Toward A Jewish Ethic Regarding Female Sexual Dysfunction (FSD)

The cover of the most recent *Inside* magazine, Philadelphia's quarterly on Jewish life and style, has a picture of a harried-looking young woman sitting up in bed with her sleeping husband in the background. The picture is accompanied by the title "No Sex Please, We're Married." This eye-catching picture captures a reality acknowledged privately by many, but publicly by few. Creating and maintaining a healthy sex life are difficulties all couples face. Many factors contribute to this challenge. Notable among these factors, writes Sally Friedman, is fatigue resulting from a high percentage of dual-career couples, or "DINS" (Double Income, No Sex).[1] Child-rearing and many other stressors play into the picture, causing both genders to avoid sex. All of this is compounded by the inability of most couples (especially heterosexual couples) to communicate about sex.

We might be tempted to classify such difficulties as **sexual dysfunction**, much as we call a family dysfunctional when its members do not relate to each other as a functional family according to societal norms. Though we may be right in calling the couple's intersexuality (that is, the sexual relationship) dysfunctional, the term **sexual dysfunction** is a term that relates to an individual's sexuality. The Dr. Joseph F. Smith Medical Library defines **sexual dysfunction** as follows:

> Sexual dysfunction is broadly defined as the inability to fully enjoy sexual intercourse. Specifically, sexual dysfunctions are disorders that interfere with a full sexual response cycle.[2]

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[1] Friedman 61

[2] "Sexual Dysfunction." Dr. Joseph F. Smith Medical Library – Health Encyclopedia. 13 January 2005 (online source).

Knowledge of male sexual dysfunction has become widespread with the advent of Viagra. **Female sexual dysfunction** (henceforth FSD), on the other hand, has been experienced by many, but named by few. This is a problem for women who suffer sexual dysfunction and their sexual partners, who are left with little guidance from health professionals and the Jewish community as to how to deal with FSD. Ignoring FSD, or treating it as if it were a male sexual dysfunction, can have deleterious effects on women and partnerships. As the Jewish community values health, physical pleasure, stable partnerships, and is committed to the needs of its members, we, the Jewish community, should respond. In the course of this paper, we will explore the types and causes of FSD, and the issues that affect its place in public discourse. We will then review the Jewish responses and values regarding FSD, and finally, we will consider appropriate ethical responses to the naming and treatment of FSD. We will begin with some definitions.

FSD: A Primer

As we begin, we encounter some difficulty with definitions. **Dysfunction** assumes a normative model of function. **Dysfunction** as the Dr. Joseph F. Smith Medical Library defines it, assumes that normal sex means a full sexual response cycle.[3] For some, **sexual dysfunction** refers only to physiological barriers to sex that require medical intervention. We need to keep in mind as we proceed that our definitions of dysfunction are based on beliefs as to normal sexual function. Ideas about normative sexual practice are always culturally conditioned. For example, in the

[3]A model developed by Masters and Johnson, which has long been considered by sex therapists as the diagnostic model, has been critiqued by feminist scholars for its attempt to equate male and female sexual response.

Victorian era, a prominent physician recommended sex only twelve times a year.[4] For the purposes of this paper, we will consider as FSD all chronic conditions that impair a woman's desired sexual function that have at least one physiological component.

We must distinguish between **primary sexual dysfunction**, a dysfunction that has always existed, and **secondary sexual dysfunction,** a dysfunction that develops after a period of adequate functioning. **Secondary sexual dysfunctions** tend to have a greater psychological component than do **primary sexual dysfunctions,** but certainly may be caused by disease, disability, and use of certain drugs.[5] Sexual dysfunctions may be **global**, affecting all sexual situations, at all times, with all partners, or they may be **situational**, dependent on the type of activity, partner, time, or other factors.

One group of **FSDs** may be termed **sexual desire disorders**, which center around lack of interest in sex. **Desire disorders** range from **inhibited sexual desire (ISD)**, in which a person experiences a very low level of sexual desire, to **sexual aversion**, in which a person has a fear or disgust of sexual activity. **Sexual aversion** is most common when a person has experienced sexual abuse. Both **ISD** and **sexual aversion** are often **secondary.** Women are more likely than men to view an absence of desire as problematic in a relationship.[6] **Desire disorders** are considered among the most complicated sexual dysfunctions to treat. They are treated using a

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[4] Wolpe and Carroll 25

[5] Wolpe and Carroll 457-8

[6] Wolpe and Carroll 458-60

variety of techniques, including psychotherapy, hormones, and aphrodisiacs. Treatment tends to be highly individualized. However, much attention has focused recently on hormone therapy.[7]

Closely related to **desire disorders** are **sexual arousal disorders.** An arousal disorder is the persistent inability to attain or maintain sufficient sexual excitement, causing distress, which may be expressed as a lack of excitement, or lack of other physical responses.[8] The terminology is often confused or subsumed under **desire disorders**, as the **arousal disorders** are often secondary to **desire disorders**, or vice versa. Treatment may be similar to that of **desire disorders,** but may include use of aids such as the EROS Clitoral Therapy Device.[9]

Another group of **FSD**s have been called **sexual pain disorders.** Another name for **sexual pain disorders** is **dyspareunia,**[10] which refers to consistent genital pain associated with intercourse.[11] There are six types of **dyspareunia**, only two of which we will focus on. All involve pain upon vaginal penetration, but in different areas and for different reasons. **Vaginismus** involves involuntary contractions of the muscle surrounding the entrance to the vagina, making penetration virtually impossible. If it is **primary**, it may be as a result of an improper pelvic alignment. As a **secondary FSD,** it can be a reaction to **sexual aversion**, or to

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[7] Some pharmacologic treatments that have been utilized in treating FSD include **estrogen, progesterone, testosterone, DHEA (Dehydroepiandrosterone), antidepressants, Buproprion, Sildenafil, and Herbals. Prostaglandin E,** and **Phentolamine** have been under investigation as possible drugs (source: Miller pp.204ff).

[8] Miller 202

[9] Miller 203. The device provides suction over the clitoris to enhance blood flow and can be used to promote stimulation prior to intercourse.

[10] Even the category of **dyspareunia** has been challenged, as it is the only group of pain disorders classified based on the type of activity it inhibits and not the area of the body it affects. Many clinicians prefer to consider **vaginismus** separately from **dyspareunia**.

[11] One website reported that 10-15% of North American women have reported some type of pain upon intercourse. (Online Source: Laumann E, Paik A, Rosen R., "Sexual dysfunction in the United States: Prevalence, predictors, and outcomes.")

one of the other pain disorders. **Vaginismus** has been treated with behavioral therapy in conjunction with the use of a series of vaginal **dilators**, with varying degrees of success.[12]

Within the category of **dyspareunia, vulvodynia** comprises a set of disorders that involve inflammation of the vulva at the entrance to the vagina. A common type is **vulvar vestibulitis,** which involves inflammation of glands around the vulva. The causes of this inflammation are unknown, but they are more often a **primary FSD** than **vaginismus**. **Vulvodynia** is very common. A recent survey cited by the National Vulvodynia association found that 16% of women in a Boston-based population survey reported a history of **chronic vulvar pain** of at least three months in duration.[13] This type of disorder is relatively prevalent among younger women, as well. Treatment may be similar to that of **vaginismus**, but may include use of topical creams or injections.

A final group of **FSDs** are various types of **anorgasmia**. **Anorgasmia**, an inability to reach orgasm, is probably the most well-recognized **FSD**. **Anorgasmia** is much more common in women than men**,** and it can be **primary** or **secondary**. **Situational anorgasmia** is used to refer to women who can only have orgasms with a certain type of stimulation.[14] The treatments are various, including masturbation training, which has been considered controversial, and systematic desensitization, in which in which a process of gradual exposure[15] neutralizes the anxiety-producing aspects of sexual situations.

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[12] Wolpe and Carroll 468

[13] "Chronic Vulvar Pain May be a Highly Prevalent Disorder." *National Vulvodynia Association News.* Press Release of April 14, 2003. Online Source.

[14] Wolpe and Carroll 461-2

[15] Wolpe and Carroll 469

The medical community itself is largely ignorant of many of these disorders, but centers that specialize in treating FSD have seen rising demand for their treatment.[16] The prevalence of FSD has been hotly debated. A 1999 study based on the 1992 US Health and Social Life Survey found that some form of sexual dysfunction was reported among 43% of females, as compared with 31% among males. The majority of the complaints related to emotional problems and stress, particularly among women reporting arousal disorder.[17] National associations and clinics have been founded in order to raise awareness of disorders and improve women's health. Despite the growing demand, many physicians doubt the veracity of the 43% figure and urge caution in defining and treating these disorders.

The categories of sexual dysfunction and female sexual dysfunction appear to be purely clinical terms, but they do have moral valence. Even the use of the terminology has ethical consequences. Before we begin to establish a Jewish ethic regarding female sexual dysfunction, we need to understand its place in medical and public thought.

Our Post-Viagra Dilemma

Though sexual dysfunctions are evidenced by biological symptoms, they are almost always influenced by a psychological component. The pharmaceutical industry has largely obscured the psychological input to sexual dysfunction.

In this age, we have become accustomed to treating our maladies with pills. Nowhere is this more evident than with sexual dysfunction. Viagra, a drug originally developed to treat heart

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[16] Women's Treatment Center (WTC) in Plainview, NY, for example saw a 400% increase in inquiries, from 500 to over 2000 per month, over a 3-year period from 1999-2001. (Online Source - "Vaginismus Statistics." Women's Therapy Center.)

[17] Miller 200

conditions, was found to have a commercially beneficial side effect: it allowed men with erectile dysfunction to sustain an erection. Viagra's success vaulted the pharmaceutical treatment of erectile dysfunction into commercial status. This has had benefits as well as costs. Positively, Viagra has provided many men with a way to continue having active sex lives despite erectile dysfunction, and has raised public awareness of sexual dysfunction in general. Negatively, Viagra has led many to the assumption that all sexual dysfunction can be treated with a pill, and it has raised expectations regarding sexual function in ways that may not be realistic or even desirable. By placing an exclusive focus on male sexuality as the limiting factor in heterosexual relationships, Viagra has created reinforced the unhealthy assumption that females should constantly be sexually available to their male partners, sensitively responding to those partners' cues.

Discussion of female sexual dysfunction has been limited to the medical community until recently, despite the prevalence of FSD among women in the United States. Unsurprisingly, FSD has made its entry into the public forum as a reaction to Viagra. The commercial and clinical success of Viagra has polarized and limited discussion of FSD. Recent debate in the medical community has focused on the negative impact of "medicalizing" (better, pharmaceuticalizing) FSD. We have begun to see the emergence of medicalizing FSD with recently publicized tests of various drugs, each being touted as "the female Viagra", each as the panacea for FSD.[18] The sheer amount of web hits on Google for "Viagra for women" (near 3

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These include Intrinsa (a testosterone patch), Viagra itself (Sildenafil), DHEA, L-arginine amino acid cream (various names including Dream Cream and Satisfaction Cream), Zestra (a fluid with herbal and vitamin components), and other herbals (including Avlimil, Therafem, and countless others). None of these has met with much clinical success, nor has any one drug been marketed successfully to the exclusion of others.

million) as compared with "female sexual dysfunction" (698,000) underscores the problem involved in making treatments for a group of disorders easily marketable.

Physicians and therapists have written that the category of FSD itself may be harmful. First, it is only a quick semantic leapfrog from 'erectile dysfunction' to 'sexual dysfunction' to 'female sexual dysfunction'. Pharmaceutical companies are using the statistics and categories in order to push new drugs. Physicians are rightly concerned that women with various sorts of FSD will expect that a Viagra-type drug will be able to cure them, when in fact male and female sexuality are vastly different. The vast majority of complaints about male sexual dysfunction have been in reference to failure of physical response.[19] Female sexuality is affected by hormonal differences, and is highly susceptible to social constraints; female needs for orgasm are often not met well by conventional intercourse,[20] and there is a much greater psychological component in inhibited sexual response.[21] As one physician said, "You're not going to find one sexy pill that's going to suddenly drive women wild with desire."[22] The use of pharmaceuticals without sufficient guidance from physicians, and other accompanying therapies, can do more harm than good for improving women's sexuality.

Second, FSD**,** unlike erectile dysfunction, has widely varying sources of causation, and it is medically misleading to create an artificial group such as female sexual dysfunction**.** Rather than mongering a cure-all for a made-up category, physicians should be doing their diagnostic

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[19] In one study 68% for men compared with 20% for women - Bancroft 454

[20] "...the sexual act, vaginal intercourse, which is biologically necessary for reproduction, is not well designed to elicit orgasm or stimulate the clitoris in women. The majority of women require some alternative or additional form of stimulation in order to experience orgasm." Bancroft 453

[21] Bancroft 452-3

duties and treating human beings. Specifically, physicians are calling for sexual pain disorders to be reconceptualized as genital pain disorders.[23] They make a convincing analogy: although back pain is a major cause for work disability, we don't call back pain a work disorder. Proponents of FSD would offer the counter-argument that taking sexual pain disorders out of the realm of FSD will cause health professionals to ignore the psychological impact of these disorders on a woman's sexuality and self-image.

In a final argument against the use of FSD terminology, a feminist critique charges that the creation and marketing of FSD is only a further instance of male-oriented medicalization. It may only be the new manifestation of a patriarchal attempt to control female sexuality, to take a bunch of very private issues and make them issues for couples. Even if this is too far-fetched, certainly Viagra has reinforced a cultural emphasis on male, rather than female sexuality. Women, especially older women, are now being asked to keep up with their Viagra-pumped mates. A certain degree of fluctuation in sexual function, it is argued, may be normal, and not necessarily an indicator of a disease state, or even of a need to seek professional help.[24] Couples will always have differing sexual needs and desires, and there are numerous modalities outside of medicine available to mediate these differences. Labeling this healthy dynamism as sexual dysfunction may actually obstruct the normal ways partners work these things out, substituting diagnosis for communication.

All of these factors lead us toward limiting the use of FSD as a category. But this is not the whole story. Beyond the media and political hype, there is a private reality lived by many

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[22] Qtd. in Thomas (online source)
[23] Binik, et al. 428.

[24] Thomas (online source)

women who are dealing with sexual dysfunction of one kind or another, perhaps as high as 43% of American women.[25] We now turn to this reality in examining the case for further awareness of FSD.

The Private Reality

Many women with FSDs have not sought any sort of help. For instance, 40% of women who responded that they have experienced chronic vulvar pain chose not to seek treatment.[26] This figure does not include those who chose to withhold information about FSD from the survey. Of those who sought treatment, 60% saw three or more clinicians.[27] These statistics highlight two important factors supporting further raising of public awareness regarding FSD. First, a number of factors discourage women from seeking help. Second, clinicians are generally ignorant as to the nature and treatment of FSD, especially pain disorders.

A website entitled "Straight Talk about Female Sexual Dysfunction" lists the factors that keep FSD a secret for so many women. First, discussing FSD, even with a close group of friends, is quite daunting. It may not seem socially appropriate, or unpleasant, and the response is unpredictable. Even if the social atmosphere is receptive, fear of revealing intimate matters that concern one's partner often causes women to withhold. Second, although sex is so pervasive in our culture, there is a perceived norm that everyone's sex life is normal. To reveal one is below a perceived norm incurs the risk of losing standing in society. Third, society itself

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[25] See 1999 Report reference on p. 5, above.

[26] "Chronic Vulvar Pain May be a Highly Prevalent Disorder." (online source)

[27] Ibid.

has created the myth of a certain type of sexy woman as the ideal. Comparison to this myth is itself the cause of FSD for many. Admitting FSD may feel like conceding failure. Beyond the crush of societal imposition on female sexuality, there are relationship issues to consider. Even though one's partner may be one's strongest support in times of need, FSD is different because it affects the relationship with that partner. The partner may perceive it as an affront to his/her sexual ability or attractiveness. On the whole, there is a fear that revealing FSD to a partner will cause a tremendous change in the relationship.[28]

A largely ignored category of women includes those who do not have partners, perhaps a larger number than partnered women with FSD. For these women, FSD can be paralyzing, affecting interest in dating, and destroying confidence. For them, even more than for partnered women, the choice to seek treatment for FSD carries the risk of social stigma. They may ask themselves who would be interested in dating such a woman with the uncertainty of a relationship without sex looming overhead. They may feel less responsible to seek treatment without the motivation of doing so for the sake of a relationship or partner. The plight of the single is often ignored in Jewish communities, who offer little more than the occasional mixer or matchmaking for the sophisticated singles of today.

Even if a woman does seek help, finding an informed clinician can be difficult. This is especially true regarding the sexual pain disorders, for which education, even among gynecologists, has been poor. Several reasons contribute to this: the politics of FSDs described above, the multimodal approach to treating FSDs (which requires a great deal of time on the clinician's part, as well as coordination with other health professionals), and simple ignorance.

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[28] "Talking about Female Sexual Dysfunction." Straight Talk about Female Sexual Dysfunction.com. (online source)

For these reasons, organizations have begun disseminating information about FSDs over the internet, as well as educating through specialized clinics. But the key audiences are missed: the doctors who simply don't understand FSD, and the women affected by it who don't know how to name it and where to seek help. I believe this is where the Jewish community is needed to assist.

The Jewish Community's Response to this Point

The underlying message in so many Jewish communities to couples is, "Procreate, and *then* we will take care of you." Elliott Dorff, the Conservative movement's most prominent ethical voice, advises, "Even if young couples choose to use contraceptives for a time, they are well advised, both medically and Jewishly, not to wait too long."[29] This emphasis on childbearing - which appears in traditional as well as non-traditional settings - undermines sensitivity to individuals and couples dealing with FSD. We have seen some softening of the hard line as consciousness has been raised to fertility issues. An abnormally high percentage of fertility specialists are Jews, demonstrating perhaps a subconscious dedication of Jews to continuity and family[30].

But this too is informed by a Jewish valuation of making babies, above all else, as the purpose of sex. As a result, there is still insensitivity to sexual dysfunction in Jewish communal discourse. Sex is about more than procreation, especially in our post-industrial age. Healthy sexual relationships have Jewish and practical value aside from procreation. Communities would do well to sustain relationships and families by supporting development of healthy sexual

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relationships rather than overlooking them. It is important to consider how Jewish tradition should serve to guide our decision-making.

Halacha

Unfortunately, *halacha*, traditional Jewish law, offers little in the way of direct guidance as to how to deal with FSD in our day and age. *Halacha* essentially codifies a pre-industrial approach to sexual behavior, in which paternity and procreation were the main guidelines in shaping normative sexual practice.[31] Female sexuality was to be controlled, and was often feared by rabbinic authorities, as evidenced by this law in Maimonides' Mishneh Torah:

> ...the Sages have said that in the case of a woman who is so barefaced as to brazenly demand intercourse, or seduces a man in order to make him marry her, or persuades her husband to have intercourse with her when his intention is to visit his other wife, or does not wait three months after the death of her husband before remarrying - with the result that the parentage of the child is in doubt - all children born of such women become renegades and sinners who become separated in the sufferings of exile.[32]

We must view these musings regarding female sexuality as a product of a set of cultural values that we no longer hold. It is impossible to create a Jewish sex ethic regarding FSD with such a negative view of female sexuality. Moreover, the *halachic* category most similar to the woman with FSD is the *moredet*, or rebellious wife, who refuses to live with her husband. Maimonides rules that if such a woman testifies regarding her husband, "I dislike him and cannot willingly be intimate with him," the husband is to be compelled to divorce her immediately, for she should not be forced to have intercourse with one whom she hates.[33] Certainly we do not wish to begin

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[30] Teutsch "Towards a Jewish Sex Ethic" 4-6
[31] Teutsch "Towards a Jewish Sex Ethic" 4-6

[32] Qtd. in Rosner 101. Mishneh Torah, Book Five: The Book of Holiness, Chapter 21, Law 13
[33] Berkovits 364

discussion of FSD with questions of modern interpretation of hatred, with divorce as the only option.

Rather than considering FSD from a halachic model, we should consider the inherited Jewish values that inform ethical decisions on this topic. After consideration of these values, we are prepared to offer an ethical analysis of the sort *halacha* is used to, in which we may articulate general principles and then apply them to situations on a case-by-case basis. Several fundamental Jewish values come into play and should be considered here.

Beliefs and Values Applicable to Female Sexual Dysfunction[34]

***Ahava* (Love)** - Love between partners, friends, parents and children is a central source of joy and growth. Judaism sees God as the ultimate source of love, and that it is manifested in God's creation and in our relationships. Valuing love causes us to work toward sustaining relationships. Love can be expressed in many ways, and sex is only one of those ways. FSD should not be viewed as an end to *ahava*, rather *ahava* should be stressed as continually informing the process of encountering FSD.

Physical Pleasure - Judaism affirms through many texts that we should take physical pleasure in our bodies and the senses we are gifted with. Sex, too, should be a source of physical pleasure for both partners, not only an obligation or a mere means to an end. We strive for an ideal of *simcha*, joy. It is Jewishly legitimate for partners to be motivated to deal with FSD by a desire to have mutually pleasurable sex.

***B'riyut* (Health and Wellness)** - Jewish tradition advises us to pursue bodily, emotional, and spiritual health through protective measures, by avoiding destructive activities like drug

[34] List and explanation of values adapted from Teutsch, *A Guide to Jewish Practice* 15-25

addiction, by obtaining medical help where appropriate, and by seeking out beneficial activities like exercise. Rather than being asked to suffer painful or limiting conditions in solitude, we are urged to seek help in order to be as healthy as we can. For many women FSD seriously challenges *b'riyut*. FSD may also pose a challenge to the *b'riyut* of the woman's sexual partner. The choice to seek help for FSD needs to come from the affected individual, however, as it is her *b'riyut guf* that is of primary concern.

***Kehilla* (Commitment to Community) -** Community is the domain in which humans fulfill themselves in relationship to one another. As *Pirkey Avot* tells us, "Do not separate from the community."[35] Communities are to manifest the ideals of their members and of *k'lal yisra'el* (the entirety of the Jewish people). In order to be sustainable, according to Martha Acklesberg, communities should "support and sustain all those family forms . . . that provide contexts for striving toward the realization of the divine."[36] Whether or not one agrees with Acklesberg's criteria for supporting a family, each *kehilla* should be true to its own criteria based on shared values. *Kehilla* stresses not only the importance of commitment to community, but commitment to realizing the shared values of that community, which may include *b'riyut* and *simcha*. Therefore, communities should be inclusive of, and sensitive to, people dealing with FSD. Some communal context(s) should be created for addressing the issue of FSD.

***Brit* (Covenant) -** The idea of covenant, of a binding promise with mutual obligations, informs all relationships within Judaism, be they between partners, or between the Jewish community and its members. In any covenant, it is essential to understand the

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[35] Pirkey Avot 4:7

[36] Acklesberg 302

developing needs of the partners in the relationship, which will change over time. Partners need to communicate these needs to each other in order to sustain *brit.* It is essential for communities to offer what they can in terms of support for women/couples dealing with FSD, in order to be true to the communal *brit* with individual members, (be they single or partnered). If the idea of *brit* is an important Jewish concept, the community should especially support partnerships as living manifestations of *britot* between partners.

***Hesed* (lovingkindness)** - Caring for each other is part of what makes us fully human. A partner of an FSD-affected person should manifest *hesed* by being patient, listening, giving time, and being willing to step out of personal wants (including desire for sex with the partner) to be there for her. Both partners have the responsibility to manifest *hesed,* as this will serve to strengthen the relationship and make each partner feel deeply loved. This shift in and of itself may have a positive impact on the way FSD is perceived within a given relationship.

***Hadracha* (Education) -** Jews strive towards life-long learning as an ideal. By continuing to learn, we provide new sources of meaning and enrich our experience of life. All facets of life, including FSD, can serve as material that helps us to better understand ourselves and the world around us.

***Hidur Mitzvah* (Beautifying Jewish Observance)** - By enhancing our practice in our own ways, we take ownership of our Jewish lives. FSD can prove a blessing if it forces us to actively explore and consider the ways we make love. As the *Inside* magazine article above notes, the emphasis on career success has taken time away from development of relationships.

Jews should take time to beautify the *mitzvah* of sex and their intimate understandings of their partners.

***Sh'lom Bayit* (Peace at Home) -** The baseline value for a functioning Jewish household is *sh'lom bayit*. Members of the household should respect one another and each other's boundaries, in order to create a mutual trust. Abuse and humiliation destroy that trust. Exploitation of differences in power done in the name of *shlom bayit* serves to undermine mutual respect.[37] *Sh'lom bayit* is not a sufficient reason to compromise one's basic values, or to demand extreme self sacrifice, but it begs us to act sensitively and with the integrity of the household in mind.

Fidelity/Honesty - Keeping promises creates a sense of safety that sustains relationships, adding warmth and trust. If decisions are made that alter a promise made earlier in the relationship, they should be openly discussed and mutually agreed upon. FSD can force partners to openly discuss many aspects of their sexual relationships that were merely implied earlier. For example, there will probably need to be a discussion of what acceptable means may be used for partners to meet their own sexual needs outside of the mutual sexual relationship. Due to the high risks involved in such a discussion, it is imperative that partners be able to trust one another. Furthermore, a great deal of material of an intimate nature can be shared with others (therapists, clinicians, friends, support groups) outside of the partnership. It is essential, not only to establish trust with these individuals, but also to be able to trust one's partner to guard and divulge one's own information wisely.

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[37] Acklesberg 305

***Tzniyut* (modesty) -** Maintaining the dignity of others and of oneself and respecting the sacred nature of sexuality involves making thoughtful decisions about how and when to express and share information about our sexuality. Judaism affirms the right of individuals to keep some material private. Even a rabbi may lie about sexual encounters if it is necessary to conceal the dignity of another person.[38] As such, discussion of FSD should be private, with the consent of a partner if possible, and with individuals worthy of trust.

***Taharat HaLashon* (Proper Speech) -** Jewish tradition regards speech as a divine gift, endowed with the power to create or destroy. Thus, speech should be carefully guarded. Sustainable communities and relationships rely upon recognition of the potential damage caused by improper speech. FSD is a sensitive topic, requiring a high degree of *taharat halashon.*

Autonomy - Though not necessarily a traditional Jewish value, autonomy is generally regarded as a value in our current American value system. We should not take it for granted that we generally believe that adults have the exclusive right to make decisions for themselves, perhaps excepting situations that are life-threatening or those that directly affect others. In this current climate, most Americans would agree that a woman's own sexuality falls within her private domain. Therefore, the choice to seek help for dealing with FSD should belong to the affected woman, and should not be made for her.

With all of the issues and values considered, we are well-equipped to make some recommendations regarding a Jewish ethical response to FSD.

Ethical Imperatives Regarding Jewish Communal Response to FSD

[38] Babylonian Talmud, Tractate Baba Metzia 23b-24a

The clearest imperative regarding FSD is public education. As we saw above, ignorance of the facts of FSD can lead to manipulation by drug companies, or a lack of sensitivity and action on the part of individuals and communities affected by FSD. Education allows *kehillot* to be trained sensitively to an issue that certainly affects members of the community, and reinforces the importance of *hadracha* in ensuring *b'riyut guf*. As stated above, education is also a goal of national organization focused on FSD, but their reach is limited. It is important for Jewish communities to recognize that sexuality is a Jewish topic. Exclusion of a positive discussion of sexuality within a Jewish context gives the mistaken impression that Judaism, and by extension Jewish communities, have nothing to say about this topic. This can isolate and alienate committed members of a Jewish community for whom exploring sexuality, or dealing with FSD is an issue. If communities are indeed inclusive, then education is imperative.

The one caveat to this education, and all other ethical imperatives regarding this topic, is that *tzniyut* should be preserved. Public embarrassment is not only counter-productive, it is considered as an affront to one's dignity akin to murder. The modes for this education in a synagogue/community center setting might be a sermon or adult education program around the topic, along with availability of materials to congregants and clergy in a discreet manner that does not publicly identify the person seeking information. Pamphlets deposited in bathrooms, or included in information packets to couples in pre-marital counseling (along with information about genetic testing, abuse, etc.) are a few possibilities. Unless it is requested directly by an individual, the education should be offered in a general way, without implying the suspicion that any particular person is affected by FSD.

The nature of the education can parallel the information shared in the first three sections of this paper: the clinical types and prevalence of FSD, the current issues surrounding the

medicalization of FSD, and the acknowledgment of the private reality of FSD for many affected women. Depending on the circumstance, a discussion of Jewish values may be appropriate. Printed material should also include information on national organizations, further information sources, and local physicians/centers that offer treatment.

The most important target audience for this material should be single women. For the reasons listed above[39], single women are often the least informed and the least likely to seek help on their own. Couples, on the other hand, will have more financial and educational resources, as well as internal support structures. For the benefit of single women, it is most important to view seeking treatment for FSD in terms of *b'riyut.* If FSD was to be seen as an issue only in the context of partnership, not only would these women be alienated even further, but Jewish communities would also imply a negative judgement of any extra-marital sexuality. While the issue of who should be having sex, and when, is a larger ethical question we cannot explore here, the implication of such an approach would be that Jews do not think sexuality matters outside of a marital context. As the sexual revolution has taught us, sexuality is an integral piece of human identity, even outside of relationships. The values of *kehilla* and *brit* impel Jewish communities to devote resources in order to include singles and to address their personal needs. For single women affected by FSD, the greatest need is for a non-judgmental, supportive community.

Education on FSD should be offered not only for the direct benefit of affected individuals and *kehillot*, but also for doctors. It is no secret that a relatively high percentage of Jews are physicians. We cannot ignore the benefit that this demographic gives us in battling ignorance of this prevalent group of disorders. The sensitivity with which the Jewish community presents the

[39]See section entitled "The Private Reality"

topic has the ability to offset the shut-down reaction to the bombardment of new drugs designed to take advantage of the category of FSD.

Beyond education, communities should provide support for families and individuals with FSD, to uphold the *brit* between communities and members, and to sustain the units that make up the *kehilla*. The first important step is providing communal education, which should result in a higher degree of consciousness around FSD. People will think more about comments and assumptions that might alienate those dealing with FSD, contributing to *taharat halashon*. A tremendous amount of support is created merely by maintaining a safe environment.

Communities should be concerned with the *b'riyut* - both physical and mental - of their members. Providing counseling and support groups through communal institutions can get tricky, as most professional and lay leaders are not trained in dealing with the particulars of FSD. But the reality is that many will feel comfortable confiding in a clergy member, or receiving support from a single-gender synagogue group. *Tzniyut* and confidentiality should certainly be maintained. Often, an FSD-affected individual is searching for someone to provide compassionate listening. The attribute *hesed* should guide supporters in these encounters. Practical support can be provided through references to outside as well as self-help resources.

Behind Closed Doors: Jewish Directives in Personal Dealing with FSD

Even more than communities, individuals and families dealing with FSD can find guidance in their journey through the Jewish values listed above. Each scenario provides its own challenges, and the application and interpretation of these values is up to the individuals involved. Nonetheless, these values can make the journey ethical in a Jewish sense.

With regards to single women dealing with FSD, autonomy looms larger than any of the Jewish values, with the possible exception of *b'riyut guf.* The choice to seek treatment should not be foisted upon such an individual, but should be actively sought by the woman herself. How, where, why, and when she chooses will vary depending on her circumstances. Her journey may be infused with different Jewish values along the way, as an expression of *hiddur mitzvah*.

The Jewish values listed above are primarily regarding issues of relationship, and thus they tend to be more readily applicable in the private sphere to partnerships. First of all, the fact that we place an importance on physical pleasure and *briyut* means that unhealthy or painful sex are not Jewishly sanctioned. Of course, sexual relationships fluctuate, hitting high and low points. But there needs to be an honest communication about sex in relationships, in order to ensure *sh'lom bayit.* Partners should establish their own norms, rather than attempting to conform to an imagined societal regimen.

Secondly, journeying through FSD can be rough on a relationship. *Hesed,* lovingkindness, is the key to getting through difficulty. Through mutual appreciation and exploration of *ahava*, a relationship can deepen as a result of this process. Entering into a renewal of *brit* at significant stages along the way emphasizes the continuity of relationship amid dynamic changes. If changes are made in an assumed norm of sexual behavior in or outside of the relationship, the value of fidelity/honesty enjoins upon us to try to reach a mutual understanding.[40]

[40] Regarding extramarital relationships, frequency or absence of sex, kinds of sexual behavior allowed, ways of communicating a desire for sex, or ways of communicating that sex is not desired, etc.

Concluding Thoughts

There are surely difficulties in raising the issue of FSD, both for public awareness, and for individuals who personally encounter FSD. For those individuals, clergy and community leaders who choose to confront FSD, I offer utmost support and sincere admiration. One upside is that we have the ability to bring our Jewish selves into an aspect of our private lives. Dealing openly with sexuality, especially in the context of relationship, has the benefit of personalizing the way sex happens, so that we give it the sense of *hiddur mitzvah*. FSD can prove a challenge to relationships, but it also provides a unique opportunity to infuse an important part of our lives with meaning.

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