Practical Recommendations to Work With Couples presenting with "Unconsummated Marriages" in Any Health Care Settings

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The term"unconsummated marriage" (UCM) originally referred to"the failure to perform successful sexual intercourse at the beginning of the marriage."Over the years, working across 22 countries, I came to refine this definition to embody the cultural context of the couple. The working definition that I utilize is "failure to perform successful sexual intercourse within a marital constitution within the time frame that is expected by the couple's cultural context."

Based on my personal clinical observations for over a decade now, by the time a couple decides to see a health care professional in North America or the UK, they fall into three main timeframes:

- Married less than a year (only 10%)
- Married more than 4 years (up to 80%)
- Married more than 10 years (10%)

This ratio is based on my practices in London and New York City, which mainly accommodate couples from the Middle East and South Asia, among other varyied ethnic backgrounds. A practitioner working within a Middle Eastern country (especially Midwives, OBGYNs and Urologists) might see a significantly higher number of couples within the first year of marriage since they would be the first point of contact, and the socio-cultural pressure is much greater to consummate the marriage as soon as the wedding night. One of the reasons for this earlier health seeking action is the lack of trained and licensed psychosexual therapists within most of the Middle Eastern countries, in addition to the socio-cultural pressure of consummating the marriage within the first year. This timeline may be influenced by the legal system of the country (for example, a couple is eligible for divorce if they could not consummate the marriage within a year – from either the male or the female side) or may be due to the pressure on the couple to start a family. Although there are only fragmented documents on the above-mentioned points, these could prove critically important for colleagues who work with individuals or couples to help them get through their problem. As we all know, the motivation behind the visit to the health care professional indicates the compliance and, ultimately, the outcome of therapy/treatment.

This paper aims to provide some practical recommendations to colleagues working with individuals and couples who present with UCM regardless of the main underlying issue (the male sexual issue or the female).

Moving further from the literal definition of UCM, in most academic settings the term UCM has largely been replaced with the specific underlying issue that the couple presents with (in order of statistical frequency: vaginismus, erectile dysfunction and premature ejaculation). However, as it is still a widely used term for patients, this terminology has been utilized within the context of this practical paper.

There is a good body of literature to examine the predisposing and precipitating factors behind UCM (for examples, please refer to Badran, et al 2006, Abraham, 1956, Michetti, et al. 2014). Most of the contributing factors are known to be of psychogenic origin, due either to socio-cultural pressure on the accomplishments of the wedding night, or the general anxiety the individuals have regarding the initiation of their sexual encounter. These factors are further complicated by the couples' lack of information regarding sexual organs, their function, and ingrained misconceptions regarding what the outcome should be.

Introducing the HAT Model:

The overarching framework this paper would like to propose is the Holistic Assessment and Therapies model (HAT), which considers a bio-psycho-socio-legal assessment of the situation. Furthermore, as the acronym suggests, HAT stands for different roles that a health care professional takes on to address the patients' needs. We can all identify with instances where we only needed to give out information to solve a patient's problem, while at other times we claimed a role of an authority figure to convince the individual/couple that what was suggested (be it a homework or a specific sexual conduct) was to their best interest coming from a place of knowledge and care especially when there was a doubt about the acceptance of the recommended practice by the person's religious beliefs or personal preferences.

Although this approach is likely to be more appealing to colleagues with a psychosocial background, medically-trained professionals could also benefit from this approach by creating a holistic overview regarding the assessment and management process of sexual issues (especially when underlying psychogenic factors are at play).

Utilizing this approach, not only can we accurately diagnose the person presenting the problem (for example, female pain disorder) but we can also go further to examine the dynamic of the relationship (such as fear of intimacy).

PLISSITR Model:

Many medically-trained colleagues work in settings that do not support adequate evaluation time for this holistic assessment; however ,almost everyone will have time to cover the initial steps of the PLISSIT model (Jack Annon, 1976) which has an added element of R (Referral) in the HAT approach. Thus, the whole model is presented as PLISSITR:

- **Permission** (let the individual and the couple know they are not alone, offer them sympathy and reassurance that this will be resolved, as it has been for many other couples)
- **Limited information** (using simple props can go a long way in providing education to clients who have never had a systematic and accurate sexuality education)
- **Specific suggestions** (use of lubricants, specific techniques that might suit a particular couple, changes in lifestyle, etc.)
- **Intensive therapy** (which could be a referral to a trained psychosexual therapist or, in the absence of such a professional, the use of medical treatment to solve the immediate problem (e.g., medication to help with erectile dysfunction that originated due to anxiety or dyspareunia and may be resolved with local anesthesia, training with dilators, etc.)
- **Referral** (at this point, the health care professional could use his/her network of referrals to bring in colleagues with complementary expertise to help with the treatment/management of the sexual problem and offer ongoing support to the individual or couple, as needed).

With a focus on providing limited information to individuals and couples (which seems to be the majority of the work with couples presenting with UCM), there are seven things to consider when using educational props:

- Feel comfortable with it (including how it functions)
- Explain why you are using it
- If you don't know the clients/patients well enough – or you suspect that their spiritual/cultural beliefs might contradict the use of specific materials – ask in advance if this form (e.g., picture) will be acceptable to use with them and why it is important to do so
- Consider using specific props/discussion on technique in individual sessions (e.g., perineum massage)
- Take extra care to choose bias-free props (size, color, shape)
- Store with caution
- With more explicit props, utilize a more formal authoritative style

- Use your position as the heath care authority to overcome the clients'/patients' hesitation or shame around being presented with a sexuality-related prop

Main styles of delivering information regarding sexuality:

The four main categories of delivering information – Formal Authority, Demonstrator, Facilitator, Delegator – that were introduced by Fischer and Fischer in 1979 have been adapted in the HAT model to benefit the clients/patients in an accessible, non-offensive, acceptable way. These four styles can be adapted to health care settings and, more specifically, to psychosexual therapy, and would come together to offer the holistic educational benefits to the clients/patients.

These could be explained as follows:
For teaching sexuality and relationship issues, one can use the formal authority method of instruction, to discuss the importance of the topic one wants to bring up (for example, testicular exam). One could then use the demonstrator style and model the proper way of doing the exam (you can simply use your words, use graphs, pictures or just your hands on a model to demonstrate). Have the client(s) participate in the demonstration by asking questions rather than giving answers. For example, "What are some important things I must remember when I examine myself?"(Answers may include the frequency of the exam, the routine they need to build around it, and any unusual finds.) One could also make suggestions for how to build a routine or where might be best to do the exam, and then facilitate participation by having the client(s) come up with other options that would be suitable for them. When the health care provider asks a client to do an exercise which requires personal adjustments, (s)he may delegate, instructing the client to come to the next lesson with their own list of preferences and how they decided to perform the exercise/exam, etc. In this way, they will be more likely to continue with the exercise. Fischer and Fischer (1979), adapted for Psychosexual Therapy by Nasserzadeh, S. (2013)

Summary

Unconsummated marriage seems to be an overarching terminology that couples use to describe their failure at attempting intercourse with their spouse. Current research from various Middle Eastern countries supports the claim that vaginismus, followed by erectile dysfunction and premature ejaculation, are the main underlying reasons for these failed attempts. As the main predisposing factor noted to be largely psychogenic has been shown to be lack of sexuality education, this paper attempts to provide some practical concepts and recommendations for health care professionals in any setting using the HAT approach to assist them with the provision of necessary information in an accessible, comfortable and acceptable manner.

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