Unconsummated Marriage ("Honeymoon Impotence"): 25 years' Experience with 871 Couples, in Kermanshah, Iran.

Elham Kazemi[1], Javaad Zargooshi[2*], Mozhgan Fatahi Dehpahni[2], Marzieh Kaboudi[3], Behzad Mahaki[4,5], Youkhabeh Mohammadian[6,7]

[1.] Fertility and Infertility Research Center, Health Technology Institute, Kermanshah University of Medical Sciences, Kermanshah, Iran.

[2.] Department of Sexual Medicine, Kermanshah University of Medical Sciences, Kermanshah, Iran.

[3.] Department of Sexual Medicine, Kermanshah University of Medical Sciences, Kermanshah, Iran. Department of Reproductive Health, Kermanshah University of Medical Sciences, Kermanshah, Iran

[4.] Department of Bio-Statistics and Epidemiology, School of Health, Kermanshah University of Medical Sciences, Kermanshah, Iran.

[5.] Social Development and Health Promotion Research Center, Kermanshah University of Medical Sciences, Kermanshah, Iran

[6.] Department of Clinical Psychology, Kermanshah University of Medical Sciences, Kermanshah, Iran.

[7.] Clinical Research Development Center, Imam Khomeini and Mohammad Kermanshahi and Farabi Hospitals, Kermanshah University of Medical Sciences, Kermanshah, Iran

*** Corresponding author.** Javaad Zargooshi, MD. Professor of urology. Chair, Department of Sexual Medicine, Kermanshah University of Medical Sciences, Kermanshah, Iran. Email: jzargoushi@kums.ac.ir

Abstract

Background: Unconsummated marriage (UCM) is a condition in which the first coitus in a marriage has not occurred in "due time" and thus the bride remains a virgin. UCM, which occurs early in married life, can sometimes last for years and have significant negative effects on a couple's sexual satisfaction. Here we report our experience with 871 couples in Kermanshah, Iran.

Methods: Electronic medical records of couples with UCM, seen by Zargooshi from 1996 to 2021, were reviewed. Some patients whose data were reported in our previous articles at 2000 and 2008, were not included here. For transparency, we voluntarily sent the full identifying data of our patients to the Journal during the first submission of the manuscript.

Results: Associated conditions include erectile dysfunction (49.8%), premature ejaculation (14.6%), male hypoactive sexual desire disorder (7.2%), and vaginismus (12.5%). Intracavernosal injection (ICI) was used as the treatment of choice. The consummation rate was 95.1%. We used ICI in presence of vaginismus, too. It may appear "ungentle" to approach the vaginismus this way. However, the couples preferred this expeditious treatment over a time-consuming, and ineffective alternative.

Conclusions: In most cases, UCM is due to psychogenic ED, for which ICI (not psychological interventions) is the best treatment because the typical couples who present with UCM are noncompliant with time-consuming treatments. Therefore, the most effective treatment was intracavernosal injection and then the administration of type 5 phosphodiesterase drugs and the most ineffective treatment was psychological counseling.

Keywords: Erectile Dysfunction; Sexual Dysfunctions, Psychological; Papaverine; Phentolamine; Marriage Consummation, Unconsummated, Cross-Cultural
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Introduction

Unconsummated marriage (UCM) is a condition in which the first coitus in a marriage has not occurred in "due time" and thus the bride remains a virgin. (Zargooshi 2000 and 2008). UCM may occur at the beginning of married life, and prolonging its treatment can have significant negative effects on a couple's sexual satisfaction According to Kaplan and Sadock, UCM is a marriage in which the couple has never had sex (Kaplan 1996, Masters 2007). Balint first appeared in 1961 in an article entitled; "The other part of medicine" He referred to this disorder and since then many cases of this disorder have been reported worldwide (Balint 1961). The importance of UCM relies on its consequences. A review of family court cases has shown that 50% of divorces in Iran occur due to untreated sexual disorders, and if properly intervened and treated, half of these divorces will not take place (Nasehi 2017).

This disorder is a biopsychosocial problem and hampers many patients both men and women and sometimes it can take several years to treat (Masters 2007). Studies have shown that sometimes the onset of sexual intercourse after marriage is delayed not only on the first attempt (Karakoç 2008) but even for years after marriage to the point that sometimes intercourse never takes place (Sadock 2015). Masters and Johnson reported a case of UCM that lasted 17 years, and in Iran cases of the disorder were reported that lasted as long as 15 to 18 years (Masters 2007, Bahrami 2007).

Due to cultural and social issues, the prevalence of UCM in the Middle East and Arab countries is high, (Zargooshi 2000 and 2008, Hosseini 2007). In these countries, sex is allowed only within the framework of marriage. Girls must be virgins when they marry. Especially in rural areas, the groom's family needs proof that the bride never had sex before, and the proof is the bleeding from the hymen onto a handkerchief during the first coitus. If the bride cannot produce this proof on her wedding night, her family and the groom's family are shamed (Zargooshi 2008). Due to globalization, UCM is no longer limited to developing communities. The prevalence of UCM among clinicians worldwide has been reported to be 2-20% (Özdemir 2008).

This disorder also has a significant prevalence in Iran, so that the failure rate on the first attempt to succeed in Iran is reported to be 61% (Eftekhar 2009).

There are various known reasons for the onset of UCM, which may be related to each partner. However, the most common cause is mental disorders, especially performance anxiety (PA) disorder, which is known as the main psychological cause of UCM (Badran 2006). Males sexual dysfunctions including Erectile dysfunction (ED), premature ejaculation (PE), and hypoactive sexual desire disorder (HSDD) are involved in UCM. In some cases, vaginismus makes it difficult or impossible for a couple to have sex (Gindin 2002).

Vaginismus is the most common gynecological disorder in UCM, meaning involuntary contraction of one-third of the external muscles of the vagina that prevents intercourse and may occur primary or secondary. Although women consciously want to have sex, they subconsciously prevent it (Hiller 1996). Vaginismus may also be associated with dyspareunia (Association AP 2013). In DSM-5, Vaginismus and dyspareunia

have been merged into the "Genito-pelvic pain/penetration disorder".

Vaginismus is more common in educated women (Bernstein 1997) and is often culturally dependent. For example, in Turkey, it accounts for 73% and in the United Kingdom 15.5% of UCM (Ward 1994). Vaginal penetration phobia has similar clinical complaints to vaginismus. It has also been suggested as another female cause of UCM that has clinical manifestations similar to vaginismus. This disorder often responds well to cognitive-behavioral therapy and systematic desensitization. The most important known cause for this disorder is insufficient sexual knowledge (Muammar 2015). Moreover, genital mutilation and its consequent pain for sexual intercourse can affect women's sexual wellbeing and, subsequently, be a cause for UCM (Auricchio 2021). Possible rare causes rely also on chronic known causes for dyspareunia such as endometriosis (Noventa 2015) and congenital pathologies such as Asherman Syndrome (Carugno 2020). In particular, endometriosis can have both clinical symptomatology (Scioscia 20121) and a psychological stress impairment (Brasil 2019, Laganà 2017). Rare but existing causes rely on post-treatment cervical cancer patients. In this case, on one hand, vaginal stenosis occurs (Laganà 2021), on the other vulvovaginal atrophy (Buzzaccarini 2021). Finally, the urinary tract pathology could also stress the woman's quality of life and sexual wellbeing (Patnaik 2017). Prolapse or other vaginal laxity accounts for a minimum percentage, but they could also be responsible for the low quality of life and UCM (Vitale 2018, Deltetto 2021).

In Iran, the most important psychological cause of UCM in women is fear of sex and in men PA (Zahran 2012). This disorder in men is not only due to their psychological weaknesses and performance anxiety but also due to fear of being humiliated by the bride's family (Althof 2002). According to a study of 200 UCMs in Iran, couples are under severe social pressure to have sex shortly after marriage (Zargooshi 2000). Lack of timely and appropriate treatment of this disorder can lead to many problems for young couples, including reduced intimacy between them and the aggravation of sexual problems and eventually infertility and their separation (Zargooshi 2000, Watson 1982). However, intracavernosal injection (ICI) is a very effective method that responds quickly in most cases and avoids the problems mentioned above (Zargooshi 2008).

Although UCM is a common social and medical problem in many parts of the world, it is not appropriate to prevent or treat it before complications occur, and it is only after its occurrence and the onset of anxiety and complications when couples go to medical centers and receive treatment (Özdemir 2008).

Considering the above-mentioned and the major role of sexual issues in married life and the negative impact of long-term UCM on the outcome of marriage and the cause a lot of stress and worries for couples, this article examines the causes of UCM in 857 patients with this complaint and how medical professionals should respond to their treatment.

Lack of timely and appropriate treatment of this disorder can lead to many problems for young couples, including reduced intimacy, aggravation of sexual problems and eventually infertility and divorce (Zargooshi 2000, Watson 1982). Previously, we have reported our experience with UCM in 2000 (Zargooshi 2000) and 2008 (Zargooshi 2008). Here we are updating our documentation of the problem.

Materials and Methods

This descriptive-analytical study was performed in order to identify the demographic characteristics, clinical findings and the effect of treatments performed on 857 couples seen by Dr. Zargooshi from November 12, 1996 to July 13, 2021. From the first day of launching his clinic, Dr. Zargooshi has recorded the full patients' data into an electronic system, the UNESCO's CDS/ISIS. The patients come from western Iran (Kermanshah, Ilam, Kurdistan, Hamedan, and Lorestan). All patients signed the written informed consent form upon acceptance, permitting us to use their data in research and follow-up and to send their data and their full names to scientific journals. They also authorized us to use and disclose their medical record, for research purposes. Thus, for transparency, the full, identifying data of our patients were sent to the Journal along with the first submission of this manuscript.

For all couples with UCM, we routinely obtained a full psychosocial, sexual, medical, marital, and medication history, covering personal biological, psychological, and sexological issues; relational problems, family-of-origin, culture, gender, class, and religious issues. Some patients whose data were reported in our previous articles (Zargooshi 2008, Zargooshi 2000), were not reported here again.

Intracavernosal injection (ICI) was used as the first-line treatment. All visits and ICIs were performed by Dr. Zargooshi. The ICI began with 20 mg of Papaverine hydrochloride. The dose was increased to 40 mg in nonresponders. Patients who fail to respond to the 40-mg dose received 10-mg Phentolamine plus 40-mg Papaverine. The goal was to achieve an erection sufficient for penetration and lasting for 1 hour after attempting coitus.

Participants

In this study, the electronic records of 857 couples with complaints of UCM after marriage during the last 25 years were evaluated. All of these individuals were evaluated by taking the required history, clinical examination, laboratory and paraclinical examinations. The inclusion criteria for all of these individuals were the couple's inability to have vaginal sex after marriage. Exclusion criteria for couples on the decision to divorce were due to severe conflicts that prevented them from continuing treatment. Demographic characteristics of the couple including age, sex, place of residence, duration of marriage and duration of the problem were extracted from the medical record. Other information recorded in the file that was examined included the main reason for the UCM from the clients point of view, the history of sexual problems, history of diseases, operations and surgery, drug use, history of alcohol, smoking or drug addiction, their type of marriage and if it was traditional and without a history of intercourse prior to marriage. In most cases, physical examinations and requests for follow-up, laboratory tests, hormonal examinations and other paraclinical examinations are performed. The occurrence or non-occurrence of secondary sexual characteristics in these individuals was carefully examined. Laboratory tests included fasting blood sugar, cholesterol, triglyceride, creatinine tests, and hormonal tests included testosterone (T) and free testosterone (FT), FSH, LH, SHBG, DHEAS, PSA, and prolactin (PRL).

The type of treatment recorded in the patients' records included injecting papaverine with or without phentolamine into the cavernous bodies of the penis or Intracavernosal injection (ICI), oral medications, teaching specific techniques to clients

or referring to a psychologist, and in some cases referring to a gynecologist for hymenectomy.

Data analysis

Sampling was done by census method and included 857 files of clients with UCM complaints. For all quantitative and qualitative variables in the study, descriptive statistics analysis was performed using SPSS software version 20, IBMC, New York, USA to calculate the mean and standard deviation, frequency (percentage), median, maximum and minimum.

Ethical consideration

This study was reviewed by the ethics committee of Kermanshah University of Medical Sciences and approved with the ethics ID IR.KUMS.REC.1397.925. An informed consent form was completed and signed by all clients upon acceptance by the clinic.

Results

Among the 65365 cases who referred to the sexual health clinic of Kermanshah University of Medical Sciences and Dr. Zargooshi's office from 1996 to 2020 with complaints of sexual and urological problems, 871 (1%) complained about UCM. All participants in the study lived in one of the five western provinces of Iran (Kermanshah, Ilam, Kurdistan, Hamedan or Lorestan) with customs and cultures almost similar to each other and with a smaller number of other provinces or Iraq. The age of the men participating in the study varied from 19 to 76 years (mean 30±7.83) and for women from 13 to 51 years (mean 25±6.85). The duration of UCM varied from one hour after attempting to have sex to 13 years after marriage, but in most cases (50%) the referral occurred less than one month after marriage. Most referrals occurred in less than a week (n = 211), during the month (n = 384) and the mean duration of treatment varied depending on the underlying cause of UCM. For example, patients with ED often responded more quickly to treatment (Table 1).

Table 1. Demographic characteristics of couples with UCM

Parameter	Min.	Max.	Mean	SD
Age (years)				
Women	13	51	25	6.85
Men	19	76	30	7.83
Age difference*	>1	18	2.2	1.95
Duration of UCM	One hour	13 years	226 days	17.29
		Percent		
Substance abuse		4.0		
Residence				
Kermanshah		78.0		
Ilam		11.5		
Kurdistan		2.5		
Hamedan and Lorestan		2.0		
Iraq		1.5		
Others		4.5		

* Age difference (Wife and Husband age difference).

The complaint of most clients (427 patients) (49.8%) was erectile dysfunction. Due to the prohibition of premarital sex in our study population, it was not possible to know the sexual status of the participants in the study before the onset of UCM, but 37 of these people were already married and had not experienced this problem in a previous marriage.

Of the 274 cases who complained of premature ejaculation (PE), 46 reported ejaculation time in just a few seconds. Another 32 people were initially diagnosed with antepartum. 19 cases measured ejaculation time as one minute, 15 cases as 2 minutes, and others as 3 to 15 minutes. Of these, 75 cases were based on the DSM5 diagnostic criterion, which takes less than a minute. If we use the International Society for Sexual Medicine (ISSM) as a criterion for determining that Primary PE is less than one minute, the result is the same 75 cases, and in the case of Secondary PE, which is three minutes or less, the actual number is 125 cases (14.6%) (23).

Hypoactive sexual desire disorder in 62 cases (7.2%), female hypoactive sexual desire disorder (FHDD) in 15 cases (1.75), unfamiliarity with intimacy techniques in 23 cases (2.5%), homosexuality in 3 cases (0.35%), hard or abnormal hymen was reported in 4 cases (0.36%).

83 patients (9.7%) were psychologically supervised due to psychological problems such as depression, nervousness, bipolar, obsessive-compulsive disorder, very poor body image and other mental health problems. Many patients had more than one complaint.

34 cases reported drug or tobacco addiction, including 13 (1.5%) opium addicts, 12 (1.4%) smokers, 2 (0.02%) hookah addicts, and 2 (0.02) heroin addicts, 1 person (0.01%) used cannabis, 2 people (0.02%) used tramadol and 2 people (0.02%) used methadone.

In clinical examinations, 62 men had varicocele and 16 had hydrocele, one was pyrene and one was hypospadias (Table 2).

Table 2. Results of physical examination of men with UCM complaints

Disorder or abnormality in examination	UCM (N.)	UCM (%)
Male anatomical defects		
Small penis	5	0.60
Peyronie's disease	1	0.11
Varicocele	62	7.40
Hydrocele	16	1.90
Hypospadias	1	0.11
Testicular atrophy	6	0.70
Anatomical abnormality of women		
Hard hymen	3	0.35
Abnormal hymen	1	0.01

The most important causes of UCM in this study were erectile dysfunction (49.8%), premature ejaculation (14.6%), vaginismus (12.5%), hypoactive sexual desire disorder (7.2%), psychological problems (9.7%), female hypoactive sexual desire disorder (1.75%), and a combination of several physical and mental problems (3%) (Table 3).

Table 3. Etiological factors of unconsummated marriage

Dysfunction type	UCM (N.)	UCM (%)
Vaginismus	117	12.50
ED	427	49.80
PE	125	14.60
HDD	62	7.20
FHDD	15	1.75
MSM	3	0.35
PA, depression and other mental disorders	83	9.70
A combination of several physical and mental problems	25	3.00
Total	857	100

In the ICI treatment process, which was performed by injection of papaverine with or without phentolamine in 185 patients, which was completely successful in 164 cases (88.6 %) and there was a response to appropriate treatment, and in 21(11.4) patients no response to the drug was observed and 12cases also developed priapism, which either resolved spontaneously or was treated successfully using the corporal blood aspiration-adrenaline injection (Phenylephrine was unavailable).

Of the 21 people who did not respond to papaverine injections, 19 had erectile dysfunction and one had severe hypoactive sexual desire disorder. One couple later presented with infertility and one had premature ejaculation within seconds. Two cases had a history of depression and neurological problems, and two people needed psychological counseling and were referred to a psychologist. One person complained of a small penis size (7 cm) (Table 4).

Table 4. Treatment results of UCM clients.

Treatment	Outcome	
	Successful	No Response
Men ICI (n=185) Phosphodiesterase type 5 (n=189) Clomipramine (n=62)	164 (88.6%) 145 (77%) 59 (95%)	21(11.4%) 44 (23%) 3 (5%)
Women Hymenectomy	No referral	
Cuple Psychological counsult (n=50)	0 (0%)	50 (100%)

Of the 189 cases who took phosphodiesterase type 5 (sildenafil or tadalafil), 19 (10%) consummated their marriages and it was generally useful in 145 (77%). 62 cases used clomipramine to treat PE and 59 (95%) responded to this treatment (Table 4).

18 couples were referred to our center by the court to investigate and confirm sexual problems and filed for divorce. The number of brides who underwent thick hymenectomy due to vaginismus or hymen was 42 cases (Table 4).

It may also be the case that the diagnosis of these people was not made due to abnormal tests (Table 5). Fourteen couples who did not respond to treatment later consummated their marriages spontaneously. Of 871 couples, 198 were lost to follow-up.

Table 5. Hormone profiles and tests of UCM clients.

Parameter	Min.	Max.	Mean	SD
FBS	55	286	94.37	21.46
CH	10	299	178.18	42.22
TG	21	456	132.20	72.09
Cr	0.6	1.7	0.98	0.17
T	0.1	930	9.77	56.18
FT	0.3	267	14.73	24.30
FSH	0.7	74	12.43	24.31
LH	0.1	15	3.08	5.41
SHBG	0.1	114	26.39	17.53
DHEAS	1.9	807	62.49	136.55
PSA	0.5	7.2	0.91	1.60
PRL	1.9	807	62.49	136.55

In cases of PE, too, our treatment of choice was ICI. We prescribed most commonly Clomipramine, but also Dapoxetine, or selective serotonin reuptake inhibitors (SSRIs) such as fluvoxamine, paroxetine, Citalopram, or sertraline. In 141 patients who received Clomipramine, 17 (12%) consummated their marriages. Consummation rate with all other PE treatments was much less, in the range of 6-11%. Of 57 couples whom we sent to the psychologists/ "counselors"/ "sex therapists" in Kermanshah and Tehran, none consummated their marriages.

Discussion

UCM is a medical social problem, especially in the Middle East (Gindin 2002). With increasing globalization, more cases are seen in industrialized countries, too. In many rural areas, UCM can lead to early divorce. Our UCM caseload is much more than psychologists because the patients fear stigmatization in case of going to psychologists, while they easily shielded their true problem (UCM) under neutral urological conditions when questioned by others about their reason for presentation to us.

In different studies, different reasons have been suggested by urologists, gynecologists, sex therapists and psychologists as the main cause of this disorder in different societies. But in almost all researches, cultural and social factors were effective in creating the importance of this disorder.

In one study, psychological factors were the cause of 74.4% of patients, and performance anxiety in 7.3% of patients, vaginismus in 8.4%, premature ejaculation in 3.4% and unknown factors in 6.8% cases were seen. In this study, similar to our study, PE was reported as an important psychological factor (Ghanem 1998). In our study, among psychological factors, PA in men played an important role, but contrary to our results in this study, the role of erectile dysfunction was not clear. The frequency of vaginismus was very close to our results and premature ejaculation was much less

reported. Bardan et al. conducted a study on 191 UCM in Egypt and found that the most common cause of this problem is mental disorders (74. 4%). In this study, organic causes were involved in 7.3% of cases, vaginismus in 8.4%, premature ejaculation in 1.3% and other factors in 8.6% of UCMs (Badran 2006). The role of male factors in this study was less than in our study.

Expressing the desires and wishes of couples, expressing their sexual preferences to each other, realizing the special desires of the spouse that arise as a result of acquaintance before sexual intercourse, and talking about sexual issues, has a great effect on reducing sexual problems after marriage (Whestheimer 2005, Chiou 2006). The positive effect of this issue in the faster treatment of our clients in the study was seen more dramatically than in cases without previous acquaintance and interest.

The mean age of couples in our study was lower than in industrial societies. This is because men and women in industrialized countries are less likely to marry because of different social conditions in the West than in the Middle East. Additionally, the freedom to engage in premarital sex in those countries is greater than in Eastern countries, including Iran (Michetti 2014).

Barmely et al. reported that the duration of treatment in 60% of cases was 6 months and in another study 1.5 years (Bramley 1981). Although accurate statistics on delay in marriage are not available due to the lack of public consultation at the time of the disorder, in some studies, the prevalence of failed marriages has been reported to be 2-20% among people visiting clinics (Gindin 2002). In one study, the disorder accounted for 17% of sexual health clinic referrals (El-Meliegy 2004), and in our study, it was estimated at 14% over 24 years.

In another study, the cause of failure in intercourse was reported in 67% of female cases, 7% of male cases and 26% of cases of both sexual partners. The prevalence of each of the sexual disorders in this study was as follows: vaginismus was present in 81% of cases, erectile dysfunction in 10.5% and premature ejaculation in 5% of patients (Addar 2004). The results of this study were different from our research and the role of female factors was more important and male factors such as erectile dysfunction, which was a high number of our clients in this study, included 10.5% of cases. It should be noted that in most cases, more than one factor and the complaint was the cause of UCM. Of course, the role of psychological pressure from families and close relatives to have sex and provide evidence that the hymen has been breached on the bride and groom should not be ignored, and many clients (more than half of them) attribute this to the inability to have sex.

In one study, cultural causes were found to be effective in the incidence of these problems in different regions. Lack of sex education, immaturity of both sexual partners, excessive dependence on the original family, cultural influences such as strict religious rules, and sexual restrictions by parents and society are characteristics that are seen in UCM couples. Feelings of guilt, shame and inadequacy of the couple, infertility, hesitation in marital relations and finally divorce are among the complications that arise from this problem (Mirzaie 2002, Semnani 2003). The role of all these factors in our study was also evident; while many of these patients can be easily assisted with education on genital mutilation, physiology, and sex education (Ganjlu 2003, Sadock 2007)

In the course of treatment of all clients of UCM, all biological, psychological, couple therapy, family, social and cultural issues were considered. In all stages of treatment in this study, our focus is on the couple and we do not pay attention to just one person in this direction.

For known medical causes, a peculiar and tailored approach should be performed as treatment (Puente Gonzalo 2020).

Regarding the effect of psychological therapies on clients, due to the existence of sanctions in Iran and the impossibility of access to some effective drugs, including papaverine, which was used in the past, we had to refer some clients for psychotherapy, but unfortunately in most cases, the treatment was not successful. Or at least we did not have knowledgeable and experienced psychologists available.

It should be noted that the imposition of sanctions by other countries in Iran and the lack of access to these drugs have led to disruption in the treatment process of clients. This is because previous research has shown that ICI can be the best treatment for a UCM in most cases, although this treatment is not very specific. However, it is very fast and effective. Therefore it is useful in this group of clients due to the fact that as time goes by, the woman's fear increases and escalates and becomes more and more of an issue. HDD, ED, and PA also occur in men, and hope for treatment decreases over time. On the other hand, in the Middle East and Arab countries, due to cultural conditions, there is not enough opportunity for psychological treatment, which is often time-consuming, and patients expect their problems to be solved as soon as possible. Fulfilling this desire, even in cases where the UCM problem is caused by feminine reasons, helps to solve the problem faster by creating a proper erection with the help of ICI.

The description of the anatomy of the reproductive system was often successful for clients who were unaware or had a negative or erroneous view of sexuality, as well as for clients who complained of vaginismus. This issue was more pronounced in most patients, especially in the treatment of vaginismus and female hypoactive sexual desire disorder and anorgasmia in women. In other cases, the next effective treatment was hymenectomy and the use of type 5 phosphodiesterases such as sildenafil and tadalafil. It should be noted that the psychological factors involved in our experience disappeared after having a hymenectomy or second sexual intercourse. Hymenectomy was recommended only in cases where there were no severe male disorders, such as severe erectile dysfunction, without a proper response to treatment, or if the divorce was not taken seriously due to frequent marital conflicts.

Numerous reports have suggested that the impact of cultural issues in developing countries is very effective in increasing cases of vaginismus and premature ejaculation compared to developed countries (Addar 2004). This was seen in our study, and problems and strictures related to traditional culture increased the incidence of vaginismus in women due to fear of first coitus and premature erection and ejaculation in men, especially men with performance anxiety. To the extent that sometimes, due to ignoring these limitations, over time, this problem was solved spontaneously and without treatment.

The high response rate to ICI in our patients is suggestive of the absence of neurogenic and vasculogenic ED.

Lack of sex education, immaturity of both sexual partners, excessive dependence on the original family, cultural influences such as strict religious rules, and sexual restrictions by parents and society are characteristics that are seen in UCM couples. Feelings of guilt, shame and inadequacy of the couple, infertility, hesitation in marital relations and finally divorce are among the complications that arise from this problem (Mirzaie 2002, Semnani 2003).

Conclusion

UCM is mostly psychological/interpersonal in origin. Performance anxiety and cultural pressures to consummate the marriage in "due time" are the

main etiological factors in psychogenic ED in UCM.

However, psychological and "counseling" interventions are inappropriate for this condition, because they are time-consuming. ICI is best suited for these couples, considering its low cost, safety, affordability, and immediacy.

Based on the experiences of 857 couples in this study, we concluded that the best treatment for these clients is to first conduct a comprehensive interview with the couple. If there are conflicts and marital problems between them, the first step in treatment is to resolve these problems. This should be done with the help of experienced psychologists and couples therapists. The next step may be a hymenectomy depending on the cause of the failed marriage. This surgery is recommended only if there are no unresolved marital conflicts between the couple and the man does not have severe erectile dysfunction and does not respond to treatment. In this study, we performed a study and compared different treatments to find that ICI is a very useful treatment even in men who have premature ejaculation, and although ejaculation occurs, it is possible to continue the intercourse due to the hardness of the penis. This possibility is also effective in cases where a female factor such as vaginismus is involved. It should be noted that in all these cases, since men and women, due to the cultural reasons mentioned earlier, are under severe psychological stress from the family to have a relationship sooner, they have no complaints about this intervention and apply this method of pressure.

Therefore, it is better to consider UCM as a sexual disorder medicine. This disorder should be seen as a disorder of marital medicine and we should not overemphasize psychological problems. In this study, we concluded that in countries with similar cultures and customs to Iran, psychological factors are the main problems and with the disappearance of the physical problem over time, the mental problem disappears.

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