was not useful. After the therapeutic relationship became secure, the problem was formulated by the wife, in the following terms:

„We are a couple that got married because I thought he was the kind of man I could be happy with. I come from a family where there were very often situations of physical and verbal aggression, my father was an alcoholic. My husband and I, we were students at different faculties in Iasi, we met at a party, in a common group of friends. He was a very quiet, shy young man, he didn't drink alcohol, I felt attracted to him and after the first meeting I can say that I was the one who proposed to meet again. When we finished college, we returned to Vaslui, got hired and got married. The relationship deteriorated about 5 years after the birth of my daughter, my husband became more and more distant. He canceled me as a woman, because I felt that he no longer wanted me, that he no longer liked me. After giving birth, I gained about 10 kg, I thought this was the cause. I went on drastic weight loss diets, I even had to go to the U.P.U because they had affected my health. I changed my habits, my clothes, I went to beauty salons more often. I was careful to always be elegant, thinking that maybe that's how I become attractive. Nothing happened that I wanted, as if I only existed for housekeeping and cooking. I started to be the one who expresses and initiates intimacy, thinking that maybe that's what she wants. Nothing has changed, on the contrary, he has started to notice that I have an exaggerated, indecent, vulgar behavior. Over time, even his coming home made me tense and indisposed, because I didn't know how to behave, I repressed every desire. For a while, sexual self-satisfaction methods worked, but not for long. I became angry with him, and in my fits of rage I began to reproach him about everything other than our intimacy".

As can be seen, the sexual inhibition of the husband led to important tensions in the couple. It is understandable that all the stories above are from several psychotherapy sessions. The maladapted defense mechanisms led to an alienation of the partners from each other, rigid boundaries were drawn within the dyad and thus each feels rejected, misunderstood and alone. The husband comes from a practicing religious family (father was the priest of the home parish), he believes that sexuality has its role only to ensure reproduction. Behaviors that clearly convey sexual desire are unacceptable and need to be corrected. He would have liked to have two children, some time after the birth of his daughter he had a sexual life because he thought they would conceive a second child. In the recurrent depressive episode he went through, he managed to calm his ambivalent state that he felt - the doctor estimated that it is possible to have certain disorders in sexual behavior. This helped him to justify his cancellation of sexuality in a convenient way, to „dress up" the feeling of guilt he felt when his wife reproached him for not having sexual relations anymore.

The general objective of the husband, in psychotherapy, was to calm down the wife, to be „clarified" by the therapist that there is no

need to maintain sexual relations in order to have a good relationship. The absence of a sex life does not imply a divorce - that's how it's normal for her to think. The general objective of the wife's psychotherapeutic intervention was to regain her femininity through her husband's love and attention, to have a normal life in which sexuality is present. At first glance, the two goals seemed totally contradictory, but they also had a common note - we want to be good with ourselves and our choices. After the clinical evaluation, we intervened through specific psychotherapeutic techniques, following:

- identifying and changing maladaptive cognitions/behaviours, which formed a stasis in the fluidity of the relationship;
- awareness and change of dysfunctional patterns;
- awareness of own resources and reassurance of the support network;
- sensory concentration (pleasure without demand) – experiencing pleasure without performance pressure or monitoring;
- identification of catalysts from sexual activity.

Case study 2

Established legal couple, with a relationship of approximately 10 years, two children aged 9 and 6 respectively. The one who requests psychotherapeutic intervention is the husband - 46 years old, accusing problems related to the decrease in vital energy, mental fatigue, fear of illness and death, irritability and intolerance to frustration, self-isolation, anhedonia. The client reports that in the last year he changed his job, he traveled a commute of approximately 160 km, which meant more fatigue. He passed an exam for a leadership position in the military system, although he believes that this should have given him satisfaction, he is always dissatisfied. 7 years ago, my father was diagnosed with lung cancer and died shortly after. The father was the resource person, they talked very often on the phone, he experienced the loss very intensely, he doesn't even know now if the process is over. The mother was diagnosed with breast cancer a year ago, she moved to Bucharest to live with her daughter, for periodic health monitoring. He is unpredictably and often called to Bucharest to support his sister and mother, when difficult situations arise.

The wife (44 years old) takes care of the business of her parents who died during the COVID period, she gets involved on Saturdays and Sundays, helping with supply and administration activities. In the last year, he made a series of analyzes and investigations in different medical departments, no organic problems were identified, but a presentation to the psychiatrist was recommended. For about 2 months he has been receiving antidepressant and anxiolytic medication, he appreciates that he does not feel any recovery in his general condition.

In the first session, the level of depression and anxiety was clinically assessed, with tests from the CAS ++ battery:

- Emotional distress scale,
- Personality test, attitudes and autonomy ABS II,
- PDSQ Test,
- HAMA Scale.

The tests established as a psychodiagnostic note, an emotionally unstable personality configuration - major episode of depression, with elements of psychosomatic anxiety evident.

In the first 5 sessions, the client reports that before the onset of depression symptoms, there was a period of several months in which he felt an obvious impairment of sexual behavior. Although he was known to be an active partner, easily stimulated and capable of a good quality sexual act, he had to accept that he no longer feels the sexual desire. Regardless of how the moments of intimacy in the couple evolve, he avoids and rejects his wife's initiative, he no longer feels attracted to any physical aspect of his partner. This situation persists strongly, he does not understand what happened, he associates the loss of sexual capacity with the cancellation of masculinity, accepting the state of illness and even death. He feels feelings of repulsion, confusion, inadequacy. The relationship with his wife has deteriorated a lot in the last period - they can no longer find a common register of activities, he feels criticized

and misunderstood, accused of being unfaithful. He reports that he does not have another relationship, he thought that maybe he should look for another sexual partner, to check if he feels the sexual desire in a different way.

The couple also went through stages of emotional sterility, they were separated for a few days, but now divorce is frequently discussed. The insights regarding his entire course and the states that make him feel out of balance, offered him another perspective - sexual dysfunction generated the state of depression or depression generated the loss of sexual interest. In the reports that the client makes, he conveys that it is very important for him to find out the answer.

The client does not want couples psychotherapy, he refused the proposal to be present in the therapy with his partner, so far 10 sessions have been completed. Techniques were used to reduce the level of depression and anxiety, to explore alternative forms of sexual expression - relaxation techniques, methods of reaffirming sexual life. It is intended to relaunch the proposal for the wife to be present in the psychotherapy sessions, evaluating in this way:

- the pattern of the relationship,
- validation, support and growth of the changes that the client appreciates as obvious
- other aspects that can recover well-being.

Another route of the intervention could be the identification of the client's needs, from the perspective in which he wants to clarify his decision regarding maintaining the marriage or divorce.

THE QUANTITATIVE METHOD

The research group is represented by 20 respondents, aged between 25-58 years, in consensual or legally established relationships. It should be mentioned that the requests for the psychotherapy service were not in terms related to sexual dysfunction, but predominantly related to:

- affecting the capacities of initiative and maintenance on tasks,
- stages of mourning for different losses (job, health, close people),
- support in starting some important changes,
- needs clarification on various topics,
- amplifying impulse self-control skills,
- low vitality and loss of meaning in life, and so on.

The two assessment tools were selected, because when applied in pairs for the same respondent, the working hypothesis could be verified in a more targeted way. In other words, it was possible to evaluate if:

- in situations where mutual knowledge between partners has a high level and the items for the questions regarding sexuality obtained a high score, thus correlating with a high level of satisfaction in the couple;

- in situations where mutual knowledge between partners has a low level and the items for the questions regarding sexuality obtained a low score, thus correlating with a low level of satisfaction in the couple;

1. Scale for measuring marital satisfaction - Dyadic Adjustment Scale (Graham B. Spanier) it includes 32 items that evaluate the quality of the relationship, as it is perceived by the partner. It is a general measure of satisfaction in the intimate couple by using total scores. The subjects answered each question using several Likert scales, the total score summing up the quota obtained for each item. The total scores range from 0 to 151, with low scores indicating low marital satisfaction and high scores indicating high marital satisfaction. Useful for research, is the fact that it is possible to facilitate the observation of different dimensions of the relationship and a score can be calculated for each subscale separately.

2. Interappreciation questionnaire of sexual-affective needs and abilities (I.Mitrofan 1984), offers answers with negative or affirmative meaning with reference to the attitudes, feelings and beliefs of the respondent as well as from the perspective of the couple's partner. At the same time, the comparative analysis of the percentages reveals the weight of the degrees of mutual knowledge and implicitly of sexual dysfunctionality in the couple. An important aspect offered by the application of this tool is that it allowed us to evaluate how the partners'

assessments regarding the relationship are aggregated and if these assessments have similar or different points.

RESULTS

The scale for measuring marital satisfaction was applied to evaluate the quality of the couple's relationship, the degree of satisfaction of expectations regarding sexuality within the relationship, as well as aspects such as dyadic satisfaction (DS), dyadic cohesion (DC), dyadic consensus (DCon) and expression affective (AE).

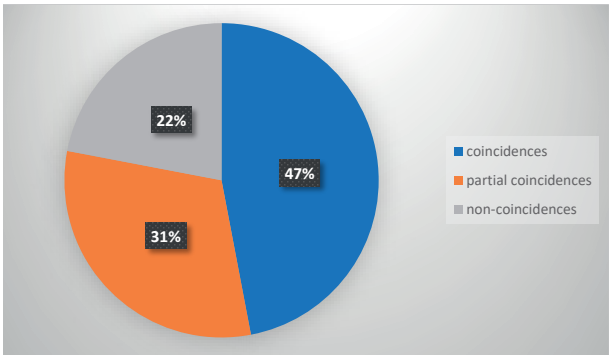
DS – with items 16, 17, 18, 19, 20, 21, 22, 23, 31, 32. The maximum score that can be obtained is 45, and the minimum is 0. Results obtained: score obtained for high level = 13-45 for a number of 13 subjects; score obtained for an average level = 16-30 for a number of 5 subjects; score obtained for a low level = 0-15 for a number of 2 subjects.

DC – with items 24, 25, 26, 27, 28. The maximum score that can be obtained is 24 and the minimum is 0. Results obtained: score obtained for high level = 17-24 for a number of 16 subjects; score obtained for an average level = 9-16 for a number of 3 subjects; score obtained for a low level = 0-8 for a subject.

DCon – with items 1, 2, 3, 5, 7, 8, 9, 10, 11, 12, 13, 14, 15. The maximum score that can be obtained is 65, and the minimum is 0. Results obtained: score obtained for high level = 45-65 for a number of 14 subjects; score obtained for an average level = 21-44 for a number of 3 subjects; score obtained for a low level = 0-20 for a number of 3 subjects.

AE – with items 4, 6, 29, 30. The maximum score that can be obtained is 10 and the minimum is 0. Results obtained: positive affective expression = 6-10 for a number of 18 subjects; negative affective expression = 0-5 for a number of 2 subjects.

The questionnaire - the comparative analysis of the percentages, reveals the weight of the degrees of mutual knowledge and, implicitly, of sexual affective dysfunctionality in the couple. Overall statistical grade: 47% coincidences, 31% partial coincidences, 22% non-coincidences. Mutual knowledge with distortions and deficits prevails globally in a percentage of 53% for the evaluated respondents, who requested specialist support for other accusations, than those regarding marital satisfaction/ dissatisfaction or aspects related to sexual affective needs.



DISCUSSIONS

It can be seen that the two concepts - sexual dysfunction and couple problems - correlate at a fairly high level. Where sexual inhibition is manifested, the partners do not have enough resources to look for solutions together and thus the risk of relationship instability increases. When the couple is not in interrelational balance, the affective emotional transfer becomes rigid, the moments of intimacy are more difficult to build, the tension creates prolific gaps for sexual inhibition. We can add in this context a „hybrid" model of the installation of induced sexual inhibition - when one of the partners sanctions a certain behavior of the other partner, by increasing the control over the decision to have or not to have a sexual activity. Most of the time, dyadic satisfaction indicates the existence of a stable interpersonal relationship, resulting from the integration of interpersonal experiences, in the form of affectively polarized patterns, which are maintained over long periods of time. The degree of satisfaction in the couple is influenced by the level of satisfaction of needs within the relationship. Another important aspect to mention is staying in a deadlock that amplifies the level of dysfunctionality. The partners have the expectation that things will be resolved, to change, but without each making any changes. Dysfunctions are accentuated, the circularity

of the problems amplifies and includes an ever wider range of situations, leading to the loss of important resources for the balance of the couple. Having reached this point, some of the partners choose maladaptive „solution" options:

- denying the problem,
- the need for answers by finding a culprit,
- adaptating to dysfunctionality,
- replacing adapted solutions with other affectogenic contents,
- self-blame,
- loneliness,
- self-isolation.

Of course, there are also partners who, on the basis of still viable resources, call for adapted solutions: discussing the problem with the manifestation of an expressed interest in finding solutions together, calling for psychotherapeutic and/or medical specialist support.

From the information obtained through quantitative evaluation methods and case studies, it can also be observed that in couples where communication is authentic on a digital and analog level, the degree of trust between partners is higher, the level of sexual inhibition is lower and, respectively, the quality of life of couple is a better one. The present study has certain limitations. First of all, the group was a convention group, consisting mainly of people who requested psychotherapy services. It is possible that the results will be different, for people who do not go through periods of blockage in their relationship or their own existence. The results can be different for people who are not in the stage of identifying solutions and are kept in a specific homeostasis. It is also important to note that the study is transversal. For a more precise interpretation, it is necessary that the results clearly establish the relationship between the variables.

Although the work presents the above-mentioned limitations, its implications remain important. We can consider that the verified hypothesis brings more resources for the psychotherapeutic process. The obtained data can effectively guide in understanding the client's problems, in identifying working hypotheses and psychotherapeutic objectives. Considering the circular causality between the instability of the couple relationship and sexual dysfunctions, we can use assessment and intervention techniques/tools that will optimize the psychotherapeutic intervention.

CONCLUSIONS

The research within the work confirms the formulated hypothesis - sexual dysfunction and couple problems influence each other, in a circular causality. The higher the dysfunctionality in the relationship - maladaptive patterns of communication, diffuse boundaries, roles poorly anchored in resources and expectations - the higher the level of sexual inhibition. The higher the sexual inhibition is, the more the level of couple problems increases and no solutions are identified to overcome the blockages.

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