

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 to 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 Delpont (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.