Research Article

ISSN 3071-2904

International Journal of Mental Health Research

Virginity, Marriage, and Mental Health in Africa: Psychopathological Analysis of a Case Report

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Received: 13 Aug 2026; **Accepted:** 14 Sep 2026; **Published:** 25 Sep 2026

Citation: Hugo Hermann Bohongwe Divahe, Mane Diop, Layal Ridhoine, et al. Virginity, Marriage, and Mental Health in Africa: Psychopathological Analysis of a Case Report. Int J Ment Health Res. 2026; 1(3): 1-4.

ABSTRACT

Introduction: *In Africa, female virginity remains a strict tool of social and familial control. While sociology has documented this norm, its psychiatric repercussions remain poorly explored. This study analyzes how marital and virginity pressures can trigger severe psychiatric disorders.*

Methods: *Clinical case of a 29-year-old female student hospitalized in Dakar. Diagnosis was established using ICD-11 criteria. Data were gathered through clinical evaluations and interviews following patient stabilization, with informed consent.*

Results:

- *Vulnerabilities: Childhood excision (age 4) causing psychosexual trauma; transculturation from rural life to Dakar managed via denial of hymen loss.*
- *Triggers: Arranged marriage at age 25. Absence of wedding night blood caused an honor conflict and family rejection.*
- *Clinic & Outcome: Severe depression with psychotic features (damnation ideas, hallucinations, delusions). Paroxetine induced a manic switch, revising diagnosis to Bipolar I Disorder, stabilized with sodium valproate.*

Discussion: *Cultural rupture created an identity fissure. Defloration without social proof triggered "nuptial psychosis". The manic episode acted as a defense mechanism (omnipotence) against narcissistic collapse and "fallen woman" stigma.*

Conclusion: *Virginity requirements and marital pressure remain major sources of severe psychological suffering. Psychiatric care in Africa must combine pharmacotherapy with ethnopsychiatric listening to cultural distress.*

Keywords

Virginity, Marriage, Bipolar I disorder, Nuptial psychosis, Transculturation.

Introduction

In Africa, the sacralization of female virginity remains deeply rooted despite slow sociocultural transformations [1]. It persists as a major tool of familial, religious, and social control over women's sexuality starting from puberty [1]. However, for educated, urban

young women, this norm is increasingly experienced as a social constraint rather than a personal conviction [1]. In response, circumvention strategies are emerging, although they carry risks of stigmatization [1]. In certain regions, the fear of family dishonor and the preservation of virginity still drive early marriages, with deviance being synonymous with sin and shame for the lineage [2].

While sociology has documented this phenomenon extensively, medicine has paid little attention to its psychiatric repercussions [3]. Marriage, through its psychological, familial, and religious implications, constitutes a major life event [3]. For the young virgin woman, it can prove to be a factor of stress of paramount importance, capable of reactivating repressed intrapsychic conflicts [4]. Very few studies highlight the direct link between chastity requirements and the mental health of female patients at the time of marital union [3,4]. It is within this framework that we report the clinical case of a patient managed in our psychiatry department for a psychic disorder whose psychopathological mechanisms are directly associated with the pressures of virginity and marriage.

Methodology

This is a clinical case study regarding a patient hospitalized in psychiatry. The diagnosis of Bipolar I Disorder (manic episode with psychotic symptoms) was established according to the criteria of the WHO International Classification of Diseases, 11th Revision (ICD-11).

Data were collected during clinical evaluation and individual interviews following the patient's stabilization. The analysis of her discourse made it possible to identify the themes of her delusion and to highlight the psychological conflict linked to marriage and the loss of virginity. The patient's consent was obtained for the use of her data for scientific purposes.

Case Report

Mrs. K. S., 29 years old, a First-Year Master's student in Telecommunications in Dakar, comes from the Fulani community and is of Muslim faith. Divorced and childless, she was brought to the psychiatric emergency unit by her mother due to major behavioral disturbances. Her clinical picture combined complete lack of self-care (incuria), social withdrawal, physical and verbal aggressiveness toward her family, as well as a marked deterioration in general condition with dehydration.

The patient's life history is marked by early trauma and major cultural shock. Originally from a rural background located 600 kilometers from the city of Dakar, she underwent female genital mutilation (excision) at the age of 4. This event, which she describes as a foundational traumatic violation, permanently altered her psychosexual development and her capacity for arousal (*« that's why it's a bit difficult for me to get sexually aroused »*). At age 18, her move to Dakar for university studies caused a true transculturation. Confronted with a modern urban environment, she engaged in multiple flirts (*« we would flirt and they would put their fingers in my private parts... it hurt and I would stop »*), while maintaining avoidance strategies against penile penetration *(« often incomplete, I preferred to contract myself to discourage my partner »*) to preserve her hymen. She notably relied on denial and the magical belief that the hymen regenerates after a few months of abstinence.

Marriage to a paternal cousin at age 25 constituted the main stressor and trigger for psychic decompensation. The wedding night was experienced as a painful and forced experience (*« I was afraid of being in pain... he forced me and I didn't like it »*). The absence of bleeding on the white bedsheet (*« there was no blood on the sheet, and he was indifferent »*) immediately triggered an honor conflict between the two families, with her in-laws accusing her of having lost her virginity. The marriage then became highly conflictual, marked by restrictions imposed by her spouse and the permanent mourning of her violated purity. This event reactivated her repressed intrapsychic conflicts.

In her background, Mrs. K. S. had previously presented a first psychotic disorder in 2020 during threats of disclosure of her sexual past, and a second one in 2022 at the time of her marital breakdown. For the current episode, the initial psychiatric examination highlighted severe mood collapse. It associated ideas of guilt (*« I am alone, I feel guilty.") and damnation ("it's over, they ruined my life, nobody can do anything about it, I am condemned »*), suicidal ideation, as well as visual hallucinations (*« at night, I see strange things in my room that frighten me »*), auditory-verbal hallucinations *(« The demons tell me that I am bad, I am a vampire, they ask me to insult my brother D. »*), alongside persecutory and bewitchment delusions (*« My husband cast a spell on me to hurt me »*).

On the diagnostic and therapeutic level, management followed the evolution of the illness according to ICD-11 criteria. A severe depressive episode with psychotic symptoms was initially diagnosed, prompting the initiation of paroxetine, alprazolam, and haloperidol. At the fourth week of hospitalization, the antidepressant induced a manic switch marked by euphoria, megalomania, and tachypsychia. The diagnosis was then revised to Bipolar I Disorder, current episode manic with psychotic symptoms. Discontinuation of paroxetine and initiation of sodium valproate (1000 mg/day) achieved stable euthymia at the eighth week, allowing her discharge from the hospital.

Discussion

On the epidemiological level, Mrs. K. S.'s clinical trajectory highlights the impact of internal migration and transculturation on the mental health of young women in Africa [1]. Although the patient remained within Senegal, her relocation from the village to Dakar (600 km) marks a abrupt rupture between a traditional rural environment and a "modern" urban space. It is not merely a geographical displacement, but a shock of modernity that disrupts her cultural Superego. In Dakar, she found herself confronted with urban normative reference points that appeared less constraining, allowing her to engage in multiple intimate relationships. However, this apparent freedom came into direct conflict with her

values of origin [1,2]. As Nakhle emphasizes, this confrontation between internal reality (village norms) and external reality (urban freedom) generates an identity fissure where the patient attempts to reconcile her desire for autonomy with the weight of familial debt [6].

This tension is directly observed in her relationship with sexuality, where the sequelae of female genital mutilation undergone at age 4 constitute a major early trauma. By permanently altering body image and sexual function, this genital mutilation manifested in adulthood as pain during penetration attempts and decreased libido. To preserve her hymen while exploring her sexuality in Dakar, the patient resorted to dissimulable practices (caresses, digital penetration) [4,6]. The intact hymen remains the symbolic guarantor of virginity and familial honor [2]. In Mrs. K. S., the use of denial ("the hymen regenerates after a few months of abstinence") functioned as an essential psychological defense mechanism to neutralize her guilt and maintain the illusion of compliance with parental superegoic laws [6].

The psychic functioning of women who have transgressed the virginity taboo generates "moral anxiety" linked to the fear of losing parental love [6]. Some seek to quickly finalize a marriage to legitimize defloration, a dynamic observed in the patient who agreed to marry her cousin after only two months of relationship [6]. However, in her sociocultural environment, the appearance of bloodstains on a white sheet on the wedding night is the sole social proof of purity [2]. The absence of this sign during her wedding night was experienced as a traumatic violation of her psychic envelope [7]. It immediately triggered a major honor conflict between the two families, exposing the patient to stigmatization and rejection [2,7].

This extreme emotional and cultural stress acted as the trigger for her psychiatric disorder, illustrating what Masmoudi et al. term "nuptial psychosis" [3]. Her first psychiatric episode at age 25 occurred during the nuptial period, in a climate of threats of secret disclosure by a former suitor [1,3]. Her second episode at age 27 occurred during the marital separation, under the weight of her husband's neglect and reproaches. Finally, her third episode (the current hospitalization) initially presented as severe depression with psychotic features, reflecting unfinished mourning for her virginity. The loss of this idealized love object led to hatred directed against her own drive life, explaining her ideas of guilt, damnation, and suicidal intent.

The prevalence of these psychotic symptoms aligns with epidemiological data from the Thiaroye National Psychiatric Hospital Center [8]. Ndiaye-Ndongo et al. report that 14% of patients there present hallucinations and 15.94% present persecutory delusions [8]. Furthermore, M'boussou emphasizes that the theme of persecution is closely linked to Negro-African culture, while Ahyi notes its high frequency during severe depressive episodes [8]. Finally, the manic switch observed at week 4 under paroxetine confirms that Mrs. K. S. suffered from underlying Bipolar I Disorder (ICD-11) [3]. In this metapsychological perspective, the manic episode functioned as an ultimate defense mechanism: omnipotence and mood exaltation served to mask the distress of object loss and deny the narcissistic collapse linked to her status as a fallen woman [3].

Conclusion

Even as African societies modernize, traditions continue to strongly influence mental health. The requirement of virginity and the pressure of marriage remain pillars of female identity, but they can also become major sources of psychological suffering.

The case of Mrs. K. S. demonstrates how the fear of dishonor and past traumas can trigger severe bipolar disorder. This work proves that in psychiatry, taking into account the patient's culture is essential. To better care for these women and prevent relapses, psychiatrists and psychologists must combine medical and psychological treatments with an attentive listening to their cultural and familial distress.

List of abbreviations

- **ICD-11:** International Classification of Diseases, 11th Revision
- **WHO:** World Health Organization

Declarations

Ethics approval and consent to participate

The study was conducted in accordance with the Declaration of Helsinki. Ethical approval was granted by the Institutional Review Board (IRB) of the Fann National University Hospital Center of Dakar. Written informed consent was obtained from the patient for participation in this study following clinical stabilization.

Consent for publication

Written informed consent was obtained from the patient for publication of this case report and any accompanying images.

Availability of data and materials

Data sharing is not applicable to this article as no datasets were generated or analyzed during the current study. All clinical data relevant to the case report are included within the published article.

Competing interests

The authors declare that they have no financial or personal relationship(s) that may have inappropriately influenced them in writing this article.

Authors' contributions

H.B. and M.D was the treating clinician and wrote the text and contributed to the literature search ; A.S. reviewed and finalised the manuscript; All authors have read and approved the manuscript.

Funding information

This research received no specific grant from any funding agency in the public, commercial, or not-for-profit sectors.

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