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The Ultra-Orthodox Jewish Couple in Israel: An Interdisciplinary Sex Therapy Case Study

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Treatment for couples presenting with sexual difficulties should consider the context of the couple's lives and their cultural milieu. Practitioners treating couples from traditional and faith-based societies should acknowledge, respect, and be willing to modify treatment to conform to the clients' beliefs. The purpose of this article is to describe the case of a young ultra-Orthodox couple presenting with unconsummated marriage and to illustrate and elucidate the multidisciplinary and culturally sensitive treatment provided.

Ultra-Orthodox Jews, or *Haredim*, are a devout and tightly knit community that make up an estimated 8–10% of Israel's 7.7 million population, with an average of eight children per family. School and extracurricular activities are sex segregated from early childhood, while marriage in the Haredi sector is encouraged at a young age. Marriages are typically arranged through parents and/or matchmakers. Haredi youth are expected to refrain from any sexual experiences, and premarital sexual education generally occurs in a limited manner, prior to the wedding. It should be noted that the Haredi community does not adhere to one central authority regarding philosophy, expectations or practice, such that differences exist within subcultures and sects of Haredi Jews (Finkelman, 2011).

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CASE STUDY

Yossi, age 27 years, and Chanie, age 24 years, both Haredi Jews, presented to our clinic with the complaint of inability to consummate their 17-month marriage. They reported that they met through a matchmaker, agreed to marry after five meetings, and married several months later. As is the norm in Haredi culture, neither had any previous sexual encounters and until the wedding night, there was no physical contact between them.

Attempts at penetration caused Chanie pain, and Yossi began experiencing difficulty maintaining an erection; eventually, the couple ceased attempting intercourse. Both partners reported feeling a great deal of individual and communal pressure, as pregnancy at this stage of marriage is an expected outcome. They described feelings of failure and isolation for not having sex, as marital relations are highly valued in Jewish married life. Yossi, who grew up as the fourth child in an ultra-Orthodox 12-person family, felt particularly frustrated, because his 62-year-old father, an active member of the community to whom many turn for help and advice, neglected to discuss sexual matters with him before his wedding. Yossi delayed seeking a bride, fearing he would fail to please his wife sexually. As is common, Yossi went to a bridegroom's counselor, who gave him advice on religious law but without any meaningful sexual guidance.

Yossi described the dynamics of his family of origin as strict and inflexible. His mother, age 57 years, the daughter of a veteran Israeli religious family, accepted his father's authority, and lacked any real influence or status outside of the home. His parents did not display warmth or affection as this was considered immodest. At first, Yossi was reluctant to attend therapy, thinking it would be sufficient if his wife attended alone; however, after being convinced to attend one meeting with Chanie, he continued to attend sessions realizing that he could express himself and speak openly without being judged on his behavior and without threatening his place in his society and family.

Chanie, the third of nine children, described growing up as a self-confident girl in a typical ultra-Orthodox family. Being attractive and a serious student as well, she was considered to be "an excellent match." While she states she now loves Yossi, she described her initial attraction to him in a cognitive way. She was drawn to his family's standing in the community and was excited about the prospect of marrying him but was unaware of experiencing physical attraction. She received premarital instruction regarding the relevant religious laws but little preparation for sexual relations. She understood, mostly from friends, that the first intercourse would be painful and unpleasant, and she would bleed, and she should attempt to relax in order to allow penetration to occur. Chanie reported feeling frustrated that she has been unable to allow penetration, and was motivated to seek treatment,

not necessarily to enjoy sex but because, as she put it, she "should be pregnant by now."

Yossi and Chanie described the dynamic that had ensued. While they initially comforted and encouraged one another, eventually they began to blame each other. Yossi complained that Chanie was uncooperative and sexually unresponsive. Chanie felt that Yossi was not attentive to her needs to engage in foreplay or proceed slowly, yet she also conceded that she had been afraid to make excessive demands.

THERAPY

The presenting complaint of this couple was unconsummated marriage. Treatment for this condition generally involves identifying the factors involved through a detailed sexual history, ruling out physiologic components, and providing education and behavioral therapy (Rosenbaum, 2009). However, given the couple's discomfort with discussion of intimacy, the first step was to reduce the couple's anxiety. This was done by normalizing their situation and emphasizing that sex is a learned activity and a sexual relationship can take time to develop. Their perception of the role of therapy as identifying and addressing pathology was reframed for them as a therapeutic journey they would take together. The repeated questions the couple raised about "how long will this take" provided the opportunity for the therapist to question the clients further regarding the pressure they were feeling. Normalizing the couple and allowing them to express what was triggering their urgency, was helpful in anxiety reduction.

Initial sessions consisted of educating the couple in basic physiological and psychosocial components of developing a sexual relationship, including the normative processes of the male and female sexual response cycle. Because Chanie's main complaint was pain with attempted intercourse, she was referred to our clinic's gynecologist in order to rule out physiological causes. The gynecologist diagnosed vaginismus and referred her as well to the clinic's physical therapist. Concurrent with sex therapy, Chanie underwent a course of physical therapy that consisted of mindfulness-based anxiety reduction (Rosenbaum, 2011, 2012), pelvic floor relaxation, and dilator therapy.

As it was determined with the educational instruction, Chanie and Yossi lacked basic knowledge about their own bodies, and each other's. Yossi reported that as a young unmarried man, when stimulated by a sexual thought or sight, he would feel guilty, and masturbate quickly to achieve relief. After marriage, he would attempt to have intercourse with Chanie soon after becoming erect, for fear of ejaculating before reaching the vagina. This would be perceived as a religious failure in their ability to properly achieve intercourse without spilling seed. Yossi came to understand that he had not

learned to contain his arousal over time and his overall ability to allow himself to perceive pleasure was limited. He and Chanie were confronted with their lack of awareness regarding the female and male genitals, and they were instructed in basic anatomy and function using illustrations and diagrams.

To learn how to give and receive pleasure, Chanie and Yossi were instructed to avoid attempting intercourse and focus instead on learning to provide and accept touch, caresses, and kisses. They were instructed in basic sensate focus exercises, designed by Masters and Johnson (1970), consisting of taking turns touching and massaging one another while avoiding the breasts and genital areas. These exercises were modified for them, as suggested in the literature (Ribner, 2003), by having them begin where they felt comfortable. Rather than begin unclothed, the couple was instructed to do the exercises initially under a blanket in their underclothes and to progress slowly as they became more comfortable. Several sessions consisted of processing the home exercises as well as learning to effectively communicate with one another. Chanie described that she felt that Yossi had become more attentive to her and as a result, she felt she could trust him more.

Concurrently, in the physical therapy, Chanie and Yossi reached the stage where he was being directed to gradually insert the dilators in a sequence beginning with watching Chanie insert, helping Chanie insert, inserting with Chanie's hand on his, and last, inserting it in to her himself while she remained passive. Chanie reported that after Yossi was able to insert the largest dilator, she felt that they achieved a deeper level of intimacy. The next time they performed the sensate-focus exercises, and were instructed to touch one another's sexual organs, Chanie recalled an incident that she related to Yossi. As a child, when walking home from school a boy approached her and asked her to touch his penis. She panicked and ran home and reported the incident to her mother, who reacted dismissively ("Maybe you didn't understand what he was asking"). Chanie was able to identify that the request that she touch Yossi's penis triggered in her the anxiety that she felt at that time. Furthermore, the lack of empathy she perceived by her mother, and feelings of powerlessness were repeated when receiving messages from her bridal instructor and friends, that she should just relax and allow him to do what was necessary. Upon hearing Chanie's story, Yossi was empathic and comforting to her. This revelation, and Yossi's containing reaction, proved to be a cathartic step in their therapy. Yossi was able to comfort Chanie and be there for her in her sadness and anxiety, recalling this event. Shortly after that, the couple began to experience complete sexual intercourse.

The evaluation and treatment process consisted of an initial intake by a rehabilitation physician/sexologist, and a physical examination of Chanie by a gynecologist. In addition, the couple attended 21 sex therapy sessions, mostly as a couple but with some individual sessions as well. They also attended 12 physical therapy sessions. The overall treatment lasted 8 months.

DISCUSSION

Several factors must be considered in the evaluation of Orthodox Jewish couples presenting with inability to consummate their marriage. Often, simple lack of information, insufficient premarital education and a cultural context strongly proscribing sexual behavior contribute to this phenomenon (Ribner & Rosenbaum, 2007). Lack of sexual education is common in the Orthodox sector and is generally provided by premarital educators (also known as kallah or bride and chatan, or groom instructors) before the wedding. In a groundbreaking study of Orthodox Jewish women and sexual life, almost half of the nearly 400 respondents, stated that while they were well educated by their kallah instructors in Jewish laws pertaining to marriage, they received insufficient preparation for sexual life. Despite the fact that almost 90 percent of the sample studied with a kallah teacher before marriage, only 50% of them learned about sexual matters from this source (Friedman, Labinsky, Rosenbaum, Schmeidler, & Yehuda, 2009). While several multidisciplinary interventions contributed to the success of our treatment, we believe that the psychoeducational component provided to this couple was perhaps the most empowering for them in achieving their goals.

Several challenges are presented to sex therapists in the behavioral treatment of unconsummated marriages in this and similar populations. There is an expectation that intercourse takes place shortly after the wedding and the inability to do so is a major cause of distress and anxiety. In Orthodox Judaism, this applies regardless of the expectation that the couple have had no previous sexual contact, which leaves the young couple experiencing major cognitive dissonance. Our immediate approach was to reduce anxiety by normalizing their situation and removing the effect of communal pressure by giving them permission to take the time they need. Furthermore, to ease them in to the experience of physical intimacy, we utilized modified sensate focus, as discussed in the literature (Ribner, 2003). Finally, respect and consideration of the patient's cultural and religious worldview was presented at the outset. In general, Haredi couples seek the guidance of religious leaders and may view secular or non-Haredi caregivers with suspicion. Our stated readiness to respect their religious dictates served to lower their initial anxiety.

The timing of sexual contact between husband and wife is governed by a set of laws known as Taharat Hamishpacha: literally, family purity. Taharat Hamishpacha requires that husbands and wives abstain from all physical and sexual contact for the duration of a woman's niddah time, that is, the length of her menstrual period plus an additional 7 "clean" days. At the end of this approximate 12-day separation, a woman immerses herself in the ritual bath (mikvah). After this, the couple is expected to resume all physical and sexual contact. The incorporation of these laws and attitudes, including the fundamental concept of monthly sexual abstinence and renewal between

husband and wife, has been cited as a key factor in promoting and maintaining Jewish marital and familial happiness (Lamm, 1987). While two thirds of respondents in the aforementioned Friedman et al. (2009) study on Orthodox Jewish women and sexual life indicated that the experience of ritual immersion in a mikvah was religiously enhancing, many women cited anxiety about the turning on and off of physical intimacy and the required sexual relations on mikvah night. Our treatment considered these findings in the light of Chani and Yossi's experience. Chani expressed that she felt resentful that when she was in her Niddah period, Yossi paid less attention to her, yet became emotionally available as she was about to undergo ritual immersion. She also expressed anxiety about mikvah night as representing the resumption of failed opportunities for sexual relations and conception. For his part, Yossi expressed his difficulty as well with turning himself on and off, explaining that when he was unable to touch Chanie, he preferred to refrain from emotional intimacy as well, as containing his desire for her was difficult. These expressions allowed the treatment to focus on helping Chanie and Yossi enhance their emotional communication during the Niddah period, and to reduce anxiety about mikvah night expectations.

Within marriage, Jewish law considers the fulfillment of sexual desire between the couple as positive elements of the relationship and both spouses are expected to fulfill each other's desire for intimacy. Few rules dictate the actual nature of sexual activity between a husband and wife and the general consensus is that any sexual act that does not involve deliberate ejaculation of semen outside the woman's vagina is permissible (Ribner & Rosenbaum, 2007). Fear of ejaculation outside the context of sexual intercourse was a significant factor contributing to anxiety in the couple, particularly as related to the exercises that were provided that proscribed intercourse. The effect of ejaculation restrictions on sex therapy has been discussed in the literature (Ribner, 2004). We presented to the couple our willingness to work within the confines of their religious dictates, but reported to them that in our experience, consulting with the rabbi on how to best approach these restrictions had proven to be helpful in the past. The couple's rabbi with whom they consulted, reduced their anxiety regarding extravaginal penetration and provided ideas to circumvent this restriction without compelling Chanie to experience pain or give up on her necessary boundaries.

While a behavioral approach is sometimes sufficient, usually couples dynamics must be explored. In dealing with traditional marriages, the literature has suggested the sociological theory of exchange as a relevant therapeutic tool (Rosenbaum, 2009). 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). Trust and commitment are key concepts in social exchange theory. While in most cases a woman's inability to allow penetration, despite her desire to do so, stems from fear of pain,

complete trust in her partner is necessary for this to occur. This trust is established on the basis of behaviors 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. Chanie's ability to become vulnerable and trust Yossi emerged from exploring this couple's dynamic. This reached a catharsis as Chanie was able to trust Yossi with the incident that likely triggered her fears around sex. Yossi's ability to contain Chanie was crucial in establishing the safe environment with Yossi that she needed in order to allow him inside her.

CONCLUSION

This case represents a glimpse into a unique faith-based community. Working with this community requires the therapist to suspend judgment and work within the confines of the clients' cultural milieu. This case also represents an interdisciplinary approach that considered and addressed all the following contributors including lack of education, lack of body awareness in both partners, systemic anxiety, vaginismus with accompanying pelvic floor dysfunction, erectile difficulties, and the effect of a traumatic childhood sexual experience. Treatment interventions included psychoeducation, behaviorally based sex therapy, psychodynamic exploration, and mindfulness-based physical therapy. We believe that the strength of our interventions is based on the integrated team approach and the availability of all the necessary services onsite in our interdisciplinary rehabilitation center (Heruti & Ohry, 2005).

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