**Halachic and medical motivators of seeking pelvic floor physical therapy rehabilitation in ultra-orthodox women**

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**Précis**

**Abstract**

*Objectives:* Pelvic-floor functions play an important role in the quality of life of each woman, and twofold in ultra-orthodox (Haredi) women, since problems in this region harm their ability to conduct religious commandments (e.g., the bleeding prevents the possibility of immersing in the mikveh). The aim of this study was to examine whether halachic repercussions are an additional causative factor beyond medical motivation for ultra-orthodox women in turning to pelvic-floor rehabilitation.

*Methods:* Sixty-five ultra-orthodox women completed questionnaires on pelvic-floor function, religion, and the association between them.

*Results:* The percentage of women who stated that their motivation for seeking the treatment was both medical and halachic was considerably higher than those who stated that the motivating factor was either a medical or a halachic one. In women with all studied pelvic-floor–related disorders (pelvic organ prolapse, urinary incontinence, or difficulty having sexual intercourse), the obstacle to upholding the religious commandments is a very important factor in the decision to seek medical treatment.

*Conclusions:* The halachic aspect is a very important factor in the life of the ultra-orthodox woman. Inability to fulfill the commandments is the strongest motivation for religious women to seek treatment.

**Keywords**: physical therapy, pelvic floor, ultra-orthodox women, treatment

**Introduction**

Pelvic-floor medicine deals with the treatment of tissue, muscle, and ligament deficiencies in the pelvic floor. These deficiencies sometimes result in urine and fecal incontinence, sexual dysfunction, organ prolapse, and organ dysfunction.1 Each symptom deeply affects a woman’s quality of life. Religious, and especially ultra-orthodox (Haredi), women suffer twofold: everyday functioning is impaired, and their ability to properly fulfill religious commandments is also damaged.2

In the ultra-orthodox community, Halacha has a great influence on every aspect of life. Thus, a medical problem will be handled not only when it is medically disturbing but especially when the problem leads to a conflict with Halacha and the ability to fulfill commandments (or “mitzvoth”).

In this study, we focused on three main areas of pelvic-floor rehabilitation: incontinence, pelvic organ prolapse (POP), and pain during sexual relations.

The aim of this study was to examine whether halachic repercussions for ultra-orthodox woman are an additional cause for seeking pelvic-floor rehabilitation treatment, beyond the general medical motivation common to women of all sectors. Our hypothesis was thatultra-orthodox women attach great importance to the halachic implications of a medical issue and seek pelvic-floor physical therapy not only for the treatment but to help them fulfill the religious commandments.

**Methods**

This study was conducted between January and May 2015 among ultra-orthodox women. The inclusion criteria were women aged 20 to 65 years from the ultra-orthodox cities of Bnei Brak and Elad who came to treatment in the clinic for pelvic-floor rehabilitation and who agreed to fill out the questionnaire.

*Ethical issues:*Participation in the study was voluntary. Patients who met the inclusion criteria were requested to sign an informed consent form. They received an explanation of the methods and procedures of the study. After signing the form, they filled out the questionnaire in a separate room next to the clinic. They were requested to complete the questionnaire anonymously, after completing all treatment procedures, so that patient–therapist relationships would not affect their answers.

*Tools:* The questionnaire included 140 questions and was based on several Hebrew questionnaires as well as questions relevant to the topic of research. It was developed by the researchers and adapted to the unique topic of research and the target population. The measurement scale in the questionnaire was the Likert scale. The items were disclaim statements, and the range of answers was a range of consensus, where *1* expressed disagreement with the statement, opinion, or action and *5* expressed strong agreement. For some of the questions, it was also possible to mark *6* (*irrelevant*), because not every woman experiences the same symptoms.

After asking for patients’ personal details, the questionnaire was divided into groups of statements according to subject.There were a total of 8 such groups. In each group, the means of the answers on a scale of 1 to 5 were calculated, or on a scale of 1 to 6 in groups of questions where women were given an option to mark *6* (*irrelevant*).

*Procedure:* The data were collected in pelvic-floor rehabilitation clinics in Bnei Brak and Elad by a single researcher (L.T.). The study continued until the desired number of subjects was reached. Questionnaires were in Hebrew and were filled out anonymously.

*Statistical analysis:* All statistical computations were performed using SPSS 21.0 for Windows (SPSS, Chicago, IL, USA). Descriptive statistics were used to characterize the sample.

To examine the significance of the statements, we used different analyses. For comparing deficiencies between age groups, a χ2 test was performed for each phenomenon.

**Results**

*טבלה 1 מאפיינים דמוגרפיים של הנבדקות (מספרים ואחוזים)*

|  |  |  |
| --- | --- | --- |
| משתנים | ערכים | N (%) |
|  |  |  |
| **גיל** | 20-50  50+ | (80%) 52  (20%) 13 |
| **הגדרה דתית** | חרדית  דתית-לאומית  מסורתית  אינני דתיה | (100%) 65  (0) 0  (0) 0  (0) 0 |
| **מצב משפחתי** | גרושה  אלמנה  נשואה  רווקה | (3.08%) 2  (1.54%) 1  (95.38%) 62  (0) 0 |
| **ארץ מוצא** | ישראל  אסיה ואפריקה  אירופה  אמריקה הדרומית  אמריקה הצפונית | (78.46%) 51  (6.16%) 4  (6.16%) 4  (1.54%) 1  (7.69%) 5 |
| **השכלה** | 12> שנות לימוד  12=שנות לימוד  סמינר  מכללה/תואר ראשון  מאסטר | (0) 0  (15.38%) 10  (66.15%) 43  (16.92%) 11  (1.54%) 1 |
| האם עובדת כרגע  הריון בזמן נוכחי  **ממוצע ילדים** | כן  לא  כן  לא | (80%) 52  (20%) 13  (6.15%) 4  (93.85%) 61 |
|  |  |  |

מטבלה 1 ניתן לראות כי 80% מהמטופלות שענו על השאלון, הינן בגילאי 20-50 ואילו שאר הנשים (20%) הן מעל גיל 50. גילן הממוצע של המשתתפות הינו 37.478 (SD=1.57) כאשר הגיל הצעיר ביותר הוא 21 והמבוגר ביותר 63. רובן הגדול נשואות (95.38%) כאשר נבדקת אחת אלמנה (1.54%) ושתי נבדקות גרושות (3.08%). כל הנבדקות מגדירות את עצמן כחרדיות (100%). מרבית הנבדקות ילידות הארץ (78.46%) 4 מתורכיה תימן ומרוקו (6.16%) 4 מצרפת ובלארוס (6.16%) 1 מארגנטינה (1.54%) ו-5 מארה"ב (7.69%). מבחינת השכלתן 15.38% מהנשים בעלות השכלה תיכונית, 66.15% למדו בסמינר, 16.92% סיימו תואר ראשון ומטופלת אחת (1.54%) בעלת תואר שני.

בעת ביצוע המחקר 80% מהנשים הצהירו שהן עובדות לעומת 20% שלא. רובן המוחלט לא בהריון 93.85% ו-4 מהנבדקות (6.15%) בהריון בזמן מילוי השאלון.

טבלה 2 התפלגות הליקויים ברצפת האגן לפי קבוצות (מספרים ואחוזים)

***(n=65)***

|  |  |  |
| --- | --- | --- |
| משתנים | ערכים | N (%) |
|  |  |  |
| **אי שליטה בשתן ו/או צואה** | כן  לא | (73.85%) 48  (26.15%) 17 |
| **צניחה של אחד או יותר מאברי האגן** | כן  לא | (44.62%) 29  (55.38%) 36 |
| קשיים או כאבים בקיום יחסים | כן  לא | (30.77%) 20  (69.23%) 45 |

בטבלה 2 מתוארים הליקויים שנחקרו, מסווגים על פי 3 קבוצות עיקריות. החלוקה אינה דיכוטומית, מכיוון שניתן לראות מספר ליקויים אצל אישה אחת, לדוג' תתכן אישה המדווחת על דליפת שתן וכן על צניחת רחם, לכן השלם הינו יותר ממאה אחוז. בשאלון הנבדקות התבקשו לציין את הליקויים מהן הן סובלות ועל פי תשובתן לענות על השאלות הרלבנטיות למצבן.

The sample included 65 women. As shown in Figure 1, 100% of women aged 50+ years reported urine deficiencies, compared to 67% in the group aged 20–50 years. This is a statistically significant difference (χ12 = 5.75, *P*

In terms of prolapse, 38.46% in the age group 50+ years reported the condition, compared to 46.15% in the age group 20–50 years. The difference is not statistically significant.

In the field of difficulties in sexual relations, the data change. In the age group of 20–50 years, 36.54% reported difficulties, compared to 7.69% in the age group of 50+ years. This difference is statistically significant (χ12 = 4.06, *P* = .0438).

Figure 2 shows the average, taken from the questionnaire, regarding the period of time from the moment the impairment started until the day the questionnaire was filled out: 1 = *a few months ago*, 2 = *between 1 and 2 years*, 3 = *2 to 5 years*, 4 = *5 to 10 years*, and 5 = *more than 10 years*.

The data were collected only from women who replied that a question was relevant for them. Women with fecal incontinence came for treatment in the shortest time (M = 1.5, SD = 1.00). To check the ranking of sections dealing with the same domain, we made an ANOVA rendering with repeated measures. This process upgraded the sections, from the highest-average to the lowest-average section.

Regarding difficulty urinating, the period of time for coming to treatment was the longest from the onset of the symptoms, possibly related to the women themselves and the time it took for them to seek treatment after receiving a medical referral. The problem may actually stem from the stage of the medical referral, a process that does not always coincide with the appearance of symptoms.

We will now focus on 4 main topics, for which we asked the same question, and the conclusion we drew from analysis of the answers. The question was, “In general, if you were asked to define the most crucial motivation when referring to physical therapy treatment, what is your answer?”

1. Regarding incontinence: Two women (4.8%) marked that taking action to solve a situation of urinary incontinence was due solely to the halachic motive, 19 women (45.2%) said that their motive was only medical, and 21 women (50%) indicated that the motive was combined, both halachic and medical (Figure 3).
2. Regarding POP: Of the 28 women who replied that the impairment was relevant for them, 5 (17.9%) responded that a referral for the condition of the POP stemmed from the halachic motive only, 11 women (39.3%) answered that the motive was only medical, and 12 women (42.9%) indicated that the motive was combined, both halachic and medical (Figure 4).
3. Regarding difficulties in sexual relationship: Of the 19 women who replied that the impairment was relevant for them, 3 women (15.8%) noted that the search for treatment for difficulties in sexual relations stemmed solely from the halachic motive, 4 women (21.05%) said that the motive was only medical, and 12 (63.2%) indicated that the motive was combined, both halachic and medical (Figure 5).
4. In general: All women, regardless of their specific impairment, were asked about the halachic or medical motive for treatment. Of the 65 women who responded to this question in full (i.e., they marked motives in all defects) or partially (they marked motives only for a particular impairment and ignored impairments that were probably irrelevant to them), only 2 (3.08%) marked in all the columns that the halachic problem was the sole motive (see Figure 6). Fifteen women (23.08%) specified the medical condition as a sole motive, and 48 women (73%) noted that the medical and halachic components had a significant influence on reaching out for treatment.

The halachic aspect is a very important element in the life of ultra-orthodox women, as shown by the same average of their answers to statements such as *Religion plays a central part of my life* and *I feel obligated to fulfill religious commandments* on a scale of 1 to 5 (SD=0.35 and M=4.84 the average was 4.94 SD=2.42).

The percentage of women who responded that the reasons motivating them to seek treatment were both medical and halachic was significantly higher than the percentage of women who responded that only the medical or halachic reason was the catalyst, which supported the research hypothesis. Of the 65 women who completed questionnaires, only 2 (3.08%) indicated on all the statements that the halachic aspect was the only motivating factor, whereas 15 women (23.08%) noted that the medical situation was the sole motivating factor and 48 women (73%) indicated that both medical and halachic aspects were a major reason for their request for treatment.

1. בקבוצת ההיגדים הרביעית בשאלון נשאלו הנשים: מה מהמצבים הבאים יגרום לך לפנות לטיפול באופן מיידי?

כאן באופן מובהק קיבל ממוצע גבוה ביותר (M=4.98 SD=0.14) ההיגד "הייתי פונה לטיפול באופן מיידי אם היה לי קושי בכניסה להריון בגלל הליקוי ברצפת האגן" מבין הנשים שענו כי הנושא רלבנטי לגביהן. לאחריו קיבל ההיגד "אם אחשוש שמצבי הגופני גורם לי להתגנות על בעלי " ( M=4.754 SD=0.738)

שאר המשתנים לפי הממוצע מהגבוה לנמוך

אם היו לי דימומים בגלל הצניחה שהיו מקשים עלי להיטהר לטבילה(M=4.7 SD=0.939)

אם אמנע מקיום יחסים עקב הכאבים שלי (M=4.54 SD=1.01)

כשלא הצלחנו לקיים יחסים במשך תקופה (M=4.14 SD=1.23)

כשגיליתי שיש לי צניחה (M=4.114 SD=1.3)

כשמצאתי שאני לא נקייה בזמן תפילה (M=4.062 SD=1.19)

את הממוצע הנמוך ביותר קיבל המשפט "כשגיליתי שיש לי דליפת שתן" (M=4.00 SD=1.18) אך למרות היותו הנמוך ברשימה עדיין הממוצע שלו גבוה ביחס לסולם של 1-5.

**Discussion**

*Incontinence* can present as urinary or fecal incontinence. Urinary incontinence appears in different forms. It can be a result of physical effort3 or characterized by frequent bathroom visits or by the inability to restrain urine release, which impairs quality of life. Fecal incontinence is also derived from the defective activity of the pelvic-floor sphincters, but its social consequences are far more extensive.4,5 Between 7% and 37% of women in this study who were aged 20 to 39 years reported a certain level of lack of control, and 9% to 39% of women over age 60 reported a daily urine leak.6

Fecal incontinence prevalence is between 2% and 6%7 after the first vaginal birth and affects approximately 9% of women during the first 3 months postpartum.4 If we also add the lack of control over gases, the frequency is even higher.

For the religious woman, there is an obligation to make blessings and pray, which cannot be implemented if a person is unclean,8 due to their sanctity. Urine or feces incontinence will prevent a woman from praying. In the worst scenario, if she prayed when unclean, her prayer would be considered an abomination as if she had not prayed at all.9–11 For an ultra-orthodox woman, this seriously impairs a religious way of life.

*POP* is a condition in which one or more of the pelvic organs are not in their anatomical place. It can occur in each of the pelvic organs, in part of an organ, or in several organs together.8 The prolapse occurs when the structures that were designed to maintain the pelvic organs are damaged, weak, or under high or continuous pressure.9 As in many situations, the prolapse can be mild, moderate, or severe. POP is considered to be one of the most significant anatomical complications of birth. Almost half of all women who have had one or more children experience some degree of prolapse, and 10% to 20% are also symptomatic.10

Many women are diagnosed by their gynecologist as suffering from slight prolapse, but it will not always be felt or accompanied by symptoms.11 Others feel a bulge in the vaginal area, especially at the end of the day or after some strain. The drop may also include additional problems such as loss of urine, difficulty in emptying the intestines, pain in the lower back or pelvis, pain or discomfort while having a relationship, and decreasing the image of self and quality of life.10,12

POP may be represented by mild symptoms such as discomfort or pain but can also develop into a situation preventing sexual relations or conception. In addition, the appearance of blood prevents immersion in the ritual bath, or Mikveh.xx (Shemesh 2004). This situation is also unpleasant and awkward from a personal and conjugal perspective. Another difficulty is that the very existence of the prolapse is not aesthetic and can make the husband recoil from his wife. All these are common to all women, but there are additional halachic implications that amplify the situation (Responsa Hatam Sofer, Vol. 2, No. 145).

*Pain and/or difficulty having sexual relations:* This impairment can appear among newlywed couples experiencing difficulty with sexual contact as a result of overcontraction of the pelvic-floor sphincters or due do vestibulodynia—oversensitivity of the vestibule.13 It can also appear among couples during sexual intercourse, when the woman experiences different forms of pain in the pelvic area. This strong and annoying pain prevents the possibility of sexual contact and accompanies the woman in everyday functions, not just within the framework of sexual relations.14 This situation causes many couples to avoid intercourse, and as a result, it prevents implementing an essential part of Jewish religious marital life. It also prevents procreation.15,16

We discovered that in the group of women experiencing urinary incontinence, the effect on their ability to fulfill religious commandments is significant and difficult. However, there was not a significant difference between the percentage of those who noted that the motivating factor for seeking treatment was both medical and halachic and those who noted that the factor was only halachic. On the issue of prolapse, the percentages of medical-halachic motivation were higher, but there were women who responded that if the prolapse would lead to difficulties or delayed immersing in the Mikveh (ritual bath), they would definitely turn to treatment. Among those who came to the clinic because of difficulties during intercourse, the halachic-medical factor was the most prominent factor, and women indicated a strong dependency between the ability to fulfill commandments and the body functioning. This symptom, especially, influences both the life of the woman with her pain and feelings and also the life of the couple and its functioning, together with all its ramifications. In other words, when there is a halachic difficulty in addition to a medical dysfunction, the blow is harsher and more damaging to quality of life, and it makes religious women more active in turning to treatment.

Bilu and Witztum say that the starting point in the therapeutic dialogue with ultra-orthodox women must be the understanding that religion is what gives them the main set of expressions through which the illness experiences are expressed. On this basis, therapeutic approaches can be creatively integrated into spiritual–religious elements.16

**Conclusion**

Correct guidance by professional treatment specialists, from the stage of verbal reference and theory, can assist in making information accessible and supporting successful treatment and greater cooperation.

We live in a very diverse cultural/ethnic, religious, sectoral, and even sub-sectoral world. Such wealth embodies many faces in our society, and we must know all the implications of this diversity.17

As physical therapists and as a team working with a population engaging in such sensitive and intimate issues, we need to recognize not only the language and terminology unique to each type of population but also the factors that motivate them to perform any actions.  
The clear conclusion from this study was that the importance of halacha in the eyes of ultra-orthodox women is not at all detached from their daily lives. It covers many faces/aspects of their way of life and the factors that shape their personality, desires, and attitudes toward themselves and those around them, requiring us as professionals to listen to them and pay close attention to the details that create their complex identity and the different nuances between the different types of populations.

**Figure legends**

**Figure 1.** Pelvic floor dysfunction by age in the studied sample (*N* = 65).

**Figure 2.** The average time between dysfunction onset and arrival for treatment.

**Figure 3**. The motivation to start physical therapy treatment (N = 42).

**Figure 4**. The most important motive when referring to treatment because of pelvic organ prolapse (*N* = 28).

**Figure 5**. The most important motive when referring to treatment because of difficulties in sexual relationships (N = 19).

**Figure 6.** The main motive when referring to physical therapy treatment (*N* = 65).

Figure 1.

Figure 2.

Figure 3.

Figure 4.

Figure 5.

Figure 6.

**References**

Åkervall S, Al-Mukhtar Othman J, Molin N, Gyhagen M. Symptomatic pelvic organ prolapse in middle-aged women—a national matched cohort study on the influence of childbirth. *Am J Obstet Gynecol* 2019;19:

Baumel SD. *Sacred Speakers: Language and Culture among the Ultra-Orthodox in Israel*. 2006.

Bo K, Frawley HC, Haylen BT, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for the conservative and nonpharmacological management of female pelvic floor dysfunction. *Int Urogynecol J* ;28(2):191–213.

Bornstein J, Goldstein AT, Stockdale CK, et al. 2015 ISSVD, ISSWSH, and IPPS consensus terminology and classification of persistent vulvar pain and vulvodynia. *J Sex Med* ;13(4):607–612.

4. Brown SJ, Gartland D, Donath S, MacArthur C. Fecal incontinence during the first 12 months postpartum. *Obstet Gynecol* 2012;119(2, Part 1):240–249.

Buckley BS, Lapitan MC. Prevalence of urinary incontinence in men, women, and children—current evidence: findings of the Fourth International Consultation on Incontinence. *Urology* 2010;76(2):265–270.

Bump RC, Norton PA. Epidemiology and natural history of pelvic floor dysfunction. *Obstet Gynecol Clin North Am* 1998;25(4):723–746.

Caro Y. *Shulhan Arukh* [Heb.]. Jerusalem; 1976.

Eason E, Labrecque M, Marcoux S, Mondor M. Anal incontinence after childbirth. *CMAJ* 2002;166(3):326–330.

5. von Gontard A, Baeyens D, Van Hoecke E, Warzak WJ, Bachmann C. Psychological and psychiatric issues in urinary and fecal incontinence. *J Urol* 2011;185(4):1432–1437.

Gyhagen M, Bullarbo M, Nielsen TF, Milsom I. Prevalence and risk factors for pelvic organ prolapse 20 years after childbirth: a national cohort study in singleton primiparae after vaginal or caesarean delivery. *BJOG* 2013;120(2):152–160.

HaKohen YM. *Mishnah Berura.* Jerusalem: Da’at Yosef; 1993.

Haylen BT, de Ridder D, Freeman RM, et al. An International Urogynecological Association (IUGA)/International Continence Society (ICS) joint report on the terminology for female pelvic floor dysfunction. *Neurourol Urodynam* 2009;29(1):4–20.

Maimonides M. *Mishneh Torah* [Heb]. Jerusalem: Machon Mishnat HaRambam; 1985.

Melamed E. *Peninei Halakha: Nashim*, Israel:Machon Har Bracha; 2006.

Minassian VA, Drutz HP, Al-Badr A. Urinary incontinence as a worldwide problem. *Int J Gynecol Obstet* 2003;82(3):327–338.

Ribner DS, Rosenbaum TY. Evaluation and treatment of unconsummated marriages among orthodox Jewish couples. *J Sex Marital Ther* 2005;31(4):341–353.

Schreiber (sofer) M. *Teshuvot Hatam Sofer* [Heb]; 1903.

Shemesh A. *‘Holi Hashvira’[Heb] (Hernia and Uterine Prolapse) according to the Responsa Literature,* Assia, 73–74. (2004) 104–117.

Roets L. The experience of women with genital prolapse. *Curationis* 2007;30(3):7–14.

Rosenbaum TY, Barnard E, Wilhite M. Psychosexual aspects of vulvar disease. *Clin Obstet Gynecol* 2015;58(3):551–555.

Talmud Bavli. *Tranctate Berachot.* Jerusalem: Tal-Man; 1981.

Weisberg E, Kern I. Judaism and women’s health. *J Fam Plann Reprod Health Care* 2009;35:53–55.