THE RHYTHM METHOD FOR THE REGULATION OF BIRTH

"We need to dissipate all climate of fear, or panic or impatience... For the more serious the problem, the greater the need for calm and sobriety."

• **F. DEL RIO**

The population problem is with us. It is a serious problem. It is a difficult problem to solve because of its very complexity and implications for future generations. The cooperative effort of all is needed, if we honestly and earnestly wish that it does not deteriorate at too fast a tempo, and hereby renders impossible the use of means and ways leading to its effective and permanent control and solution. In the words of our bishops "We need to dissipate all climate of *fear,* or *panic* or *impatience*... For the more serious the problem, the greater the need for *calm* and *sobriety.*"[1]

One often hears or reads that the Catholic Church in our country, by virtue of the unconditional assent given to the doctrine of he "Humanae Vitae" by the Catholic Bishops of the Philippines[2] is rendering very difficult, if not impossible, the participation and cooperation of the largest sector of our population in the solution of this present problems,

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[1] Manila Times, July 10, 1969, p. 11-A: "Population Issue"

[2] Manila, October 12, 1968: pp. 1-20. No desire on my part to make further comments on this matter. It has been both my privilege and my duty to work in this field for nearly fourty years. That's about enough. This is a field which will remain "obscure" as long as "fallen man" stubbornly refuses to contemplate it in the light of reason, and above all, in the light of Faith. To-day a good many of us blissfully choose to *ignore the problem,* and do a great real of rationalizing with our sympathetic heart attuned to the needs of "modern man," a new "tertium genus hominum," that for all we seem to know it is just a higher loving animal!"

thru means which are as effective and relatively unexpensive as no other known to us today, viz., the i.u.d. and the pill.

Furthermore, and as an effect of the Bishop's attitude refered to, or for some other reason, the Catholic sector of our population has taken and attitude which is not only conservative but of *sheer passivity*, bordering on "defeatism," or "who cares!"

There is no desire of being "apologetic, or controversial. I gladly take notice of the loyalty of our Bishops to the doctrine of the Church *the traditional doctrine she has been maintaining with "constant firmness"* But one can not feel equally happy about the second critical statement. But is it factual and true? Speaking at a seminar on "Youth's positive role in national development," held in Taal Vista Lodge, Tagaytay City, March 5-9, 1969, Mercedes Concepcion,[3] one of the speakers, said in part: "The impact of limiting our population growth will not be felt until your children are born. No matter what we do now, we still have to live in the world of our own making for the next twenty years.

"If you ask, "What have the institutions done about the population problem?" In terms of the school, again, I can say "almost nothing."... If we look at the Church — at the Roman Catholic Church — I can only say, and in fact I can quote one member of the clergy who, in Cebu City, deplored the Church's *unwillingness* to open *rhythm clinics*, which under the recent encyclical is allowed. The priest felt that if *rhythm clinics* were operated in every province, from Batanes to Jolo, in an all-out drive, and if every single Catholic couple were to practice rhythm, the impact (although this method has a much lower effectivity rate when compared to *all* other modern methods) would still bring down the birth rate."[4]

I share the great concern of the distinguished scholar-demographer for appropriate action, without delay, in order to solve *gradually* the nation's serious population problem. It seems true what she says about *the school contribution*. But it sounds to *me amazingly surprising* to hear of the (Roman Catholic Church) *unwillingness to* open rhythm clinics

[3] She is the Head of the Institute of Population and member of John XXIII and Paul VI "Commissione di studio sui problemi della populazione, della famiglia, et della natalita" C c/r LOss. Rom., March 29-30, 1965.

[4] "Youth's positive role in national development" pp. 37-38

which according to the recent encyclical is allowed. True, the Humanae Vitae says —" If then, there are serious motives to space out births, which derive from the physical or psychological conditions of husband and wife, or from external conditions, the church teaches that it is then licit to take into account the natural rhythms immanent in the generative functions, for the use of marriage in the infecund periods only, and in this way to regulate birth without offending the moral principles which have been recalled earlier."[5]

Then she quotes approvingly "*one member* of the (Catholic) clergy who in Cebu City, *deplored* the Church's unwillingness to open rhythm clinics." This is news to me, and perhaps to most of my catholic priests living and working in this sector of the Vineyard of the Lord. To the best of my knowledge the just quoted statement is groundless, and it is a matter of much regret it has received the publicity in no way deserves.

To set up "rhythm clinics" in every province, takes much money; to own or operate them efficiently necessitates more money. Each of the rhythm clinics call for at least one qualified part-time physician and subsidiary personnel, and last but not least, competent married counselors. Granted *that some* of these persons are willing to render service free, in some instances, how many bishops can afford to have the technical personnel, within reach, as well as the money, and then proceed to set up and operate one or more "rhythm clinics" in their ecclesiastical jurisdiction? In an statement issued by the Chairman, Episcopal Commission on Social Action, last July, we read this pertinent words: "Cognizant of their primary mission which is one of the supernatural order, our dioceses are still being burdened with the construction of churches, seminaries and schools. *It seems hardly known that several of our dioceses* are in such state of need that they still continue to get annual subsidy from the Holy See. Several dioceses, too, not even *ten years old, hardly subsist.*"[6] We are told that Catholic Missions in the Philippines were granted during the 1968-1969 period a subsidy amounting to 2,687,200.00 pesos.

"The priest felt that *if* rhythm clinics were operated in every province, from Batanes to Jolo, in an all-out drive, and *if* every single

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[5] "H.V.", n. 16 pp. 13-14 (St. Paul Publications)
[6] "Filipinas", July 26, 1969, p. 5, c. 4

Catholic couple, were to practice rhythm the impact... would still bring down the birth rate." A few months ago, another priest came out in the local press, suggesting " an all-out drive" with the "pill" as an effective and easy way of reaching the same goal! The fact is that the population problem is not as *simple* and its solution as *easy as* these priests choose to tell us. Let us do hard work, instead of indulging in bright dreams!

Where do rhythm clinics come in? Marital chastity has to be scrupulously observed. Marital rights can be exercise only in the light of duties to be fulfilled. This means not only the observance of the law of God, which is the law of man's nature, — the law of reality, i.e. the respect for the objective order established by the Creator; it means further that the right to beget children is qualified and conditioned by the sacred duty to educate them in accordance with postulates engraved in the very heart of men, and distinctly stated by the Church in *Can.* 1113: "Parents are bound by a most serious obligation to provide to the best of their power for the *religious* and *moral*, as well as for the *physical* and *civic education* of their children, and also to provide for their *temporal welfare.*" It isn't *bearing* children that ought to be considered and pondered seriously by married couples, but rather *rearing* them, in the full sense of the word. To accept children "as they come," and leave their upbringing at the mercy of unpredictable circumstances is not human, much less Christian. Vatican II doctrine on "responsible parenthood" is briefly and clearly stated by Paul VI thus: "It is for the parents to decide, *with full knowledge of the matter,* on the number of their children taking *into account their responsibilities towards God, themselves*, the *children they have brought into the world*, and the *community* to *which they belong.*"[7] In this doctrinal context one can readily understand the "licitness of recourse to infecund periods" and the important role the "rhythm clinics" can play. "If then, there are serious motives to space births which derive from the physical or psychological conditions of husband and wife, or from external conditions, the Church teaches that it is licit to take into account the natural rhythms immanent in the generative functions" -- but it is also true that only in the former case are they able to

[7] "Populurum Progressio", par. 37

renounce the use of marriage in the fecund periods, when for just motives, procreation is not desirable, while making use of it during the agenesic period to manifest their affection and to safeguard their mutual fidelity. By so doing, they give proof of a truly and integrally honest love" (See the whole n. 16 of the "H.V.").

The knowledge we possess of the monthly agenesic periods in fertile women and the use one makes of this knowledge in "rhythm clinics" is placed first of all, as service of the best interests of the family of responsible parents, committed to the idea of "responsible parenthood" such as we have just outlined in the light of christian teaching, *consequently* and *secondarily it can help very effectively together with other measures towards bringing within control the population problem.* This knowledge is being misused" if made to serve primarily to control births, rejecting children, while sex pleasures are enjoyed freely, without restrain, by married couples!

Prof. M. Concepcion is of the belief that "the rhythm method has a much lower effectivity (in bringing down the birth rate) when compared to *all* other modern methods." She is entitled to her opinion, but I rather listen to gynecologists and general practitioners, many of whom think otherwise.

I honestly believe catholic physicians can make a substantial contribution to the welfare of the family and of the nation in close cooperation with other elements of the community, if provided with clear and reliable working knowledge of this so called " safe-period." It was with this objective in mind that I approached the assistant-Director of the "Institute for the Study of Human Reproduction" in UST, Dr. Bienvenido Angeles, and submitted to him the request for help in a field of knowledge where his competence is well known, and soon be obliged me with an answer, which I am pleased to offer readers of Boletin Eclesiastico, particularly parish priests, physicians in rural areas, social workers, etc. It is my fervent hope and prayer this information will serve the praise worthy objectives it is intended to serve.

BASIS: — Scientific discoveries:

1. Ovulation occurs in the great majority of women, once a month, within one menstrual cycle.

a) In women who have "regular menstrual cycles with intervals of 27 to 32 days, ovulation occurs at about the middle of this period.

b) Women who have moderately prolonged cycles of 35-45 days intervals between menstrual periods ovulate a little later, i.e., 16 to 12 days before the onset of the next menstruation.

c) Women who have markedly irregular cycles have correspondingly irregular ovulations.

2. The released ovum "lives" only for a minimum of 12 to a maximum of 24 hours, very rarely 36 hours. This means that it can only be fertilized within that narrow period of time while it waits in the Fallopian tubes of the uterus.

3. The spermatozoa, ejaculated into the genital tract of the woman, remains "alive" i.e., maintains their fertilizing capacity, in a great majority of cases, for 72 hours or three days, not infrequently to as long as 5 days, and very rarely up to 7 days.

OBJECTIVE OF THE DIFFERENT METHODS IN THE USE OF THE INFERTILE PERIOD:

1. Determine the ovulation time of each individual woman, every month.

2. Sexual intercourse must be limited to those days when fertilization will not be possible, namely:
   a) at least 6 days before expected/actual ovulation.
   b) at least 2-3 days after actual ovulation.

PROBLEMS IN THE USE OF THE RHYTHM METHOD:

I. Technical:

1. How to determine the exact date of ovulation.
   a) In many cases, this is relatively easy and possible.
   b) In many cases, this may be difficult, but with patience and persistence, this can be done.

2. To date, the occurrence of ovulation is detected by means of signs that are manifest after the ovum has been released from the ovary. There are some physical signs that may be noticed by the women

tending to predict the phenomenon. These could be relied upon after a time of observation and study of the pattern in each particular individual.

II. Behavioral:

1. Attitude of the husband, regarded as the key to the success of the practice of rhythm, because abstinence from marital relations is more of a strain, generally on the part of the man.
2. Motivation of the couple may be defective. If sound determination is evident in husband and wife, spurred by the love and respect of each for the other, many minor difficulties and even major problems will not constitute as obstacles to the practice of rhythm.

III. Psychological:

If the mind and the will of the husband and wife are not prepared to accept the change in the sexual pattern that they need to adopt, this could produce undue strain in their interrelations, which could also involve the whole family.

UTILIZATION OF THE FERTILE AND INFERTILE PERIODS:

Based on the method employed in the determination of the ovulation time, there are a few procedures currently being followed depending upon the degree of effectiveness desired by the practicing couple knowing their capabilities, weaknesses and needs.

It must be said that haphazard dealing with such an intricate, individual medical and para-medical personnel and other persons who undertake the task of advising the rhythm method without having obtained sufficient knowledge and training in the matter.

It must be said that haphazard dealing with such a" intricate, individual and intimate problem is bound to give poor results. This gives the general impression that rhythm is not a reliable method. The fact is that many observations and studies have proven the effectiveness of the use of the infertile period quite comparable to the other current contraceptives being employed today. However, though it is not easy, there is nothing

wrong with the technique. It is the faulty administration, both on the part of the adviser and the user, whose understanding and/or motivation could be deficient, that cause the number of failures notoriously ascribed to the rhythm method.

Procedures:

I. Calculation of the possible periods of fertility, so that the couple could avoid having sexual relations during this time.

1. "Crude" method:

Labelled the 10-day method, it divides the menstrual cycle into three ten-day periods. The first is counted from the first day of menstruation (Day 1) and designated as "infertile." This is followed by the second ten days termed "fertile" and therefore abstention days. The third ten days precede the next menstruation and constitute the second "infertile" phase.

The simplicity of this way of advising has attracted a great many followers among busy medical and para-medical personnel and others who are not inclined to spend time nor effort in this regard. There have been many failures in this method.

A more rigid schedule had been adopted by some practitioners as a modification of the above rule of 10. This comes in the form of Fives, i.e., five days before and five days after menstruation in which the couple are advised to have marital relations, therefore entailing about three weeks of abstinance. This could be relatively effective following these two observations:

a. The count of five days after menstruation should not be interpreted as starting from the last day of bleeding, but from day 1 (onset).

b. The particular woman on whom this method is to be employed must never have had a menstrual cycle of less than 25 days in her menstrual history since her first menstruation.

2. "Formula" method:

This method has been well studied abroad with very effective results in a great number of couples who have used it.

a. Obtain an accurate record of at least 6 successive menstrual cycles of the particular woman being advised. (12 would indeed increase the effectiveness)

b. Count the number of days interval between each menstrual onset starting from the first day of bleeding, (Day 1) even if this occurs as mere spotting, up to the day preceding the next menstruation.

c. Get the smallest and largest counts indicating the shortest and longest of the recorded menstrual cycles.

d. Apply these numbers to the following formula:

shortest cycle minus 20
Longest cycle minus 10

The results obtained indicate the inclusive days of the cycle when a pregnancy can occur (fertile period) thus requiring complete abstention from intercourse, even in the form of "withdrawal" or coitus interruptus.

It should be kept in mind that the counting should always be from Day 1.

Example: A record of 6 cycles gives the following data as menstrual interval days:

26 — 27 — 28 — 29 — 30 — 32
Shortest cycle — 26 minus 20 = 6
Longest cycle — 32 minus 10 = 22

Interpretation: Counting from Day 1: — There should be no sexual intercourse (again not even withdrawal) from Day 6 to Day 22 of each cycle. Therefore marital relations may be allowed from Day 1 to Day 5 and from Day 23 until the onset of the next menstruation.

It may be stated here, in addition, that there are no medical objections to sexual relations at the time when there is menstrual bleeding. Esthetic objections do exist.

II. The detection of ovulation in a particular woman and the use of the knowledge obtained for the adoption of rhythm as a means of avoiding conception.

1. Presumptive signs:

The items below are arranged from the more obvious and constant to those of the less obvious and not frequently observed phenomena. If they are correlated with more accurate methods to be described further on, they can constitute valuable and reliable signs in the practice of rhythm.

a) Mucus vaginal discharge.
This occures in varying forms and on variable days preceding the release of the ovum from the ovary.

a. 1 A thick, viscid, tenacious mucus discharge may precede ovulation by some three or four days. "Thick" as used above does not refer to amount.

a. 2 A thin, watery, threadable discharge may precede ovulation by one or two days. Threadability is the property of the mucus to be drawn out or stretched between the fingers.

When constantly present and well-observed in every instance in the woman, then these varying mucus discharges may be applied in the practice of rhythm in the following manner, with "relative" effectiveness:

There must be no sexual relations from the time the thick discharge appears until after 10 days, counting from the day of its appearance.

Precautions: — A physical examination should eliminate any gynecological conditions that could obscure and confuse the otherwise normal processes.

— The occurrence of only a thin, watery discharge (i.e., without a previous thick discharge) necessitates abstinence througout the whole period starting from the end of the mens-

trual bleeding up to and including six days from the time the watery discharge has been observed.

These calculations have been premised on the studies conducted by several investigators who verified the relationship between the discharges and the occurance of ovulation.

Thus: — thick mucus discharge— 4 days before ovulation.
thin mucus discharege— 2 days before ovulation
"Life of the ovum — 1 day after ovulation
prescribed safe margin— 3 days after ovulation

Total 10 days, after which it may be considered relatively safe to resume sexual relations.

This method remains to be verified with more studies and is therefore not conclusive.

b) Softness of the cervix

If the woman would consent to a procedure involving a self-examination, she, or her husband, could be taught and trained to feel, with the fingers, that part of the cervix projecting into the upper end of the vaginal canal softens at the time of ovulation in comparison to other times — somewhat similar to the soft tip of the lips and relatively hard tip of the nose, correspondingly.

It follows that there should be no intercourse from the period of menstruation until after three days of feeling the softness of cervix, unless the foregoing calculations are concomitantly used. Again, this method remains to be verified with more conclusive studies.

c) Pain. Some keenly observant women feel a sharp sudden twitch or heaviness dragging sensations on either right or left lower abdominal (iliac hypogastric) more regions at the time of ovulation. If these are confirmed by more exact methods of determining, the occurence of ovulation, and if constant, then this sign may be employed in the use of Rhythm —

again by abstaining from intercourse until the pain appears and resuming 2-3 days after its occurrence.

In the same manner, this has to be verified and applied as in the previous items.

d) Slight bleeding or spotting of blood at about the middle of the mens trual cycle may also signify the occurance of ovulation, though this sign is the least constant.

These presumptive signs have been enumerated and described to complete the information on this subject. They are not usually recommended for practical use specially on a "do-it-yourself" basis, unless correlated with more exact methods or if the couple are not so particular whether conception occurs or not and are willing to subject or lend themselves to a scientific study to accumulate data and thus provide eventual reliability in their use. Further, before depending on these methods, it is important to seek the help of a trained physician, nurse or layman who has done previous study, training and experience in this matter.

2. Positive signs of ovulation and their application.

a) Body Temperature changes.

Extensive, thorough and fully verified world-wide studies have established the consistent finding that there are definite alterations of body temperature in each individual woman during her menstrual and ovulatory cycles.

A "basal" or low temperature is registered during the menstrual and pre-ovulatory stages of the cycle. A shift to a higher level of temperature occurs at the time of ovulation remaining at this level until the day of onset of the next menstrual period.

The rise constitutes at least 0.2 as much as 0.6 in the Centigrade scale and from 0.5 to 0.10° in the Fahrenheit scale.

In a great majority of women, this rise of temperature is therefore rather easily noted and quite conclusive. In others, the picture maybe obscured by a number of variations due to some

extraneous conditions. It is generally considered that the initial employment of the method necessitates the guidance of a trained person.

Nevertheless, the technique, correctly employed, constitutes a most reliable sign of actual ovulation and hence, the prudent regulation of sexual relations concomitant to the gathered and cumulative data provide a stable and effective means for the avoidance or regulation of conception.

Technique:

The woman's body temperature is taken *daily* in the first few months. Later, after she has acquired more experience and confidence in the method, this maybe reduced to the period in which ovulation is expected to occure.

a) Although oral temperatures could suffice, preference is given to rectal temperatures because of less variability in the registration. In either case, the ordinary clinical thermometer is used corresponding to the prefered route, i.e., oral or rectal.
b) Daily notations are made from the first or second day of menstruation through to the next period.
c) The best time for taking the temperature is the usual awakening time in the morning (preferably at the same time each morning) when the body has had a sufficent period (at least three hours) of rested sleep, i.e., *before rising from bed.*
d) Readings are best recorded in a graphing paper where the "ovulatory" rise can be easily observed.

Application and expected effectiveness.

a. If sexual relations are limited to the *post-ovulatory period* (high level temperatures) a non-pregnancy rate 96 to 98% may be expected.
b. The conjugal act may not be started until after having observed at least THREE "high" temperatures on THREE *successive* days. This high level marks the infertile period which continues up to the onset of the next menstruation. Hence, the couple can freely "use" these days without hesitation.

CAUTION — If the temperature drops to the previous basal level after 1 or 2 (false) rises, these are to be desregarded and counting only resumed and maintained on the succeeding high registers for three successive days.

c. If the couple desires to make use of the pre-ovulatory phase, they should limit themselves to the menstrual and immediate few post-menstrual days, using the previously stated formula of calculating the first day of the infertile period by substracting 20 from the shortest cycle.

The use of this pre-ovulatory phase increases slightly the risk of pregnancy, bringing down the effectiveness. This is due to the ocurrence of early ovulation not previously taken into account in the menstrual history of the particular woman involved, as stated previously.

Problems:

There are indeed a number of variations in the overall picture which at the initial experience of the couple may be obscuring and confusing. It is advised therefore that they seek the services of a person, who has had previous good and reliable training and experience in the use of the method.

Such problems as grossly irregular temperatures, absence of a definite rise, or very slight difference in the temperature recordings or a very gradual or "step-ladder" rise, and others may be interpreted by these experienced persons.

Women who have just delivered should be advised to seek a knowledgeable person for instructions.

"CONTROLLED RHYTHM" is the name given to a method recently adopted by Family Planning Specialists following an extensive study of the technique in the past few years. This method is resorted to when the woman exhibits periods of non-ovulation as shown by her temperature readings, causing undue strain on the couple brought on by the prolonged abstinence from sexual relations.

In such case, the woman may be put on a 10-day regimen of progestine pills to be started on Day 18 following absence of a tem-

perature rise indicating a delayed or anovulatory cycle. After completion of the 10 days of pill taking, the woman will experience the usual "withdrawal bleeding".

In such a procedure, sexual relations may be resumed only after three days of taking the pill, with the assurance that this has established its contracepive effect of suppressing an otherwise delayed ovulation. This is therefore a means of trying to regularize or induce the regular pattern of ovulation. Thus, if the method is followed for three successive months, it is hoped that the ovulatory pattern will be restored and rhythm followed with the usual temperature method.

A similar procedure may be followed in women who had not been menstruating after delivery. Furthermore, in those women who have overlong menstrual cycles of 40 or more days interval.

Again, it would not be amiss to point out that this needs the guidance of experienced personnel.

b) Other methods of detecting ovulation.

It is only for the sake of completion and information that these are being enumerated, because the techniques involve laboratory procedures needing the services of trained personnel for satisfactory and reliable administration and interpretation.

1. "Ferning" — this is the appearance of a fern-leaf pattern when a small amount of cervical mucus is smeared on a glass slide and allowed to dry. This occurs on the time of ovulation. Otherwise, no definite pattern is formed during the non-ovulatory phases of the menstrual cycle.
2. Chloride Test — a pharmaceutical firm in the United States has marketed a product in a box called the ESTRINDEX KIT, containing a number of materials for the purposes of taking samples of cervical mucus and testing for the presence of chloride by rubbing the swabbed mucus on sensitive paper. Positive manifestations indicate the time of approaching ovulation. It is a simple procedure that can be done easily by any ordinary woman. To all

indications, following a long period of testing, the method is reliable and therefore quite effective. The only drawback is its unavailability in the local market, and even if found occasionably, the prices would be quite high.

3. Excretion of hormones — There are certain substances identifiable by laboratory procedures in the urine of the woman at the time of ovulation. The means of extracting them from the urine and analyzing them entails a long and complicated process.

4. Microscopic examination of cellular material from the vagina, cervix, and uterus giving information as to what is the stage of the menstrual or ovulatory cycle at the time of examination. Again this needs expert attention.

5. Finally, there are at present many studies being conducted not only for a more simple and practical way of detecting ovulation but hopefully for a way of pre-determining ovulation. Once these experiments are verified and perfected, the practice of rhythm would be greatly enhanced, simplified and made 100% effective.

Still, all things being considered, the main problem of the practice of rhythm is focused on the attitudes, motivations and spirit of the husband and wife in addition to mental capabilities. To some it could constitute a most difficult way of preventing or regulating birth because of the aspect of non-indulgence. To others it would be most easy, inspiring and rejuvenating it to the family and community where they belong.

BENEFICIAL EFFECTS:

1. Upliftment of man's dignity and restoration of man's place and role in creation. This may be achieved because the method entails moderation — control of self — which is a step forward in his evolution to the original state assigned to him by the Creator. Voluntary control of this strong urge could enable him to elicit the same with regards other degrading acts.

   The claim that frustration of these impulses leads to neurosis is mainly unfounded. Regulation of the instinct by *conscious* control of *reason* is *suppression* which the mind of man distinguishes

as necessary, beneficial and is thus not harmful to him. If such control is subconscious and permanent, this is *repression* which is the cause of neurosis.

2. Enhancement of marital relationships.

a) Since the moderation and self control implies consideration, respect and regard on one for the other, the appreciation manifested by each of the partners would be a reward shown in multifarious endearing ways.

b) Non-indulgence in the sexual act for brief periods of time increases the value of the act, moving it from the level of the biological instinct to the quintessence of a voluntary human act. The fully mature man is one who has learned to fuse the sexual impulse with love. Pure physical gratification is the mark of a sexually subnormal or immature individual.

c) The ever-increasing love between the partners in marriage creates a permanent bond. For love is a cognitive act which makes the lover grasp the innermost core of the personality of the loved one. In its expression in the sexual act, the lovers deeply probe into the mystery of each other's soul, enriching and invigorating one and the other.

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