A CRITICAL ASSESSMENT OF THE EXPERIENCES AND PERCEPTIONS OF THE COUPLE IN AN UNCONSUMMATED MARRIAGE

by

TANYA MARIE ROBINSON

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PROMOTOR: PROF. SULINA GREEN

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Declaration

I, the undersigned, hereby declare that the work contained in this dissertation is my own work and has not previously, in its entirety or in part, been submitted at any university for a degree.

TANYA M ROBINSON

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SIGNATURE

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DATE

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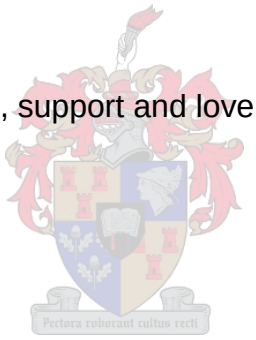

SUMMARY

It is generally accepted that the inability to consummate a marriage causes couples great distress, and can finally lead to divorce. Limited research has been done on the unconsummated marriage in South Africa. International studies have pointed out that the unconsummated marriage is a reality and a prevalent problem. While medical and therapeutic intervention is available, many people still suffer in silence and feel embarrassed about their condition.

The purpose of this study was to gain a better understanding of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage. In order to achieve this goal, the objectives of the study were to explore the experiences of the couple in an unconsummated marriage in order to obtain the couple's perception of their marriage; to present a literature overview on the subject of marriage within the context of the family life cycle; to describe the nature and causes of an unconsummated marriage; to critically describe approaches and models that may be used for the assessment of an unconsummated marriage; and to reflect on the implications of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage within a postmodern systemic framework.

The purpose of the literature study was to provide a context for the research study. The researcher conducted an extensive literature review in order to establish and refine the research subject and to guide the empirical study. An exploratory study was executed and the purposive non-probability sampling method utilised. The sample for this study was obtained from Intercare Medical Centre, Johannesburg and The Square Medical Centre, Umhlanga between April 2004 and November 2004. Ten couples that have not consummated their marriage were included in the sample. An interview schedule with open-ended questions was used to conduct joint interviews with the couples.

The empirical study enabled the researcher to draw certain conclusions. The main conclusion was that males and females in an unconsummated marriage experience and perceive control-related problems; negative feelings towards

their own and their partner's body; a fear of engaging in an intimate relationship and other phobias; a feeling of sin and moral dilemma; feelings of guilt and shame; the manifestation of depression and apathetic attitudes; personal distress and psychological problems; a feeling of serious regret and sadness; self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes; and lastly, a lack of information on how to be sexually intimate with a partner.

A number of recommendations flowed from the findings. The main recommendation was that healthcare professionals such as social workers should be better educated about the phenomenon of the unconsummated marriage in order to make a correct diagnosis and deliver high quality medical and therapeutic intervention.

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OPSOMMING

Dit word algemeen aanvaar dat ‘n egpaar wat in ‘n sekslose huwelik verkeer, baie stres ervaar en dat dit uiteindelik tot ‘n egskeiding kan lei. Weinig navorsing oor die sekslose huwelik is tot dusver in Suid-Afrika gedoen. Internasionale studies dui daarop dat sekslose huwelike ‘n realiteit en taamlik algemene probleem is. Hoewel mediese en terapeutiese intervensie wel beskikbaar is, ly mense in stilte en voel hulle skaam en ongemaklik oor hul kondisie.

Die doel van die studie is om ‘n beter begrip te vestig vir die emosionele en psigo-sosiale ervarings en persepsies van die egpaar in ‘n sekslose huwelik. Om dié doel te bereik, is die doelwitte van die studie om die ervarings van die egpaar in ‘n sekslose huwelik te verken ten einde die egpaar se persepsie ten opsigte van die huwelik te bepaal; om ‘n literatuuroorsig te verskaf van die huwelik in die konteks van die gesin se lewensiklus; om die aard en oorsake van ‘n sekslose huwelik krities te bespreek; om benaderings en modelle wat gebruik kan word vir assessering van ‘n sekslose huwelik krities te bespreek; en om vanuit ‘n postmodernisties-sistemiese raamwerk te besin oor die implikasies van die emosionele en psigo-sosiale ervarings en persepsies van die egpaar in ‘n sekslose huwelik.

Die doel van die literatuurstudie was om ‘n konteks vir die navorsingstudie te skep. Die navorser het ‘n uitgebreide literatuuroorsig gedoen ten einde die navorsingsonderwerp te vestig en verfyn en om as basis vir die empiriese ondersoek te dien. ‘n Verkennende studie is gebruik saam met ‘n nie-waarskynlike doelbewuste steekproef. Die steekproef vir die studie is verkry by Intercare Mediese Sentrum, Johannesburg en die Square Mediese Sentrum, Umhlanga tussen April 2004 en November 2004. Tien egpare wat in ‘n sekslose huwelik leef, is by die steekproef ingesluit. ‘n Onderhoudskedule met oop vrae is gebruik om gesamentlike sessies met die egpare te hou.

Op grond van die empiriese studie is tot sekere gevolgtrekkings gekom. Die belangrikste gevolgtrekking was dat beide mans en vrouens in ‘n sekslose huwelik beheer verwante probleme ervaar; negatiewe gevoelens teenoor hul eie

en hul eggenoot se liggame koester; vrees vir ‘n intieme verhouding en ander fobies ervaar; ’n gevoel van sonde en morele dilemma het; die gevoel van skuld en skaamheid ervaar; depressie en ’n apatiese houding manifesteer; persoonlike angs en sielkundige probleme ervaar; ernstige skuldgevoelens het en hartseer voel; gebuk gaan onder self-blaam, self-destruktiewe gedrag, mutilasie, selfmoordgedagtes en -episodes; en laastens voel hulle het ’n gebrek aan inligting oor hoe om seksueel intiem te verkeer met hul eggenoot.

Aanbevelings is na aanleiding van die gevolgtrekkings gemaak. Die belangrikste aanbeveling is dat professionele mense in gesondheidsorg, soos maatskaplike werkers, beter onderrig moet word ten opsigte van die sekslose huwelik ten einde ‘n korrekte diagnose te kan maak en hoë-kwaliteit mediese en terapeutiese intervensie te kan lewer.

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CHAPTER 1

INTRODUCTION

1.1 MOTIVATION FOR STUDY

The motivation for the study is done from a theoretical and a practice perspective.

1.1.1 Theoretical perspective

The inability to consummate a marriage causes couples great distress, and can finally lead to divorce. In order to select relevant intervention strategies for these couples, it is of critical importance to assess the couple's emotional and psycho-social experiences and perceptions of their unconsummated marriage. According to Laumann (1999:357), 31% of men and 43% of women in the United States of America suffer from sexual dysfunction. Rosenbaum (2003:1) states that women's magazines, popular internet sites and television programmes today openly discuss sexuality, sexual health and sexual problems. Topics range from erectile dysfunction to persistent arousal, but the unconsummated marriage is rarely mentioned.

While documented statistics on the prevalence of unconsummated marriages in the United States of America is unavailable, it has been estimated that up to one per cent of all couples treated at infertility clinics have not consummated their marriage (Rosenbaum, 2003:1). Jeng (2003:1) noted that 212 sexual partners in unconsummated marriages visited his practice in Taiwan from 1991 to 2000. According to him couples who cannot consummate their intimate relationship are among the most stressed clients seen in clinical practice, and the most grateful when successfully helped. They are frequently embarrassed about what they consider a shameful inadequacy and tend to be secretive about their problem. Couples subjectively construct their own views of reality on why they cannot consummate their marriage, and irrationally blame themselves for their difficulty (Jeng, 2003; Renshaw, 2003).

McIntosh (2003), a clinical sexologist in South Africa, reported that in the week following a television segment on the matter of unconsummated marriage, she received no less than 200 e-mails and phone calls from couples anxiously seeking treatment. During treatment McIntosh (2003) found that couples spoke about their unconsummated marriage with great difficulty, and that they would leave it unaddressed for a long period of time because of shame and embarrassment. Furthermore McIntosh (2003) found that couples in an unconsummated marriage are often confused about the cause of the condition.

The causes of the unconsummated marriage are argued in numerous research studies (Laing, 1995; Goodwin & Agronin, 1997; Berman & Berman, 2001; Graig, 2003; Jeng, 2003; Katz & Tabisel, 2003; Elhers, 2004). These studies indicate that there are various bio-psycho-social causes for an unconsummated marriage. According to Elhers (2004), unconsummated marriages often go hand in hand with environmental beliefs (such as that you will fall pregnant when you have sex), traditions (sex before marriage is a taboo), violations (having been sexually molested or raped) and conditioning (parents informing children that sex can only take place in a loving marital relationship). In an attempt to address the unconsummated marriage from a postmodern perspective, DeShazer (1991) and White (1995) (in Goldenberg & Goldenberg, 1998:89), maintain that healthcare professionals should not focus on the bio-psycho-social cause of the problem only, but should turn their attention to the paradigm shift that couples need to undergo in order to obtain optimum sexual health. The clients should be encouraged to change their behaviour and move into a new paradigm (Braunert, 2004:2).

Arguing from a systemic perspective, Goldenberg and Goldenberg (1998:28) explain that the spousal (husband-wife) unit is at the epicentre of the family system. This system is central to the functioning of the family in its early years and continues to play a major role during the lifespan of the family. Any malfunction in the spousal relationship as a system is bound to resound in other areas of the system's functioning. Couples in unconsummated marriages might be faced with the following problems: touch aversion, communication barriers, infidelity and distrust (McIntosh, 2003).

Elhers (2004), a medical doctor in Umhlanga, explains that treating unconsummated marriages in South Africa is difficult because of the lack of research in his country. It is therefore imperative that healthcare professionals obtain a better understanding of the experiences and perceptions of a couple in an unconsummated marriage. This could be accomplished through research. A better understanding of people's experiences and perceptions in an unconsummated marriage will ultimately lead to improved medical and therapeutic intervention strategies (Henk & Martin, 1996; Vollard, 1996; Seipel, 1998; Elhers, 2004).

1.1.2 Practice perspective

This researcher is a social worker in private practice at Intercare Medical Centre, Johannesburg and The Square Medical Centre, Umhlanga. The researcher practises with Dr. Leon Elhers, a medical practitioner at The Square Medical Centre, Umhlanga, focusing on sexual health. In addition, the researcher works with Mathew Grounds, a counselling psychologist in a couple's clinic at Intercare Medical Centre, working with marital and relationship problems. The researcher's individual casework involves sexual dysfunction intervention, individual therapy, play therapy with children, and statutory assessments.

The researcher has been involved with sexual health since 1999. In 1999, while doing her pre-graduate degree in social work she worked with Dr. Elna McIntosh at DISA-Clinic, a reproductive health centre in Hurlingham Manor, Sandton. The researcher obtained a master's degree in social work in 2003 on the research topic: A social work investigation on the socio-emotional influence of sexual problems on young women.

The researcher was involved in a small practice at DISA-clinic where she consulted various patients who were struggling with sexual problems, and the practice kept growing. During this time the researcher became aware of the problems that couples in unconsummated marriages face. She then compiled a book for her patients which focused on various sexual problems. The book was titled "When Sex Turns Sour" and was based on her master's research project. She printed numerous copies and distributed them to healthcare professionals to

inform them about sexual problems that women struggle with. After distributing the book, the practice expanded even more and the researcher moved her practice to Intercare Medical Centre. Professionals (general practitioners, gynaecologists, nurses, social workers and psychologists) in the area started to refer patients to the practice.

In November 2003 the researcher was approached by Dr. Leon Elhers, a medical practitioner, to share a practice with him in Umhlanga, KwaZulu-Natal, focusing on sexual problems and dysfunction. The practice received referrals from professionals in the area and also from the Southern Africa Sexual Health Association (SASHA) helpline in KwaZulu-Natal. The researcher has been a registered member of the Southern Africa Sexual Health Association for the past three years and received patient referrals from their helpline. The pharmaceutical company Pfizer sponsored the researcher to do talks on sexual health, and referrals came from these talks. The researcher presented a paper on unconsummated marriages at the First African Sexual Health Conference sponsored by SASHA at the Crowne Plaza, Sandton, on 26 February 2004, and received numerous referrals after this.

The following are healthcare professionals who refer patients to the practice:

- Yvette Stacey (SASHA Helpline - KwaZulu Natal and Johannesburg)
- Dr. Leon Elhers (Medical Practitioner - Umhlanga)
- Dr. Mike Robinson (Medical Practitioner - Umhlanga)
- Dr. Corne Coetzee (Gynaecologist – Umhlanga Rocks Medi-Clinic)
- Dr. Andrula Christodoulou (Medical Practitioner - Intercare)
- Dr. Karin Smit (Medical Practitioner - Intercare)
- Dr. Karen Watson (Gynaecologist - Bedfordgardens)
- Elmari Craigh (Social Worker/Sexologist – Pretoria)
- Glenda Baitman (Nurse- Hurlingham Manor)

1.2 PROBLEM STATEMENT

International studies (Berman & Berman, 2001; Jeng, 2003; Rosenbaum, 2003) indicate that the unconsummated marriage is a worldwide reality and a prevalent

problem. While some treatment is available, the problem is usually cloaked in silence, embarrassment and discomfort, even by many members of the health care professions. In Taiwan, where sexual education has been in place for decades, professionals consult numerous couples who have not consummated their marriage. Jeng (2003:1) states that in human sexual behaviour, the penetration of the penis into the vagina (penal-vaginal intercourse) and ejaculation in the vagina is normally the way to achieve the task of reproduction and express intimacy. This is one of the pleasures that a newly married couple look forward to most, that of being happy and having a mutually satisfying sexual relationship. Failure to achieve this satisfaction, and perhaps worse, being unable to have intercourse at all, can have a shattering effect on their marriage, resulting in marked stress, frustration, hostility, and even divorce. There are still conservative healthcare professionals such as social workers, who are familiar with the problem of an unconsummated marriage but who feel too uncomfortable to address this problem because they find it hard to openly talk about sex with their patients in medical and therapeutic intervention (Laing, 1995; Goodwin & Agronin, 1997; Berman & Berman, 2001; Jeng, 2003; Katz & Tabisel, 2003).

Renshaw (1989:50) adds that the unconsummated marriage is a real and difficult problem, yet is not even listed in the International Classification of Diseases. Acceptance of an unconsummated marriage by both parties is rare. The problem is that an unconsummated marriage often causes shame, frustration, and despair. People of all socio-economic groups and education levels are affected. Although problems caused by the failure to consummate a marriage are well documented (Renshaw, 1989; Jeng, 2003), it appears that still very little is known about the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage.

1.3 GOALS AND OBJECTIVES

The goal of this study is:

- To gain a better understanding of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage.

The objectives of the study are:

- To explore the experiences of the couple in an unconsummated marriage in order to obtain insights into the couple's perception of their marriage.
- To present a literature overview on unconsummated marriages within the context of the family life cycle.
- To describe the nature and causes of an unconsummated marriage.
- To critically describe approaches and models that may be used for the assessment of an unconsummated marriage.
- To reflect on the implications of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage within a postmodern systemic framework.

1.4 RESEARCH METHODOLOGY

In the next section the research methodology used in this study is discussed, with specific reference to the review of existing literature, the research design, population and sample, the data collection method, and lastly the presentation and analysis of data.

1.4.1 Literature control

The purpose of using existing literature is to provide a literature control for the findings of the research study. The researcher conducted an extensive literature control in order to verify the research findings. The literature control was primarily aimed at gaining a better understanding of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage. The intention was to learn from other researchers how they have theorised and conceptualised the research issues, what their empirical findings were and what research instruments they have used (Mouton, 2001:6). The researcher consulted books and journal articles on the following issues: Marriage within the context of the family life cycle - causes of the unconsummated marriage, selected approaches and models focusing on marriage and family functioning. Most of the literature control consisted of studies conducted in other countries. Through the literature control, insight was gained into the relevant concepts and theories investigated in previous studies,

and those that are in accordance with the aim and objectives of this study have been applied in this research.

The literature control was used to explain the themes of the empirical study. The literature (Leedy, 1993; Denzin & Lincoln, 2000; Mouton, 2001) makes it clear that after having done an empirical study, it is possible to identify certain propositions which will agree with reality if the theory is applicable. The process of inductive logic, then, consists of gathering data and making deductions from it, and testing those deductions against a literature control. Inductive studies test the findings derived from the study against literature. In this study ten themes were inductively extracted from the findings. A questionnaire was then used in interviews to explore the emotional and psycho-social experiences and perceptions of couples in an unconsummated marriage. Inductive logic was thus used, to identify the ten themes and a literature control then followed to verify the findings of the study.

1.4.2 Research design

According tot the literature (Leedy, 1993; Denzin & Lincoln, 2000; Mouton, 2001), a research design is a plan; the structure and strategy of the research. A research design attempts to answer the following basic questions: Who and what will be studied? What strategies of enquiry will be used? What methods or research tools will be used to collect and analyse empirical data? It provides the overall framework for collecting data and provides a format for the detailed steps in the study: What data is needed? Where is the data located? How will the data be collected? How will the data be analysed and interpreted? Creswell (1998:2) defines a research design as the entire process of research from conceptualising a problem to writing a narrative.

This is a qualitative study and the methods of data collection are guided by the phenomenological approach. In phenomenology the researcher, according to De Vos (2002:273), should be able to enter the “subject’s life world” or “life setting” and view phenomena from the participant’s vantage point. This is accomplished mainly through naturalistic methods of study, analysing the conversations that researchers have with participants. Long and in-depth interviews are also utilised

in phenomenological studies. Individuals who have experienced the particular phenomena are identified, data is systematically collected and meanings and themes are analysed (De Vos, 2002:273).

The design of this study is aimed at gathering information or data that would help provide clear answers to the following issues: What are the psycho-social emotional experiences and perceptions of the couple in an unconsummated marriage? Any scientific study in social work should have at least one of three primary objectives: to explore, to describe, or to explain (Arkava & Lane, 1983:11). Williams and Grinnell (1990:304) describe exploratory studies as studies whose purpose it is to gather data or facts in instances where little is known about the field of study. Where more is known about the research topic, a study can be expected to provide a higher level of knowledge. The appropriate research design would then also be descriptive. Mouton and Marais (1990) state that exploratory research may be conducted by means of a review of the related social science and other pertinent literature, and also by an investigation involving people who have practical experience of the problem to be studied.

This is an exploratory study to which a qualitative approach is applied. Babbie (1998:90) states that much of social research is conducted to explore a topic, or to provide a beginning familiarity with that topic. This approach is typical when a researcher examines a new interest or when the subject of study itself is relatively new (Royse, 1998:217; De Vos, 2002:339). Qualitative research depends on the presentation of solid descriptive data, so that the researcher leads the reader to an understanding of the meaning of the experience or phenomenon being studied. Delport and Fouche (2002:356) emphasise that, when working from a qualitative perspective, attempts are made to gain a first-hand, holistic understanding of phenomena. Data collection takes shape as the investigation proceeds. The qualitative approach is used in this study to present a holistic understanding of the experiences and perceptions of couples in an unconsummated marriage.

1.4.3 Population and sample

Population and sample are discussed here in order to identify the population of the study from which the sample was drawn, and to explain the sampling procedure that was applied.

A population can be defined as any group of subjects that are of research interest, or a large group of cases from which a researcher draws a sample (Goddard & Melville, 2001:34; Neuman, 2003:541). A sample is a smaller representation of a whole population. In research, the observation or study of a phenomenon in its entirety would be time-consuming and impossible to do. Theory has shown that researchers need to observe or interview only some of the people or phenomena involved in order to obtain a usable idea of the characteristics of the subjects or of the whole population (Arkava & Lane, 1983:157; Mouton & Marais, 1990:157; Mark, 1996:107; Reamer, 1998; De Vos, 2002:199; Strydom & Venter, 2002:199).

Non-probability sampling does not use random sampling, whereas probability sampling does use random sampling (Mark, 1996:402). In qualitative research the tendency is to use non-probability or non-random samples; the sample size is rarely determined in advance and limited knowledge usually exists about the population from which the sample is drawn. In qualitative research the focus is on how a small collection of cases, units or activities illuminates life. In qualitative studies, therefore, less emphasis is placed on representativeness (Fortune & Reid, 1999:471; Neuman, 2003:211). In order to ensure that the information collected is directly relevant to the problem under investigation, a purposive non-probability sampling method is used. Strydom and Delport (2002:336) state that in purposive sampling the researcher thinks critically about the criteria for inclusion in the sample and then chooses the sample case from the population accordingly (De Vos, 2002:208).

A purposive non-probability sampling strategy was used in this qualitative study. The criteria for including a couple were as follows:

a) The couple had to be in an unconsummated relationship.

b) The couple had to be married.

c) Therapeutic intervention should have started already. The research session was to be scheduled only after their second therapeutic session, since it was important that the researcher first established a relationship of trust between herself and the couple.

d) The couples were not excluded because of their religion, culture, educational background or age.

The sample for the study was obtained from patients referred to Intercare Medical Centre, Johannesburg and The Square Medical Centre, Umhlanga. All patients who had been diagnosed by healthcare professionals as having an unconsummated marriage, who fitted the criteria during the set period of time (April 2004 to November 2004), and who had been referred to the researcher, were asked to take part in the research study. The first three couples who were willing to take part in the study were used in the pilot study (at Intercare Medical Centre, Johannesburg). The next ten couples (at Intercare Medical Centre, Johannesburg and The Square Medical Centre, Umhlanga) who were willing to be part of the research study were the sample.

It was explained to the couples that the researcher was conducting research on the experiences and perceptions of couples in an unconsummated marriage. A research session was scheduled for after the willing couples' second therapeutic session. The researcher considered it important to conduct the research session only after the second session of the therapeutic intervention, since a relationship of trust had to be established prior to the research session. All of the couples approached agreed to take part in the research study. The researcher is of the opinion that the couples agreed to be involved in the research study for the following reasons:

a) They were directly referred to the researcher for therapeutic intervention by a healthcare professional, so they already had trust in the researcher's ability to help them overcome their problem.

b) They trusted the healthcare professionals who referred them.

c) They were desperate to find help and a healthcare professional who understood their problem.

d) A relationship based on trust between the couple and the researcher was established before the research session.

1.4.4 Data collection

Social work researchers and practitioners obtain data by interviewing people and asking questions, observing them, or using secondary materials such as case records and statistical data (Fortune & Reid, 1999:250; De Vos, 2002:303; Greef, 2002). In this study the instrument for collecting data was an interview schedule, which would be used in face-to-face interviews. Given the sensitive nature of the research topic it was important to collect the data in a therapeutic setting rather than through a quantitative, cold, statistical data method, and therefore interviews were used as the data collection method. According to De Vos (2002:303) interviews, also sometimes referred to as in-depth interviews, merely extend and formalise conversation. At the root of in-depth interviewing is an interest in understanding other people's experience and what they make of that experience. An in-depth interview is focused and discursive, and allows the researcher and participant to explore an issue at length. It is used to determine the individual's perceptions, opinions, facts and forecasts, and their reactions to initial findings and potential solutions (Collins, 1998:8).

De Vos (2002:340) states that the researcher should plan for the recording of data in a systematic and appropriate manner that will facilitate analysis. This is done before data collection commences. Data analysis in a qualitative inquiry could involve a two-pronged approach. The first would be to analyse data at the research site during data collection. The second would involve analysing data away from the site, following the period of data collection. In this study the data was collected by means of an interview schedule during a face-to-face and joint interview with each couple (see Appendix A). The interview schedule was structured and was based on the research question. Ten sub-questions emerged, which were explored during the interviews with couples in an unconsummated marriage.

The objective of the interview was to explore the emotional and psycho-social experiences and perceptions of the couple. The interview schedule contained

questions on the following ten themes: control-related problems; feelings about one's own and one's partner's body; fear of engaging in an intimate relationship and experiencing phobias; sin and moral dilemma; guilt and shame; manifestation of depression and apathetic attitudes; personal distress and diagnosis of psychological problems; regret and sadness; self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes; and lastly, the lack of information on how to be sexually intimate with a partner. The ten themes which would be covered during the interview were formulated as open questions in the interview schedule.

A pilot study was conducted in April 2004 with three couples that were already registered as the researcher's patients, and who were interviewed on a weekly basis at Intercare Medical Centre, Johannesburg regarding their unconsummated marriage. The researcher explained to the three couples that a research study was being planned on the emotional and psycho-social experiences and perceptions of couples in an unconsummated marriage, and enquired whether they would be willing to take part in the pilot study. It was explained that should they be willing to take part in the study, two separate research sessions of 60 minutes each would be allocated to focus on the research. It was made clear to the patients that these sessions would not form part of the therapeutic process, that they would remain anonymous, and that they would not be billed for the two sessions. In Table 1.1 the time frame of the data collection during the pilot study is presented.

Table 1.1: Time frame of the data collection during the pilot study

The pilot study with the three couples was conducted at Intercare Medical Centre, Johannesburg.

Pilot study	**Date of first pilot research session**
Couple 1	1 April 2004
Couple 2	5 April 2004
Couple 3	5 April 2004

Pilot study	**Date of second pilot research session**
Couple 1	8 April 2004
Couple 2	7 April 2004
Couple 3	8 April 2004

The researcher presented the interview schedule to the pilot study couples at the end of their second therapeutic session. A consent form was included, which they were requested to sign if they agreed to take part in the research. They were also requested to study the schedule before the first research session, scheduled for the following week.

During the research session that followed the researcher completed the interview schedule and also took written notes. During each interview both the female and the male participants were given an opportunity to respond to the questions, and the researcher wrote down their answers immediately after each response.

After completion of the interview schedule, the participants stated that the interviews were too structured and did not afford them sufficient opportunity to openly discuss their real feelings. The interview schedule was therefore adapted. The researcher decided to allow more time for open discussion during the second research session. The open discussion would follow on the discussion of each theme. Subsequently, the ten themes were discussed during the second research session and the researcher wrote down the participants' responses. In addition, written notes were made on the open discussion and these were added to the interview schedule (see Appendix A). It was found that the explanations given by the participants were a more in-depth, accurate reflection of what the couples experienced and perceived. Feedback received

from the participants indicated that they had now felt freer to voice their feelings about the way they experienced and perceived their situation. Further therapeutic sessions with the couples were scheduled for after the research sessions, and this formed part of their ten week intervention and treatment programme.

The ten couples comprising the research sample were approached (at Intercare Medical Centre, Johannesburg and The Square Medical Centre, Umhlanga) between May 2004 and November 2004. Because a purposive non-probability sample was selected the researcher decided to approach all couples who were referred to these practices — and who matched the set criteria for inclusion — until ten couples were found for the research session. The following table presents the time frame of the data collection.

Table 1.2: Time frame of the data collection during the research sessions

The research session with ten couples was conducted at Intercare Medical Centre, Johannesburg and The Square Medical Centre, Umhlanga.

The research session was scheduled after the second therapeutic session with three couples at The Square Medical Centre, Umhlanga.

Couple	**Date**
1. Couple 1	7 May 2004
2. Couple 2	7 May 2004
3. Couple 3	8 May 2004

The research session was scheduled after the second therapeutic session with seven couples at Intercare Medical Centre, Johannesburg.

Couple	**Date**
1. Couple 4	3 May 2004
2. Couple 5	5 May 2004
3. Couple 6	26 April 2004
4. Couple 7	13 May 2004
5. Couple 8	10 May 2004
6. Couple 9	27 July 2004
7. Couple 10	9 November 2004

1.4.5 Data presentation and analysis

Data analysis involves making sense of the collected data. It represents an ongoing process of reflection about the data, asking analytic questions, and taking notes throughout the study. It is not sharply divided from other activities in the process, such as collecting data or formulating research questions. It involves using data, asking general questions and developing an analysis of the information supplied by participants. Phenomenological research identifies significant statements to generate meaning; it attempts to re-story the participants' stories in such a way as to develop themes or trends on the subject of investigation (Creswell, 2003:190-191). Qualitative data analysis involves organising data according to themes and related categories (Robert & Greene, 2002:763). Unlike quantitative data, no exact formulas exist for analysing qualitative data. There are some widely accepted procedures, but no formulas. Instead, analysing qualitative data requires subjective judgment and interpretation (Reamer, 1998; Bless & Higson-Smith, 2000).

Creswell (1998:142-165) believes that the process of data analysis and interpretation can best be represented in a spiral image – a data analysis spiral. In this study data will be analysed according to Creswell's (1998:142-165) approach, which suggests five concurrent flows of activity: collecting and recording data; managing data; reading and making notes; describing, classifying, interpreting; representing and visualising. The direct responses given in the interviews will be reproduced and the researcher will present the main themes and related themes that emerged.

Data analysis will be discussed in more depth in Chapter 2.

1.5 ETHICAL CONSIDERATIONS

Ethics in research is discussed with the view to explicating the ethical context within which the study was conducted. Ethics refers to a standard of conduct to ensure moral behaviour. A fundamental question is whether the study itself is ethical. Issues that need to be considered when assessing whether or not a Social Work study is ethical, include the question of whether the study will contribute towards the harmful labelling of people, thus causing serious

psychological distress or much needed treatment to be withheld (Fortune & Reid, 1999:30-31).

The following may be regarded as guidelines for social work researchers as suggested by The Code of Ethics of the National Association of Social Workers in the United States of America (Williams, Tutty & Grinnell, 1995:41).

The researcher should:

- carefully consider possible consequences for research participants
- ensure that the consent of participants is voluntary and informed, without any implied deprivation or penalty for refusal to participate, and with regard for participants' privacy and dignity
- protect participants from unwarranted physical or mental discomfort, distress, harm, danger or indignity
- ensure that the evaluation of a case, or the services rendered, be discussed for professional purposes only and only with people directly and professionally involved
- treat all information obtained about participants confidentially
- take credit only for work actually done in direct connection with scholarly and research endeavours, and give credit to the contributions made by others

These ethical guidelines were adhered to in this study and an in-depth explanation will follow on how these guidelines were applied.

- **Guideline one: The researcher should carefully consider possible consequences for research participants.**

The participants were fully aware of the nature of this study. The goal and the objectives of the study were explained to them when they were approached to take part in this study. To protect the participants from possible emotional harm, it was explained to them that the questions in the interview schedule could trigger emotions that they were not aware of, or that they might feel uncomfortable in answering some of the questions. The interview schedule was given to the

participants at the time, i.e. when they were requested to take part in the study, in order for them to be able to read and study the questions ahead of the research session. This was done to prevent the stress of their having to answer questions which they did not understand or had not seen.

The participants were informed beforehand that they could immediately ask for containment and emotional support during the research session, and that a session could be scheduled for them if they wanted to address certain feelings before they continued with their therapeutic intervention. It was also explained to them that they could at any time withdraw from the study if they so wished.

- **Guideline two: The researcher should ensure that the consent of participants is voluntary and informed, without any implied deprivation or penalty for refusal to participate, and with regard for participants' privacy and dignity.**

It was explained to the participants that a research study was being conducted on the emotional and psycho-social experiences and perceptions of couples in an unconsummated marriage, and they were asked whether they would be willing to participate in the study. It was explained to the three couples that were approached at Intercare Medical Centre, Johannesburg after their second therapeutic session, that they could form part of the pilot study, and that two research sessions would need to be conducted to do the research for the pilot study. To the ten couples that were part of the research sample (seven couples at Intercare Medical Centre, Johannesburg and three couples from The Square Medical Centre, Umhlanga) it was explained that if they were willing to participate in the study, one session would be used to focus specifically on the research. It was clearly explained to the patients that these research session/s would not form part of their therapeutic intervention programme and that they would not be billed for these sessions.

The research study was explained to the couples as comprehensively as possible, and full permission for involving them was requested from the couples who formed part of the study. A consent form (Appendix A) had to be completed before the research session took place. It was emphasised that if they chose not

to take part in the research study their therapeutic intervention would not be affected in any way, and that further therapeutic sessions would be allocated for intervention.

- **Guideline three: The researcher should protect participants from unwarranted physical or mental discomfort, distress, harm, danger or indignity.**

The research session was scheduled for after the second therapeutic session, since the researcher wished to develop a relationship of mutual trust before then. Because the research study explores sexual behaviour or the absence thereof, it could become embarrassing and awkward for the participants. It was important that the participants be made to feel as comfortable as possible with the researcher, as well as with the therapeutic intervention and the research study. Therefore, it was important that the participants felt secure in the therapeutic environment and confident that they would receive the correct therapeutic intervention to address their problem. It was important that the participants felt comfortable and that they would be willing to take part in the research study, not only for their own benefit but also because they would be helping other people in unconsummated marriages by exploring their own perceptions and experiences of the problem.

- **Guideline four: The researcher should ensure that that the evaluation of a case, or the services rendered, be discussed for professional purposes only and only with people directly and professionally involved.**

Information about the participants was only disclosed to referring healthcare professionals, when the researcher reported on their progress and confirmed that they were taking part in the research study. No further information was disclosed to healthcare professionals that were not directly involved with the participants.

- **Guideline five: The researcher should treat all information obtained about participants confidentially.**

The researcher is a registered member of the South African Sexual Health Association (SASHA), the South African Council for Social Service Professions (SACSSP), the South African Association of Social Workers in Private Practice (SAASWIPP), and the Board of Healthcare Founders (BHF). This enables the researcher to see patients in private practice at Intercare Medical Centre, Johannesburg and at The Square Medical Centre, Umhlanga, and to deliver therapeutic services. The researcher adheres to the ethical guidelines of the professional boards, including their stringent rules for protecting a patient's right to confidentiality.

- **Guideline six: The researcher should take credit only for work actually done in direct connection with scholarly and research endeavours and should give credit to the contributions made by others.**

In this study no multiple collaborative relationships were formed to assist with the research study. Consequently there were no ethical concerns regarding collaborative relationships or professional conduct. Sharing research credit with collaborators is not an ethical issue in this study, and neither was there sharing of authorship.

The researcher is of the opinion that the above ethical guidelines were sufficiently taken into consideration while the research study was planned and carried out. The study did have certain limitations, which will now be discussed.

1.6 CLARRIFICATION OF TERMS

1.6.1 Unconsummated marriage

The literature (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003) defines the unconsummation of a marriage as follows: Unconsummation among couples who have never had successful sexual intercourse (coitus) is termed primary unconsummation; whereas, among couples who have experienced successful sexual intercourse (coitus) before, it is termed secondary unconsummation. Both

primary and secondary unconsummation is classified as an unconsummated marriage or as unconsummated coitus.

1.6.2 Vaginismus

Vaginismus is defined as the involuntary spasm of the pelvic muscles surrounding the outer third of the vagina, specially the perineal muscles and the levator muscles. In severe cases of vaginismus the adductors of the thighs, the rectus abdominis, and the gluteus muscles may be involved. This reflex contraction is triggered by imagined or anticipated attempts at penetration of the vagina or during the act of intromission or coitus (Masters & Johnson, 1970; Ellison, 1972; Kaplan, 1974; Jeng, 2003; Renshaw, 2004).

1.7 LIMITATIONS OF THE STUDY

The shortcomings of this study are discussed in order to highlight some of the problems that were encountered and which may have affected the quality of the study. The main limitation and deficiencies of this study could be summarised as follows:

Initially, the lack of literature on unconsummated marriages, seen in particular from a social work perspective, was a problem. However, this problem was resolved by consulting relevant literature in related disciplines, psychology in particular. Another problem was the limited availability of previous studies done in South Africa, with the result that the bulk of the literature reviewed is from countries such as the United States of America and Thailand. This means that the literature pertains mainly to these countries, yet the sample for the study was drawn from among South Africans only.

The interviews were not audio-taped. Padgett (1998) found that audio-taping allows the interviewer to concentrate on what is being said and is more inclusive than note taking. In retrospect the interviews should have been audio-taped, which would have made the transcripts more detailed. Completing the interview schedules and taking notes while interacting with the participants was difficult, since the researcher had to write down the direct responses and the male and female participant had to wait their turn to respond to the questions. After each

theme on the schedule an open discussion followed on that theme, while the researcher had to take notes. This would have been easier if the discussion had been audio-taped and transcribed. Audio-taping had initially been considered, but two of the three couples in the pilot study indicated that they would feel uncomfortable with that. This influenced the researcher's decision to reconsider, and it was finally decided not to audio-tape the interviews. The researcher was afraid that participants might feel unhappy or uncomfortable about being audio-taped and withdraw from the study.

When the questions in the interview schedule were formulated, the researcher adhered to the following basic principles suggested by Delport (2002:165):

- Sentences should be brief and clear, and the vocabulary and style of the questions should be understandable to the participants.
- Questions and response alternatives need to be clear and should not reflect the bias of the researcher.
- Every question should contain only one thought.
- Every question should be relevant to the purpose of the questionnaire.
- Abstract questions not applicable to the milieu of the respondents should rather be avoided. Researchers should also not take it for granted that respondents have any knowledge about a subject.
- The sequence in which the questions are presented, should be general, non-threatening questions first, and more sensitive, personal questions later.

The researcher's questions in the interview schedule could be regarded as leading questions. The researcher attempted to formulate ten questions around each of the ten themes which were deduced from reviewing the literature. The questions in the interview schedule did indeed guide the participants' reflection on their experiences and perceptions, and led them to thinking about a specific theme. The researcher is of the opinion that couples need a framework to guide their reflection on their experiences and perceptions, because it was found in practice before that couples in an unconsummated marriage find it difficult to define their feelings about the way they perceive and experience their situation.

Therefore, the researcher believes that leading questions were called for in this study, but this can also be viewed as a limitation of the study.

The following section focuses on the presentation of the research.

1.8 PRESENTATION OF THE RESEARCH

Chapter one of the dissertation sets out the motivation for the study; presents the problem statement; describes the goals, objectives, and research methodology; discusses ethical considerations, and indicates the limitations of the study.

Chapter two outlines the process of qualitative data analysis and focuses on the research results and a discussion of the results, the participants' profiles, participants' responses during the interviews, the summary of the ten themes and related themes that have been identified. The goal of this chapter is to explore the experiences of a couple in an unconsummated marriage in order to obtain information on the couple's perception of their marriage. The structure and lay out of the dissertation is different of the pattern that is usually followed because a qualitative study was done. The findings of the study are presented before the literature control. The following three chapters; chapter three, four and five presents the literature control.

Chapter three briefly discusses marriage and family development. The purpose is not to present an in-depth theoretical discussion of the marriage but mainly to provide a starting point and context. The goal of this chapter is to present a literature overview of marriage within the context of the family life cycle. Emphasis is placed on marriage as a social institution, essential characteristics of marriage, the functions of marriage and family, marital satisfaction and family stability.

The goal of chapter four is to describe the nature and causes of an unconsummated marriage. Consequently chapter four focuses on the definition of an unconsummated marriage and the diagnosis of the unconsummated marriage. It outlines Vaginismus as the main cause of unconsummated

marriages, describes the causal factors in the development of Vaginismus and coping mechanisms for managing Vaginismus.

Chapter five presents selected approaches and models focusing on marriage and family functioning. The goal of this chapter is to critically describe approaches and models that may be used in assessing an unconsummated marriage. Emphasis is placed on the postmodern-systemic approach, the Circumplex model, Beavers Systems model and McMaster model. The chapter furthermore outlines how to achieve healthy sexuality through therapeutic intervention after an assessment has been done according to the above-mentioned approaches and models.

Chapter six contains conclusions, comments and recommendations based on the research findings. The goal of this chapter is to reflect on the implications of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage within a postmodern-systemic framework.

CHAPTER 2

THE EMOTIONAL AND PSYCHO-SOCIAL EXPERIENCES AND PERCEPTIONS OF THE COUPLE IN AN UNCONSUMMATED MARRIAGE

2.1 INTRODUCTION

The objective of this chapter is to explore the experience of couples in unconsummated marriages in order to obtain information on how a couple in an unconsummated marriage perceive their situation and their marriage. Research studies (Berman & Berman, 2001; Jeng, 2003; Renshaw, 2004) indicate that the unconsummated marriage is a real problem that brings great distress to many married couples. It has been found that couples who cannot consummate a sexual relationship are among the most stressed couples seen in clinical practice, and the most grateful when successfully helped. The couples are frequently embarrassed about what they consider a shameful inadequacy, and they tend to be secretive about their problem. They may irrationally blame themselves for their difficulty, often feeling that they are being punished (Goodwin & Agronin, 1997; Jeng, 2003; Renshaw, 2004).

The literature (Ward & Ogden, 1994; Goodwin & Agronin, 1997; Reissing, Binik & Khalife, 1999; Jeng 2003; Renshaw, 2004) indicates that an unconsummated marriage can influence the emotional and psycho-social wellbeing of both the female and the male partner to such an extent that they give up hope, which limits their motivation to change their situation. In an unconsummated marriage a vicious cycle develops in which both parties are broken down and become sexually dysfunctional because of one partner's sexual inability. Consequently the husband-wife unit in an unconsummated marriage breaks down because of interrelated problems associated with a sexless and ultimately childless marriage.

Against this background, the goal of the study was to gain a better understanding of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage. In order to achieve this goal, the researcher attempted to find answers to the following critical question: What are the

emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage? The research results of the study are presented in this chapter. Creswell's (1998) spiral model was used to analyse the qualitative data.

2.2 PROCESS OF QUALITATIVE DATA ANALYSIS

Creswell (1998:142-165) believes that the process of data analysis and interpretation may best be presented as a spiral image – a data analysis spiral. Creswell (1998) is of the opinion that the researcher moves in analytic circles rather than using a fixed linear approach. For the purpose of this qualitative study, Creswell's spiral image was applied. This spiral image is illustrated in Figure 2.1.

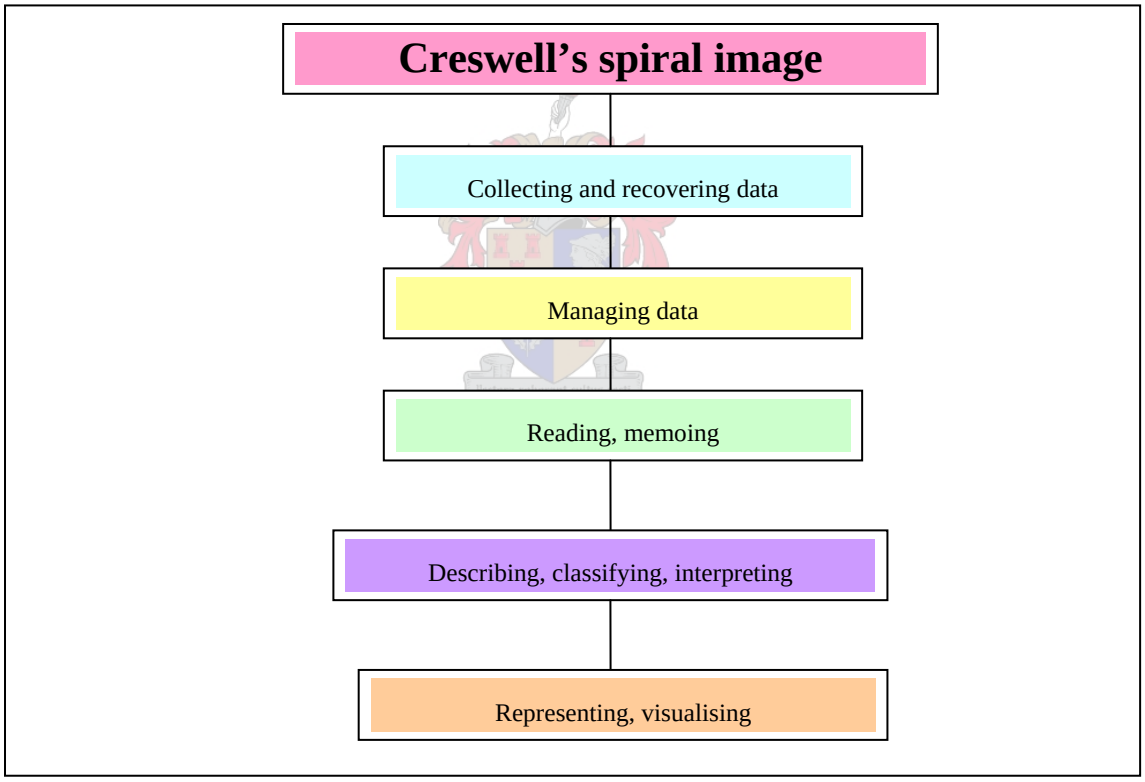


Figure 2.1: Creswell's data analysis spiral
Source: Creswell (1998)

The subsections below focus on the five steps in Creswell's (1998) data analysis spiral — collecting and recovering data; managing data; reading and memoing;

describing, classifying and interpreting; and lastly representing and visualising the data — and explains how each step was applied in this study.

2.2.1 Data collection and recording: the twofold approach

Creswell (1998) and Greef (2002) state that the researcher should plan for the systematic recording of data in a manner that is appropriate and will facilitate analysis, before data collection commences. Data analysis in a qualitative inquiry involves a twofold approach. The first aspect involves data analysis at the research site during data collection. The second aspect involves data analysis away from the site following the period of data collection. In this study, the researcher completed the interview schedules during the interviews.

2.2.2 Managing data

According to Creswell (1998) managing data is the first step in data analysis away from the site. Managing data as the first loop in the spiral starts off the process. At an early stage of the analysing process, researchers organise their data into file folders, index cards or computer files. For this study, all the completed interview schedules and written notes were typed up and organised into computer files.

2.2.3 Reading and writing memos

Creswell (1998) explains that after the organisation and conversion of the data, researchers continue their analysis by getting a feeling for the whole database. Creswell (1998) quotes Agar (1980) as follows: “Read the transcripts in their entirety several times. Immerse yourself in the details, trying to get a sense of the interview as a whole before breaking it into parts.” Creswell (1998) states that during the reading process, the researcher may list on note cards the data available, perform the minor editing necessary to make field notes retrievable, and generally “clean up” what seems overwhelming and unmanageable. In order to make the data obtained in this study more manageable, participants’ responses were extracted from the interviews and tabulated according to the ten set themes covered in the interview schedules.

2.2.4 Describing, classifying and interpreting

Creswell (1998) states that in this loop of the spiral category, the information obtained is at the heart of the process of qualitative data analysis. According to Creswell (1998:144) classifying means taking the text or qualitative information apart in an effort to find categories, themes or dimensions of information. Interpretation involves making sense of the data, seeking out the "lesson learned". In this study the ten main themes that featured in the interview schedule were used to describe, classify and interpret data. Related themes were identified by analysing the responses to the questions in the open discussions and observations, and by consulting the notes that the researcher made during the interviews.

2.2.5 Representing and visualising

Creswell (1998) states that in the final phase of the spiral, researchers present their data by packaging it in the form of text, tables or figures. In this study:

- A table and numerous figures are used to present the participants' profiles.
- Answers were tabulated in order to present the participants' responses to the ten themes.
- Figures were constructed to interpret the participants' responses.
- The ten main themes and identified related themes were summarised in table form.
- Text was used to explain the research results.

2.3 RESEARCH RESULTS AND DISCUSSION

The research findings will be discussed in this section, focusing on the participants' profiles, the participants' responses during the interviews, and a summary of the ten main themes and identified related themes.

2.3.1 Profile of research participants

Table 2.1 contains information about the participants with regard to years married, age, religion and career.

Table 2.1: Profile of couples (participants)

Couple	Years married	Age		Religion		Career	
		Male	Female	Male	Female	Male	Female
1	Seven (7) years	30	28	Protestant Christian	Protestant Christian	Electrical engineer	Book keeper
2	Thirteen (13) years	39	36	Catholic	Catholic	Own export company	Own export company
3	Two (2) years	29	23	Jewish	Jewish	Engineer	Student
4	Eight (8) years	33	29	Protestant Christian	Greek Orthodox	Plummer, gym instructor	Accountant
5	Two (2) years	28	23	Hinduism	Protestant Christian	Professional sportsman	Accountant
6	Nine (9) years	34	31	Catholic	Catholic	Accountant	Lawyer
7	Five (5) years	29	27	Protestant Christian	Protestant Christian	Farmer	House wife
8	Seven (7) years	36	31	Jewish	Christian	Own company	Business consultant
9	One (1) year	24	24	Catholic	Catholic	Construction	Secretary
10	Ten (10) years	35	34	Protestant Christian	Protestant Christian	Lawyer	Medical Doctor

Table 2.1 allowed the researcher to create a profile of the participants by tabulating information on the number of years married, their age, religion and career. The profile indicates that the sets of participants are not of the same age, have not been married for the same length of time, do not have the same religious backgrounds, and have different occupations. The tabulated data will now be presented in the form of charts and diagrams, starting with Figure 2.2 on the duration of each unconsummated marriage.

2.3.1.1 The duration of the unconsummated marriage

Figure 2.2 indicates that the participants have not been married for the same number of years, but for periods ranging from one to thirteen years.

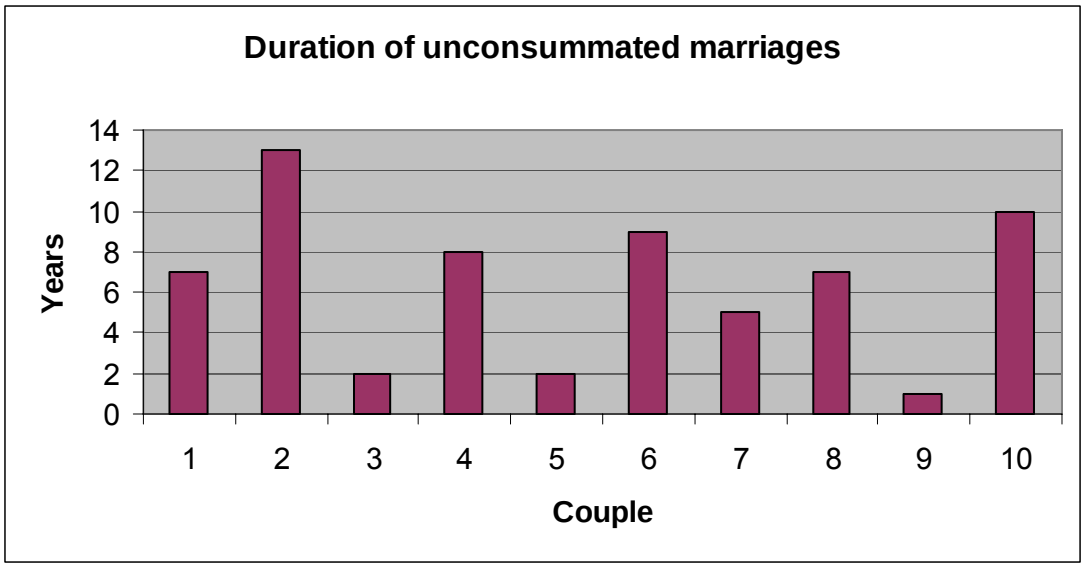


Figure 2.2: Duration of unconsummated marriages

Figure 2.2 indicates that the participants have been in their respective unconsummated marriages for a varying length of time. The problem of an unconsummated marriage is difficult to overcome, since it makes both partners feel helpless and unable to change the situation. A learned helplessness develops and adds to the time which elapses before the couple seeks treatment. One of the main reasons that couples in unconsummated marriages often do not receive treatment, is because of their fear of change (Carnes, 1997; Frandsen, Hafen, Karren & Smith, 2002).

Carnes (1997:92) explains that a paradigm shift needs to occur to encourage couples to seek treatment for their problem sooner rather than later, and to prevent couples from remaining in the same situation year after year. Central to the paradigm shift should be a new understanding and acceptance of their sexuality.

2.3.1.2 The age group of participants

Figure 2.3 indicates the age of the male and the female participants.

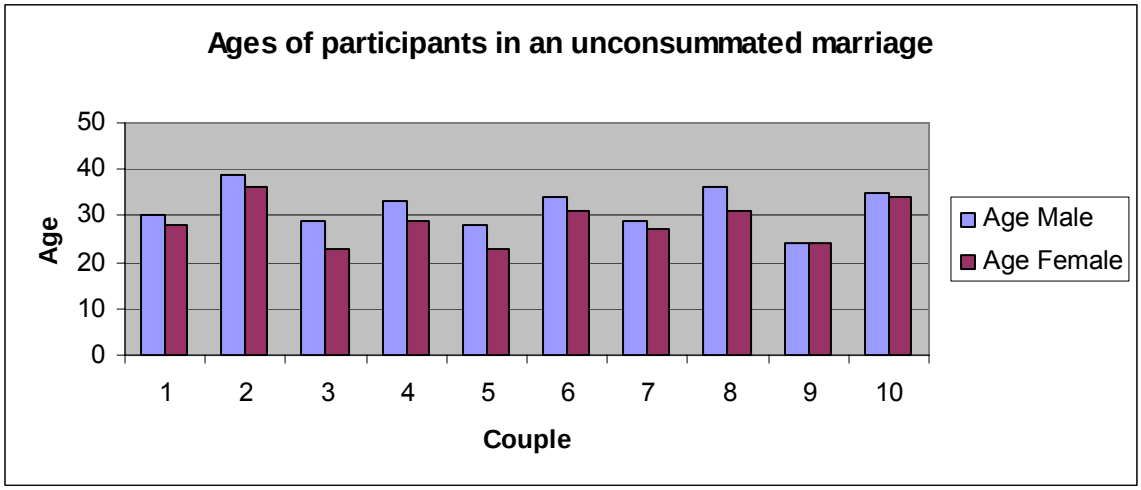


Figure 2.3: Age of male and female participants

Figure 2.3 indicates that the participants are at a specific life stage, called young adulthood — their ages vary from 23 to 39 years of age. Craig (1996:473) explains that the adult years account for approximately three-quarters of a person's life span. Conventionally, adulthood is defined in terms of three periods or stages: young adulthood (the 20s and 30s), middle adulthood (the 40s and 50s), and later adulthood (age 60 and over).

According tot Craig (1996:508) families present an important context for adult development. The family unit formed by adults for the purpose of parenting children, is called the family of procreation and is a significant milestone in early adulthood. In the theory of Erickson (1950), generativity is a central developmental task of adults, which they fulfil through the vocation and artistic production of child-rearing. This milestone of early adulthood, this central developmental task of adults, often passes by couples in an unconsummated marriage, since procreation is problematic in a sexless marriage. Couples are prevented from reproducing naturally. The following section will focus on the religious belief systems of participants.

2.3.1.3 The religious belief systems of participants

Figure 2.4 indicates the religion of the participants.

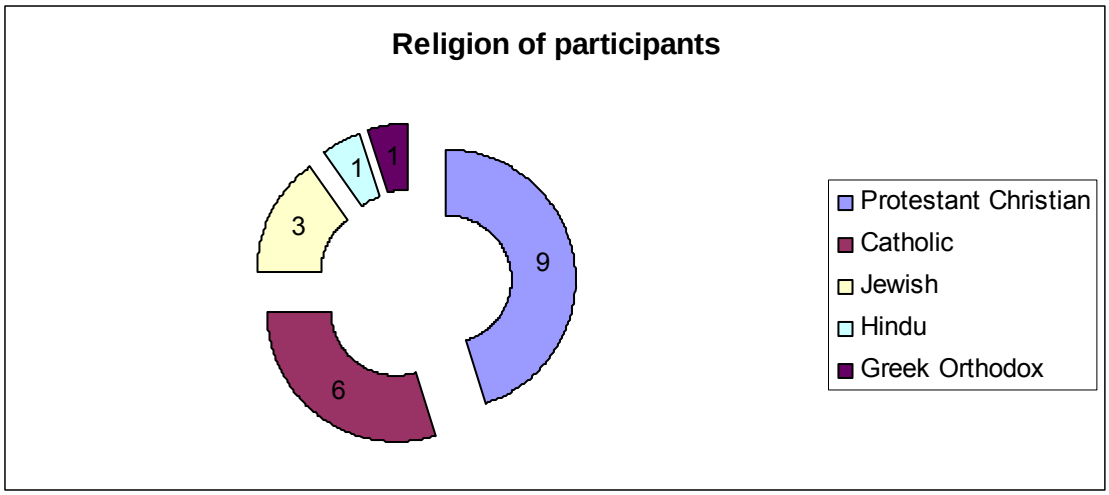


Figure 2.4: Religion of participants

As shown in Figure 2.4, all the participants belonged to a religious belief system. The religious belief systems that were indicated were Protestant Christian, Catholic, Hinduism, Greek Orthodox, and Judaism. Nine participants, therefore the majority of participants in this study were Protestant Christian, six were Catholic, three were Jewish, one was Hindu and one was Greek Orthodox.

Many authors (Masters & Johnson, 1970; Rosenbaum, 2003; Renshaw, 2004) believe that unconsummated marriages are more common in faith-based communities, where sexual intercourse is supposedly postponed until marriage. The assumption is that sexual intercourse among the deeply religious is considered “a taboo behaviour”. Jeng (2003) believes that there is a correlation between couples in an unconsummated marriage and their belonging to a religious belief system, which inspires guilt because of the religious message that “sex is a taboo behaviour”. A moral and orthodox upbringing serves to condition believers that sex before marriage is a mortal sin. In this study it has been found that participants battle to re-programme their thoughts after marriage — they still tend to feel that sexual intercourse is sinful and dirty. This finding concurs with the literature on religious guilt, which indicates that people often feel guilty about indulging in sexual intercourse (Masters & Johnson, 1970; Jeng, 2003; Rosenbaum, 2003; Renshaw, 2004).

2.3.1.4 Occupation of participants

Figure 2.5 indicates the various occupations of the participants.

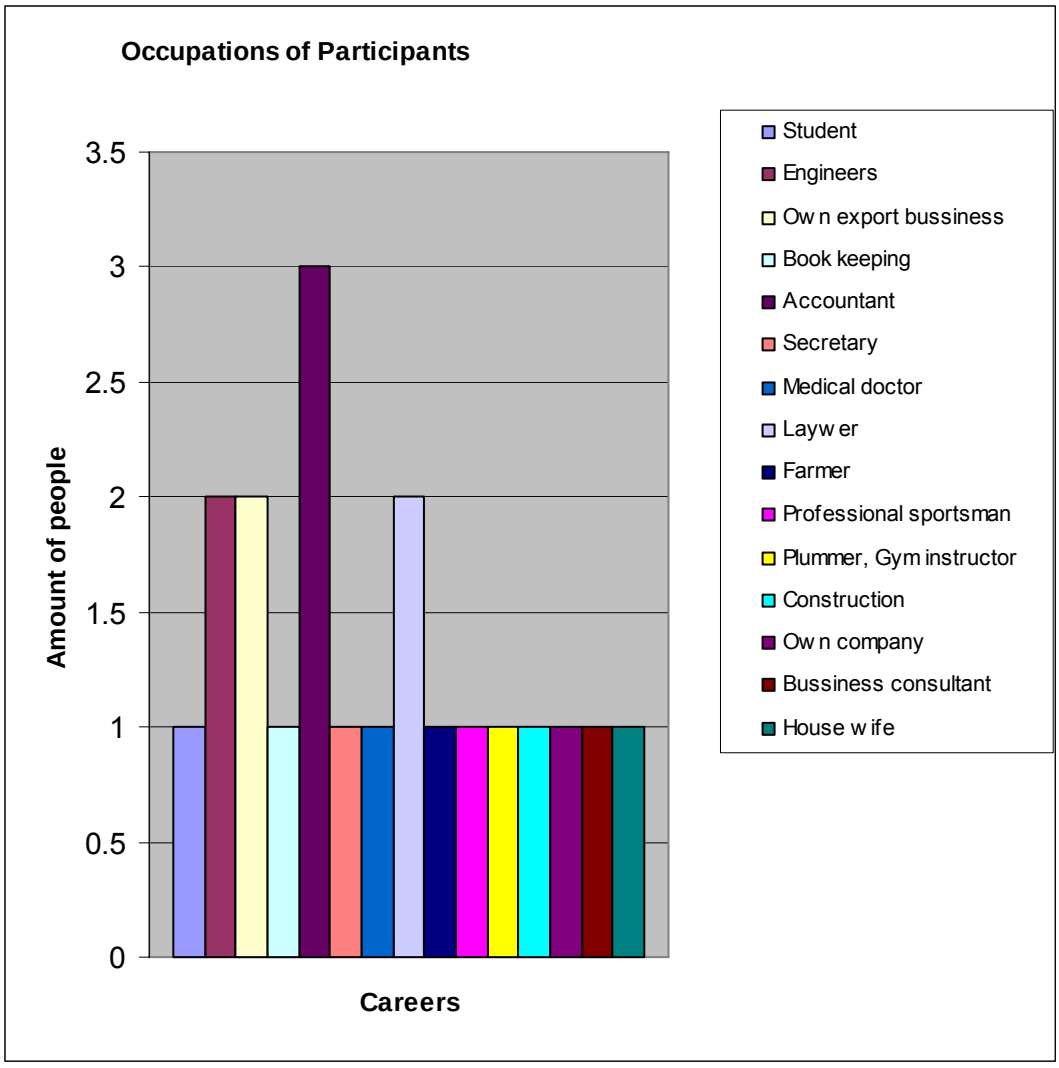


Figure 2.5 Occupations of participants

Figure 2.5 indicates that the participants have a varied occupational background. The participants did indicate during the interviews that they feel stressed at work and find it hard to relax when they are in their home environment. The participants' occupations are accounting (3), own export company (2), engineering (2), law (2), student (1), book keeping (1), secretarial work (1), medicine (1), farming (1), professional sports (1), plumbing and gym instruction (1), construction (1), running an own company (1), business consultant (1), and being a housewife (1).

It was found that participants feel extremely pressured financially and also feel stressed in their work environment. The participants feel that there is immense pressure from society to be very successful and to be affluent at a very young age. It was found that financial pressures and the pressure to succeed in a money-conscious society are sorely felt by participants. The participants experience a lack of free time to relax and to rest, and feel that they are physically and emotionally exhausted, which prevents them from feeling any desire to have sexual intercourse. This concurs with research findings reported in the literature (Elliot, 1996; Coontz, 1997; Jeng, 2003; Renshaw, 2004), namely that stress prevents couples from having sexual intercourse and that the modern day life style can prevent couples from being intimate with each other.

The next section presents an in-depth analysis of each theme. The participants' responses are given in order to shed some light on the way that couples in an unconsummated marriage experience and perceive their situation.

2.3.2 The participants' experiences and perceptions of their unconsummated marriage

The study was motivated by the desire to critically assess the experiences and perceptions of a couple in an unconsummated marriage. The following section focuses on the research results as obtained from the interviews. The verbatim excerpts of participants are presented, followed by a literature control. The first section looks at theme one: control-related problems.

2.3.2.1 Theme 1: Control-related problems

Theme one corresponds to question one in the interview schedule, namely: "Do you experience control-related problems?" Verbatim excerpts from the interviewees with regard to control-related problems are presented in Table 2.2.

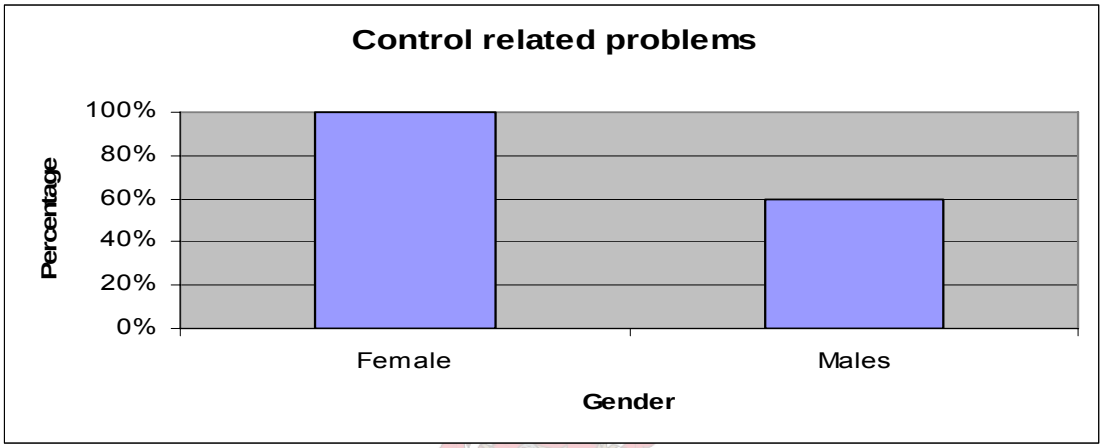
Table 2.2: Control-related problems

COUPLE	FEMALE	MALE
1	I do have control problems as I do not allow sex in our marriage. I associate control with the words stubborn, will and can.	I don't think I struggle with control issues. I associate control with the words force, must, now, shall and can.
2	I know that in a lot my sexual experiences the feeling of not having control does affect me. I tense up as I feel a loss of control. I have also realised that I always feel pressured and tense. I associate control with the words orgasm, not-pressurised, power over what is going to happen.	I have no control problems. I associate control with the words work, money, sports and tidiness, definitely not with sexual intercourse.
3	I am totally out of control when my husband comes close, I want to run, it feels as if everything tenses up and I want to choke. I have no control over this; it nearly feels like a panic attack. I guess thinking about it, I do have control problems – I am extremely tense.	I sometimes try and take control of our sex life but when my wife starts crying and tensing up I feel like a complete rapist. I would rather her take some form of control so that I can't hurt her.
4	Yes, I feel I can control how far I want to go during sexual intercourse which to me is my major problem. Experiencing the slightest pain prevents me from consummating my marriage.	I am a very easy going person- go with the flow my wife is more in control of a lot of issues.
5	I don't think I experience control related problems, however I think my husband does like to be in control. I sometimes feel that I do not have enough control in my own life.	No. Control to me suggests self-discipline and planning.
6	I think control is to be able to do something about a situation that is not working for you or your partner. Therefore, I don't think either me or my husband knows how to take control over this situation. We try to ignore it and after nine years of ignoring the sex issue, we want children but still no one is taking control over the situation. I think it is quite weird because in other areas of our lives we are fantastic in taking control over a situation.	If I look back on life, I can't believe that this is happening. Considering my wife was so scared in the beginning, I did not want to put too much pressure on her. I felt that with time things would get better, but it didn't. I think I need to look at this as a business deal, because there I can take control and make things happen.
7	My husband has control related problems; I think that sexually he struggles to take control of the situation. Because I am not to sure how to initiate any sexual act, I struggle to take control over our sexual lives.	I know this sounds ridiculous, but I just don't know what to do and what is expected from me sexually. I wish my wife can take control over the situation because I just don't know how to approach her. This is killing our marriage and I know I need to take some responsibility and control over our sex lives.
8	I will classify myself as the ultimate control freak. I think I drive my work colleagues, friends, family, myself and my husband up the wall. Sexually I know there is definitely a huge problem; I assume that it is because I feel I can not control that area of my life.	I sometimes loose control; I get extremely angry and frustrated with our sexless marriage and feel that I just want to walk out. Honestly if this problem does not get sorted out soon I think we will look at perhaps separating.
9	I experience extreme control problems. Everything in my life has always been organised and I am always in control of life. I definitely think this has a huge impact on my sexual thoughts because I can not even imagine not being in control sexually. In the past I have tried letting go but I always go back to my controlling patterns.	I think my wife is a total control freak. She always wants to do everything herself, I feel that I am not even needed in this relationship. I am also a person that likes to be in control but with my wife's control 'issues' someone has to let go and it is normally me!
10	I feel that my husband is always bullying me into a sexual activity. As soon as he comes near me, I tense up and I feel that I am not in control of the situation. I normally just get up and go and do something else.	If I leave it up to my wife nothing will ever happen, so I need to take control of our sex lives. Unfortunately I am not doing a very good job because after seven years we have still not consummated the marriage.

Interpretation of Table 2.2

Table 2.2 contains participants' reflections on the matter of control. Blue indicates no control-related problems. Purple reveals an overly developed sense of self-control and an obsession with being in control. Fear of losing control is identified by the colour green; and yellow represents fear of taking control.

Figure 2.6 indicates the percentage of participants (n=10) who experience control-related problems.



n=10

Figure 2.6: Control-related problems

Figure 2.6 indicates that all of the female participants (100%) and six of the male participants (60%) experience control-related problems. Control-related problems are manifested in three related themes revealed by the participants' responses, namely: an over-developed sense of self-control and obsessing about being in control; fear of losing control; and the fear of taking control. Consequently, the next section deals with these related themes, focusing first on the matter of an overly developed sense of self-control and the obsession to be in control.

Figures 2.7 and 2.8 indicate the percentages of female and male participants who experience control-related problems, with responses grouped according to related themes.

Figure 2.7 indicates the percentage of female participants who experience control-related problems; responses are grouped according to related themes.

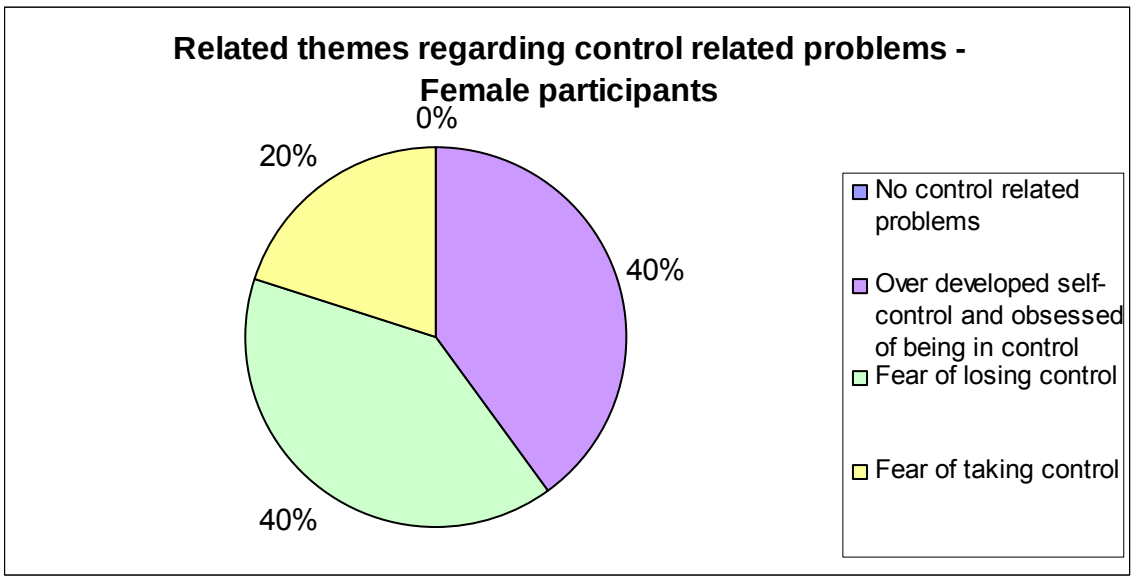


Figure 2.7: Female participants struggling with control-related problems, with responses grouped according to related themes.

The percentage of male participants who experience control-related problems is presented in Figure 2.8. Responses have been grouped according to related themes.

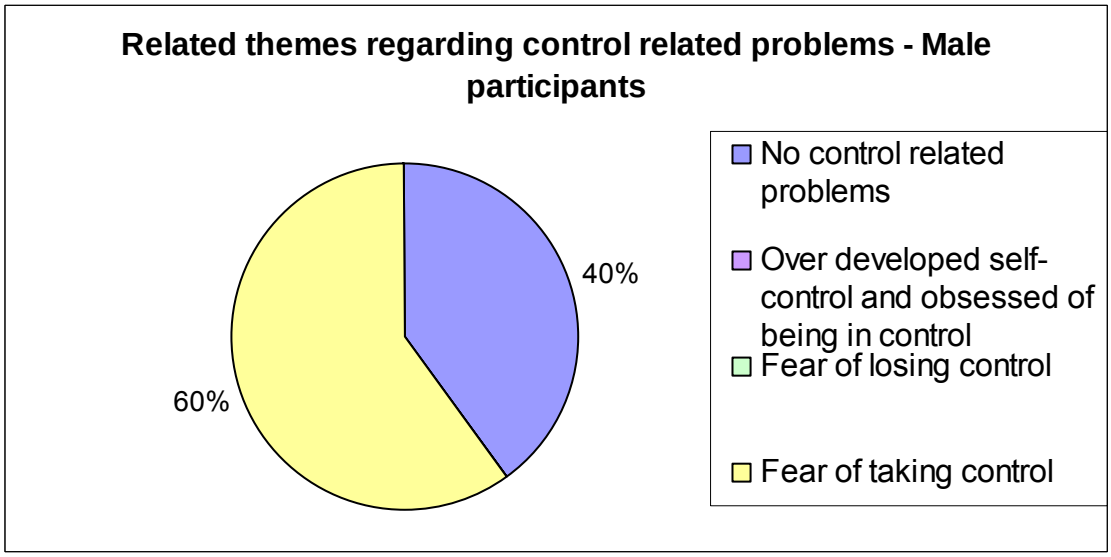


Figure 2.8: Male participants struggling with control-related problems, with responses grouped according to related themes.

a) An over-developed sense of self-control or obsession to be in control

Table 2.2 indicates that four female participants who were interviewed for this study have stated that they are extremely controlling in all areas of their lives, i.e. career, organisation, and finances. These are the words of a female participant who experiences an over-developed sense of self-control and is obsessed with being in control:

> I experience extreme control problems. Everything in my life has always been organised and I am always in control of life. I definitely think this has a huge impact on my sexual thoughts because I can not even imagine not being in control sexually. In the past I have tried letting go but I always go back to my controlling patterns.

These four female participants came across as being very assertive in all areas of their lives except for their sexuality and romantic relationship. These female partners in the unconsummated marriages explained that they have control problems and endeavour to be in control of the sexual experience, which consequently causes sexual problems. None of the male participants struggled with an over-developed sense of self-control or were obsessed with being in control. The literature (Carnes, 1997; Goodwin & Agronin, 1997; Jancin, 2001; Jeng, 2003; Renshaw, 2004) confirms that the female partner in an unconsummated sexual relationship often experiences control problems with regard to sexual intercourse. According to Carnes (1997) and Renshaw (2004), females in an unconsummated marriage are often very controlling in all areas of their lives and find it difficult to cope with the feeling of being dominated or controlled by their sexual partner. These female partners would rather be in control than be sexually intimate with their partners. Goodwin and Agronin (1997) explain that sexual activity poses a possible threat to the individual's self-control and they therefore rather avoid any sexual contact. This brings us to the next related theme, namely the fear of losing control.

b) Fear of losing control

As indicated in Table 2.2 four female participants said they were afraid of losing control during a sexual experience and that they always needed to feel in control in order to feel safe and secure. One participant commented as follows:

> I know that in a lot my sexual experiences the feeling of not having control does affect me. I tense up as I feel a loss of control. I have also realised that I always feel pressured and tense. I associate control with the words orgasm, not-pressurised, power over what is going to happen.

When the female participants spoke about their fear of losing control they appeared frustrated and discouraged. Their need to be in control means that being sexually intimate is regarded as too much of a risk. There is a definite tendency for the female partners in an unconsummated marriage to battle with the fear of losing control and the feeling that agreeing to sexual intercourse would take away their feeling of being in control. When their husbands take control of the sexual situation, they feel afraid of possible penetration and will manipulate the sexual situation to gain back the control. None of the male participants in this study expressed a fear of losing control.

According to Carnes (1997:40) the person who causes the sexless marriage because of the fear of losing control — mostly the female partner — could be regarded as a sexual anorexic. Denial of sex enables the sexual anorexic to maintain a certain control over the partner. The sexual anorexic feels out of control, and by not giving in to sexual intercourse finds that she can regain control, thus manipulating the partner in order to regain her lost sense of control and power.

The following section looks at another related theme, namely the fear of taking control.

c) Fear of taking control

As indicated in Table 2.2 six out of the ten male participants who were interviewed in the study explained that they wished that they could have more control over their sex lives. A fear of taking control is expressed in statements such as:

> I know this sounds ridiculous, but I just don't know what to do and what is expected from me sexually. I wish my wife can take control over the situation because I just don't know how to approach her. This is killing our marriage and I know I need to take some responsibility and control over our sex lives.

The six male participants felt that they could not take control of the unconsummated situation, because to them taking control is associated with force, aggression and violent behaviour. The men explained that they mostly feel frustrated with the situation, but fear that if they put pressure on their spouse to perform sexually, it would merely worsen the situation. It was discovered that men in an unconsummated marriage could be made to feel like rapists, if they felt that they were forcing their spouse to be intimate with them. It seems, moreover, that the male partners perceive their wives as controlling and a bit selfish. There was a definite indication that the male partners in these unconsummated marriages are melancholic and find it hard to take control of a situation.

The literature (Jancin, 2001; Jeng, 2003; Renshaw, 2004) suggests that it is very difficult for the male partner to interact sexually with their spouse, or take control of a sexual situation, when the female partner has a sexual problem. The male partners often feel that they do not want to hurt their spouses, or they feel — because of their spouses' negative reaction or constant rejection — that they are abusing their spouses sexually if they attempt to have sexual intercourse. The literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) confirms that feeling rejected is a common complaint, stemming from men's ego about sex, and their primal interpretation of the sexual act as a measure of emotional expression. Feelings of sexual inadequacy are an

inevitable outcome. Furthermore, sexual void affects all male partners by virtue of their sexual orientation. However much outer course may be satisfying, intercourse is still the cardinal way to sexual satisfaction and validation.

Table 2.2 indicates that two female participants fear taking control. The two female participants explained that they do not know how to take control of a sexual situation and feel embarrassed and ashamed about their incompetence. One female participant commented as follows:

> My husband has control related problems; I think that sexually he struggles to take control of the situation. Because I am not to sure how to initiate any sexual act, I struggle to take control over our sexual lives.

According to Renshaw (2004) women often find it hard to initiate sexual intercourse, or to take control of a sexual situation, since they do not know how to do it. Renshaw (2004) explains that girls are usually raised with the idea that they should rather not initiate sexual intercourse, and parents seldom give their daughters enough information on how to be sexually intimate with their partner, or on how to exercise some control in a sexual situation.

The Beavers system model (Beavers & Hampson, 2003:554) offers a useful map for identifying levels of family health or dysfunction when looking at the specific problem of control in an unconsummated marriage. The observational subscales of the Beavers system model include overt power [control-related problems], parental coalitions, closeness, mythology, goal-directed negotiation, clarity of expression, responsibility, permeability, range of feelings, mood and tone, irresolvable conflict, and empathy. The style subscales include dependency need, overt/covert conflicts, physical spacing, concerns/lack of concerns of appearance to the outside, profession of closeness, degree of assertiveness/aggressiveness, and ease of expression of positive-negative feelings (Barker, 1998:73; Beavers & Hampson, 2003:554). When the level of control has been assessed using the Beavers system model, control problems

can be addressed in therapeutic interventions. The next section will consequently focus on the second theme, namely feelings towards the own body and/or the partner's body.

2.3.2.2 Theme 2: Feelings towards the own body and/or the partner's body

Theme two corresponds to question two in the interview schedule, namely: "How would you describe your own body and your partner's body?" Verbatim excerpts from the interviewees regarding their feelings towards their own and/or their partners' bodies are presented in Table 2.3

Table 2.3: Feelings towards the own body and/or the partner's body

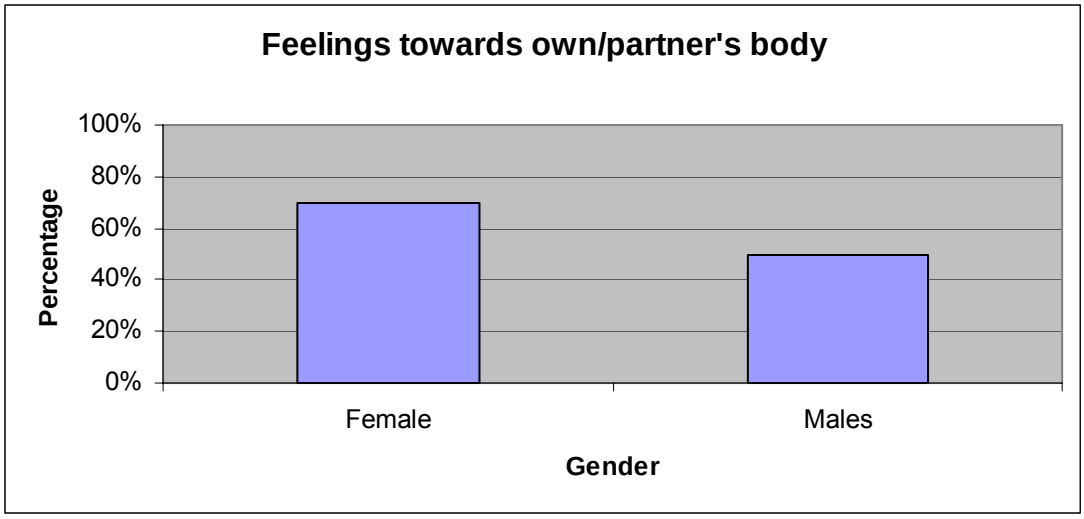
COUPLE	FEMALE	MALE
1	Partner's body is perfect in my eyes. My body well, breasts are too small and I would like to be thinner than I am. I am not happy with my bum and legs. When I think about my body I think about my ugly legs, bum and breasts. But I think my body is functioning and healthy.	I have dealt with negative feelings about my own body ages ago as a teen. No real negative feelings towards my partner's body.
2	I don't have any negative feelings about my partner's body. My body on the other hand is unattractive; my vagina is ugly, sensitive and sore. When I think about my body, I always think about my unattractive, ugly vagina.	My negative feelings are that I am an extremely hairy person. I feel that I do no have an attractive smile and my feet are really ugly. My negative feeling towards my partner is that she lacks confidence in herself. She has never been treated in a way a woman should be treated. When I think about my body words come up like smile, stomach, feet and hair. These are all thought of in a negative way.
3	I think I am quite average, there is nothing wrong with myself or with my partner's body.	We feel quite comfortable with each other's bodies. The problem normally comes in when attempting to have sexual intercourse. I can immediately feel a wall between us and the physical attraction will disappear instantaneously.
4	My weight- there is always that constant reminder that I must lose weight but also I am not motivated enough to go through losing the weight. My husband's body I have no problems with, I am happy with the way he looks.	I wish I was thin again, as first we met, then I had more muscle. I don't have any negative feeling about my wife's body but I know she is uncomfortable with her weight and she sometimes is very shy around me when she is naked.
5	My body is not perfect but okay, I would say my negative feelings about my body do not consume me. My partner's body, I find attractive but the male body does not hold too much sexual attraction for me.	I think my body should be a bit more fit and needs some more strength. My partner's body needs to be fitter and she needs to look after herself a bit more. I wish it was beautiful, strong and fit, and

	When I think about my body, I would say, it is fine but loose a little weight and that I do not take enough time to take care of it.	healthy.
6	I have always struggled with my own self-image and was hospitalized because of eating disorders. I struggled with bulimia for a long time and it is difficult to accept that I am a normal healthy human being.	There is nothing more frustrating to me than my wife's weight issue. This is definitely the problem because we can't even be naked together, or she will begin moaning about how she looks and what she has eaten. This, for me, is a huge frustration and if things go on like this, I will need to do something drastic. I have thought of just having an affair.
7	I feel fine with my body but my husband has huge issues about his body. He lost his leg in a farming accident and feels quite embarrassed about it. It definitely affects me because I don't know how to approach him when it comes to sexual intercourse.	I have issues about my body, I think my partner is beautiful, but I can't image that she finds me remotely attractive.
8	I think I am fat and ugly, no wonder my husband does not want to touch me. I am totally out of control when it comes to eating; I think it is my way of coping with problems.	I am at a point in my life, where I really think we need to look at having a family. But my wife thinks I hate her, every time I start talking about sex she gets angry and changes the topic. I need help because this is getting out of hand.
9	I hate my genitals, they smell and are extremely ugly and disgusting. I can not understand the concept of actually having intercourse. I find it quite repulsive thinking of touching my partners genitals. If I can stay in a sexless marriage forever, I would be quite alright with it.	I have given up hope; I think my wife has a total distorted perception of how she looks and what I think. I can't even touch her then she gets jumpy. I am not the most gorgeous person out there but I am starting to think I am an absolutely vulgar human being in my wife's eyes.
10	I guess I sometimes feel negative about how I look. I would love to go for plastic surgery to enlarge my breasts and perhaps for a nose job, but other than that I feel okay. My husband can perhaps loose a few pounds but I don't actually mind.	My wife is beautiful; I wish that she can see it! Every time I touch her, she cringes away and tells me how fat she is. I don't know how to help her she has been on every diet possible, but still she thinks there is something wrong with her.

Interpretation of Table 2.3

Table 2.3 indicates how participants feel about their own and/or their partner's body, and also reflects themes related to feelings about the own and/or partner's body. Blue points out that there are no negative feelings about the own body and/or the partner's body. Negative body image and a lack of self-esteem are indicated in yellow. Green indicates a distorted body image.

Figure 2.9 reflects the percentage of participants (n=10) who have negative feelings about their own body or their partner's body.



n=10

Figure 2.9: Negative feelings towards own body and/or partner's body

Figure 2.9 indicates that seven of the female participants (70%) and five of the male participants (50%) have negative feelings towards their own body and/or their partner's body. Two related to negative feelings about the own and/or partner's body can be identified from the responses of the participants, namely a negative body image and a lack of self-esteem; and a distorted body image. This will now be discussed, starting with negative body image and a lack of self-esteem.

Figures 2.10 and 2.11 indicate the percentage of female and male participants, respectively, who experience negative feelings about their own body and/or their partner's body. Responses have been grouped according to related themes.

Figure 2.10 indicates the percentage of female participants who experience negative feelings towards their own body and/or their partner's body. Responses have been grouped according to related themes.

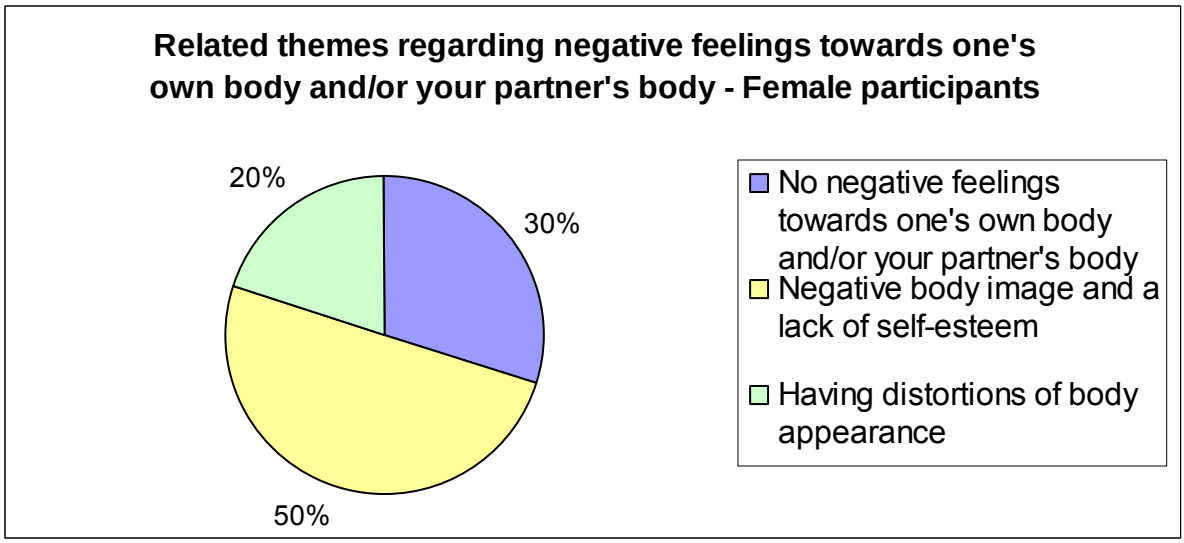


Figure 2.10: Female participants experiencing negative feelings towards their own body and/or their partner's body.

The percentage of male participants who experience negative feelings towards their own body and/or their partner's body is presented in Figure 2.11 (responses are grouped according to related themes).

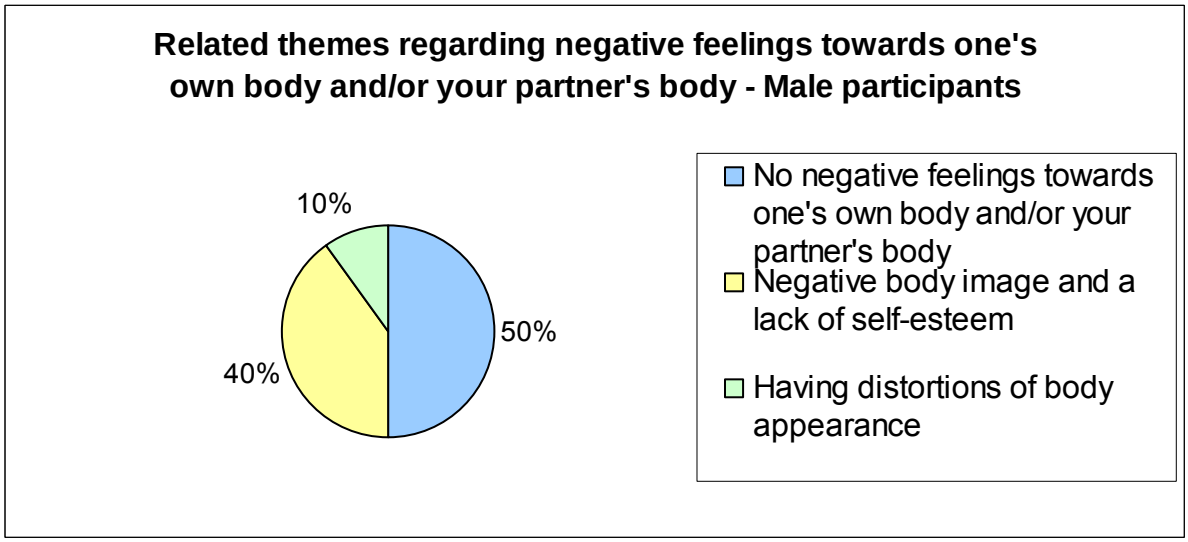


Figure 2.11: Male participants experiencing negative feelings towards their own body and/or their partner's body.

a) Negative body image and a lack of self-esteem

Table 2.3 indicates that five female participants and four male participants in the study have a negative body image and a lack of self-esteem. The couples made comments such as the following:

> I think I am fat and ugly, no wonder my husband does not want to touch me. I am totally out of control when it comes to eating; I think it is my way of coping with problems.

> I wish I was thin again, as first we met, then I had more muscle. I don't have any negative feeling about my wife's body but I know she is uncomfortable with her weight and she sometimes is very shy around me when she is naked.

The feelings expressed by these participants about their bodies indicate that a negative body image and a lack of self-esteem could reflect a common theme in an unconsummated marriage. In general, the male partners seemed to feel more positive about their bodies than the female partners. Underlying feelings when participants spoke about their own and their partner's body were relatively negative.

Carnes (1997:159) emphasises that sexuality cannot be separated from the rest of one's being. Without the ability to nurture and be sensual, people's sexual lives will be a disappointment. Likewise, for sexual intercourse to occur, it is necessary to feel deserving and attractive and positive about oneself. If a person's self-image is poor, it will necessarily affect the sensual and sexual part of his or her life. Problems of self-image, in fact, become more difficult and complex when sexuality comes into play. Self-image is like a lens through which a person views his or her life (Carnes, 1997; Goodwin & Agronin, 1997; Jeng, 2003; Renshaw, 2004). The focus in the next section is on the related theme of a distorted body image.

b) A distorted view of physical appearance

Table 2.3 indicates that two female participants and one male participant have a distorted view of their bodies, which is demonstrated in statements such as the following:

> I hate my genitals, they smell and are extremely ugly and disgusting. I can not understand the concept of actually having intercourse. I find it quite repulsive thinking of touching my partners genitals. If I can stay in a sexless marriage forever, I would be quite alright with it.

> I have given up hope; I think my wife has a total distorted perception of how she looks and what I think. I can't even touch her then she gets jumpy. I am not the most gorgeous person out there but I am starting to think I am an absolutely vulgar human being in my wife's eyes.

During the interviews it was found that unrealistic expectations existed about physical appearance. It appeared that in particular the body image of female partners was distorted. Irrationally perfectionist expectations and a preoccupation with bodily sensations were found; also a perception among some participants that their bodies were dirty or unclean. Participants viewed their bodies, including their genitals, as unattractive and disgusting. Therefore, related to the distorted body image, there is a very strong negativity towards genitals. The female partners' body image is associated with their sense of self-worth and self-concept and they consequently regard themselves as unattractive. When body image was discussed in the interviews, the females generally became very emotional and tearful.

According to Goodwin and Agronin (1997), and Jeng (2003), female partners in an unconsummated marriage have distorted views regarding their own bodies, and eating disorders such as anorexia nervosa are commonly found among

these women. They project these things onto the relationship and this becomes a vicious cycle. The male partners start feeling rejected, resentment sets in, and this causes further interrelated problems in their marriage. The male partners who said that they felt resentful became very frustrated when they spoke about the problem. They came across as both frustrated and guilt ridden. Their sense of guilt was based on their perceived lack of understanding and for not being more supportive towards their partner. The male partners were of the opinion that their wives were mostly obsessed about their bodies and that they had a seriously distorted view of their physical appearance, which affected the relationship in a negative manner.

A postmodern perspective challenges the assumption that a fixed truth or reality exists (Barker, 1998:39; Goldenberg & Goldenberg, 1998:89). The postmodern perspective is important with respect to a couple in an unconsummated marriage, in particular in order to address their cognitive distortions and irrational belief system about their own and their partner's body (especially the female participants), and to assist the couple in changing into a new paradigm.

The next section concentrates on the third theme, namely the fear of engaging in an intimate relationship and experiencing phobias.

2.3.2.3 Theme 3: Fear of engaging in an intimate relationship and the experience of phobias

Theme three corresponds to question three (a) and (b) in the interview schedule, namely: (a) "How do you experience intimacy in the marriage?" (b) "Do you experience a phobia of engaging in an intimate relationship?" Verbatim excerpts from the interviewees on the matter of a possible fear of engaging in an intimate relationship, and the experience of phobias, are quoted in Table 2.4.

Table 2.4: Fear of engaging in an intimate relationship and the experience of phobias

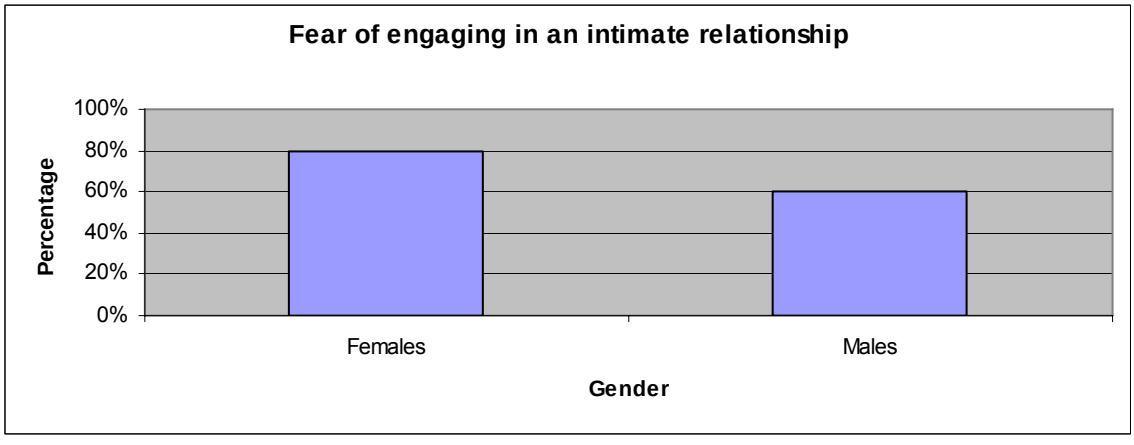
COUPLE	FEMALE	MALE
1	(a) I fear- it is definitely a phobia- sexual intercourse or anything related to sex because I think any touching will end up in an attempt to have sex. (b) No phobia.	(a) No fear for intimacy, rather fear for the lack of intimacy that will end up in us divorcing. (b) No phobia.
2	(a) I don't fear intimacy as such; I guess I just fear that I could get hurt if I refuse sexual contact. I am more scared of the sexual side, because of pain. (b) No phobia - fear of intimacy.	(a) I do not fear intimacy. My partner definitely fears intimacy and sexual intercourse. (b) I do not have a phobia for engaging in an intimate relationship.
3	(a) I have a preconditioned idea that sexual intercourse will be extremely painful. My mother always told us that if you have sex before marriage you will die of pain. What I did not know is that she had an abortion before she met my dad and it is her issues that we have to deal with twenty years later. (b) I don't think I have a phobia for sex but I am scared of the pain.	(a) There is definite fear of being with my partner and being intimate. Both of us are very scared to hurt each other and that is why we have never had sex. I think we both struggle to imagine how we one day will be able to be intimate with each other. (b) No experiences of phobias, just scared.
4	(a) There is no fear of intimacy just the fear of the pain related to this. I feel if I can relax and get past the pain issue I can be totally intimate sexually with my husband. (b) No phobias.	(a) I wouldn't call it fear because we are very intimate but haven't reached that point on consummating our marriage. There is a line to be drawn when a lady says 'stop' and 'stop' means stop no matter what. (b) No phobias.
5	(a) Do not fear intimacy with husband but am afraid of the pain of sexual intercourse. Would love to have a very intimate relationship but no sex has caused a barrier in our relationship. (b) No phobia.	(a) I don't have fear of engaging in intimate relationship. I do need commitment from my partner though. I would also like to feel a bit more wanted to engage more. (b) No phobia.
6	(a) No intimacy what so ever. (b) There is no doubt about it I am extremely afraid of being with my partner sexually. I am so scared that I sometimes think it is better to rather get a divorce and be alone for the rest of my life.	(a) We struggle to have any form of intimacy in our relationship. (b) I think we have infected each other with our fear, this is a vicious cycle of fearing something that is supposed to be so normal, I don't know if this is a phobia.
7	(a) I think we both fear to be intimate with each other. It is very weird when we are alone and there is even a slight chance of being intimate, we will look for something else to do. (b) I don't think it is a phobia, just fear.	(a) I do feel I have a fear of touching myself or my wife, I feel funny to even think of sex. I think I fear being alone with my wife. We struggle to do anything intimate together. (b) The fear of being alone with my wife has nearly developed into a phobia.
8	(a) Intimacy is something that we don't experience. (b) I fear pain, any form of pain. A friend told me at school that she had sex and that it was so painful that she just wanted to die. After that I think I have told	(a) We don't have any intimacy in our marriage. (b) My wife has a phobia for pain. I can just touch her and she will say I am hurting her. I do understand but it is driving me insane because it has to be in her head and she

	myself that I will die if I have sex.	can't seem to understand how frustrating it is.
9	(a) I fear penetration; it feels as if I just want to run away when people talk about sex. I have developed this total aversion of being intimate with my partner. (b) No phobia.	(a) I fear being intimate with my partner because I know how she hates it when I approach her in a sexual way. (b) I think because of her problems, I have developed a phobia now for approaching her for any sexual pleasure.
10	(a) I have a thousand excuses of not wanting to have sexual intercourse and being intimate. (b) I didn't even know that there was something like this, but I definitely experience a severe panic feeling and phobia for intercourse.	(a) There is no intimacy in the marriage. (b) I think my wife has a phobia, and I don't know how to help her anymore. But, this is not the only phobia that she has, she is afraid of nearly everything for example water, snakes, dogs etc.

Interpretation of Table 2.4

Table 2.4 indicates fear of engaging in an intimate relationship and the experience of phobias, and related themes regarding fear of engaging in an intimate relationship and the experience of phobias. Excessive fear of intimacy and sexual intercourse is indicated in yellow. No fear of intimacy is specified in pink. Green reflects a manifestation of related phobias and purple indicates no phobias.

Figure 2.12 indicates the percentage of participants (n=10) who are afraid of engaging in an intimate relationship. Responses have been grouped according to the related themes.

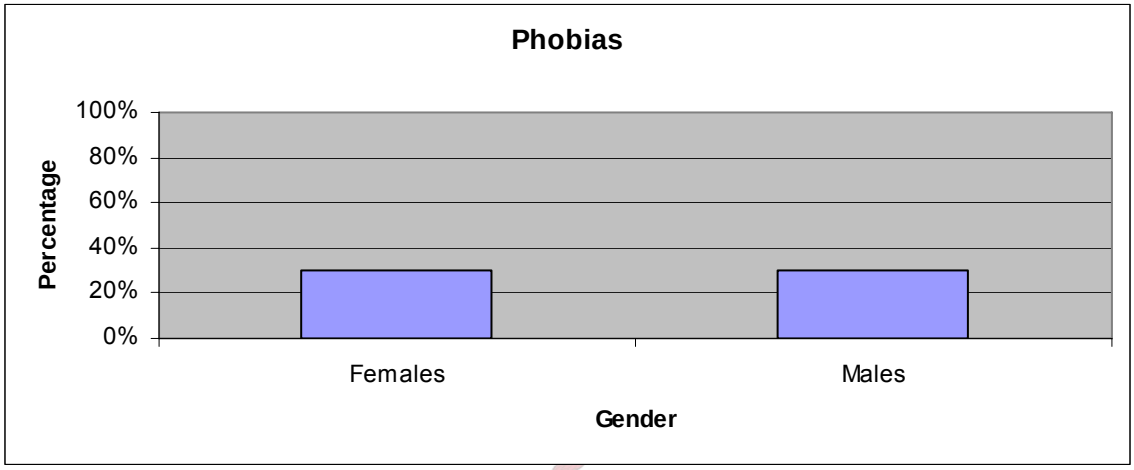


n=10

Figure 2.12: The fear of engaging in an intimate relationship

Figure 2.12 reveals that eight of the female participants (80%) and six of the male participants (60%) had a definite fear of intimacy and sexual intercourse.

Figure 2.13 presents the percentage of participants (n=10) who experienced phobias.



n=10

Figure 2.13: Phobias

As indicated in Figure 2.13 a manifestation of phobias was found during this research study. Three of the female participants (30%) and three of the male participants (30%) experienced phobias.

The third theme investigated the incidence of being afraid to engage in an intimate relationship and of experiencing phobias. Two themes related to this theme (of being afraid to engage in an intimate relationship and of experiencing phobias) are revealed by the responses that the participants gave. This first related theme is an excessive fear of intimacy and sexual intercourse, and the second a manifestation of other related phobias. The next section will focus on the first of the related themes, namely excessive fear of intimacy and sexual intercourse.

Figure 2.14 indicates the percentage of female participants who experience a fear of engaging in an intimate relationship and who experience phobias. Responses have been grouped according to related themes.

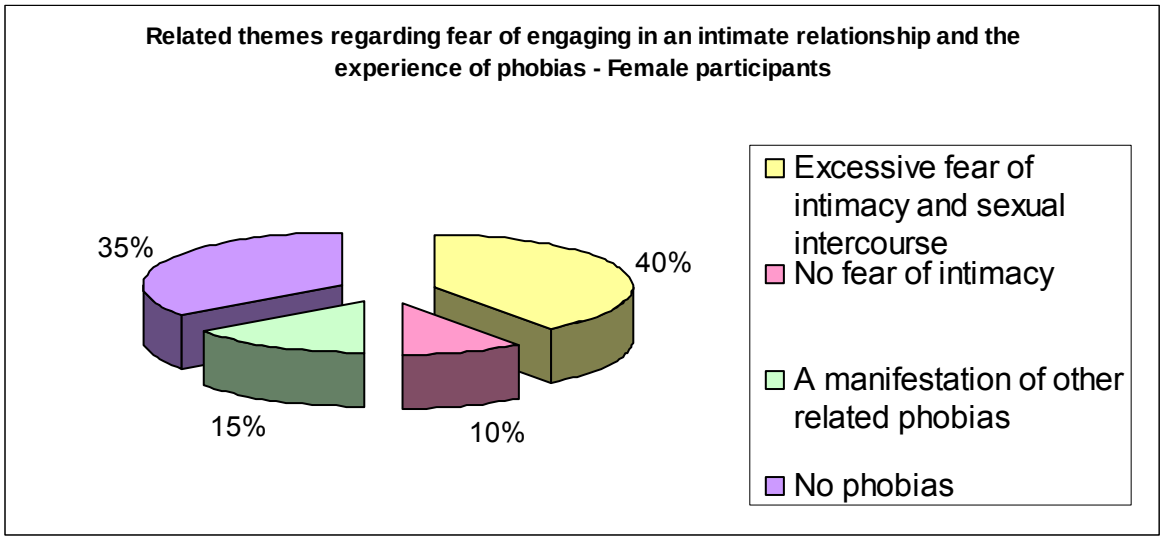


Figure 2.14: Female participants who experience a fear of engaging in an intimate relationship and experience phobias, with responses grouped in related themes.

The percentage of male participants who are afraid of engaging in an intimate relationship and experience phobias is presented in Figure 2.15. Responses have been grouped according to related themes

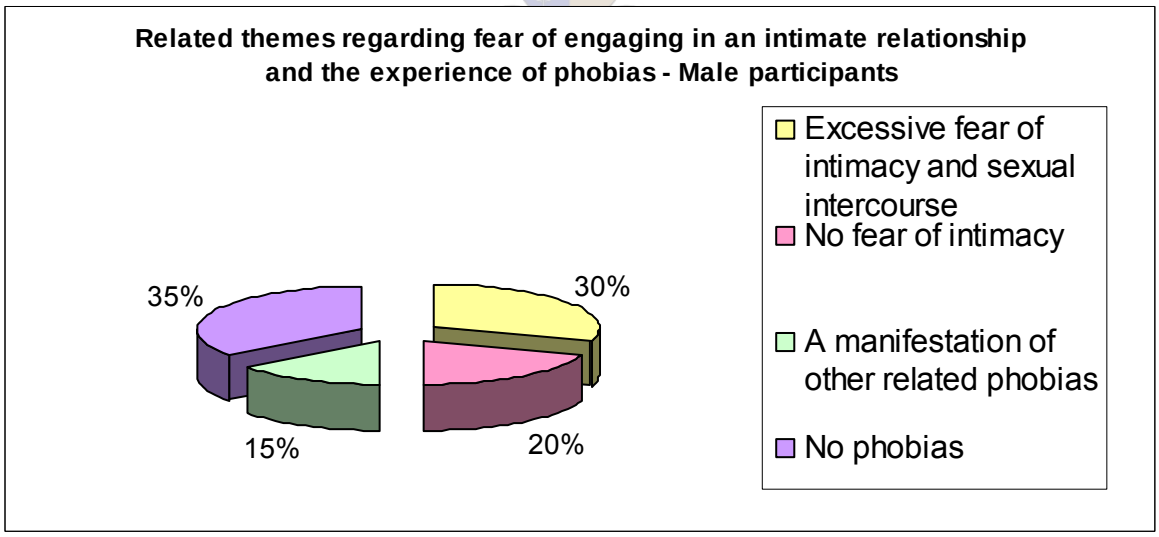


Figure 2.15: Male participants who experience a fear of engaging in an intimate relationship and experience phobias, with responses grouped according to related themes.

a) Excessive fear of intimacy and sexual intercourse

Table 2.4 indicates that eight female participants and six male participants in this study have an excessive fear of intimacy and sexual intercourse. Participants commented as follows:

> I think we both fear to be intimate with each other. It is very weird when we are alone and there is even a slight chance of being intimate, we will look for something else to do.

> I do feel I have a fear of touching myself or my wife, I feel funny to even think of sex. I think I fear being alone with my wife. We struggle to do anything intimate together.

According to Carnes (1997:42) the inability to consummate a marriage is often related to the fear of engaging in intimacy and sexual intercourse, even though the couple is already married. The literature (Moller & Fallstrom, 1991; Basson, Berman, Burnett, Derogatis, Gerguson & Fourcroy, 2000; Jeng, 2003; Renshaw, 2004) agrees that couples in an unconsummated marriage often seem to dread sexual pleasure, fear sexual contact and avoid intimacy. This can be linked to the next related theme, namely the manifestation of other related phobias.

b) The manifestation of other related phobias

According to the responses in Table 2.4 three female participants and three male participants experience other related problems. These were the words of a female and a male participant, respectively:

> I didn't even know that there was something like this, but I definitely experience a severe panic feeling and phobia for intercourse.

I think because of her problems, I have developed a phobia now for approaching her for any sexual pleasure.

Their experience of real phobic feelings was described by the couples and it became evident that the female partners had episodes of extreme anxiousness because of what they perceived to be a threatening event. According to the literature (Moller & Fallstrom, 1991; Basson *et al.,* 2000; Jeng, 2003; Renshaw, 2004) the aversion to sex becomes the barrier that keeps the private, vulnerable self safe. A definite terror of sexual intercourse develops and it becomes a sexual phobia. Other phobias too may develop, for example social phobia, agoraphobia — fear of the market place —and claustrophobia. This becomes a vicious circle, since any sign of intimacy triggers the assumption that this will lead to an attempt at sexual intercourse and thus the fear is triggered, which causes extreme anxiety.

The next section will consequently focus on the fourth theme, namely a feeling of sin and moral dilemma.

2.3.2.4 Theme 4: Feeling of sin and moral dilemma

Theme four corresponds to question four in the interview schedule, namely: "How does your religious life and spiritual system shape the way you feel about sexual intercourse?" Verbatim excerpts from the interviewees regarding this theme of sin and moral dilemma are presented in Table 2.5.

Table 2.5: Feeling of sin and moral dilemma

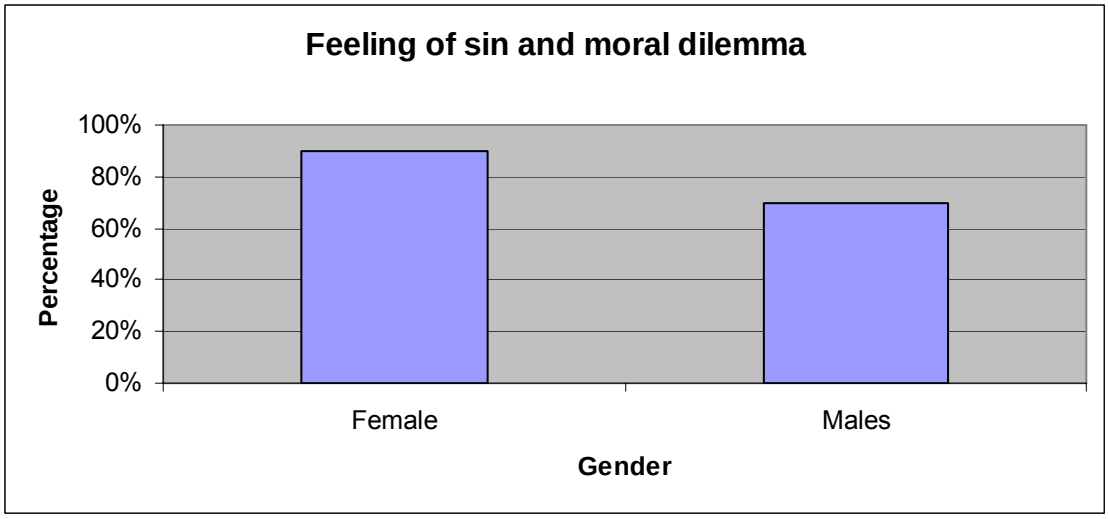
COUPLE	FEMALE	MALE
1	My religious belief is no sex before marriage. Secondly, sex was never spoken freely in my parent's home. When I think of my religion and belief system regarding sex, I think of no sex before marriage.	Doing something against one's or both partner's will is against my belief and is therefore sin. My belief system speaks of peace and love and when I think of spirituality, I think of home, quietness, and cleanliness.
2	I have been brought up to believe that I should never have sex before marriage and definitely should not have had sex with more than one person. I do feel guilty and it feels as if I am doing something wrong and sinful. When I think about my religious beliefs regarding sex, I think no sex before marriage, sex with	We are definitely brought up that sex before marriage is a taboo.

	one man, guilt, secretiveness, and shame.	
3	My faith is being tested. After struggling for so long I am tempted to relinquish my religion. Emotionally, spiritually I feel exhausted.	I feel alone in this frustrating situation, I doubt whether anyone is hearing my prayers.
4	I never came from a family that was very religious and therefore religion was never a topic when it came to sexual intercourse. I personally feel sex before marriage should not happen but in the same breath feel with today's society people tend to move and have better relationships outside of marriage and by living together I feel it depends on the individuals and I chose to be married first and respected that.	My religious belief never interacted with my sexual life; they are both two separate entities.
5	No sex before marriage – anything sexual was sinful unless between husband and wife. My husband wanted to have sex before marriage but I didn't – we did everything besides penetration but I felt like I had sinned because of this but I also wanted to make my 'now husband' happy. I feel sex is meant for marriage.	My religious and spiritual belief encourages me to have a healthy life. I am encouraged to be with my partner. Sex is also promoted with my partner in healthy conditions. It is seen as an important part of a relationship and marriage. We need to respect each other.
6	My mom told me that just sinners and bad people have sex, perhaps I still believe that.	I feel that we are being cursed and punished.
7	As long as I can remember I was told that sex before marriage is a sin, not that we ever actually talked about it.	My wife and I were brought up very similarly – just thinking about sex is sinful and now that it is not sin we can not do anything.
8	I am very spiritual but it feels as if no one is listening, I feel totally isolated and feel like giving up hope. I think I'm being punished.	I come from quite a religious background and it has been imprinted in me that sex before marriage is wrong. Therefore, I waited, but now I'm wondering why I still have to wait. I really don't know how many times I can still pray about this.
9	I never had penetrative intercourse, but I still fooled around before I got married and feel extremely guilty about it because of my belief system. I feel that God is punishing me because of what I have done.	We are very religious and feel that we are being punished. Now confronted with this situation in our marriage, we find our faith dwindling. We feel alone and unable to confide in anyone.
10	Because of my religious orientation, I never had sex before marriage. I fail to understand why it is so difficult now that we are married. Perhaps not every one is made to have sexual intercourse.	Considering that both of us are religious I find it difficult to understand why we are being punished like this.

Interpretation of Table 2.5

Table 2.5 reflects the feeling of sinfulness and being faced with a moral dilemma, and related themes regarding this feeling. Yellow indicates that the participants are blaming their religious belief systems and are experiencing religious conflict. The perception that God might be punishing them is indicated in purple. Green points to the fact that there is no blaming of a belief system; no religious conflict; no feeling that God is punishing them

Figure 2.16 indicates the percentage of participants (n=10) who had a feeling of sin and moral dilemma.



n=10

Figure 2.16: Feeling of sin and moral dilemma

Figure 2.16 indicates that nine of the female participants (90%) and seven of the male participants (70%) experience a feeling of sinfulness and moral dilemma. The fourth theme in this study relates to the idea that sex is sinful and presents a moral dilemma. Two sub themes related to this perception of being sinful and in a moral dilemma could be inferred from the responses of the participants, namely: blaming religious belief systems and experiencing religious conflict; feeling that God is punishing them. The next section will focus on the first related theme, namely blaming religious belief systems and experiencing religious conflict.

Figure 2.17 and Figure 2.18 reflect the percentages of female and male participants who experience a feeling of sin and moral dilemma. Responses have been grouped according to related themes.

Figure 2.17 indicates the percentage of female participants who experience a feeling of sin and moral dilemma, with responses grouped according to related themes.

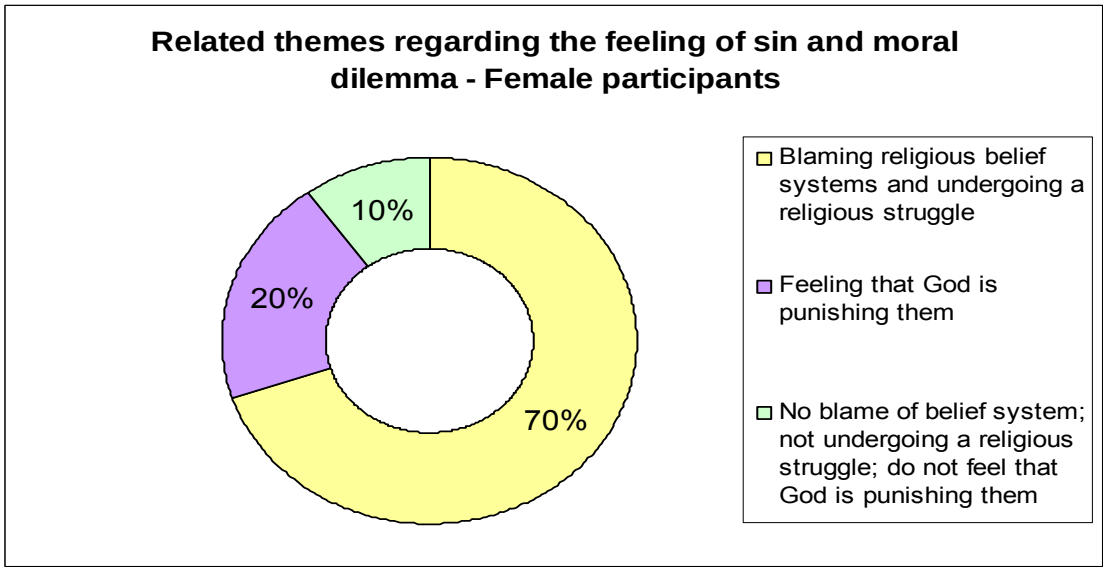


Figure 2.17: Female participants experiencing a feeling of sin and moral dilemma, with responses grouped according to related themes.

The percentage of male participants who indicated that they experience a feeling of sin and moral dilemma is presented in Figure 2.18. Their responses have been grouped according to the related themes.

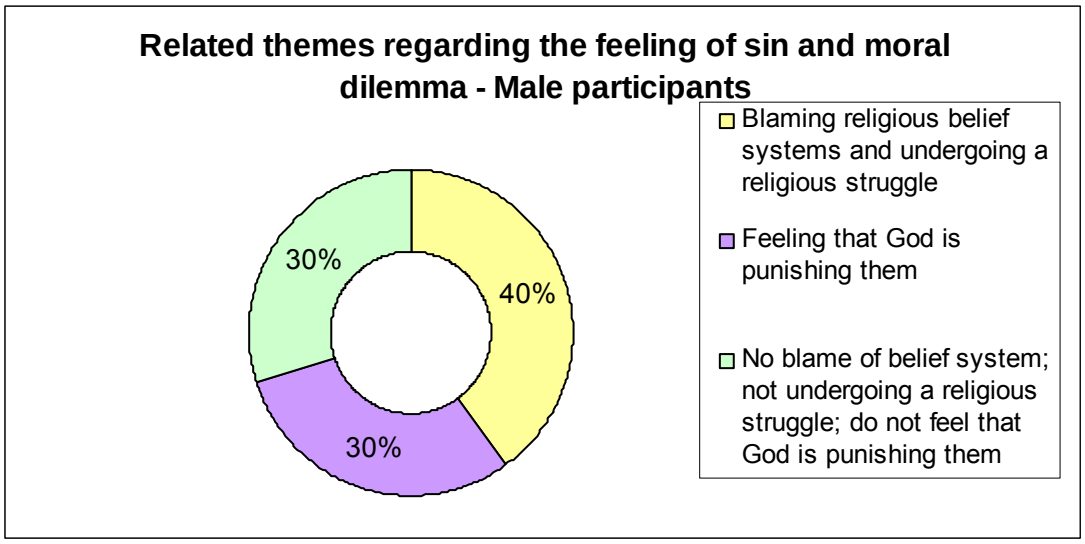


Figure 2.18: Male participants experiencing the feeling of sin and moral dilemma, with responses grouped according to related themes.

a) Blaming religious belief systems and experiencing religious conflict

Table 2.5 indicates that seven female participants and four male participants blame their religious belief systems for their inability to have a healthy sexual relationship and are experiencing religious conflict. The following comments are examples of this:

> My faith is being tested. After struggling for so long I am tempted to relinquish my religion. Emotionally, spiritually I feel exhausted.

> I feel alone in this frustrating situation, I doubt whether anyone is hearing my prayers.

It became obvious during the interviews for this study that most participants blame their unconsummated marriage on their religious belief systems, and that they experience religious conflict because they are not receiving help from their God. It was predominantly evident among the female participants, who indicated that they felt frustrated and that they were conditioned by their religion to feel shameful and guilty about sexual intercourse. Many authors (Masters & Johnson, 1970; Rosenbaum, 2003; Renshaw, 2004) believe that unconsummated marriages are more common in faith-based communities, where sexual intercourse is postponed until after the couple is married. According to Rosenbaum (2003), many couples feel that God has abandoned them; they feel alone in their struggle. They thought God would help them in consummating the marriage and feel disappointed in God that they cannot have sexual intercourse.

During the interviews it became clear that once the couple was married, the partners could not get over their primary conditioning and would avoid sexually arousing activities that might lead to sexual intercourse. These were the words of a male participant:

> I come from quite a religious background and it has been imprinted in me that sex before marriage is wrong. Therefore, I waited, but now I'm

> wondering why I still have to wait. I really don't know how many times I can still pray about this.

According to Rosenbaum (2003:1) a factor in faith-based communities that apparently contributes to unconsummated marriages in particular and sexual dysfunction in general, is the lack of premarital sexual education, an insufficient understanding of female and male anatomy and physiology, and a strong sense of modesty, which may inhibit sexual behaviour. Religious belief systems can have an effect on the consummation of a marriage. Numerous couples are unable to break the pattern — stipulated by religious rules — that characterises their sexual relationships prior to marriage, and this conditioning then renders them incapable of consummating their relationship after marriage (Rosenbaum, 2003:1).

b) Feeling that God is punishing them

It is indicated in Table 2.5 that two female participants and three male participants feel that God is punishing them. This perception is expressed in statements such as:

> I never had penetrative intercourse, but I still fooled around before I got married and feel extremely guilty about it because of my belief system. I feel that God is punishing me because of what I have done.

> Considering that both of us are religious I find it difficult to understand why we are being punished like this.

Couples in an unconsummated marriage report that they blame their religious belief system and feel that God is punishing them; consequently this becomes a religious conflict. As a result of their religious struggle couples often feel negative towards God, their religion and spirituality. The literature confirms (Masters & Johnson, 1970; Renshaw, 2004) that couples in an unconsummated

marriage feel that God is punishing them by not allowing them to have sexual intercourse. Some authors (Barnes, 1986; Silverstein, 1989) are of the opinion that high moral expectations inculcated in the couples, or sexual guilt resulting from a strict religious upbringing, may result in their feeling that God is punishing them when the marriage remains unconsummated.

In the next section the focus is on feelings of guilt and shame, the fifth theme.

2.3.2.5 Theme 5: Guilt and shame

Theme five corresponds to question five in the interview schedule, namely: "Do you experience guilt and shame when thinking about sexual intercourse?" Verbatim excerpts from the interviewees regarding possible feelings of guilt and shame are presented in Table 2.6.

Table 2.6: Guilt and shame

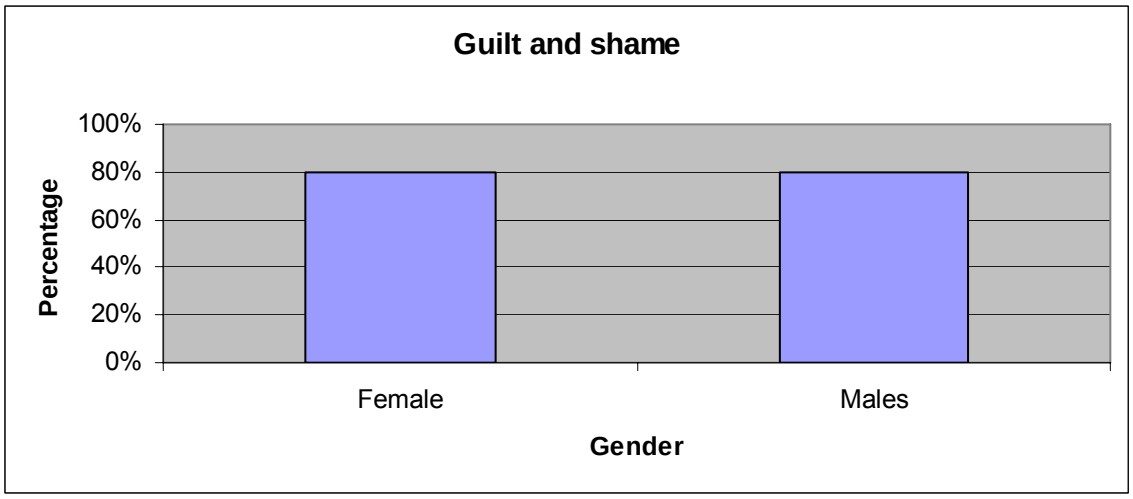
COUPLE	FEMALE	MALE
1	Do not experience guilt or shame; just have intense fears for sex. I feel imperfect, unable and abnormal.	Sometimes feeling of guilt for not being understanding enough – could have been more supportive should have worked harder on issues along time ago. I feel down, depressed, sad, cranky and lousy.
2	I feel as though I shouldn't think about things like that, that it is wrong. I feel shame towards my parents and more myself!	I do have a feeling of shame, when my partner and I engage in sexual intercourse. It's because she can not engage in the pleasure of sex at all.
3	I feel humiliated every time we try and discuss it and usually it just ends up in an argument. Both of us feel guilty about how disrespectful an argument can become while discussing this specific issue. I feel really ashamed of how I talk to my husband when this topic comes up.	I don't feel as shameful as I feel guilty. I feel guilty for always forcing the issue. I know it is a sensitive situation but I still sometimes get quite irritated and frustrated with my wife's lack of interest to try. I guess deep down I actually feel quite rejected as a man.
4	I feel no guilt and shame because it's a problem we as a couple are experiencing consummating the marriage. Not guilty or shameful about intercourse.	I don't feel guilty or shameful about anything to do with sex.
5	No guilt now but I did feel guilty about sexual behaviour before marriage. I feel guilty and ashamed about not satisfying my husband, pretending to everyone it is fine, forgiveness by God.	When I think about guilt and shame, I think of being disrespectful, doing wrong things, hurting people intensely.
6	Everyday I feel shame and guilt about what is happening in our lives. I feel totally abnormal and can not understand why we are being punished like this.	I think it is more the shame than the guilt that is a problem for me. When my friends start talking about their great sex lives I just laugh. I actually don't know what to say, I feel embarrassed that something so normal is such a big issue in our lives.
7	I feel guilty and shameful about pushing my husband away. It became worse and worse with time and spiralled into one big mess. I wish things could be different, but I don't know how to even begin changing this situation.	I feel guilty towards my wife for not doing my manly duties. If I could just get rid of my negative body image, things would go much smoother in the bedroom. Unfortunately we have with time drifted apart and this obviously causes problems in our relationship.

8	I have been brought up to feel shameful about just thinking of sex. I feel that I have been conditioned to feel guilty and shameful about even thinking of sex.	I don't think anyone will ever understand how it is to be in an unconsummated marriage and the shame that comes with it. Every time my family asks us when we are having children I want to run. I have run out of excuses. I really feel shame and guilt about lying to myself and my family about the seriousness of this situation. I think I have been in denial about our problems for a long time.
9	I feel extremely guilty, I am not sure about what exactly but I do think it is about not satisfying my partner. I wish I could change it but every time we try we are just back to square one.	I feel guilty about thinking about other women and it also causes me great shame. Sometimes I think I am just going to give up on us, but then I start feeling guilty and shallow. I start reasoning that it is impossible to leave someone just because you are sexually dissatisfied. The problem is it is, killing our relationship.
10	I am not to sure what cause the guilt and shame but I think I have felt guilty all my life of just being myself. I feel guilty about disappointing my parents, I feel guilty for not always being a strong believer and I feel guilty about not pleasing my partner. I guess all this guilt sometimes makes me feel depressed.	I am guilty of not doing anything about this situation. I wish I have addressed some of our issues a long time ago. I think I also feel guilty for sometimes hurting my wife when we try and have sexual intercourse. You can conclude that I am ashamed of sometimes reverting to forceful behaviour.

Interpretation of Table 2.6

Table 2.6 reveals feelings of guilt and shame and picks up on related themes regarding guilt and shame. Yellow indicates negative sexual conditioning, and pink indicates that a participant feels emotional and unmotivated to try and change. Blue points to no feelings of guilt or shame.

Figure 2.19 indicates the percentage of participants (n=10) who experience feelings of guilt and shame.



n=10

Figure 2.19: Guilt and shame

Figure 2.19 clearly indicates that eight of the female participants (80%) and eight of the male participants (80%) experience feelings of guilt and shame in their unconsummated marriage. Guilt and shame is the subject of the fifth theme in this research study, but the responses of the participants have revealed two related themes. These two related themes to the theme of guilt and shame are: negative sexual conditioning, and feeling emotional and unmotivated to try and change. The next section will focus on the first of these related themes, namely negative sexual conditioning.

Figure 2.20 and Figure 2.21 provide a breakdown of the incidence of feelings of guilt and shame among female and male participants, respectively. The breakdown groups participants according to related themes.

Figure 2.20 indicates the percentage of female participants who experience guilt and shame, with responses grouped according to related themes.

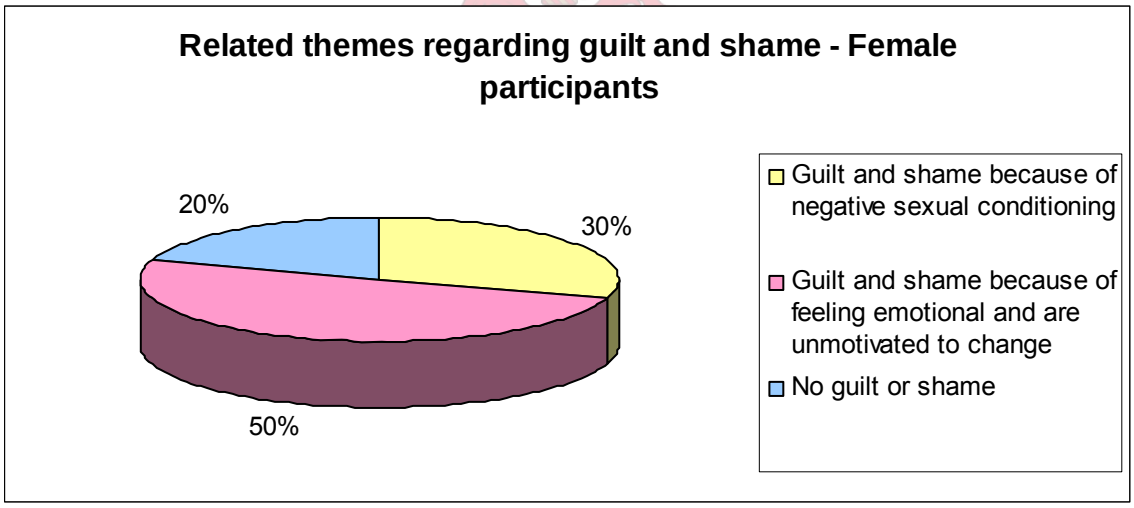


Figure 2.20: Female participants who experience guilt and shame, with responses grouped according to related themes.

The percentage of male participants who experience guilt and shame, with their responses grouped according to related themes, is indicated in Figure 2.21.

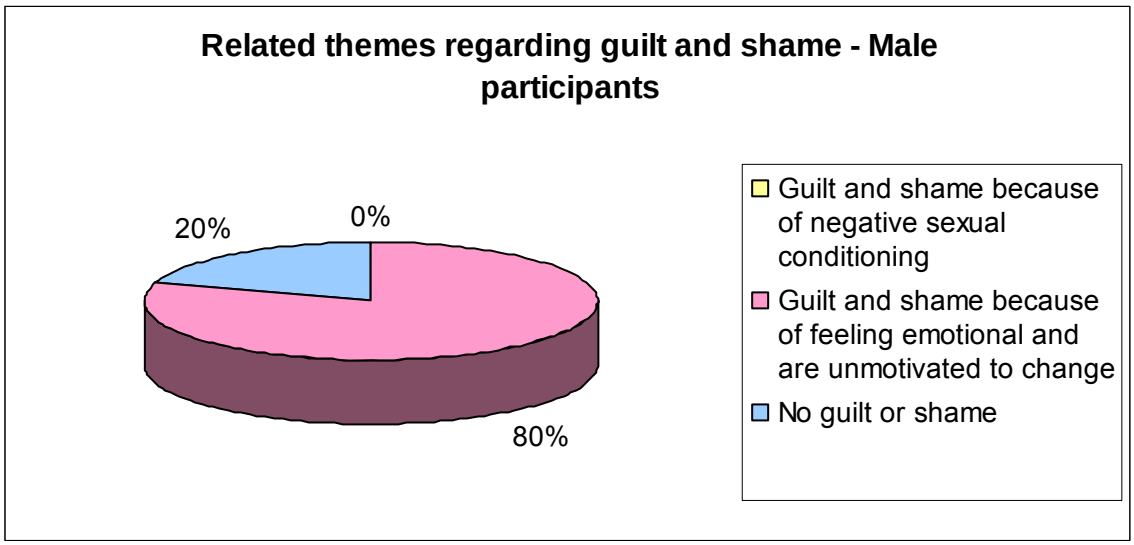


Figure 2.21: Male participants who experience guilt and shame, grouped according to related themes.

a) Negative sexual conditioning

Table 2.6 reveals that three female participants and no male participants experience guilt and shame because of negative sexual conditioning. These are the words of a female participant who experienced negative sexual conditioning:

> I feel as though I shouldn't think about things like that, that it is wrong. I feel shame towards my parents and more myself!

The literature (Silverstein, 1989; Basson, 1996; Reissing *et al.,* 1999; Jeng, 2003; Renshaw, 2003; Renshaw, 2004) confirms that to be socialised and conditioned by negative sexual messages can have a detrimental effect on a person's healthy sexual development, and thus eventually on his or her ability to consummate a marriage. Sex is then associated with guilt and shame, and the marriage and its consummation are adversely affected. It was clear in this study that negative programming from parents about sexuality and appearance is a problem, which takes this investigation to the related theme of feeling emotional and not motivated to change.

b) Feeling emotional and unmotivated to change

Table 2.6 reflects that five female participants and eight male participants experience guilt and shame because they feel emotional yet are unmotivated to change. Comments they made during the interview included these, for example:

> I feel guilty and shameful about pushing my husband away. It became worse and worse with time and spiralled into one big mess. I wish things could be different, but I don't know how to even begin changing this situation.

> Sometimes feeling of guilt for not being understanding enough – could have been more supportive should have worked harder on issues along time ago. I feel down, depressed, sad, cranky and lousy.

The participants expressed guilt because of their lack of motivation to change or for failing to address their sexual problems. It was found that their lack of commitment to change their situation causes a lot of shame and guilt in the relationship. It was evident that some couples felt very despondent and unmotivated to change. Some were tearful and cried when they spoke about their problem. The participants felt shameful because of their emotional state of mind. Some said that they were regularly emotional and tearful, cried often and felt guilty about their emotional behaviour. According to the literature (Rosenbaum, 2003; Renshaw, 2004) an unconsummated marriage can be a very emotional situation because of the feelings of frustration and helplessness that the couple experiences. The learned helplessness and inability to want to change the situation also causes great distress and emotionality in the relationship.

Within a postmodern approach (White, 1995; Walsh, 2003) narrative therapy could be useful in dealing with the guilt and the shame that a couple experiences in an unconsummated marriage. The literature (Hoffmann, 1990; Gergen, 1991; Ogden & Ward, 1995; White, 1995; Goldenberg & Goldenberg, 1998; Hoffmann,

2002; Walsh, 2003) suggests that narrative therapy should be guided by a few basic assumptions: that people have good intentions and neither want nor need problems; and that they can develop empowering stories when separated from their problems and constraining cultural beliefs. Problems are not thought to be caused by family interaction or psychodynamics; instead, therapeutic focus shifts away from pathology within people or families and toward an appreciation of the toxic effects of many dominant discourses in the social world (White, 1995; Walsh, 2003).

In the next section the focus is on the sixth theme, namely the manifestation of depression and apathetic attitudes.

2.3.2.6 Theme 6: Manifestation of depression and apathetic attitudes

Theme six corresponds to question six in the interview schedule, namely: "Would you say that feelings of depression or apathetic attitudes toward your partner have manifested?" Verbatim excerpts from the interviewees regarding the manifestation of depression and apathetic attitudes are presented in Table 2.7.

Table 2.7: Manifestation of depression and apathetic attitudes

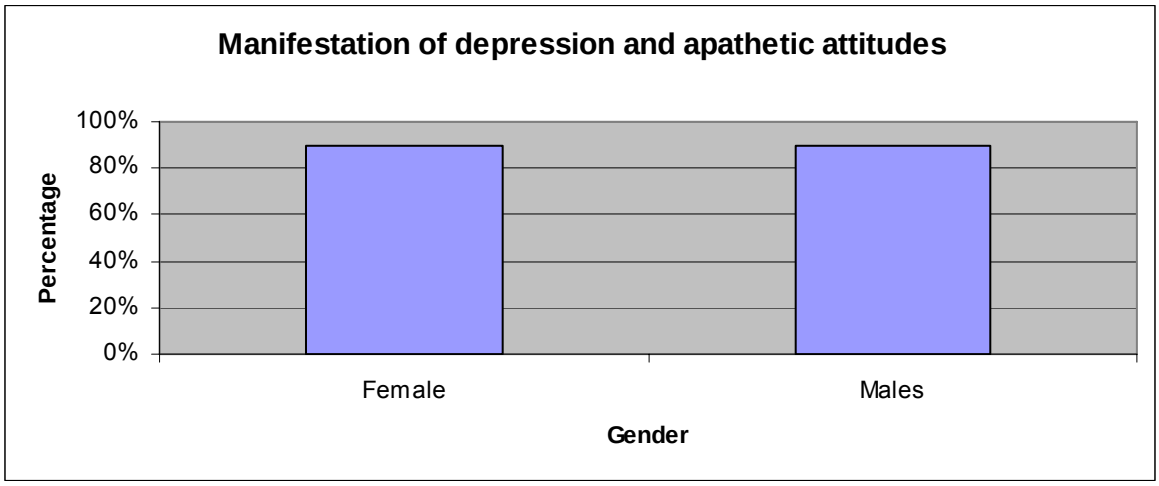
COUPLE	FEMALE	MALE
1	I do feel apathetic towards my partner. I am going through depression as I would love to be normal like other women and be able to have a baby.	Gets me down at times and leaves me negative towards partner and situation.
2	I feel slightly depressed about it, but am feeling a lot better now that I know I am getting help. I sometimes get an apathetic attitude towards the problem, by thinking that 'why is it such a big deal as I can live without it. I sometimes felt apathetic towards my partner, because I couldn't understand why it was such a big deal, and I just wanted to be a virgin again and hide behind that excuse!	I don't feel depressed, I sometimes feel depressed for my partner's sake.
3	I do really sometimes try to be positive, but it is really getting me down to the point where I really do feel depressed. I don't think I will go on medication but this needs to be sorted out.	This problem is causing us to feel cold towards each other. We will nearly never be intimate including even kissing. My wife always thinks it will lead to something. Sometimes I feel down and a bit depressed about our relationship.
4	I can't say depression because as a couple we openly discuss how we feel and being in this together somehow relaxes me. I do however sometimes feel anger towards myself because I feel it's all in my mind and if only I could get past the pain stage everything will be alright.	Yes, because I want us to carry on with our lives and one day have a child of our own. It just irritates me when I hear my friends talk about their kids and I don't have any because of this stumbling block we encounter. It also hurts me when my dad asks me when he is going to have a grand child and specially because my mom in not around anymore.
5	I definitely feel depressed.	I think it is more of a frustration towards the circumstances and situations than to my partner.

6	I have been on anti-depressants for numerous years. Since our honeymoon nine years ago and being confronted with this problem, I have found my depression just becoming worse. Sometimes I feel quite close to my husband but when we become too comfortable I suddenly tense up again.	I don't see myself as a depressed person over all; this situation is just putting a lot of strain on us. I battle to deal with it because I really don't know what to do. I would say that I sometimes feel apathetic towards my partner, perhaps it is also a bit of resentment.
7	This is really depressing; I think that there in nothing more depressing than sitting in an unconsummated marriage.	You bet it is depressing, I think I am a bit depressed after the accident. But besides this problem I won't say our marriage is that bad. We are a bit cold and apathetic towards each other.
8	I feel apathetic towards my partner, I think he feels the same just to touch each other is nearly impossible. Just thinking of it makes me feel sick and you can say depressed.	I have sort of given up, I feel totally apathetic and cold.
9	I feel extremely depressed. I am currently on anti-depressants but at the end of the day it is not actually helping me or my husband in consummating the marriage.	Sometimes I just feel that I just don't care anymore. There is a definite apathetic feeling towards my partner. I feel that she is sometimes not trying hard enough but just by saying that I feel guilty again. It is really extremely frustrating.
10	I guess you can say I am sort of depressed. I really struggle to deal with this situation and I have sort of blocked it out and try not to think about it. I know it can't carry on like this because our relationship is taking strain.	I would say that I am prone to depression. I was on Sypromil before this situation. This is definitely not helping my depression. I feel a bit apathetic towards the situation; I blame myself and my wife for this problem.

Interpretation of Table 2.7

Table 2.7 indicates a manifestation of depression and apathetic attitudes as well as themes related to this: depression about sexual inadequacy and functioning (yellow); tension of the whole body (green). A complete absence of feelings of depression and apathy is indicated in purple.

Figure 2.22 indicates the percentage of participants (n=10) who manifested depression and apathetic attitudes.



n=10

Figure 2.22: Manifestation of depression and apathetic attitudes

According to Figure 2.22 nine of the female participants (90%) and nine of the male participants (90%) experience or have experienced feelings of depression and apathy towards themselves, the situation or their partner. The manifestation of depression and apathetic attitudes was set to be investigated as the sixth theme researched in this study. Two related themes have been identified from the responses of the participants, namely: Depression about sexual inadequacy and functioning; and tension of the "whole" body. The next section subsequently focuses on the related theme of feeling depressed about sexual inadequacy and functioning.

Figure 2.23 and Figure 2.24 indicate the percentages of female and male participants who experience a manifestation of depression and apathetic attitudes, with responses grouped according to related themes.

Figure 2.23 indicates the percentage of female participants who experience a manifestation of depression and apathetic attitudes, with responses grouped according to related themes.

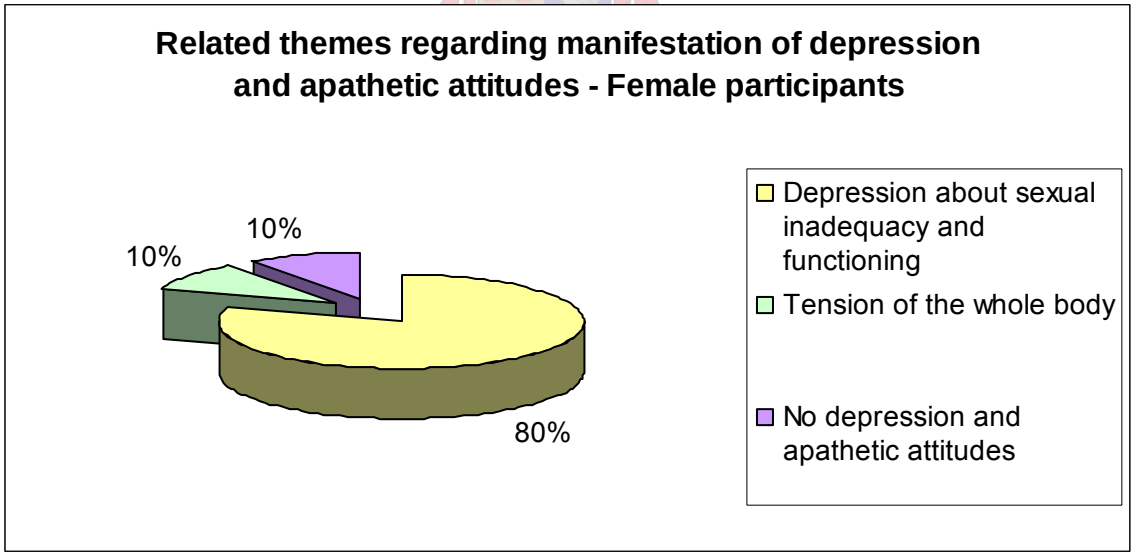


Figure 2.23: Female participants who experience a manifestation of depression and apathetic attitudes, with responses grouped according to related themes.

The incidence of male participants who experience a manifestation of depression and apathetic attitudes is reflected in Figure 2.24. Responses have been grouped according to related themes.

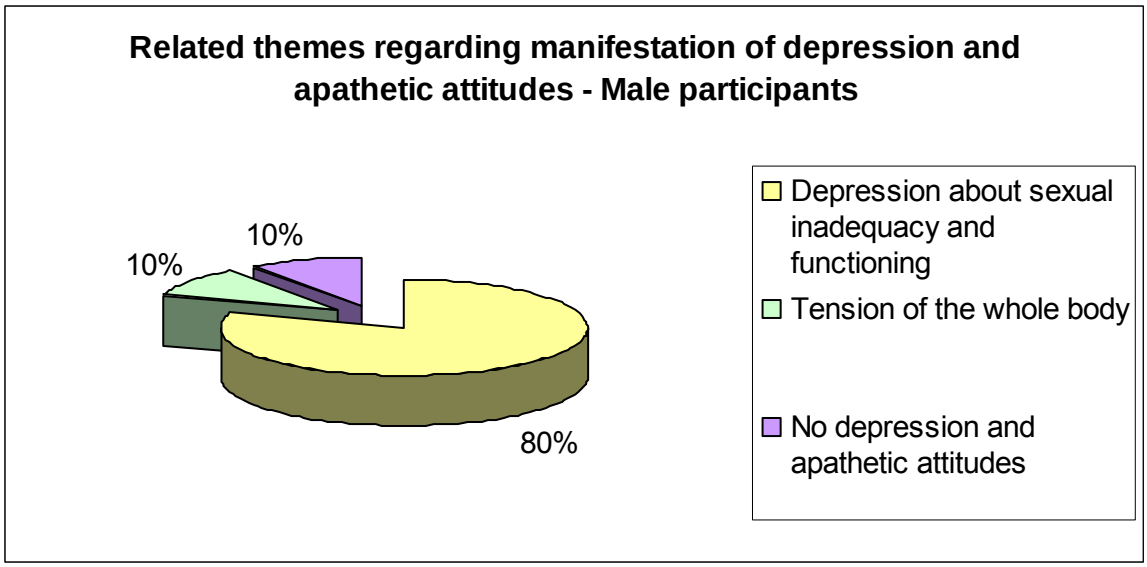


Figure 2.24: Male participants who experience a manifestation of depression and apathetic attitudes, with responses grouped according to related themes.

a) Feeling depressed about sexual inadequacy and functioning

Table 2.7 reflects that nine female participants and nine male participants experience depressed feelings or symptoms of depression. Comments they made regarding their feelings of depression about their sexual inadequacy and functioning are as follows:

> I feel extremely depressed. I am currently on anti-depressants but at the end of the day it is not actually helping me or my husband in consummating the marriage.

> You bet it is depressing, I think I am a bit depressed after the accident. But besides this problem I won't say our marriage is that bad. We are a bit cold and apathetic towards each other.

There is a definite tendency among both male and female partners to experience feelings of depression in an unconsummated marriage. The experience of feeling depressed and despondent, as described by the couples, was reflected in their facial expressions and body language. The literature (Nevid, Rathus & Greene, 1997; Reissing *et al.,* 1999; Nawal, 2000; Jancin, 2001; Jeng, 2003; Renshaw, 2004) confirms that depression and unconsummated marriages go hand in hand. Throughout this study it was found that the couples experienced depression about their sexual inadequacy and sexual malfunctioning. They also experienced symptoms associated with both anxiety and depression. This usually led to an internalisation of emotion and an apathetic attitude towards the partner.

b) Tension of the whole body

During the interviews it was observed that the participants seemed very anxious, since they looked quite tense. The participants acknowledged that their whole body felt affected by having to cope with an unconsummated marriage, and they indicated that it put a lot of strain on them emotionally, physically and psychologically. They stated that they felt cold and apathetic towards their partners, and during the interviews this could be observed in the participants' body language. Table 2.7 indicates that one female participant and one male participant conceded that their unconsummated marriage affected not only their sexual life but also their emotional, physical and psychological wellbeing. Their comments were, for example:

> I have been on anti-depressants for numerous years. Since our honeymoon nine years ago and being confronted with this problem, I have found my depression just becoming worse. Sometimes I feel quite close to my husband but when we become too comfortable I suddenly tense up again.

> This problem is causing us to feel cold towards each other. We will nearly never be intimate including even kissing. My wife always thinks it

will lead to something. Sometimes I feel down and a bit depressed about our relationship.

According to the literature (Nevid, Rathus & Greene, 1997; Reissing *et al.,* 1999; Nawal, 2000; Jancin, 2001; Jeng, 2003; Renshaw, 2004) depression is a whole-body illness, involving the body, mood and thoughts. It affects the way people eat and sleep, the way they feel about themselves, and the way they think about things. It causes a breakdown in the husband-wife unit in an unconsummated marriage and causes an apathetic attitude towards each other and the relationship.

The Circumplex model (Barker, 1998:71; Olson & Gorall, 2003:514) can be very helpful when intervention is done with the couple who feel depressed and apathetic towards their relationship. The Circumplex model is particularly useful in making diagnoses in relationships, as it focuses on the relational system and integrates three dimensions that have repeatedly been considered highly relevant in a variety of family therapy models and family therapy approaches. Family cohesion, flexibility, and communication, the three dimensions in the Circumplex model emerged from a conceptual clustering of over 50 concepts developed to describe marital and family dynamics (Barker, 1998:71; Olson & Gorall, 2003:514) and can contribute when dealing with depression in therapeutic intervention.

The next section focuses on the seventh theme, namely feelings of personal distress and the diagnosis of psychological problems.

2.3.2.7 Theme 7: Personal distress and diagnosis of psychological problems

Theme seven corresponds to questions seven (a) and (b) in the interview schedule, namely: (a) “Do you think you experience personal distress?” (b) “Have you been diagnosed with a psychological problem?” Verbatim excerpts from the interviewees on the theme of personal distress and diagnosis of psychological problems will be presented in Table 2.8

Table 2.8: Personal distress and diagnosis of psychological problems

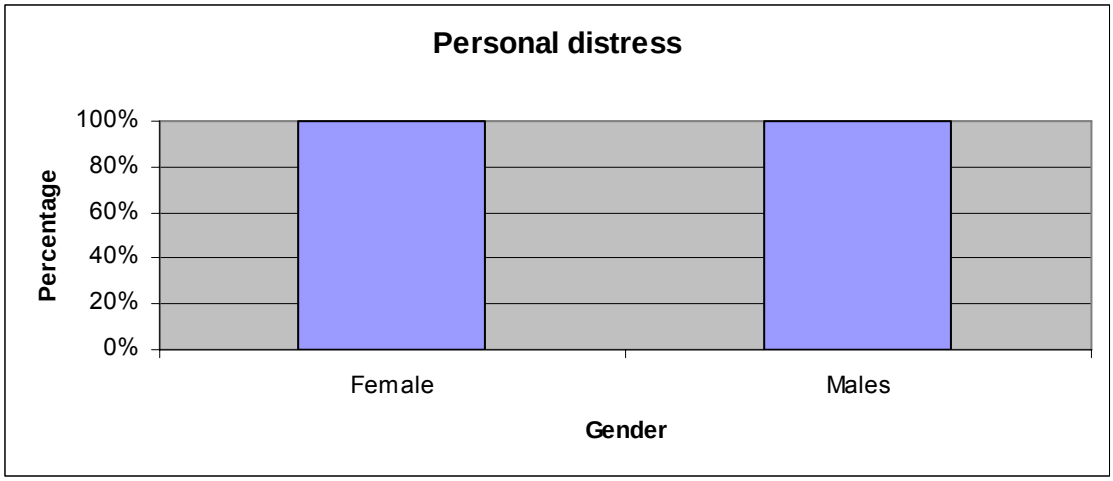
COUPLE	FEMALE	MALE
1	(a) I do experience personal distress as these problems feel like a mountain on my shoulders. I feel sad; thinking of suicide and feel regretful. (b) I do think I have psychological problems, as the fear I have of having sex is not normal.	(a) I do experience personal distress; I get very irritable and annoyed. I become very quiet and cry. (b) No psychological issues or history of psychological issues.
2	(a) I felt as though there was something very wrong with me. I felt as though I was different to everyone else. I couldn't understand why I was this way, it made me very depressed and angry. I was also scared and unsure. I sometimes feel scared of a relationship; angry, confused and hateful. (b) I think something is wrong with me.	(a) Feel distress towards Vaginismus. (b) I don't think I struggle with psychological problems. I just feel that I am not doing the right stuff and in the right manner. I feel a bit depressed because of the fact that I can not satisfy my partner.
3	(a) I am very anxious and stressed and feel that I can not relax. This causes great distress in my life to the point where I feel panic and ready to start hyperventilating. Should things not change, I think our marriage will end and that in itself makes me anxious. I am inclined to stress quite a bit and this situation is causing personal distress for both husband and myself. (b) I think the fear and phobia of sex is definitely a psychological problem.	(a) I feel depressed when thinking about our marriage. Sometimes when I have a bad day I dream of how it would be in a normal situation. I am convinced that this is not a normal marriage. It causes personal distress and I feel like hiding away. I don't want to talk about it any more as I feel all discussions just goes on and on in circles. (b) I think both of us have developed some psychological problems due to this problems for example being over-emotional and sensitive, being obsessed in other areas of our relationship, being extremely depressed and sad.
4	(a) Yes, this is the main cause of the problem. If I could relax or not tense up it would make consummating the marriage easier. (b) I can't psychologically feel that I have a problem but I feel that maybe there's something tensing me up or not relaxing me.	(a) Yes, because I feel as if I can't perform as a man and as a husband to my wife. It is also related to the inability to produce offspring. (b) No.
5	(a) It is a heavy burden to bear. (b) No psychological problems but definite relationship problems in that a distance grew between us in all aspects of our relationship. I am confused by the problem, and feel this is an unhappy relationship.	(a) I do feel distress as it does not seem healthy or natural in a marriage. (b) I do not think that there is a psychological problem. I think the situation is out of hand and control, I am disappointed and do not like what is happening. This causes an apathetic feeling towards my partner.
6	(a) I feel like this abnormal freak who will never be able to function as a normal woman. This causes great distress in my life and sometimes I think that I am not coping with this situation and it is influencing my whole life. (b) There is a definite psychological problem - I am struggling with depression. In addition to this I have a poor body image to such an extent that I have in the past presented with eating disorders. I sometimes feel that no one understands me and that I am totally alone in the world.	(a) I think the family pressure to conceive a child is quite stressful, causing me personal distress. When I see a baby advert or when I hear the word baby I want to run. I feel anxious and I always think someone is going to raise the topic. This "baby issue" is causing a lot of stress in our relationship and we don't know how to deal with it. (b) It is possible that because of this sexless marriage psychological problems may develop. I sometimes feel trapped and don't know how to go on with this relationship. I am scared that it is going to end up in a divorce.
7	(a) I am very scared that this problem will cause our marriage to end in a divorce. I have always been scared that I will face divorce one day. My parents were divorced	(a) This situation is definitely causing personal distress in my life and sometimes the sadness becomes prevalent as anger, irritation, frustration

	and it caused a lot of sadness in my life. Sometimes I still feel sad about my childhood. I think because of my childhood I have always been a bit stressed in relationships. (b) I don't think I have a psychological problem, but I do sometimes struggle to deal with this situation and feel quite depressed and sad.	which can be quite hurtful. (b) I think to some extent I do have psychological problems. I feel very hostile toward my self and blame myself for our bad marriage. I think I have a lot of unresolved issues about the accident and have never dealt with them. This is putting a lot of strain on our relationship.
8	(a) I think that our sexual relationship has caused a lot of stress in our relationship. Every argument that we seem to have will end up in an argument about our sex life. (b) I think I may have some degree of psychological problems. My personal history reflects that I always became anxious and panicky. Everyone always tells me that I am a very stressed and tense person.	(a) I am stressed about this situation and it is causing me to become quite nasty and irritable. I sometimes act totally out of character and I am sure it is caused by the frustration and personal distress that I feel towards this situation.(b) I don't feel that I have psychological problems. From my point of view, I think it is my wife who struggles with a few problems.
9	(a) I am actually scared in the evenings to go home because it normally ends in a fight. My husband will approach me and I will reject him – it is a vicious circle. I feel very stressed about this situation. (b) No psychological problems.	(a) I do experience severe personal distress. (b) I have come to the point where I think it is all in her head. She is telling herself it is going to be a total disaster. It is definitely a psychological problem that is now a sexual problem.
10	(a) There is definitely personal distress on my side when I think about this relationship, my partner and our non existent sex life. (b) I guess you can say it is a psychological problem because I know that I tell my self that it is going to be painful and I immediately start to hyperventilate. He doesn't even have to touch me; just the thought of having sex makes me very anxious.	(a) I feel totally rejected by my wife and this causes great distress. I feel cheated and feel that as a man there is something wrong with me and that is why she doesn't want to have sex with me. (b) I am convinced that due to this situation, I have developed some psychological problems like doubting my self, blaming my self, feeling obsessed and preoccupied with sex.

Interpretation of Table 2.8

Table 2.8 reflects personal distress and diagnosis of psychological problems and related themes regarding personal distress and diagnosis of psychological problems. Yellow indicates manifestation of related disorders, whereas blue points out negative thinking and obsessive concern and conditioned anxiety. Psychosomatic problems are specified in blue and displaced emotions are reflected in purple.

Figure 2.25 indicates the percentage of participants (n=10) who experience personal distress.

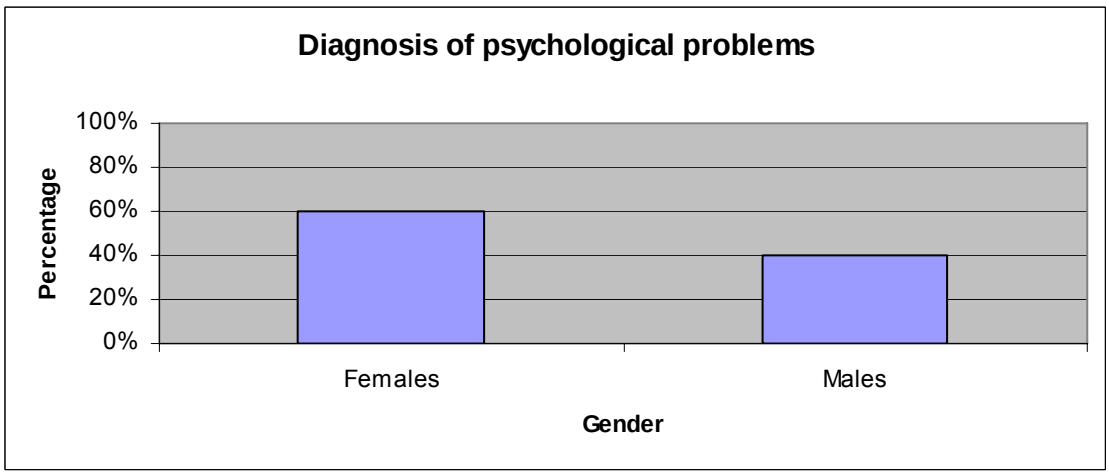


n=10

Figure 2.25: Personal distress

Figure 2.25 indicates that all (100%) of the female participants and all (100%) of the male participants experienced personal distress because of their unconsummated marriage.

Figure 2.26 indicates the percentage of participants (n=10) who experience psychological problems.



n=10

Figure 2.26: Diagnosis of psychological problems

According to Figure 2.26 six of the female participants (60%) and four of the male participants (40%) have either been diagnosed with psychological problems by a healthcare professional, or they themselves are of opinion that they experience psychological problems. The seventh theme in the study relates to personal distress and possible psychological problems. Four related themes to this theme were identified on the basis of responses given by the participants, namely the manifestation of related disorders; negative thinking and obsessive concern as well as conditioned anxiety; psycho-somatic problems; and lastly displaced emotions. The next section will focus on the first of these, namely the manifestation of related disorders.

Figure 2.27 and Figure 2.28 indicate the percentages of female and male participants who have indicated that they experience personal distress or psychological problems. Their responses have been grouped according to the related themes that emerged.

Figure 2.27 indicates the percentage of female participants who experience personal distress or psychological problems, with responses grouped according to the related themes.

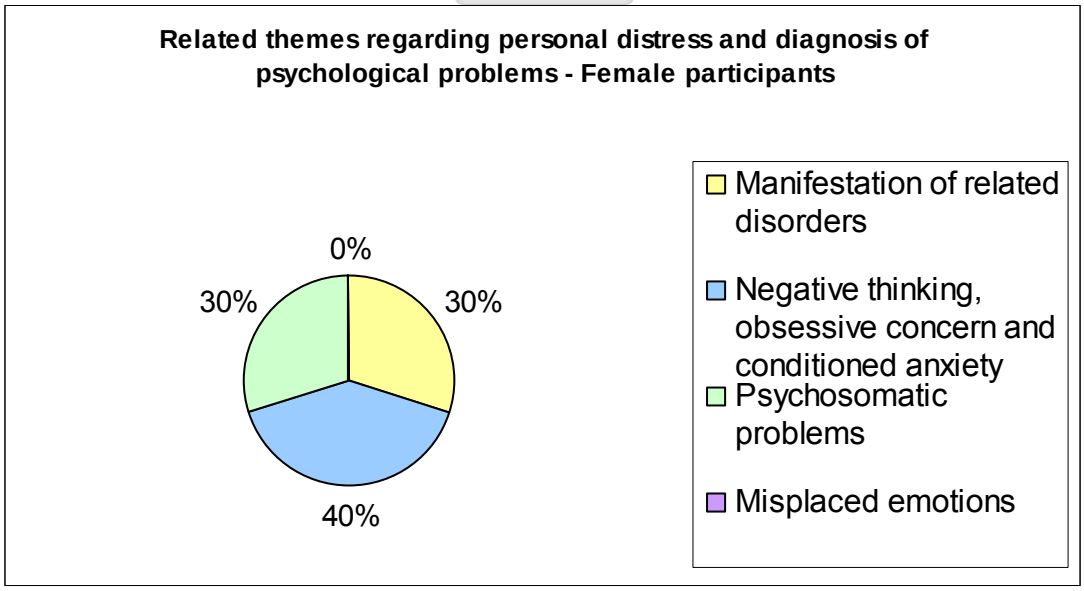


Figure 2.27: Female participants who experience personal distress or psychological problems, with responses grouped according to related themes.

The percentage of male participants who indicated that they experience personal distress or psychological problems is indicated in Figure 2.28. Their responses have been grouped according to related themes.

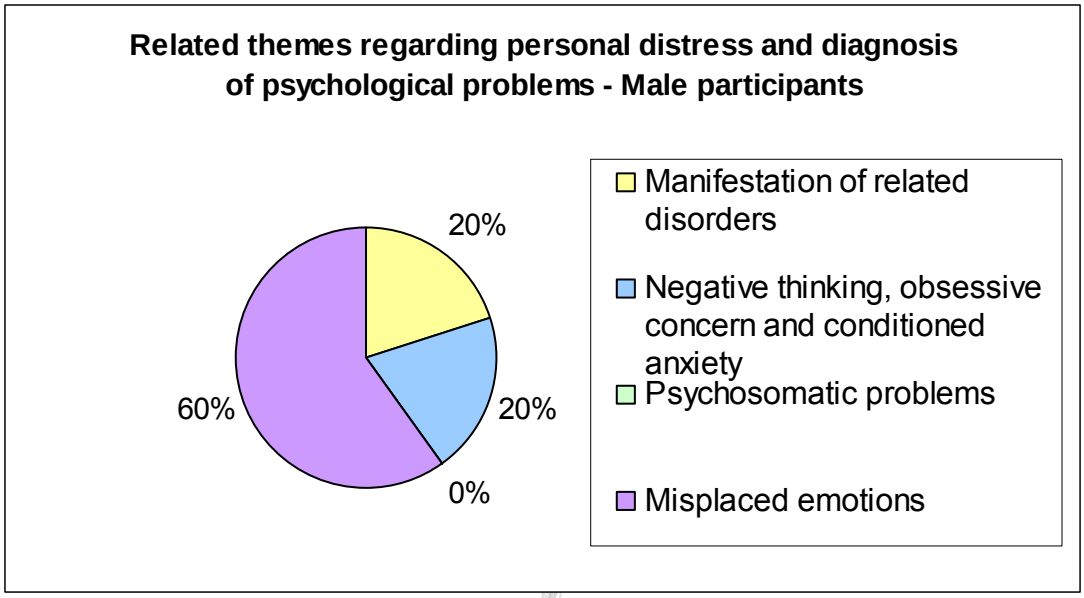


Figure 2.28: Male participants who experience personal distress or psychological problems, with responses grouped according to related themes.

a) Manifestation of related disorders

Table 2.8 indicates that three female participants and two male participants indicated a manifestation of related disorders. This manifestation of related disorders is reflected in statements such as:

> I think that our sexual relationship has caused a lot of stress in our relationship. Every argument that we seem to have will end up in an argument about our sex life. I think I may have some degree of psychological problems. My personal history reflects that I always became anxious and panicky. Everyone always tells me that I am a very stressed and tense person.

> I feel depressed when thinking about our marriage. Sometimes when I have a bad day I dream of how it would be in a normal situation. I am convinced that this is not a normal marriage. It causes personal distress and I feel like hiding away. I don't want to talk about it any more as I feel all discussions just goes on and on in circles. I think both of us have developed some psychological problems due to this problems for example being over-emotional and sensitive, being obsessed in other areas of our relationship, being extremely depressed and sad.

Katz and Tabisel (2002) and Shah (1999:1) explain that one of the pleasures that newly married couples look forward to, is a happy and mutually satisfying sexual relationship. Failure to achieve this satisfaction, and worse, being unable to have intercourse at all, can have a shattering effect on the marriage, resulting in marked stress, frustration, hostility and even divorce.

In this study it was found that some female and male participants have disorders characterised by phobias, deep-rooted fears, depression and impaired social skills which affect not only their sexual responses but other aspects of their relationship as well. In these cases, the sexual disturbance is just one facet of a very disturbed marriage. Moreover, Shah (1999:2) suggests that family pressures, lack of privacy, and job stress, can sometimes generate so much stress within a marriage that sexual intimacy is not possible. This consequently causes great personal distress. The literature (Shah, 1999; Jeng, 2003; Renshaw, 2003; Renshaw, 2004) confirms that diagnosed psychological problems are prevalent in an unconsummated marriage, and that all the interrelated problems cause personal distress which negatively influences the husband-wife subsystem. The following section will focus on another related theme, namely negative thinking, obsessive concern, and conditioned anxiety.

b) Negative thinking, obsessive concern and conditioned anxiety

As is clear from Table 2.8, four female participants and two male participants indicated negative thinking, obsessive concern or conditioned anxiety. For example, participants commented as follows:

> I am actually scared in the evenings to go home because it normally ends in a fight. My husband will approach me and I will reject him – it is a vicious circle. I feel very stressed about this situation. No psychological problems.

> I think the family pressure to conceive a child is quite stressful, causing me personal distress. When I see a baby advert or when I hear the word baby I want to run. I feel anxious and I always think someone is going to raise the topic. This "baby issue" is causing a lot of stress in our relationship and we don't know how to deal with it. It is possible that because of this sexless marriage psychological problems may develop. I sometimes feel trapped and don't know how to go on with this relationship. I am scared that it is going to end up in a divorce.

Negative thinking and obsessive concern or worry about the sexual intentions of others, and conditioned anxiety, are experienced by many couples in an unconsummated marriage. The literature (Miller, 1990; Katz, Gipson & Turner, 1992; Kaminer, 1992; Jeng, 2003) states that negative thinking patterns are often found in couples in an unconsummated marriage. The next section focuses on another related theme, namely psychosomatic problems.

c) Psychosomatic problems

Table 2.8 indicates that three female participants indicated psychosomatic problems, but no male participants. Psychosomatic problems are reflected in statements such as:

> There is definitely personal distress on my side when I think about this relationship, my partner and our non existent sex life. I guess you can say it is a psychological problem because I know that I tell my self that it is going to be painful and I immediately start to hyperventilate. He doesn't even have to touch me; just the thought of having sex makes me very anxious.

The literature (Ellison, 1968; Carnes, 1997; Beckmann, Bender, Bodden-Heindrich, Kuppers & Rechenberger, 1999; Renshaw, 2003) states that couples in an unconsummated marriage often feel ill, but this is mostly psychosomatic because they feel so helpless and emotionally tired. Stomach aches, headaches, panic attacks and episodes of hyperventilation, excessive agitation and anger were experienced by the participants in this study. Participants seemed to feel that these symptoms were stress related. The next section focuses on yet another related theme, namely displaced emotions.

d) Displaced emotions

Table 2.8 indicates that no female participants have displaced emotions, and that six male participants displace their emotions. The following words of a male participant are indicative of displaced emotions:

> I am stressed about this situation and it is causing me to become quite nasty and irritable. I sometimes act totally out of character and I am sure it is caused by the frustration and personal distress that I feel towards this situation. I don't feel that I have psychological problems. From my

point of view, I think it is my wife who struggles with a few problems.

During the interviews it was found that displaced emotions were common among the male participants. The emotional sadness that the men taking part in this study experienced, tended to get displaced by — and projected as — anger, hostility and irritation. The male partners felt that over time they had developed symptoms of what could be viewed as psychological problems. The literature (Jeng, 2003; Renshaw; 2004) confirms these findings and states that males often displace the emotion of sadness and are more prone to anger, losing their temper and becoming nasty and resentful because of the unconsummated marriage. They also often feel guilty and ashamed about their reactions and the lack of understanding they show their spouses.

Postmodern theory (Freedman & Combs, 1996; Laird, 1998; Walsh, 2003) can be utilised in addressing personal distress and psychological problems. Laird (1998) and Walsh (2003) explain that postmodern therapists have been especially wary of claims of objectivity, which they regard as unobtainable. They eschew psychiatric diagnostic categories, as well as family typologies and evaluation schemes, regarding these as reductionist, dehumanising, and marginalising differences from norms. Accordingly, it is imperative to re-author and rewrite the couple's perceptions and experiences in order to motivate and encourage the couple to change their behaviour patterns. It is important not to normalise according to society rules; the goal should rather be to change the couple's behaviour patterns so that the relationship can be more functional. Narrative therapists "situate" themselves with patients, and assume a nonexpert, collaborative stance (Freedman & Combs, 1996; Laird, 1998; Walsh, 2003).

The next section focuses on the eighth theme, namely regret and sadness.

2.3.2.8 Theme 8: Regret and sadness

Theme eight corresponds to question eight of the interview schedule, namely: "Do you have feelings of regret and sadness?" Verbatim excerpts from the

interviewees regarding possible feelings of regret and sadness are presented in Table 2.9.

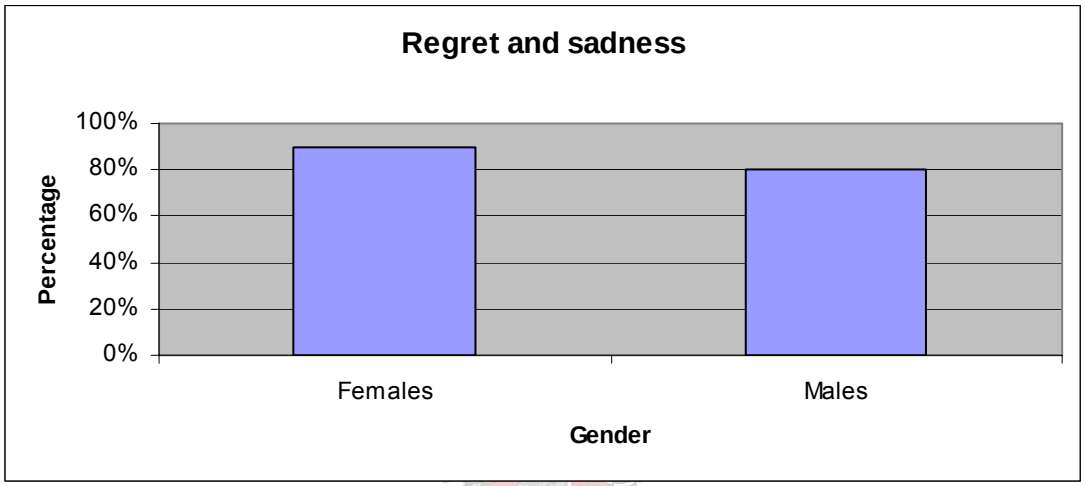
Table 2.9: Regret and sadness

COUPLE	FEMALE	MALE
1	I do not regret not having sex with other partners, as it is against my belief to have sex before marriage. I do have regrets regarding the inability to have sex with my soul partner. I feel hopeless and alone.	No not actually. Sometimes I do feel sad, moan and cry.
2	I guess maybe having had a one night stand, I regret it because I felt very used.	No regrets or sadness.
3	I have thought of just telling my husband to go and have sex with someone else. I guess that is irrational thinking but I have no energy to think about how to change our destructive situation.	I feel sad because perhaps we will never have children of our own. I don't know if this situation is ever going to change, but I hope it does. I think that if it is goes on like this the marriage may end. I sometimes regret the way I speak and act towards my wife. I just feel so annoyed with this sex situation.
4	I don't feel regret or sad about things I have done.	No not al all.
5	I do feel regret and sadness because I have sinned according to my religious beliefs. I do regret all the time we have lost.	I regret not taking opportunities, missing out on things, and unable to reach or meet expectations.
6	Sad is putting it mildly. I sometimes feel that this is the root of my severe depression. I think if we can solve this problem I will feel much better. I sometimes regret being me. I wish overall that I could be different because then our relationship would not be so unhappy and my husband would be more satisfied.	Overall I feel sad and depressed about the situation. I always try to look at the positive but in this case I just see a dark cloud.
7	I am definitely sad and emotional when I think about our sexless marriage. I think this is the reason I regret a lot of other behaviour I bring into this marriage. I sometimes feel that I am just in the way.	I regret of not giving my wife what she deserves, I sometimes wonder why she doesn't leave. But I can't imagine life with out her; this makes me feel totally depressed and sad.
8	I feel emotionally destroyed, I have cried so many times about this situation even to the point of depression. I regret not doing anything sooner about our problem.	I regret that in our marriage we never tried harder. I think we just felt too stupid to get professional help so we tried to fix it ourselves. I am sorry we lost so many years together.
9	I feel extremely sad about our marriage; I never imagined that this is possible in a relationship. Before this happened to us, I had never even heard of it before. I regret not getting help sooner and ignoring the problem.	I sometimes feel very sad especially when we try to have sexual intercourse and my wife just starts crying. It feels as if I am hurting her. Usually after we tried, I regret mentioning the topic and hurting her again.
10	I was molested as a child and I regret not telling anyone. I am still wrestling with the hurt that someone else brought into my life when I was a child. Sometimes I feel like the six year old girl that was so helpless. I know it sounds terrible but it sometimes feel as if my husband is molesting me when we play around. I feel very sad and emotional when thinking about my childhood.	I can't believe that sex can be such a big issue, but in our lives that is what is causing all our problems and it makes me sad. I think sometimes the sadness presents wrongly and I get angry. I resent the angriness but I am just so frustrated, I don't know what to do anymore.

Interpretation of Table 2.9

Table 2.9 reflects feelings of regret and sadness as well as related themes regarding regret and sadness. Yellow indicates shame and self-loathing over sexual experiences. Feelings of fatigue or loss of energy are indicated in blue, whereas the absence of regret and sadness is represented by the colour purple.

Figure 2.29 indicates the percentage of participants (n=10) who have regrets and experience sadness.



n=10

Figure 2.29: Regret and sadness

Figure 2.29 indicates that nine of the female participants (90%) and eight of the male participants (80%) experienced feelings of regret and sadness. Regret and sadness were identified as the eighth theme. Two related themes to regret and sadness may be identified from the responses of the participants, namely shame and self-loathing over sexual experiences; and a feeling of fatigue and loss of energy.

Figure 2.30 and Figure 2.31 indicate the percentages of female and male participants who experience regret and sadness. Responses have been grouped according to related themes.

Figure 2.30 indicates the percentage of female participants who experience regret and sadness, with responses grouped according to related themes.

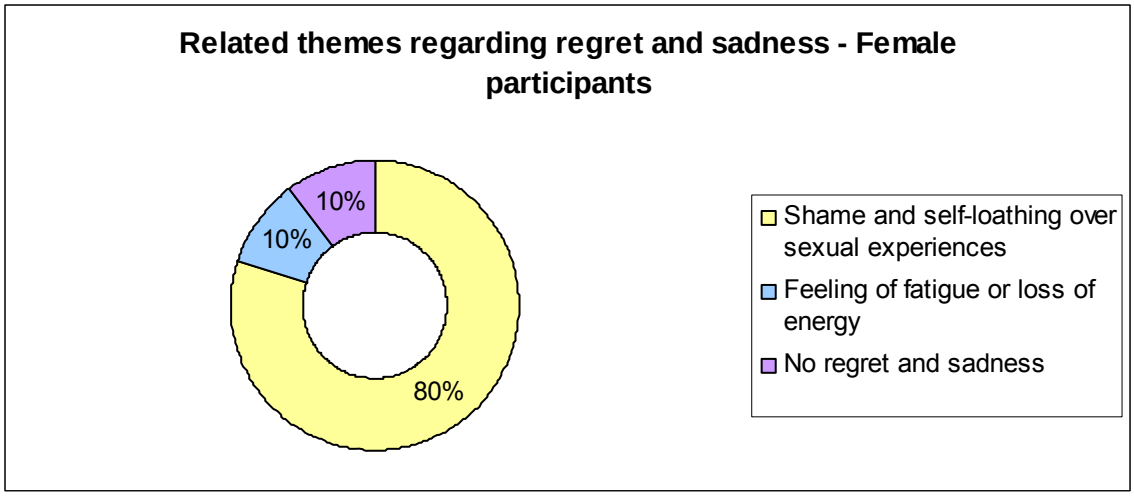


Figure 2.30: Female participants who experience regret and sadness, with responses grouped according to related themes.

The percentage of male participants who indicated that they experience feelings associated with regret and sadness is presented in Figure 2.31. Responses have been grouped according to related themes.

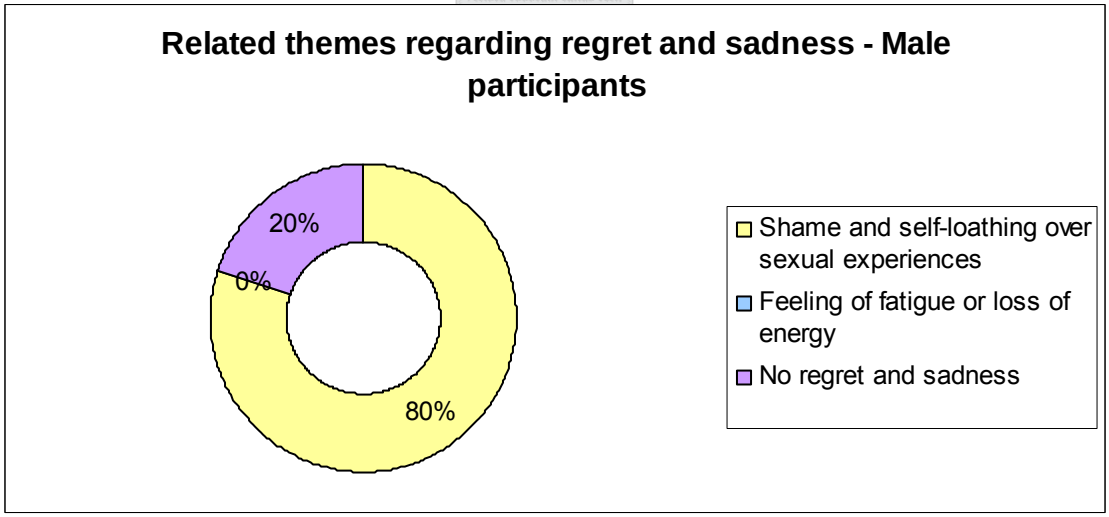


Figure 2.31: Male participants who experience regret and sadness, with responses grouped according to related themes.

a) Shame and self-loathing over sexual experiences

Table 2.9 indicates that eight female participants and eight male participants experience shame and self-loathing over their sexual experiences, or lack thereof. Comments they made included for example:

> I am definitely sad and emotional when I think about our sexless marriage. I think this is the reason I regret a lot of other behaviour I bring into this marriage. I sometimes feel that I am just in the way.

> I sometimes feel very sad especially when we try to have sexual intercourse and my wife just starts crying. It feels as if I am hurting her. Usually after we tried, I regret mentioning the topic and hurting her again.

The prevalence of sadness and unhappiness was obvious during the interviews with the couples. Participants gave vent to repressed emotions during the interviews and their facial expressions and body language reflected that they were enduring emotional pain and sadness. Nawal (2000:1) states that couples in an unconsummated marriage experience extreme sadness due to past sexual experiences but also because of their present situation, the unconsummated marriage. Shah (1999:1) and Jancin (2001) explain that the regret and sadness they feel frequently lead to patterns of behaviour where they blame themselves for what is going on; sometimes they also shift the blame to their partners. The following section will focus on the other related theme, namely feelings of fatigue or loss of energy.

b) Feelings of fatigue or loss of energy

Table 2.9 indicates that one female participant and no male participant said that she experienced a feeling of fatigue or loss of energy. These were the words of the one female participant who indicated that she experienced feelings of fatigue or loss of energy:

> I have thought of just telling my husband to go and have sex with someone else. I guess that is irrational thinking but I have no energy to think about how to change our destructive situation.

Carnes (1997:89) explains that couples in an unconsummated marriage often feel tired or emotionally exhausted because of the helplessness that they experience. It was found that participants were indeed emotionally drained as they felt sad and unhappy regarding their marriage.

The next section focuses on the ninth theme, namely self-destructive behaviour and self-blame.

2.3.2.9 Theme 9: Self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes

Theme nine corresponds to questions nine (a), (b), and (c) in the interview schedule, namely: (a) "Do you blame yourself for this condition?" (b) "Do you feel self-destructive?" (c) "Have you ever thought of self-mutilation or suicide?" Verbatim excerpts from the interviewees regarding the topic of self-blame/self-reproach, self-destructive behaviour, mutilation and suicide are presented in Table 2.10.

Table 2.10: Self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes

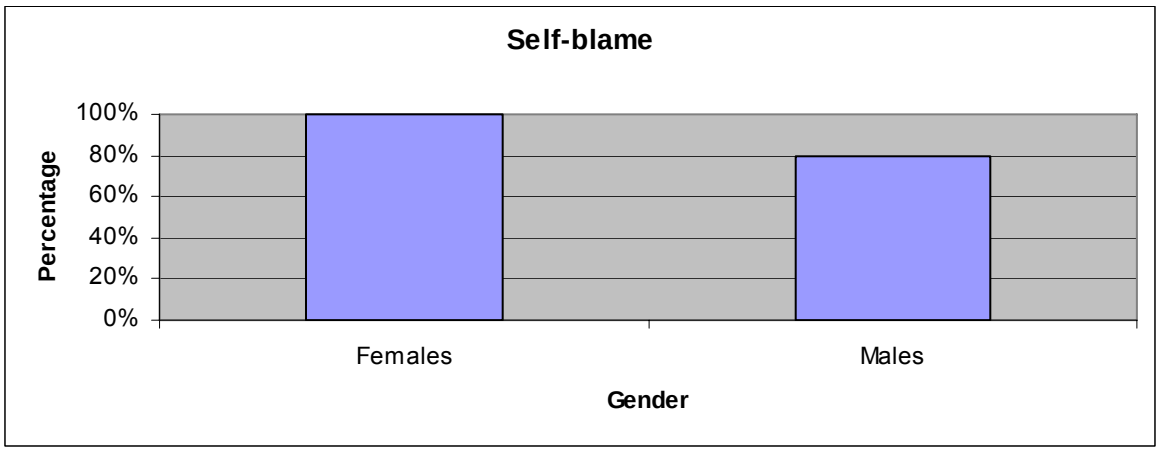
COUPLE	FEMALE	MALE
1	(a) I definitely blame myself not being able to having sex, and therefore my partner is suffering under these conditions which are unfair on him. When I think of self-blame, I think about sex, my mother and my beliefs. (b) I feel self-destructive and I have already thought of suicide, as I felt that there was no solution to my problem and I was/am a burden in my partner's life. (c) Thoughts of suicide.	(a) No just feel frustrated. (b) I feel angry, and fight, swear, and sometimes feel violent. There is definitely a lack of self-control when I think about myself. (c) Feel violent, lack of self-control. Not suicidal.
2	(a) I sometimes feel like I do it on purpose and I definitely then blame myself. (b) I have never been self-destructive; I always want the best for myself. I just feel that if I just learnt to relax, be more carefree, it would go away and I would be fine. (c) Not suicidal.	(a) No. (b) Not what so ever. (c) Definitely not.
3	(a) I feel extremely irritated and frustrated with the situation. I	(a) I do blame myself for not being more grown up about this

	think it is related to self-blame because I really have always blamed myself through out my life for most things that went wrong. (b) I think to an extent I am self-destructive. (c) I don't think I will ever commit suicide though.	situation. Sometimes we find ourselves fighting like children about this. (b) I think we are destructive in the way we talk to each other and sometimes it feels like we are emotionally destructive and intentionally hurtful. (c) No thoughts on mutilation and suicide.
4	(a) Not to please my husband causes a lot of self-blame. Pain is my major problem in my life and not being able to control or relax myself causes a lot of self-blaming. (b) No. (c) I have never thought about suicide or anything related.	(a) I do blame myself because we should have had sexual intercourse on the night we were married. (b) No I don't feel I am self-destructive. (c) No.
5	(a) I do blame myself for not getting help. I blame myself for making my husband unhappy and for prolonging and ignoring the situation. (b) I don't feel I am destructive in other areas except for the sex, and would never consider suicide but have sometimes wished to die due to an unhappy relationship. I wouldn't harm myself though. (c) No suicidal thoughts.	(a) I blame myself for the mistakes we have made, about penetration and things that could be controlled. (b) I did not take enough initiatives because I am afraid people would have judged us. I am definitely too conscious about other people's feelings and this I see as self-destructive. (c) No suicidal thoughts.
6	(a) I don't think I am always that emotionally stable. Sometimes I do blame myself for not pleasing my husband but then I get angry and wonder what he actually does to make this better. (b) Feel self-destructive. (c) I have tried to commit suicide when I was younger by drinking an overdose of pills. To be honest, I sometimes feel like doing it again but then feel that I will never have the guts to really succeed in an attempt. I feel frightened when I think of what has gone through my mind sometimes.	(a) I do blame myself especially after being so nasty and mean. I really feel guilty and sad about what I have said. (b) I am not self-destructive, but I think the things I say are destructive. I can become quite nasty not that it is going to help the situation. After being so nasty and mean I really feel guilty and sad about what I have said. (c) Not suicidal.
7	(a) I do blame myself for not having sex with my husband; I think if I really have to be honest I have a sort of aversion towards his amputation. I blame myself for not being a nicer person. (b) I am not self-destructive. (c) I don't think I will commit suicide but it has crossed my mind.	(a) I struggle to deal with my emotions and I then start blaming myself for everything that has happened. (b) Sometimes I feel so depressed; I think I have self-destructive thoughts. (c) I don't think I will commit suicide because after the accident I can be happy that I am still alive.
8	(a) I do take responsibility for this situation but through blaming my self I self-destruct. (b) My thoughts and my actions are self-destructive. Since a child I have never felt that I deserve pleasure. I didn't think it will manifest in my sex life later. (c) I don't feel suicidal or like mutilating myself.	(a) I do blame myself and wife for this situation. (b) I feel this situation is destroying us emotionally. We are disrespectful towards each other and sometimes I do think it would be healthier to just get a divorce because the situation is destructive. (c) No suicidal thoughts have ever crossed my mind.
9	(a) I do blame myself for the situation. (b) I feel very self-destructive. (c) I sometimes feel like killing myself, I know it is desperate measures and I will perhaps never do it, but I have thought about it.	(a) To some extent I blame my wife but then I feel guilty again. Perhaps it has been me all along. (b) Don't feel self-destructive. (c) It has never crossed my mind to commit suicide.
10	(a) I do blame myself and feel frustrated with myself because of my lack of sexual competence. (b) I do feel self-destructive. (c) I have mutilated my self in the past to get rid of the pain. I can't explain it all, all that I know is that I have never felt such a frustration trapped in my body.	(a) I blame myself of not being patient enough. I sometimes do put a lot of pressure on my wife to do something but I don't know what strategy to use to get any intimacy out of this relationship. (b) I am not self-destructive. (c) No mutilation or suicide attempts.

Interpretation of Table 2.10

Table 2.10 offers reflections on self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes, as well as themes related to self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes. Self-destructive behaviour in order to limit, stop, or avoid sex are indicated in purple. Yellow reflects a loss of enjoyment or interest in pleasurable activities. Green specifies that it is not a related theme.

Figure 2.32 indicates the percentage of participants (n=10) who experience self-blame.

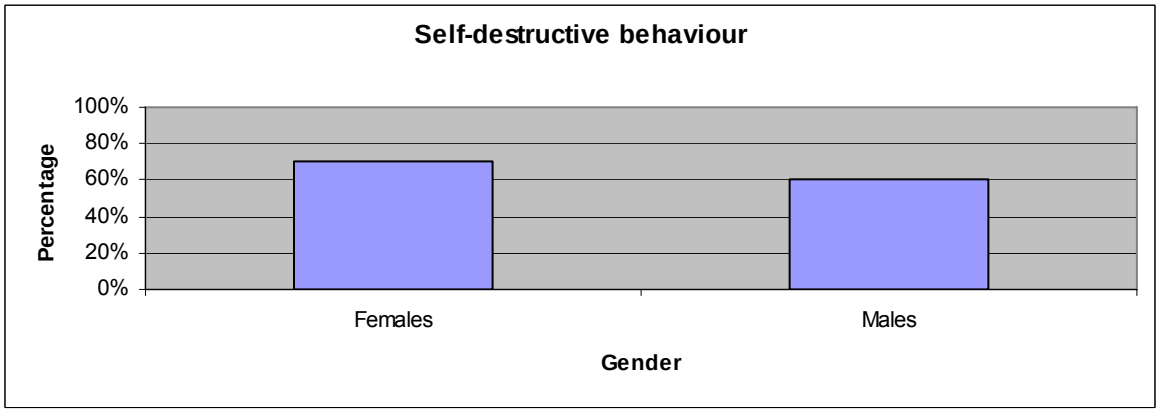


n=10

Figure 2.32: Self-blame

Patterns of self-blame were found that may consequently lead to self-destructive behaviour. Figure 2.32 indicates that all of the female participants (100%) and eight of the male participants (80%) blame themselves for the unconsummated marriage.

Figure 2.33 indicates the percentage (n=10) of participants who give evidence of self-destructive behaviour.

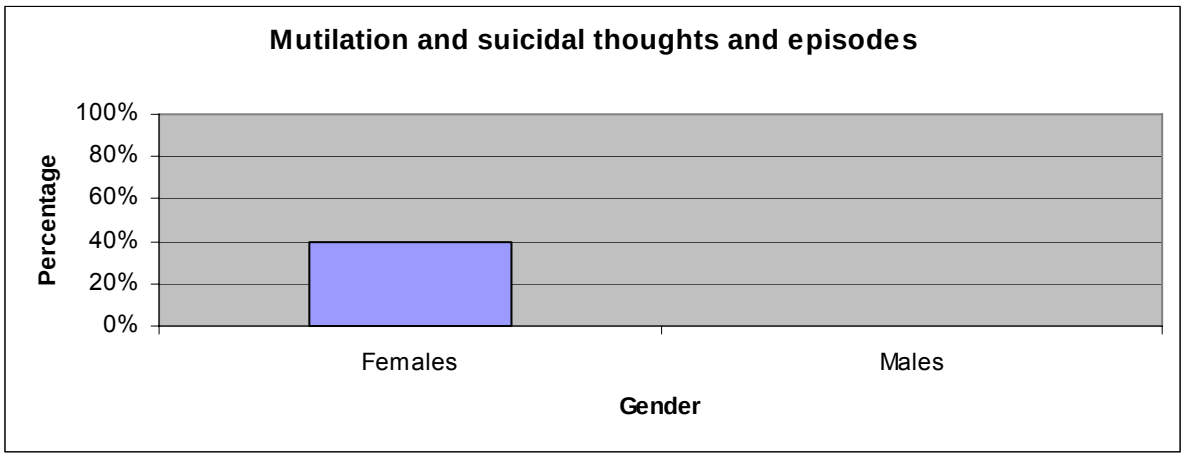


n=10

Figure 2.33: Self-destructive behaviour

Figure 2.33 indicates that seven of the female participants (70%) and six of the male participants (60%) stated that they experience self-destructive behaviour.

Figure 2.34 indicates the percentage of participants (n=10) who mutilate and have suicidal thoughts and episodes.



n=10

Figure 2.34: Mutilation and suicidal thoughts and episodes

Figure 2.34 indicates that four of the female participants (40%) and none of the male participants (0%) in this study mutilate themselves or have suicidal thoughts and episodes. The ninth theme addresses the incidence of self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes. Two related themes to self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes may be identified from the responses of the participants, namely: self-destructive behaviour to limit, stop, or avoid sex; loss of enjoyment or interest in pleasurable activities. The following section will focus on the first related theme, namely self-destructive behaviour to limit, stop, or avoid sex.

Figure 2.35 and Figure 2.36 indicate percentages of female and male participants who experience self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes. Responses have been grouped according to related themes.

Figure 2.35 indicates the percentage of female participants who experience self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes, with responses grouped according to related themes.

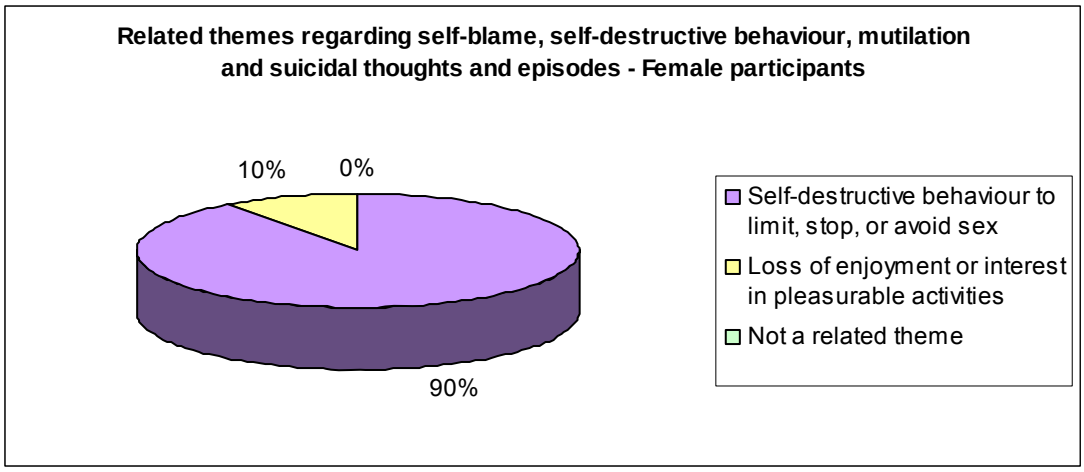


Figure 2.35: Female participants who experience feelings related to the theme of self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes.

The percentage of male participants who experience self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes, is presented in Figure 2.36. Responses have been grouped according to the three related themes.

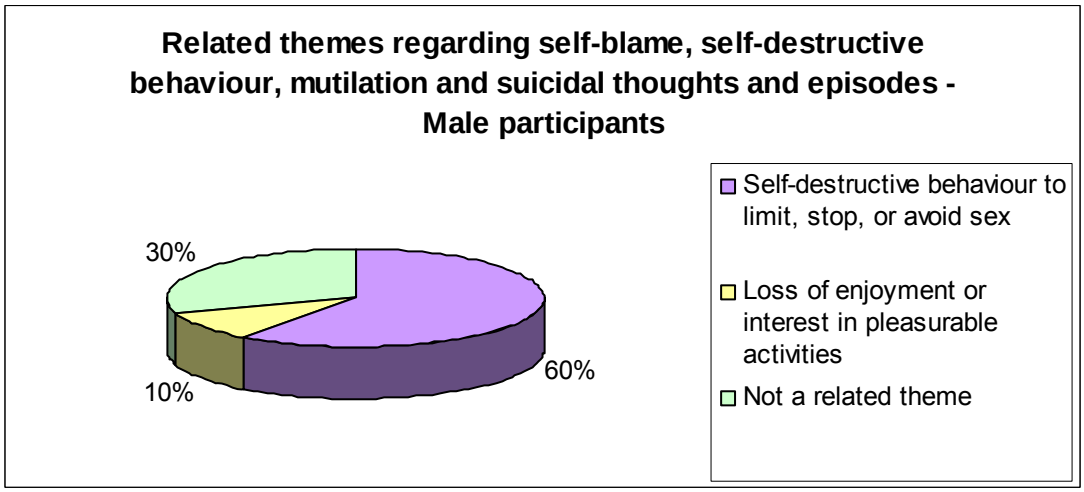


Figure 2.36: Male participants who experience self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes, with responses grouped according to related themes.

a) Self-destructive behaviour to limit, stop, or avoid sex

Table 2.10 indicates that nine female participants and six male participants have attempted, or have thoughts about, self-destructive behaviour to limit, stop, or avoid sex. Self-destructive behaviour to limit, stop, or avoid sex is evidenced in statements such as:

> I do blame myself and feel frustrated with myself because of my lack of sexual competence. I do feel self-destructive. I have mutilated my self in the past to get rid of the pain. I can't explain it all, all that I know is that I have never felt such a frustration trapped in my body.

> I do blame myself and wife for this situation. I feel this situation is destroying us emotionally. We are disrespectful towards each other and sometimes I do think it would be healthier to just get a divorce because the situation is destructive. No suicidal thoughts have ever crossed my mind.

Carnes (1997:41) explains that self-hatred often expresses itself as anger, resulting in self-destructive behaviour. It is often found that people do not feel happy and secure within themselves, but rather than deal with their insecurities they hide and repress these feelings. The secret insecurity then festers, which subconsciously influences the person's perception of the world. Irrational behaviour is often the consequence of this. People who are not true to themselves inevitably have a false, irrational and unreal way of looking at the world, themselves and other people and this could lead to the desire to self-mutilate or commit suicide.

The literature confirms (Jancin, 2001; Lorber & Moore, 2002; Katz & Tabisel, 2002; Jeng, 2003) that in an unconsummated marriage the couple hide and repress their real feelings because they do not want to hurt their partner. Consequently they internalise their emotions and they start blaming themselves

for the problems in their sexual relationship and lack of consummation. If this internalisation should continue for a period of time, then the affected person will find it increasingly difficult to cope with all the hidden emotions and blame, and consequently self-destructive thoughts and behaviour will emerge.

b) Loss of enjoyment or interest in pleasurable activities

As indicated in Table 2.10 one female participant and one male participant stated verbally that they felt a loss of enjoyment or interest in pleasurable activities. Comments they made included for example:

> I do take responsibility for this situation but through blaming my self I self-destruct. My thoughts and my actions are self-destructive. Since a child I have never felt that I deserve pleasure. I didn't think it will manifest in my sex life later. I don't feel suicidal or like mutilating myself.

> I blame myself of not being patient enough. I sometimes do put a lot of pressure on my wife to do something but I don't know what strategy to use to get any intimacy out of this relationship. I am not self-destructive. No mutilation or suicide attempts.

During the interviews learned helplessness was evident, including a loss of enjoyment or interest in pleasurable activities. It was found that participants have an aversion to sexual activity and that sexual activity or intimacy is not seen as positive. The literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Renshaw, 2004) indicates that couples in an unconsummated marriage are unable to view sexual intercourse as a pleasurable and exciting activity.

According to Carnes (1997:143) cultivating a genuine delight in sensuality, playfulness, and pleasure runs contrary to a bias in Western culture dating back

to Plato. Plato positioned two worlds: an ideal one and the world in which people actually live. This idea is known as Platonic dualism, with the real world clearly inferior to the ideal world. The Apostle Paul echoed this idea when he wrote about the kingdom of God, or heaven, towards which Jesus was leading humanity. Heaven, of course, was spiritual and perfect, contrary to a physical world filled with sin. The same idea was later immortalised in St. Augustine's *The City of God*. Being spiritual meant denying the body, which was basically lust-driven and evil. The needs and desires of the body, regardless of how pleasurable or natural, were to be spurned if one was to have any hope of redemption and happiness in the next life — to reach heaven, in other words.

Carnes (1997:143) explains that cultural ambivalence about pleasure and sex has been carried forward through the centuries from Plato into Christianity via St. Paul and St. Augustine, and finally spreading into the various branches of Christianity after Martin Luther's reformation. With such a long tradition of an anti-sexual, anti-pleasurable bias, it should not be surprising that to experience pleasure or provide another with pleasure is, for many people today, also connected with shame. Western culture in particular has long been hedonistic and pleasure seeking, while at the same time believing such pleasure is bad and evil. There is a long history of being sex aversive, the result of which is that many people feel tremendous guilt and shame about sexual thoughts and sexual acts.

The next section will focus on the tenth theme, namely the lack of information on how to be sexually intimate with a partner.

2.3.2.10 Theme 10: Lack of information on how to be sexually intimate with a partner

Theme ten corresponds to question ten in the interview schedule, namely: "Would you say that you are informed on how to be sexually intimate with your partner?" Verbatim excerpts from the interviewees regarding a lack of information on how to be sexually intimate with a partner are presented in Table 2.11.

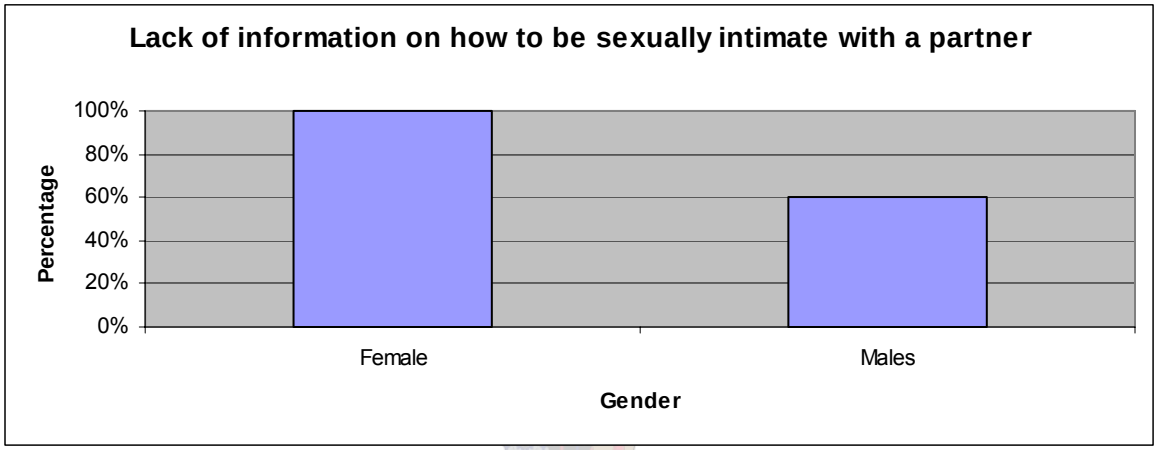
Table 2.11: Lack of information on how to be sexually intimate with a partner

COUPLE	FEMALE	MALE
1	It has never been explained to me on how to be sexually intimate. I feel sexual intimacy is to know and understand each ones body and needs i.e. touch, caressing.	I don't think anybody can ever be fully informed on the subject because people are so different. When I think about sexual intimacy I think it should be nice, quiet, peace, relaxed.
2	I think in a way I do, nothing was ever explained to me, unless you count what you learnt at school, which has nothing to do with intimacy. I had to learn myself, and I guess I still sometimes feel very unsure of myself. Intimacy for me is touching, kissing, caressing, oral and penetrative sex.	I don't lack information, I feel sexual intimacy is body touching, kisses, holding each other at night when sleeping, caressing each other, foreplay, sexual intercourse, and being happy.
3	I have never felt sexy, I always thought that my parents never told me that I am a beautiful girl. All that I can remember is that they said we actually wanted a boy. I think that will stick with me for the rest of my life. I always tried to get their attention but they were too busy with the brothers and the farm. I never discussed anything with my mom, not ever my first period.	I come out quite a hard working family where my parents are both professionals. I can hardly remember seeing them. We didn't have a very close relationship then but now we are spending quite a lot of time together. We never discussed anything sexually. My dad just always said to be careful we don't want little accidents. I don't think it caused any damage. Although they never directly spoke about sex and intimacy, they showed us in their relationship what love really is.
4	No one explained to me what goes on when you are supposed to be sexually intimate. Sexual intimacy is a bond between each other, being able to communicate and be there together through anything. Being free and totally in control of your needs and desires.	I don't think I lack information but no one has ever told me how to be sexually intimate with a partner. It was definitely a taboo discussion. I feel that sexual intimacy is being in love with someone that you could share anything with and someone who you can make love to and not just have sex with.
5	I feel I have a lack of information, no one has explained it to me. Sexual intimacy is not just sex but this is a big part of it which brings two people together. When I think of sexual intimacy it means to me to completely trust my partner with no barriers and to be romantic.	I would agree that I am not informed enough due to circumstances. I have never been told or given any kind of information in this regard. I think sexual intimacy is about being with a partner who one can be very close with as a person and physically. Sexual intimacy to me means to be physical, having sex, and being close to one another.
6	I can't remember my parents ever talking about sex with us. I think it has affected me in a negative way because I am still wondering why it is this 'BIG SECRET'.	I grew up in a single home and my mother was always very affectionate and caring. I think that is why this is so difficult for me because there is no intimacy in this relationship with my wife.
7	My sister and I were never exposed to anything sexual. The things we learnt were from friends. When I have children, hopefully one day, I will inform them more about sexuality and what to expect.	Sexual talk or nudity was never discussed in our house. I was a border from grade one and therefore I think I mostly learnt sex from school. I have never been an affectionate person but after the accident things got seemingly worse.
8	I was told that sex is evil and immoral. I don't think we ever discussed anything positive about sex, never mind how to be intimate. We were quite a close family but I don't think the sexual messages did me any good.	My family were quite open when it came to sexual information. They said it is for marriage but there was no negative stigma attached. However, it was never indicated that it could be problematic in a marital relationship. I did not expect this!
9	I came from a family that didn't touch affectionately at all and who thought sex was dirty. We learnt that good people don't have sex and bad people do have sex. I think this has always stayed with me and today I am paying the price.	Sex was never a discussion in our home. We never talked about it and I don't think it was ever talked about once until I went to varsity. Then I was told that if I was to make a girl pregnant I should not come home again.
10	I can remember how my mom always told me to loose weight. She said that if I keep on eating like this no one will ever love me. Perhaps I still believe her and think who can love a fat person like me.	I never grew up in a very touchy home. We never hugged or kissed – sometimes I find it difficult to show affection.

Interpretation of Table 2.11

Table 2.11 presents responses about a lack of information on how to be sexually intimate with a partner. The responses reflect related themes to the theme of lack of information on how to be sexually intimate. Yellow indicates sexual anxiety; pink points to obsessive self-doubt about sexual adequacy; green indicates that a participant does not lack information on how to be sexually intimate with a partner.

Figure 2.37 indicates the percentage of participants (n=10) who lack information on how to be sexually intimate with a partner.



n=10

Figure 2.37: Lack of information on how to be sexually intimate with a partner.

Figure 2.37 indicates that all of the female participants (100%) and six of the male participants (60%) feel that they have a lack of information on how to be sexually intimate with a partner. A possible lack of information on how to be sexually intimate with a partner was identified as a tenth theme of the investigation. Two related themes to the theme of lack of information about sexual intimacy emerged from the responses of the participants, namely sexual anxiety and obsessive self-doubt about sexual adequacy.

Figure 2.38 and Figure 2.39 indicate the percentages of female and male participants who experience a lack of information on how to be sexually intimate with a partner. Responses have been grouped according to the related themes that were identified.

Figure 2.38 indicates the percentage of female participants who lack information on how to be sexually intimate with a partner, with responses grouped according to related themes.

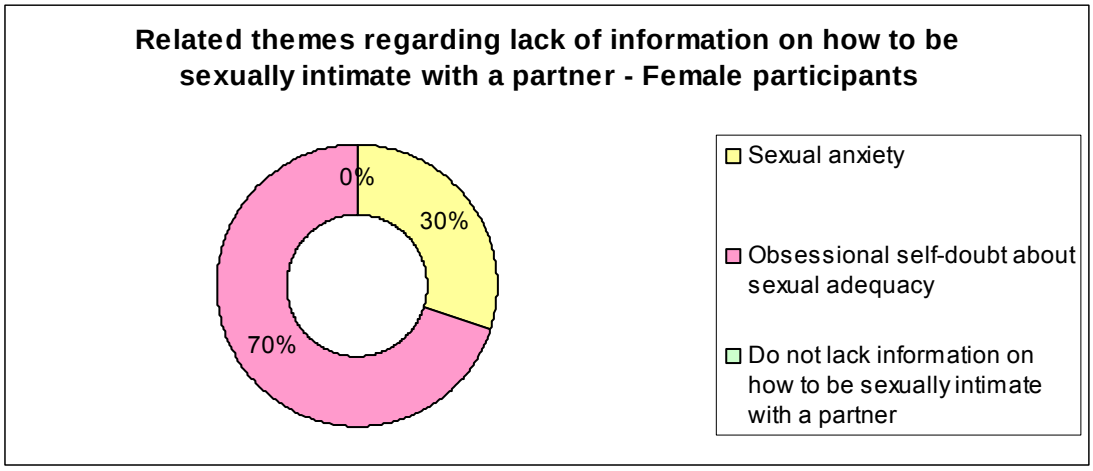


Figure 2.38: Female participants experiencing a lack of information on how to be sexually intimate with a partner, with responses grouped according to related themes.

The percentage of male participants who indicated a lack of information on how to be sexually intimate with a partner is presented in Figure 2.39, with their responses grouped according to related themes.

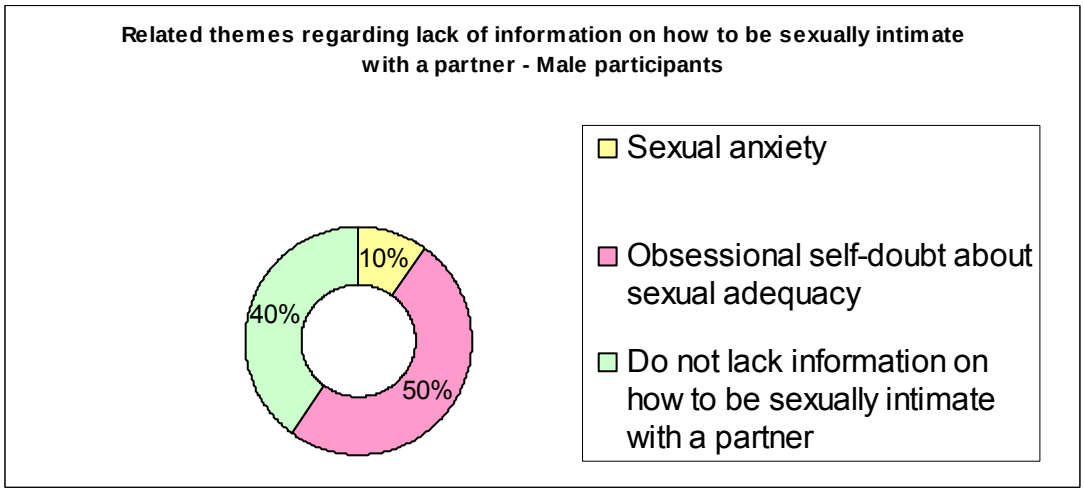


Figure 2.39: Male participants experiencing a lack of information on how to be sexually intimate with a partner, with responses grouped according to related themes.

a) Sexual anxiety

As indicated in Table 2.11 three female participants and one male participant experienced sexual anxiety due to a lack of sexual information on how to be sexually intimate with a partner. Sexual anxiety is evidenced in statements such as these:

> I came from a family that didn't touch affectionately at all and who thought sex was dirty. We learnt that good people don't have sex and bad people do have sex. I think this has always stayed with me and today I am paying the price.

> Sex was never a discussion in our home. We never talked about it and I don't think it was ever talked about once until I went to varsity. Then I was told that if I was to make a girl pregnant I should not come home again.

A history of no sex education and anxious feelings about sex is found in both male and female participants. People who have not been able to consummate their marriage tend to come from rigid, religious families who do not openly discuss sexuality and this can be the cause of sexual anxiety (Rosenbaum, 2003:1).

Carnes (1997:41) too is of the opinion that couples who are unable to consummate their marriage tend to come from "rigid" families. These families are very controlling. Usually one person is in charge and there is little or no negotiation about the rules. If a family member does not measure up to expectations, punishment is severe, arbitrary, and immediate. A family system is "closed" when the family is extremely resistant to new ideas. It is dangerous in such a family to make a mistake. Perfection is expected. Growing up in this kind of family leaves children with few options (Carnes, 1997; Jeng, 2003; Rosenbaum, 2003; Renshaw, 2004).

According to the literature (Carnes, 1997; Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Renshaw, 2004) children may become perfectionist and try to blend in by adopting the given values of the family or, in an effort to be their own person, resist all demands and become rebellious. They may even do both, which means that on the surface they will appear to have adopted the family's values, but secretly they rebel and defy the rules of the family. However, no matter which option the child chooses, there will be implications of fearfulness. Usually these families tend to view sex in a negative light as well. Sex is treated in a moralistic and condemning fashion. Parents are extremely judgmental and punitive about sexual issues where the children are concerned. Yet the children may often discover that one or both parents exhibit a series of sexual behaviours that violate the code preached to the children. In rigid families there is a tendency for the offspring to have a secret life. At the very least, they learn the lessons taught by people with little or no affection, or in a puritanical, sexually repressed or anxious family environment (Carnes, 1997; Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Renshaw, 2004).

b) Obsessive self-doubt about sexual adequacy

Table 2.11 indicates that seven female participants and five male participant experienced obsessive self-doubt about their sexual adequacy. Participants would make comments such as the following:

> I can remember how my mom always told me to loose weight. She said that if I keep on eating like this no one will ever love me. Perhaps I still believe her and think who can love a fat person like me.

> Sexual talk or nudity was never discussed in our house. I was a border from grade one and therefore I think I mostly learnt sex from school. I have never been an affectionate person but after the accident things got seemingly worse.

The participants indicated that they were not well educated about sexuality and that they felt sexually inadequate. A few men indicated that they felt ashamed because of their inability to produce off-spring and consequently felt that they were inadequately performing their male duty. The literature (Goodwin & Agronin, 1997; Jancin, 2001; Katz & Tabisel, 2002; Jeng, 2003) confirms that the more rigid the family background was, the more problems would arise in the new husband-wife subsystem with a concomitant effect on the couple's sexual life. Because no or very little information was given by the family on sexual intercourse and intimacy, a mental block develops and this frequently causes a marriage to remain unconsummated because of the lack of information that the couple have about sexual intercourse.

Barker (1998:17) and McGoldrick and Carter (2003:379) state that in order to understand how a person evolves, it is important to examine his or life within the context of both the family and larger cultural contexts, which change over time. Consequently the family life cycle should be emphasised when assessing couples in an unconsummated marriage in order to obtain insight into the origin of the problem. It was found during the interviews that the couples in these unconsummated marriages experience sexual anxiety and guilt, shyness and embarrassment, and obsessive self-doubt about their sexual adequacy. This could be linked to the fact that a lack of information on how to be sexually intimate with a partner causes self-image problems and self-doubt.

The ten main themes and the related themes will now be summarised.

2.3.3 Summary of the ten main themes and the related themes

The participants' responses afforded the researcher more insight into the ten themes discussed during the interviews, which made it possible for related themes to be identified.

Table 2.12: Schematic summary of identified main themes and related themes

	MAIN THEMES	RELATED THEMES FOR FEMALES AND MALES
1	Experience of control related problems	• Over developed self-control and obsessed with being in control • Fear of losing control • Fear of taking control
2	Feelings towards one's own body and your partner's body	• Negative body image and lack of self-esteem • Having distortions of body appearance
3	Fear of engaging in an intimate relationship and the experience of phobias	• Excessive fear of intimacy and sexual intercourse • A manifestation of other related phobias
4	Sin and moral dilemma	• Blaming religious belief systems and undergoing a religious struggle • Feeling that God is punishing them
5	Guilt and shame	• Negative sexual conditioning • Feeling emotional and unmotivated to change
6	Manifestation of depression and apathetic attitudes	• Depression about sexual inadequacy and functioning • Tension of the whole body
7	Personal distress and psychological problems	• Manifestation of related disorders • Negative thinking and obsessive concern and conditioned anxiety • Psycho-somatic problems • Misplaced emotions
8	Regret and sadness	• Shame and self-loathing over sexual experiences • Feeling of fatigue and loss of energy
9	Self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes	• Self-destructive behaviour to limit, stop, or avoid sex • Loss of enjoyment or interest in pleasurable activities
10	Lack of information on how to be sexually intimate with a partner	• Sexual anxiety • Obsessional self-doubt about sexual adequacy

2.4 SUMMARY

The research findings contained in this chapter reflect the various experiences and perceptions of a couple in an unconsummated marriage, and afford insight into the way that the couples view the sexual dimension of their marriage. The findings allowed a profile to emerge of the couple in an unconsummated marriage.

The unconsummated marriages under investigation varied in length. A tendency to procrastinate in making any attempt to change the sexual dynamics of the marriage was evident. This can be ascribed to the couples' fear of change. The participants all formed part of the period of young adulthood (the 20s and 30s) where parenthood is a milestone that the couples are unable to achieve due to their sexless marriage. Furthermore, the participants belonged to a religious belief system and experience sexual guilt. This can be ascribed to their negative sexual conditioning, which was faith-based. The participants had careers that they or their partners perceived as stressful and which prevented them from feeling relaxed and willing to participate in sexual intercourse.

The participants' responses indicated that the experiences and perceptions of a couple in an unconsummated marriage may be summarised in ten main themes and twenty three related themes. The findings will give healthcare professionals such as social workers further insight into the experiences and perceptions of the couple in an unconsummated marriage, which can effectively be utilised in medical and therapeutic intervention.

Where chapter two contained a critical assessment of the experiences and perceptions of the couple in an unconsummated marriage, chapter three will focus on marriage within the context of the family life cycle.

CHAPTER 3

MARRIAGE WITHIN THE CONTEXT OF THE FAMILY LIFE CYCLE

3.1 INTRODUCTION

This chapter presents a literature overview of marriage within the context of the family life cycle. Marriage, family development and the family life cycle consist of a sequence of predictable events or periods. It begins with leaving the family of origin and includes milestone events, like couple formation, marriage, and the birth of the first child (Hogan, 1993; Craig, 1996; Chakrabanti & Sinha, 2002). According to Barker (1998:20) two main areas need to be considered whenever a family present for intervention. One is the family's developmental stage. The other is the family's structure and method of functioning. It has been found that many of the clinical problems with which families present are related to difficulties in making the transition from one developmental stage to the next. When this is the case, the healthcare professional needs to consider how the developmental process can be assisted. Are there any roadblocks – either in the family's social context or within the family itself – which can be removed by any means available to the healthcare professional?

Consequently, this chapter aims to focus on marriage and family development and the milestone events that occur in the family life cycle. There will be an emphasis on the first milestone of marriage and family development, which according to Dunvall and Miller (1985) in Barker (1998:17), may be defined as the married couple without children. Marriage as an institution and the characteristics and functions of a marriage will be discussed. This chapter will be concluded with a description of marital satisfaction.

3.2 MARRIAGE AND FAMILY DEVELOPMENT

McGoldrick and Carter (1999), and Walsh (2003), explain that a person is born into a family. People develop, grow, and hopefully die in the context of a family. Problems are framed by the formative course of the family's past, the present tasks it is trying to master, and the future to which it aspires. Embedded within the larger socio-political culture, marriage and family development or the family

life cycle, is the natural context within which to frame individual identity and development, and to account for the effects of the social system.

Numerous marriage and family development schemes and models exist which identify the various milestones in a family life cycle. According to Dunvall and Miller (1985) in Barker (1998:17), marriage and family development may be divided into eight milestones:

1. Married couples without children.
2. Childbearing families, in which the oldest child is less than 30 months of age.
3. Families with pre-school children, in which the oldest child is between two and a half to six years of age.
4. Families with school-going children, in which the oldest child is between six and thirteen years of age.
5. Families with teenagers, in which the oldest child is between thirteen and twenty.
6. Families launching young adults, starting with the first child's departure from the home and ending when the last one goes.
7. Middle-aged parents, from the 'empty nest' to retirement.
8. The stage of ageing family members, the period from retirement to death (Dunvall and Miller, 1985 in Barker, 1998:17).

Craig (1996:516) agrees with Dunvall and Miller (1985) in Barker (1998:17) that families develop over a period of time and go through predictable developmental stages marked by milestone events. The **first milestone** is reached when the individual leaves his or her family of origin. This separation may occur at the time of marriage, or sooner if the individual has opted for independence and goes to live either alone or with a group. The first milestone includes the courtship process before the transition to the second milestone of getting married.

Barker (1998:16) states that when a man and a woman meet the courtship is a preliminary to the development of a family. The courting partners both bring to the relationship their value systems, their temperamental and personal characteristics and their capacities to love and enter into a giving, sharing

relationship. Each partner has needs and looks to the other to meet them, usually without being consciously aware of these needs. Young people often enter into a courtship relationship on the basis of feelings of mutual sexual attraction, though some relationships develop primarily out of companionship and mutual interests. Cowan and Cowan (1992) say that the element of romantic love is often strong, and in contemporary Western society tends to be reinforced by the mass media, popular music and the youth culture generally. To all this is often added the projection, by one member of the courting couple onto the other, of those characteristics that will meet the other member's emotional needs. This is the state of being 'in love'; the 'loved' partner with whatever characteristics that the other person needs him or her to have.

According to Posner (1992) and Hogan (1993) the courtship should last long enough for each partner to discover whether the other one does actually meet his or her emotional needs. Sometimes marriage or parenthood, or both, are entered into before this process is complete. This increases the risk that the relationship will run into difficulties. Many couples enter into a courtship, only to abandon it when they realise that they are not suitable for each other. Eventually, though, the couple may decide to commit themselves to each other, and it is still customary to formalise this by having a marriage ceremony (Compare Wallace & Gotlib, 1990; Cowan & Cowan, 1992; Posner, 1992; Hogan, 1993; Barker, 1998; Hogan, 2002).

Consequently the **second milestone** is usually marriage, with all the concomitant adjustments of establishing a relationship with a new individual or with a new family network. The most common **third milestone** is the birth of the first child and the beginning of parenthood. This occasion is sometimes called the establishment of a family of procreation, or the transition to parenthood. During the past 50 to 100 years, family cycles have changed in timing as well as in nature. Not only are more people living longer than ever before, but their ages at various points in the family cycle, and the average time span from one milestone to another, have changed (Wallace & Gotlib, 1990; Cowan & Cowan, 1992; Craig, 1996; Barker, 1998).

In an unconsummated marriage the inability to have sexual intercourse and produce offspring hinders marriage and family development (Jeng, 2003; Renshaw, 2004). Consequently the family life cycle of marriage and family development is fixed at the first milestone of the eight milestones identified by Dunvall and Miller (1985) in Barker (1998:17).

3.3 THE FAMILY LIFE CYCLE

Barker (1998:17), and McGoldrick and Carter (2003:379), state that in order to understand how people evolve, it is important to examine their lives within the context of both the family and larger cultural contexts, which change over time. The family life cycle should therefore be investigated. Each system (individual, family, and culture) may be represented schematically along two time dimensions: one is historical (the vertical axis), and the other developmental and unfolding (the horizontal axis). Figure 3.1 represents the life cycle with relation to the individual, the family, the culture.

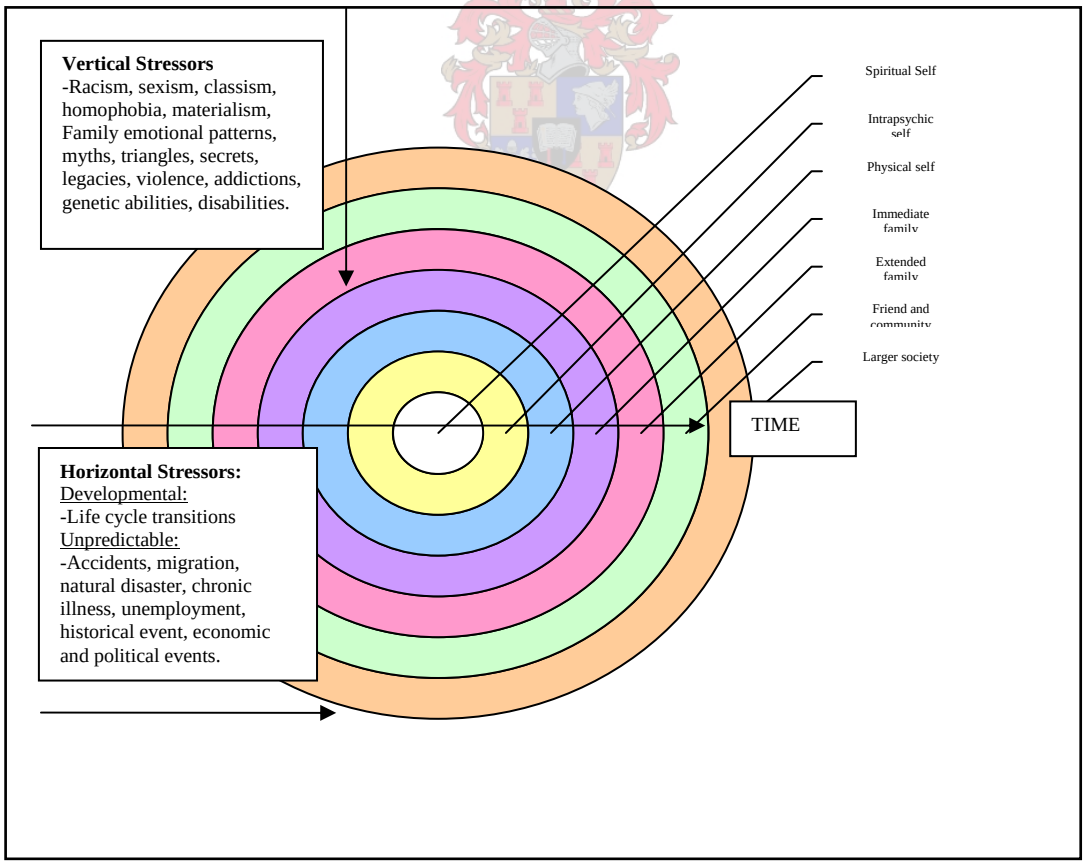


Figure 3.1: The life cycle - The individual, the family, the culture
Source: McGoldrick and Carter (2003:379)

As indicated in Figure 3.1 by McGoldrick and Carter (2003:379), the vertical axis includes an individual person's biological heritage and intricate programming of behaviours, temperament, possible congenital disabilities, and genetic makeup. The horizontal axis relates to the individual's emotional, cognitive, interpersonal and physical development over the lifespan within a specific sociohistorical context. Over time, the individual's inherent qualities can either become crystallised into rigid behaviours or elaborated into broader and more flexible repertoires. Certain individual stages may be more difficult to master, depending on one's innate characteristics and the influence of the environment (Gecchin, 1987; Fallicov, 1988; Barker, 1998; Walsh, 1998; McGoldrick & Carter, 2003).

At the family level, the vertical axis includes the family history and the patterns of relating and functioning transmitted down the generations, primarily through the mechanism of emotional triangling. The vertical axis includes all the family attitudes, taboos, expectations, labels, and loaded issues when in the process of growing-up. At a sociocultural level, the vertical axis includes cultural and societal history, stereotypes, patterns of power, privilege and oppression, social hierarchies, and beliefs that have been passed down through the generations. A group's history and particularly its legacy of trauma will influence families and individuals as they go through life (Bowen, 1978; Carter, 1978; McGoldrick & Carter, 2003).

According to McGoldrick and Carter (2003:380) the horizontal axis relates to community connections, current events, and social policy as they impact on the family and the individual at a given time, including the consequences in people's present lives of the society's "inherited" vertical norms of racism, sexism, classism, and homophobia, as well as ethnic and religious prejudices manifested in social, political, and economical structures that limit the options of some and support the power of others.

The literature (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003; Renshaw, 2004) indicates that there are various physical and psychogenic causes and stressors that bring about an unconsummated marriage. Vertical stressors and horizontal stressors can be a contributing factor for a marriage to remain

unconsummated. From the empirical study it is evident that the causes and stressors of an unconsummated marriage are rooted in the person's family life cycle. Consequently it is important to use the information in Figure 3.1 in order to identify stressors, as this exercise could be useful when engaging in therapeutic intervention with the couple in an unconsummated marriage.

3.4 MARRIAGE AS A SOCIAL INSTITUTION

The literature (Rich, 1982; Hogan, 1993; Craig, 1996; Chakrabanti & Sinha, 2002) suggests that marriage may be defined as a relatively permanent sexual union, implying a number of interlocking statutes and roles. The family may be defined as a marriage with the addition of progeny; in other words, the family refers to a limited social system composed of two individuals and their offspring.

The origination of the family and the historical types of families that have evolved throughout history are of importance in order to understand the issue of the family as a social institution. The three chief historical families are the large patriarchal family characteristic of ancient society, the small patriarchal family which had its origin in the medieval period, and the modern democratic family which to a great extent is a product of the economic and social trends accompanying and following the industrial revolution. An important shift has occurred in families: the shift from a patriarchal to a democratic family structure (Madanes, 1991; McGoldrick & Carter, 1999; McGoldrick & Carter, 2003; Walsh, 2003). It may be argued that the patriarchal family structure has had an important influence on unconsummated marriages, if one considers the definite power which was related with sexual activity in a marriage (Renshaw, 1989; Jeng, 2003).

Gottman (1999) explains that the fear of the breakdown of the family has haunted many societies and each generation seems to be witnessing difficulties which predict the family's collapse. The fear of a breakdown of a family is not a new phenomenon and has always been a global problem. Throughout history, no social institution has been subjected to so much scrutiny as the family. McGoldrick and Carter (2003) and Walsh (2003) say that because ideas on family and society are bound together, the fear that the family is in a state of

crisis is mixed with an even more fundamental anxiety that the very foundation of society is being threatened. A couple entering a marital relationship often experiences anxiety and strain, because they have been conditioned by society to believe that their marriage has little chance of success owing to the high divorce rate. The bleak picture of marriage that is sketched may thus cause a subconscious fear of commitment among couples.

Preparation for marriage may involve elaborate rituals of dating, courtship and engagement. The bond is symbolised by a wedding rite; subsequently, the new roles of husband and wife, in relation to each other and the rest of society, are clearly defined. The community sanctions this union, which is expected to ensure emotional sustenance, sexual gratification, and financial security for couples and their family (Rich, 1982; Hogan, 1993; Craig, 1996; Chakrabanti & Sinha, 2002). According to Schulz (1972) and Posner (1992) marriage is the social institution wherein coitus is permitted in societies. Sexual intercourse is a widely accepted and normal activity within the social structure of marriage. The literature (Schulz, 1972; Posner, 1992, Craig, 1996; Bourg, 2004) places great emphasis on the sexual realm of a relationship, and all definitions of marriage stress the component of reproduction and children as part of a normal heterosexual marital relationship (Craig, 1996; Bourg, 2004). It can be argued that the sexual realm is an essential characteristic of a marital relationship and that it consequently becomes problematic when the marriage remains unconsummated (Schulz, 1972; Posner, 1992, Craig, 1996; Bourg, 2004).

Larsen (1996) and Cain (2001) explain that the relationship between marriage, sex and reproduction varies from one society to the next. It has been noted that some societies do not regard a marriage as finalised until the woman has given birth to a child. According to the literature (Blake, 1979; Wallace & Gotlib, 1990; Larsen, 1996; Barker, 1998; Cain, 2001) marriage is usually intimately associated with child bearing. Renshaw (1989) and Bourg (2004) state that the pressure to have children has been recorded throughout history. In 1984, as in 1915, a woman who chose to remain childless would in all likelihood in some orthodox societies be censured; she would be classified as abnormal, selfish, immature, and possibly neurotic (Polit, 1978; Blake, 1979).

The literature (Renshaw, 1989; Posner, 1992; Hogan, 2002; Katz & Tabisel, 2002) suggests that even now, in the twenty first century, society and families still pressurise the husband-wife unit to produce offspring. By remaining childless, both sexes are flaunting the basic assumption upon which conventional family life appears to be founded: that once married, all 'healthy', 'normal' adults are committed to accepting the responsibility of parenthood and are well equipped for the parental role. This is the public image of parenthood epitomised by the young married couple, happy and contented, with children (Wallace & Gotlib, 1990; Larsen, 1996; Cain, 2001; Katz & Tabisel, 2002).

However, Barker (1999) and Walsh (2003) explain that marriage tends to be misunderstood as a joining of two individuals. It really represents the changing of two entire systems, as well as an overlapping of systems to develop a third subsystem (the couple). Women tend to turn back to their parents for more connection; whereas men may increase their separation from their families of origin, seeing the couple's relationship as replacing the family of origin. In fact, a daughter is also a daughter-in-law for the rest of her life, because she typically gains responsibility for the connectedness with and care of her husband's family as well. It can be argued that the development of the third subsystem is usually problematic in an unconsummated marriage because of the complexity of the relationship (Lipschutz, Liberman, Kuppermann, Mathias & Steege, 1996; Barlow, Dawes, Jenkinson, Kennedy, Vessey, Zudkin & Zondervan, 2001; Jeng, 2003).

Achieving a successful transition to couplehood may be an extraordinary difficult proposition in our time. The couple is in the midst of a transformation from a male-female relationship to that of partnership, reflecting educationally, occupationally, and in emotional connectedness. Couples may be considered to be renegotiating family status while facilitating traditional rituals around marriage. Both partners represent their symbolic movement from their parents to their partners (rather than just the woman from her father). This can potentially provide couples with the opportunity to redefine traditional family relationships in a way that may make their future marital accommodation more equitable (Barker, 1999; Walsh, 2003).

Within a postmodern-systemic perspective the transition to marriage is an important time for helping couples look beyond the stereotypes that have been so problematic for family development. Yet, in spite of the fact that for couples living together before marriage this is less of a marked transition than it used to be, many couples resist looking at the fallacies of their myths about marriage until later, when problems predictably surface (Carter & Peters, 1997; Gottman, 1999; McGoldrick & Carter, 1999; McGoldrick & Carter, 2003).

McGoldrick and Carter (2003) explain that the failure to renegotiate family status with the family of origin may also lead to marital failure. Nevertheless, it appears that couples are very unlikely to present with extended family problems as the stated issue. Problems reflecting the inability to shift family status are usually indicated by defective boundaries around the new subsystem. In-laws may be too intrusive, and the new couple may be afraid to set limits, or they may have difficulty forming adequate connections with the extended systems, cutting themselves off in a tight twosome. At times, the inability to formalise a marriage indicates that the partners are still too enmeshed in their own families to define a new system and accept the implications of this realignment. It is useful in such situations to help the system move to a new definition of itself rather than to get lost in the details of incremental shifts the couple may be struggling over (sex, money, time) (Gottman, 1999; Hogan, 2002; McGoldrick & Carter, 2003).

3.5 ESSENTIAL CHARACTERISTICS OF MARRIAGE

Barker (1998:205) and Bourg (2004) state that there is no easy way to define a healthy marriage. An essential characteristic, perhaps, is that the respective emotional needs of the two partners are met. Research (Frandsen, Hafen, Karren & Smith, 2002; Hogan, 2002) has suggested that a good marriage offers many health benefits. Conversely, a negative impact on health can occur when marriage involves events like frequent conflict, anger, jealousy, criticism, moodiness, extreme financial problems, abuse and sexually related problems. Jeng (2003:54) suggests there may be a connection between marital and gynaecological problems. Therefore, problems in a marriage may result in the marriage remaining unconsummated and consequently this may result in an

unhealthy and dysfunctional relationship (Posner, 1992; Barker, 1998; Chakrabanti & Sinha, 2002; Frandsen, *et al.,* 2002; Jeng, 2003; Bourg, 2004).

Kaslow and Robinson (1996) report on a study involving fifty seven couples who had been married between twenty five to forty six years. In the study the eight elements reported with the greatest frequency by the participants as being important were: lifetime commitment to marriage; respect for one's spouse as a best friend, which includes mutual self-disclosure; loyalty to one's spouse and the expectation of reciprocity; strong shared moral values; commitment to sexual fidelity; desire to be a good parent; faith in God and spiritual commitment; and lastly companionship with one's spouse, including spending a great deal of enjoyable time together over the course of a lifetime.

Other elements that were found to be important were the belief that marriage is a partnership; that love is an important ingredient for the relationship to work; a sense of responsibility towards the partner; enjoyment of an established lifestyle and the wish not to change it; religious convictions about the sanctity of marriage; a sense of closeness resulting from shared experiences throughout life; appreciation of closeness and comfort with each other, and continuing attraction to the partner. Qualities desired in a marriage were financial and economic security; mutual sexual fulfilment; expression of affection; openness, honesty, candour; frequent exchange of ideas; consensus about sexual behaviour; good problem-solving ability; sensitivity and consideration for the needs of the spouse; good listening and doing interesting things together (Kaslow & Robinson, 1996).

It is evident from Kaslow and Robinson's (1996) study that sexual fulfilment forms an important part of a happy and functional marriage. Consequently it can be argued that without the sexual component of a marriage, the marital relationship may become problematic and unhealthy. The next section will identify elements in a couple's relationship which make the relationship either happy and functional or unhappy and dysfunctional.

3.5.1 Functional and happy couples

According to Gottman (1999) and Walsh (2003) happy couples most often show fondness and admiration, an awareness of each other and their love map; they glorify struggles and speak of we-ness. Walsh (2003:508) explains that a happy couple that are still "in love" show unique characteristics in the way they describe their marital past. Fondness and admiration are two of the most crucial elements in a rewarding and lasting romance. Partners convey a fundamental sense that their spouse is worthy of admiration. Although even happily married couples have times when they are frustrated by their partners' flaws, they still remember that the person they married is worthy of honor and respect. Along with fondness and admiration, happy spouses usually show an awareness of each other and their relationship. This is clear in the way expansive couples describe the details of their past.

Happy spouses are also intimately familiar with their partner's world. Carter and Peters (1997) explain that couples remember the major events in each other's history and keep updating these facts and feelings as their partner's world changes. In contrast to couples who are unhappy in their marriage, happy couples approach hardships as trials to be overcome together and believe that these struggles make their relationship stronger. Happy couples emphasise both the difficulty of their experiences and pride in how they managed through it all. Their struggles bring them closer together as they endure challenging outside events and work to prevail. Furthermore when happy couples describe their marital past, each partner tends to use the words "we" and "us" as opposed to "he" or "she" or "I". This simple pattern reflects the degree to which couples perceive themselves as a team rather than as an individual (Kaslow & Robinson, 1996; Carter & Peters, 1997; Gottman, 1999; Walsh, 2003).

3.5.2 Dysfunctional and unhappy couples

There are various elements that can cause unhappiness in a marriage, which may lead to a dysfunctional relationship (Hogan, 1993; Walsh, 2003). The following are six psychological characteristics that make for unhappiness in a marriage. First, an unhappy temperament as indicated by a predisposition to be pessimistic rather than optimistic. Second, neurotic tendencies expressed by

being touchy, grouchy, lonesome, easily hurt, and bothered by useless thoughts. Third, dominating and domineering behaviour characterised by a determination to get one's own way and by disregarding the feelings of others. Fourth, a lack of self-confidence, which can cause great unhappiness in a marriage. Fifth, a critical, inconsiderate attitude toward others. Sixth, an excessive desire for self-sufficiency, as indicated by usually facing troubles alone and avoiding asking the partner's advice. It can be argued that these psychological characteristics may lead to the type of dysfunctional marriage often seen in unconsummated marriages (Hogan, 1993; Gottman, 1999; Walsh, 2003).

Unhappy couples are negative towards each other, have chaotic perceptions and feel acute disappointment and disillusionment. Walsh (2003:507) says that distressed spouses tend to express negativity and criticism toward each other, even when remembering such pleasant events as their wedding or honeymoon. Unhappy spouses may also be vague and unclear about what attracted them to their spouse. The husband and wife may find it difficult to think of a single quality they admired about their spouse before they were married. Unhappy couples tend to perceive the world as chaotic. According to Hogan (1993) and Gottman (1999) many couples have to deal with difficult situations such as a financial loss or stress at work. When this type of event occurs in an unhappy relationship, however, the couple tend to view their lives as out of control or chaotic. They easily see themselves as being battered by outside events.

There is a helpless quality to these perceptions; couples feel unable to overcome their stress and hardship. Often these couples are indeed dealing with major stresses, but the critical thing that defines their relationship is a sense of hopelessness. They believe that there are no solutions to their problems. One final pattern Walsh (2003:507) mentions among unhappy couples is their disappointment and disillusionment with their relationship. Each partner has given up on their marriage and expresses depression about the relationship. A tone of sadness and resignation often accompanies their communication patterns. Unhappy couples also seem unable to articulate what makes a successful marriage. It is as if their personal disappointment alters their general view of marriage, making it difficult to define a happy relationship.

Considering the above, it becomes evident that definite elements prevail to differentiate between couples as happy and functional or unhappy and dysfunctional. Lastly, it is imperative that the couple, as a limited social system, should not be seen as a subsystem of the family of origin on either side of the spousal relationship, but as a unique system functioning in its own right. Exploring the limited social system within the context of the family system of origin will afford insight into both the concept of the family, and the expectations of the family and marital relationships (Kaminer, 1992; Hogan, 1993; Gottman, 1999; Walsh, 2003).

3.6 THE FUNCTIONS OF MARRIAGE AND FAMILY

According to Barker (1998:15) a marriage and a family have various functions. These include:

- The provision of at least the basic necessities of life for its members.
- Reproduction and the continuation of the species.
- The rearing and socialisation of children.
- Provision for the legitimate expression of the marital couples' sexuality.
- The provision of mutual comfort and support for its members.

The literature (Hogan, 1993; Barker, 1998; Gottman, 1999; Walsh, 2003) suggests that these functions do not all apply equally to every family's situation. Some couples elect not to have children; in others the children have grown up and left home. Society and communities may provide support, for instance in the form of schools, which socialise as well as educate, and other institutions such as youth groups or church groups to supplement what the family does. Many societies provide social service agencies to assist families, or to take over the care of children when families fail to do this properly. Financial and material help is often provided, on a varying scale, to needy families.

According to Barker (1998:16) many of the functions that are now carried out by society's agencies were in the past performed by the extended family. This consisted of a kinship network of grandparents, uncles, aunts, adult siblings, cousins and other relatives. Sometimes people unrelated by blood, but living in

the same social network also participated. This is still the situation in many parts of the world. But in industrial societies, especially large urban societies, the extended family and the neighbourhood community generally play a smaller role. Thus the nuclear family, that is, the parent or parents and their children, is faced with a bigger task than it used to have. Of course even in industrial societies there are still villages, small towns and rural areas in which extended family networks continue to function well; even in the cities some extended family networks exists. These networks are mostly found among communities comprised of groups which have recently migrated to the cities. As the generations succeed each other there is a tendency for such families to become more 'nuclear'.

In every family situation the various functions, as identified above, tend to accord with the couple's needs. As long as both partners in the marriage are satisfied and fulfilled and pleased with the functioning and purpose of their marriage, marital satisfaction and family stability is possible. Subsequently, the next section will focus on marital satisfaction and family stability with particular reference to Sternberg's (1986) triangular theory.

3.7 MARITAL SATISFACTION AND FAMILY STABILITY

Marital satisfaction and family stability are important in order for a couple to have a happy and functional marriage. The literature (Craig, 1996; Barker, 1998) suggests that central to marital satisfaction and family stability is the formation of an intimate, loving relationship. Intimacy, the essential part of an enduring, satisfying, emotional bond, is the basis of love. Sternberg (1986) in Craig (1996:511) states that the triangular theory of love demonstrates the complexity of achieving the types of successful intimate relationships that are defined as love relationships.

The triangular theory of love has three components. First, there is intimacy, the feeling of closeness that occurs in love relationships. It is the sense of being connected or bonded to the loved one. Passion is the second component of love, according to Sternberg's (1986) theory. This refers to the forms of arousal that lead to physical attraction and sexual behaviour in a relationship. Sexual

needs are important, but not the only form of motivational needs involved. For example, needs for self-esteem, affiliation, and succorance may also play a role. Sometimes intimacy leads to passion; at other times passion precedes intimacy. The final component of Sternberg's (1986) love triangle is decision/commitment. This component consists of a short-term and a long-term aspect. The short-term aspect is reflected in the decision that a person loves someone. The long-term aspect is the commitment to maintain that love. Again, the relationship of decision/commitment to the other components of love can vary.

Sternberg (1986) developed a taxonomy of love relationships to demonstrate the possible combinations, and this taxonomy is presented in Table 3.1.

Table 3.1: Taxonomy of kinds of love based on Sternberg's triangular theory

	Component		
Kind of love	**Intimacy**	**Passion**	**Decision/Commitment**
Liking	+	-	-
Infatuated love	-	+	-
Empty love	-	-	+
Romantic love	+	+	-
Companionate love	+	-	+
Fatuous love	-	+	+
Consummate love	+	+	+

Note: + = component present; - = component absent. These kinds of love represent limiting cases based on the triangular theory. Most loving relationships fit between categories because the various components of love are expressed along continua, not discretely.

Source: Sternberg (1986)

Table 3.1 reflects that to be in a satisfying and stable relationship it is important to have a marriage relationship marked by consummate love. Sternberg (1986) in Craig (1996:511) states that many couples mistake infatuation for consummate love. And in many marriages, the passion dies and the relationship becomes one of companionate love. Intimacy can be destroyed by a denial of feelings, particularly of anger. Fear of rejection also blocks off intimacy, especially when it leads to a false identity designed to cater to others rather than to fulfil important

internal needs. Traditional courtship and dating patterns may even discourage intimacy if they involve only ritual rather than honest exchange. Some extreme opposites are even more harmful: casual sex, gamesmanship, and sadistic honesty. Brutal candour and contrived aloofness are never fertile ground for creative intimacy (Sternberg, 1986 in Craig, 1996:511).

3.8 SUMMARY

In this chapter, the notion of marriage as a social institution has been discussed. From the discussion it is clear that marriage and family development are marked by specific milestones. If the couple are unable to have sexual intercourse it means the marriage is fixed at the first milestone of family development: they are a married couple without children. A comprehensive overview was given of the family life cycle and it was pointed out that both vertical and horizontal stressors can become contributing factors in an unconsummated marriage. It is therefore important to identify possible stressors when embarking on a medical or therapeutic intervention with a couple in an unconsummated marriage.

It was apparent in this chapter that there are various essential elements which characterise a functional and happy marriage. It was evident that sexual fulfilment plays an important part in a happy and functional marriage. Conversely, it was found that the lack of sexual fulfilment in a marriage can cause unhappiness and dysfunction, as is often seen in unconsummated marriages.

The functions of marriage and family were discussed and it was indicated that reproduction and the continuation of the species was one of these functions. An unconsummated marriage may be regarded as dysfunctional in this regard, since reproduction in a natural way cannot take place.

Evidence was found in this chapter that marital satisfaction and family stability are important components of a happy and functional marriage. From this discussion it was clear that Sternberg's (1986) triangular theory of love with its three components, namely intimacy, passion and commitment forms the corner stone of marital satisfaction and family stability.

In the following chapter the nature, diagnosis and causes of an unconsummated marriage will be described. Vaginismus as a cause of unconsummated marriages will be investigated in depth and coping mechanisms will be explored.

CHAPTER 4

THE NATURE AND CAUSES OF THE UNCONSUMMATED MARRIAGE

4.1 INTRODUCTION

The objective of this chapter is to describe the nature and causes of an unconsummated marriage. It is important that the practitioner who treats couples in an unconsummated marriage have a broad knowledge base with regards to the nature and the causes of the unconsummated marriage, as this will enable him or her to deliver high-quality medical and therapeutic intervention. According to Renshaw (2004:4) an unconsummated marriage is a real and difficult problem. The causes of an unconsummated marriage are legion; people of all socioeconomic groups and education levels are affected (Somkuti, Steege & Stout, 1991; Goodwin & Agronin, 1997; Jancin, 2001; Renshaw, 2003; Renshaw, 2004).

4.2 THE NATURE OF AN UNCONSUMMATED MARRIAGE

Katz and Tabisel (2002:169) state that sexual intimacy and consummation are a powerful vehicle for transmitting feelings between partners in intimate relationships. Consummation integrates sex and sexuality with the special zone of intimacy that is unique to an intimate partnership. This zone includes the couple's private feelings, actions, sexual experiences, and emotional connection, and acts as the barometer of the relationship, sensing positive and negative forces as they occur. Being able to develop a rich, gratifying private zone not only serves as the engine for the relationship, but also reaffirms the emotional and sexual maturity of the partners. When a marriage remains unconsummated, intimacy in the marital relationship can be problematic and this may infiltrate into other areas of the relationship and cause dysfunction in the marital (husband-wife sub-system) relationship.

The literature (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003) defines the unconsummation of a marriage as follows: Unconsummation among couples who have never had successful sexual intercourse (coitus) is termed primary unconsummation; whereas, among couples who have experienced successful

sexual intercourse (coitus) before, it is termed secondary unconsummation. Both primary and secondary unconsummation are classified as an unconsummated marriage or as unconsummated coitus. Obtaining a correct diagnosis on why the unconsummation occurs and then discovering the underlying etiologies are critical to healthcare professionals including medical practitioners, gynaecologists, urologists, psychiatrists, psychologists and social workers, as the diagnosis enables them to provide accurate medical and therapeutic intervention.

4.3 THE DIAGNOSIS OF THE UNCONSUMMATED MARRIAGE

Diagnosis of the sexual problem is extremely important, since the problem cannot be treated with the correct intervention if the problem has not been accurately assessed and diagnosed. It is therefore important to do a thorough sexual history survey and assessment when a couple comes to a healthcare professional with a sexual problem. The literature (Katz & Tabisel, 2002; Renshaw, 2004) suggests that when diagnosing a sexual problem, healthcare professionals should ask patients to describe what bothers them, what sensations they feel that upset them, the symptoms of the problem and what made them come for treatment. A diagnosis can then be made based on the presenting symptomology. During a sexual history survey and assessment it is important to focus on both the male and the female partner, as the problem that causes the marriage to remain unconsummated could reside with either or both. Renshaw (2004:4) explains that many unconsummated marriages may be misdiagnosed by healthcare professionals if they do not ask appropriate questions about the problem during the assessment.

Renshaw (2004:4) mentions the following questions that should be asked in an assessment of sexual history and possible physical causes:

- How is your sexual functioning?
- Do you have a history of sexual problems?
- Are you aware of any physical problems, injuries, gynaecological problems, or genital deformities that may be causing sexual problems?
- Have you previously been diagnosed with a sexual dysfunction?
- Do you have children? Has this marriage been consummated?

- Have you ever undergone a sexual examination with your gynaecologist or urologist?
- Do you experience pain when attempting sexual intercourse?

Jeng (2003:6) states that the focus should be not only on physical causes, but also on the psychogenic causes, for example personal stress, which can cause the marriage to remain unconsummated. Jeng (2003:6) states that an essential element of the new diagnostic system to diagnose lack of consummation is the inclusion of a personal distress criterion in the diagnostic categories of the assessment. The assessment of personal distress can be made through clinical interviews and standardised questionnaires. Jeng (2003:6) emphasises that currently there are no validated sexual distress specific instruments for immediate use in clinical trials of the unconsummated marriage. Clinical assessment of personal distress involves querying the patient about the level of dissatisfaction concerning the sexual difficulty (Ridder & Schreurs, 1996; Kaneko, 2001; Ohkawa, 2001; Renshaw, 2004).

Asking the correct questions and diagnosing the correct cause of the unconsummated marriage is therefore of extreme importance. Healthcare professionals should therefore be aware of the various physical and psychogenic causes relating to an unconsummated marriage to guide them in their sexual history survey and assessment. The next section will focus on the causes of the unconsummated marriage.

4.4 CAUSES OF THE UNCONSUMMATED MARRIAGE

It is important to be aware of the various causes of an unconsummated marriage. Healthcare professionals need to know how to address the causes in the intervention programme when they treat couples who have been unable to consummate their marriage. It is important that healthcare professionals know which cases need to be treated through medical intervention and which of them need therapeutic intervention.

Two main categories can be identified, namely physical causes and psychogenic causes (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003; Renshaw, 2004). Renshaw (1989:51) states that important psychogenic causes surface in unconsummated marriages and are often completely enmeshed with the physical causes. It can be quite hard in some cases to establish what was primary or secondary to the sexual problem. The next section investigates physical causes of the unconsummated marriage first and after that the psychogenic causes.

4.4.1 Physical causes of the unconsummated marriage

A physical cause is a bodily problem; a medical condition that needs to be treated through medical intervention. In an unconsummated marriage that might be caused by physical factors, the physiology and the relevant symptoms need to be evaluated, and the precise physiological mechanism detected and understood for proper medical intervention to occur (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003).

According to Kaplan and Steege (1983), the multiple physical causes that may interfere with consummation or sexual intercourse, range from major irreversible ones (fortunately rare) to much more common minor and treatable types of problems as displayed in Table 4.1.

Table 4.1: Physical causes that can prevent sexual intercourse

A. Female Factors
1. Vaginal obstructions -imperforated or rigid hymen -vagina agenesis or other congenital abnormalities -vaginismus -pelvic or abdominal tumour impinging on vagina -foreign bodies in vagina -uterine prolapse
2. Painful gynaecological conditions -atrophic vaginitis -infected bartholin cyst -vaginal infections -pelvic inflammatory disease (PID) -genital allergies and irritations

-endometriosis -painful pelvic and abdominal tumour and inflammations -infected pelvic inflammatory disease(PID)
3. Other painful and obstructive conditions - severe skeletal and pelvic deformities -neurological conditions causing spasm and/or abnormal movements (e.g., cerebral palsy) -extreme obesity
B. Male Factors
1. Inadequate phallus -absent penis, micropenis and other congenital abnormalities -loss or damage to penis due to injury or surgery -penile deformalities; chordee, hypospadias, phimosis -organic impotence -organic anejaculation
2. Painful urological conditions - severe skeletal and pelvic deformalities -arthritis -neurological injuries and disease (e.g. spinal cord injuries and disease; cerebral palsy; degenerative disease) -extreme obesity
C. Female and Male Factor -Incompatible Size of Partner's Genitals

Source: Kaplan and Steege (1983)

Table 4.1 classifies physical problems in three main categories, namely physical problems that the female partner may experience, physical problems that the male partner may experience, and physical problems that may affect both.

Female factors that may prevent sexual intercourse are divided into three categories, namely vaginal obstruction, painful gynaecological conditions, and other painful and obstructive conditions. Vaginal obstructions make sexual intercourse difficult or impossible owing to the occlusion of the vaginal opening, the spasm of the pelvic floor or vaginal deformalities. Painful gynaecological conditions can create sexual problems by causing tenderness or pain when attempting sexual intercourse. Other painful and obstructive conditions such as a wide variety of medical illnesses cause sexual problems.

The literature (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003) suggests that sexual behaviour and sexual functions are both controlled in important ways by the nervous system. The brain itself is the ultimate synthesiser of sensory input (touch, sight, sound, taste, smell) and transforms electric impulses sent to it by nerve fibres into perceptions of pleasure, pain, and human emotion. Similarly, impulses sent from the brain to other organs, including the genitals, translate sexual desire into sexual response. For these reasons, it is easy to see why many diseases or injuries of the nervous system can lead to sexual difficulties.

Male factors that can prevent sexual intercourse may be divided into two categories, namely inadequate phallus, and painful urological conditions. An inadequate phallus can prevent sexual intercourse since it means the penis is absent, damaged, deformed or dysfunctional. The category of painful urological conditions includes various medical conditions that can prevent or hinder sexual intercourse. The inability to have sexual intercourse can also be related to the inability to have normal erections in response to psychological arousal, or the inability to ejaculate, or the fact that the person has no pelvic sensation. The incompatible size of a partner's genitals can be problematic in sexual intercourse. This can prevent them from engaging in sexual intercourse owing to severe pain which both male and female partner may experience (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003).

4.4.2 Psychogenic causes of the unconsummated marriage

A psychogenic cause is a mental problem; a psychological condition that needs to be treated through therapeutic intervention. In an unconsummated marriage that is embedded in psychogenic causes the behavioural, psychodynamic, and systematic aspects of the symptoms need to be evaluated and the precise psychological mechanism should be detected and understood for proper therapeutic intervention to occur (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003). Table 4.2 lists the psychogenic causes that can prevent sexual intercourse.

Table 4.2: Psychogenic causes that can prevent sexual intercourse

A. Female factors -psychogenic dyspareunia -Inhibited sexual desire (ISD) -vaginismus -phobic avoidance of intercourse, on the basic of panic disorder or simple phobia -ambivalence about or rejection of the partner -unconscious conflict about sex, commitment, pregnancy, motherhood, fear of injury during sex and/or childbirth -psychotic delusions about penetration -deliberate avoidance of intercourse
B. Male factors - psychogenic dyspareunia -inhibited sexual desire (ISD) -performance anxiety -impotence (which may be specific to penetration attempts) -premature ejaculation -phobic avoidance of intercourse on the basis of panic disorder or simple phobia -ambivalence about or rejection of the partner -unconscious conflict about sex, commitment, parenthood, fear of injuring the partner -pathological passivity which prevents active thrusting -psychotic delusions about penetration (vagina dentata) -deliberate avoidance of intercourse (sexual aversions) -mental retardation
C. Problems in the relationship - poor sexual technique - lack of information - poor communication -neurotic interactions : power struggles, contractual disappointment, mutual parental transferences - incompatible sexual fantasies - incompatible marriage - relationship problems secondary to alcoholism and substance abuse

Source: Kaplan and Steege (1983)

Table 4.2 indicates that numerous psychogenic problems may prevent sexual intercourse and cause a marriage to remain unconsummated. Psychogenic causes are found among both female and male partners. There may also be relationship problems that cause the marriage to remain unconsummated. Jeng (2003) says that the psychogenic problems that prevent sexual intercourse are

mostly rooted in fear and anxiety. The literature (Renshaw, 1989; Jeng, 2003; Renshaw, 2004) suggests that the sexual relationship is usually affected if there are problems in one of the other facets of the marital relationship. Couples who harbour resentments towards each another may choose the sexual arena for the combat. Communication problems, moreover, may be linked to general marital dissatisfaction. Couples who find it difficult to communicate their sexual desires and needs may lack the means to help their partners become more sexually effective.

Though many physical and psychogenic causes could lead to an unconsummated marriage, Jeng (2003:38) found only 6 different etiologies of primary vaginal penetration failure for the 129 couples in his study. These are vaginismus, lack of sex information, premature ejaculation, erectile dysfunction, congenital tract abnormalities and sexual aversion/phobia. According to Jeng (2003:33) vaginismus could be regarded as the leading cause of unconsummated marriage.

The literature (Kaplan & Steege, 1983; Renshaw, 1989; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that the term unconsummated marriage is more or less equal to the term vaginismus. In Friedman's book *Virgin Wives – A Study of Unconsummated Marriages*, all 100 cases studied are related to vaginismus (Friedman, 1962). In most unconsummated marriages, the painful female condition of vaginismus is prevalent (Kaplan & Steege, 1983; Renshaw, 1989; Jeng, 2003; Renshaw, 2004).

4.5 VAGINISMUS AS CAUSE OF THE UNCONSUMMATED MARRIAGE

An understanding of vaginismus is vital needed and a thorough description of the condition will consequently be presented.

4.5.1 Description of vaginismus

According to Renshaw (2004) the healthcare professional, Huguier first introduced the term "vaginismus" in 1834, as the title of his Master's thesis. Trotula Of Salerno in her 1547 treatise on "The Diseases of Women", probably provided the first description of what is now called vaginismus as a tightening of

the vulva so that even a woman who had been seduced before might appear to be virgin. It was concluded that vaginismus represented an involuntary, painful, spasmodic contraction of the vulvo-vaginal canal provoked by a hypersensitivity specific to the genital organ. The notion of hypersensitivity specific to the genital organs was questioned and it was suggested that the vaginal muscle spasm represented a phobic reaction resulting from fear of pain. The importance of psychotherapy and education rather than surgery and dilatation was stressed. While it was correctly identified as conditioned response, vaginismus was considered to constitute a hysterical or conversion symptom, being conceptualised as a symbolic expression of a specific subconscious inner conflict (Renshaw, 2004).

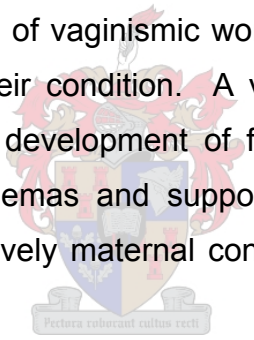
Vaginismus is defined as the involuntary spasm of the pelvic muscles surrounding the outer third of the vagina, specially the perineal muscles and the levator muscles. In severe cases of vaginismus the adductors of the thighs, the rectus abdominis, and the gluteus muscles may be involved. This reflex contraction is triggered by imagined or anticipated attempts at penetration of the vagina or during the act of intromission or coitus (Masters & Johnson, 1970; Ellison, 1972; Kaplan, 1974; Jeng, 2003; Renshaw, 2004). According to Basson (1996), in the "Report of the international consensus development conference on female sexual dysfunction", vaginismus is defined as the recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with vaginal penetration, which causes personal distress.

Vaginismus classically in its severest form makes penetration virtually impossible and causes a severe burning pain, but there are less pronounced degrees of vaginismus, characterised by a "stiffening" of the vaginal musculature, allowing penetration, yet accompanied by the same sort of pain. The condition may be primary (present from the first attempt of penetration) or secondary (following physical or psychological trauma, infection, menopausal change or pelvic pathology) (Basson, 1996; Jeng, 2003; Renshaw, 2004). Consequently the cause-or-effect relationship of pain in vaginismus will be discussed.

4.5.2 The cause-or-effect relationship of pain in vaginismus

The cause-or-effect relationship of pain in vaginismus needs to be considered by healthcare professionals in order to deliver high-quality medical and therapeutic intervention to the couple in an unconsummated marriage. Is the pain secondary to some factor other than the putative vaginismic muscle response (e.g., vulvar vestibulitis syndrome, infections, and sexually transmitted infections), or is pain the result of the spasmodic muscle activity (Silverstein, 1989; Goodwin & Agronin, 1997; Reissing *et al*., 1999; Jeng 2003; Renshaw, 2004).

Dawkins and Taylor (1961) suggested that fear of pain is a symptom rather than a cause of vaginismus, but others (Blazer, 1964; Ellison, 1972) have stressed its possible causal and maintaining role in the sexual disorder. In an interview study (Blazer, 1964) of 476 women with vaginismus, Blazer (1964) listed fear of pain as the primary reason for abstinence. This was supported by Ward and Ogden's (1994) findings, in which 74% of vaginismic women reported fear of pain as the primary reason underlying their condition. A variety of childhood experiences have been implicated in the development of fear of pain, including childhood physical trauma, such as enemas and suppositories, fear of a violent father (Silverstein, 1989) and negatively maternal conditioning (Ward & Ogden, 1994; Jeng 2003).



There is a definite relationship between sexuality, fear and pain. Goodwin and Agronin (1997) and Jeng (2003) state that when a person perceives a dangerous situation, the body reacts quickly to protect itself. Deep in the brain, a group of interconnected centres, collectively called the limbic system, process incoming sensory stimuli and assess in a split second the significance of these stimuli. If the limbic system perceives danger, it evokes the urge to either fight off or flee from the danger. The reaction is called the fight-or-flight response. The emotion of fear is associated with this nervous response and signals the body to react. The response is then mediated by activation of an automatic part of the nervous system called the sympathetic nervous system.

According to Goodwin and Agronin (1997), sympathetic nerve pathways prepare the body for fight or flight by increasing heart rate and breathing, raising blood

pressure, shunting circulation to critical organs, tightening muscles, raising hair on end, increasing sweat, dilating pupils, and increasing vigilant scanning of the environment. Neurological pathways for sex and feeding are inhibited. Pain sensation in the body may be dulled as the body concentrates fully on the danger. Each of these changes in the body serves a unique purpose and guarantees the best chance of survival. When there is no danger, an opposing set of automatic nerve pathways called the parasympathetic nervous system relaxes the body and mediates other functions such as digestion and sexual arousal (Silverstein, 1989; Reissing *et al*., 1999; Jeng 2003).

The literature (Goodwin & Agronin, 1997; Jeng, 2003) explains that although a person's body reacts physically in similar ways as animals during the fight-or-flight response, the human psychological response to danger is more complex. The emotion of fear may be triggered by actual danger, situations only perceived as dangerous, or situations that have come to be associated with danger. This is called a conditioned response. The experience of fear, unease, or discomfort when no threatening object is in sight, is called anxiety. Anxiety can be mild, waxing and waning over minutes to hours, or it can become sudden and severe and involve an incapacitating physical response called a panic attack. A person experiencing a panic attack may often feel as if death is imminent, and may engage in frantic behaviours to escape the situation. Panic attacks in response to specific triggers are called phobia (Goodwin & Agronin, 1997; Jeng, 2003; Renshaw, 2004). Vaginismus could be described as a panic attack. It is so severe that it can be regarded as a phobia of penetration.

Under ideal conditions, the parasympathetic nervous system prepares the body for a relaxing, playful, and sexually pleasurable activity. When the body is relaxed, it is maximally responsive to sensual touch, and both the mind and body allow for the build-up of sexual excitement and eventually of sexual climax (Kennedy, Dorothy & Banes, 1995; Goodwin & Agronin, 1997). More research (Goodwin & Agronin, 1997; Jeng, 2003; Renshaw, 2004) has begun to focus on phobias of sexual intimacy, including fear of male or female genitals or fear of vaginal penetration. The panic reaction related to these phobias can be so severe that people adapt their lives to avoid them, by giving up sexual

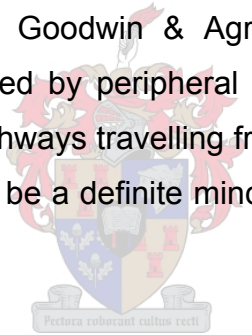
relationships or by limiting sexual contact to only certain activities. A woman may be anxious about a sexual situation for many different reasons. She might anticipate that sex will hurt. She might be worried about her body image, angry at her partner, concerned about whether she's a good lover, or upset about something outside the sexual realm (job-related or financial concerns) (Kennedy *et al*., 1995; Goodwin & Agronin, 1997; Jeng, 2003).

This anxiety of the female may be related to unknown and wholly subconscious causes, such as underlying guilt about sex, uncertainty about her partner, or conflict over her sexual orientation. As anxiety increases in these circumstances, her body might react as if she were in real danger and activate the fight or flight response, which in turn inhibits the sexual response cycle. This inhibition may occur at any point along the pathway from desire, to arousal, to orgasm. It may not be experienced as an obvious response to danger, especially when the anxiety is less tangible or unconscious. Instead, a woman might be aware of her sexual problem and not recognise the fear or anxiety that inspired it. This reaction, in turn, could lead to more anxiety and new emotions of frustration, disappointment, and shame (Goodwin & Agronin, 1997; Jeng, 2003; Renshaw, 2004). Though vaginismus is related to the subconscious mind and anxiety, the condition can be identified as a result of a physical condition.

According to Goodwin and Agronin (1997) and Kennedy *et al.* (1995) tissue damage is normally one of the subjective experiences of pain. This serves as the immediate and most telling indication of injury and disease. Pain can result from actual tissue damage, such as a cut, or from potential damage, such as the heat from a flame before it actually burns one's hand. Pain may be acute, such as the sharp hurt of a twisted ankle, or chronic, such as the ache of a degenerative disc in the back. The tissue damage may be mild, but interpreted as severe, and hence the pain feels worse than what would be expected. Pain can even result from imagined tissue damage, such as when someone believes that they have been injured more seriously than they have actually been injured. The actual tissue damage may not bear any relation to the degree of pain, but the pain is still real. Too often, pain is only taken seriously when the source is clearly visible, such as the pain from a large gaping wound or an angry sore. Pain

depends on the experience of the injured and the manner in which the individual views it.

Goodwin and Agronin (1997) and Renshaw (2004) explain that pain is a complex interaction between nerve pathways, the spinal cord, and centres in the brain, particularly the deep cerebral nucleus called the thalamus. Pain is transmitted from peripheral pain receptors, called nociceptors, to a gate-like mechanism in a part of the spinal cord called the dorsal horn. There are several types of peripheral nerve endings, and each detects a different source of painful stimulation — the three possible sources are intense pressure, thermal damage, and inflammation. Certain nerve pathways transmit painful stimuli from peripheral endings to the spinal cord and then up into the brain. Other peripheral pathways serve to "close the gate" in the spinal cord and inhibit transmission of pain. Still other pathways travel downward from the brain and interact with this gate (Kennedy *et al*., 1995; Goodwin & Agronin, 1997; Jeng, 2003). The perception of pain is influenced by peripheral nerve pathways travelling to the brain as well as by central pathways travelling from the brain — a true mind-body interaction. There appears to be a definite mind-body interaction when a person is battling with vaginismus.



When painful sensations occur regularly during sexual activity, a woman may begin to view sex as dangerous, which then inspires apprehension, anxiety and the predictable fight-or-flight response. Dyspareunia is the condition where genital pain is caused by sexual intercourse. Sexual dysfunction may also result from discomfort or pain which occurs during sexual intercourse but in other parts of the body, such as joint pain, shortness of breath, or chest pain due to physical exertion. Such nongenital pain during sex can decrease pleasurable sensations and lead to inhibited sexual arousal, climax, and, eventually, decreased desire (Goodwin & Agronin, 1997; Jeng, 2003). It is important for healthcare professionals to understand the cause-or-effect relationship of pain in vaginismus, since the healthcare professional needs to be able to identify the cause of the vaginismus and the effect it has on the couple. Identifying the cause and the effect is very important in treating the couple in an

unconsummated marriage, because the healthcare professional needs to treat the cause in order for the effects to be reduced.

The relationship between sexuality, fear and pain and the causes-or-effect relationship with pain makes vaginismus a complex problem which can only be treated through medical and therapeutic intervention after having done a thorough assessment of the problem. Consequently it is important to focus on the causal factors associated with vaginismus in order to gain a better understanding of why vaginismus occurs, and why it can cause a marriage to remain unconsummated.

4.5.3 Causal factors in the development of vaginismus

The literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that there are various causal factors associated with vaginismus. A comprehensive list of factors that could cause vaginismus will be discussed, namely past illness, surgery and medical procedures; cultural variations of sexuality; misinformation, ignorance, and guilt about sexuality; parental or peer misrepresentation of sex and sexuality; sexual violation and abuse; religious orthodoxy, inhibitions and taboos; parental indulgence and over-protectiveness; failed penetration experiences and a fear of infection; fear of pregnancy; and lastly the fear of relationships, intimacy and the loss of control.

Some may be obvious causal factors; others may be hidden deep in a person's emotional vault and will need exploration in therapeutic intervention to bring to the surface. Every woman will have her own combination of causal factors for her vaginismus.

4.5.3.1 Past illness, surgery and medical procedures

The literature (Goodwin & Agronin, 1997; Hunt, 2002; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that scary or painful events, especially if they happened in childhood, are common forces responsible for the reflexive fighting against being touched or entered. Additional complications may include the lack of understanding of what happened in the past, remembering being held down or forced to comply, memories of being alone and isolated during the

frightening event. It is important to note here that the past trauma does not need to have been limited to the genitalia in order to provoke such a reaction; the basic feeling of "done to" anywhere else in the body can cause the same reaction of feeling helpless, feeling trapped or feeling in pain and can result in vaginismus.

4.5.3.2 Cultural variations of sexuality

According to Katz and Tabisel (2002:108), intimate sexual relationships offer the partners an opportunity to explore their own individual sexuality, as well as communicate it to the other. Through this process, men and women develop their sexual experiences and preferences, likes and dislikes. Exposure to more than one such relationship, be it a brief attraction to the boy in class at age twelve, or a deep, involved emotional relationship as an adult, will validate a person's own selection skills, sexual choices, and life's goals. However, the literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that such liberal views are not shared by all cultures, nor are other sexuality issues, such as homosexuality, adultery, pornography, birth control, oral sex, body purification for sex, abortion, sex education, male and female genital circumcision, or polygamy.

Cultural expectations have presented an ongoing conflict to women, especially in cultures that do not accept equality in the relationship. Such expectations include being sexually available for the man whenever he is interested; performing sexually for him regardless of the woman's sexual needs; getting pregnant as a proof of his manhood; minimising her own sexual preferences; accepting the husband's philandering if the wife does not perform sexually in a satisfactory manner; accepting a divorce if the marriage is not consummated; disallowing use of birth control. The resulting emotional and physical toll of these forces is devastating regardless of the woman's level of cultural acceptance, making vaginismus either an inevitable outcome of stress, or a retaliatory tool (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004).

4.5.3.3 Misinformation, ignorance, and guilt about sexuality

Vaginismus patients show a high degree of ignorance and misinformation. A lack of sex education has also been noted in studies of vaginismic women

(Carnes, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2003). It has further been hypothesised that this lack of information along with the identification with an erotophobic mother lead to fear of pain and ultimately the withdrawal from intercourse.

Sexual guilt is a definite causal factor in the development of vaginismus. Sexual guilt is the result of deeper sexual conflict, leading in turn to a fear of punishment and an even stronger physical defence reaction. The personal theories of vaginismic women regarding the causes and effects of their condition were evaluated by Ward and Ogden (1994). Sixty-seven "sufferers" and 22 "ex-sufferers" gave the second highest rating for causality to "being brought up to believe sex was wrong." Basson (1996) found that women in her study held negative views about sexuality in general, and sexual activity before marriage in particular. Women with vaginismus generally feel shame, disgust and dislike of their genitals. These negative feelings and conceptualised misinformation regarding healthy social behaviour are learned from identification with mother figures (Silverstein, 1989; Basson, 1996; Reissing *et al.,* 1999; Jeng, 2003; Renshaw, 2004).

4.5.3.4 Parental or peer misrepresentation of sex and sexuality

According to Silverstein (1989) and Katz and Tabisel (2002:109) parental or peer misrepresentation of sex and sexuality is a causal factor in developing vaginismus. Parental or peer misrepresentation of sex and sexuality include statements such as that sex is bad, sex is for the man only, sex always hurts, the man cares about himself only, or just pretend sex is good and get it over. Female adolescents who accept these statements without speaking up or without checking their validity, will often develop vaginismus as a way to avoid sex. They will join the ranks of other females who interpret sexual intercourse as negative and painful (Silverstein, 1989; Katz & Tabisel, 2002).

4.5.3.5 Sexual violation and abuse

It has been argued that experiencing or witnessing sexual trauma is a causal factor in the development of vaginismus (Silverstein, 1989; Gelles, 1993; Biswas & Ratnam, 1995; Renshaw, 2004). However, in studies with control or

comparison groups, no significant group difference in the prevalence of sexual abuse was noted (Hawton & Catalan, 1990; Glanz & Spiegel, 1996; Renshaw, 2003; Renshaw, 2004). In one study (Basson, 1996) the prevalence of sexual abuse in vaginismic women was actually lower than that in the general population. When asked to indicate their causal attributions for developing vaginismus, current sufferers and ex-sufferers ranked sexual abuse as least important (Ward & Ogden, 1994).

Katz and Tabisel (2002:110), however, state that childhood sexual abuse is a devastating trauma with a life-long impact on body and mind, and that it is a causal factor in the development of vaginismus. Childhood sexual abuse is an assault of the body and the mind, whether it happens once or twice, or whether it is an ongoing event in the child's life, perpetrated by one person or more people. Sexual abuse invades the skin, the largest organ in the body; it overwhelms the immature mind that must attempt to make sense of what is happening and of the rights and the wrongs; and it shatters the emotional being by imposing fear, intrusion, lack of safety, and helplessness. To cope with the fear, guilt, shame, and confusion about the body's reactions, the child will escape into the only component that cannot be manipulated, namely the mind, blocking the bodily experiences, be they painful or pleasurable, forced or safe, often enlisting vaginismus as the protector (Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004).

According to Katz and Tabisel (2002:109), the inability to say no to an unwanted sexual situation causes the feeling of being forced, of being option-less, of the need for self-protection, and this may lead to vaginismus. Being pressurised into having vaginal intercourse leads to emotional disengagement and to vaginal friction and irritation due to inadequate lubrication. Women who suffer from vaginal dryness, and those who do not know how to manage dryness that could be caused by hormonal changes or taking certain medications, may become even more reluctant to engage in intercourse, developing vaginismus as a result of the conditioned struggle to decline or resist penetration.

The literature (Goodwin & Agronin, 1997; Berman & Berman, 2001Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that rape is an equally

devastating intrusion on a person's personal space and safety as childhood sexual abuse, but with an intellectual difference. Whereas childhood sexual abuse involves a youngster who does not yet understand the body and why it reacted the way it did, nor can appreciate the size of the intruder's genitals in true physical proportions (through the eyes of a grownup), rape victims have matured and understand their genitals and what sex is about (whether they are sexually experienced or not) and do not perceive the trauma as a measure of love or confusion by the intruder. However, vaginismus is still used by rape victims as a coping mechanism, and especially as a tool to re-establish trust and safety.

4.5.3.6 Religious orthodoxy, inhibitions and taboos

The literature (Masters & Johnson, 1970; Silverstein, 1989; Biswas & Ratnam, 1995; Katz & Tabisel, 2002; Renshaw, 2004) suggests that vaginismus may result from a childhood characterised by excessively severe control, stemming from religious orthodoxy. Katz and Tabisel (2002:104) explain that religious inhibitions and taboos play a crucial role in establishing vaginismus, and are some of the leading causes of this condition. The religion itself is not the determining factor; the source of inhibitions is rather the religious guidelines on sex and sexuality for the female adolescent and the woman. Katz and Tabisel (2002:105) have worked with Christians of all denominations (including Catholics, Protestants, members of the Church of Jesus Christ of Latter-Day Saints [Mormons]), as well as Muslims, Jews, Hindus, and others, all blending together in a similar fashion when reflecting on their vaginismus problem and the effect of a strict religious upbringing and certain religious expectations.

4.5.3.7 Parental indulgence and over-protectiveness

The literature (Berman & Berman, 2001; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that parental indulgence and over-protectiveness is a causal factor in developing vaginismus. Parental indulgence and over-protectiveness limit the child's ability to deal with life in a healthy, appropriate way: to face challenges, to overcome fears, and to face the unknown. Specifically, there will be voids in the following needed experiences: the need to explore the body and its functions, including accepting pain as an inevitable feature of life; the need to explore conflict and the ability to develop constructive

mechanisms for resolution; the need to experience mistakes and failures in order to learn from them and improve; the need to understand the self, with own attributes and limitations; finally, the need to learn boundaries, responsibilities, and consequences.

Children who are shielded from what their parents perceive as "the harshness of life" are often left helpless, with poor social and coping skills, and with poor self-esteem and limited self-definition. Poor self-image and feeling unattractive can easily lead to physical inhibitions during sexual intimacy. The stress associated with poor self-image will often facilitate the development of vaginismus (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004).

4.5.3.8 Failed penetration experiences and a fear of infection

Katz and Tabisel (2002:112) explain that failed penetration experiences such as the inability to insert a tampon, or a painful first sexual or gynaecologic experience, will often leave such an impression on the woman that she may fear future penetration. in preventing recurrence of the same trauma. Another common experience is that of a first-time intercourse with a partner who was not experienced enough to realize that if not lubricated, sexual intercourse can cause vaginal chafing, pain, infection, and a lasting conviction that penetration is painful.

The literature (Masters & Johnson, 1970; Silverstein, 1989; Biswas & Ratnam, 1995; Katz & Tabisel, 2002; Renshaw, 2004) suggests that a fear of vaginal penetration may be associated with a fear of infection. The genitals in general and the vaginal canal in particular are not sterile environments, and irritations and infections do occur, mostly as a result of excessive friction such as intercourse inside a dry vaginal canal, or upon contact with an infected partner, including cold sores that may be transmitted to the genitals through oral sex. Fear of infection could bring about vaginismus as an attempt at self-protection.

4.5.3.9 Fear of pregnancy

Katz and Tabisel (2002:122) state that the fear of pregnancy has led to many women developing vaginismus as the ultimate method of birth control, and as a

way of saying no to starting a family or to abandoning their careers. The literature (Biswas & Ratnam, 1995; Hunt, 2002; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) indicates that sometimes vaginismus may develop after childbirth, when it is inadvertently used as a way of coping with the new demands of family life, or in resentment of having to cope with the responsibilities of caring for the baby.

4.5.3.10 Fear of relationships, intimacy and the loss of control

According to Katz and Tabisel (2002:127), a woman may develop vaginismus in an attempt to manage a fear of relationships, and of intimacy, upon realising that sexuality, and vaginal penetrations, are inevitable components of intimate relationships. She may rationalise her fears and inadequacies by telling herself that she is not a capable or worthy sexual partner (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004). The literature (Lamont, 1994; Harrison, 1996; Reissing *et al.*, 1999; Katz & Tabisel, 2002; Renshaw, 2004) suggests that the fear of loss of control during the act of intercourse may easily present as vaginismus. The woman is being entered by another and is the receiver of the act. Some women may interpret this primal feeling as loss of control, causing them to develop vaginismus as their way to regain that control.

These various causal factors associated with vaginismus need to be assessed and addressed in the medical and therapeutic intervention extended to couples, since both partners develop coping mechanisms in order to cope with vaginismus in their unconsummated marriage. The following section will focus on coping mechanisms that both partners may develop if faced with the phenomenon of vaginismus.

4.5.4 Attempted coping mechanisms for managing vaginismus

Katz and Tabisel (2002:151) state that in order to cope with the effect of vaginismus, both the female and the male partner employ a range of survival tools. They attempt to paint a normal picture of their marriage to themselves and to the outside world, despite the devastation of the condition. The strain of hiding their secret from everybody that expects their family life cycle to flow in a normal

pattern, such as parents and family, friends and colleagues, is often difficult to bear.

Various coping mechanisms that may be employed in an attempt to deal with vaginismus will subsequently be discussed.

4.5.4.1 Rationalisation

According to Katz and Tabisel (2002:151), rationalisation is an attempt at self reasoning; to find an explanation that makes sense, such as “I am not ready for intercourse”; “It will happen when my body is ready for it”; “It is genetic…my mother had a problem, too”; “I must not do it before I am married.” These are not healthy excuses but rather an effort to minimise the impact of the problem and to disengage from the need to address it.

4.5.4.2 Busyness

The literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that busyness is a common coping tool aimed at avoiding life’s difficulties. Busyness entails keeping life so active as to disallow any opportunity for unwanted thoughts of for facing the problem of vaginismus. It may include excessive volunteering, immersing oneself in endless higher education, becoming a workaholic, maintaining instability through constant relocation or travelling.

4.5.4.3 Avoidance

Avoidance is the act of circumventing, of making sure not to come in contact with the problem. It means planning life so as to avoid any opportunity for encountering the problem, such as refusing to watch movies that include scenes of intimacy and sexual activity; refusing to take birth control pills that were prescribed to regulate heavy periods because they are a daily reminder of vaginismus. On the relationship level, avoidance might mean starting a fight to avoid intimacy, pretending to be asleep when one’s partner is awake (Harrison, 1996; Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004).

4.5.4.4 A compromised relationship

According to Katz and Tabisel (2002:255) the sense of inadequacy and poor self-esteem that often characterises vaginismus sufferers, may prompt the woman to seek and accept partners and relationships that are less than desirable. The literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that some women may happily accept relationships with men who suffer from erectile dysfunction; others date much older men with a diminished sexual drive. Many are in relationships with men whom others may regard as below their expectations, but who accept the woman for who she is, regardless of penetration difficulties. Compromised relationships tend not to be maintained once the condition is cured and the women move on with their newly empowered lives.

4.5.4.5 Somatisation

According to the literature (Harrison, 1996; Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004), somatisation is the phenomenon of multiple and recurring physical complaints for which medical intervention is constantly being sought, yet for which a physical explanation cannot be found. In other words, here is a coping mechanism where the upset, angry mind sends the body to speak up for it in the hope that it will draw attention and bring explanations and resolutions to the unsolved problem. Somatisation consumes a person's life, preventing the experience of calmness, pleasure, safety, and healthy fulfilment of self. An integral component of somatisation is the hyperactivity of the Sympathetic Nervous System (SNS) with its fight-or-flight reaction, which facilitates the establishment of a conditioned anxiety that will accompany the symptomology, adding to the sense of being controlled by the condition.

During the time of somatic experiences, the individual is convinced of her physical disorder, for which she would rather find a physical cure than face the reality of it being a psychophysical condition. The conflict will send the person on an endless search for the right answer to her problem, eventually finding clinicians who prescribe medications or perform surgeries just to pacify the patient or because the clinicians was not able to recognise the somatic

presentation. It is up to the treating clinician to explore the symptomology while reassuring the patient of competency in understanding the condition. Somatisation in women who suffer from vaginismus may include tactile (touch) hypersensitivity, chest pains, headaches, irritable bowel syndrome (IBS), eating disorders, rectal pains, sleep disorders, fibromyalgia, jaw pains, and muscle pains anywhere in the body. Somatisation may be used as a tool to avoid intimacy (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004).

4.5.4.6 Separating

According to Katz and Tabisel (2002:151), separating from the relationship is an unfortunate outcome of the frustration that surrounds vaginismus. Everyone hopes that the partner will stand by, will cope with the limitations and will still love them. Most partners seem to show a strong commitment to the relationship, and then separation is not an option. However, this is not always the case. Some men leave because they do not wish their sexual need for penetration to be compromised; others leave because they wish to father children in the natural, biological way and are not willing to compromise. Some female partners leave because they feel that their intimacy is incomplete without penetration; some men claim that the lack of penetration reflects on their masculinity, suggesting failure, and that they therefore need to move on to be with women who can accept penetration. Many vaginismus sufferers encourage their partners to leave, feeling unworthy of their commitment and inadequate in themselves. Other vaginismus sufferers refuse to address the problem and allow the disintegration of the relationship, which they perceive as less painful than the idea of seeking treatment (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004).

4.5.4.7 Substance abuse and depression

The literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) indicates that substance abuse takes coping mechanisms to a different level, where chemicals are used to numb the mind, to lower emotional and physical defences and to heighten self-esteem. Katz and Tabisel (2002:157) state that depression, suffering in silence, and “going through the motions” are

emotional vehicles that signal resignation and the feeling of being helpless and hopeless. These existences are the most desperate, with the sufferers having lost all the emotional energy to cope, to continue searching for answers, to be able to find a positive in their lives.

4.5.4.8 Artificial insemination and adoption

When the couple wishes to start a family but cannot have intercourse, they may opt for artificial insemination or adoption. These options are not taken lightly. The couple need to sort out their feelings about not having a child the biological way, about staying a virgin yet being a parent, about having somebody else's child, and about facing questions from family and friends — difficult emotional situations that parallel the difficulty of overcoming vaginismus (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004).

4.5.4.9 Body shutdown

According to the literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) body shutdown is a most powerful coping tool for dealing with sexual inhibitions, the fear of penetration, the need for control, poor body image and vaginismus. Body shutdown is a tentative state of existence in which the woman has trained herself to deflect and resist physical and sexual contact in order to maintain a self-protective balance. Body shutdown is a learned response, a conditioned pattern of reacting to vaginismus. Body shutdown can easily turn into an automatic response, becoming familiar and quite comforting to the point that it pushes away the normal, biological response to sexual intimacy.

These coping mechanisms maintain the problem and allow the unconsummated marriage to continue for years on end. Fear of change prevents the couple from seeking intervention and addressing the sexual problem.

4.6 SUMMARY

In this chapter the nature of an unconsummated marriage was discussed. It was made clear that the lack of consummation may be primary or secondary. Some couples in an unconsummated marriage may in other words have experienced

sexual intercourse (coitus). The information presented in this chapter indicates the complexity of an unconsummated marriage due to the interrelated physical and psychogenic causes. It is clear that healthcare professionals should do a thorough sexual history survey and assessment to prevent misdiagnosis and ensure high-quality medical and therapeutic intervention.

Vaginismus was furthermore presented as a common cause of the unconsummated marriage. A comprehensive description of vaginismus was given and its cause-or-effect relationship with pain was emphasised. This information should give healthcare professionals more insight into the mind-body interaction which occurs when a couple have to deal with Vaginismus. Causal factors in the development of vaginismus were discussed comprehensively. An overview of each factor was given and various coping mechanisms in managing vaginismus were also discussed. From this discussion it is clear that healthcare professionals need to obtain a better understanding of this sexual problem and the impact it has on the affected couple.

In the following chapter selected approaches and models in assessing the functioning of a marriage and family will be discussed. The chapter will focus on the postmodern-systemic approach, the Circumplex model, the Beavers system model, the McMaster model, and lastly on sexual health theory.

CHAPTER 5

SELECTED APPROACHES AND MODELS FOR ASSESSING MARRIAGE AND FAMILY FUNCTIONING

5.1 INTRODUCTION

This chapter will critically describe approaches and models that may be used in an assessment of an unconsummated marriage. Various approaches and models can be utilised to assess marriage and family functioning, and many of them may also be useful in a therapeutic intervention aimed at obtaining optimum sexual health.

A postmodern systemic approach, from a social work perspective, will be followed while considering three applicable family therapy models, namely the Circumplex model, the Beavers system model and the McMaster model. When healthcare professionals such as social workers need to assess couples and promote sexual health through therapeutic intervention in an unconsummated marriage, these three models may afford insight into the relevant marital and family systems, family competence and family functioning. Furthermore, these family therapy models provide therapeutic tools and intervention strategies applicable to marriage counselling and will consequently be helpful to healthcare professionals in understanding the couple in an unconsummated marriage and the marital and family dynamics relevant to this particular system.

5.2 THE POSTMODERN-SYSTEMIC APPROACH

A postmodern perspective challenges the assumption that a fixed truth or reality exists (Barker, 1998:39; Goldenberg & Goldenberg, 1998:89). Braunert (2004:2) explains that ‘pluralism’ is the ‘keyword’ of postmodernism. Postmodernism stands for an end to the wish for unity and wholeness of ‘modernism’. It means not to believe in ‘meta-narrations’, but to accept a diversity of narrations, which between themselves may be inconsistent. The dissolution of the unit conceptions is a precondition for the postmodern idea of plurality. A man or woman thinks in postmodern terms when he or she is beyond the obsession of

unity, conscious of an irreducible variety of forms of language, thinking and living, and when he or she knows how to deal with their reality.

Walrond-Skinner (1981:11) explains that systems theory was conceived by Ludwig von Bertalanffy in the 1940s, in order to provide a working model for conceptualising phenomena which did not lend themselves to explanation by the mechanistic reductionism of classical science. In particular, systems theory seemed able to provide a unifying theoretical framework for both the natural and the social sciences, which needed to employ concepts such as organisation, wholeness and dynamic interaction, none of which lent itself easily to the methods of analysis employed by the pure sciences. Ackoff (1960) places systems theory in its developmental context and states that the tendency to study systems as an entity rather than as a conglomeration of parts is consistent with the tendency in contemporary science no longer to isolate phenomena in narrowly confined contexts, but rather to open interactions for examination and to examine larger and larger slices of nature.

A postmodern-systemic approach can be utilised when couples in an unconsummated marriage need to undergo a paradigm shift which will enable a couple to change their unhealthy sexual behaviour to healthy sexual behaviour. In an unconsummated marriage the couple may be seen as a family, that is a subsystem (husband-wife unit), which functions in various other systems, for example the extended family, business and social environment. The family systems perspective has advanced the conceptualisation of the family from a linear, dyadic view of causality to the recognition of multiple recursive influences within and beyond the family that shape individual and family functioning and has an influence on healthy sexuality. Early family therapy theory and practice remained pathology-oriented, attending to dysfunctional family processes implicated in the ongoing maintenance of individual symptoms, if not their origins. In recent decades, there has been a welcome shift in therapeutic focus and aims toward greater recognition and enhancement of family strengths (Barker, 1998; Walsh, 2003). Walsh (2003) is of the opinion that a postmodern-systemic approach can be utilised effectively to recognise and enhance family strengths and consequently improve family functioning. In order to obtain a better

understanding of the postmodern-systemic system, the following section will focus on the systemic approach, followed by an in-depth explanation of the postmodern approach.

5.2.1 The systemic approach

Like Walrond-Skinner (1981:11) Barker (1998:27) also explained that systems theory was proposed by Von Bertalanffy as a general theory explaining the organisation of parts into wholes. A system is a complex of interacting elements. The importance of systems theory to family therapy lies in the ideas and concepts it has brought to the field. These include the following, according to Barker (1998:28):

- Families (and other social groups) are systems, whose properties are more than the sum of the properties of their parts.
- The operation of such systems is governed by certain general rules.
- Every system has a boundary, the properties of which are important in understanding how the system works.
- The boundaries are semi-permeable; that is to say some things can pass through them while others cannot. Moreover it is sometimes found that certain material can pass through one way, but not the other.
- Family systems tend to reach relatively, but not totally, steady states. Growth and evolution are positive, indeed usual. Change can occur, or be stimulated, in various ways.
- Communication and feedback mechanisms between the parts of a system are important in the functioning of the system.
- Events such as the behaviour of individuals in a family are better understood as examples of circular causality, rather than as being based on linear causality.
- Family systems, like other open systems, appear to be purposeful.
- Systems are made up of subsystems and themselves are parts of larger supra-systems (Barker, 1998:28).

It is consequently understood that the married couple is structured as a family (a system) that forms part of interacting elements. According to systems theory,

therefore, the couple in an unconsummated marriage cannot be considered in isolation but should be viewed within a holistic framework.

Walsh (2003:31) explains that the systemic approach of the Mental Research Institute (MRI) in Palo Alto, the problem-solving model of Haley and Madanes, and the Milan systemic approach were more concerned with developing a theory of therapeutic change than a model of family functioning. Haley (1976) makes a careful distinction between the two, believing that clinicians have been hampered by theory that attempts to explain pathology but does not lead to problem solving. Symptoms are seen as a communicative act, appearing when an individual is locked into an interactional pattern and cannot see a way to change it. Assuming that all families confront problems, the MRI model (Weakland, Fisch, Watzlawick & Bodin, 1974; Boscolo, Gecchin, Hoffman & Penn, 1987) focuses on how families attempt to handle or resolve normal problems in living.

According to Barker (1998) and Walsh (2003) families may maintain a problem by the misguided means they are using to handle it. An attempted solution may worsen the problem, or may itself become a problem requiring change. Therapy focuses on problem resolution by altering feedback loops that cause symptoms. The therapeutic task is to reformulate or recast the problem in solvable terms. The therapist's responsibility is limited to initiating change that will get a family "unstuck" from unworkable interactional patterns.

Systemic therapists view healthy families as highly flexible; the families draw on a large repertoire of behaviours to cope with problems in contrast to the rigidity and a paucity of alternatives in a dysfunctional family. Beyond this generalisation, they deliberately avoid definitions of normality, with a tolerance for differences and idiosyncrasies of families, and believe that each family must define what is normal or healthy for itself in its situation (Haley, 1976; Jackson, 1977; Madanes, 1991; Barker, 1998). Haley (1976) selectively focuses on key family variables involving power and organisation that are considered relevant to therapeutic change. A variety of arrangements could be functional if the family deals with hierarchical issues (i.e., authority, nurturance, and discipline) and establishes clear rules to govern the power and status differential. Implicitly,

systemic therapists assume an asymptomatic perspective on family normality, equating the absence of symptoms with normality and health, and limiting therapeutic responsibility to symptom functional alternatives. They contend that most families do what they do because family members believe it is the right or best way to approach a problem, or because it is the only way they know.

According to Walsh (2003:32), the Milan team (Selvini Palazzoli, Boscolo, Gecchin & Prata, 1980) emphasised that this requires learning the language and beliefs of each family to see the problem through its members' eyes, taking into account their values and expectations which influence their approach to handling a problem and their inability to change. Through techniques such as relabelling and reframing, a problem situation is strategically redefined to cast it in a new light and to shift a family's rigid view, to alter a destructive process. Similarly, circular questioning, positive connotation, and respectful curiosity (Boscolo *et al.,* 1987; Gecchin, 1987) are used to contextualise symptoms, attribute benign intentions, and generate hope.

Accordingly these techniques are very useful as it is argued that couples in an unconsummated marriage often have tunnel vision and easily feel trapped. The couples feel helpless in an unconsummated marriage and are afraid to change their sexual behaviour. They consequently maintain their unhealthy sexual behaviour (Jeng, 2003). It is imperative that they be motivated to recast their reality and redefine their problems. Problems are also depathologised by viewing them as normative life-cycle complications, considering their adaptive functions for the family, and suggesting the helpful, albeit misguided, intentions of caring members trying to help one another. In such reformulations, new solutions can become apparent (Walsh, 2003:32).

5.2.2 The postmodern approach

Stemming from systemic models, solution-focused and narrative approaches are based in constructivist and social constructionist views of reality (Hoffman, 2002). According to Walsh (2003:32) they shift the therapeutic focus from problems and the patterns that maintain them, to solutions that have worked in the past or might work now, emphasising future possibilities. As in the Mental Research

Institute (MRI) model, it is believed that people are constrained by narrow, pessimistic views of problems, limiting the range of alternatives for solution. However, they reject the earlier assumption that problems serve alterior functions for families and are oriented toward recognising and amplifying patients' positive strengths and potential resources (DeShazer, 1991; Berg, 1997).

Postmodern therapists do not believe that there is any single "correct" or "valid" way to live one's life (O'Hanlon & Weiner-Davis, 1989). According to Walsh (2003:32) postmodern therapists believe what is unacceptable for some may be desirable or necessary for others. Thus, therapists should not impose on patients what they think is normal. Rather than search for structural or psychical flaws in distressed families, postmodern therapists focus on the ways people describe themselves, their problems, and their aims (O'Hanlon & Weiner-Davis, 1989; Walsh, 2003). Narrative therapists' avoidance of generalisations about what is normal or abnormal is grounded in Foucault's (1980) observations about the abusive power of dominant discourses. Nichols and Schwartz (2001) describe this concern: Too often in human history, judgements made by people in power have been imposed on those who have no voice. Families were judged to be healthy or unhealthy depending on their fit with ideal normative standards. With their bias hidden behind a cloak or science or religion, these conceptions became reified and internalised. One-size-fits-all standards have pathologised differences due to gender, cultural and ethnic background, sexual orientation, and socioeconomic status.

Laird (1998) and Walsh (2003) explain that postmodern therapists have been especially wary of claims of objectivity, which they regard as unobtainable. They eschew psychiatric diagnostic categories, as well as family typologies and evaluation schemes, as reductionistic, dehumanising, and marginalising differences from norms. Accordingly it is imperative to reauthor and rewrite the couple's paradigm of perceptions and experiences in order to motivate and encourage the couple to change their behaviour patterns. It is important not to normalise according to society rules, but the goal should rather be to change the behaviour patterns so that the relationship can become more functional.

Narrative therapists “situate” themselves with patients, and assume a nonexpert, collaborative stance (Freedman & Combs, 1996; Laird, 1998; Walsh, 2003).

Patients are encouraged to inform their therapists about their predicaments and to correct the therapists’ faulty assumptions that do not fit their experience (Anderson & Goolishian, 1988; Anderson, 1997; Barker, 1998). Because both clinicians and families are steeped in the larger cultural discourses, White (1995) challenges therapists to be transparent: to disclose beliefs that inform their therapy and fully own their ideas as their subjective perspective, biased by race, culture, gender and class. According to Walsh (2003:32) therapists try not to make assumptions or judge patients in ways that objectify them, so as to honour their unique stories and cultural heritage.

Narrative therapy is guided by a few basic assumptions: that people have good intentions and neither want nor need problems; and that they can develop empowering stories when separated from their problems and constraining cultural beliefs. Problems are not thought to be caused by family interaction or psychodynamics; instead, therapeutic focus shifts away from pathology within people or families and toward an appreciation of the toxic effects of many dominant discourses in the social world (White, 1995; Walsh, 2003). Walsh (2003:34) believes that therapeutic goals extend beyond problem solving to a collaborative effort to help people reauthor their life stories and rewrite their futures. Through language and perspective, problem situations are reframed toward more empowering constructions that enable problem resolution. Respectful inquiry and conversations aim to free patients from oppressive personal and cultural assumptions, enlarge and enrich their stories, and encourage them to take active charge of their own lives.

A postmodern-systemic approach can be very useful in enabling couples in an unconsummated marriage to attain optimum sexual health. The following guidelines may enhance the therapeutic intervention:

- The focus should be on problem solving and exploring various alternative solutions.

- The problem situation (the unconsummated marriage) should be reframed to enable problem resolution.
- It is important to explore future possibilities with the couple in order to motivate them to address their problem.
- Narrative therapy should be applied and the couple should reauthor their life story and rewrite their futures.
- The couple's positive strengths and potential resources should be explored.
- The couple should be encouraged to change their behaviour and make a paradigm shift.

The next section will concentrate on three family therapy models, namely the Circumplex model, the Beavers system model and the McMaster model. These particular models were selected as they are useful when assessing marriage and family functioning and attempting to identify factors that make the marriage or family system dysfunctional. The Circumplex model will be discussed first and the three dimensions of the Circumplex model namely couple and family cohesion, couple and family flexibility, couple and family communication will form the focal point of the discussion. Furthermore the couple and family map and hypotheses derived from the Circumplex model will also be discussed.

5.3 THE CIRCUMPLEX MODEL

According to Barker (1998:71), and Olson and Gorall (2003:514), the Circumplex model, its historical roots, basic concepts, and dimensions, are grounded in systems theory. An updated graphic representation of the Circumplex model is called "the couple and family map". The Circumplex model is particularly useful as a relational diagnosis, because it is focused on the relational system and integrates three dimensions that have repeatedly been considered highly relevant in a variety of family therapy models and family therapy approaches. Family cohesion, flexibility, and communication, the three dimensions in the Circumplex model, emerged from a conceptual clustering of over 50 concepts developed to describe marital and family dynamics.

The model is specifically designed for family research, clinical assessment, treatment planning, and outcome effectiveness of marital and family therapy (Olson, 2000). The Circumplex model is both a theoretical model with testable hypotheses and a descriptive model for understanding couple and family functioning. The model has been used increasingly in clinical work and research with diverse samples of couples and families in terms of ethnicity/race, family structure, sexual orientation, and social class. The couple and family map is also designed for clinical assessment, treatment, planning, and evaluation of therapeutic outcomes. The ultimate goal of the Circumplex model is to bridge research, theory, and clinical practice (Barker, 1998; Olson, 2000; Olson & Gorall, 2003).

Below, the three dimensions of the Circumplex model which focus on family functioning will be discussed, namely couple and family cohesion, couple and family flexibility, and couple and family communication. It is important that the therapist who works with a couple in an unconsummated marriage should have a thorough knowledge of the couple's functioning.

5.3.1 Dimension one: couple and family cohesion

The first dimension, family cohesion, is defined as the emotional bonding that couple and family members have with one another. Within the Circumplex model, some of the specific concepts or variables used to diagnose and measure the family cohesion dimension are emotional bonding, boundaries, coalitions, time, space, friends, decision making, interests, and recreation. Cohesion focuses on how systems balance separateness versus togetherness (Barker, 1998; Olson & Gorall, 2003).

Table 5.1 displays levels of couple and family cohesion. The presentation in Table 5.1 indicates the importance of cohesion in couples and families, and suggests that this is an important dimension for a relationship to function well.

Table 5.1: Couple and family cohesion

	Disconnected (disengaged)	**Somewhat Connected**	**Connected**	**Very Connected**	**Overly Connected (enmeshed)**
Couple/Family Score	**1 2**	**3 4**	**5 6**	**7 8**	**9 10**
1. Emotional bonding	Extreme emotional separateness. Lack of family loyalty.	Emotional separateness. Limited closeness. Occasional family loyalty.	Emotional closeness. Some separateness. Good loyalty to family.	High emotional closeness. Some separateness. High loyalty to family.	Extreme emotional closeness. Little separateness. Loyalty demanded.
2. Family involvement	Very low involvement or interaction.	Involvement acceptable. Personal distance preferred.	Good family involvement. Some personal distance.	Involvement emphasized. Personal distance allowed.	Very high involvement. Fusion, over dependency.
3. Marital relationship	Frequent affective responsiveness. High emotional separateness. Limited closeness.	Some affective responsiveness. Emotional separateness. Some closeness.	Good affective responsiveness. Emotional closeness. Some separateness.	Affective interactions encourage and preferred. High emotional closeness. Low separateness.	High responsiveness and control. Extreme closeness, fusion. Limited separateness.
4. Parent-child relationship	Low parent-child closeness. Rigid generational boundaries.	Some parent-child closeness. Somewhat clear generational boundaries.	Good parent-child closeness. Generally clear generational boundaries.	High parent-child closeness. Clear generational boundaries.	Excessive parent-child closeness. Lack of generational boundaries.
5. Internal boundaries Time (Physical and Emotional) Space (Physical and Emotional) Decision Making	**Separateness dominates.** Time apart maximized. Rarely time together. Separate space needed and preferred. Individual decision making emphasized.	**More separateness than togetherness.** Time alone important. Some time together. Separate space preferred. Sharing of family space. Individual decision making but joint possible.	**Balance of togetherness and separateness.** Time together important. Time alone permitted. Sharing family space. Private space respected. Joint decisions preferred.	**More togetherness than separateness.** Time together important. Time alone permitted. Sharing family space respected. Joint decisions preferred.	**Togetherness dominated.** Time together maximised. Little private space permitted. Decisions by parents, imposed on children.
6. External boundries Friends Interests activities	**Mainly focused outside the family.** Individual friends seen alone. Disparate interests. Mainly separate activities.	**More focused outside than inside family.** Individual friends seldom shared with family. Separate interests. More separate than shared activities.	**Balanced focus inside and outside of family.** Individual friends shared sometimes with family. Some joint interests. Balance of shared and individual activities.	**More focused inside than outside family.** Individual friendships often shared with family. Many joint interests. More shared than individual activities.	**Mainly focused inside the family.** Family friends preferred. Limited individual friends. Joint interests mandated. Separate activities seen as disloyal.
Cohesion	**Very Low Unbalanced**	**Low to Moderate Balanced**	**Moderate Balanced**	**Moderate to High Balanced**	**Very High Unbalanced**

Source: Olson and Gorall (2003:545)

Table 5.1 indicates that there are five levels and six dimensions of cohesion. The five levels range from disengaged/disconnected (extremely low cohesion) to somewhat connected (low to moderate), to connected (moderate), to very connected (moderate to high), to enmeshed/overly connected (extremely high). It is hypothesised that in this five-level rating for each dimension, the three central or balanced levels of cohesion (somewhat connected, connected, and

very connected) make for optimal family functioning. The extremes or unbalanced levels (disengaged or enmeshed) are generally seen as problematic for relationships over the long term. In the model's balanced area of cohesion, families are able to strike equilibrium, moderating both separateness and togetherness. Individuals are able to be both independent from and connected to their families (Olson & Gorall, 2003:541). Extremely high levels of cohesion (enmeshed) and extremely low levels of cohesion (disengaged) tend to be problematic for individuals and relationship development in the long run. On the other hand, a relationship having moderate scores is able to balance being separate and together in a more functional way. Although there is no absolute best level for any relationship, many will have problems if they function at either extreme level for too long. Also, it is expected that couple and family systems will change levels of cohesion over time (Barker, 1998; Olson & Gorall, 2003).

The literature (Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that couples in an unconsummated marriage may experience emotional separateness and limited closeness. The empirical study reported on in detail in Chapter 2 makes it evident that couples in an unconsummated marriage do indeed experience cohesion problems because of a lack of intimacy. Couples are despondent or frustrated with each another and become emotionally disconnected. The prevalence of emotional separateness, limited closeness and cohesion problems were endorsed by the findings in the empirical study for example responses by participants in theme three: Fear of engaging in an intimate relationship and the experience of phobias. These responses included couple five (female participant*): No sex has caused a barrier in our relationship and couple seven* (female participant): *It is very weird when we are alone and there is even a slight chance of being intimate, we look for something else to do.* Cohesion problems were also identified by male participants for example couple seven: *I fear being alone with my wife.* It is therefore important to assess the couple's cohesion through applying the first dimension of the Circumplex model, since lack of cohesion can contribute to the fact that the marriage remains unconsummated. If it is assessed that the couple live according to the extreme or unbalanced levels of cohesion (disengaged or enmeshed), altering certain patterns could form part of the therapeutic intervention programme.

5.3.2 Dimension two: couple and family flexibility

The second dimension, family flexibility, is the amount of change in the system's leadership, role relationships and relationship rules. As explained by Olson (2000), and Olson and Gorall (2003:519), couples and families need both stability and change. The ability to change, when appropriate, is one of the characteristics that distinguishes functional couples and families from dysfunctional ones. Moderate flexibility is needed in a happy and healthy relationship (Barker, 1998; Olson & Gorall, 2003). Levels of couple and family flexibility are displayed in Table 5.2.

Table 5.2: Couple and family flexibility

	Inflexible (Rigid)	**Somewhat flexible**	**Flexible**	**Very flexible**	**Overly flexible (chaotic)**
Couple/Family Score	**1 2**	**3 4**	**5 6**	**7 8**	**9 10**
Leadership	Authoritarian leadership.	Primary authoritarian, but some egalitarian leadership.	Generally egalitarian leadership.	Egalitarian leadership with fluid changes.	Limited and/or erratic leadership.
Discipline (for families only)	Autocratic "law and order". Strict, rigid consequences. Not lenient.	Somewhat democratic. Predictable consequences. Seldom lenient.	Often democratic. Often negotiated consequences. Somewhat lenient.	Usually democratic. Usually negotiated consequences. Generally lenient.	Laissez-faire and ineffective. Inconsistent consequences. Very lenient.
Negotiation	Limited negotiations. Decisions imposed by parents.	Structured negotiations. Decisions made by parents.	Flexible negotiations. Generally agreed-upon decisions.	Flexible negotiations. Agreed-upon decisions.	Endless negotiations. Impulsive decisions.
Roles	Limited repertoire. Strictly defined roles. Unchanging routines.	Roles stable, but may be shared. Few changes of roles. Routines sometimes change.	Role sharing. Some changes of roles. Routines sometimes change.	Role sharing and making. Fluid changes of roles. Routines often change.	Lack of role clarity. Role shifts and role reversals. Few routines.
Rules	Unchanging rules. Rules strictly enforced.	Few rule changes. Rules firmly enforced.	Some rule changes. Rules generally enforced.	Often rule changes. Rules flexibly enforced.	Frequent rule changes. Rules inconsistently enforced.
Flexibility	**Very low Unbalanced**	**Low to Moderate Balanced**	**Moderate Balanced**	**Moderate to High Balanced**	**Very High Unbalanced**

Source: Olson and Gorall (2003:547)

Table 5.2 indicates that the specific concepts of flexibility include leadership (control, discipline), negotiation styles, role relationships, and relationship rules. Flexibility concerns the way in which systems balance stability with change. The five levels of flexibility range from rigid/inflexible (extremely low) to somewhat flexible (low to moderate), to flexible (moderate), to very flexible (moderate to high), to chaotic/overly flexible (extremely high) (Olson & Gorall, 2003:520). Couples and family systems balanced on flexibility are able to manage both stability and change. A somewhat flexible relationship tends to have democratic leadership characteristics, with some negotiations. Roles are stable, with some role sharing, and rules are firmly enforced, with few changes. There are few rule changes, with rules firmly enforced. A flexible relationship has an equalitarian leadership with a democratic approach to decision making. Negotiations are open and active. Roles are shared and there is fluid change, when necessary. Rules can be changed and are age-appropriate. A very flexible relationship has a tendency toward frequent change in leadership and roles. Rules are very flexible and adjusted readily when there is a need for change (Barker, 1998; Olson & Gorall, 2003; Walsh, 2003).

Unbalanced couples and families tend to be either at the extreme of too much stability (rigid) or too much change (chaotic). In a rigid relationship, one individual is in charge and is highly controlling. There tends to be limited negotiations with most decisions imposed by the leader. Roles are strictly defined, and rules do not change. A chaotic relationship has erratic or limited leadership. Decisions are impulsive and not well thought out. Roles are unclear and often shift from individual to individual (Olson & Gorall, 2003:520).

In summary, Olson and Gorall (2003:520) state that extremely high (chaotic) and extremely low levels of flexibility (rigid) tend to be problematic for individuals and relationship development in the long run. Relationships with moderate scores (structured and flexible) are able to balance change and stability in a more functional way. Although there is no absolute best level for any relationship, many relationships tend to have problems if they always function at either extreme of the model (rigid or chaotic) for an extended period of time.

The literature (Goodwin & Agronin, 1997; Katz & Tabisel, 2002; Jeng, 2003; Renshaw, 2004) suggests that couples in an unconsummated marriage operate very rigidly because of their overt control. There is no time for pleasure in the relationship and their tasks and roles are clearly defined and structured. It is a strict and rigid relationship and there is no allowance for flexibility. The prevalence of rigidity and overt control are confirmed in the empirical study for example in Table 2.2 control related problems is identified. In couple one (female participant) responded: *I do no allow sex in our marriage. I associate control with words like stubborn, will and can.* Male participants also confirm overt control for example couple eight (male participant) stated: *I sometimes loose control; I get extremely angry and frustrated.* Consequently, it can be helpful to assess the couple's flexibility through the second dimension in the Circumplex model so that the couple may be assisted, through therapeutic intervention, to become moderately flexible and balanced.

5.3.3 Dimension three: couple and family communication

According to Olson and Gorall (2003:520) communication, the third dimension in the Circumplex model, is considered a facilitating dimension. Communication is considered critical for facilitating couples and families to alter their levels of cohesion and flexibility. Using positive communication skills enables couples and families to alter their levels of cohesion and flexibility to meet developmental or situational demands. Table 5.3 indicates levels of couple and family communication.

Table 5.3: Couple and family communication

Low ← Facilitating → High

Couple/Family Score	1 2	3 4	5 6
Listener's skills **Empathy** **Attentive listening**	Seldom evident Seldom evident	Sometimes evident Sometimes evident	Often evident Often evident
Speaker's skills **Speaking for self** **Speaking for others*** ***Note reverse scoring**	Seldom evident *Often evident (reversed)	Sometimes evident Sometimes evident	Often evident Seldom evident
Self-disclosure	Infrequent discussion of self, feelings, and relationships	Some discussion of self, feelings, and relationships	Open discussion of self, feelings, and relationships.
Clarity	Inconsistent and/or unclear verbal messages. Frequent incongruences between verbal and nonverbal messages.	Some degree of clarity, but not consistent across time or across all members. Some irrelevant/distracting nonverbals and asides. Topic changes not consistently appropriate.	Members consistently tracking. Few irrelevant/distracting nonverbals and asides. Facilitative nonverbals. Appropriate topic changes.
Continuity/Tracking	Little continuity of content. Irrelevant/distracting nonverbals and asides frequently occur. Frequent/inappropriate topic changes.	Some continuity, but not consistent across time or across all members. Some irrelevant/distracting nonverbals and asides. Topic changes not consistently appropriate.	Members consistently tracking. Few irrelevant/distracting nonverbals and asides. Facilitative nonverbals. Appropriate topic changes.
Respect and regard	Lack of respect for feelings or message of other(s). Possible overly disrespectful or belittling attitude.	Somewhat respectful of others, but not consistent across time or across all members. Some incongruent messages.	Consistently appears respectful of other's feelings and messages. Few incongruent messages.

Source: Olson and Gorall (2003:548)

As indicated in Table 5.3, couple and family communication is measured by focusing on the family as a group with regard to its listening skills, speaking skills, self-disclosure, clarity, continuity or tracking, respect and regard. Listening skills include empathy and attentive listening. Speaking skills include speaking for one self and speaking for others. Self-disclosure relate to sharing feelings about oneself and the relationship. Tracking refers to staying on a topic, and respect and regard refer to the affective aspects of communication. Studies investigating communication and problem-solving skills in couples and families have found that systems balanced on cohesion and flexibility tend to have very good communication, whereas systems unbalanced on these dimensions tend to have poor communication (Barker, 1998; Olson, 2000; Olson & Gorall, 2003).

The literature (Jeng, 2003; McIntosh, 2003; Renshaw, 2004) suggests that couples in an unconsummated marriage experience strained relationships. They generally have bad communication patterns, feel negative about their relationship and are stressed and worried. These couples struggle to express and communicate how they feel about their relationship. A closed, non-assertive communication pattern has been found within couples that experience sexual problems. Through the empirical study it has become evident that couples in an unconsummated marriage do experience communication problems and struggle to express how they experience and perceive their problem. In theme six: the manifestation of depression and apathetic attitudes both male and female participants made statements confirming the experience of strained relationships. Examples of this can be found in couple one (female participant*): I do feel apathetic towards my partner and couple three* (male participant) commented: *The problem is causing us to feel cold towards each other.* Therefore it would be important to assess the couple's communication through the third dimension in the Circumplex model in order to address communication problems with the couples in the therapeutic intervention.

The next section will focus on couple and family mapping. The family map is useful not only for describing family dynamics, but also for identifying the present state of the family system, and for reflecting on and addressing the past, and on change and future dynamics and system configuration.

5.3.4 The couple and family map

Olson and Gorall (2003:520) state that knowing one's family is important, because people often use their own family of origin as a reference for the type of marriage and family they either want or do not want. Individuals attempt to recreate the type of family system they had as a child or attempt to create a family that is the opposite of what they had in their childhood. Thus, the adaptability between individuals and their respective families of origin is a critical variable in determining how functional and satisfying the relationship system is likely to be.

According to Barker (1998) and Olson and Gorall (2003) couples need to balance their levels of separateness-togetherness on cohesion and their levels of stability-change on flexibility. When partners differ in their preferences regarding the balance on these dimensions, these levels can be altered by a couple to achieve a level that is acceptable to each partner. In other words, the levels are dynamic, in that they can and do change over time. An important distinction in the Circumplex model is defined between balanced and unbalanced types of couples and family relationships. Olson and Gorall (2003:521) state that there are nine balanced types that exhibit somewhat connected, connected, or very connected levels on cohesion and somewhat flexible, flexible, or very flexible levels on flexibility. Unbalanced relationship types are characterised by either extremely high or extremely low cohesion levels, combined with either extremely high or extremely low levels of flexibility: chaotically disengaged, chaotically enmeshed, rigidly disengaged, and rigidly enmeshed.

Balanced couples and families will generally function more adequately across the family life cycle than unbalanced couples. An important issue in the Circumplex model relates to the concept of balance. Even though a balanced family system is placed at the three central levels of the model, these families do not always operate in a 'moderate' manner. Being balanced means that a family system can experience the extremes on the dimension when appropriate, but they do not typically function at these extremes for long periods of time (Olson & Gorall, 2003:522).

Couples and families in the balanced area of the cohesion dimension allow their members to experience being both independent from and connected to their family (Barker, 1998:71; Olson & Gorall, 2003:520). Balance refers to maintaining some level of stability in a system, while openness to some chance variables is necessary. Being extreme on these two dimensions might be appropriate for certain stages of the life cycle or when a family is under stress, but it can be problematic when families are stuck at the extremes. Couples and families will modify their levels of cohesion and flexibility to deal effectively with situational stress and developmental changes across the family life cycle. According to Olson and Gorall (2003:520) this hypothesis deals with the capacity

of the couple and family system to change (second-order change) in order to deal with stress or to accommodate changes in members' development and expectations. The Circumplex model is dynamic in that it assumes that couples and families will change levels of cohesion and flexibility, and thus family system type, and it is hypothesised by Barker (1998:72), and Olson and Gorall (2003:520), that change is beneficial to the maintenance and improvement of the couple and family functioning.

The literature (Jeng, 2003; Renshaw, 2004) suggests that couples in an unconsummated marriage are generally unbalanced. Therefore it is important to assess, according to the couple and family map, how balanced or unbalanced the couple is and to enable couples to balance their levels of separateness-togetherness on cohesion and their levels of stability-change on flexibility through the therapeutic intervention. Within the framework of the postmodern systemic approach, the Circumplex model proves to be a useful tool for the purpose of assessing the marriage and couple as system. From within the Circumplex model, the three dimensions namely family cohesion, flexibility and communication are useful tools in assessing and constructing an appropriate family configuration through therapeutic intervention, with the purpose of facilitating change, adaptability and resilience within the system.

With regard to the second model, namely the Beavers system model, it is sometimes claimed that this model conforms better to clinical reality than does the Circumplex model (Barker, 1998; Beavers & Hampson, 2003). The Beavers system model differs from the Circumplex model as it is based on two axes. According to Beavers and Hampson (2003:551) the Beavers system model emphasizes family competence, that is, how well a family as an interactional unit performs the necessary and nurturing tasks of organising and managing itself.

5.4 THE BEAVERS SYSTEM MODEL

The Beavers system model can also be used to assess and classify family functioning. Beavers and Hampson (2003:551) state that highly related to competence is the development of confidence and self-esteem in individual family members, which carries with it increasing trust, clear and direct

communication, and the ability to resolve or accept differences. Competent families are more readily able to resolve conflict and communicate openly and directly. These fortunate families are also more often optimistic, whereas less functional families show limited ranges of feelings and more pessimism. The Beavers system model is a useful map for identifying levels of family health or dysfunction.

5.4.1 Rating scale and sub-systems

A rating scale was developed and these are subscales of the Beavers system model.

- The observational subscale includes overt power, parental coalitions, closeness, mythology, goal-directed negotiation, clarity of expression, responsibility, permeability, range of feelings, mood and tone, irresolvable conflict, and empathy.
- The style subscale includes dependency need, overt/covert conflicts, physical spacing, concerns/lack of concerns of appearance to the outside, profession of closeness, degree of assertiveness/aggressiveness, and ease of expression of positive-negative feelings (Barker, 1998:73; Beavers & Hampson, 2003:554).

The empirical study agrees with the available literature (Katz & Tabisel, 2002; Jeng, 2003) and indicates that couples in an unconsummated marriage are more deprivated about their feelings and are negative and pessimistic about their relationship and their lives. In theme six: manifestation of depression and apathetic attitudes, comments were documented reflecting negative attitudes and pessimism regarding the relationship by both male and female participants. Examples of this can be found in couple ten (female participant): *I know it can not carry on like this because our relationship is taking strain and couple nine* (male participant*): Sometimes I just feel that I do not care anymore.* Therefore it can be useful to apply the Beavers system model in assessing the couple in an unconsummated marriage. In the rating scale of the Beavers system model the subscales can be used to assess and identify the level of family health or dysfunction of the couple in an unconsummated marriage. According to Beavers

and Hampson (2003:551) the following are concepts central to the Beavers system model. *Family functioning* – observable, live, interactional functioning – takes precedence over symptoms or typology. Attempting to label clinical typologies, such as “schizophrenic,” “addictive,” or “co-dependent,” yields little clinically useful information about the functional strengths and vulnerabilities of families and their members. *Family competence*, ranging from effective, healthy family functioning through midrange to severely dysfunctional patterns, is viewed along a progressive continuum rather than in segmented categories. This concept promotes the view that observable and measurable growth and adaptation in families is possible.

Several families at similar competence levels may show different functional and behavioural styles of relating and interacting. The most competent families are able to shift their functional style as developmental changes occur, whereas the most dysfunctional families show a marked rigidity in functional style. Family assessment involves perceptions of family events from at least two sources: the therapist (“outsider”) and each family member (“insider”). Competence in small tasks (such as discussing an issue or resolving a conflict) is related to competence in the larger areas of living, raising children, and managing a family (Beavers, 1981; Hampson, Beavers & Hulgus, 1989; Beavers & Hampson, 2003).

5.4.2 Competence dimensions of family functioning

Figure 5.1 presents the details of the Beavers system model of family functioning.

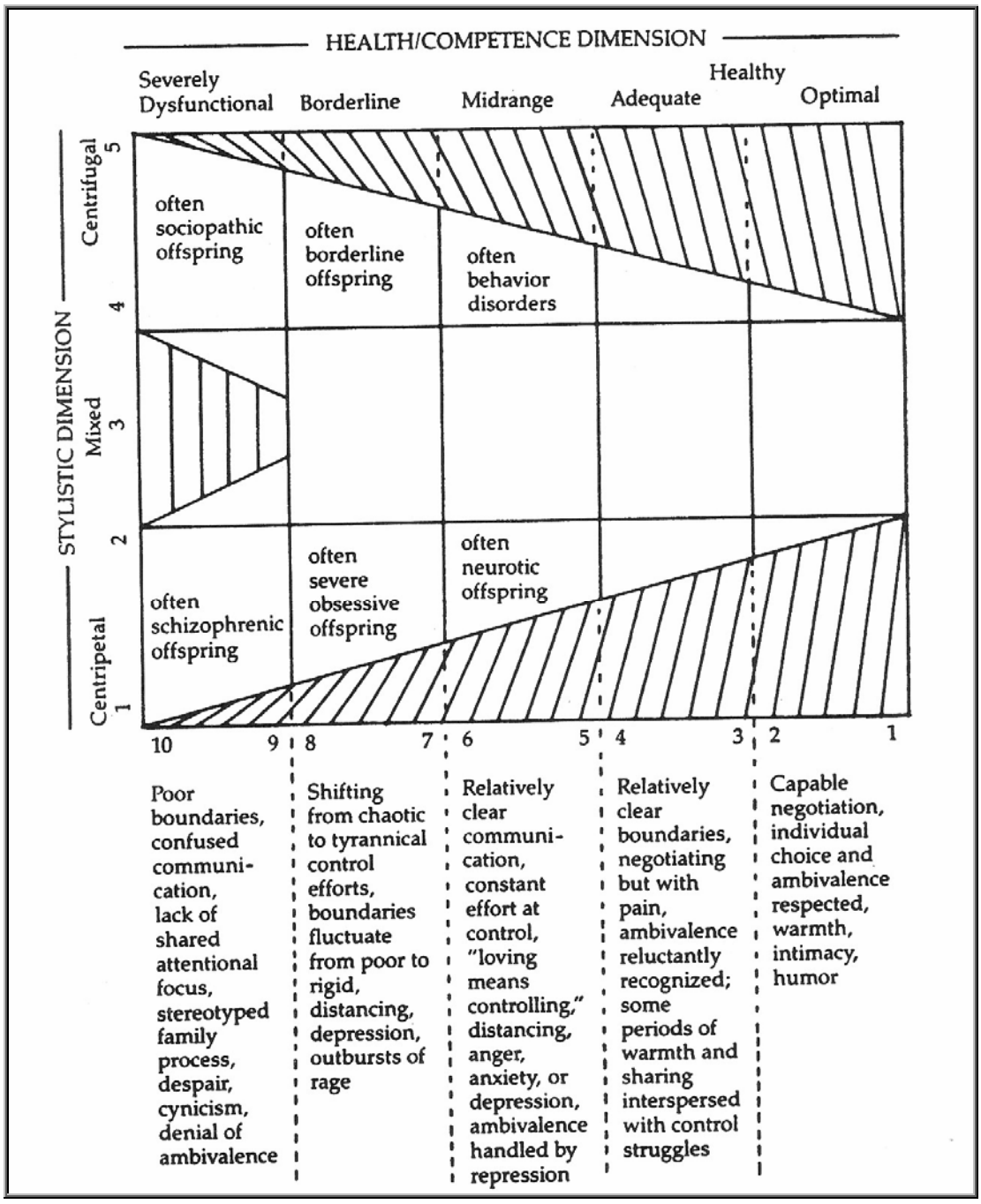


Figure 5.1: Beavers system model of family functioning

Source: Olson and Gorall (2003:555)

According to Beavers and Hampson (2003:554), the horizontal axis of the model represents the continuum of family competence, ranging from optimal functioning (ratings of 1 or 2, on the right) to severely dysfunctional (ratings of 9 or 10, on the left). This continuum of family competence shows regression from the capacity for equally powered successful transactions through marked dominance-submission patterns to extreme rigidity (chaotic, with little coherent interaction).

The vertical axis represents family style, ranging from highly centripetal (rating of 1, lower end) to highly centrifugal (rating of 5, upper end). Style refers to the degree of centripetal (CP) or centrifugal (CF) qualities in the family. Centripetal family members seek satisfaction more often from within the family, and children are slower to leave home; centripetal family members, looking for satisfaction within the family, are somewhat less trustful of the world beyond the family boundaries; centripetal families try to repress, suppress, or deny negative or hostile feelings and play up the positive, caring ones. Centrifugal family members look for satisfaction in the outside world, and the children often leave home earlier than the developmental norm; centrifugal family members seek gratification from outside the family unit more than from within it; centrifugal family members are wary of affectionate messages and are more comfortable with negative or angry feelings.

The model in Figure 5.1 is intended to suggest that more extreme styles are to be found in the more dysfunctional families, and blended and flexible styles in more competent families. Therefore, the model is in the shape of an arrow, representing the clinical and empirical findings that healthy families show a flexible and blended family style, such that they can adapt stylistic behaviour as developmental, individual, and family needs change over time. At the most dysfunctional end of the competence dimension are the most extreme and inflexible family styles. Here, extreme rigidity and limited coping skills preclude variation in style. The V-shaped “notch” on the left represents the finding that severely disturbed families show more extreme and inflexible styles, with no moderation or blending of stylistic behaviour (Barker, 1998:74; Beavers & Hampson, 2003:554).

In conclusion, Barker (1998) explains that the Beavers system model differentiates between the healthy functional family and the less healthy or dysfunctional family on the basis of the two axes; the horizontal axis representing the continuum of family competence while the vertical axis represents the family style where extreme styles are found in dysfunctional families and flexible styles are found in more competent families. Competent families are able to adapt stylistic behaviour as developmental individual and family needs change over time. To the other extreme dysfunctional families are found to be inflexible, rigid and struggle to adapt to change.

The literature (Jeng, 2003; Renshaw, 2004) indicates that couples in an unconsummated marriage tend to be inflexible, and find it difficult to adapt to change, which according to the Beavers system model is dysfunctional. Through the empirical study it became evident that couples in an unconsummated marriage tend to be less competent and more dysfunctional. Inflexibility, rigidity and the inability to adapt to change became evident in this study. In theme one: control related problems, became evident among both male and female participants. Couple nine (female participant): *Everything in my life has always been organised and I am always in control of my life.* This also became evident in male participants for example couple six (male participant): *I think I need to look at this as a business deal, because there I can take control and make things happen.* The Beavers system model can therefore be useful in assessing and identifying the competency of the couple. The identified problems that make the couple less competent can consequently form part of the therapeutic intervention.

The next section will focus on the third family therapy model, namely the McMaster model. The McMaster model is based on a systems approach (Barker, 1998; Epstein, Ryan, Bishop, Miller & Keitner, 2003).

5.5 THE MCMASTER MODEL

While observable and measurable growth and adaptation in families is made possible by the Beavers system model, the McMaster model focuses on the parts of the family that are interrelated. The McMaster model deals with the current

functioning of the family (Barker, 1998; Epstein, *et al.,* 2003). Epstein, *et al.* (2003:583) explain that one part of the family cannot be understood in isolation from the rest of the system. The McMaster model sees the family as an open system consisting of subsystems (individual, marital dyad) and relating to other, larger systems (extended family, schools, industry, religions). The unique aspect of the dynamic family group cannot simply be reduced to the characteristics of the individuals or interactions between pairs of members. Rather, there are explicit and implicit rules, plus action by members, that govern and monitor each other's behaviour (Barker, 1998; Epstein *et al*., 2003).

Epstein *et al*. (2003:581) state that it is exceedingly difficult to describe or define a healthy or normal family according to the McMaster model. In an attempt to describe a normal family, the variables to consider multiply by quantum leaps. A family is conceptualised as a system of interacting individuals being acted upon and in turn acting on a number of other systems at obvious levels, such as surrounding subcultures, culture, economic domain, and biological substrates of the individuals concerned. Barker (1998) and Epstein *et al.* (2003:583) explain that the McMaster model of family functioning does not cover all aspects of family functioning. It focuses on the dimensions of functioning that are seen as having the most impact on the emotional and physical health or problems of family members. Within each dimension, concepts have been defined as ranging from "most ineffective" to "most effective". It has been hypothesised that "most ineffective" functioning in any of these dimensions can contribute to clinical presentation, whereas, "most effective" functioning in all dimensions supports optimal physical and emotional health as indicated below in Table 5.4.

Table 5.4: Summary of dimension concepts in the McMaster model of family functioning

a) Problem solving: Two types of problems: Instrumental and affective Seven stages to the problem-solving process: (1) Identification of the problem, (2) Communication of the problems to the appropriate person (s), (3) Development of action alternatives, (4) Decision on one alternative, (5) Action, (6) Monitoring the action, (7) Evaluation of success Postulated: • Most effective when both instrumental and affective problems are solved. • Most effective when all seven stages are carried out. Least effective when families cannot identify problem (stop before step 1).
b) Communication Instrumental and affective areas Two independent dimensions: Clear and direct; (2) Clear and indirect; (3) Masked and direct; (4) Masked and indirect Postulated: • Most effective when able to communicate well in both instrumental and affective areas. • Most effective when clear and direct. • Least effective when masked and indirect.
c) Roles Two types of repetitive tasks: Necessary and other Two areas of family functions: Instrumental and affective Necessary family function groupings: Instrumental, Provision of resources, Affective, Nurturance and support, Adult sexual gratification, Life skills development, Systems maintenance and management Role functioning is assessed by considering how the family allocated responsibilities and handles accountability for them. Postulated: • Most effective when all necessary family functions have clear allocation to appropriate individual(s) and accountability is built in. • Least effective when few necessary family role functions are not addressed and/or allocation and accountability are not maintained.
d) Affective responsiveness Two groupings: (1) Welfare emotions (e.g., love, joy, concern) and (2) Emergency emotions (e.g., sadness, fear, anger) Postulated: • Most effective when a full range of responses is appropriate in amount and quality to stimulus. • Least effective when range is very narrow (one or tow affects only) and/or amount and quality is distorted, given the context.
e) Affective involvement A range of involvement with six styles identified: (1) Absence of involvement; (2) Involvement devoid of feelings; (3) Narcissistic involvement; (4) Empathic involvement; (5) Over involvement; (6) Symbiotic involvement Postulated: • Most effective with empathetic involvement • Least effective with symbiotic involvement and absence of involvement
f) Behaviour control Applies to three situations: (1) Dangerous situations; (2) Meeting and expressing psychobiological needs and drives (eating, drinking, sleeping, eliminating, sex, and aggression); (3) Interpersonal socializing behaviour inside and outside the family Standard and latitude of "acceptable behaviour" determined by four styles: Rigid, flexible, laissez-faire (i.e., no standards), chaotic (random implementation of styles 1-3) Postulated: • Most effective: flexible behaviour control • Least effective: chaotic behaviour control

Source: Epstein and Bishop (1981)

The McMaster model of family functioning in Table 5.4 indicates that it is important to describe how a healthy and normal family should look on each of the dimensions of family functioning. The assumption is made that a primary function of today's family unit is to provide a setting for the development and maintenance of family members on social, psychological, and biological levels (Epstein, Levin & Bishop, 1976; Epstein & Bishop, 1981; Epstein *et al.,* 2003). Consequently the following section will focus on the dimension concepts and tasks of family functioning of the McMaster model.

5.5.1 Task completion and problem-solving

According to Epstein *et al. (*2003:587) family problem solving refers to a family's ability to resolve problems to a level that maintains effective family functioning. Although not all family issues are problematic, those issues or problems that threaten the integrity of the family (or the emotional or physical health of its members) should be addressed and resolved. Barker (1996:65) states that the following processes are considered to be involved in task accomplishment and problem-solving: identifying the tasks to be accomplished; exploring alternative approaches and selecting one, taking action, evaluating (or monitoring) results and making any necessary adjustments; and communicating the existence of the problem to whoever needs to know about it. The literature (Barker, 1996:65; Epstein *et al.,* 2003:584) suggests that the McMaster model also distinguishes between instrumental and affective problems. The former comprise such things as the provision of food, shelter, or clothing, or the management of the family's finances. The latter are concerned with feelings, examples being serious hostility or distrust between family members.

Epstein *et al.* (2003:584) state that in the course of fulfilling this function, families will have to deal with a variety of issues and problems or tasks, which are grouped into three areas: the basic task area, the developmental task area, and the hazardous task area. The basic task area, the most fundamental of the three, involves instrumental issues. For example, families must deal with the problems of providing food, money, transportation, and shelter. The developmental task area encompasses those family issues that arise as a result of development over time.

These developments are often conceptualised as a sequence of stages.

- On the individual level, these include crises of infancy, childhood, adolescence, and middle and old age.
- On the family level, these might be the beginning of a marriage, the first pregnancy, or the last child leaving the home.
- The hazardous task area involves handling crises that arise as a result of illness, accident, loss of income, job change, and so forth (Barker, 1998:64; Epstein *et al.,* 2003:584).

It can be argued that a couple may encounter difficulties when dealing with the three tasks and that this will consequently cause distress in their relationship. Epstein *et al.* (2003:584) found that families unable to deal effectively with these three task areas are most likely to develop clinically significant problems, and or chronic maladaptive functioning in one or more areas of family functioning.

5.5.2 Communication

Epstein *et al. (*2003:587) explain that communication is the exchange of verbal information within a family. Although all behaviour may be seen as a form of communication, the McMaster model focuses on verbal communication. According to Barker (1996:65), and Epstein *et al.* (2003:584), the McMaster model considers mainly verbal communication, not because they discount the importance of non-verbal communication, but because of the practical difficulties of measuring and collecting data on non-verbal content. Critical aspects of communication, whether verbal or non-verbal, are the clarity, directness and sufficiency of communication sent by family members to each other, and the availability and openness of those to whom the communication are addressed. Communications may be affective (the expression of feeling), instrumental (related to the ongoing or needed activities of everyday life), or neither affective nor instrumental (for example, the expression of opinions on works of art). Clear as opposed to masked communication is generally desirable, since 'masked' (that is, vague, disguised or ambiguous) messages increase the likelihood of confused and distorted reception. It is also generally better if communications are sent directly from sender to receiver, rather than through a third person.

When messages are sent indirectly they may be distorted, and the third party involved may be placed in a difficult position, trapped between sender and receiver.

5.5.3 Roles

Family roles are defined as the repetitive patterns of behaviour by which family members fulfil family functions. There are some functions that all families have to deal with repeatedly in order to maintain an effective and healthy system (Epstein *et al.,* 2003:587). The literature (Barker, 1996:65; Epstein *et al.,* 2003:584) states that roles have been defined as "prescribed and repetitive behaviours involving a set of reciprocal activities with other family members". Task accomplishment requires that there should be a suitable allocation of roles, and that the family members do what their roles require. Roles should be assigned, mutually agreed and enacted; and they should be integrated with one another. For satisfactory task accomplishment they should also cover all the things that need to be done. In most families many of the roles to be performed are not allocated in a formal way; they rather become habitual patterns of behaviour carried out by particular family members. Sometimes, however, it is necessary for family members to get together and agree upon whatever needs to be done but is not being done.

The McMaster model distinguishes "necessary" family functions, that are roles that must be performed for healthy family functioning, and "other" family functions. Necessary functions include the provision of material resources; nurturance and support of family members and the sexual gratification of the marital partners; and life-skill development and the maintenance and management of the family system. "Life skills" refers to such matters as supporting children through school, helping members obtain and keep jobs, and assisting them in their personal development. "Systems management and maintenance" refers to the provision of leadership in the family and to the process of decision making, maintaining the family's boundaries and establishing and maintaining its standards. "Other" family functions are those unique to particular families, such as 'scapegoating' or 'idealising' a family member (Barker, 1996:65; Epstein *et al.,* 2003:584).

5.5.4 Affective responsiveness

According to Epstein *et al. (*2003:594) the family's potential range of affective responses, both qualitative and quantitative, are examined. Affective responsiveness is the ability to respond to a given stimulus with an appropriate quality and quantity of feelings, and is concerned with two aspects of the quality of affective responses. Firstly, do family members demonstrate an ability to respond with the full spectrum of feelings experienced in human emotional life? Secondly, is the emotion experienced at times consistent with the stimulus and/or situational context?

Epstein *et al. (*2003:594) state that the quantitative aspect focuses on the degree of affective responses along a continuum; from absence of response, through reasonable or expected responsiveness, to over responsiveness. Whereas the dimension considers the overall pattern of the family's responses to affective stimuli, it focuses more than any other on the capacity of individual members to respond emotionally, and not on their actual behaviour. There is a distinction between two categories: welfare emotions and emergency emotions. Welfare emotions consist of affection, warmth, tenderness, support, love, consolation, happiness, joy. Emergency emotions consist of responses such as anger, fear, sadness, disappointment, and depression. At the healthy end of the dimension, the McMaster model conceives of a family that possesses the capability to express a full range of emotions. In most situations, members experience the appropriate emotion, and when an emotion is experienced, it is of reasonable intensity and duration.

5.5.5 Affective involvement

Affective involvement is the extent to which the family shows interest in and values the particular activities and interests of individual family members (Epstein *et al.,* 2003:595). The literature (Barker, 1996:65; Epstein *et al.,* 2003:595) suggests that affective involvement is a matter of "the degree and quality of family members' interest in and concern for one another". Ideally a family will meet the emotional needs of all its members until they reach a stage of development at which some of these needs are met by people outside the family group. The McMaster model distinguishes various types of affective involvement,

as well as being concerned with the degree to which family members are involved with each other. The following types of involvement are listed in the model:

- Absence of involvement. This implies that the family members live rather "like strangers in a boarding house". They are frequently alienated and unfulfilled.
- Involvement devoid of feelings. In such families the involvement of family members with one another seems to arise from a sense of duty, a need in one member to control another, or curiosity.
- Narcissistic involvement. Here one family member is involved with another in order to bolster his or her own feelings of self-worth, rather than because of real concern or caring for the other person.
- Empathic involvement. This is based on a real understanding of the needs of those with whom the subject is involved, resulting in responses that meet those needs.
- Over-involvement and symbiotic involvement describe a similar concept of enmeshment, the latter seen only in seriously disturbed relationships.

5.5.6 Behavioural control

Barker (1996:65), and Epstein *et al. (*2003:584), state that behaviour control refers to the influence that family members have on one another. The McMaster model recognises four basic styles of behaviour control, namely rigid, flexible, *laissez-faire* and chaotic. Rigid control is high on predictability but low on constructiveness and adaptability. It may work quite well for maintenance functioning — the performance of day-to-day tasks and roles — but is less successful when change is required or developmental tasks need to be confronted. Flexible styles of control are predictable but constructive, and can adapt appropriately to changed circumstances. *Laissez-faire* styles are fairly predictable but low on constructiveness. In *laissez-faire* families task accomplishment tends to be poor and there are often problems of communication and role allocation. Chaotic styles of control are low in both predictability and constructiveness. These styles are unpredictable, switching from rigid to flexible to *laissez-faire,* so that no one knows what to expect. Changes occur more

according to the mood of the family than on the basis of changes in the family's situation and needs. The instability and inconsistency that characterise these families usually result in poor functioning.

The McMaster model can be very helpful in exploring the dimension concepts of family functioning and tasks with the couple in an unconsummated marriage. Dimension concepts and tasks which are problematic for the couple can consequently be addressed in the therapeutic intervention and will create a setting for how a couple may function well on a social, psychological and biological level. The empirical study confirmed that both male and female participants were affected on social, psychological and biological level. In theme seven: personal distress and psychological problems, male and female participants communicated the effects of unconsummation. Examples of this can be found in comments by couple six (female participant): *This causes great distress in my life and sometimes I think that I am not coping with this situation and it is influencing my whole life* and couple seven (male participant): *This situation is definitely causing great distress in my life and sometimes sadness becomes prevalent in anger, irritation and frustration which can be quite hurtful.* The couple in an unconsummated marriage can be assessed through the McMaster model in order to identify whether the couple are effective or ineffective regarding their problem solving, communication, roles, affective responsiveness, affective involvement and behaviour control.

After a thorough assessment has been done on family functioning according to the Circumplex model, the McMaster model and the Beavers system model within a postmodern-systemic framework, optimum sexual health should be prioritised in medical and therapeutic intervention. The following section will discuss how to attain healthy sexuality, focusing on the husband-wife subsystem in the unconsummated marriage.

5.6 A MODEL OF HEALTHY SEXUALITY IN THE FAMILY

Carnes (1997:89) states that healthy sexuality should be prioritised in the family in order to have a healthy and functional family. To modify sexual behaviour, the husband-wife subsystem needs to understand how the system functions and how

to change the whole system. Significant change only occurs if there is a paradigm shift.

5.6.1 Key factors of healthy sexuality

Carnes (1997:93) refers to James Maddock, a family researcher, who has constructed a model of healthy sexuality in the family. Maddock identifies five key factors which should be prioritised by the husband-wife subsystem in the therapeutic process if the couple want to change their sexual behaviour:

1. A healthy family finds a balanced interdependence between male and female members, who are equally respected and with shared power and control.
2. A healthy family creates a balance through boundaries that define individuality, yet permit physical and emotional closeness.
3. A healthy family facilitates communication that enhances, but also distinguishes nurturing, affection, and erotic contact.
4. A healthy family helps members to develop sexual values, meanings, and attitudes that are shared, and supports individuals if they differ.
5. A healthy family defines itself as a unique sexual system that can agree or disagree with community, family of origin, and culture, but remain connected to those groups.

According to Carnes (1997:93), James Maddock sees the family as an environment in which healthy sexuality is taught, supported, and nurtured, and therefore the members of the husband-wife subsystem should help and support each other in addressing the sexual problem.

5.6.2 Dimension strategies and principles of healthy sexuality

Carnes (1997:91) explains that in the twelve-step programme, change starts with the first step. When the couple in the unconsummated marriage admit that they have a sexual problem, and that the sexual problem will not change without professional assistance, they reach into the new paradigm. The admission of powerlessness undermines the tyranny of the old core beliefs. The couple learn that they do not have to change alone, but have their partner who will support them and will also undergo change. Further, that they can have support and that

not having it means they are vulnerable to abuse or exploitation. Some people and even some professionals interpret powerless to mean helpless. They fear that such a message permits irresponsibility (Harrison, 1996; Carnes, 1997; Jeng, 2003; Renshaw, 2004).

On the contrary, the first step is an admission that the old solutions do not work no matter how hard a person tries them. A first step in the right direction is an incredible act of courage. The couple allow themselves to be tremendously vulnerable yet at the same time taking on an extraordinary responsibility by following the one route that is still available: asking for help. All painfully learned rules about safety, protection, perfectionism, and control have to be set aside. Experienced therapists call this a paradoxical intervention (Carnes, 1997:94). The therapeutic process for the unconsummated marriage should encourage and facilitate a paradigm shift for the husband-wife subsystem. The paradigm shift will be explicated in Table 5.5.

Table 5.5: The paradigm shift

THE PARADIGM SHIFT	
First-Order Changes	**Second-Order Changes**
The unconsummated couple believe:	**Recovery creates new beliefs:**
• That they are unworthy and unloveable.	• That they are precious and loveable.
• That they cannot depend on others.	• That others will help them meet their needs.
• That they will have to take care of themselves.	• That they can have support.
• That relationships make them vulnerable to abuse and exploitation.	• That relationships do not have to be abusive or exploitive.
• That sex is terrifying.	• That sex can be safe and loving.
• That sex must be controlled and repressed.	• That sex is an authentic expression of self.
• That intimacy and sex cannot be combined.	• That sex works best when there is healthy bonding.

Source: Carnes (1997:94)

Table 5.5 reflects first-order and second-order changes. This portrays the difference between a couple sustaining the problem (first order) and the fundamentally altered behaviour (second order). It is important to give a framework of accurate and structured information to the couple in an unconsummated marriage, so that they can see the paradigm shift that needs to take place in the therapeutic intervention. The husband-wife subsystem should be made aware of the reality that they can have a fulfilled relationship and should be able to function effectively in all the dimensions of a relationship. The therapist should give the couple information on the dimensions of healthy sexuality and provide supportive strategies in attaining a healthy sexual life.

Carnes (1997:97) explains that it is important for a couple in a sexless marriage to explore their own sexuality according to the twelve strategies, and principles of healthy sexuality. These dimensions represent principles described as the basic elements of the new paradigm: mutuality and equality; individual respect and dignity; commitment to a non-abusive, non-violent, and non-exploitive loving relationship that adds meaning to life. These twelve dimensions are displayed in Table 5.6 and should be integrated into the life of a couple in an unconsummated marriage before change will occur.

Table 5.6: The twelve dimensions, strategies, and principles of healthy sexuality

DIMENSIONS OF HEALTHY SEXUALITY	SUPPORTIVE STRATEGIES	12 STEP PRINCIPLES
Nurturing – the capacity to receive care from others and provide care for self.	Seek models of nurturing and note how they apply to our sexuality. Plan specific ways to nurture self and allow others to nurture us. In general, to practice acceptance and self-care.	**The first step** asks us to let others care for us and to learn to take care of ourselves. This means giving up control, letting go, and trusting others.
Sensuality- the mindfulness of physical senses that creates emotional, intellectual, spiritual, and physical presence.	Determine what rules prevent you from being sensual and focused on the present. Plan concrete and specific ways to notice what your senses are telling you. Integrate your sense awareness into your sexual imagery.	**The second step** reminds us that an awareness of little things helps us to trust that there are larger forces at work in our lives. A sense of wonder emerges if we are present to our lives.
Self-image – a positive self-perception that includes embracing your sexual self.	Ask, what were the agendas of the original "programmers" of your sexuality; discover which no longer fit in your life, and what help you can get now. Construct new sexual affirmation.	**The third step** underlines the leap of faith necessary to believe in ourselves. The time-honoured "act as if" principle assumes a Higher Power who made us lovable and sexual.
Self-definition – a clear knowledge of yourself, both positive and negative, and the ability to express boundaries as	Begin taking a stand about who you are as a sexual person. Clarify sexual priorities and set boundaries so that you can be safe and sexual. Cultivate discernment through daily mediation,	**The fourth step** asks a "fearless" inventory of who we are which demands a more honest expression of our needs.

well as needs.	reading, and sexual atonement.	
Comfort – the capacity to be at ease about sexual matters with oneself and with others.	Create greater comfort about sex by identifying and overcoming negative and dysfunctional family, religious, and cultural messages about sex. Confronting issues of sexual preferences. Resolving issues created by sexual abuse.	**The fifth step** helps us to be fully known by others, including all of our "dark side." This helps us to be comfortable to integrate those pieces we used to hide.
Knowledge – a knowledge base about sex in general and about one's own unique sexual patterns.	Pay attention to the many ways sexual issues enter and affect your day-to-day life. Learn more about sexuality. Operate on the basis of information, not "rules." Develop a plan to learn more about your sexual self.	**The sixth step** encourages us to look deeper for "holes" or areas that need work in our life. Some of our most important lessons come to us here.
Relationship – A capacity to have intimacy and friendship with both those of the same gender and opposite gender.	Examine your own beliefs about men and women. Develop deeper relationships with those of both genders. Learn to separate the erotic from relationships with those of the gender to which you are attracted. Identify those in your life who support your efforts to change.	**The seventh step** allows us to take another leap of faith that these more difficult issues will also be overcome. Working them out adds to our spiritual and life experience.
Partnership – the ability to maintain an independent, equal relationship that is intimate and erotic.	Explore how the principles of healthy sexuality can change the rules of abandonment. Seek out tools to confront sexual exploitation and sexualized conflicts, needs, and self-destructive patterns. Learns and practice behaviours which build and enhance enduring relationships.	**The eighth step** demands a "rigorous" honesty which becomes central to healthy relationships. This honesty makes all relationships durable and our sexual relationship renewable in its eroticism.
Nongenital sex – the ability to express erotic desire emotionally and physically without the use of the genitals.	Learn more about nongenital touch, and plan time to enjoy its pleasures. Practice communicating needs and desires; express what feels good. Reduce focus on orgasm; increase focus on the whole process of sex. Use touch to gradually acclimatize self to more fearful levels of sexual contact.	**The ninth step** is the action step that requires us to do what we can to keep our relationships in order. That means to use all means that we can and to make amends for those areas in which we have not done enough. It also means that when we stop over important parts like nongenital expression, we can make up for it.
Genital sex – the ability to freely express erotic feelings with the use of the genitals.	Identify and work through problems of control and power in sex. Confront impotence and pre-orgasmic conditions. Review resources on sexual information and techniques. Choose some new sexual techniques, and make a plan for experimenting with them.	**The tenth step** builds on the principles of the previous nine and asks that these principles be practiced in our lives. Few activities demand the integration of these principles more than the use of the genitals.
Spirituality- the ability to connect sexual desire and expression to the value and meaning of one's life.	Seek out models for creating and communicating meaning in sex. Acknowledge the link between sexuality and spirituality. Examine sexual history to determine where you find meaning in sex. Learn to communicate meaning concurrently and consistently.	**The eleventh step** encourages us to constantly improve our spiritual consciousness. In that way, we remember our connectedness and purpose.
Passion – the capacity to express deeply held feelings of desire and meaning about one's sexual self, relationships, and intimacy experience.	State publicly how you have changed as a result of this process. Publicly witness your "conversion" – your new beliefs, values, and ways of living. Leave the "observer of life" status and actively participate in the world around you.	**The twelfth step** asks that we bear witness to our experience to others. Given the centrality of sex in our lives, this includes sexual experiences as well.

Source: Carnes (1997:93)

Table 5.6 illustrates that central to the paradigm shift for the unconsummated couple will be a new understanding of their sexuality according to the twelve dimensions, strategies, and principles of healthy sexuality. The couple will learn to see sex as an authentic expression of self that can be safe and loving (Carnes, 1997:93). The couple will also confront their biggest fear, which is to combine intimacy and sex. Consequently they will discover sexual intercourse actually works best when there is healthy bonding.

5.7 SUMMARY

This chapter presented pertinent approaches and models that could be utilised when assessing marriage and family functioning in couples in an unconsummated marriage. The couple in an unconsummated marriage should be seen as the male and female partner forming the couple, functioning as a family: this family unit should be seen as a system forming part of other systems. Therefore, it is important to study the couple as a family unit which functions as a system with other interrelated elements, and all the relevant systems should be assessed.

Within the postmodern systemic framework the three models — the Circumplex model, Beavers system model and McMaster model — were discussed to indicate their usefulness in assessing marriage and family functioning in couples in an unconsummated marriage. From this chapter it became evident that the Circumplex model is grounded in systems theory and is useful as a "relational diagnosis," because it focuses on the relational system and integrates three dimensions namely family cohesion, flexibility, and communication to describe marital and family dynamics.

The Beavers system model emphasises family competence, that is, how well a family as an interactional unit performs the necessary and nurturing tasks of organising and managing itself. According to the McMaster model of family functioning, the emphasis should rather be on health than on normality. A healthy family is neither necessarily average nor merely lacking in negative characteristics. Rather, it has described positives. The McMaster model of family functioning focuses on the following six dimensions: problem solving,

communication, roles, affective responsiveness, affective involvement, and behaviour control. Each dimension was discussed in this chapter.

It has been demonstrated that couples in an unconsummated marriage do not function optimally, and therefore the three models can be used in assessing the couple's functioning. Identified problems may then be addressed through the medical and therapeutic intervention extended to the couples. When social workers and other healthcare professionals treat couples in an unconsummated marriage, Maddock's five key factors of healthy sexuality, and the twelve dimensions, strategies and principles of healthy sexuality of Carnes (1997), should receive priority attention. It has become apparent that the therapeutic process for the unconsummated marriage needs to encourage and facilitate a paradigm shift for the husband-wife subsystem to attain optimum sexual health.

The final chapter in this dissertation will present the conclusions and recommendations of the study. Based on the empirical results and findings regarding the experiences and perceptions of the couple in an unconsummated marriage, recommendations will be made to healthcare professionals and to the couple in an unconsummated marriage. Directions for further research will also be pointed out.

CHAPTER 6

CONCLUSION AND RECOMMENDATIONS

6.1 INTRODUCTION

The objective of this chapter is to reflect on the implications of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage within a postmodern systemic framework. Limited previous research has been done on the unconsummated marriage in South Africa. Consequently, social workers and other healthcare professionals have limited knowledge of this phenomenon (Robinson, 2003a; Robinson, 2003b; McIntosh, 2003). International studies (Jeng, 2003; Rosenbaum, 2003; Berman & Berman, 2001) have pointed out that the unconsummated marriage is a reality and a prevalent problem. While medical and therapeutic intervention is available, the unconsummated marriage is still cloaked in silence, embarrassment and discomfort. The inability to consummate a marriage causes couples great distress, and can finally lead to divorce. In order to select relevant medical and therapeutic intervention strategies for these couples, it is critically important to do a thorough sexual history survey and assess the couple's emotional and psycho-social experiences and perceptions of their unconsummated marriage.

In this study, Chapter 2 explored the experiences of the couple in an unconsummated marriage in order to obtain the couple's perception of their marriage. The empirical research yielded insights into the experiences and perceptions of the couples, and the findings were summarised in the identified main themes and related themes. This enabled the research question to be answered. Chapter 3 presented a literature overview on the marriage within the context of the family life cycle. Chapter 4 described the nature and causes of an unconsummated marriage. Chapter 5 critically described approaches and models that may be used for the assessment of an unconsummated marriage. The goal of the study was reached, as a better understanding of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage was gained. The purpose of this section is not to repeat all findings, but to highlight the major trends in this study.

6.2 CONCLUSIONS AND RECOMMENDATIONS

Conclusions and recommendations will be based on the findings of the study and will be presented according to the profile of the participants and the objectives of this study, which were the following: to explore the experiences of the couple in an unconsummated marriage in order to obtain the couple's perception of their marriage; to present a literature overview of the institution of marriage within the context of the family life cycle; to describe the nature and causes of an unconsummated marriage; to critically describe approaches and models that may be used for the assessment of an unconsummated marriage.

6.2.1 The profile of the participants

The empirical study indicated that couples may remain in an unconsummated marriage for years on end because of a learned helplessness that develops. The duration of the shortest unconsummated marriage investigated in this study was one year, and the longest was thirteen years. Furthermore it was noted that all participants came from a specific stage of life, known as young adulthood (23 to 39 years of age). It was also established that participants belonged to various belief systems, with the majority of participants being Protestant Christian. It was also found that participants came from various professions and perceived their profession to be very stressful.

From the above findings it can be concluded that the length of time that a marriage remains unconsummated may vary. Furthermore it can be concluded that unconsummated marriages are prevalent during young adulthood; that the couples are conditioned by their religious belief system to believe that sexual intercourse is sinful, and that couples struggle to cope with stress levels caused by both their professions and financial expectations.

Based on the findings and conclusions the following recommendations can be made:

- To seek intervention as soon as possible after diagnosis and for the couples not to prolong the process through feeling helpless and ashamed about the problem.

- To explore religious guilt and shame regarding sexual intercourse in the therapeutic intervention to enable couples to accept that sexual intercourse forms an important part of a marital relationship.
- To refer couples to a religious counsellor or pastor, who may assist the couple to overcome their religious guilt and sense of shame.
- To provide coping mechanisms in the therapeutic intervention to enable couples to manage their stress levels more effectively.

6.2.2 The experiences and perceptions of the couple in an unconsummated marriage

The following are findings, conclusions and recommendations regarding the experiences and perceptions of the couple in an unconsummated marriage.

6.2.2.1 Control-related problems

In this research it was found that female and male participants indicated that they struggle with control-related problems and that this affects their sexual functioning. The empirical study indicated that all female participants have over developed self-control and are obsessed with being in control, or that they are afraid of losing control. The female participants suggested that they become fearful if they feel that they do not have control in their life situations, and that this also applies in a sexual situation. Conversely, it was found that the male partners are more inclined to fear taking control. More than half of the male participants suggested that they do no want to be forceful in a sexual situation and therefore would rather not take control in their sexual lives. It can be concluded that the participants appeared to acknowledge that they struggle with control and that that their control-related problems prevent them from engaging in a sexual relationship.

Based on the findings and conclusions the following recommendations can be made:

- Female partners in an unconsummated marriage need to learn how to relax in a sexual environment, and how to be less controlling in their daily functioning.

- Males in an unconsummated marriage need to learn how to be more sexually assertive, to enable them to initiate some form of sexual activity.

6.2.2.2 Feelings towards the own body and/or the partner's body

It was noted that female and male participants indicated that they had negative feelings towards their own bodies and/or their partner's bodies. However, it was found that more female participants than male participants had a negative body image and a lack of self-esteem, or a distorted view of their own physical appearance.

The conclusion can be reached that both females and males in an unconsummated marriage experience problems related to low self-concept.

Based on the findings and conclusions the following recommendation can be made:

- Low self-concept should be explored in therapeutic intervention in order for females and males to nurture themselves and to feel more deserving, attractive and positive about themselves.

6.2.2.3 Fear of engaging in an intimate relationship and experiencing phobias

The empirical study indicated that all female participants and less than half of the male participants have a fear of engaging in an intimate relationship. It was also established that numerous female participants manifested other fears and phobias, and anxiety was also detected.

It can be concluded that especially among females the fear of, or phobia about an intimate relationship triggers anxiety that prevents the couple from consummating their marriage.

Based on the findings and conclusions, the following recommendation can be made:

- Neuro-linguistic programming (NLP) and cognitive behavioural therapy (CBT) could be considered as they are effective in treating fear, phobias and anxiety during therapeutic intervention.

6.2.2.4 Feeling of sin and moral dilemma

Findings underscore the fact that more than half of the female and male participants experience feelings of sin and moral dilemma. It was evident that participants felt that they were conditioned by their religious belief system to feel shameful and guilty about sexual intercourse. The empirical study verifies that couples often feel negative towards God, their religion and spirituality, and may feel that God is punishing them.

It can be concluded that unconsummated marriages are often found in faith-based communities, and that subsequent to years of being conditioned to believe that sexual intercourse is a taboo behaviour, couples struggle to accept that sexual intercourse is acceptable after marriage.

Based on the findings and conclusions the following recommendation can be made:

- Religious leaders need to incorporate the positive attributes of sexual union in their sexual discussions, in order to prevent conditioned sexual fear and anxiety resulting from religious belief systems.

6.2.2.5 Guilt and shame

The majority of the participants indicated that they experience guilt and shame because of their unconsummated marriage and their lack of motivation to change their behaviour. It was evident that the participants had been negatively programmed about sexual intercourse. It was found that the participants feel that their shame and guilt are caused by negative sexual messages that they receive from family members and friends. It was noted that the couples in an unconsummated marriage are very emotional and feel sad about their situation.

It can be concluded that shame and guilt arise in an unconsummated marriage due to negative sexual conditioning and the lack of motivation to change the situation. It can also be concluded that an unconsummated marriage is experienced as an extremely emotional process filled with sadness.

Based on these findings and conclusions, the following recommendations can be made:

- Couples in an unconsummated marriage should be motivated in the therapeutic intervention to break the pattern of negative conditioning, and the therapist should contain the emotional process of the couple.
- Couples in an unconsummated marriage should be motivated in the therapeutic intervention to change their thoughts and patterns regarding sexual behaviour.

6.2.2.6 Manifestation of depression and apathetic attitudes

Findings underscore that most participants struggle with depression or symptoms of feeling depressed. It was furthermore found that the participants felt that their whole body was affected by the marriage remaining unconsummated. The participants indicated that they felt emotionally, physically and psychologically strained.

The conclusion can be reached that an unconsummated marriage is an interrelated body-mind-and-soul experience, and that it may become a “whole-body” illness characterised by depressive symptomology.

Based on these findings and conclusions, the following recommendations can be made:

- Medical and therapeutic intervention should be combined to treat depression in couples that find themselves in an unconsummated marriage. Anti-depression medication could be prescribed by a medical practitioner and therapeutic intervention may be helpful in exploring depressive feelings.

- Progressive relaxation that teaches people how to monitor muscle tension and relaxation should be considered in assisting couples with the “whole-body” illness that the unconsummation of a marriage cause.

6.2.2.7 Personal distress and diagnosis of psychological problems

The empirical study verified that all participants experienced personal distress because of their unconsummated marriage. It was noted that some participants did manifest other related disorders and had been diagnosed with psychological disorders such as anxiety disorders, mood disorders, eating disorders, and adjustment disorders. Furthermore, findings indicated that participants experienced negative thought patterns and obsessive concern, and experienced conditioned anxiety. These can also be symptoms of the diagnosed disorders. It was established that some participants experience psycho-somatic problems due to the psychological stress that an unconsummated marriage causes. The empirical study further indicated that male participants often struggle to validate correct emotions and displace sad emotions through the projection of aggressive emotions.

It can be concluded that very high levels of personal distress are evident in couples in an unconsummated marriage, and other related disorders often manifest as well.

Based on the findings and conclusions the following recommendations can be made:

- Medical and therapeutic intervention should be combined to treat personal distress. Medication for treating psychological problems should be prescribed by a psychiatrist.
- Biofeedback training (BFT) and progressive relaxation should be considered in therapeutic intervention. Relaxation training combined with biofeedback training has been shown to be effective in treating personal distress. Biofeedback training helps people to gain control over various bodily functions, such as muscle tension and brain waves, by giving them information (feedback) about these functions in the form of auditory

signals or visual displays. Learned behavioural change should be facilitated.

6.2.2.8 Regret and sadness

Findings underscore the fact that nearly all female and more than half of the male participants feel regret and sadness. Furthermore it was noted that feelings of shame and self-loathing were evident, and that these were projected onto the couple's present relationship. It was also established that the participants felt emotionally exhausted, and feelings of physical fatigue or loss of energy were also prevalent.

It can be concluded that being in an unconsummated marriage can be emotionally draining; a person may consequently even feel physically exhausted. Furthermore, the conclusion can be reached that previous sexual experiences in a person's life can be detrimental to future sexual functioning, and can cause for the person to feel serious regret and sadness.

Based on the findings and conclusions, the following recommendations can be made:

- During therapeutic intervention with the couple in an unconsummated marriage, post-modern systemic therapy may assist the couple to focus on the future and to let go of the past. Post-modern systemic therapy focuses on "the here and the now" and this will enable the couple to deal with what is happening to them now and will help them to focus on the future.
- A regular exercise routine and healthy diet may also help couples to feel more energetic; exercise will also facilitate the production of endorphins which will make them feel happier and may counteract sadness.

6.2.2.9 Self-blame, self-destructive behaviour, mutilation and suicidal thoughts and episodes

The empirical study indicated that all female participants and more than half of the male participants indicated that they sometimes experience self-hate and a feeling that they hate life. Self-destructive behaviour and self-blame are evident and there is a cause-effect situation, since self-destructive behaviour will result in self-blame, and self-blame will result in self-destructive behaviour. It was also established that participants have an aversion to most sexual acts, but there is also an aversion to anything that is pleasurable in life.

It can be concluded that couples in an unconsummated marriage show high-risk behaviour regarding self-destructiveness, such as self-mutilation that is associated with an increased risk of suicidal thinking. Furthermore, it can be concluded that couples in an unconsummated marriage are averse to the idea of having pleasure in their lives.

Based on these findings and conclusions, the following recommendations can be made:

- In the therapeutic intervention emphasis should be placed on self-acceptance and self-love. Couples in an unconsummated marriage should be taught how to nurture themselves and each other.
- If there is a high risk of suicide, the patient should be referred to a psychiatrist and hospitalisation should be considered.

6.2.2.10 Lack of information on how to be sexually intimate with a partner

Findings underscore the fact that all female participants and more than half of the male participants felt that they lack information on how to be sexually intimate with a partner. It was established that participants felt they had had limited sexual education during their upbringing. Furthermore it was noted that the lack of sexual education caused them sexual anxiety, and also caused participants to doubt themselves and feel sexually inadequate.

It can be concluded that couples in an unconsummated marriage often had a limited sexual education and as a result their sexual knowledge is restricted.

Based on these findings and conclusions, the following recommendation can be made:

- Families, educational institutions, and religious institutions should be made aware of the importance of high quality sexual education during childhood in order to empower children with sexual knowledge that they can use throughout their lives.

6.3 MARRIAGE WITHIN THE CONTEXT OF THE FAMILY LIFE CYCLE

It was found that marriage and family development are marked by specific milestones. Consequently, it was evident that within an unconsummated marriage, marriage and family development are fixed at the first milestone, namely being a married couple without children. Furthermore it was found that vertical and horizontal stressors in the family life cycle can be a contributing factor for a marriage to remain unconsummated. It was further noted that marriage is a social institution and is usually intimately associated with child bearing. The study noted that there are various essential characteristics of marriage that are needed in order to make a couple functional and happy, and that mutual sexual fulfilment is an essential characteristic. It was found that there are various functions of a marriage, and that reproduction and the continuation of the species form an integral part of these functions. It became evident that marital and family satisfaction can be based on three components, namely intimacy, love and decision/commitment, and that a satisfying and stable relationship is marked by consummate love.

Based on the above findings, the following conclusions can be reached. Firstly, the unconsummated marriage inhibits the child bearing, sexual fulfilment, and the reproduction and continuation of the species. Therefore marriage as a social institution and its peculiar characteristics and functions, are restricted by an unconsummated marriage. Secondly, the conclusion can be reached that because of the unconsummated marriage, couples experience low levels of intimacy and passion. Decision making and commitment to the relationship are

adversely affected, while the strong bond of consummate love is absent. Therefore, it can be concluded that marital satisfaction and family stability are at a low level in an unconsummated marriage.

Based on these findings and conclusions, the following recommendations can be made:

- Couples in an unconsummated marriage should at least have the option of having children and should therefore be motivated in therapeutic intervention to change their sexual behaviour patterns and strive to fulfil the essential characteristics and functions of a marriage and family as social institution.
- During the therapeutic intervention the therapist should focus on couples therapy and emphasise the three components of marital satisfaction and family stability, namely intimacy, passion, and decision/commitment in order to create consummate love in the couple's marriage.

6.4 THE NATURE AND CAUSES OF AN UNCONSUMMATED MARRIAGE

In the literature study it was found that an unconsummated marriage occurs when sexual intercourse (coitus) is unsuccessful, and it was clearly indicated that intimacy is problematic in these marriages. It was furthermore found that a correct diagnosis of the unconsummated marriage by a trained health care professional is important in order to provide accurate medical and therapeutic intervention. In this study it became evident that there are various physical and psychogenic causes of an unconsummated marriage. It was found that in unconsummated marriages vaginismus is prevalent, and the cause-or-effect relationship of pain in vaginismus and the mind-body connection of vaginismus were clearly evident in the literature. Furthermore, various causal factors of vaginismus were found, and it became evident from this study that various coping mechanisms are developed in the attempt to manage vaginismus.

Based on the above findings, the following conclusions can be reached. Firstly, it can be concluded that the unconsummated marriage is a difficult problem and that diagnosis is complicated because of the interrelated physical and psychogenic causes. Secondly, it can be concluded that vaginismus is mostly

found in an unconsummated marriage, and in this research study all the female participants were diagnosed with either primary or secondary vaginismus.

Based on these findings and conclusions, the following recommendations can be made:

- Healthcare professionals should become better educated about the prevalence and implications of the unconsummated marriage. This will facilitate making a correct diagnosis in order to be able to deliver high quality medical and therapeutic intervention.
- Healthcare professionals should be made aware of professionals who specialise in intervention with couples in unconsummated marriages, thereby facilitating referrals and preventing patients from getting lost in a maze of referrals.
- It is important for the healthcare professional and the couple to view the unconsummated marriage as a couple's problem and not as an individual problem in order to prevent one partner feeling isolated in the process.
- Medical and therapeutic intervention should be combined (a bio-psycho-social approach) in order to attend to both the physical causes and the psychogenic causes.
- Healthcare professionals should gain insight into vaginismus and should understand the mind-body interaction in patients with vaginismus, as it often presents itself in the unconsummated marriage. Clear insight and a deep understanding of vaginismus will benefit the intervention program.

6.5 THE APPROACHES AND MODELS FOR THE ASSESSMENT OF AN UNCONSUMMATED MARRIAGE

It was found that selected approaches and models can be utilised to assess marriage and family functioning within an unconsummated marriage. It was evident that the postmodern-systemic approach, the Circumplex model, the Beavers system model, and the McMaster model are effective for assessing couples in an unconsummated marriage and promoting optimum sexual health in intervention. It was found that the McMaster model focuses on all the parts of the family as being interrelated. One part of the family cannot be understood in

isolation from the rest of the system. Family functioning cannot be fully understood by simply understanding each of the parts. The structure and organisation of the family are important factors determining the behaviour of family members.

It was furthermore found that the Beavers model emphasises family competence, that is, how well a family as an interactional unit performs the necessary and nurturing tasks of organising and managing itself. It was also found that the Circumplex model is a relational diagnosis and integrates three dimensions namely; family cohesion, flexibility, and communication. Furthermore Maddock's five key factors of healthy sexuality, and the twelve dimensions, strategies and principals of healthy sexuality of Carnes (1997), would facilitate a paradigm shift in order to obtain optimum sexual health in a marriage.

Based on the above findings the following conclusions can be reached. Firstly, it can be concluded that it is important to do a thorough assessment of marriage and family functioning in order to deliver high quality medical and therapeutic intervention. Secondly, it can be concluded that optimum sexual health can be attained if a healthy sexuality is promoted and a paradigm shift occurs in the marriage.

- Healthcare professionals should apply the principles of postmodern theory and systems theory when working with a couple in an unconsummated marriage.
- The Circumplex model should be used to assess and construct family configurations that will facilitate change, adaptability and resilience within the system.
- The Beavers system model should be used as a map for identifying levels of family health or dysfunction, in order to assess the competence of the couple's relationship in an unconsummated marriage.
- The McMaster model should be used in order to focus on the whole family system and to obtain insight into the family dynamics.

- To attain optimum sexual health with couples in therapeutic intervention:
    - Healthcare professionals should encourage and facilitate a paradigm shift for the husband-wife subsystem.
    - The couple should explore their own sexuality according to Carne's twelve strategies and principles of healthy sexuality.
    - Maddock's five key factors should be prioritised by the healthcare professional in therapeutic intervention.

6.6 RECOMMENDATIONS ON RESEARCH DIRECTIONS

It is recommended that further research be conducted into the following areas:

- Research should focus on more in-depth studies regarding the unconsummated marriage within a South African context.
- Research should explore the unconsummated marriage from a multi-cultural perspective in different population groups within a South African context.
- Research is needed to contribute to the development of standardised assessment scales and questionnaires in order to do a thorough historical survey and assessment with a couple in an unconsummated marriage.
- Research is required for developing a medical and therapeutic intervention plan in treating couples within an unconsummated marriage.
- Research is needed for developing a training programming for healthcare professionals in order to educate healthcare professionals on the subject of the unconsummated marriage.

6.7 FINAL CONCLUSION

From this study it can be concluded that the unconsummated marriage poses a real and complex problem for the couple who are affected. The unconsummated marriage affects both the male and female spouse physically, psycho-socially and emotionally. The implications of the unconsummated marriage are clearly profound. It is therefore imperative that healthcare professionals such as social workers gain insight into the complexities of the problem as described in this

study, in order to be able to deliver high quality medical and therapeutic intervention in promoting optimum sexual health.

6.8 FINAL REMARK

The emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage were explored in this study. In conclusion, it is the wish of the researcher that the findings of this research will give healthcare professionals such as social workers a better understanding of unconsummated marriages, and that this report will make a difference in the treatment extended to couples through medical and therapeutic intervention.

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APPENDIX A: Interview Schedule

Couple ___

Male Partner

I ……, hereby consent to the information hereby reflected to be used strictly confidentially for the research project of Tanya M Robinson. No names will be reflected in the actual research document. Reference to participants will anonymous.

Signed: ……

Date: ……

Female Partner

I ……, hereby consent to the information hereby reflected to be used strictly confidentially for the research project of Tanya M Robinson. No names will be reflected in the actual research document. Reference to participants will anonymous.

Signed: ……

Date: ……

Goal: The goal of this interview is to gain a better understanding of the emotional and psycho-social experiences and perceptions of the couple in an unconsummated marriage.

Themes that will be covered in the unstructured interview:

Control related problems; Feelings towards one's own body and your partner's body; Intimacy in the marriage; Sin and moral dilemma; Guilt and shame; Depression and apathetic attitudes; Personal distress and diagnosis of psychological problems; Regret and sadness; Self-blame, self destructive behaviour, mutilation and suicidal thought/episodes; Lack of information on how to be sexually intimate with a partner.

Couple ___

Personal Information:

Years married: _____

Age:	Male- _____	Female- _____
Religion:	Male- _____	Female- _____
Career:	Male- _____	Female- _____

1. Do you experience control related problems?

Male

Female

Open discussion

2. How would you describe your own body and your partner's body?

Male

Female

Open discussion

3a. How do you experience intimacy in the marriage?

Male

Female

Open discussion

b. Do you experience a phobia of engaging in an intimate relationship?

Male

Female

Open discussion

4. How does your religious life and spiritual belief system shape the way you feel about sexual intercourse?

Male

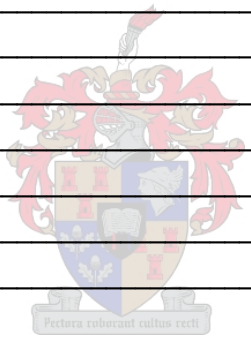
Female

Open discussion

5. Do you experience guilt and shame when thinking about sexual intercourse?

Male

Female

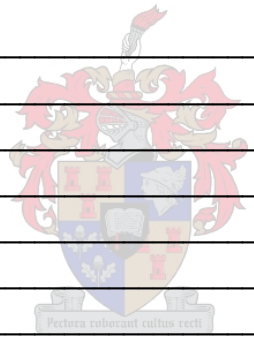


Open discussion

6. Would you say that feelings of depression or apathetic attitudes toward your partner have manifested?

Male

Female



Open discussion

7a. Do you think you experience personal distress?

Male

Female

Open discussion

b. Have you been diagnosed with a psychological problem?

Male

Female

Open discussion

8. Do you have feelings of regret and sadness?

Male

Female

Open discussion

9a. Do you blame yourself for this condition?

Male

Female

Open discussion

b. Do you feel self-destructive?

Male

Female

Open discussion

c. Have you ever thought of self-mutilation or suicide?

Male

Female

Open discussion

10. Would you say that you are informed on how to be sexually intimate with your partner?

Male

Female

Open discussion