

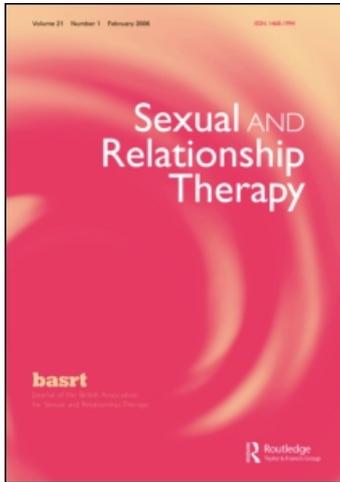
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Applying theories of social exchange and symbolic interaction in the treatment of unconsummated marriage/relationship

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The application of sociological theories in clinical practice introduces a broader dimension to the existing therapeutic approaches available to the mental health practitioner. Rather than deal with a presenting problem or dysfunction by focusing solely on the presenting symptoms, or delving exclusively into a client's internal psyche, applying social theory in a clinical manner adds the element of interpersonal relationships and the connection of the client with his or her social world. This article will describe a therapeutic approach to treating clients and couples in an unconsummated relationship who present with a specific sexual dysfunction or problem that is commonly addressed with sex counseling or sex therapy. Drawing upon sociological micro theories of exchange and symbolic interactionism, this approach combines classic medical, cognitive and behavioral interventions with a process of discovery that leads to an understanding of the social context out of which the problems emerged and are maintained.

Keywords: unconsummated marriage; couples therapy; vaginismus; sexual dysfunction; symbolic interactionism; exchange theory

1. Introduction

The results of Laumann's National Health and Social Life Survey (Laumann, Paik, & Rosen, 1999), reporting a prevalence of sexual dysfunction in 43% of women and 31% of men, sparked an ensuing debate over the definition of sexual dysfunction, as described by the DSM-IV TR (American Psychiatric Association, 2000). Sexual dysfunction is traditionally defined as a problem in one or more of the four physiological phases of sexual function, as described by Masters and Johnson (1970) beginning with desire and continuing with arousal, plateau and orgasm. This model, as well as Helen Singer Kaplan's (1974) revised three-stage version which included only desire, arousal and orgasm, described sexual function in a linear based fashion implying that sexual activity is driven by desire in both women and men. Newer models of female sexual function have suggested that women are often motivated to engage in sexual activities in order to achieve emotional intimacy, rather than because of spontaneous physiological desire. Lack of desire or arousal should, therefore, be explored not only bio-medically, but with an emphasis on the social and relational context (Basson, 2001). Ongoing debate has been sparked as well, over sociological studies such as Laumann's and others that attempt to measure

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sexual “satisfaction”. Questions have arisen over the ability to separate relational (marriage) and sexual satisfaction (Lawrence & Byers, 1995). Additional questions include: should satisfaction be measured by the attainment of orgasm or by the overall quality of the sexual experience? (Whipple, 2002). Finally, how does one interpret the meaning of intimacy, sexual function and satisfaction in a contextual manner?

It is generally acknowledged that sexual problems are multi-factorial and treatment should be multidisciplinary. Practically, physicians and other health professionals may address the physiological component, a psychodynamically trained therapist may explore the client’s individual psyche and a couple’s therapist may focus exclusively on the dyad. To truly address context, however, the clients’ roles and identities within their social world must be understood. Sociological theory offers an additional dimension to treatment that examines the significance and of the presenting condition within the clients’ social interactions. This article describes a multi-disciplinary approach to unconsummated marriages or relationships, highlighting ways in which sociological theory offers additional perspectives in allowing clients to gain insight and solve problems.

2. Sociological theory

Sociological theories are theoretical frameworks that sociologists use to explain and analyze how social action, social processes and social structures work. Social exchange theory and symbolic interactionism (SI) and are two popular theoretical approaches that have guided research on family interactions (Clark, 1997). Social exchange theory is a social psychological perspective that explains social relationships as a process of negotiated exchanges between parties that is based on the concept of rewards, punishments and resources (Homans, 1958). This theory, which has roots in economics, psychology and sociology, posits that human relationships are formed and maintained based on the use of a subjective cost-benefit analysis. For example, when a person perceives the costs of a relationship as outweighing the perceived benefits, then the theory predicts that the person will choose to leave the relationship. The SI theory emphasizes the dynamic interaction present between people and their social worlds (Blumer, 1969). Symbolic interactionism researchers investigate how people create meaning during social interaction, how they present and construct the self and how they define situations of co-presence with others (Stryker, 2000). One of the perspective’s central ideas is that people act as they do because of how they define situations (Cooley, 1902). While social exchange and SI each represent unique theories, they are often synthesized to provide a useful framework for understanding and predicting the development of intimate relationships (Stephen, 1984).

3. Unconsummated marriage/relationship

Unconsummated marriage refers to a social phenomenon rather than a specific dysfunction and does not appear in the DSM. As such, the term “unconsummated marriage”, which has religious and legal as well as sexological connotations, is not clearly defined in the literature. The frequency of unconsummated marriage is not known, yet is thought to be a more common phenomenon in traditional societies (Ozdemir, 2008). There does not appear to be a consensus regarding the exact

definition of unconsummated marriage or, when referring to an unmarried couple, unconsummated relationship. However, it is generally understood to refer to a situation in which vaginal-penile sexual intercourse between a heterosexual couple in a committed intimate relationship has not taken place. There is a paucity of literature available on the characteristics of couples presenting with non-consummation. It is this author's clinical experience, however, that a wide spectrum of sexual behaviors is reported by these couples. Some present with a complete lack of physical intimacy while others report that sexual activity, including manual and oral sex, is a vibrant component of their intimate lives. Furthermore, the level of distress related to lack of sexual intercourse may vary amongst couples, with some who report a great deal of distress and seek out help early in the relationship and others presenting to treatment only when they seek to start a family. Finally, levels of distress may differ between partners, whereby the less distressed partner may be reluctant to seek treatment.

Inability to carry out the act of sexual intercourse is generally attributed to a sexual disorder identified in the female partner, i.e. vaginismus or dyspareunia, and/or a sexual disorder identified in the male partner, i.e. erectile dysfunction or premature ejaculation. Several factors must be considered in the evaluation of a couple with the presenting problem of inability to consummate their relationship. Often, simple lack of information, insufficient premarital education and a cultural context strongly proscribing sexual behavior contribute to this phenomenon (Ribner & Rosenbaum, 2004). Providing basic anatomical and physiological information and specific suggestions according to the PLISSIT model (permission, limited information, specific suggestions, intensive therapy) (Annon, 1976) may be sufficient in empowering the couple to achieve sexual intercourse. When a specific dysfunction is identified, treatment is provided to the client presenting with the dysfunction, often involving the partner in the treatment process.

A comprehensive assessment includes a physical examination and may include consultation, medication, surgical intervention, referral to a mental health provider and/or treatment with a pelvic floor physiotherapist. The contemporary approach to most dysfunctions, including female sexual pain disorders, recognizes that psycho-sexual, relational, physiological and contextual factors combine to create and/or perpetuate the problem. This author's physiotherapy-based "hands-on" approach to the treatment of female sexual pain disorders, a common cause of unconsummated marriage, has been documented (Rosenbaum, 2005) and recognizes the need for a model that incorporates not only physical treatment of the disorder, but which addresses the problem within the context of the relationship. This includes the therapist's attempt to gain understanding in how the couple presents and organizes around the problem: How is the presenting problem perceived by each partner? Is there attribution of blame? What is the significance of the dysfunction itself and how is that perceived by the couple? Who is aware of this situation and in what way is outside intervention (community, parents, religious leader) perceived in assisting or perpetuating this condition?

When the sexual condition is perceived as the presenting problem, rather than a symptom of underlying problems in a relationship, the practitioner is faced with the challenge of reframing the condition and helping the couple recognize the role of the dysfunction as the scapegoat. Couples frequently state, "We have a great relationship and get along well, the only problem we have is the sexual one." Often, the client with the problem, or their partner, requests a pill, cream or injection

to trigger or restore sexual desire, arousal and orgasm or to eliminate pain. The suggestion that there may be inter-relational dynamics worth exploring may be perceived negatively and defensively by one or both of the partners, particularly those with sincere beliefs that the problem is a technical one or with anxieties about revealing to themselves, each other and the therapist, that perhaps there are problems in the relationship. Because it is important to address the clients' therapy goals in a cooperative fashion, the technical problem first needs to be validated and addressed. Often, difficult relational dynamics will emerge around the technical intervention (e.g. "My wife isn't doing her exercises" or "My husband thinks the problem is mine but he lost his erection when we tried yesterday").

4. Relevance of exchange theory

Sociological theory adds an additional dimension to practitioners working with a couple in this situation or any situation in which one partner wants sex and the other has less interest, desire or ability. Drawing from exchange theory, which makes use of the concepts of rewards, resources and costs, a perceptive therapist may wish to examine how sexual activity is being utilized as a resource, a commodity that may be offered or held back or a reward offered in exchange for good behavior. The therapist may also wish to discover the value, whether instrumental or socio-emotional, that each partner places on this reward: What is each partner's perception of his or her costs in terms of the outlay required in offering or being receptive to sex? Is physical pain experienced by the woman, for example, perceived by her as a punishment? Does her perception of "victim" due to experiencing pain come at a cost to her husband, who may feel guilty for wanting and asking for sex, knowing that it is painful for her? Does that cost prevent him from initiating in the future and is this then perceived as a lack of interest by the woman who, despite her not wanting to have sex, wants her husband to show interest anyway? Perhaps the fact that she wants him to initiate sex despite her lack of interest is that asking for sex is the only way he knows how to give her the reward of feeling worthy and attractive. All the above scenarios, when identified, can be addressed through therapeutic intervention that suggests alternative and more effective ways to communicate.

Developing a therapeutic approach solely on the basis of exchange is clearly problematic in clinical practice. Applying rational theory rooted in economics to human behavior assumes that such behavior is motivated solely by cognitive processes (Lawler, 1999). Particularly in matters of sexuality, where drive often overpowers rational thinking, attributing sophisticated cost/outcome motivations to people's actions reduces man to economist and ignores his multi-dimensional nature. Furthermore, while it is tempting to consider sex a resource, a commodity viewed as an instrumental reward by men and a socioemotional one by women, this view completely disregards the myriad of meanings that sex and intimacy may hold for a man, for a woman and for the dyad.

Exchange theory, however, does have value in a therapeutic setting, particularly when the therapist can encourage clients to consider the emotions that underlie their behaviors. For example, therapeutic technique based on exchange theory may posit that a man's premature ejaculation serves as a punishment, a passive aggressive manifestation of his sense of distributive injustice in his relationship with a wife he perceives as controlling (Grote, Clark, & Moore, 2004). While pure exchange theorists may attribute rational forethought to this behavior, therapy should focus

less on whether or if this behavior was consciously motivated, but more on the feelings underlying the behavior, how to access those feelings, communicate them effectively and modify the exchange relationship within the couple, such that both partners perceive fairness in a balanced and healthy way.

Another question that exchange theory would encourage the therapy to explore would be whether and how the dysfunction is serving either the client with the presenting condition or his/her partner. Often, the partner without power in the relationship is the one with the presenting symptom (Bagarozzi, 1990). These may include somatic type issues such as back pain, pelvic pain or genital pain, which all affect sexual function. Simply addressing the pain without exploring how the pain acts to punish, how intimacy is avoided by both partners as a result and how the affected partner becomes dependent and shifts the focus of attention to herself, misses an important element in the dynamics surrounding the dysfunction. Symptoms of chronic pain, with its ensuing need for the rewards of attention and care, may be developed by a partner in an involuntary relationship as a method of getting his or her needs met by the partner who, by not providing reciprocity and by giving less, is more powerful. This author's approach to the treatment of chronic pain has always been to identify physiological factors thereby validating the pain for the patient and his or her partner. Therefore, rather than attribute rational motivation to the pain, which could also cause the partner in pain to feel invalidated, treatment should focus on providing tools for each partner to communicate what he feels he is owed, whether in instrumental or emotional rewards, in order to restore healthy balance in the relationship.

Trust and commitment are key concepts in exchange theory (Blau, 1964, Cook & Emerson, 1978). Trust is seen as necessary to allow individuals to expect fairness and justice in the long term and commitment involves building relationship stability through high levels of reward reciprocity. In the therapeutic setting, these concepts may be borrowed and modified by downplaying the calculative element and introducing the emotional one. While in most cases a woman's inability to allow penetration, despite her desire to do so, stems from fear of pain, often legitimately (Weijmar Schultz et al., 2005), complete trust in her partner is necessary for this to occur. This trust is established based on behaviors, both in the bedroom and in the larger contexts of their intimate life. A woman who feels that her partner is "a soft place to fall" will be more likely to allow herself to be vulnerable. Treatment may focus on helping both partners understand that being vulnerable and exposed is necessary to allow complete intimacy and to "let each other in". Perhaps it will be identified where trust is lacking and ways to cultivate this trust may be negotiated. Individual past histories, including sex abuse or relationship rejection, may be explored vis-à-vis its impact on allowing trust to develop in the relationship.

Because behavioral therapy is standard in sex therapy, techniques derived from exchange theory may easily follow a behavioral model. In situations where sex is identified as being used as a commodity, to trade for attention, status or goods, the couple may be encouraged to impart new meaning to sex. Where sex remains a source of anxiety for one or both partners, the focus can shift to different types of pleasurable activities to perform together. Couples may be encouraged to draw contracts, communicating their actual needs, and not only what they perceive to be expected of them. Couples who are in crisis over sex, whether one partner is uninterested or unable, will present with issues of power and control and often display feelings of anger, resentment and betrayal. Rather than attribute rational and

sophisticated calculations regarding cost, punishment and reward, a perceptive therapist will explore the dynamics with which the couple has learned to organize around these feelings.

5. Relevance of symbolic interaction

A comprehensive review of SI and the study of sexuality has been published by Longmore (1998) who examined key SI concepts, including sexual scripting, identities, self, self-concept and socialization. While these concepts appear to have relevance in the clinical setting, Longmore, as well as other authors (Plummer, 2003; Simon & Gagnon, 2003), have focused on SI within the context of sex research. While a paucity of literature exists on the clinical applications of SI on the treatment of sexual dysfunction, suggestions for applying these theories in clinical practice are discussed below.

Symbolic interactionism views an individual's core sense of self as existing in the co-constructions of realities in views of self and others. All roles are seen to exist in reciprocals, so that in marriage, spouses' views, understandings and expectations of each other have the potential to impact the core sense of self and, consequently, the perceived quality of life that each partner experiences. From this perspective, self-identity and quality of life for women is tied not only to their views of themselves as caring and healthy individuals, but also to the ways they perceive themselves as viewed by others. Male sexuality may also be affected by how men perceive that others view them. Social messages to men linking masculinity with sexual performance may act as a source of anxiety, possibly triggering and maintaining the sexual problem. The significance of this is that a woman presenting with a sexual dysfunction, such as genital pain, cannot simply be treated as a woman with a vagina that requires fixing. Rather, her role as a woman, including her sexual role and the sexual scripts she has been socialized with, are deeply affected. Furthermore, how she perceives herself is greatly affected by how her partner perceives her, as well as by how she perceives her partner perceives her, although these perceptions may not be the same. Similarly, a man experiencing a sexual dysfunction requires more than techniques or medications to facilitate erection or delay ejaculation. His role and sexual scripts may be affected as well as his self-esteem. Many individuals seek a quick fix to a sexual problem, an easy way to provide genital tumescence or lubrication. The practitioner's challenge is to assist the client and couple in ascribing meaning to the presenting problem, as well as to how they act on the stage in the drama of their sexual (and non-sexual) life. The SI influenced therapeutic approach would likely posit that an individual with a sexual dysfunction, who is in an intimate relationship, must seek treatment within the context of the relationship, i.e. couples therapy.

The principles of SI are the following: humans act toward things on the basis of the meanings that things have for them, the meanings of things derived from social interaction and these meanings are dependent on, and modified by, interpretations between interacting individuals. Men and women use symbols and exist in a world of meaning created by those symbols. Sexual behavior, like all human behavior, is symbolic and is associated with a variety of activities, each with different meanings, including, but not limited to, having children, attaining physical pleasure, creating intimacy, achieving spirituality and exerting power (Laumann, Gagnon, Michael, & Michaels, 1994).

Therapeutic applications of SI, perhaps even without attributing these applications to this theory, already exist in much of the literature regarding sexuality and sexual function. The concept of ascribing meaning to sexual activity, and developing insight into the individual meanings for each person and for the couple, is useful in reframing the meaning of sex for couples who are dissatisfied with their intimate lives. An example of exploring the meaning of sex is evident in the “Good-Enough Sex” model for couple sexual satisfaction, introduced by Metz and McCarthy (2007). The authors suggest that at different times sex is experienced as pleasure, stress relief, mature playfulness and, on occasions, as a spiritual union. Intimate couples can value multiple purposes for sex and use several styles of arousal. “Good-Enough Sex” recognizes that among satisfied couples the quality of sex varies from day to day and from very good to mediocre or even dysfunctional. Reasonable expectations are an important feature of sexual satisfaction and protect the couple from disappointment and sexual problems in the future.

A large area of SI research deals with socialization – the processes through which personalities and self-concepts are formed, values and attitudes are transmitted and the culture of one generation is passed to the next. Applying these concepts therapeutically may offer insight in the treatment of many presenting conditions of sexual dysfunction, including unconsummated relationships. For example, individuals are committed to a particular role identity, they are motivated to act according to their conception of the identity and to maintain and protect it, because their role performance implicates their self-esteem. For a woman in a faith-based society, whose self-concept and self-esteem has been socialized and defined by a culture that values chastity and virginity, taking on a new role as a married woman and a new identity as a sexual human being, may be a source of cognitive dissonance. Furthermore, a woman’s reflected appraisal may be wrapped up in how she perceives that others, who may see or know that she is sexually active, see and judge her. This contributes to how she sees herself, and if her self-image is negatively affected, her sexual problems will be perpetuated.

Symbolic interactionists may theorize that young couples in an unconsummated relationship are actors on a stage, with each person having a tacitly understood role in social relations but lacking knowledge about the rules regarding how to interact in such an intimate setting. In this situation, a practitioner may encourage the couple to learn communication skills and begin to increase verbal and non-verbal communication with activities such as prolonged eye contact or sensate focus exercises, generally utilized in helping to desensitize couples with sexual difficulties. These interventions may help reduce self-consciousness, clearly an inhibitor of sexual intimacy. The inability of a woman to become aroused or reach orgasm, for example, may result from the fear of how she perceives her partner may think of her with her real self, presented without clothes or makeup. Once again, cognitive therapy designed to modify these perceptions individually and as a couple may be helpful.

Symbolic interactionism theory can be valuable in attempting to understand the dynamics of a couple presenting with an unconsummated relationship, particularly of long standing duration, who do not achieve therapy goals, despite objective improvement of the presenting sexual dysfunction. Couples often define themselves by the boundaries they have drawn and have become accustomed to. Although they are highly motivated to “step across the line”, they have labeled each other and themselves as “the couple who doesn’t have sex” for so long, this has become their default status quo. Changing that status becomes a source of anxiety and raises

many potential questions such as: What if my partner can function, but I can't? What if we can do it, but it's not pleasurable? What if he or she wants to do it every night? Allowing these fears to be verbalized enables the therapeutic intervention to focus on how the dysfunction has served as a boundary, but that it is an unnecessary one, as boundaries can be established in healthier and more functional ways. Encouragement can be provided that the process of enjoying sex is not an overnight one and rather is learned along the way.

6. Conclusion

This article offers a treatment paradigm that suggests a multimodal approach to the treatment of sexual dysfunction, specifically unconsummated relationships, in couples. This approach encourages the practitioner to examine the multi-factorial components that may contribute to this presentation. Specifically, the practitioner is encouraged to consider the sociological context that is a crucial aspect of this particular presentation. Exchange theory is an appropriate clinical sociological approach in that it considers a couple's relationship in terms of balance of power, justice and fairness and, as illustrated, merges well with a behavioral approach. Symbolic interactionism theory considers the significance of the problem within the couple's social world. In some traditional societies, for example, the failure to consummate a marriage does not only represent a problem of two individuals, but rather has communal implications (Ribner & Rosenbaum, 2004). The reality of community pressure and its influence on this couple are important aspects of the social context that should not be ignored.

Applying sociological theory clinically as an isolated approach to the treatment of sexual dysfunction has limitations. These include a lack of attention to physiological factors, as well as individual psychological issues. Therefore, this approach is suggested to provide an additional dimension to treatment that is essentially multi-disciplinary. Practitioners are encouraged to educate themselves regarding the presence of physical conditions, such as chronic pelvic and genital pain syndromes (Rosenbaum & Owens, 2008), and to validate and treat presenting symptoms. Cognitive behavioral treatment approaches as described in the classic sex therapy literature are encouraged. Treatment approaches and suggestions gleaned from the sociological micro theories of exchange and SI are offered and suggested as part of multidisciplinary approach to the treatment of unconsummated relationships.

Notes on contributor

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