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MODESTY RULES:

CONDUCTING SEX THERAPY WITH ULTRA-ORTHODOX JEWISH COUPLES

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ABSTRACT

Since the introduction of sensate focus in the 1960s, sex therapists have relied on this original model for the treatment of sexual disorders. Sensate focus requires abstinence from sexual intercourse during the initial stages of therapy and suggests specific activities such as masturbation during later stages of therapy. The religious beliefs of Ultra-Orthodox (Haredi) Jews include specific guidelines for sexual behavior which are often incongruent with standard treatment protocols for sex therapy. Therapists working with the Ultra-Orthodox will increase the likelihood of successful treatment outcomes if they demonstrate respect for the values and mores of their patients, are willing to work within their religious parameters and are able to effectively modify treatment protocols.

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INTRODUCTION

Religious beliefs are one of the many reasons that determine whether people experiencing sexual dysfunctions will seek treatment. Because of strict religious doctrine, those who need sex therapy may be reluctant to either seek out therapy or to fully benefit from the treatment. Research has shown that people who come from conservative religious backgrounds tend to be sexually inexperienced and lack fundamental knowledge about sexuality (Simpson and Ramberg, 1992). For some, religious orthodoxy plays a primary role in their sexual dysfunction and for others, a secondary role. Regardless, therapists who treat sexual dysfunctions in the religious orthodox must be sensitive to their patients' values and mores, be familiar with the teachings of the religion as they pertain to sex therapy, and be willing to effectively modify their treatment protocols to suit their patients' needs.

This purpose of this dissertation is to explore religious influence on the sexuality of Ultra-Orthodox Jews and the implications for conducting sex therapy with this population. The first chapter will explain who the Ultra-Orthodox Jews are and briefly describe the history of Jewish sexual intimacy norms. Chapter two will highlight factors which influence sex therapy with Ultra-Orthodox Jewish couples. The third chapter will point out specific considerations for therapists who work with Ultra-Orthodox Jews. Chapter four will introduce some of the pioneers of modern sex therapy and describe current treatment protocols for sexual dysfunctions. Finally, the fifth chapter will explain how to conduct traditional sex therapy for the treatment of various sexual disorders, as well as how to modify those treatments for Ultra-Orthodox Jews.

CHAPTER 1

HISTORY OF SEX IN JUDAISM

Nothing makes people as nervous as sex, or at least unregulated sex.

Berne, 1970

Ultra-Orthodox Jews

Ultra-Orthodox or Haredi (plural: Haredim) Jews are a subdivision of Orthodox Jews. The Ultra-Orthodox are divided into Hassidim which either follow a particular rabbi leader (or rebbe) or subscribe to a particular school of thought (b'nai yeshiva). The word Haredi means God fearing and refers to those who identify themselves as the most extreme of the Orthodox Jews. Strict observance of Jewish laws defines how the Ultra-Orthodox live their lives. They do not deviate from Biblical teachings and tend to favor stricter versus more lenient interpretations (Ribner, 2003). In order to remain true to their beliefs and lifestyle, the Ultra-Orthodox must "…maintain a social solidarity among themselves and a cultural distance from (and often a hostility toward) the surrounding larger secular society" (Heilman and Witztum, p. 525).

The following distinguish Ultra-Orthodox Jews from others: a particular mode of dress, such as wearing black hats, long ear locks, and caftans for men and modest clothing for women, including wigs or kerchiefs to cover shorn heads; living in segregated Haredi neighborhoods; attending gender-segregated schools; rigorous study of religious texts and daily prayer; speaking Yiddish; emphasis on marriage and family; specific rules regarding behavior before and after marriage; (Ribner, 2003; Heilman and Witztum, 1997).

Sexual intimacy norms

The emphasis on marriage and family has its biblical origins in Genesis. Two verses underscore the importance of getting married and having children: "It is not good for man to be alone" (Genesis, II, 18) and "Be fruitful and multiply" (Genesis, I, 28). In order to meet these requirements, the Ultra-Orthodox believe that sexuality should be scrupulously regulated (Heilman and Witztum, 1997). For instance, sex may only occur between a man and a woman who are married to each other, and is for the purpose of companionship and procreation. A couple has fulfilled their obligation to "be fruitful and multiply" when they have produced at least two children, ideally one boy and one girl (Onedara, 2008). Additionally, the husband has the obligation to ensure that his wife is sexually satisfied. In fact, great importance is placed on the sexual satisfaction of both spouses (Boteach, 1999). Further regulations state that ideally sexual intercourse should take place in the missionary position (male superior), with the lights turned out or dimmed, and during predetermined times of the month. Sexual relations are not permitted during menstruation or for five to seven days thereafter, as stated in Jewish Family Purity Laws (Daniels, 2009).

Jewish Family Purity Laws are based around a woman's menstrual cycle. Since sexual relations are not permitted during menstruation and for approximately one week thereafter, a woman is considered to be in a state of niddah (literally "to be separate") during this time. A woman ceases to be in a state of niddah following this timeframe only when she has immersed herself in a ritual cleansing bath known as a mikvah (from the root "to hope") (Slonim, 1995).

During the time that a woman is in a state of niddah, she and her husband do not have any physical contact with each other. Upon completion of the mikvah, the couple may once again resume sexual relations. Over time, this repeated cycle of separation, cleansing and

consummation purportedly heightens a couple's sexuality and aids in making their sex life a priority (Slonim, 1995). Compared to other American groups, those who follow the Family Purity Laws reportedly have the most active sex lives over the course of their lives (Kinsey, 1949).

With emphasis on regulating sexual activity and the obligation to produce children, the concept of family is very important to Ultra-Orthodox Jews. Historically, Jews have been a minority, and at times, a persecuted minority. Nearly six million Jews were put to death during the holocaust. A pervasive belief is that "the one and a half million children who died in the concentration camps need to be replaced, and families rebuilt" (Keshet-Orr, p. 221-222).

As strong as the concept of family is among Ultra-Orthodox Jews, one other concept rivals, if not surpasses it in importance: modesty. With regard to sexual intimacy norms, dress and behavior, the concept of modesty among Ultra-Orthodox Jews is key (Ribner and Rosenbaum, 2005; Keshet-Orr, 2003; Slonim, 1995). Originally, the early Hebrews did not have a word for sex or sexual intercourse. Rather, the term yahda (knowing) or yediah (knew) was used as in "Adam knew his wife Eve" (Genesis 4:1). Even today, the Hebrew language uses words such as pleasuring and engaging when describing the intimate relationship between a man and a woman (Walker, 1971). The role of modesty in sexual relations and the implications for conducting sex therapy will be discussed further in Chapter 2.

CHAPTER 2

FACTORS INFLUENCING SEX THERAPY WITH ULTRA-ORTHODOX JEWS

Individuals will follow the teachings of their religion when determining their own sexual behaviors and attitudes.

Lefkowitz, 2004

Lifestyle

Several factors influence the efficacy of sex therapy with Ultra-Orthodox Jews. These factors include the lifestyle of the Ultra-Orthodox, their emphasis on modesty, their religious beliefs and the religious or cultural background of the therapist working with them. To begin with, as previously mentioned, the Ultra-Orthodox Jews tend to live in Haredi neighborhoods for most, if not all, of their lives. Their children grow up attending gender-segregated schools and have very little outside influence in the form of television, movies, or magazines. Some may have received limited sex education at school but all other outside sources of media are generally not used to educate one about sexual matters (Daniels, 2009).

Because of the importance of getting married and producing children, the Ultra-Orthodox Jews favor marrying at a young age. The average age of engaged couples ranges from eighteen to twenty-one. Marriages are rarely prearranged anymore; however, most couples are introduced through family and then asked if there is any interest in the other person. If the answer is yes, they meet again approximately three times. Contact is not permitted during these meetings and occasionally a third party will be present. Shortly thereafter, an engagement is expected. If there is no interest, no relationship is pursued (Daniels, 2009; Ribner and Rosenbaum, 2005).

In more recent years, once a couple has become engaged they are permitted the use of premarital advisors to prepare them for their wedding night. Couples are expected to consummate their marriage the night of or shortly after their wedding (Ribner, 2003).

Because of limited sex education and little discussion in the home regarding sexual matters, there exists a basic lack of knowledge regarding sex. Additionally, due to lack of premarital contact resulting from religious mores, this population tends to be sexually inexperienced (Simpson and Ramberg, 1992).

Modesty

A second factor influencing the efficacy of sex therapy with Ultra-Orthodox Jews is the emphasis placed on modesty. The importance of modesty most likely comes from the biblical phrase "and you shall walk in modesty with your God" (Micah, VI, 8). Modesty is pervasive in the daily lives of the Ultra-Orthodox Jews as evidenced by their attire and behavior. Dressing conservatively (e.g. elbows and knees covered), having little information about sexuality, and a limited vocabulary to describe sexual organs and functions are examples of how modesty is ingrained in the lives of the Ultra-Orthodox Jews. However, on their wedding night (or shortly thereafter) a couple is expected to be completely naked with each other and consummate their marriage. In this case, the act of sexual intercourse may not feel very modest. In fact, it may feel uncomfortable and awkward. Sex therapists often rely on visual aids, language and treatment techniques that may not seem very modest to the Ultra-Orthodox population (Ribner and Rosenbaum, 2005).

Religious factors

A third factor influencing the efficacy of sex therapy with the Ultra-Orthodox Jews is that religious teachings restrict, forbid or regulate certain activities. To begin with, premarital sex is prohibited. As previously mentioned, Ultra-Orthodox couples spend very little time with one another before they become engaged. They are not allowed physical contact with each other and often will have a third party present. Therefore, the first time either one sees their spouse naked will most likely be on their wedding night. In fact, this is probably the first time either one has seen a member of the opposite sex unclad (Ribner, 2003). Therapists must be prepared to sensitively and tactfully educate Ultra-Orthodox couples about basic anatomy and physiology.

A second religious edict is that sex is for procreation. In Western culture, this is not necessarily the case. For the Ultra-Orthodox Jews, reproduction and pleasure are inextricably linked (Turner, Fox, and Kiser, 2007). Sex therapists must consider whether or not to prescribe sexual intercourse if it is for any other purpose than to produce children.

Third, masturbation and nocturnal emissions are prohibited because nonvaginal ejaculation is not sanctioned. Since procreation is one of the main purposes for sexual intercourse, there is no other acceptable receptacle for the ejaculate except the vagina. For pregnancy to result, the semen must be contained in the vagina (Ribner, 2003). Ejaculate that is non-vaginally contained is viewed as wasted and may be referred to as “destruction of seed” or “spilling of the seed” (Ribner, 2004, p. 304). This “destruction of seed” is an egregious transgression, equated with the taking of a life (Ribner, 2004). This prohibition precludes a sex therapist from recommending masturbation as a treatment modality.

Fourth, sexual intercourse may only take place during predetermined times. The Family Purity Laws dictate that sexual intercourse, as well as any other physical contact, may not take

place while a woman is menstruating. When menstruation ceases, the woman must wait five to seven days and then submerge herself in a ritual cleansing bath, the mikvah. Only then may sexual relations resume. This pattern of two weeks on and two weeks off is to continue until menopause (Ribner, 2003). Not only does this pattern preclude spontaneity for two weeks out of each month, but it may also interfere with recommendations by the sex therapist to engage in or refrain from sexual activity in order to remedy a dysfunction.

Finally, religious teachings state that the husband has a duty to satisfy his wife sexually. This is to be accomplished in the missionary position with the lights turned out or dimmed (Keshet-Orr, 2003). However, it may not be possible to sexually satisfy a woman in the missionary position. Treatment recommendations may be limited.

Perceptions of therapists

A fourth factor influencing the efficacy of sex therapy with Ultra-Orthodox Jews is the reluctance to seek help from therapists. Sex therapists tend to be less conservative and less traditional than their Ultra-Orthodox Jewish patients (Turner, Fox, and Kiser, 2007). This may lead to patients feeling misunderstood. Ultra-Orthodox Jews generally prefer to seek help from their religious advisors (Nassar-McMillan and Hakim-Larson, 2003). Religious advisors most often refer people to sex therapists for matters relating to fertility or for issues that threaten the integrity of a marriage. For instance, refusing to have sexual relations with one's spouse is grounds for divorce. Ultra-Orthodox couples are more likely to heed the advice of their rabbis and seek professional help for these types of issues (Blass and Fagan, 2001).

Another reason that Ultra-Orthodox Jews may not seek out professional help is the fear that therapists may suggest or promote changes, which are incongruent with their beliefs (Bergin,

1980). They may not trust therapists and may feel that therapists have ulterior motives. Simply seeking professional help from a therapist forces one to face the possibility that "the therapist may disapprove or devalue the religious way of life and try to deconvert the believer as part of the therapy" (Heilman and Witztum, p. 523). Furthermore, Ultra-Orthodox Jews will probably not attempt alternative treatments that in any way deviate from their religious traditions.

Finally, even the Ultra-Orthodox Jews who are open to seeking professional help may have a bias toward therapists who are not of the same cultural or religious background. They may feel that an outsider could not possibly understand them well enough to help and would actually prefer a therapist who shares their same religious views (Wolf and Stevens, 2001). An example of this would be the belief that only a Jewish therapist could understand the implications of a Jewish son marrying a Gentile (Watson, 1997).

CHAPTER 3

THERAPIST CONSIDERATIONS

I find that the harder I work, the more luck I seem to have.

Thomas Jefferson

Rabbis

The role of a rabbi in the Jewish community is to make decisions about issues pertaining to Jewish law and tradition. Couples may consult rabbis when questions arise about sexual functioning and Jewish law. Because of the emphasis on marriage and procreation, rabbis will exercise as much flexibility as possible to insure that satisfactory sexual functioning and procreation are made possible for couples (Ribner, 2004). As a result, clinicians who treat Ultra-Orthodox Jewish couples should consider developing a working relationship with rabbis, as doing so is likely to yield positive results. Therapists who have consulted rabbis in an effort to help their patients with sexual intimacy issues report gaining more lenient rulings on sexual intimacy norms (Ribner, 2004; Levine, 2004).

Therapists who choose to consult with rabbis in order to find appropriate treatments for their patients should be prepared to discuss the following details of treatment with the rabbi:

1. The most effective recommended treatment for the particular dysfunction; any alternate treatments and the implications of those treatments; any potential negative outcomes of treatment, particularly religious ones
2. The timeframe for treating the dysfunction; possibilities of worsening a condition; possibilities of non-compliance

3. Whether or not the course of treatment may exacerbate the problem before improvement is experienced
4. Implications of not treating the dysfunction
5. A willingness to recommend less effective treatments in order to remain within religious parameters (Ribner, 2004).

Religious beliefs & cultural norms

A second recommendation for therapists who work with Ultra-Orthodox Jewish couples is that they must be willing to work within the parameters of the couples' beliefs. Particularly in the areas of marital and sexual functioning, clinical integration of religious practices can have a positive effect (Thayne, 1997). First and foremost, therapists should inform their patients that, as a condition of therapy, they may consult their rabbi during any stage of therapy (Ribner, 2003). This will serve to reassure patients that therapists respect their religious way of life and are not out to deconvert them.

Second, therapists should be mindful of modesty as a cultural imperative when working with Ultra-Orthodox Jews. Modesty is more than a mode of dress for this population; it is ingrained in their culture and is very much a part of who they are and how they conduct their lives. Therapists must remain cognizant that the overwhelming majority of Ultra-Orthodox Jews will have had little or no premarital physical contact with the opposite sex. Even after couples are married and have begun sexual relations with each other, the experience of being completely naked with a member of the opposite sex may continue to feel unnatural. Therapists should offer empathic understanding and strive to normalize this potentially awkward situation. Therapists may consider suggesting a more modified form of sensate focus. (Sensate focus will be

explained in detail in chapter four). For instance, if a couple is initially uncomfortable being completely naked with each other, the therapist may suggest that they remain fully or partially clothed and simply exchange back rubs. Then they may progress to being naked from the waist up and exchange front and back caresses. From there, once their comfort level has increased, they may undress completely and engage in sensate focus. This will allow some sense of modesty and control as couples become more comfortable with each other (Ribner, 2003).

Additionally, therapists must use professional judgment to distinguish between normal responses to previously prohibited behaviors, which are now permitted in marriage, and the use of modesty as a means of control (i.e. to create physical distance from spouse). A certain amount of apprehension about sex is to be expected; however, consultation with a rabbi may be necessary "when the invocation of modesty serves a dynamic rather than sacred function…" (Ribner, 2003, p.168).

Third, therapists working with Ultra-Orthodox Jewish couples must structure interventions in accordance with Family Purity Laws. This means honoring the cycle of two weeks of permitted sexual and physical contact followed by two weeks of physical separation/sexual abstinence. Therapists should emphasize the benefits of the two week break and help couples to make the most effective use of that time. For instance, the regular two week breaks can create a natural transitional period from one phase of treatment to the next. Additionally, knowing that there is a definite stopping point for activities may serve to decrease anxiety over new activities that are still somewhat uncomfortable. The time of separation is an opportunity for couples to focus on and enhance other aspects of their relationship. Studies have shown that observing the two week on/two week off cycle may serve to heighten sexual passion, enhance sexual intimacy, and create greater fidelity between couples (Blass and Fagan, 2001).

Furthermore, the two week break ensures that the therapist will not inadvertently prolong a phase of treatment (Slonim, 1996; Ribner, 2003).

Finally, therapists should anticipate a limited range of vocabulary for sexual terminology and possibly poor communication skills regarding sexual matters (Keshet-Orr, 2003). Words that describe sexual organs and sexual functioning are not common to the Ultra-Orthodox Jews. Metaphoric phrases referencing sexual acts and organs are abundant in Jewish religious literature. Examples include *the organ* to describe a penis and *that place* to describe a vulva or vagina (Ribner, 2003, p. 169). Therapists need to be aware that using explicit sexual language may provoke anxiety in some Ultra-Orthodox Jews. A therapist should gauge a couple's comfort level with sexual terminology before assigning any exercises. If necessary, the therapist should help the couple find suitable, agreed upon terminology. Additionally, underscoring the influence of modesty once again, therapists should know that Ultra-Orthodox women are socialized to be less verbally expressive about sexual matters as compared to the men (Ribner, 2003).

Sensitivity to values

Therapists working with Ultra-Orthodox Jews should make every effort to avoid disregarding or debasing their values and beliefs. Heilman adequately described a value-sensitive approach as one that:

> both respects and leaves intact the values of religious patients (even when these seem to conflict with the general world view and common goals associated with contemporary psychotherapy) and at the same time treats the patients by making use of the idioms, symbols, and culture from which they come to help them resolve the problem that has stimulated them to seek help (Heilman and Witztum, p. 524).

Therapists can practice value-sensitive therapy by being free from bias and open to patients of different cultures. They can familiarize themselves with the culture and philosophies

of the Ultra-Orthodox populations and appreciate the experiences of individuals from other traditions and backgrounds (Turner, Fox, and Kiser, 2007).

CHAPTER 4

SENSATE FOCUS

Sex should be a treat for all the senses: sight, sound, smell, taste, temperature, and touch.

Berne, 1970

Masters and Johnson

To better understand how to conduct sex therapy with Ultra-Orthodox Jews, it is first necessary to understand how traditional sex therapy operates. This chapter will familiarize the reader with some of the pioneers of modern sex therapy, highlight their contributions to this field and briefly explain what sensate focus is and how it is applied in the treatment of sexual disorders.

The field of sex therapy was revolutionized in 1970 with the publication of *Human Sexual Inadequacy* by William Masters and Virginia Johnson. Masters and Johnson were a research team at the Department of Obstetrics and Gynecology at Washington University in St. Louis, Missouri. Their research centered on treating sexual dysfunctions and studying the human sexual response cycle, which they described as excitement, plateau, orgasm and resolution. The procedures outlined in *Human Sexual Inadequacy* offered a brief, structured and widely successful approach to sexual dysfunctions. The procedures were simple but the program was intensive. The program was conducted over a two week period in which couples, referred to as marital units, participated daily (Barlow and Durand, 2002). Masters and Johnson referred to this treatment as Conjoint Marital-Unit Therapy and insisted on treating the couple as a unit because “there is no such thing as an uninvolved partner in any marriage in which there is some

form of sexual inadequacy" (Masters and Johnson, p. 2). A male and female co-therapist team worked together to facilitate communication between the participants. Masters and Johnson were the first co-therapist team. The therapists provided basic sex education, debunked misconceptions about sex, increased communication between couples and most importantly, diminished sexual performance anxiety by removing the fear of failure. They accomplished this task through sensate focus and nondemand pleasuring (Barlow and Durand, 2002).

Sensate focus is a learning experience in which couples cease sexual intercourse for a specified period of time (i.e. a few days or a few weeks) and concentrate on pleasurable sensations derived from caressing and fondling each other's bodies and genitals (Kaplan, 1974). Intercourse is prohibited to prevent focusing on one's sexual performance and thus, provoking anxiety. Fear of failure is removed because orgasm and sexual intercourse are not the purpose of the exercise. Nondemand pleasuring is a method to reawaken sexual arousal through fondling and caressing. Again, intercourse is prohibited in order to reduce anxiety brought on by the need to perform sexually (Barlow and Durand, 2002).

Masters and Johnson would begin their two week intensive program with a couple by giving an overview of the program and by completing an intake interview. Then each participant would be interviewed separately by the same-sex therapist and asked detailed questions about their sexual history and medical history. The following day, the opposite-sex therapist repeated the interview. Discrepancies in interviews gave indications to problem areas. On the third day of treatment, Masters and Johnson would meet with the couple to talk about their discoveries. Then the couple was instructed to begin implementing sensate focus and nondemand pleasuring. The couple would meet with the co-therapists daily to discuss their progress and/or any areas of concern (Masters and Johnson, 1970).

Masters and Johnson prepared the couple for sensate focus and nondemand pleasuring exercises by explaining how the process works. The couple was told to practice the exercises unclothed in the privacy and comfort of their room (in this case, the room they were provided by Masters and Johnson). There was to be a minimum of stress and no outside interruptions. No specific timeframe for the duration of each exercise was given. Instead, the couple was instructed to engage in the exercises for however long they wished, but not to the point of frustration or fatigue. One partner was chosen by Masters and Johnson to initiate the exercise. The initiator was told to approach the other partner and begin with light touching, caressing and fondling. If preferred, massage oils or lotions could be used. The receiving partner was simply to enjoy the sensations and to indicate on which areas of the body he or she wished to be touched. Breasts and genitals were to be excluded from touch and the exercises were not to culminate with sexual intercourse until instructed by Masters and Johnson. The following day, the co-therapists would meet with the couple to discuss what happened. The next instruction was for the recipient to become more active in the exercise by placing his or her hand over the initiator's hand and by guiding the hand to indicate where to touch. At this point, breasts and genital areas are included in areas to touch (Masters and Johnson, 1970).

Dr. William Granzig of the American Academy of Clinical Sexologists describes the following modifications to Sensate Focus in his course outline for the Clinical Treatment of Male Sexual Dysfunctions (Granzig, 2004).

Sensate Focus I

The purpose of this exercise is to use one hour, two or three times per week, to give and

receive *nongenital* touching without leading up to intercourse and to focus on the sensation of being touched, rather than sexual goals. In both parts of this exercise you and your partner will have an opportunity to get and give a body rub involving different types of touching, stroking, and massaging. In the second half of the exercise you will get a chance to teach your partner what you enjoy and how you want to be touched. You will also learn about your partner's preferences and how it feels to give physical pleasure. In both parts of the exercise, touching is to be an end in itself and not a prelude to intercourse or anything else. The goal is to feel comfortable giving and receiving physical pleasure, *not* to produce sexual excitement or orgasm.

Before you begin, agree on a time for this exercise. Two 30-minute blocks of time during the same day are suggested. They can be back to back, but because the receiver may not immediately be ready to give, you may agree to schedule an hour break before switching roles. As always, plan the session for a time when you will not be interrupted and choose a location that is warm and offers both privacy and comfort.

PART ONE

Flip a coin to determine who will *receive* first. Both giver and receiver undress and the receiver lies face down (but will turn over midway through the receiving half hour). If the receiver wants to try it, a lubricant such as hand lotion, massage oil, or baby powder may be used. The giver touches, strokes, and rubs the receiver's body, doing whatever the *giver* thinks of trying. Although there is a lot of leeway to try different types of touching, when you are the giver, keep your touch relatively light, avoiding the heavy kneading of deep muscle massage, which could cause discomfort.

The giver is *not* to touch the receiver's genitals or breasts, or his or her own. The giver is to focus on touching, exploring the receiver's body, and discovering what the *giver* likes to do.

The receiver is to focus on the sensations created by the giver's touches, noticing what is particularly pleasurable, neutral, or un-enjoyable. The receiver should use the ways of communicating described in the last exercise to provide the giver with feedback on the experience of being touched. This feedback is important and will enable your

partner to touch you in the most pleasing way in the future. The receiver should remember to turn over, in order to receive touching on both sides of the body.

After thirty minutes, partners switch roles. When both have taken their turns as giver and receiver, the exercise is over. Partners should then take some time to discuss their feelings and reactions, including what they thought about remaining passive while receiving and being "in control" while giving.

REMEMBER--even if you become sexually aroused, you and your partner are not to have intercourse, nor should you attempt to have orgasms during the experience.

PART TWO

After you and your partner have repeated Part One of this exercise twice-alternating who receives first-you can move on to Part Two.

Do exactly what you did in Part One (including not touching genitals or breasts), only this time the *receiver* is in complete control, instructing the giver on where and how to touch. The giver simply follows these instructions.

The receiver should use this opportunity to find out what feels enjoyable, giving in to any curiosity about being touched in certain ways or in certain places that do not usually get touched. It is the receiver's responsibility to make sure that they get touched the way they desire, even if this means repeating instructions several times. Hand guiding, described in the last exercise, may be useful, especially if it's hard to verbalize at first.

The giver should do everything asked unless the request causes special discomfort. Again, switch roles after thirty minutes and discuss the experience afterward, especially your reactions to giving and following instructions, being in charge, or doing what was asked of you.

After you have done both parts of this exercise twice without encountering problems, you can proceed.

Sensate Focus II

This exercise is identical to the previous one, with one exception--this time genital and breast touching is included.

Again, with your only goal being to learn for yourselves and teach each other what feels good, you and your partner will take turns touching and stroking each other's body *as well as* your own genitals or breasts.

As in Sensate Focus I, the first two times you do this exercise the *giver* will be in charge. As the giver, you should explore, caress, stroke, and "play with" your partner's body in any way you desire. Try to figure out what pleases you. As the receiver, unless your partner does something that hurts you or makes you very uncomfortable, you are to remain passive, focusing your attention on your own responses. If both of you feel comfortable with it, the giver can use mouth as well as hands on any part of the receiver's body.

After you have done the exercise twice with the giver in charge, it is time to turn over the controls to the receiver. As the receiver, you will tell your partner where and how to touch you, as well as indicating how you are responding to different touches. As the giver, you will do what your partner asks of you, unless you feel uncomfortable with the request.

Following each Sensate Focus II session, after both of you have given and received, discuss your experience-recognizing that more intense feelings are likely to come up now

that you are experiencing genital and breast touching.

From: *Clinical Treatment of Male Sexual Dysfunctions* by Dr. William Granzig.

Masters and Johnson reported a near 100% success rate in the treatment of premature ejaculation using sensate focus. Premature ejaculation is one of the easiest male sexual disorders to treat (Kaplan, 1987). Although the rate of recovery differs depending on the particular sexual disorder, Masters and Johnson reported that the vast majority of their 790 participants improved significantly or recovered (Barlow and Durand, 2002). Other specialty sexuality clinics who

base their treatments on Masters and Johnson's methods also report high percentages of improvements in their patients, though not as high as the percentages reported by Masters and Johnson. This is most likely due to the original screening process that Masters and Johnson employed. Their marital units were required to fly to St. Louis, commit to a two-week intensive program, and to follow instructions implicitly. This required money, time, and dedication (Granzig, 2004).

Pioneers

Another major contributor to the field of sexology was James Semans. Semans introduced the stop/start technique, sometimes referred to as the squeeze method, to the treatment of premature ejaculation. The squeeze technique works by stimulating the penis, either by self or a partner, to a nearly full erection. Then the partner firmly squeezes the frenulum, where the head of the penis joins the shaft, to decrease arousal. This method is repeated until the male partner (of a heterosexual couple) is able to briefly insert his penis into the vagina without thrusting. If arousal occurs too quickly, the penis is removed and squeezed. This method helps men to become aware of and better able to control their arousal levels and ejaculations. Success rates for premature ejaculation over the past twenty years have been reported between 60% and 90% using this method (Durand and Barlow, 2002).

Critics

Although sensate focus provided an original model for the treatment of sexual dysfunctions and has been the backbone of modern sex therapy, it is not without critics. The late Helen Singer Kaplan, another pioneer in the field of sex therapy known for establishing the first

clinic for sexual disorders at a medical school, questioned Masters and Johnson's advocacy for co-therapists in the treatment of sexual dysfunctions. Kaplan believed that one therapist would suffice (Kaplan, 1974).

Another outspoken critic of Masters and Johnson's methods is Dr. Stephen Lipsius, an Associate Clinical Professor of Psychiatry and Behavioral Sciences and of Obstetrics and Gynecology at George Washington University School of Medicine. Lipsius challenges the need in sex therapy to proscribe intercourse. He believes that proscription is an excessive restriction which often leads couples to drop out of treatment. Lipsius advocates a more moderate proscription when treating certain sexual dysfunctions (Lipsius, 1987).

Over the years, sensate focus has proven beneficial in the treatment of sexual dysfunctions, whether its methods are followed exactly as Masters and Johnson intended or conducted with modifications.

CHAPTER 5

MODIFICATIONS IN THE TREATMENT OF SEXUAL DYSFUNCTIONS FOR ULTRA-ORTHODOX JEWISH COUPLES

Sensate focus encourages an openness—physically and emotionally—that can be perceived as antagonistic to the value of modesty.

Ribner, 2003

Moderate vs. total proscription of sexual intercourse

This chapter will examine prescribing sensate focus, the most prominent, identifiable treatment intervention mentioned in the literature, without prohibiting sexual intercourse in the treatment of sexual dysfunctions with Ultra-Orthodox Jews. This includes a consideration for moderate proscription versus total proscription of sexual intercourse. Moderate proscription allows a couple to proceed with sexual intercourse if they so choose while engaging in sensate focus exercises. However, the couples are informed that for the best results, they should not proceed with sexual intercourse until instructed by the therapist. A total proscription of sexual intercourse implies that under no circumstances should a couple engage in sexual intercourse until given permission by the therapist. Finally, modified treatments of various sexual disorders, which are congruent with the religious beliefs of Ultra-Orthodox Jews, will be presented.

Since the introduction of sensate focus by Masters and Johnson, it has been standard practice in the treatment of sexual dysfunctions to prescribe sensate focus. Until 1979, this practice appears to have gone unquestioned (Lipsius, 1987). A few practitioners have since questioned the efficacy of a ban on sexual intercourse that accompanies sensate focus. Some clinicians believe that a total ban on intercourse may be detrimental to some couples (Lipsius, 1987) while others found that proscribing intercourse did not contribute to the effectiveness of

encouraging sexual communication between couples (Takefman and Brender, 1984). Even Kaplan stated, "Couples who have good sexual rapport may be instructed to engage in coitus at the outset" (Kaplan, 1974, p. 401).

When treating Ultra-Orthodox Jewish couples, therapists roughly have a two-week window each month in which they can prescribe sexual activity in order to comply with religious sanctions. Depending on the reason for which the couple is seeking treatment, the therapist may proscribe intercourse for a few days, a few weeks, or even longer. Banning sexual intercourse during the time period in which Ultra-Orthodox Jewish couples may engage in sexual activity, may not be acceptable to them or their rabbis. For instance, regardless of how difficult, painful, or impossible it may be to engage in sexual intercourse, some couples may feel that it is their duty to *attempt* intercourse in order to fulfill their obligations of procreation and companionship. In this type of situation, the therapist must respect the patients' wishes and suggest a more moderate proscription, even though doing so may yield minimal improvement and/or prolong recovery (Keshet-Orr, 2003; Lipsius, 1987). Ultimately, when working with Ultra-Orthodox Jews, sensate focus exercises need to be individualized and the proscribing of intercourse also needs to be individualized.

Moderate proscription

If standard treatment protocol for sexual dysfunction is sensate focus, which implies a total proscription of sexual intercourse until advised by the therapist, when should a therapist prescribe sensate focus with a moderate proscription on sexual intercourse? The following are a list of sexual disorders that may be treated successfully with moderate proscription of sexual intercourse. These apply to Ultra-Orthodox Jews as well as secular populations:

1. Female Sexual Arousal Disorder
2. Male Erectile Disorder
3. Female Orgasmic Disorder
4. Male Orgasmic Disorder (Lipsius, 1987).

Total proscription

Total proscription of sexual intercourse is recommended when treating the following:

1. Premature Ejaculation
2. Vaginismus
3. Dyspareunia (Lipsius, 1987).

Total proscription is preferable initially, as there is an automatic involuntary reflex response which must be managed with certain methods (i.e. stop-start/squeeze and desensitization/dilation) before satisfactory sexual intercourse is possible. The most difficult sexual dysfunction to treat for Ultra-Orthodox Jewish males is premature ejaculation. Premature ejaculation is defined as "Persistent or recurrent ejaculation with minimal sexual stimulation before, on, or shortly after penetration and before the person wishes it" (DSM-IV-TR, p. 554). Interestingly, premature ejaculation is the most common male sexual dysfunction and one of the *easiest* disorders to remedy in secular societies (Durand and Barlow, 2002). The reason premature ejaculation is problematic to treat in Ultra-Orthodox Jewish men, is that treatment protocol recommends masturbation with extra-vaginal emission and intercourse in the female superior position, neither of which are sanctioned. A typical treatment recommendation for premature ejaculation (for non-Orthodox Jewish patients) would be as follows:

1. The husband lies on his back while the wife masturbates him and he is instructed to focus on the sensations.
2. When he feels that orgasm is near, he instructs his wife to stop masturbating him and to squeeze his penis at the frenulum until the urge to ejaculate abates.
3. After the urge to ejaculate has passed, he instructs his wife to continue masturbating him.
4. Once again, when the urge to ejaculate is near, he asks her to stop and squeeze.
5. This exercise is repeated four times. On the fourth trial, he does not ask his wife to stop and ultimately ejaculates.
6. After successfully repeating this exercise (step one through five) two times, the wife then introduces a lubricant, which is designed to be more arousing.
7. After three or four successful completions using the lubricant, the couple is ready for sexual intercourse. The wife assumes the female superior position and allows the husband to guide her hips and to set the rhythm.
8. When he feels the urge to ejaculate, he stops guiding her and waits for the urge to pass.
9. After three or four successful attempts in the female superior position, the couple may then try sexual intercourse in the side-by-side position.
10. Intercourse in the male superior position is reserved for last, as it is the most difficult position from an ejaculatory control point of view.

The couple can expect positive results in two to ten weeks. From then on, the couple is instructed to continue the exercises at least once each week (Kaplan, 1987).

Modified sensate focus for premature ejaculation

The next modified recommendations for the treatment of premature ejaculation apply to Ultra-Orthodox Jewish couples:

1. Instruct the couple that at any point during the sensate focus exercises if the husband reaches his arousal threshold, they may engage in full sexual intercourse.
2. Since ejaculate must be vaginally contained and the husband is not permitted to masturbate himself, instruct the wife to masturbate her husband and apply the squeeze technique when orgasm is close. (An alternate suggestion will be given if the wife is unwilling to masturbate her husband. See #6).
3. After several successful attempts of heightening and reducing sexual excitement, the wife is instructed to use the basilar squeeze technique (i.e. squeezing the penis where the shaft meets the body) while quickly inserting the penis into her vagina to avoid reaching orgasm prior to penetration.
4. The husband may then ejaculate intra-vaginally.
5. The exercises should be repeated often so that the husband begins to recognize and gain control over his ejaculations.
6. In the event that the wife refuses to masturbate her husband, instruct the couple to commence with non-genital sensate focus exercises.
7. As the husband becomes aroused and orgasm is near, stop the exercises until his arousal level has subsided. Then continue with non-genital sensate focus exercises several more times.

8. As the husband becomes aroused and ejaculation is imminent, instruct the wife to use the basilar squeeze technique to quickly insert the penis into her vagina and allow the husband to ejaculate intra-vaginally (Ribner, 2003).

Ultra-Orthodox Jewish couples should be informed at the onset of treatment that if the penis is not inserted into the vagina soon enough, extra-vaginal emission is possible. They should be advised to consult their rabbi and discuss possible ramifications for this occurrence. Additionally, couples should consider consulting their rabbi to determine if any other sexual positions, besides male superior, are sanctioned. If a couple is trying to conceive and premature ejaculation (or erectile dysfunction) is preventing the couple from engaging in sexual intercourse, some rabbis may consider sanctioning extra-vaginal ejaculation. Extra-vaginal ejaculation may be permissible in rare cases, provided that (1) it is not used for contraceptive measures and/or (2) premature ejaculation is so problematic that a couple will not be able to procreate without successful resolution of this disorder (Ribner, 2004). As previously mentioned, standard treatment protocol for premature ejaculation is total proscription of sexual intercourse; however, when treating Ultra-Orthodox Jewish couples, modifications are necessary in order to remain within religious parameters.

Vaginismus

The next sexual disorder for which treatment protocol recommends total proscription of sexual intercourse is vaginismus. Vaginismus is defined as "Recurrent or persistent involuntary spasm of the musculature of the outer third of the vagina that interferes with sexual intercourse" (DSM-IV-TR, p. 558). A diagnosis of vaginismus is typically "made during routine gynecological examinations when response to pelvic examinations results in the readily observed

contraction of the vaginal outlet" (DSM-IV-TR, p. 557). However, this is not always the case. In the Ultra-Orthodox Jewish community, it may be the inability to consummate a marriage (versus a routine exam) that leads a couple to consult their rabbi, once again underscoring the importance of sexual satisfaction and procreating (Ribner and Rosenbaum, 2005).

The treatment for vaginismus is the same for both secular and Ultra-Orthodox Jewish women: desensitization and dilation. Usually a licensed medical professional will begin by inserting a finger into the vagina. Next, a small dilator is inserted. Then, a slightly larger dilator is inserted. The dilators increase in size until the patient can have sexual intercourse without experiencing vaginal spasms and pain. This course of treatment takes approximately two weeks before vaginismus is cured. Individual results will vary (Katz, 2009). Occasionally, a woman's hymen will be too thick to be comfortably penetrated by a penis and she will have to seek medical assistance to break through the hymen (Daniels, 2009).

Sex therapists may be the first people in which some women will confide when they experience painful intercourse or are unable to have sexual intercourse (Katz, 2009). Vaginismus may negatively affect current relationships or be the reason that some women avoid developing new relationships. To diagnose vaginismus, a therapist should ask a woman if she is able to comfortably tolerate the following in her vagina:

1. Finger
2. Tampon
3. Applicator (e.g. applicator used in the treatment of yeast infections)
4. Pelvic exam speculum
5. Penis or dilator

A diagnosis of vaginismus is given if a woman answers *no* to any one item or combination of items listed. If she answers *yes* to all of the questions, she will not be diagnosed with vaginismus (Katz, 2009).

Dyspareunia

The third sexual disorder in which total proscription of sexual intercourse is recommended is dyspareunia. Dyspareunia is defined as "Recurrent or persistent genital pain associated with sexual intercourse in either a male or female" (DSM-IV-TR, p.556). Dyspareunia is "rarely a chief complaint in mental health settings" (DSM-IV-TR, p. 555). Typically, patients seek medical attention for this disorder. They are referred to therapists when no abnormalities are found. The genital pain reported by these patients may cause them to avoid sexual relationships, disrupt current relationships, or prevent them from developing new relationships (DSM-IV-TR). These are the issues that therapists will address in therapy with secular and Ultra-Orthodox Jewish patients.

Other sexual disorders that may require modifications to standard treatment protocols for the Ultra-Orthodox populations include Male Erectile Disorder (Erectile Dysfunction), Male Orgasmic Disorder (Retarded Ejaculation), Female Sexual Arousal Disorder, and Female Orgasmic Disorder.

Modified sensate focus for Male Erectile Disorder

Male Erectile Disorder is defined as "Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate erection" (DSV-IV-TR, p. 547). The treatment protocol for erectile dysfunction calls for masturbation and extra-vaginal orgasm,

which suggests that this sexual disorder requires some modifications to be acceptable for Ultra-Orthodox Jewish couples. Standard treatment recommendations include:

1. Sensate focus I and II, which usually leads to a partial or full erection
2. Achieving an erection without ejaculating
3. Extra-vaginal ejaculation
4. Inserting the penis into the vagina without ejaculating
5. Sexual intercourse with intra-vaginal orgasm (Kaplan, 1987).

Modified treatment recommendations for Ultra-Orthodox Jewish couples include:

1. Sensate focus I and II
2. Achieving an erection without ejaculating, as wife manually stimulates husband's penis; consult rabbi if wife is opposed to manual stimulation
3. Inserting the penis into the vagina without ejaculating
4. Sexual intercourse with intra-vaginal orgasm.

Modified sensate focus for Male Orgasmic Disorder

Male Orgasmic Disorder (Retarded Ejaculation) is defined as "Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase during sexual activity that the clinician, taking into account the person's age, judges to be adequate in focus, intensity, and duration" (DSM-IV-TR, p. 552). The treatment protocol for Male Orgasmic Disorder calls for masturbation in the presence of one's partner before graduating to sexual intercourse with ejaculation. Treatment recommendations include:

1. Sensate focus I and II

2. Masturbation in the presence of a partner
3. Sexual stimulation with concomitant distraction
4. Sexual intercourse with ejaculation (Kaplan, 1987).

Besides the suggestion to masturbate in the presence of one's partner, an additional problem for those suffering from delayed orgasm is that the female partner may become sore or uncomfortable if intercourse lasts for an extended period of time. At this point, the male typically withdraws his penis and ejaculates extra-vaginally. For Ultra-Orthodox Jewish couples, the following modifications are recommended:

1. Sensate focus I and II
2. Allow the wife to manually stimulate the penis; if wife is opposed to masturbating her husband, consult with a rabbi
3. Sexual stimulation with concomitant distraction
4. Sexual intercourse with ejaculation.

Modified sensate focus for Female Orgasmic Disorder

Female Orgasmic Disorder is defined as "Persistent or recurrent delay in, or absence of, orgasm following a normal sexual excitement phase" (DSM-IV-TR, p. 549). The treatment protocol for Female Orgasmic Disorder calls for masturbation alone, as well as masturbation in the presence of a partner. While masturbation is prohibited for men, it is not prohibited for women (Daniels, 2009). Standard recommendations include:

1. Sensate focus I and II
2. Masturbation to orgasm while alone

3. Masturbation with a partner
4. Sexual intercourse with orgasm (Kaplan, 1987).

Modified treatment recommendations for Ultra-Orthodox Jewish couples are:

1. Sensate focus I and II
2. Husband manually stimulates wife or uses a vibrator to masturbate his wife in the event that she is uncomfortable masturbating herself; consult a rabbi regarding permission to use sexual aids
3. Sexual intercourse with orgasm.

Modified sensate focus for Female Sexual Arousal Disorder

Female Sexual Arousal Disorder is defined as "Persistent or recurrent inability to attain, or to maintain until completion of the sexual activity, an adequate lubrication-swelling response of sexual excitement" (DSM-IV-TR, p. 544). The treatment protocol for Female Sexual Arousal Disorder calls for sex in the female superior position. Standard recommendations include:

1. Sensate focus I and II
2. Nondemand intercourse in female superior position (i.e. female is in complete control of all movement and is to focus on herself and her own sensations)
3. Sexual intercourse to orgasm (Kaplan, 1987).

Modified treatment recommendations for Ultra-Orthodox Jewish Couples include:

1. Sensate focus I and II
2. Nondemand intercourse in any acceptable position for the female; consult rabbi if unclear about rulings on female superior position or side by side position

3. Sexual intercourse to orgasm.

In each of the previous treatment protocols, masturbation is a standard recommendation. With the emphasis on vaginally contained ejaculate for the Ultra-Orthodox Jews, alternate treatment recommendations are necessary. In some instances, either spouse may be opposed to masturbating the other. Consultation with a rabbi is critical at this juncture, as effective treatments are limited in number. Therapists must also be prepared to accept that *some* improvements in their patients' conditions are better than *none.*

CONCLUSION

Sex therapists have been using sensate focus to treat sexual disorders since this model was first introduced in the 1960s. The religious beliefs of Ultra-Orthodox Jews include specific guidelines for sexual behavior which are often incongruent with standard treatment protocols for sex therapy. Because of strict religious doctrine, those who need sex therapy may be reluctant to pursue therapy. On the other hand, strict religious doctrine may very well be the reason that some Ultra-Orthodox Jews will seek out treatment. Because marriage and procreation are fundamental tenets, some Ultra-Orthodox Jewish couples may seek sex therapy on the advice of their rabbi if they are having difficulty consummating their marriage, difficulty conceiving, or unable to sexually satisfy their spouse.

Sensate focus is the most prominent, identifiable treatment intervention mentioned in the literature for treating Ultra-Orthodox Jewish couples. It is structured so that modifications can easily be made. Depending on the rabbi and his recommendations, Ultra-Orthodox Jewish couples will likely find a helpful, acceptable modification for virtually any sexual disorder when using sensate focus as an intervention. Additionally, it is worth noting that a majority of the literature covering Ultra-Orthodox Jews focused on the treatment of sexual disorders for men, but not for women. This is curious given that it is a husband's duty to satisfy his wife. An examination of additional treatment methods for this population would make an interesting topic for future research.

Therapists who wish to successfully treat sexual dysfunctions in the Ultra-Orthodox Jewish populations must be knowledgeable about Family Purity Laws, understand ejaculatory restrictions (i.e. ejaculate must be vaginally contained), and be willing to modify treatments to conform to religious teachings. Otherwise, they are likely to be met with resistance and/or be

ineffectual. Cultural or religious incongruence between patients and therapists do not necessarily make therapy impossible or unsuccessful; however, therapists must demonstrate sensitivity to the values of this population and understand the significance of modesty in their culture. While not all Jewish patients will present as Ultra-Orthodox, the strong cultural mores and religious beliefs of Judaism may nevertheless be an integral part of who they are. That is, religion informs sexuality.

This dissertation focuses specifically on sex therapy with Ultra-Orthodox Jewish couples. It is beyond the scope of this paper to address conducting sex therapy with any other members of the Haredi community. For instance, sensate focus exercises for single Ultra-Orthodox Jews were not addressed. In accordance with their religious beliefs, sexual intercourse is only allowed between a married man and his wife. Therefore, sex therapy for Ultra-Orthodox singles was not addressed. Other non-sanctioned relationships which were excluded include mixed religious relationships, adulterous relationships, same sex relationships, and transgender or gender dysphoric relationships. This excludes a large portion of the population. Further research in this area would be warranted.

GLOSSARY

Haredi: Plural Haredim; "God fearing" and refers to those who identify themselves as the most extreme of Orthodox Jews; also referred to as Ultra-Orthodox

Family Purity Laws: Based around a woman's menstrual cycle; refers to timeframe in which couples may engage in sexual intercourse; intercourse is not permitted during menstruation or for five to seven days thereafter, and then only after the woman has immersed herself in the mikvah

Mikvah: "to hope"; a ritual cleansing bath taken monthly, five to seven days following the end of menstruation

Modified proscription: Regarding sensate focus, refers to the permissibility to engage in sexual intercourse before ideally being instructed to do by the therapist; used in the treatment of Ultra-Orthodox Jewish couples who must conform to religious guidelines

Niddah: "to be separate"; refers to a menstruating woman

Nondemand pleasuring: Technique to increase sexual arousal by fondling and caressing

Sensate focus: Sex therapy in which couples concentrate on pleasurable sensations from caressing and fondling. Intercourse is forbidden to prevent focus on sexual performance and the anxiety it may produce (Barlow and Durand, p. G-15).

Squeeze technique: Procedure in which a penis is stimulated to nearly full erection and then the frenulum is squeezed to reduce arousal

Stop/Start technique: Essentially the same as the squeeze technique; terms are often used interchangeably; As a male is learning to gain control over his ejaculatory response, he inserts his penis into his partner's vagina and controls the movement of her pelvis. To reduce arousal, he *stops* her pelvic movement, allows his excitement to drop, and then *starts* the movement again.

Total proscription: Regarding sensate focus, refers to abstaining from sexual intercourse until instructed to do so by the therapist

APPENDIX

Therapeutic Assessment Tool for Treating Ultra-Orthodox Jewish Couples

Questions are to be asked by the therapist when the presenting problem is a sexual disorder.

1. Reason for today's visit:

    Husband:

_____

    Wife:

_____

2. When and how did you first learn about sex?

    Husband:

_____

    Wife:

_____

3. Was sex ever discussed in the home while you were growing up?

    Husband:

_____

    Wife:

_____

4. How did you meet each other?

    Husband:

_____

Wife:

_____

5. How much time did you spend getting to know each other before getting married?

Husband:

_____

Wife:

_____

6. Describe any experiences of shame, guilt, or anxiety concerning sex:

Husband:

_____

Wife:

_____

7. How was your first sexual experience with each other?

Husband:

_____

Wife:

_____

8. Is your sex life satisfactory? If not, please explain:

Husband:

_____

Wife:

_____

9. Do you have children? If yes, how many? If no, is that a problem for you?

Husband:

_____

Wife:

_____

10. Do you observe the Family Purity Laws? Always? Sometimes? Never? Please explain:

Husband:

_____

Wife:

_____

11. Are you now or have you ever experienced low desire or no desire for sexual activity?

Husband:

_____

Wife:

_____

12. Do you experience any pain during sexual intercourse?

Husband:

_____

Wife:

_____

13. Do you experience orgasm with sexual intercourse? Always? Sometimes? Never?

Please explain:

Husband:

_____

Wife:

_____

14. Does sexual activity create anxiety for you?

Husband:

_____

Wife:

_____

15. (To wife) Are you able to maintain sufficient lubrication in your genitals during sexual activity? Always? Sometimes? Never? Please explain:

Wife:

_____

16. (To husband) Do you have difficulty attaining or maintaining an erection?

Always? Sometimes? Never? Please explain:

Husband:

_____

17. (To husband) Do you ejaculate before you wish to or before you are able to penetrate your wife?

Husband:

_____

18. What terminology do you use to refer to your sexual organs?

Husband:

_____

Wife:

_____

19. What other concerns do you have that I may not have mentioned?

Husband:

_____

Wife:

_____

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DISSERTATION APPROVAL

This dissertation submitted by Claudia M. Rieman has been read and approved by three faculty members of the American Academy of Clinical Sexologists.

The final copies have been examined by the Dissertation Committee and the signatures which appear here verify the fact that any necessary changes have been incorporated and that the dissertation is now given the final approval with reference to content, form and mechanical accuracy.

The dissertation is therefore accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy.

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