Sexual problems in marriage: non-consummation

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Introduction

The inability of a married couple to enter into the physical relationship of sexual intercourse has seemed to lawyers so striking a negation of the contract and ends of marriage that courts have been willing to accept evidence of this occurrence as grounds for annulment. Apart from the medico-legal context, doctors were for long hesitant in their approach to non-consummation. They did not encourage early referral, their treatments were piecemeal and their aims uncertain; they tended to overlook not only warnings before the marriage and residual handicaps after its consummation, but also abnormalities in the marital partner and in the mutual relationship. In the last 15 years, however, there has been a convergence of clinical approaches to the unconsummated marriage and a concentration on the disordered interactions within it. This paper views non-consummation as a symptom and sign of marital pathology, and attempts to identify those components of its treatment which play an important part in the successful outcomes that have been reported.

Physical contact

Physical examination of male and female patients presenting with unconsummated marriages has always been essential in order to diagnose or exclude physical disease, which in rare cases may be important. In addition, the functional abnormality of vaginismus can be demonstrated in no other way. Other benefits follow from this necessary physical contact. The assessment of emotional factors is often facilitated, and in women attitudes of shame, disgust or resistance during vaginal examination by the doctor or by themselves may have greater prognostic significance than the presence or absence of an intact hymen or vaginismus (Dawkins & Taylor, 1961; Friedman, 1962). Moreover, the diagnostic examination is continued into the beginning of physical treatment when the woman is herself progressively involved in inserting a finger or dilators, or stretching the hymen, under the guidance of the doctor (Malleon, 1942; Mears, 1958). One component of this therapy is the breaking down of an anxiety-provoking situation into lesser stages, which can then be surmounted in the presence of

adequate relaxation. Another is the authority of a parental figure, who places an initial ban on intercourse and later gives approval and sanction. Insofar as anyone's experiences of bodily needs, gratifications and hurts began in a child-parent setting, a physical level of communication with an acceptable therapist may be a necessary step for many patients towards integrating forbidden parts of the body into a working self-image. Treatment methods in which the physical examination is combined with forms of psychotherapy are reported as enabling up to 90% of women to consummate their marriages (Ellison, 1968). However, these series were selected on various criteria, and there is no systematic controlled study of treatment in a consecutive sample.

Education

A certain level of factual knowledge concerning sexual anatomy, physiology and technique may be postulated as a prerequisite to the establishment of satisfying intercourse. If this is lacking, instruction may be the main part of treatment and there appear to be a few couples who require little else. Sexual ignorance in itself has been given great emphasis by some writers. Blazer, who sought out and interviewed 1000 American married virgins, classified the reasons for non-consummation advanced by the wives into fifteen categories; he argued that only two of these, impotence in the husband and homosexual preference in the wife, accounting for 17% of the cases, would distort the sexual relationship if the women had adequate scientific knowledge of sex at their disposal (Blazer, 1964). However, study of his remaining categories suggests that the women in them had disorders of their psychosexual development ranging from mild to extremely severe and included a proportion of Sleeping Beauties who are notoriously resistant to instruction. His sample was collected through appeals and newspaper advertisements as well as through treatment agencies, and the motivation for change in his subjects was not assessed. Ellison in her retrospective study of 100 women with severe primary vaginismus found ignorance and misinformation in over 90% (Ellison, 1968). Again, the distinction is not clearly drawn between lack of factual information and the expres-

sion of morbid attitudes. The impression of Dawkins & Taylor was that the frequently encountered ignorance in their seventy women 'was a symptom rather than a cause of the difficulty, refusal to seek or accept information about sex being part of a personality problem' (Dawkins & Taylor, 1961). In such cases, factual instruction provides a necessary contact with reality, but it can be only the framework for a wider education.

The clinical application of learning theories has been employed by behaviour therapists in the neighbouring field of chronic frigidity (Lazarus, 1963; Brady, 1966). In a series where previous treatment had included medical instruction, or marriage guidance with recommended reading, in half the cases and psychotherapy in a quarter, Lazarus reported a change, after desensitization, to enjoyable intercourse in those of his patients who had clear-cut fears, were motivated to improve and were anxious introverts as opposed to hysterical extroverts. Hostility to their husbands or themselves was an unfavourable factor.

Exploring fantasies

The fears and fantasies of women with unconsummated marriages have been widely reported (Malleison, 1954; Mears, 1958; Dawkins & Taylor, 1961; Friedman, 1962; Ellison, 1968). Images of the vagina being too small, of its rupture, childbirth, rape, suffocation, degradation or of disgust for the male organs and semen are among the commonest. The earlier accounts found a link with childhood traumata from penetration in medical or surgical procedures or from sexual exposure, but such events are probably not unduly frequent in the lives of patients and the significance of these fantasies is less historical than symbolic. They are representations of the bad and forbidding aspects of sex. The number of fantasies volunteered or discovered has some correlation with the length and difficulty of treatment (Friedman, 1962). At the same time, since they are the overt expression of conflicts and parts of the self otherwise hidden, their exploration and interpretation offer a means by which the patient can gain awareness of herself and the opportunity to modify her feelings. Those fantasies which are acted-out in role-playing rather than verbally may also call for interpretation, provided the therapist has examined his own feelings before acting on them.

Because factual information concerning the parents and siblings of patients is usually lacking, the descriptions of upbringing supplied to the therapist should perhaps be regarded as a further group of fantasies, and one which the therapist is more inclined to share uncritically. Writing of a sample of women with few other neurotic symptoms and generally good object relations, Abraham con-

sidered that most of her patients had Oedipal attachments to their fathers and could be helped to achieve 'some measure of orgasmic satisfaction', whereas a minority who did not profit appeared to be pre-oedipally fixated to the mother and had greater aggression to men (Abraham, 1956). More recent writers have singled out the adverse effect on the female patient of her mother's reported disgust with sex (Dawkins & Taylor, 1961; Ellison, 1968). Whether such patients can benefit from physical and emotional contact with a female therapist presumably depends on the nature and degree of their identification with their mothers and the ability of the therapist to use transference material. Reports by patients of sexual dysfunction in siblings are relatively uncommon, and this could suggest that specific factors in the individual are needed in addition to adverse influences from one or both parents.

Settings in which wives are treated for non-consummation but their husbands are seen little, if at all, do not provide adequate opportunity for comparing marital fantasy with reality. A sizeable proportion of the husbands are said to be unduly forbearing and passive or to have sexual difficulties themselves of varying duration and severity (Friedman, 1962). This argues for the inclusion of husbands in the treatment setting, as does the need for corroboration by them of their wives' claims for improvement. It can be accepted that many women can be helped to consummate their marriages without direct and simultaneous treatment of their partners, but these marriages are probably among the less disordered and it remains open whether additional help could not have been given through treating the couple.

Treating the couple

Some behaviour therapists have claimed important advantages from involving husbands in their wives' treatment. Madsen & Ullman required the husband to take part in all the stages of a desensitization programme designed to treat a wife's frigidity (Madsen & Ullman, 1967); they considered that this participation educated him to understand his wife's difficulties better and increased his motivation to help her, improved communication between the couple, and assisted generalization of the wife's relaxation in the treatment setting to daily life situations. With some provisos, they permitted intercourse to occur while desensitization continued and used the feed-back information to develop the treatment hierarchies. Cooper reported a case of non-consummation where therapeutic failure was transformed into success by modifying the husband's protective attitudes and behaviour towards his wife, and persuading him to pass dilators into her vagina whilst she was relaxed (Cooper, 1969).

Similar elements of mutual learning, freer communication and progressive physical involvement are found in the therapy programmes developed by Masters & Johnson during their 11 years' experience of treating marital couples for a variety of sexual disorders (Masters & Johnson, 1970). They report the outcome in twenty-nine cases of vaginismus, which was relieved in all cases and rapidly succeeded by the achievement of orgasm in most. Not all these women had unconsummated marriages; a proportion was having rare or unsatisfactory intercourse, sometimes with an earlier pattern of normal sexual relations, but the contributory factors included cases of severe trauma through rape, homosexual conflicts, and sexual disorders in many of the husbands, especially primary impotence. The specific measures used to treat vaginismus comprised the transmission of anatomical and physiological information, a physical demonstration to both partners of the functional abnormality involved, and the passage of dilators by the husband under his wife's guidance.

In the total series of 510 couples which they report, Masters & Johnson found it necessary to treat 223 (44%) for sexual disorders in both partners. The extent of this overlap and the possible presence of further cases of non-consummation in their other categories of male and female disorders make some consideration of their general approach and methods relevant here. Couples are investigated and treated by a team of doctor and behavioural scientist, of whom one is male and the other female, in the course of a 2-week stay in St Louis. The programme begins with physical examinations, laboratory investigations and full life histories, with special reference to the psychosexual development and experiences of each partner. The difficulties which the couple have experienced in mutual communication and sexual interaction are then summarized in the light of their individual personalities, values and beliefs at a round-table conference, and treatment aims are set with an emphasis on developing sensory appreciation and sexual pleasure between the couple and avoiding set performance expectations or aloof spectator attitudes on the part of either partner. Thereafter, progress in their mutual physical and emotional re-education is discussed at daily sessions with the therapists, who adopt the role of impartial experts and discourage transferences onto themselves.

Factors other than their actual treatment methods are likely to affect the results reported by Masters & Johnson. As they emphasize themselves, the selection of patients operates to exclude those with overt psychiatric disturbances and to include those with middle-class backgrounds and a high level of education and motivation: 90% of the couples travel from elsewhere in the country to spend 2 weeks together with one topic in mind and with expectation height-

ened by the research prestige of the Foundation. Nevertheless, the low failure rates, both after 2 weeks and at 5-year follow-up, for a variety of sexual disorders treated in large numbers suggest that these principles and methods of helping couples to treat each other within the physical and emotional context of their marriage represent an important advance.

Exploring levels of interaction

In this country, Dicks and his team at the Marital Unit of the Tavistock Clinic have for many years employed a variety of techniques in treating couples (Dicks, 1959, 1967). In particular, they have studied the different levels at which the couple interact as a dyad, and have developed concepts to describe mechanisms and patterns of individual and collusive functioning, with which they can frame hypotheses for further testing. Of a sample of 100 couples followed up, seven were known, and a further eight believed, not to have consummated their marriages. Many of these wives showed more or less unconscious masculine identifications, or had fantasies of rejecting or damaged mother figures. The husbands often shared with them taboos exerted by internalized antilibidinal objects, so that collusive role-playing was common. Not all the cases were treated and the outcome for non-consummated marriages was not specified. It is not yet clear what the indications are for such specialized joint marital therapy, or how far these techniques can be employed with less sophisticated patients and therapists.

Treatment aims and settings

If non-consummation is a manifestation of marital disorder, it is logical to direct treatment at the marriage. The exceptions that prove the rule are those few cases where consummation is achieved after no more physical and emotional contact with the therapist than the wife requires in order to become confident that she is a normally structured, functioning and feeling woman, for here we are making the assumption that the deficiencies in the marriage were mild and will be made good by the ongoing relationship with the, perhaps unassessed, husband. Where the wife does not attain this confidence, is not in touch with her sexual self or sees her husband as an aggressor, consummation may occur but is likely to be succeeded by other sexual disorders in one or both partners and by conflicts in other areas. The recognition and interpretation of fantasies in the wife may give warning of and reduce such impairments, but husbands also stand to gain in confidence in their role, deepen their sexual awareness and lose their phobia-provoking image when they are brought into the treatment situation. Therapies which deliberately focus on the marital interaction can provide opportunities for the couple

to treat each other's sexual difficulties through a mutual process of physical and emotional discovery and adaptation. Some partners, whose sexual relations are determined by idealizations against shared prohibitions, or by projections onto each other of hated aspects of themselves are locked in false positions, from which they can only be rescued by opportunities to re-open communications in the prohibited areas and to take back into themselves their bad alongside their good feelings in the knowledge that their vulnerability is safe in their partner's keeping. Finally, a proportion of unconsummated marriages is unlikely to be altered by any approach so far described, notably those where one or both partners show gross psychosexual immaturity or deviation, complete lack of motivation, deliberate dissimulation or overt hatred and contempt.

A setting which could include all the components of treatment for marriages which have been outlined would have to offer accessibility, confidentiality, medical and psycho-therapeutic skills, time for marital counselling and research into consumer satisfaction. Such a paradigm can at present be found neither in the governmental agency serving a community such as the health services, nor in the voluntary body meeting a particular need such as the marriage guidance councils, but as the one extends its facilities and the other increases its professionalism, there is hope that the gap can be filled. In that event, non-consummation will be treated in the context of the total needs of the marriage, and may well lose its isolated position as a clinical entity.

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