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ORIGINAL ARTICLE

Unconsummated marriage: can it still be considered a consequence of vaginismus?

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Unconsummated marriage (UM) is the failure to perform successful sexual intercourse at the beginning of the marriage. Vaginismus has been traditionally reported as the leading cause. ED is also a leading cause for UM. This appears to be a significant problem in the conservative middle-Eastern societies and in the developing countries, where couples are strongly prevented by religious rules and cultural taboos from sexual experiences before wedding. One could think that according to major sexual freedom and information, in Western countries UM is now disappearing, but the number of observed cases by the authors in 2008–2012 was relevant. The aim of this study is to compare the literature data from non-Western countries with the features of UM in Western ones, focusing on cases observed by the authors, and to verify whether the etiology of UM proposed in the '70s is still relevant, outlining any changes that occur in current reality. In our series, traditional appearance of UM is no more effective, while the role of man is undervalued, because of his frailty, lack of self-confidence and ignorance, expressing a social and cultural change of man's role in the couple.

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INTRODUCTION

Unconsummated marriage (UM) can be defined as the failure to perform successful sexual intercourse at the beginning of the marriage.[1] It usually occurs in the first few nights of marriage and so it is frequently referred to as 'honeymoon impotence' or 'wedding night impotence'.[2] This appears to be a significant problem in non-Western societies, where it is the reason for the sexual and andro-gynecological visits, with an incidence that varies from 8 to 17% in different geographical areas.[3–5] Usually, the groom and bride had no intercourses with penetration before marriage, neither with the mate nor with other previous partners.[6] Vaginismus has been traditionally reported as a leading cause for UM[7,8] In vaginismus there is an unwilling spasm of the perivaginal muscles, which prevents penetration or makes it difficult.[8] ED is also a leading cause for UM.[9] In these patients, ED has often psychogenic origin[10] and it may be primary or secondary to vaginismus.[11] Kaplan,[8] who first discussed extensively the UM topic, believes that female sexual dysfunction could be considered as *primum movens* in this couple sexual dysfunction. In these cases, as a result of repeated failures in an attempt to penetration, the man often develops an ED, which can perpetuate even after the vaginismus has been successfully treated.[12,13] According to literature, male and female phobic personality traits could have an important role in developing several sexual dysfunctions including UM. Furthermore, phobia can be or become a specific sexual phobia regarding fear to feel pain during penetration, making impossible any intercourse. UM seems to be very common in the conservative middle-Eastern societies and in the developing countries, where couples are strongly prevented by religious rules and cultural taboos from sexual experiences before wedding[1,14] Both conditions take place in a very rigid socio-educative context. Such considerations derive from studies conducted in countries where women are subject to inhibitions and constraints on sexual activity.[3,15,16] The aim of this study is to compare the literature data from non-Western countries with the features of UM in Western ones, focusing on the cases observed by the authors, and to verify whether the etiology of UM proposed by Kaplan in the '70s is still relevant nowadays, outlining any changes in current reality.

MATERIALS AND METHODS

We evaluated 24 couples treated in our outpatient's clinic from January 2008 to February 2012 for UM. All women were proposed to undergo a gynecological examination to evaluate the condition of hymen, and verify whether there was any vaginal or perineal spasm. In five cases this was not possible because of their refusal. Later in the treatment they accepted to perform an external visit. All men were submitted to the following uro-andrologic examination to rule out organic ED: total and free testosterone, prolactin, follicle-stimulating hormone, luteinizing hormone measurements; penile nocturnal rigidometry; dynamic penile ecocolor-doppler with intracavernous injection of PGE1 20 μg. Also, some men refused to undergo examinations at the beginning; these were performed later during the treatment.

The following parameters were considered in both partners: age; graduation; sexual experiences, with or without penetration, with previous partners. A questionnaire (Table 1) was given to both partners to investigate their genital anatomic–physiological knowledge and sexual awareness. The patients were asked to specify whether ideological or religious belief had influenced their sexuality before wedding. Duration of the marriage before the first consult was collected. The motivation of the first consult was defined as direct (for example, 'we are not able to have a sexual intercourse') or indirect (for example, wish of conception, premature ejaculation, pain, other). It was also investigated as to which partner pressed to request consultation.

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