CASE REPORT

Unconsummated Marriage in Sub-Saharan Africa: Case Reports

Valentino M. Lema

Aga Khan University, Nairobi. Kenya. P.O. Box 25594-00603; Nairobi. Kenya

* **For Correspondence**: *E-mail: vmlema@gmail.com; Phone: +254-711860582*

Abstract

Unconsummated marriage is a condition where newly married couples are unable to achieve penile-vaginal intercourse for variable periods despite desire and several attempts to do so. Its exact cause(s) is/are unknown, but performance anxiety resulting from or leading to other conditions is reportedly the major etiological factor. It is thought to be more prevalent in traditional and conservative religious communities where premarital sexual exposure is strictly prohibited. Most publications on unconsummated marriage have originated from North America, European and Middle Eastern countries. There have not been any such reports from sub-Saharan Africa, which is home to diverse cultures and traditions regarding premarital sex and marriage. This paper presents a sample of four cases with unconsummated marriage managed by the author in his private clinic based in the city of Nairobi Kenya, over the past five years. Possible etiological factors and management approaches are discussed, with a review of relevant literature. *Afr J Reprod Health 2014; 18[3]: 159-165)*

Keywords: Unconsummated marriage, sub-Saharan Africa, Presentation and management.

Résumé

Le mariage non consommé est une condition où les couples nouvellement mariés sont incapables d'atteindre les rapports vaginaux pour des périodes variables, malgré le désir et plusieurs tentatives de le faire. Sa/ses cause (s) exacte(s) est / sont inconnue(s), mais l'anxiété de performance en conséquence de, ou en menant à d'autres conditions, serait le principal facteur étiologique. On croit qu'elle est plus répandue dans les communautés religieuses, traditionnelles et conservatrices où l'exposition sexuelle avant le mariage est strictement interdite. La plupart des publications sur le mariage non consommé provenaient de l'Amérique du Nord, de l'Europe et des pays du Moyen-Orient. Il n'y a pas eu de tels rapports de l'Afrique subsaharienne, qui est le foyer de diverses cultures et traditions concernant le rapport sexuel avant le mariage et le mariage. Cet article présente un échantillon de quatre cas avec le mariage non consommé gérés par l'auteur dans sa clinique privée située dans la ville de Nairobi, au Kenya, au cours des cinq dernières années. Les facteurs étiologiques possibles et des approches de gestion sont abordés, avec un examen de la documentation pertinente. *Afr J Reprod Health 2014; 18[3]: 159-165)*

Mots-clés: mariage non consommé, Afrique sub-saharienne, présentation et gestion.

Introduction

In most societies the wedding ceremony functions as symbolic consent between two adults – man and woman, to live together as husband and wife and for physical intimacy. One of the key components and perhaps determinants of a successful marriage is satisfactory sexual relations – penile-vaginal intercourse.

Normal sexual function is a bio-psychosocial process which relies on a coordination of psychological, endocrine, vascular and neurological factors. It incorporates family, societal and religious beliefs and may be influenced by one's health status, sexual knowledge, experience, attitude and interpersonal relationships. It is often assumed that every person who consents to marriage is physically, emotionally, psychologically as well as socially ready and able to have normal sexual intercourse. Indeed in most societies of the world a wedding ceremony is expected to include consummation of the marriage on the same day or soon thereafter, and in some proof that this has happened is not only expected but demanded[1,2,3]. Some couples may mutually agree to defer consummation of their marriage for a few days or even weeks for a number of reasons. However when the couple is unable to

consummate despite desire and several attempts to, there may be profound distress in either one or both members of the couple[3,4,5.]

Unconsummated marriage, also referred to as white marriage[6], or honeymoon impotence[7,8] is used to describe a situation in which a couple has not been able to have normal penile-vaginal intercourse despite several attempts following their marriage[3,6,9]. The exact prevalence thereof is unknown, but it is thought to be more common in traditional and conservative religious cultures such as Judaism, Hinduism and Islam[1,2,3,4,5]. It is contended that in societies in which there is ample opportunity for premarital coitus and where it is not culturally or socially prohibited, unconsummated marriage is extremely rare as most individuals would have had premarital sexual experience either with the same partners or others. They would also have had time to get to know each other well before marriage, thus being comfortable with one another at the time of marriage unlike in societies where there are strict rules regarding relationships of members of opposite sexes prior to marriage. While in most societies in sub-Saharan Africa (SSA) there is none or not much restriction in this regard, there are communities in which chastity especially on the part of the woman is strictly observed and any transgression thereof is frowned upon or severely punished.

One of the earliest published accounts on unconsummated marriage was from the US by Malleson (1954)[10]. While the initial reports were from the West, mainly the USA[10,11,12,13], most, if not all of the more recent publications have been from the Middle East and Mediterranean Countries such as Egypt, Iran, Israel, Saudi Arabia and Turkey[1-5,7,8,14.]

The fact that there has not been any publication on unconsummated marriage from sub-Saharan Africa in the English literature does not necessarily imply that it is rare or non-existent. It might just be a reflection of lack of awareness among other factors.

This paper presents a sample of four couples out of ten with unconsummated marriage managed by the author in the past five years in his private clinic based in the city of Nairobi, Kenya, where he manages individuals with sexual problems. Possible etiological factors and management approaches are discussed, citing relevant literature.

Case Reports

No 1: A young Indian couple aged 28 and 25, presented to the author with a history of failure to conceive. They had been married for five years. Both were virgins at the time of marriage, which had been arranged by the two families. They were first cousins - their mothers being sisters and had therefore known each other since their childhood. They had not sought medical help till then.

There was no relevant medical history. On sexual history inquiry both indicated they had regular satisfying sexual intercourse. There was no history of dyspareunia. The woman had regular menstrual cycles, bleeding for 4 to 6 days every 28 – 30 days, with no dysmenorrhoea or menorrhagia.

On physical examination both were in good general health. The man had a well built masculine physique and normal genitalia. The woman had a well developed and mature feminine body. The external genitalia were normal but the hymen was still intact with no evidence of defloration. Upon further inquiry on the nature of the “normal sexual intercourse”, the man indicated he had been having coitus inter-femora.

The couple was counseled and given an explanation on the most likely cause of their infertility. They then received education on female sexual anatomy as well as normal sexual intercourse, i.e. penile-vaginal intercourse. The man was shown the vaginal introitus where he ought to penetrate. They were greatly relieved at the same time surprised. They confessed that no one had given them any sex education. They were encouraged to go home and try penile-vaginal intercourse. When they were seen two weeks later the couple was very happy they had been able to finally consummate their marriage. A year later I had the honour of delivering their first child, a healthy baby boy.

No 2: A young African couple in their late 20’s, was referred to me by a fellow gynecologist, with a history that six month after their wedding ceremony they had not been able to consummate their marriage. The bride had spent close to six years pursuing her tertiary education overseas and

had returned to her home country about two years previously. The two had known each other from their childhood and their families were close. They had not been sexually intimate either before or after she returned home. Every time the man brought up the issue of sex the woman would have an excuse. He therefore decided to be patient till they were married.

On the wedding night and subsequent days thereafter, the woman would not let her husband even touch her genitalia claiming that she was afraid it would be too painful. Intimacy was a problem as even kissing her was always a struggle, claiming she found it distasteful. Whenever the husband attempted to penetrate she would close and cross her legs. This situation had led to a palpable strain between them with the husband threatening to leave her on several occasions. Each time she would promise she would try but it never worked out.

On examination both were in good general health. The woman had a well developed and mature feminine body, the external genitalia were normal and healthy, and the hymen had evidence of defloration.

A decision was made to counsel each separately to elucidate the core problem. It eventually transpired that the woman was a lesbian, a sexual orientation she had started while at the university, but had not had the courage to tell her family or fiancé. She had married due to family pressures and had hoped that in so doing she would be able to overcome her sexual orientation. She had had a brief heterosexual liaison after high school. The man had had a number of girlfriends before the marriage. She was counseled and encouraged to confide in her spouse and together decide what to do thereafter. She came to see me six months later for counseling and advice on sexual health issues. The marriage had been annulled by mutual agreement.

No 3: A young man aged 30 and his fiancé aged 28 both of African descent, presented at my private clinic two weeks before their planned church wedding. They wanted advice on i) medicines to delay her menstrual period as it would have started on the eve of or actual wedding day They wanted to be able to enjoy their honey moon which they both looked forward to with great anticipation, ii) contraception as they wanted to delay conception for at least six months after the wedding, iii) sexuality in general as they were still virgins – despite having been friends for over five years, from their university days. I received a call from the man late at night on the wedding day, complaining that they had not been able to consummate their marriage, despite several attempts. His bride would not allow penetration, as she was afraid it would be too painful. She would not even let him touch her genitalia. He had driven out of the house out of frustration and anger. He was advised to drive back home slowly and not to attempt sexual intercourse again that night. They were seen the next day in the clinic.

They were taken through sexual education with details on sexual anatomy and physiology. An examination of the woman revealed normal, healthy external genitalia. The hymenal opening was of normal size and not rigid. She was assured that it is normal for virgins to experience mild to moderate discomfort during defloration. She was encouraged to have adequate foreplay on which they had been counseled during the first visit. including allowing her husband to touch her genitalia. They were also advised not to rush into penetrative intercourse until she felt comfortable enough. They were followed on a weekly basis and during the third week, they had been able to attempt consummation which she said was very painful initially. They were encouraged to continue trying but with adequate foreplay.

Four months after their wedding day they came to see me as she had missed her menstrual period. An early intrauterine pregnancy was confirmed on ultrasound examination.

No 4: A 28 year old African lady, who had been my patient for about a year and half came to see me one afternoon asking for contraceptive advice as she was getting married in a month's time. After counseling she was put on combined oral pills, to start on her next menstrual period which was due in about two weeks' time.

She came to see me again four days after her wedding complaining that they had not consummated their marriage as a result of which she had left the "husband" at their honey moon hotel. She reported that after the wedding which had been a lavish affair, they had flown to one of

the country's seaside resorts for the honey moon courtesy of the groom's father. However on the wedding night she had waited for consummation of their marriage, but the groom complained of exhaustion after all the running around with the wedding preparations. When she woke up the following morning, he was nowhere to be seen. She eventually found him drinking at the hotel bar with some friends. Over the next two days nothing happened and whenever she asked him whether there was a problem he would just say he was too tired. He would not even let her touch or kiss him. When I inquired whether they had ever had sexual intercourse before the wedding day she told me they had not even kissed. They always met in the company of either family or friends thus precluding intimacy. She had not been bothered by that. She had however been sexually active and had had two boyfriends before her marriage. She was however not sure if he had any heterosexual experience.

I was not able to see him as the marriage was dissolved thereafter. The woman has not remarried two years later, but has a steady boyfriend.

Discussion

Whereas majority of newly wedded couples are able to consummate their marriages either on their wedding nights or soon thereafter, evidence from published reports from both developed and developing countries indicate that variable proportions are unable to despite intense desire and several attempts to do so for variable periods after solemnisation of the unions. Satisfying sexual relation is critical for well-being of individuals and survival of their marriages. It is often stated that the first sexual experience is a significant event that influences subsequent sexual function and relationship with ones partner[9].

The actual prevalence of unconsummated marriage in general adult population is unknown due to lack of awareness, wrong diagnosis[3,5,12] and the fact that not all couples with unconsummated marriage will need or seek medical help, as well as the stigma associated with it in some communities[14,15,16]. Kinsey (1953) estimated that about 2% of couples of sexual age are incapable of consummating their marriages[17]. Most of the published accounts are case reports often involving a few couples treated by the authors, just like this paper. There have been very few studies involving men and/or women managed for various health conditions some of whom have been found to have unconsummated marriage. El-Meleigy (2004) and Famy (1995) reported that unconsummated marriage accounts for 4 to 17% of patients seen in sexual health clinics in Egypt and Saudi Arabia[7,14]. Ozdemir (2008) gave a figure of 24% among patients with sexual dysfunction in Turkey[4]. Other studies have reported rates ranging from 2 to 20% among patients seen in various clinics such as infertility or psychiatric[10,15,18]. Cognisant of the high prevalence of various sexual dysfunctions globally, and the high proportions of various sexual dysfunctions associated with unconsummated marriage[3,4,5,10,12,13,14], it is fair to conclude that unconsummated marriage is more common that hitherto reported.

The fact that there has not been any publication on unconsummated marriage from sub-Saharan Africa could be a reflection of lack of awareness on the part of general population and health care providers. It may also be due to the fact in some communities there are culturally acceptable and sanctioned mechanisms of resolving such problems without exposing the concerned individuals. I have attended to ten couples with unconsummated marriage in my private clinic in the last five years, out of whom eight are indigenous Africans and two of Indian descent. Of the African couples one is from another African country. I am currently managing three other newly married couples with the same problems, one of them an Indian couple. All these are from middle and upper social class and well educated. An andrology colleague in one of the largest private hospitals in East Africa tells me that he often sees young men in their mid-20's with erectile dysfunction who are planning to or have recently married and are not able to have sexual intercourse with their partners. The above scenarios underline the fact that UCM is not rare in SSA.

Performance anxiety is considered the major etiological factor for unconsummated marriage[1,3,5,14,16]. This may contribute to or manifest as premature ejaculation (PE) of such

severe degree as to make penile-vaginal penetration impossible, erectile dysfunction (ED) or vaginismus. Badran et al (2006) in their study in Egypt (n=191) found that psychological factors accounted for 74.4% of which performance anxiety contributed to 52.9%[1]. In one of the largest and revealing studies on unconsummated marriage, Blazer (1964) (n=1000), found that the main problem was fear of pain on the part of the woman[12]. Studies from the East show higher incidence of premature ejaculation and vaginismus than those from the West[4,5,19,20,21]. Some of the factors contributing to performance anxiety are lack of appropriate or poor knowledge and misconception about genital anatomy and sexual physiology[1,3,4,5,15]. Ellison (1968) reported that of her study group of women with severe primary vaginismus (n=100), >90% were due to ignorance and misinformation[13]. Strict up-bringing as obtains in some communities of Iran, and among Orthodox Jews[2,3] has been partly blamed for that. Among the physical causes predisposing to unconsummated marriage is penile vasculature abnormalities as reported by Usta et al (2001) in Turkey who noted that 27.7% of men with unconsummated marriage in their study had penile vascular abnormalities leading to ED[8]. Among the presented cases, the Indian couple had poor knowledge of sexual anatomy, but no performance anxiety. The other three cases had evidence of performance anxiety for various reasons. Number three had evidence of vaginismus, while for number four the man probably had erectile dysfunction. Case number two was unique in the sense that the bride had an aversion to heterosexual relations due to her sexual orientation. She only got married to conform to societal expectation, and had faked fear of pain to avoid being intimate with her groom. Zargoshi (2008) reported homosexuality as one of the factors contributing to performance anxiety and unconsummated marriage in their study[20]. One of the three couples I am currently managing the wife's vaginismus has led to erectile problems in her spouse. In another couple the problem is more on the man's side. The wife is ready and eager to consummate but every time they try the man loses erection and is therefore unable to achieve penetration. Studies have reported situations where vaginismus may affect the man's erection which will also require treatment as part of the overall management of the couple[21].

The motivation for seeking medical advice may be influenced by the severity of the problem as perceived by the couple or one of them, who has the problem man or woman, couple's desire to get a solution, as well as their awareness. They may seek help due to acknowledgement of a problem by the couple; threat of divorce, abandonment, or extramarital affairs, or physical/verbal/ psycho-logical abuse by one of the members of the couple; or desire to start a family. Others may be advised, encouraged or even compelled to seek help by close relatives or friends[4,5]. Of the presented cases one couple was seen for infertility during which they were found to have unconsummated marriage. One sought help as the husband had threatened to annul the marriage or seek sexual gratification elsewhere hardly a day after marriage. Another was seen after annulling her marriage out of frustration and the last one because she wanted out of the marriage due to her sexual orientation. There are reports of gays and lesbians especially in more conservative societies who get married to conform to societal expectations and decide to live together as husband and wife without sexual intimacy[1]. I have been looking after two of patients with other sexual health issues whose husbands have confessed to being gay several years after marriage. They have one child each. One has decided to stay despite not being intimate with her husband, while the other has opted out of the marriage. Although these reported cases show some similarities with those reported elsewhere, unconsummated marriage might have more serious consequences on concerned individuals in SSA, such abandonment as observed elsewhere or infidelity with all attendant sequelae.

As shown by previous studies the interval between wedding ceremony and seeking help range from a day to as long as 22 years[3,4,11,12,15,20,23-25]. The presented cases sought medical help from a few hours after the wedding ceremony to five years. The interval is influenced by the reason for seeking medical help, with couples wishing to start a family having the longest intervals[24,25], as shown by the first presented case, while those with ED or vaginismus

present early[3,4,20], as shown by three of the presented cases. Of the three I am currently managing, one has severe vaginismus and was seen hardly a week after the wedding night, while one has erectile problem and was seen a week after their wedding.

Not all couples with unconsummated marriage will need treatment, as some may eventually be able to consummate after varied periods and a small proportion may even achieve conception and deliver healthy babies despite not consummating their marriage[2,20]. Others may not seek medical help either because they find alternative ways of having satisfying intimate relations[12] as the presented Indian couple who were quite happy with inter-femora sex, which they considered normal. The majority of couples with unconsummated marriage will however require treatment, depending on the identified primary problem[2,3,5], as well as associated factors. For most of them ensuring they have appropriate and adequate knowledge of genital anatomy and sexual physiology is critical. The couples should also be encouraged and guided to have free and open communication on sexual matters between the two of them. These should be complemented with appropriate counselling and psychotherapy. As the majorities have psychogenic conditions, psychosocial therapy is considered the mainstay treatment[3,4,11,25.] With an empathetic approach to help build their confidence and self-esteem, most couples are able to not only consummate their marriage but also have a lasting and satisfying sexual relationship. Two of the presented four cases had education on genital anatomy and sexual physiology as well as counselling on intimacy, after which they were able to have normal sexual intercourse. They were even able to achieve a conception shortly thereafter.

Conclusion

With the changing sexual norms, life styles as well as increased awareness, it is very possible we will see more couples with sexual problems including unconsummated marriage. Likewise with the disintegration of the hitherto traditional and cultural sexual education systems for young people, as well as encouragement for young people to abstain till marriage due to the HIV/AIDS pandemic in Africa, a good proportion of young adults will enter into marriage with poor or no knowledge at all of sexual anatomy and physiology, something I am seeing quite a lot in my clinic.

It is important that health providers are aware of the condition and the diverse complaints which affected individuals may presented with. Whereas the goal of treatment is for the couple to be able achieve penile-vaginal intercourse, it is important to bear in mind that consummation alone does not mean a successful outcome in the treatment of unconsummated marriage. The pleasure and happiness of the couple after several satisfying sexual intercourses should be the ultimate aim of treatment. It is also critical to look for any residual problems after the consummation. In this regard therefore it is necessary to follow up the couple for a while after the initial successful consummation.

References

1. Ribner DS, Rosenbaum TY. Evaluation and treatment of unconsummated marriages among Orthodox Jewish couples. *J Sex Marital Ther 2005*;31: 341–53
2. Zargooshi J. Unconsummated marriage: Clarification of aetiology; treatment with intracorporeal injection. *Br. J. Urology Int 2000*; 86:75–9.
3. Badran W, Moamen N, Fahmy I, El-Karaksy A, Abdel-Nasser TM, Ghanem H. Etiological factors of unconsummated marriage. *Int J Impot Res. 2006*;18:458–463
4. Özdemir OŞimşek F; Özkardeş S; Incesu C; Karakoç B. The Unconsummated Marriage: Its Frequency and Clinical Characteristics in a Sexual Dysfunction Clinic. *J. Sex Mar. Ther. 2008*; 34: 268–279,
5. Addar MH. The unconsummated marriage: Causes and management. *Clin Exp Obstet Gynecol 2004*; 31:279–81.
6. Abraham G; Passini W. Introduction a la Sexologie Medicale. Paris: Payol. 1974
7. Fahmy I. The management of honeymoon impotence by intracorporeal injection of vasoactive drugs. Egypt J Androl Reprod 1995; 9: 93–102
8. Usta MF; Erdoğru T; Tefekli A; Köksal T; Yücel B; Kadioğlu A. Honeymoon impotence: psychogenic or organic in origin? Urology. 2001 Apr; 57(4):758-62.
9. Carpenter, L. M. Virginity lost: An intimate portrait of first sexual experiences. New York: New York University. 2005.
10. Malleson J. Sex problems in marriage with particular reference to coital discomfort and the unconsummated marriage Practitioner 1954; 172: 389–396.

11. Abraham HC. Therapeutic and psychological approach to cases of unconsummated marriage. *Br Med J 1956*; 14:837–839
12. Blazer, J. A. Married virgins—Studies of unconsummated marriages. *Journal of Marriage Family, 1964*; 26, 213–214.
13. Ellison, C. Psychosomatic factors in the unconsummated marriage. *J. Psychosomatic Res. 1968; 12:* 61–65,
14. El-Meliegy A. A retrospective study of 418 patients with honeymoon impotence in an andrology clinic in Jeddah, Saudi Arabia. *Europ J of Sexol; Sexologies 2004*; 13: 1–4.
15. Gindin LR; Resnicoff D Unconsummated Marriages: A Separate and Different Clinical Entity. *Journal of Sex & Marital Therapy, 2002*; 28(s): 85–99,
16. Duddle M. Etiological factors in the unconsummated marriage. *Journal of Psychosomatic Research, 1977*; 21: 157–160.
17. Sadock VA. Normal human sexuality and sexual and gender identity disorder. In: Sadock BJ, Sadock VA (eds). Kaplan & Sadock's Comprehensive Textbook of Psychiatry. *Lippincott Williams & Wilkins: Baltimore, 2000*, pp 15747–1607.
18. Kinsey, A. C., Pommeroy W. Sexual behaviour in the human female. Philadelphia: W. B. Saunders. 1953
19. Yasan A; G¨urgen F. Marital Satisfaction, Sexual Problems, and the Possible Difficulties on Sex Therapy in Traditional Islamic Culture. *Journal of Sex & Marital Therapy, 2009*;35:68–75,
20. Zargoshi J. Male sexual dysfunction in unconsummated marriage: Long-term outcome in 417 patients. *J. Sexual Med. 2008* 5 2895–2903.
21. Perelman M. A. FSD Partner Issues: Expanding Sex Therapy with Sildenafil. *J. Sex Mar. Ther. 2002*; 28(s):195–204.
22. Simons, J. S., & Carey, M. P. Prevalence of sexual dysfunctions: Results from a decade of research. *Archives Sexual Behavior, 2001; 30:*177.
23. Chakrabarti N, Sinha VK. Marriage consummated after 22 years: a case report. Sex Marital Ther. 2002 Jul-Sep; 28(4):301-4.
24. Mirzaie N, Saremi AT. A fourteen year unconsummated marriage and its successful treatment (a case report). *J. Reprod Infertil. 2002*; 3(2):59-63.
25. Akpınar E; Saatçı E. An unconsummated marriage: a case report. *Marmara Medical Journal* 2007; 20(3):182-185.