Inability to Consummate Marriage (Unconsummated Marriage): Causes, Diagnosis, Treatment and the Integrative Unani Approach

By Dr. Nizamuddin Qasmi

Founder & Chief Physician, Saira Health Care
Focused Practice in Sexual Disorders & Infertility
BUMS, Hamdard University, Delhi
MD, CGO, Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK
Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Introduction: A Sensitive Problem That Is Usually Treatable

When a newly married couple comes to me and says,

"Doctor, we have been married, but we have still not been able to complete sexual intercourse,"

the first thing I tell them is:

Please do not blame yourself, and do not blame your partner. We first need to understand what is preventing penetration.

The inability to consummate a marriage, often called **unconsummated marriage (UCM)** in the medical literature, refers broadly to a situation in which a married couple who wishes to have penile-vaginal intercourse has been unable to achieve it successfully.

Importantly, **unconsummated marriage is not itself a single disease or psychiatric diagnosis**. A very recent 2026 review focused on South Asia emphasizes that it is better understood as a marital or clinical situation that can result from sexual dysfunction, genital pain, psychological distress, relationship factors, inadequate sexual knowledge or a combination of these.

The underlying cause may be on the male side, the female side, both sides, or may be primarily psychosexual.

Common causes include:

erectile dysfunction, vaginismus or genito-pelvic pain/penetration disorder, severe performance anxiety, painful intercourse, premature ejaculation before penetration, low sexual desire, inadequate sexual knowledge and, less commonly, anatomical or hormonal problems.

A systematic review published in *The Journal of Sexual Medicine* evaluated 27 studies involving 1,638 men and 1,587 women. Across studies that included both partners, **vaginismus and erectile dysfunction were the most commonly reported causes**, and about 16.6%–26% of cases involved factors affecting both partners. The authors concluded that a multidisciplinary combination of sex education, medical treatment, psychosexual support and surgery when indicated was the most appropriate overall strategy. The evidence base was, however, mainly low-quality case series, so published success percentages should never be interpreted as guarantees for an individual couple.

In the South Asian setting, this problem deserves particular attention. A 2026 review found that genito-pelvic pain, erectile dysfunction, premature ejaculation, fear, anxiety and depression were recurring causes, while stigma and lack of sexual education sometimes delayed professional care for months or even years.

From my perspective as a physician working in sexual disorders and infertility, one of the most important principles is therefore:

Do not treat an "unconsummated marriage." Treat the specific medical, sexual, psychological or relationship factor that is preventing comfortable, consensual intercourse.

What Exactly Does "Consummation" Mean Medically?

The word *consummation* is also used socially, religiously and legally, but in clinical sexual-medicine literature it generally refers to successful **penile-vaginal penetration** in a married heterosexual couple.

However, I prefer to explain this carefully.

Sexual health is much broader than penetration. A couple may have desire, affection, kissing, arousal, erection and orgasm yet still be unable to achieve vaginal penetration because of vaginismus, pain, erection loss or fear.

WHO describes healthy sexuality as involving physical, emotional, mental and social well-being and emphasizes that sexual experiences should be **safe, respectful and free from coercion and violence**.

Therefore:

Marriage does not remove the need for consent.

Neither partner should be forced to tolerate painful or unwanted penetration simply because they are married.

This is not only an ethical point—it is also clinically important. Repeated forced or painful attempts can reinforce fear, pelvic muscle tightening, performance anxiety and avoidance, making successful intercourse even more difficult.

Why Both Partners Should Be Evaluated

One of the biggest mistakes is immediately deciding:

“It must be the husband's problem.”

or:

“It must be the wife's problem.”

Published evidence shows that either partner can contribute and that **both partners can have a problem simultaneously**.

For example, a woman may initially have vaginismus. After several unsuccessful penetration attempts, her husband may become anxious about causing pain. He starts monitoring his erection, gradually develops erection loss and then acquires secondary performance anxiety.

The reverse can also happen.

A man may initially have mild psychogenic erectile dysfunction. Repeated attempts become stressful, his wife begins anticipating failure or pain, pelvic-floor tension increases and the problem gradually becomes a couple's condition.

This is why I prefer a **couple-oriented but individually respectful assessment**.

Each partner may also need a private conversation with the clinician.

The Most Common Causes at a Glance

Main Problem	What the Couple May Notice
Erectile dysfunction	Penis does not become firm enough or erection disappears before penetration
Performance anxiety	Erection is often normal at other times but fails during attempted intercourse
Vaginismus / GPPPD	Vaginal muscles tighten automatically, making penetration painful or impossible
Dyspareunia	Penetration causes significant vaginal or pelvic pain
Premature ejaculation	Ejaculation occurs before or immediately during attempted penetration

Main Problem	What the Couple May Notice
Low sexual desire	One or both partners have little desire or arousal
Poor sexual knowledge	Couple does not clearly understand anatomy, arousal, lubrication or penetration
Anatomical conditions	Genital anatomy mechanically interferes with penetration
Hormonal/medical disease	Diabetes, testosterone deficiency, neurological disease, thyroid problems or medicines affect sexual function
Relationship/psychological factors	Fear, depression, trauma, conflict or pressure interferes with intimacy

The main purpose of evaluation is to determine which of these applies.

Male Cause No. 1: Erectile Dysfunction

Erectile dysfunction, or ED, is one of the most important male causes of unconsummated marriage.

A man may experience normal desire and even begin with a good erection, but as soon as penetration is attempted, the erection becomes weak.

Another man may be unable to obtain sufficient rigidity at all.

This can result from physical disease or psychological factors.

Current EAU sexual-medicine guidance identifies diabetes, metabolic disease, cardiovascular disease, hormonal problems, neurological disorders, medicines and psychological or relationship factors among important causes of ED. A proper ED assessment includes medical and sexual history, physical examination and metabolic or hormonal testing when clinically appropriate.

“Honeymoon Impotence” and Performance Anxiety

An older expression sometimes used in medical literature is **honeymoon impotence**.

I generally avoid the word *impotence* because it is stigmatizing.

The more accurate description is **situational or psychogenic erectile dysfunction associated with performance anxiety at the beginning of marriage**.

A man may have completely normal erections during sleep, in the morning or during masturbation but repeatedly lose the erection when intercourse is attempted.

The cycle may look like this:

First unsuccessful attempt → fear → excessive monitoring of erection → stress response → erection becomes weaker → another unsuccessful attempt → stronger fear.

The patient then begins thinking:

“What if I cannot do it tonight either?”

His entire attention shifts away from arousal and toward performance.

This psychological distraction can itself inhibit erection.

The latest 2026 South Asian review identifies fear, anxiety, depression and psychosexual factors as important contributors to non-consummation.

Current EAU guidance likewise recognizes performance-related distress, anxiety and relationship factors in ED and recommends psychological or cognitive-behavioural treatment when appropriate.

Does Performance Anxiety Mean the Man Is “Weak”?

No.

This is something I explain very clearly.

A man with situational ED may have:

normal testosterone, normal penile blood supply, normal nerves and normal sexual desire.

His difficulty can still be very real.

Psychological sexual dysfunction is not imaginary.

Sexual arousal depends strongly on the brain. Fear activates the body's stress system, which is almost the opposite physiological state from relaxed sexual arousal.

Calling such a patient “weak,” “impotent” or “not masculine enough” generally makes the condition worse.

Male Cause No. 2: Premature Ejaculation Before Penetration

In some couples, erection is satisfactory but ejaculation occurs **before vaginal penetration can be completed**.

This can occasionally prevent consummation.

It is important, however, not to diagnose premature ejaculation simply because the first few marital encounters are brief.

Newly married men may experience very high excitement and anxiety. Some temporary early ejaculation can therefore occur.

Persistent premature ejaculation is diagnosed by considering ejaculation timing, ability to control ejaculation, distress and the overall clinical pattern.

The current 2026 EAU guideline recommends treating associated ED or genitourinary disease first when relevant and recognizes both pharmacological and psychological approaches to PE.

If PE is genuinely preventing penetration, treatment should focus specifically on ejaculatory control rather than simply giving an erection tonic.

Male Cause No. 3: Low Sexual Desire

Some husbands can obtain an erection but feel little or no sexual desire.

Possible contributors include:

low testosterone, elevated prolactin, thyroid disease, depression, medication effects, severe stress and relationship difficulties.

Low desire should therefore not automatically be interpreted as rejection of the spouse.

Nor should it immediately be treated with testosterone.

Hormonal treatment should follow appropriate diagnosis.

Male Cause No. 4: Anatomical or Genital Problems

Less commonly, penetration may be difficult because of a structural problem.

Examples may include:

severe phimosis, painful foreskin problems, significant Peyronie's curvature, certain congenital penile abnormalities or genital pain.

A focused genital examination is useful when symptoms suggest a structural problem. Current EAU guidance notes that examination of a man with erectile difficulty can reveal conditions such as Peyronie's disease and other unsuspected genital abnormalities.

Structural disease should be treated according to the actual diagnosis.

No amount of counselling can mechanically correct a severe anatomical obstruction, just as surgery is not appropriate for a purely anxiety-related erection problem.

Female Cause No. 1: Vaginismus

Vaginismus is among the most frequently reported causes of unconsummated marriage in published studies.

Vaginismus involves **involuntary tightening of the muscles surrounding the vaginal opening when penetration is anticipated or attempted**.

The woman does not consciously decide to contract these muscles.

She may genuinely want intercourse.

She may love her husband.

She may have normal sexual desire and arousal.

But as penetration approaches, her body automatically tightens.

This may produce:

burning, stinging, pain, fear or the sensation that penetration is physically impossible.

Cleveland Clinic describes vaginismus as involuntary contraction of the vaginal muscles in response to attempted penetration and notes that it can interfere with intercourse, tampon insertion and gynecological examinations.

Vaginismus and Genito-Pelvic Pain/Penetration Disorder

Modern psychiatric classification combines the older concepts of vaginismus and dyspareunia into **Genito-Pelvic Pain/Penetration Disorder (GPPPD)**.

Formal criteria include persistent or recurrent problems such as:

marked vulvovaginal or pelvic pain with attempted penetration, marked fear or anxiety about penetration-related pain, or marked pelvic-floor tightening during attempted vaginal penetration, together with clinically significant distress.

In everyday clinical practice, the word **vaginismus** remains commonly used when involuntary pelvic-floor tightening is the dominant feature.

The Fear–Tension–Pain Cycle

I often explain vaginismus to couples through a simple cycle.

The woman thinks:

"It is going to hurt."

Her pelvic-floor muscles tighten automatically.

Penetration is attempted against tight muscles.

It becomes painful.

Her brain now learns:

"I was right—penetration is dangerous."

Next time, she becomes afraid even earlier.

The muscles tighten more strongly.

Pain increases.

The cycle becomes:

fear → tightening → pain → more fear.

This cycle is not a failure of willpower.

Telling the patient to "just relax" can be frustrating and invalidating.

She needs a structured treatment programme that gives her control over the process.

What Can Trigger Vaginismus?

The exact cause is not always identifiable.

Recognized contributors include:

fear of pain, anxiety about intercourse, previous painful penetration, negative sexual experiences, sexual assault or trauma, painful genital disease and negative beliefs or fear surrounding sex.

Importantly, some patients have vaginismus **without any obvious psychological trauma**.

We should therefore never interrogate a woman as though she must have experienced abuse in order for the diagnosis to be valid.

Female Cause No. 2: Painful Intercourse

Not all painful penetration is vaginismus.

Pain can result from:

vaginal infection, vulvodynia, pelvic-floor dysfunction, inadequate lubrication, endometriosis, pelvic inflammatory disease, dermatological disease, scarring, vaginal stenosis and other gynecological conditions.

The NHS specifically lists infections, menopause, pelvic inflammatory disease and endometriosis among other possible causes of vaginal pain that can resemble or coexist with vaginismus.

This is why a woman with pain should receive appropriate assessment rather than being automatically told:

“It is psychological.”

Female Cause No. 3: Insufficient Lubrication or Arousal

Sometimes there is no major disease.

The couple may simply attempt penetration before adequate sexual arousal has developed.

Insufficient lubrication increases friction and pain.

Pain then causes fear.

Fear reduces arousal further.

The cycle can gradually become a penetration problem.

Good sexual education should therefore include information about:

emotional comfort, foreplay, arousal, lubrication, slow progression and communication.

Intercourse should never be treated like a mechanical task that must be completed immediately.

Female Cause No. 4: Anatomical Conditions

Rare structural causes may interfere with penetration.

These can include congenital vaginal abnormalities, significant vaginal narrowing or certain hymenal abnormalities.

Such conditions require proper gynecological assessment.

Some may respond to dilation, while selected anatomical problems may require surgery.

Vaginal dilators are also used clinically for conditions involving vaginal narrowing, congenital abnormalities and pelvic-floor dysfunction.

A Very Important Myth About the Hymen

Many newly married couples become anxious because they have been told that:

“The hymen must break and the woman must bleed on the first night.”

This is medically incorrect.

WHO states clearly that the appearance of the hymen cannot prove whether a woman has previously had intercourse, and there is no scientifically valid “virginity test.”

ACOG likewise explains that the hymen is only a thin membrane partially covering the vaginal entrance and that its presence or absence does not establish “virginity.”

Not every woman bleeds during first intercourse.

Lack of bleeding is **not evidence of previous sexual activity**.

Such myths can create severe marital conflict and unnecessary psychological trauma and should have no place in professional sexual healthcare.

Lack of Sexual Education Can Itself Prevent Consummation

This is more common than many people realize.

Some couples enter marriage having received almost no accurate information about sexual anatomy.

They may not clearly understand:

where the vaginal opening is, how erection and lubrication work, how penetration should occur, why foreplay matters or why forcing intercourse can make the problem worse.

The 2026 South Asian review specifically identifies inadequate sexual knowledge and cultural taboos as contributors to unconsummated marriage.

Sex education is therefore not something separate from treatment.

For some couples, **education is treatment**.

Relationship Pressure and Family Pressure

In South Asian cultures, a newly married couple may immediately face questions about pregnancy.

Family members may begin asking within weeks:

“Is there any good news?”

If intercourse itself has not occurred, this pressure can be extremely distressing.

The couple may start attempting intercourse every night out of fear rather than desire.

Both partners become anxious.

Sex turns into a test that must be passed.

The 2026 South Asian review found that sociocultural stigma, fertility expectations and reluctance to discuss sexual problems can contribute to delayed care and psychological distress.

I advise couples to protect their privacy.

Their sexual life is a health matter between themselves and the professionals they choose to involve.

Inability to Consummate Marriage Is Not the Same as Infertility

This distinction is extremely important.

If a couple has not achieved vaginal intercourse, pregnancy through intercourse obviously cannot occur.

But this does **not necessarily mean either partner is biologically infertile**.

The husband may have completely normal sperm.

The wife may ovulate normally and have healthy reproductive organs.

The obstacle may simply be penetration.

Once intercourse becomes possible, pregnancy may occur naturally.

If the couple has additional fertility concerns, those should be investigated separately.

For selected couples whose immediate priority is conception while sexual treatment continues, clinician-guided intravaginal insemination or other assisted reproductive approaches have been used in published South Asian studies.

However, reproductive treatment should not replace addressing painful or distressing sexual dysfunction when the couple wishes to have a comfortable sexual relationship.

How I Evaluate a Couple at Saira Health Care

When a couple consults me with inability to consummate marriage, I prefer not to start by prescribing a “power medicine.”

I first ask:

What happens when intercourse is attempted?

Does the man lose the erection?

Does the woman experience pain?

Does the penis reach the vaginal opening but cannot enter?

Does ejaculation occur before penetration?

Is either partner frightened?

Is sexual desire present?

Do both partners want penetration?

Has intercourse ever been successful even once?

Are there morning erections?

Does erection occur normally during masturbation?

Can the woman comfortably insert a finger or tampon?

Is there genital pain?

Have there been previous traumatic sexual experiences?

Are diabetes, thyroid disease or hormonal disorders present?

Which medicines are being taken?

These questions often reveal the direction of diagnosis before any laboratory test is performed.

The Couple Should Also Have Individual Privacy

A couple consultation can be very useful, but each person should also have an opportunity to speak privately.

A husband may not want to discuss erection failure in front of his wife.

A wife may be afraid to disclose pain, trauma, relationship pressure or lack of consent in front of her husband.

A good sexual-health consultation should therefore provide confidentiality and psychological safety.

This is particularly important because WHO's approach to sexual health explicitly emphasizes dignity, safety and freedom from coercion.

Medical Examination of the Male Partner

When erectile dysfunction is suspected, assessment may include a focused genital, endocrine, cardiovascular and neurological examination.

Depending on the clinical situation, laboratory testing can include glucose or HbA1c, lipid profile and early-morning testosterone, with other hormonal tests used when indicated.

The latest EAU guidance supports comprehensive history-taking, focused examination and metabolic/hormonal testing according to the individual patient.

Not every young man with obvious performance anxiety requires extensive investigations.

Testing should answer a medical question.

Medical Examination of the Female Partner

If pain or vaginismus is suspected, the examination should be gentle and patient-controlled.

A woman with severe penetration fear should never be forcibly examined.

The clinician can explain each step beforehand and stop whenever the patient requests.

Cleveland Clinic specifically describes strategies that give patients greater control during evaluation, while the NHS notes that the examination may be limited to ruling out other painful genital conditions.

Sometimes a complete internal examination cannot be performed initially—and that is acceptable.

Treatment can begin gradually.

Modern Treatment: Education Comes First

The 2024 systematic review of unconsummated marriage found that **basic sex education was included across treatment programmes**, with therapy chosen according to the underlying cause.

I consider this logical.

A couple should understand:

normal male and female sexual response, vaginal anatomy, erection, lubrication, foreplay, communication, penetration and the importance of consent.

They should also be told that intercourse does **not** have to be completed on the first night of marriage.

There is no medically correct deadline for first intercourse.

Treatment of Performance Anxiety

Performance anxiety is usually treated through a combination of:

sexual education, removal of performance pressure, behavioural techniques, cognitive therapy, couple communication and—when ED is also present—appropriate medical treatment.

The couple may temporarily be advised to stop making penetration the goal of every intimate encounter.

Instead, they can rebuild comfort through affectionate and non-demand sexual contact.

This is closely related to established psychosexual techniques such as **sensate focus**.

The objective is to retrain the brain to associate intimacy with comfort rather than examination and failure.

Treatment of Erectile Dysfunction

If genuine ED is present, treatment depends on the cause.

Lifestyle factors and underlying diseases should be addressed.

Current EAU guidance gives a strong recommendation for **PDE5 inhibitors such as sildenafil or tadalafil as first-line pharmacological treatment for ED**. It also recommends cognitive-behavioural therapy when psychological factors are relevant.

For a newly married man whose erection difficulty is primarily psychogenic, medication may sometimes provide temporary confidence while psychosexual therapy addresses the anxiety cycle.

But medicine should be prescribed appropriately rather than self-selected.

An Important Safety Warning About Sildenafil and Tadalafil

These medicines are not suitable for everyone.

The current EAU guideline describes concomitant use of **organic nitrates or nitric-oxide donors as an absolute contraindication** because the combination can cause potentially dangerous hypotension.

Patients with significant cardiovascular disease also need appropriate assessment.

Do not borrow ED medicine from a friend or increase the dose repeatedly because penetration has not yet occurred.

Treatment of Premature Ejaculation

When ejaculation repeatedly occurs before penetration and clearly prevents consummation, PE-specific treatment may be appropriate.

Current EAU recommendations include appropriate pharmacological treatment and psychological/behavioural management, with associated erectile dysfunction or genitourinary disease treated first when relevant.

The goal is not simply to make intercourse extremely long.

The goal is sufficient control for comfortable and mutually satisfactory sexual activity.

Treatment of Vaginismus

Vaginismus is often highly treatable, but treatment should be **gradual and patient-controlled**.

Common evidence-based components include:

pelvic-floor physical therapy, psychosexual or talk therapy and graded vaginal dilator therapy.

Cleveland Clinic lists all three as central treatment options, while the NHS additionally describes relaxation, pelvic-floor exercises, sensate focus and gradual vaginal-trainer use.

The aim is not to force the vaginal opening wider.

The aim is to teach the nervous system and pelvic-floor muscles that penetration can occur safely and comfortably.

Pelvic-Floor Physiotherapy

Pelvic-floor therapy can teach a patient how to identify, contract and—most importantly in vaginismus—**relax the pelvic-floor muscles**.

Some patients mistakenly perform repeated strong Kegel contractions even though their pelvic floor is already excessively tight.

A pelvic-floor therapist can determine what the muscles actually need.

ACOG recognizes pelvic-floor physical therapy, biofeedback, soft-tissue techniques and home vaginal dilation among approaches used when vulvar pain and vaginismus coexist.

Vaginal Dilator Therapy

Dilators come in progressively larger sizes.

Treatment normally begins with a small size that the patient can control comfortably.

Progress occurs only when the previous stage no longer produces excessive fear or pain.

There should be no aggressive forcing.

Recent clinical guidance continues to use dilators for vaginismus, pelvic-floor dysfunction and other conditions producing difficult or painful penetration.

The husband may eventually become involved in the therapeutic process if the patient wishes, but control should remain with the woman.

Lubrication and Treatment of Pain

If inadequate lubrication is contributing, an appropriate lubricant can reduce friction.

If infection, vulvodynia, dermatological disease, endometriosis or another pain disorder is present, that disease requires its own treatment.

The phrase:

“It is just vaginismus”

should never be used until other clinically relevant causes of pain have been considered.

When Surgery Is Necessary

Most unconsummated marriages do not require surgery.

But selected anatomical abnormalities may.

The 2024 systematic review reported interventions ranging from penile plication to female genital reconstructive procedures in properly selected structural cases.

Surgery should therefore be reserved for a real anatomical indication—not performed simply because penetration has not yet happened.

What Does the Unani System Say About This Problem?

Classical Unani medicine does not have a single standardized modern diagnosis that maps perfectly onto the entire concept of “unconsummated marriage.”

This is an important academic point.

An unconsummated marriage may be caused by a male erection problem, female pain disorder, psychological difficulty, an anatomical condition or both partners' factors.

It would therefore be inaccurate to assign every case to one traditional Unani diagnosis.

However, **several Unani concepts are highly relevant to particular components of the problem**.

Zu‘f-i-Bah and Male Sexual Debility

CCRUM's Standard Unani Treatment Guidelines describe **Zu‘f-i-Bah** as reduced sexual desire and reduced ability to perform sexual activity.

Traditional contributing factors include:

Istirkha-i-Qazib, or penile flaccidity, and **Umur Wahmiyya**, referring to psychological factors, together with broader concepts of physical and reproductive weakness.

This is clinically interesting because modern medicine also recognizes that both **physical erectile function and psychological anxiety** can prevent intercourse.

CCRUM's traditional treatment principles for Zu‘f-i-Bah also include **Izala-i-Awariz Nafsani—addressing psychological factors**.

Therefore, classical Unani medicine should not be reduced to the stereotype that every sexual problem is treated only with an aphrodisiac.

Psychological health is part of its traditional framework.

Mizaj: Individualized Treatment

A major strength of Unani medicine is its emphasis on **Mizaj**, or the individual's temperament and constitution.

In practical terms, this encourages me not to treat every patient identically.

Consider three newly married men.

The first has normal spontaneous erections but severe performance anxiety.

The second has diabetes-related vascular ED.

The third has genuine testosterone deficiency.

All three may say:

“Doctor, intercourse is not happening.”

But their treatment should be different.

Likewise, three women unable to tolerate penetration may have vaginismus, an infection or a structural vaginal condition.

One medicine cannot logically treat all three.

Asbab Sitta Daruriyya and Sexual Health

Unani medicine gives considerable importance to the **six essential factors—Asbab Sitta Daruriyya**—including diet and drink, bodily activity and rest, psychological activity and repose, sleep and wakefulness, environmental factors, and elimination and retention. CCRUM describes these as fundamental to maintaining health.

In the context of sexual health, this whole-person approach may involve:

healthy sleep, appropriate exercise, suitable nutrition, management of anxiety, correction of unhealthy habits and improvement of general physical health.

These measures cannot mechanically correct every cause of non-consummation, but they can be valuable components of comprehensive treatment.

Four Broad Modes of Unani Treatment

CCRUM officially describes four broad treatment modes in the Unani system:

Ilaj-bil-Tadbir — regimental therapy
Ilaj-bil-Ghiza — dietotherapy
Ilaj-bil-Dawa — pharmacotherapy
Ilaj-bil-Yad — surgery.

This framework is particularly relevant here because the inability to consummate marriage is not solved by medication alone.

One couple may need counselling.

Another may need lifestyle and anxiety management.

Another may need pharmacotherapy.

Another may need gynecological or urological surgery.

A genuinely holistic system should recognize all these possibilities.

Ilaj-bil-Ghiza: Dietotherapy

Diet should support general health rather than promise an instant increase in sexual performance.

A man with uncontrolled diabetes and ED needs a diet that improves metabolic health.

A patient with obesity requires weight management.

A nutritionally depleted patient may require improved protein, micronutrients and calorie intake.

The diet must suit the person.

I do not recommend indiscriminately consuming large amounts of honey, sweets or rich "sexual tonics," particularly in diabetic or overweight patients.

Sexual health depends on long-term general health.

Ilaj-bil-Tadbir: Lifestyle and Psychological Regulation

Unani regimental principles can complement modern psychosexual care through appropriate physical activity, sleep regulation, stress reduction and lifestyle modification.

For performance anxiety, reducing psychological pressure is particularly important.

For couples repeatedly attempting intercourse under intense fear, sometimes the first therapeutic step is actually to **stop forcing penetration temporarily** and rebuild comfort.

This allows treatment to proceed without repeatedly reinforcing the failure cycle.

Ilaj-bil-Dawa: Physician-Selected Unani Medicines

Traditional pharmacotherapy may have a supportive role when selected according to the actual patient's condition.

For example, a patient with general debility and sexual weakness may require a different traditional prescription from one whose principal problem is severe situational anxiety.

However, I do not describe any single Unani formulation as a scientifically proven universal cure for **unconsummated marriage or vaginismus**.

The available published evidence on unconsummated marriage predominantly supports diagnosis-specific multidisciplinary treatment. High-quality randomized trials proving that one finished Unani formulation reliably resolves all causes of non-consummation are currently lacking.

I believe acknowledging this evidence gap strengthens responsible Unani medicine.

Where Unani Medicine Is Especially Useful

In my clinical view, Unani medicine can make a particularly useful contribution when treatment needs to address:

general physical vitality, disturbed sleep, chronic stress, unhealthy diet, metabolic disease, psychological sexual weakness and the patient's overall constitutional state.

It also provides a framework for individualized rather than one-size-fits-all care.

But its role should complement the appropriate treatment of the actual disorder.

Vaginismus may require pelvic-floor rehabilitation.
Severe ED may require guideline-supported ED treatment.
Infection requires appropriate antimicrobial treatment when confirmed.
An anatomical obstruction may require surgery.
Trauma or major anxiety may require psychosexual or mental-health care.

A genuinely integrative approach uses each system where it is strongest.

No Responsible Treatment Should Be Forced

This requires special emphasis in a marriage-related condition.

If a woman is crying in pain, the solution is not to insist on repeated intercourse.

If a man has erection failure, humiliating him will not improve his erection.

If either partner is emotionally unready, coercion is not treatment.

WHO's sexual-health framework specifically emphasizes sexual relationships free from coercion, discrimination and violence.

Good treatment should restore:

choice, comfort, confidence and mutual intimacy.

What I Tell Newly Married Couples

There is no examination you have to pass on the wedding night.

There is no fixed amount of time intercourse must last.

The woman does not have to bleed.

The man does not have to perform perfectly on his first attempt.

One unsuccessful attempt does not mean impotence.

Pain should not simply be tolerated.

And repeated difficulty does not mean that the marriage is doomed.

Many causes are treatable once they are correctly identified.

Fertility Planning in Unconsummated Marriage

Some couples do not seek treatment until family members begin asking why pregnancy has not occurred.

When vaginal intercourse has never happened, conception cannot be used as proof that the husband or wife has a fertility disease.

The first question is:

Has semen actually been deposited in the vagina during the fertile period?

If not, infertility testing may be premature unless other reproductive risk factors exist.

When pregnancy becomes time-sensitive—for example, because of increasing female age or known fertility factors—the couple may require simultaneous sexual and fertility management.

The 2026 South Asian review reports the use of intravaginal insemination in selected couples when penetrative intercourse remained impossible.

However, this should be viewed as a reproductive option, not a treatment for the relationship's underlying sexual difficulty.

Prognosis: Can Unconsummated Marriage Be Treated?

In many cases, yes.

The 2024 systematic review reported consummation rates ranging from approximately 66.6% to 100% across different interventions and studies, including sex education, psychosexual therapy, ED medication, dilators and surgery. But the authors clearly noted that most of the underlying studies were low-quality case reports or case series.

Therefore, these figures should **not** be used to tell an individual couple:

“Your treatment has a 90% or 100% guarantee.”

Prognosis depends on:

the underlying diagnosis, duration of the problem, severity, willingness of both partners to participate, presence of physical disease and access to appropriate multidisciplinary care.

Vaginismus is generally considered treatable, with pelvic-floor therapy, psychological treatment and graded dilation forming common evidence-based approaches.

Psychogenic ED can also respond well when medical therapy is combined with appropriate counselling.

Earlier help is generally preferable to years of repeated unsuccessful attempts and growing fear.

My Special Approach at Saira Health Care

When I treat a couple facing non-consummation, I prefer a **seven-part approach**.

First, I remove blame. Neither husband nor wife should be labelled as inadequate before a diagnosis is made.

Second, I identify the exact obstacle. Is it erection loss, ejaculation, vaginal muscle tightening, pain, low desire, sexual fear, anatomical disease or a combination?

Third, I evaluate relevant medical factors. Diabetes, cardiovascular health, hormones, genital conditions, medicines and reproductive health are investigated where necessary.

Fourth, I assess the Unani constitutional picture. Mizaj, sleep, diet, physical vitality, psychological state and lifestyle are considered.

Fifth, treatment is individualized. This may include counselling, lifestyle modification, physician-selected Unani treatment, modern ED treatment, pelvic-floor therapy, dilator therapy or referral for gynecological/urological care.

Sixth, I protect fertility when pregnancy is a goal. Sexual dysfunction and infertility are assessed separately rather than confused.

Seventh, I follow the couple over time. Successful treatment should mean not only penetration, but improved confidence, comfort, communication and sexual well-being.

This philosophy is consistent with Saira Health Care's published treatment model, which emphasizes diagnosis, reversible-factor management, counselling, lifestyle care, evidence-supported treatment and supervised Unani medicine according to the individual patient.

When I Refer to Other Specialists

An integrative physician should know when another specialist is needed.

For example:

A woman with significant vaginismus may benefit greatly from a **pelvic-floor physiotherapist and psychosexual therapist**.

Persistent vaginal pain may require a **gynecologist**.

Severe structural ED or penile disease may require a **urologist/andrologist**.

Major depression, trauma or psychiatric illness may require a **mental-health professional**.

Anatomical obstruction may require a surgeon.

A couple facing both non-consummation and age-related infertility may require a **reproductive-medicine specialist**.

Referral is not failure.

It is good medicine.

About Me: Dr. Nizamuddin Qasmi

I am **Dr. Nizamuddin Qasmi**, Founder and Chief Physician of **Saira Health Care**, with a focused clinical practice in **sexual disorders and infertility**.

My professional education and training include:

BUMS – Hamdard University, Delhi
MD
CGO
Certificate in Infertility – MGBIMS, Delhi
Certificate in Urology – London, UK

Masters in Male Infertility – MasterHealthPro (HealthPro)
Integrated Sexual and Reproductive Health – ISRH, UNFPA

Saira Health Care's current public professional material identifies me as Founder and Chief Physician and lists my focused work in sexual disorders and infertility, including qualifications such as BUMS, MD, CGO, Certificate in Infertility and Certificate in Urology – London, UK.

MasterHealthPro currently lists a six-month **Male Infertility Masters** programme covering advanced male infertility and sexual-dysfunction education, including reproductive evaluation and related clinical topics.

This combined background is particularly relevant to unconsummated marriage because the problem can involve **sexual function, reproductive health, psychological factors and fertility at the same time**.

Contribution of Saira Health Care to Sexual Disorders and Infertility

Saira Health Care is a registered Unani clinic with a particular focus on **sexual disorders and infertility**. Its published services include male sexual-health disorders, female sexual-health conditions such as dyspareunia and vaginismus, and male and female infertility conditions.

One of the most important contributions a sexual-health clinic can make is to reduce misinformation.

Couples often reach us after believing myths such as:

“If intercourse does not happen on the first night, the marriage is abnormal.”

“If the woman does not bleed, she was not a virgin.”

“If the husband loses an erection once, he is impotent.”

“If penetration hurts, the wife simply needs to tolerate it.”

“Every problem can be fixed with a sexual-strength medicine.”

These ideas can create enormous harm.

My goal is for Saira Health Care to contribute not only treatment but also **accurate sexual-health education, respectful communication and diagnosis-based care**.

The clinic publicly describes its approach as combining traditional Unani treatment with individualized planning, nutritional guidance, lifestyle modification and contemporary diagnostic understanding.

Frequently Asked Questions

Is unconsummated marriage a disease?

No. It is better understood as a marital or clinical situation resulting from one or more underlying sexual, medical, psychological or anatomical factors. A 2026 South Asian review specifically recommends this conceptual distinction.

What are the most common causes?

Published evidence most often identifies **vaginismus/genito-pelvic pain and erectile dysfunction**, with performance anxiety, premature ejaculation and other psychological or physical factors also contributing.

Can anxiety alone prevent intercourse?

Yes. Severe performance anxiety can interfere with erection, and fear of pain can trigger involuntary pelvic-floor tightening.

Does one failed wedding-night attempt mean erectile dysfunction?

No. Fatigue, anxiety, unfamiliarity and intense expectations can temporarily affect erection.

Does a woman have to bleed the first time?

No. The hymen does not reliably indicate previous intercourse, and first intercourse does not always cause bleeding.

Can vaginismus be treated?

Yes. Common treatment approaches include pelvic-floor physical therapy, psychosexual therapy and graded vaginal dilators.

Can sildenafil or tadalafil help?

They may help when erectile dysfunction is an important cause. PDE5 inhibitors are guideline-supported first-line ED medicines, but they must be used appropriately and cannot be combined with nitrate medicines.

Can Unani medicine help?

Unani medicine can be particularly useful as an **individualized supportive system** addressing Mizaj, lifestyle, diet, psychological factors and associated sexual debility. Where a specific structural, pelvic-floor, hormonal or vascular disorder exists, appropriate specialist treatment should be integrated rather than delayed.

Can one Unani medicine cure every case?

No. The causes are too different for one medicine to be appropriate for every couple.

Can a couple conceive without normal intercourse?

Selected reproductive approaches can sometimes help when penetration remains impossible, but the couple should receive fertility guidance and the underlying sexual problem should still be addressed when desired.

Should both partners attend consultation?

Often, yes. The best results usually come from considering the couple together while also giving each partner privacy to discuss sensitive issues individually.

When Should a Couple Seek Professional Help?

There is no fixed number of days after marriage that defines a medical disorder.

However, I recommend seeking professional advice when repeated attempts remain unsuccessful, one partner experiences significant pain or fear, erection repeatedly fails, ejaculation repeatedly occurs before penetration, the difficulty causes significant emotional distress or the couple begins avoiding intimacy completely.

You do **not** have to wait for months or years simply because you feel embarrassed.

Early reassurance can sometimes prevent a temporary problem from becoming a deeply established anxiety cycle.

Conclusion

The inability to consummate marriage can be extremely distressing, but it should not be treated as a source of shame.

Modern research shows that **erectile dysfunction and vaginismus/genito-pelvic pain are among the most commonly reported causes**, while performance anxiety, premature ejaculation, inadequate sexual knowledge, relationship factors and anatomical conditions can also contribute. In a substantial minority of couples, both partners have relevant factors.

Recent South Asian evidence also demonstrates the importance of cultural pressure, inadequate sexual education, fear and delayed help-seeking.

Treatment must therefore be **cause-specific and multidisciplinary**.

A man with performance-related ED may require sexual education, counselling and temporary ED treatment.

A woman with vaginismus may need pelvic-floor rehabilitation, psychosexual therapy and graded dilation.

Pain requires diagnosis of the underlying gynecological condition.

An anatomical problem may require a procedure.

Couples facing infertility may need simultaneous reproductive assessment.

The **Unani system of medicine** contributes an important individualized and holistic perspective. CCRUM's traditional concept of Zu'f-i-Bah recognizes sexual debility, penile flaccidity and psychological factors, while Unani principles emphasize Mizaj, diet, lifestyle and psychological well-being.

At **Saira Health Care**, my approach as Dr. Nizamuddin Qasmi is therefore not to treat every unconsummated marriage with a single "sexual power" medicine.

I first identify whether the problem is:

male, female, psychological, anatomical, hormonal, relationship-related—or a combination of these.

I then combine appropriate modern diagnostic understanding with individualized Unani assessment and treatment, while involving gynecology, urology, pelvic-floor therapy, psychological care or reproductive medicine whenever required.

The message I want every couple facing this problem to remember is:

Marriage is not a sexual performance test. Do not force intercourse, do not blame one another and do not allow embarrassment to delay treatment. In most cases, once the real cause is correctly identified, there are practical treatment options that can help couples move toward comfortable, consensual and satisfying intimacy.

Medical Disclaimer

This article is intended for **general medical education and sexual- and reproductive-health awareness**. It should not replace individualized consultation, examination or diagnosis.

The inability to consummate marriage can result from erectile dysfunction, vaginismus or genito-pelvic pain, premature ejaculation, medical disease, psychological conditions, relationship factors or anatomical abnormalities. Treatment should therefore be individualized.

Painful or unwanted penetration should never be forced. Sexual activity should always be consensual.

Do not start sildenafil, tadalafil, hormones, sedatives, Unani medicines or other sexual-health treatments solely on the basis of an internet description. Prescription ED medicines may be dangerous when combined with nitrate therapy.

Traditional and herbal medicines contain biologically active substances and cannot responsibly be described as universally free from potential adverse effects or interactions.

No conventional medicine, Unani formulation, counselling method, dilator programme or procedure can guarantee successful consummation, pregnancy or identical results in every couple.