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Evaluation and Treatment of Unconsummated Marriages among Orthodox Jewish Couples

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Orthodox Judaism expects new brides and grooms to engage in sexual intercourse on the first night of marriage or soon thereafter, despite stringent norms forbidding premarital physical contact. Any delay for more than several weeks in consummating a marriage is seen as problematic and worthy of rabbinic or professional attention. This article examines traditional Jewish sources for this emphasis on marital sexuality, defines the problem of unconsummated marriages, discusses issues pertinent to evaluation, and suggests appropriate treatment strategies. Our focus includes both the Orthodox and Ultra-Orthodox (Haredi) elements of the Jewish community.

Within traditional societies, wedding ceremonies often function as symbolic consent for physical intimacy between individuals expected to have minimal or nonexistent premarital sexual experience. One such society, Orthodox Judaism, takes a step beyond permission and openly expects new brides and grooms to engage in sexual intercourse on the first night of marriage or soon thereafter, despite stringent norms forbidding premarital physical contact. Any delay for more than several weeks in consummating a marriage is seen as problematic and worthy of rabbinic or professional attention.

Although no research literature currently exists documenting the extent of the phenomenon of unconsummated marriages in the Orthodox Jewish community, our own and our colleagues' practice experience indicates a

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steadily rising number of such cases referred for treatment. Although "religious belief systems" have traditionally been cited as possibles causes of unconsummated marriage secondary to vaginismus (Kaplan, 1974), we believe that it is precisely the religious belief system unsupportive of unconsummated marriage that prompts Orthodox Jewish couples to seek treatment relatively early rather than suffer in silence.

In this article, we will examine traditional Jewish sources for this emphasis on marital sexuality, define the problem of unconsummated marriages, discuss issues pertinent to evaluation, and suggest appropriate treatment strategies. Our focus includes both the Orthodox and Ultra-Orthodox (Haredi) elements of the Jewish community.

SEX IN TRADITIONAL JUDAISM

The biblical phrase, "It is not good for man to be alone" (*Genesis*, II, 18) describes the emotional imperative for marriage; this is not advice, but rather a Divine guideline for the completion of each human being (Soloveitchik, 2000). Jewish scholars understood the union that accomplishes this goal as consisting of both physical and spiritual components (Friedman, 1996). The physical side was seen as essential to creating and maintaining a healthy relationship, as well as fulfilling the commandment to "be fruitful and multiply" (*Genesis*, I, 28), a requirement incumbent on every Jewish couple. Traditional Judaism sees any behavioral aspect of sexuality as confined exclusively to a marital relationship, and any other nonfamilial physical contact with someone of the opposite sex is expressly forbidden (Rosenheim, 2003).

Jewish law considers the fulfillment of sexual desire reason enough for couples to engage in sexual intercourse and in fact mandates that a couple meet one another prior to marriage to ensure that physical attraction exists. Both spouses are obligated to fulfill each other's desire for intimacy, and sexual satisfaction is a right guaranteed to the woman in her marriage contract. Few rules dictate the actual nature of sexual activity between a husband and wife, and the general view is that any sexual act that does not involve purposeful emission of semen outside the vagina is permissible. However, when and under what circumstances the couple has sex is more specifically mandated. For example, sexual activity may not take place during a woman's monthly period or for a full week thereafter and only recommences after she has immersed in a ritual purity bath. Sexual activity is not to take place when either or both partners are drunk or arguing and may not be used as weapon to punish or manipulate a spouse.

The joint goals of procreation and human completion form a powerful cultural impetus for intimate relations within a marriage. Beyond a couple's own instinctive desire for sexual contact, the community's interest is to see a union characterized by the capacity for sexual satisfaction combined with

the potential for producing a new generation. Consequently, the sooner a marriage is consummated, the sooner a couple can move toward achieving the dual goals of marital sexuality; the sooner a problem in this area can be made known, the sooner a solution can be found. Under no circumstances, however, does Jewish law or tradition mandate sexual relations if either party does not wish to do so (Kanohal, 5763 [2003]).

One guiding principle behind sexual intimacy in traditional Judaism is that of modesty, which dictates that sexual behavior and discussion remain as intimate expression exclusively between the couple. The interpretation of such modesty has varied historically by cultural norms. In some societies, notably some areas of North Africa, evidence that a couple had engaged in sexual intercourse was available through examination the next morning of the sheet from the wedding night bed or the bride's undergarments, with bloodstains indicating both the bride's virginity as well as the couple's initiation into marital intimacy (Kashani & Posner, 1973). This apparently was never a custom in Western European communities, where only the self-report of either the bride or groom would reveal that sexual intercourse had yet to occur. In contemporary Jewish society, other than a problem beyond the couple's own coping capacities, Jewish cultural norms of modesty militate against revealing any aspect of a couple's intimate life to anyone (Ribner, 2003).

PROBLEM DEFINITION

Within Jewish religious literature, no explicit time period defines an unconsummated marriage. Some couples experiment with a variety of intimate activities primarily falling into the category of foreplay and will often report enjoying physical contact and excitement and a gradual increase in their physical and emotional comfort level with a sexual partner; however, they never quite manage to achieve even partial penetration. At the other end of the spectrum, clients complain of no desire or responsiveness regarding themselves or their partners and therefore little or no physical intimacy, leading to or accompanied by feelings of fear, doubt, anger, confusion, and rejection. From a cultural/religious vantage point and from the experiences described by our clients, we define the problem of unconsummated marriage for this population as a formal marital relationship in which sexual contact is sanctioned, expected, and encouraged, where penile penetration of the vagina has yet to take place, and where this situation is a source of stress for either or both spouses.

CAUSAL FACTORS

As with any sexual dysfunction, the causes of an unconsummated marriage can be varied, complex, and interactive. We first look at those factors that

may be more gender specific and then turn to factors connected primarily to the marital relationship.

Women

Inability by the female partner to allow penile penetration may occur as a result of mechanical, physiological, emotional factors, or a combination thereof. In many cases, simple ignorance regarding female anatomy and a lack of sexual experience coupled with a history that did not include tampon use, self-exploration, or penetrative masturbation may be causal factors in preventing intercourse from occurring. Mechanical factors may also include anatomical anomalies such as a rigid or septate hymen. Insufficient lubrication, the presence of pain with attempted intercourse, fear, and anxiety are all potential factors contributing to penetration failure. As in any case of unconsummated marriage, a thorough history and physical examination is critical in ruling out painful conditions, such as vulvar vestibulitis syndrome.

As noted above, Orthodox Jewish women are expected to immerse in a ritual purification bath (mikve) prior to the wedding and after each monthly period. Part of that preparation process includes the woman inserting a clean, white cloth in her vagina to determine that the flow has ceased completely. This process, which begins the month prior to the wedding, generally ensures that women have a perfunctory knowledge of their vulvo-vaginal anatomy. Women presenting with inability to allow penile penetration may report having difficulty with these self-inspections and a history of never successfully inserting a tampon.

The reasons for this difficulty may range from insufficient understanding of female anatomy, anxiety related to vaginal penetration with resultant vaginal muscular hypertonus, or pain on contact due to vulvar vestibulitis. Although these conditions are not unique to religious women, the treatment must take into consideration the values and sensitivities of the couple. Standard treatment approaches using explicit language, visual aids, and even sensate focus exercises may need to be modified (Ribner, 2003).

Modesty is a cultural value deeply ingrained in religious women from their earliest moments. The accepted norms require that women not dress in a revealing manner to the extent that, in many communities, hemlines that fall below the knees and sleeves that cover the elbows define minimal guidelines. The expectation that a young woman raised according to these standards will reveal her body and engage in sexual intercourse immediately or shortly after the wedding is a realistic one; in most cases, consummation of the marriage does indeed occur. It is not, however, unexpected that, for many young women, sexual activity may not “feel” very modest, and the culmination of that activity, that is, intercourse, may become inhibited. Contributing to these problematic situations is the explicit and strongly mandated traditional

Jewish expectation that both marital partners be entirely naked during sexual intercourse, with nothing coming between them.

MEN

Two primary factors contribute to the male spouse's inability to achieve vaginally contained penetration: erectile dysfunction (ED) and premature ejaculation (PE). Although it is appropriate for clinicians to be mindful of the possibility of physiological etiology for either of these syndromes, the fact that those in the Orthodox community presenting with unconsummated marriages are young adults increases the probability that we are dealing with emotional or dynamic factors rather than health related ones.

Of special note with this regard is the major contributory role that anxiety may play in causing ED or PE in this group. Other than immediate blood relatives and marital partners, Jewish law forbids any heterosexual physical contact, and communal norms among those in the Ultra-Orthodox (Haredi) community severely limit even nonphysical interactions. Thus it is assumed and likely that the bride and groom will have experienced no physical touch with each other prior to their wedding, making their first night together, with its anticipation of full sexual intercourse, a potentially daunting prospect. With men expected to know "what to do," performance anxiety may well be a husband's primary emotional response to his initial experiences with marital intimacy. Consequent ED or PE may further raise anxiety levels, resulting in a marriage unconsummated for a lengthening period of time.

An additional cultural aspect, which may influence a young husband's sexual performance, is the prohibition of "spilling of the seed." Jewish law generally takes a dim view of nonvaginally contained ejaculation (Ribner, In press), which may impact in three ways on the potential of consummating a marriage:

- According to traditional sources, this prohibition includes masturbation. We may speculate as to the extent that Orthodox Jewish adolescents strictly adhere to this rule, but the negative message accompanying self-stimulation may well carry over into marriage, where partner intimacy, and accompanying stimulation, becomes abruptly permissible. If sexual expression is "bad" before the wedding, perhaps it is inherently inappropriate and therefore should be avoided;
- Fear of nonvaginal ejaculation may prompt inexperienced husbands to attempt penetration before either he or his wife may be physiologically or emotionally prepared. If the ensuing first sexual experience is evaluated as a disaster by one or both spouses, it may engender painful feelings of embarrassment and failure sufficient to preclude future attempts.

- In situations where the husband's sexual function is not impaired, his fear of nonvaginal ejaculation often impacts the female partner. For less-restrictive populations, a couple having difficulty with penetration because of issues related to female factors such as pain may be satisfied with mutual masturbation and oral sex. Due to religious dicta, however, the Orthodox Jewish couple is generally unable to rely on such activities for male satisfaction, which may well contribute to the feeling on the woman's part of bearing a burden of responsibility to "contain" her husband's orgasm.

With regard to PE as a causal factor, we are referring to a more extreme form of this problem, in which ejaculation occurs so rapidly once intimacy commences that penetration becomes an impossible task. The likelihood of such a response will be greater where a first-time-ever caress can bring the husband to heightened excitability and ejaculation well before either spouse is prepared for penetration. In some cases, this response can become patterned, making full intercourse especially difficult to accomplish.

Relationship Factors

From our experience working with Orthodox Jewish couples, we have concluded that an abysmal lack of basic information regarding sexuality may be the primary contributing cause of failure to consummate the marriage. We have seen couples in which neither partner knew the location of the vaginal opening or in which the wife, for reasons of modesty, would not direct her husband to the proper location. More commonly, however, we have worked with couples who have attempted intercourse while one or both of the partners were not aroused, who were not aware of any foreplay techniques beyond kissing and hugging, and whose discomfort and awkwardness with their own bodies prevented finding a comfortable position for penetration to take place.

It is not uncommon for Orthodox women and men, particularly in the more Haredi communities, to be physically sedentary. Haredi youth are generally ensconced in study or busy with their responsibilities as older siblings of often-very-large families. They do not have a lifestyle that involves partaking in sports or frequenting health clubs on a regular basis. Many are raised with the belief that spiritual development supercedes physical fitness in importance, and they simply do not possess the physical agility or body awareness that their secular counterparts have. Because sexual activity does demand a minimal amount of physical flexibility, body awareness, and coordination, simple awkwardness can prevent intercourse from occurring.

Understanding this problem in the context of the Orthodox Jewish community requires an appreciation of the cultural norms regarding marriage and sexuality. This faith community is not monolithic, and each subgroup

may espouse different types of values and behaviors. As one example, in Haredi communities, it is not uncommon for bride and groom to have met or seen each other only a minimal number of times prior to their wedding day (at times, only once), almost always in the presence of a third party. Thus, their initial physical spousal contact and first intimate experience will be with a virtually unknown member of the opposite sex. Although it is true that usually by the time the couple seek treatment, they have come to know each other better and often have begun to develop a bond of affection, the pattern of failed attempted intercourse, which was initiated as strangers, may well persist.

Conducting oneself as an Orthodox Jew theoretically precludes or at least severely limits access to sources of sexual information available to less-restrictive groups. Few will have been exposed to school-based sex education programs, and many, on principle, will refrain from using any media source that transmits sexual ideas or images. This prohibition may well include ostensibly benign sources of "legitimate" information, such as mainstream women's magazines. As a consequence, knowledge may be partial and flawed in areas such as physiology, sexual mechanics, communication, and emotional intimacy, contributing to dysfunctional outcomes, including unconsummated marriages.

An additional relationship factor concerns incompatible expectations. To cite one example, the principle of modesty noted above influences a great deal of Orthodox Jewish interpersonal behavior. Although conservative dress represents the most visible aspect of this value, modest conduct also influences intimate behavior (Shlanger, 1994). Among some Orthodox couples, this may be limited to issues of privacy (e.g., closed windows and doors during any sexual contact), possibly extending to no public displays of affection. For others, however, modesty may be perceived as a determinant of sexual behavior itself, providing guidelines through which to act in a proper manner, for example, restricted options regarding sexual positions or whether the room must be pitch black.

We have seen disagreement between spouses about the value base or manifestations of these guidelines that produce decidedly negative responses ("You're animalistic!" or "You're a nun!"). When these disparate views emerge acutely on a couple's wedding night, ensuing feelings of disgust, disappointment, and distancing may prevent marital intimacy for an extended period of time. On a practical level, sexual activity taking place in complete darkness can actually increase the woman's anxiety, particularly if she feels as though her husband is "groping in the dark" and fears he could actually harm her.

One final factor that may manifest itself in the spousal dynamic as an unconsummated marriage is intrapsychic phenomena such as personality disorders, residual response to childhood sexual abuse, unconscious or repressed homosexuality, and sexual aversion syndromes, among others. These

again should be dealt with in accordance with the couple's cultural norms and, when requested, in consultation with rabbinic authorities of the couple's choosing. In such cases, individual therapy may be a prerequisite for any work done with the couple.

TREATMENT CONSIDERATIONS

Because Orthodox Judaism infuses sexuality with religious meaning and expectations, instances of sexual dysfunction, such as unconsummated marriages, tend to be brought initially to the attention of community religious functionaries. Depending on existing relationships and feelings of trust, these may be the rabbi, his wife (often, for women, the go-between for issues to be raised with the rabbi) or a premarital advisor. (This last is a relatively new role, which has achieved formal communal status but for which there is as yet no universally agreed-upon curriculum, admissions standards, or quality control.) We have found that guidance from these sources regarding physical or emotional intimacy is often incomplete or mistaken.

In our joint practice, it is not uncommon for the marital therapist to see couples referred directly by rabbis or advisors, whereas the urogynecological physiotherapist will see the couple by direct referral from an examining gynecologist, particularly when dealing primarily with lack of education, female anxiety, or vaginal pain and contraction. Whether a couple is referred initially for physiotherapy or marital counseling often reflects the referring agent's perception of the problem as either physiological or emotional. We have found, however, that in most cases a variety of factors have contributed to the problem, and, as colleagues, we will refer the couple to each other to complement our approach to treatment (Bergeron & Lord, 2003).

Of critical importance at the outset is establishing an atmosphere conducive to openness and acceptance. Although this is an obvious initial goal for any treatment relationship, this preliminary phase takes on a unique perspective for these couples, who frequently present with feelings of failure at not meeting personal, spousal, and communal expectations; fear of what may be wrong with themselves or their partners; and embarrassment at not accomplishing what everyone else apparently does with ease. Hearing a message from a trusted religious functionary that the only remaining option is professional intervention may be a blessed relief but may, as well, further compound these negative perceptions. It is only the clinician's empathic stance that will enable the couple to accept treatment recommendations.

Our therapeutic experience with religious couples has helped us to formulate the following guidelines:

- An early determination should be made as to whether either or both spouses are expressing fundamental doubts about the marriage through

sexual distancing. The often-unclear answer to this question must be seen in the context of the importance that each partner ascribes to a number of cultural norms, such as saving oneself sexually for the right spouse, avoiding the personal and familial stigma of divorce, and lacking previous experience with the intensity and expectations of physical and emotional intimacy. We suggest allowing sufficient therapeutic time to raise this issue and, when possible, obtaining the couple's commitment to the integrity and potential of their relationship.

- We advocate avoiding, to the greatest extent possible, any language defining this unconsummated marriage as a "problem." Without oversimplification, clinicians should attempt to place this situation within the broader spectrum of the challenge faced by most Jewish religious couples as they confront marital sexuality for the first time. Normalization, particularly of fear and hesitation, often represents the first step in easing a couple's stress level.
- Although lack of sexual intercourse in a given marriage may derive almost exclusively from a sexual dysfunction specific to one spouse, care should be taken to emphasize the dynamic nature of intimate interaction. Similarly, responsibility for consummating the marriage rests with both spouses conceptually and, when possible, practically, as we shall describe below. Our goal is to minimize feelings of loneliness and isolation that often accompany a sense of sexual "failure" and to use this moment as an opportunity to unite these newlyweds toward a common objective.
- By the time that many religious couples finally reach a health care professional competent to treat sexual dysfunctions, they may have already spoken with rabbis, rabbis' wives, teachers, premarital advisors, parents, other relatives, and various sources of well-meaning advice. This cacophony, at times contradictory and fraught with errors, can fill the therapeutic space with untherapeutic "noise," and couples often require assistance in determining which, if any, of these voices may provide useful support or information. As an example, because of the religious/sexual interplay in Orthodox Judaism, creating a positive working relationship with the couple's rabbi becomes a clinical necessity. We have elsewhere discussed this issue in greater detail and offered specific guidelines for this relationship (Ribner, In press).
- The vast majority of religious couples that we have treated have reached adulthood after many years of formal education and are comfortable making use of cognitive skills to solve problems. Any provision of information, however, should be specific to the needs of each couple and sensitive to the cultural context. Even basics, such the physiology of male and female genitalia and the normative responses to desire and arousal, must be presented in a manner that cannot be considered salacious. To this end, we have found that line drawings taken from medical text books rarely result

in negative responses. We generally provide descriptions of the mechanics of actual intercourse verbally.

Given the importance of modesty as a communal value, a further consideration is the extent to which the clinician's gender may promote or impede a spouse's willingness to learn and explore this new, sensitive realm. We present this to each couple as a choice, both in terms of the gender of the therapist as well as whether the couple wishes to hear this information together or separately.

- When the primary impediment to consummating a marriage lies with one of the spouses, for example, vulvar vestibulitis or ED, clinicians should make use of standard protocols appropriate to the specifics of each case. The added dimension should be the inclusion of the other partner in the treatment at the earliest stage where both feel sufficiently comfortable and in the privacy and familiarity of their own homes. In the case of vulvar vestibulitis, this may mean the husband's guided insertion of a dilator into his wife's vagina and in the case of erectile dysfunction, the wife's guided manual stimulation of her husband's penis. For some spouses, direct manual touch of the other's sexual organs may fall well beyond their tolerance range, particularly in this early and inexperienced stage of the marriage. If empathy and gentle encouragement produce no change, this expectation should be suspended.
- The intolerable dyadic stress of one spouse desiring sexual intercourse and the other indefinitely and perhaps permanently unavailable as a partner engenders communal consequences. The inability or unwillingness of either spouse to provide physical intimacy where desired by the partner is grounds for divorce in the eyes of traditional Jewish law. No Jewish court will act on such a petition so long as there is hope for change, particularly during a course of professional intervention. Thus, clinicians should be sensitive to spouses who may interpret messages of patience and understanding as justification for maintaining the unconsummated status quo and avoiding the marriage's dissolution.
- At some point, the therapist may conclude that no further treatment is needed or available, and whether this marriage is ever consummated lies entirely within the purview of the two people involved. It may, in fact, be appropriate for one spouse to try to persuade, even seduce, a reluctant partner to move beyond this impediment, enabling them both to more fully develop their relationship. The therapist's continuing firm, gentle encouragement, although a justifiable clinical stance, brings with it the potential for a dangerously misunderstood message. We are aware of instances in which this encouragement has been interpreted as justification for coercion, moving in the direction of marital rape. Anyone involved in trying to help this couple must continually underscore the message that, particularly in the eyes of Jewish law, every instance of marital intimacy must be consensual.

CASE ILLUSTRATION

A young couple was referred after 6 months of marriage, reporting that they had yet to achieve intercourse. In the initial joint session with the marital therapist, the 19-year-old bride, S, was quiet and shy and barely made eye contact, and her 20-year-old husband, B, seemed confused and embarrassed. S had recently been diagnosed by an examining physician as having vaginismus.

S, began working with the physiotherapist, who explained and showed her anatomy to her using a mirror. She had several treatments consisting of inserting gradual dilators, stretching the vaginal interoitus and perineum and using pelvic floor exercise and biofeedback to reduce muscle hypertonus. Simultaneously, B was seeing the marital therapist concerning the correction of some sexual misinformation regarding male and female anatomy and the sequences and parameters of desire, arousal, and performance.

During the physiotherapy sessions, S revealed that, although she did become sexually excited with her husband, she realized that preventing penetration was the one thing she felt she had left in her life that she could still control. She acknowledged feeling genuine affection for her husband but resenting him (and their cultural norms) for creating a marital opportunity for her when she was only 19 and then compelling her to move with B to live in a foreign country away from her family and friends so that he could continue his religious studies.

For his part, B gradually spoke of long-standing guilt about premarital masturbation, which continued into the marriage when sexual satisfaction did not become available to him. His erotic fantasies centered on his wife, but he lacked the confidence and vocabulary to communicate these feelings to her and maintained some residual doubt as to whether marital sex should be considered a positive or just biologically necessary aspect of his relationship with S.

Both S and B were encouraged to be more open with each other regarding their mutual sexual attraction and were helped to create a culturally syntonic vocabulary to more comfortably and clearly express these feelings. B was advised to consult with a rabbi concerning his perception of Jewish sexual values. With the agreement of both spouses, B was included in the vaginal dilation exercises, now done in the privacy of their home, which proved to be an intimate and enjoyable activity.

Upon completion of the dilation exercise sequence, the couple was encouraged to again attempt to have intercourse, which was accomplished within several days. Residual issues impacting on their comfort with physical and emotional issues remained for both spouses and had not been significantly resolved when they left treatment, citing familial fears of communal stigma regarding the need for therapy.

DISCUSSION

Any intervention with this or similar religious couples must be predicated on a well-grounded understanding of the values and norms that govern their marital and sexual expectations. In this case, culturally determined issues included marriage at an early age, minimal prior or current access to accurate sexual information, discomfort with the language of physical intimacy, modesty as a behavioral constant, masturbatory guilt, and specific gender role behaviors. These concerns, in turn, should be seen in the context of religious and communal standards strongly advocating procreation and sexual intercourse as normative aspects of a couple's marital life.

Therapists unwilling to accept the legitimacy of these guidelines will be hard-pressed to win the confidence and trust of couples needing their professional assistance. Even those prepared to operate within religiously mandated behavioral expectations must undergo a learning process in order to properly evaluate and treat intimate problems. As in most therapeutic relationships, the initial education will come from the clients themselves. Additionally, in situations influenced by unfamiliar cultural determinants, clinicians would do well to establish links with experts, such as clergy, who can verify and explain client beliefs.

Our experience has also taught us that, although multiple voices run the risk of confusion, the complexity of the interaction between sex and culture often requires the input of more than one clinician. A large part of the progress achieved in the above-noted case resulted from our individual areas of expertise, our familiarity with the client population, and our phone contacts to coordinate our work with each spouse. Technical and financial considerations may preclude such a level of cooperation in many cases, but when it does work, it works well indeed.

The focus of our clinical experience is primarily the Orthodox Jewish community; we welcome responses from those working in various contexts where sex and culture mutually influence problem definition and treatment considerations.

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