Nefesh News

www.nefesh.org The International Network of Orthodox Mental Health Professionals

June 2005

The 9th Nefesh International Annual Conference

February 8, 2006 – February 12, 2006

Marriot Hunt Valley Inn

Baltimore, Maryland

"Working Together For Tzorchei Tzibbur: Gaining Strength from Unity and Diversity"

Since Nefesh's inception, Nefesh has devoted itself to helping address problems in the Orthodox Jewish community, and the unique needs of Orthodox Jewish Mental Health professionals. The annual Nefesh International Conference is an essential component of meeting these challenges. Many people ask, Why attend? What's so special about this conference? Our conference brings together Orthodox social workers, psychologists and psychiatrists from all over the world; Israel, South America, South Africa, Europe, Canada, the United States of America, and Australia, united in their desire, to learn, and to help others and each other. Founded 10 years ago, Nefesh International is now recognized by all segments of the Orthodox community, and organizations and individuals are reaching out to us for help on a continuous basis .In addition for those of you who have attended in the past, you know yourself what an inspiring and gratifying experience spending a Shabbos together is.

The 9th annual conference hopes to build on all the previous outstanding conferences. It's quite a challenge and we look to all of you to join us. There is a great deal of expertise among our members and we hope you will share your specialties and knowledge by responding to the call for papers, that you will find within this newsletter, as soon as possible. We have been actively preparing and are excited by the quality of the proposals we have already received.

We already have an impressive roster of speakers. Dr. Otto Kernberg, a world-renowned expert on Borderline Personality Disorders will be leading one of our pre-conference institutes on February 8th, 2006. We will be joined by esteemed Rabbonim, educators, and community activists who have dedicated their lives to Tzorchei Tzibbur. Once again, our venerated Rabbinic advisor, Rav Dovid Cohen, will be joining us. Rav Cohen has been a staunch supporter of Nefesh and of the weak and vulnerable in the Jewish community. We are also privileged to have Rabbi Tzvi Hersh Weinreb, Ph.D, Executive Vice President of the Orthodox Union, and Mr. Richard Joel, President of Yeshiva University, as well as Rabbi Abraham Twerski, M.D.

Please know that we value your input and pay attention to your requests. We have seriously considered suggestions from the participants of previous conferences and are attempting to incorporate changes where it is felt to be warranted and practical. For example, we expect to have the schedule publicized well in advance along with abstracts of the presentations.

We look forward to hearing from you. Best wishes for a healthy and good summer,

Respectfully yours,

Chana Kahn, LCSW Dr. Abe Worenklein

Conference Co-Chairs

Message from the Editor

Dear Colleagues,

We all know the benefits of technology are a double edged sword, and many of us observe our clients' marriages and families falling apart due to workaholic cell phone usage or Internet addictions. But it is important to note that as professionals we must acknowledge the ways in which Internet and email technology has allowed NEFESH to flourish. First, the Internet listserve has made editing the Newsletter a real pleasure. I have received many articles and stimulating comments over the past few months, which could only have been facilitated by the listserve. Second, we are working on an International web-based social service resource directory which is discussed elsewhere in this newsletter. In addition, at some time in the future, we hope to create an on-line version of the newsletter. So, please keep the comments and articles coming!

I gratefully acknowledge the assistance of several individuals who have helped produce this newsletter. Rifki Goodman, NEFESH administrator who does the layout and printing of the newsletter, Aviva Biberfeld ,for handling the advertisements, and Karyn Feinberg for copy and style editing.

With best wishes for a happy and healthy summer,

Simcha Feuerman, LCSW
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DISCLOSURE

Nefesh publishes articles as a service to its readers. We would like to remind the readership that Nefesh International does not recommend or endorse any particular method, institution, treatment or theory contained within a newsletter hashkafically or psychologically. As with all other religious, psychological or legal decisions you should consult with the appropriate experts in each area before implementing a particular method, decision, or intervention.

The Psychopharm Consultant

Shalom Feinberg, M.D.

REVIEW OF THE 2005 APA MEETINGS

As I sit down to write this column I have recently returned from the American Psychiatric Association meeting in Atlanta. In the few days since my return, one of the most oft asked questions by colleagues has been, "What's new in psychopharmacology and what issues stood out?" Well, the APA meeting offers a few hundred sessions over 6 days (and you thought it's hard to decide which session to attend at a NEFESH conference!) so any answer I suggest is skewed by my interests and the relatively few programs I chose to attend. But with those qualifications, allow me to share some of the information/research which stands out in my mind.

It is sometimes suggested that Bipolar Disorder is a orderly episodic illness that responds acutely to treatment and can be subsequently fully contained by appropriate maintenance therapy with mood stabilizers. The reality is that episodes can be difficult to treat, relapse is frequent, and there is much associated co-morbidity and chronic dysfunction with this illness, particularly from depressive symptomatology. Combining this reality with the economic motivations of the pharmaceutical industry has led to much research on the use of all the various atypical anti-psychotics (AAPs) for this disorder. In fact in a fairly short time span all five of the commonly prescribed AAPs (AKA Risperdal, Geodon, Seroquel, Abilify and Zyprexa) have received FDA approval for use in bipolar disorder, specifically for the treatment of acute mania. Abilify and Zyprexa also have FDA approval for ongoing maintenance therapy for the prevention of future bipolar related episodes. In addition, Symbyax, a combination pill consisting of Zyprexa and Prozac has been FDA approved for the acute treatment of bipolar depressive episodes. Zyprexa alone has also been shown to be more effective than placebo in two studies of bipolar depression. (Note that this latter research focuses primarily on bipolar I depression, recalling that bipolar I disorder consists of mania and major depressive episodes, while bipolar II disorder, probably the more common variant, consists of hypomanic episodes along with depressive episodes). I was struck with how frequently these uses of AAPs seem to come up at this year's meeting. To those familiar with the mood disorder literature, my discussion until now may not sound like new information. In contrast, a double blind placebo controlled study, unpublished as of yet, involving a few hundred patients, suggests that Seroquel in doses as low as 300mg/day will also effectively treat acute bipolar depression. Open studies find the other AAPs may have a similar role, and one can expect the pharmaceutical industry to be aggressively pursuing this line of study. Now let me (further) editorialize. While clearly, we need as many pharmacological tools as possible to address all aspects of this potentially life threatening disorder that mood stabilizers (e.g. Lithium, Depakote, and now, Lamictial,) alone often do not fully control, the AAPs are not benign agents, and they generate their own short and long term side effect risks. (These can include metabolic syndrome, diabetes, extrapyramidal symptoms and a fairly small, but not necessarily negligible risk of tardive dyskinesia.) And for patients paying out of pocket for their medications, they are not cheap. Clinicians must be cognizant of these dangers even as the pharmaceutical industry vigorously broadcasts the benefits of these agents.

Now turning to another topic, the treatment of schizophrenia. All of us who treat this disorder see the limitations of our present pharmacological strategies. While there were sessions discussing how to "tweak the meds" in order to elicit further benefit, I was struck by the increased focus on the value of cognitive behavior therapy (CBT) techniques for this illness. While initially created by Aaron Beck and others for depression and other non-psychotic illnesses, CBT can be modified and applied carefully for use in psychotic patients as well. This emphasis on talking to our patients and working within their inner world in some ways feels "Back to the Future" and needless to say is very appropriate. As space does not allow a full discussion on the specifics of this use of CBT, I would recommend that those interested in this topic read "Cognitive Therapy for Schizophrenia" by Kingdon and Turkington, Guilford Press, 2004.

Anorexia Nervosa (AN) is a life threatening eating disorder that can be amongst the most difficult illnesses to address. The therapeutic approach is usually a multi-modal one involving medical, nutritional, and psychotherapeutic components. The value of psychiatric medications for a severely, weight restricted AN patient in order to enhance weight has been disappointedly limited. (In contrast, newer antidepressants such as Prozac maybe of some value to treat co-morbid psychiatric conditions such as anxiety disorders and to prevent relapse once weight has been restored.) A few small open clinical series suggest that the antipsychotic Zyprexa may have a role in enhancing weight

gain in the acutely ill AN patient even if there are no overt psychotic symptoms. As this illness can be so resistant to treatment, any additional effective therapeutic element could be of significant value if these preliminary findings are proven true. Research data was presented on this question based on an ongoing study being jointly conducted at Columbia University here in New York and at Toronto General Hospital in Canada. Disappointedly, so far, the results do not appear impressive. Firstly, while Zyprexa did produce some weight gain in a few patients in the short term, there is no data as of yet on whether this weight gain would persist beyond the first few weeks, particularly in the case of an illness that is frequently a very chronic condition. (I would also note that this was not a placebo controlled study.) Most importantly, very few AN patients were willing to participate in a study using a medication known to produce significant weight gain and this would likely be the case in real life practice as well.

Lastly, there was a presentation suggesting that Chromium Picolinate, a natural mineral, that has been used for years as a treatment aid in type 2, non-insulin dependent adult onset diabetes mellitus, may help diminish carbohydrate cravings in binge eating patients. Two previously published studies have suggested it may have value in atypical depressive patients. Chromium Picolinate may have value in psychiatric practice though more research is indicated.

Well, this has been my subjective view of the recent APA meetings and hopefully you've found this informative. And, one last thing, Atlanta has are some good kosher restaurants if you ever find yourself in that neck of the deep south.

To the editor of Nefesh News:

Dr. Pessy Sloan's article "The Case For Special Education For Gifted Children In Orthodox Jewish Schools "addresses an issue that is too often neglected. When funds are limited, as almost always is the case in Jewish education, the needs of children who are having academic difficulties takes precedence over the bored and under stimulated gifted children. The acceleration of gifted children in ability grouped classrooms is desirable but alas, schools may not even be able to offer enrichment programs within the school setting. Boys who are gifted in religious studies such as Gemara maybe placed in a more advanced class (with all the difficulties of studying with older students) but there is less frequently such an arrangement for girls.

While Dr. Sloan's article was quite comprehensive, I feel that it is necessary to emphasize the hashkafa aspects of addressing gifted students' academic enrichment programs. In many communities, students who are gifted in secular studies are often forced to study on their own or seek enrichment outside of the Orthodox school system. This may satisfy their intellectual curiosity and academic development; however, there are risks of socializing and developing close friendships at a young age with peers of both sexes who may not be religious or even Jewish. This issue is particularly relevant to adolescent social development. While this is problematic for students gifted in the sciences the problem is even greater for students who are gifted in the arts. There are usually fewer art (or music etc) programs within the Orthodox school setting and a secular art program may violate basic elements of modesty (tsiniut) that the religious community seeks to promote. Can the Orthodox community afford to risk losing its best and brightest?

In Israel, over a decade ago, the first specialized arts high school for religious girls was established. Since then, there has been established a number of specialized high schools and more recently specialized junior high schools. In addition, other non specialized high schools are offering enrichment programs in the sciences or the arts. Both in the boys' yeshiva high schools and in the girls' ulpanot there are a number of schools that specialize in the sciences or the arts and talented students are selected to attend these schools. The programs are gratifying and demanding. In effect, the students have a triple program. An art student, for example, may have 12 hours of art theory and studio work per week in addition to religious studies and general secular studies. The students can study in depth in their field of interest in a religious environment and are exposed to appropriate hashkafa and have religious role models, while socializing with like minded religious peers.

This Israeli model of specialized schools could be adapted to other countries in metropolitan areas with a large religious population where there are many Orthodox Jewish schools.

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From The President's Desk

Nosson Solomon, Ph.D.

Since our last International Conference, many of our colleagues have been hard at work on upcoming events and developments. These have been busy months for NEFESH International, as we grow our organization. I am very pleased, in this connection to welcome into the NEFESH fold several new members in Australia, where colleagues are organizing regionally.

Planning proceeds apace on the International Conference scheduled for February 2006, as well as a series of New York-area professional training programs beginning this summer. A new and much-improved website is currently under construction and will serve several functions. Details of all these developments can be found in this Newsletter and in upcoming notices.

A serious community education initiative is underway (see this issue). This is a long-overdue venture for NEFESH that we fully expect to expand considerably during the months ahead.

Our Development Committee is active in developing for NEFESH the financial resources and security necessary to continue our work. In this vein, let me mention that many advertising opportunities are now available in NEFESH publications and on our Listserv. Members and non-members can now reach hundreds of mental health professionals while supporting NEFESH. See inside this issue for details.

All the above, as well as other efforts I have not mentioned, are no-nonsense initiatives intended to strengthen NEFESH and further our efforts to accomplish our mission. I look forward to your participation and help, as well.

Have a wonderful summer.

B'hatzlacha,
Nosson
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Manipulation in Psychological Treatment: Rabbinic View

Seymour Hoffman, PhD

In her review of "Cotherapy with Individuals, Families and Groups" (Israel Journal of Psychiatry, 37, 1, 2000), Rachel Chazan criticized the "dialectical cotherapy approach" that my colleagues and I developed and described in the book, on moral grounds. "It is difficult to accept a method of therapy based on deliberate dishonesty. It is hard to believe that the deception has no long-term ill effects. Even if it succeeds, does the end justify the means"?

According to this view, and there are many practitioner who suscribe to it, treatment approaches that make use of placebos in medical and psychological treatment and paradoxical interventions popularized by such prominent strategic therapists as Haley, Madaness, Frankl, Zeig, Rossi, Lankton, Lustig, and Milton Erickson, to name a few, would be considered "treif", "verboten" and unacceptable.

I would like to respond to the question raised by the reviewer.

Strategic therapy is a direct treatment approach that aims to relieve symptoms, resolve conflicts, and free people from their neurotic morass in the shortest time possible. This approach relies heavily on manipulation to effect change quickly and effectively.

Manipulation in the most concrete sense is the act of controlling with the hands or the mind. The use of manipulation has produced wide debate and heated reaction among psychotherapists of all persuasions. (1, 2, 3) On the one hand, there are those who decry its use because they think it is patronizing, infantilizing, presumptuous, coercive, deceptive, abusively authoritarian, unethical, inconsistent with respect for the client and incompatible with developing a trusting therapeutic relationship.

On the other hand, there are therapists who argue that “life is one big manipulation” and insist that it is involved in all forms of therapy, ranging from analytically orientated to behavioral and strategic, though it may not be equally obvious in all forms. In their view, manipulation is nothing more than influence, and in therapy, “one cannot not influence” just as “one cannot not communicate”. The question is not whether to influence or not but how to do it in the most constructive, humane, non-exploitative, effective, and expeditious manner, in order to effect positive change in the client and help him ameliorate his symptoms and resolve his conflicts. Manipulation in its most benign and simple form is no more complicated than a mother placing a band-aid or a kiss on the wound of a child to “make it all better.” In its more complex form, manipulation involves deception and shrewd, devious, and strategic interventions. (4)

Manipulation for therapeutic and altruistic motives has been sanctioned by leading Jewish religious leaders, although it was condemned when used for selfish interests because the values of integrity and honesty are paramount.

(An example of the latter is found in Tractate Yevamot (63a)): "The wife of Rav (one of the outstanding scholars in the Talmudic era, was in the habit of irritating him. When he requested from his wife to cook for him lentils, she cooked for him chick-peas and when he requested chick-peas, she would cook for him lentils. When his son Chiyah grew up, he reversed the requests of his father to his mother. Rav said to his son: 'Your mother has improved'. His son said: 'I am the one that reversed the requests to her'. His father said to him: 'This is what people say, that your son teaches you wisdom. Even so, don't do this, because it is written in Jeremiah, 'Their tongues will teach deceitful things' ").

Rashi in his commentary on *Ethics of the Fathers* (1:2) records the strategic-manipulative interventions of Aaron the High Priest, who antedated Haley and Erickson, two of the most prominent strategic therapists, by 3300 years.

Several examples are given regarding Aaron’s manipulative therapeutic methods of intervention:

One man became angry with his wife and chased her out of the house and swore that he would permit her to return only if she spat in the face of the High Priest.

When Aaron became aware of this, he summoned the woman and told her that he had an eye infection which could only be cured if she spat at it. After considerable pleading, the woman acceded to Aaron’s request. Afterwards, Aaron summoned the husband and related to him what his wife had done. As a result of this, the couple reconciled. (A similar intervention is recorded in Vayikra Rabba, 15:9).

When two men quarreled, Aaron would go to one of the disputants and inform him that he had just returned from the disputant’s friend and found him terribly upset and regretful of the pain that he had caused his fellow. Aaron would not leave the disputant until all jealousy and hatred had been removed from his heart. Afterwards, he would go to the other injured party and repeat the same thing to him. When the men met, they would fall on each other’s shoulders and tearfully reconcile.

Several examples are recorded in the Talmud of manipulative behavior by prominent religious figures whose intentions were to help fellow Jews. It is related in

Tractate Nedarim (50a) that the Prophet Elijah appeared at Rabbi Akiva's dwelling (a barn where he and his wife slept on straw) as a pauper and requested some straw for his wife who had recently given birth to lie down on. Rabbi Nissim explains that Elijah did this in order to console the couple and show them there were people poorer than themselves.

In Tractate Yevamot (11b) it is recorded that the Sages advised a woman to "playact" (to cry, tear her clothing, and dishevel her hair) when she appeared before Rabbi Judah in order to convince him that her husband had died, so that he would permit her to remarry.

In Tractate Arachin (23a), it is related that Moses the son of Etsri was the guarantor for the marriage contract of his daughter-in-law. His son, Rabbi Huna, was as a scholar with little financial resources.Abaye said: "Is there no one to advise Rabbi Huna to divorce his wife and since he is without means, his wife will collect the money from his father and afterwards Rabbi Huna will remarry her. This way he will be able to support her and himself." The Talmud explains that this kind of conspiracy is permissible when it is done for the benefit of a son who is a scholar.

An example of a psychologically more sophisticated intervention by a prominent rabbinic figure of the last century is recorded by Karlinsky. (5) The incident took place in Warsaw in 1877. Rabbi Joseph Dov Soloveitchik, an outstanding Talmud scholar, religious personality, and leader was overcome by a deep depression upon the incarceration of his highly revered and beloved mentor, Rabbi Joshua Leib Diskin, on false charges by the anti-Semitic authorities. On the Sabbath Rabbi Soloveitchik ate only the minimal amount of food necessary to fulfill the requirements of Jewish law. He isolated himself in his room and refused to receive any visitors, not even his closest students and colleagues. He discontinued going to the synagogue and teaching. A specialist who was called in to treat him recommended total rest, but added that if by chance the rabbi's spirit could be suddenly stimulated, healing would take place in a matter of minutes.

Attempts by his family, friends, students, and colleagues to pull him out of his depression failed. Even the efforts of the renowned scholar and hasidic leader, the Master of Gur, failed to lift his colleague's depression through encouragement, support, and intellectual stimulation. One day, upon hearing about Rabbi Soloveitchik's deteriorating mental and physical condition, Rabbi Meir Simha Ha'Kohen, a brilliant scholar and student of Rabbi Soloveitchik, hurried to visit his teacher. Rabbi Meir attempted unsuccessfully to engage his rabbi in a talmudic discussion, as the latter was totally engulfed by worry for his beloved colleague. At one point, Rabbi Meir quoted some of the Torah novella that he had heard from Rabbi Diskin when he had visited him in jail some months previously. As Rabbi Meir discerned some reaction from his teacher, he began to challenge and criticize Rabbi Diskin's new insights and interpretations on certain talmudic topics and vigorously disputed the conclusions. Upon hearing criticism of his beloved teacher, Rabbi Soloveitchik began to defend him by quoting texts and rabbinical authorities and explaining and analyzing his teacher's Torah. Instead of remitting, Rabbi Meir continued to challenge Rabbi Diskin's Torah, which prompted Rabbi Soloveitchik to raise his voice and marshal all his brilliance, analytic skills, and energy to refute his student's arguments and prove that his mentor was correct. Rabbi Meir soon began to raise other talmudic topics to which Rabbi Soloveitchik also responded in an increasingly intense manner.

After concluding their talmudic deliberations, Rabbi Soloveitchik accompanied his visitor to the synagogue, where he had not gone for a long time. Shortly afterward, Rabbi Soloveitchik resumed his teaching and regular activities as the spiritual leader of his community.

Another example of a creative manipulative intervention on the part of a respected rabbinic figure is an incident related about Rabbi Mordechai Lebton, the Chief Rabbi and head of the rabbinical court in Syria in the nineteenth century. One day a distraught couple appeared before the rabbi for a divorce. Though the couple had been happily married for many years, during the last year the husband had become depressed, angry, and impatient with his wife because she was barren and therefore decided to divorce her. The rabbi unsuccessfully attempted to persuade the husband to reconsider his decision since his wife was a fine meritorious person.

The rabbi, a highly intelligent and perceptive person who was able to penetrate the inner recesses of people and discern their dynamics and weaknesses, decided on a plan of action to cause the husband to revive his affection and appreciation of his wife. He instructed the couple to return the following day for the purpose of arranging the divorce procedures.

The next day, as the rabbi was preparing to divorce the couple, his student (upon pre-arranged instructions) barged in and whispered into the rabbi's ear. The rabbi unexpectedly began scolding and yelling at his student to the astonishment of the estranged couple. When queried about his unusual behavior, the rabbi explained that his student had crossed the line of propriety. "My student had the audacity to ask me to hasten the divorce proceedings so that he could propose marriage to this wonderful woman."

Upon hearing this, the shocked husband informed the rabbi that he decided to return to his wife and asked the rabbi for his blessing. The following year, a son was born to the happy couple.

The "Hafetz Haim" was consulted about how to help a young scholar, who had a fine personality, came from a good family, but was of short stature, which made it difficult to find him a suitable wife. The rabbi advised that he should wear elevated shoes at the first meeting in order to give him a taller appearance but not afterwards. The explanation given was that the potential mates should not be repelled and discouraged on first sight and that after getting to know him, his physical stature would not be a significant decisive factor.

It appears that the rabbinic attitude regarding the ends justifying the means is quite flexible, as they sanction and use manipulation when noble goals are involved such as the enhancement of people's emotional and social well-being.

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From the Desk of the Student Division

The student division continues to look for ways to develop programs related to areas of interest for Orthodox students studying for graduate degrees in Mental Health-related fields. Some ideas that are being considered are a mentoring program involving experienced professionals from the various disciplines, special presentations and/or group discussions at the next NEFESH conference related to issues relevant to students, as well as student discounts on various NEFESH products and services. For more information or to volunteer, contact Betzalel Winder, PhD, at tzali@alumni.waldenu.edu

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Great News!

THE JEWISH INTERNATIONAL RESOURCE DIRECTORY of Mental Health and Social Service Agencies

A Joint Project of **NEFESH**, Ohel Children's Home and Family Services, and **Yitti Leibel Helpline**
With the Generous Support of **TARGUM SHLISHI**, a **Raquel and Aryeh Rubin Foundation**

NEFESH has initiated the development of an International Resource Directory. Our hope is to have an on-line searchable database of social service and mental health agencies that serve the Orthodox Jewish community. This database will be available on the web as a tool for mental health professionals who serve this population.

But we need **YOU** to help us grow this database. Please send us information about any agencies you know of in your area, so they can become listed. You may do so by either logging on to: www.nefesh.org, or filling out the form below and faxing or mailing it to our NEFESH office.

THE JEWISH INTERNATIONAL RESOURCE DIRECTORY
of Mental Health and Social Service Agencies

A Joint Project of NEFESH, Ohel Children's Home and Family Services, and Yitti Leibel Helpline

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SERVICES PROVIDED:

- ❑ Alzheimers
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- ❑ Camps
- ❑ Case Management
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- ❑ Community Education
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- ❑ Crisis Intervention
- ❑ Day Programs
- ❑ Domestic Violence Prevention
- ❑ Domestic Violence Shelters
- ❑ Domestic Violence Victims Recovery
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- ❑ Family Therapy
- ❑ Financial Relief
- ❑ Food Programs
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- ❑ Holocaust Survivor Aid
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- ❑ Homeless Services
- ❑ Hospice
- ❑ Hotline
- ❑ Individual Therapy
- ❑ Inpatient Addiction Services
- ❑ Inpatient Eating Disorders
- ❑ Legal Aid
- ❑ Marital Therapy
- ❑ Mediation
- ❑ Medical Services
- ❑ Outpatient Addiction Services
- ❑ Outpatient Eating Disorders
- ❑ Outpatient Mental Health
- ❑ Parent Education
- ❑ Psychiatric Evaluations
- ❑ Psychological Evaluations
- ❑ Referrals
- ❑ Residential Services
- ❑ Residential Services for Elderly
- ❑ Respite Care
- ❑ School-based Programs
- ❑ Services for New Immigrants
- ❑ Sexual Abuse Recovery
- ❑ Sexual Offender's Treatment
- ❑ Sexual Orientation Services
- ❑ Social Supports
- ❑ Special Education Services
- ❑ Support Group
- ❑ Support Services for Cancer Victims
- ❑ Support Services for Terminally Ill
- ❑ Trauma Recovery
- ❑ Traumatic Brain Injury
- ❑ Treatment Groups
- ❑ Vocational Rehabilitation
- ❑ Youth at Risk
- ❑ OTHER

POPULATION SERVED

- ❑ Bereaved
- ❑ Elderly
- ❑ Families
- ❑ Immigrants
- ❑ Persons with Developmental Disabilities
- ❑ Persons with Gender Identity Conflicts
- ❑ Persons with Learning Disabilities
- ❑ Persons with Physical Disabilities
- ❑ Persons with Psychiatric Disabilities
- ❑ Persons with Life-Threatening Illnesses
- ❑ Pre-school Children
- ❑ School-Age Children
- ❑ Victims of Abuse
- ❑ Victims of Trauma
- ❑ Youth at Risk
- ❑ OTHER

LANGUAGES:

- ❑ Arabic
- ❑ English
- ❑ Farsi
- ❑ French
- ❑ German
- ❑ Hebrew
- ❑ Russian
- ❑ Spanish
- ❑ Yiddish
- ❑ OTHER

FEES:

- ❑ Fee for Service
- ❑ Medicaid
- ❑ Medicare
- ❑ No Fee
- ❑ Sliding Scale
- ❑ Third Party Insurance
- ❑ OTHER

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Hassidic and Gifted?

Helen Lichtman, Ph.D.
Director of Psychological Services – Kiryas Joel School District

The Rebbe's face glows with satisfaction as he pats the head of his young star pupil and rewards him with a candy for his wonderful recitation and translation of a most complex and lengthy Rashi. The boy is only 8 years old, yet he is as fluent as most teen-age bochurim. Surely he is well on his way to becoming a budding talmid chacham!

Or is he? How would our young scholar fare on a standardized Wechsler-type intelligence test translated into his native tongue, Yiddish? How would he do in the world of work – would the precariousness exhibited here evolve into a *business kup* as he struggles to make a parnasa for his growing family when he grows older? Will he distinguish himself when he reaches the steps of the Yeshiva Gedolah?

Having tested or supervised the testing of thousands of Hassidic children over the past fifteen years, I can begin to suggest answers to these questions, with some degree of confidence. At the Kiryas Joel School District, we have tested large numbers of children who had been referred for learning difficulties, articulation problems, and behavioral issues. We have also screened large numbers of preschool children who attended the community -wide Headstart program, in a collaborative effort to help that program meet their educational requirements to conduct some form of screening, while gathering normative research data for ourselves in the process.

For a child to be considered *gifted* an IQ above the 98th percentile is required. This translates, typically, into an IQ score of approximately 130 and above. Given the cultural bias of all standardized intelligence tests – even those which are non-verbal and promote themselves as being culture free - it is virtually impossible for school aged Hassidic children to meet this criterion. While some innately gifted children score as high as the superior range, their unfamiliarity with a small number of items across many subtests, or with the nature of the tasks themselves, knocks these talented children out of the competitive, inner ring of *giftedness*. At the early pre-school level, however, I have come across a small number of gifted children (those who score at/above the 98th percentile). Yet, I have no recollection of reviewing a Full Scale IQ protocol of 130 or above at the school aged level.

As the Hassidic child grows older, his world becomes increasingly different than that of his non-Hassidic peers and he is faced with a larger number of items, on these tests, that are beyond his repertoire. [For example, both Hassidic and non-Hassidic three-year-old children who are highly verbal and perceptive can tell me that the color of grass is green, because both have typically been exposed to grass in their short lifetimes. But only the attentive non-Hassidic five year old child can tell me that the picture of the "funny looking house" I am showing him is an *igloo* as it is typically taught in conjunction with the short "i" sound.]

But, let me posit a larger question? Is the Rebbe described above truly *kvelling* over the child with the highest IQ in the class? Not likely! Is the prodigy with the candy treat going to be *the most* financially successful child in the class? Once again, the odds are against it. Ah, but surely he will be the greatest talmid chacham, once he reaches the Yeshiva Gedolah! *Or will he*? While this yingel *may* be more likely to shine as a Yeshiva bochur or on standardized IQ tests than many of his peers, the inferential reasoning skills required for the deepest understanding of the gemorah are not typically recognized or cultivated in the early years where the focus is on reading fluency and on the expansion of one's rote auditory memory skills. Hence, the true talmid chochim may be sitting quietly (or not so quietly) in the back of the classroom, trying to figure out the next rashi on his own, or trying to guesstimate the ratio of gray to black hairs on his rebbe's multi-colored beard.

I recall testing an unusually bright eight year old with superior abstract reasoning skills in both verbal and non-verbal spheres. His performance was unique in the Kiryas Joel community. Rote auditory memory skills, however, were only average. When I shared my findings with his mother and asked if his rebbeim were aware of his aptitude, she commented "From where would they know? He doesn't have any opportunity to show it in school." Too often, the yeshivish model over-emphasizes rote spit-back of learned information and neither teaches or recognizes the development of higher-level thinking skills, especially in the early grades.

For the past fifteen years my staff and I have been fine-tuning our ability to interpret the performance of children in the Kiryas Joel community based on their performance on standardized measures. In a later issue I hope to expand on my findings, and also to share some exciting findings in the area of gender differences on these tests.

THE 9TH ANNUAL NEFESH INTERNATIONAL CONFERENCE
FEBRUARY 8-11, 2006, MARRIOT HUNT VALLEY INN, BALTIMORE, MD

"WORKING TOGETHER FOR TZORCHEI TZIBBUR: GAINING STRENGTH FROM UNITY AND DIVERSITY"

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B. Abstract: Attach a description of the presentation that includes the following:

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Chana Kahn, LCSW **and** **Abe Worenklein, Ph.D.**
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Please mail or fax <u>just this form</u> to the Nefesh office: P.O. Box 3027, Teaneck, NJ 07666 or 201-530-0020
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What Ever Happened To Depth Psychology?[1]
Part 1

Benzion Sorotzkin, Psy.D.

Not too long ago psychologists and other behavioral scientists prided themselves for their ability to understand emotional problems in depth. They didn't limit their perspective and analysis to the proximal, superficial causes of people's difficulties. Rather, they looked for the underlying causes by exploring early childhood experiences that shaped the developing psychic structures (e.g., self-image) and the current interpersonal conditions that interact with the influences of those psychic structures. This helped them and their patients understand what made this particular person vulnerable to particular stressors where others wouldn't have been so affected. They therefore, understood that current distressful events do not bring about emotional disorders by themselves. Rather they interact with the person's emotional makeup and especially the vulnerabilities that resulted from his early life experiences (Barlow, 2002, Chap. 8).

Therapists often had to contend with the resistance of individuals, families, and even communities, to acknowledge these deeper and often subconscious causes of problematic behaviors. This was especially true when it involved a negative assessment of parenting.

In recent years, perhaps as reaction to the pressure to solve problems quickly, many therapists have moved away from the "in-depth" perspective, both in therapy and in regard to understanding community wide problems. Technical innovations that promise quick results, with little need to understand the personal meaning of symptoms or the historical reasons for their development, became increasingly popular. Witness the explosive popularity of Eye Movement Desensitization and Reprocessing (EMDR). EMDR is described in Barlow's (2002) authoritative text on anxiety disorders as:

> Perhaps the most controversial development in the behavioral treatment of anxiety disorders…. EMDR involves having a patient imagine a feared scene while… visually track[ing] the therapist's finger as it moves back and forth across the patient's visual field. (p. 414)

Therapists flock to take expensive training courses for this technique since it promises relatively quick and easy results, even though it is difficult to conceptualize how eye movement could be helping patients overcome trauma. Unfortunately, the fact is that almost all researchers not associated with the EMDR institute have concluded that:

> EMDR appears to affect only subjective fear ratings… [T]here is evidence that the active component of EMDR is imaginal exposure [i.e., the standard behavioral treatment] and [that] the eye movements [i.e., the one innovative feature of EMDR].… are essentially irrelevant. (Barlow, 2002, p. 415).[2]

> Although controversial, [EMDR] clearly has appeal in terms of its brevity and relative ease of administration…. While some research has reported encouraging results… those studies have been criticized on methodological grounds…. And there is an emerging body of evidence to suggest that the eye movements add nothing to the efficacy of EMDR… (Creamer and Forbes, 2004, p. 393)

In spite of these troubling research findings, the popularity of EMDR will probably continue unabated for years until its magic allure slowly fades away like so many other quick-fix therapy fads of the past.

[1] **Acknowledgement:** I thank my son Eliyohu Meir for his incisive comments, on both matters of style and substance, regarding this article.

[2] See Barlow, 2002, p. 414, for a list of recent reviews of EMDR

Cognitive – Behavioral Therapy

Another short-term but more mainstream therapy is Cognitive-Behavioral Therapy (CBT), which has become the treatment orientation of choice for many if not most young therapists. CBT is held up as the paradigm of modern, evidence-based therapies that are effective, short term, and focused on the present. It is often contrasted with what the proponents of CBT consider the old fashioned, unscientific and ineffective, long-term psychodynamic psychotherapy (or depth psychology) that unnecessarily focuses on the past.[3]

Much of what is assumed to be true about CBT has been questioned by serious researchers, but deeply held convictions die hard. This is especially true regarding convictions that fill the emotional need for quick and easy fixes. Drew Westen, Ph.D., Director of the Laboratory of Personality and Psychopathology at Emory University has published numerous research articles (available at www.psychsystems.net/lab) on the effectiveness of various forms of psychotherapy. I believe he is considered to be a relatively objective scientific observer. I would like to cite some of his comments from his recent extensive review article in the *Psychological Bulletin* (Westen, Novotny, & Thompson-Brenner, 2004) on another related trend in psychotherapy - empirically supported therapies (ESTs).

In recent years there has been a movement to use, and to train therapists exclusively in the use of, empirically validated or supported therapies. This movement has led to manualized practice guidelines for various emotional disorders. Most often, these treatment manuals advocate the use of Cognitive-Behavioral Therapy (CBT). ESTs are often "distinguished… from the less structured, longer term [psychodynamic] treatments conducted by most practicing clinicians" (Westen et al., 2004, p. 632). Psychodynamic therapists who do not adhere to these EST guidelines are portrayed as old fashioned incompetents who refuse to conform to scientific data.[4]

Among their many criticisms of ESTs Westen et al. (2004) point out that:

> Many of the assumptions underlying the methods used to test psychotherapies were themselves empirically untested, disconfirmed, or appropriate only for a [limited] range of treatments and disorders. (p. 632)

Westen et al. (2004) discuss a monograph commissioned by the American Psychological Society (APS) on the treatment of depression. The monograph cites numerous studies that show that CBT, and a number of lesser known brands of 16-session psychotherapies produce initial results comparable to those obtained with medication. Over the course of 3 years, however, there is an unacceptable high rate of relapse for those treated with these brief therapies as compared to those maintained on medication. An honest appraisal of these results would be that brief therapies are ineffective for treating depression and perhaps the traditional long-term therapies are indeed necessary for lasting gains. Yet the authors of the monogram came to a very different conclusion, that only long-term "maintenance" versions *of these short-term treatments* are empirically supportable!

Westen et al. (2004) also highlight major shortcomings in many of the studies that purport to prove the superiority of CBT over psychodynamic psychotherapy. Many of the studies, for example, compare CBT to treatments purported to be similar to psychodynamic therapy (e.g., "supportive-expressive therapy") but, in fact, they are not constructed to maximize their efficacy (what he calls *intent-to-fail* conditions). In one widely quoted study that supposedly demonstrates that CBT is superior to psychodynamic psychotherapy for bulimia nervosa, the clinicians utilizing the "psychodynamically inspired" therapy were forbidden to discuss the bulimia with the patient! Can one imagine a competent psychodynamic psychotherapist treating a bulimic patient without discussing bulimia with him or her?

Westen et al. (2004) cite a study where researchers reviewed transcripts from cognitive and short-term psychodynamic therapies for depression. The study found that therapists from both groups use techniques from each other's approach and that "positive outcome was associated with the extent to which the treatment matched the empirical prototype of

[3] Contrary to popular perception, modern research has, in fact, confirmed most of Freud's core propositions (Westen, 1998).
[4] Westen et al. (2004) relate the following incident: The national licensing examination in psychology now includes a series of questions about the "correct" treatment for disorders such as depression…. [O]ne colleague who indicated that his theoretical orientation was other than CBT was asked why he practiced "an outmoded form of treatment." (p. 642)

psychodynamic psychotherapy [p.639]." In fact the extent that the cognitive therapists used cognitive techniques was found to be unrelated to the success of the therapy.

"Innovations in CBT"

Our field has so distanced itself from depth psychology, that when CBT advocates realize that an understanding in depth and a focus on the past is indeed necessary in order to truly help patients, it is presented as a "new innovation" in CBT. One example was noted above from Westen et al. (2004) when it was discovered that short term CBT leads to an unacceptable high rate of relapse, the solution was long term "maintenance" – as long as the forbidden phrase, "long-term therapy," isn't used.

In an article discussing the cognitive-behavioral treatment of those who experienced chronic childhood trauma, Goldsmith, Barlow, and Freyd (2004) advocate "adopting a contextual-ecological perspective whereby symptoms and problems must be evaluated in historical and current environmental and interpersonal contexts in which they developed and are maintained [p. 457]." This is presented as a new innovation in CBT when, in fact, this was always standard practice for any in-depth psychological treatment.[5]

Substance abuse/addiction

A recent study (Hogue, Liddle, Dauber, & Samuolis, 2004) researched the connection between the actual focus of two treatments for adolescent substance abuse (cognitive-behavioral and multidimensional family therapy), and treatment outcome. The authors report that success in therapy was related to the degree that the sessions focused on family-related themes, regardless of the treatment modality. According to the authors "these findings are in accord with the consensus that family conflict, parent-child detachment, and deficient parenting skills are primary etiological factors for adolescent substance abuse (Repetti, Taylor, & Seeman, 2002, p. 93)."

Here again is recognition of the critical importance of exploring the early relationship with parents and other family related themes for successful therapy. Yet, there seems to be a reluctance to associate this research finding with the psychodynamic therapies that many contemporary theorists are trying to distant themselves from.

The average person suffering from an addiction of any sort is commonly told by his therapist, implicitly or explicitly, that addiction is an "illness." The implication is that it is a medical/chemical/genetic disorder. The person's personal history is considered basically irrelevant to understanding the "illness." This is proclaimed in spite of the fact that researchers have failed to find any evidence for such an illness.

In my experience working with patients suffering from addictions I have found that many of them have experienced neglect or abuse in their formative years. This makes them feel undeserving of pleasure or of enjoying life in any way. This results in a desperate hunger for pleasure. When they engage in regular enjoyable activities their feelings of guilt and unworthiness inhibits any pleasurable feelings. Addictive behaviors always involve pleasures of such intensity and magnitude that it overrides all inhibitions. For anyone who is incapable of any other form of enjoyment it can easily be understood why they would become addicted. In situations where this formulation is accurate, wouldn't it be important for the patient to have this information rather than to be told that he has an "illness"?

Depression

Cognitive therapists treating depression have similarly discovered that focusing on current dysfunctional cognitions while ignoring early childhood developmental issues results in short lived change at best. Consider the following from Hayes, Castonguay and Goldfried (1996):

> Another unexplored area that has received increased theoretical attention in the CT [Cognitive Therapy] literature is a focus on patients' attachment experiences with their parents…. According to these theories, a developmental

[5] The emphasis on cognitive ideations, which is considered a major innovation of CBT, has also always been an important focus, implicitly or explicitly, of psychodynamic therapy (Gabbard & Westen, 2003, p. 835).

> focus can facilitate lasting change because it activates the cognitive-affective network and interpersonal patterns that are central to the individual's depression. Although the patient's attachment patterns are not a direct focus of CT, Beck et al. (1979) recommend a developmental focus to identify the core assumptions that form the foundation of negative belief systems. *An exploration of patients' experiences with their parents should not be a primary focus of CT* but is likely to facilitate recovery and lasting change… (p. 624, emphasis added)

This newfound acknowledgement of the importance of the "patients' attachment experiences with their parents" has not resulted in the recognition of the validity of dynamic psychotherapies that have always emphasized these developmental issues. Rather, the focus on early developmental issues is now presented as an innovation in Cognitive Therapy. However, even this concession is not presented as a focus of the treatment itself. Rather, it is presented as a technique for preventing relapse!

"Expressed emotion [EE]"

Another example I have previously cited (Sorotzkin, 2002) is research done in the area of "expressed emotion [EE]" and psychiatric illness. Years of research clearly show that psychiatric patients released from the hospital to live with their high EE family are twice as likely to relapse and return to the hospital than patients returning to low EE families are. As noted by a prominent researcher in this area (Hooley, 1998); "The term EE [expressed emotion] is rather misleading since EE is not a measure of how willing a relative is to express emotion or to vent feelings. Rather EE is a reflection of the extent to which the relative expresses critical, hostile, or emotionally over-involved attitudes toward the patient" (p. 631).

Logic would seem to dictate that if returning to a critical and hostile family can have such a devastating impact on a person suffering from an emotional disorder, it is quite plausible that living in such a family could perhaps be the origin of the disorder in the first place. The EE literature is rather open about its aversion to even consider this very plausible idea.

When researchers (Kershner, Cohen & Coyne, 1996) found compelling evidence that "high levels of critical attitudes expressed toward children play a role in the development of childhood problems," they felt compelled to add that this… "doesn't exclude the possibility that high EE… might be a reaction by parents to childhood disturbance" (p.103). They seem to be putting the responsibility of maintaining a family's healthy emotional environment on the children instead of the parents!

Chambless et al. (2001) take this a step further. They state:

> It is hardly surprising that relatives living with patients with serious behavioral disorders often have negative feelings about the patients, given the strain such disorders place on family life…. It is perhaps, more remarkable that some relatives remain low in EE. (p. 226)

The authors themselves then go on to point out all the contrary evidence:

> [S]everity of patient's symptoms… typically fail to predict relatives'… critical comments or hostility scores… and in one study, parents were found to be as critical of their well off offspring as of their schizophrenic child…. EE researchers have been slow to investigate the possibility that relatives may have personality traits that predispose them to be hostile to or critical of patients…. [e.g.], high EE relatives described themselves as more concerned with social convention than low EE relatives…. (p. 227)

Unfortunately, these findings have not led researchers to adopt the logical, common sense conclusion that high parental EE is probably a major factor in their children developing emotional disorders. In fact they "have been slow to investigate" this possibility! In addition, contrary to the researcher's assertion noted above, there **is** evidence that children in highly critical and hostile families are more likely to go on to develop serious emotional disorders (Nelson et al., 2003; see also studies cited in Barlow, 2002, Chap. 8, and in Karon & Widener, 1994).

DEPTH PERSPECTIVE ALSO LACKING IN OUR UNDERSTANDING OF COMMUNITY ISSUES

One would expect mental health professionals to be in the forefront of the effort to help the community to develop a deeper understanding of the psychological factors in community problems. They certainly shouldn't collude with the tendency to blame all of our community's ills on outside factors. As a community, we usually prefer explanations that attribute the causes for our deficiencies on factors as distant from us as possible.[6] The preferred scapegoat is the outside culture. When that doesn't work, we blame the schools and other institutions. We try our hardest to avoid attributing problems to parental factors so we can maintain the emotionally satisfying image of the benevolent parent (Moses, 1989). When that is unavoidable we try to finesse the issue by explaining that the parental error was that of permitting too much exposure to the outside environment. If even that is untenable, we will accept "objective" family problems as reasons for problems, (e.g. divorce, financial problems). Family emotional factors, such as abuse and neglect by parents, are resisted at all costs (for reasons that I have elaborated on elsewhere [Sorotzkin, 2002]).

I characterize this tendency to attribute psychological problems to outside societal factors as "offering sociological explanations for psychological phenomena." I will illustrate with a few examples.

The Internet

Much has been written in the Orthodox press regarding Internet addiction, especially in regards to pornography. Many horror stories have been recounted of supposedly well adjusted teens who, after a chance encounter with Internet pornography, became swept up in its web and developed serious emotional and/or behavioral problems as a result. It is often stated or implied that the vast majority of teens who have "gone off the *derech*" have done so primarily as a result of exposure to the Internet. This is a commonly held belief by most people in our community, even among many mental health professionals. The obvious question is; if the exposure to the outside culture is the primary culprit, why are there just as many rebellious teens in the very insular communities as there are in the more "modern" ones. This question is never addressed.

A recent posting on a NEFESH website regarding the Internet described it as a "scourge that is wreaking havoc in many many homes" and contained a letter from a young man who claimed to be the epitome of mental and spiritual health until he became addicted to Internet porn. My concern is that many people who read this will in fact assume that this is the case, rather than wonder what made this particular young man so vulnerable to such a drastic turnaround. In fact, if one reads his letter carefully one can see clear evidence of a young man suffering from unhealthy perfectionism (Flett & Hewitt, 2002; Sorotzkin, 1985) which often has the paradoxical effect of bringing the perfectionist to the most depraved behaviors (Sorotzkin, 1998, 1999). In discussing this issue with colleagues I often find that they also believe that a well-adjusted young man with an open and comfortable relationship with emotionally supportive parents can easily become addicted to Internet porn. When I suggest that in order for that to happen there usually has to be preexisting risk factors, they feel that I am underestimating the dangers of the Internet.

I want to make it clear that I am well aware of the dangers to one's spirituality that can result from exposure to the seamier side of the Internet and other "cultural" media. But I believe we are misleading parents when we imply that it is this exposure that is the main (if not only) cause of teen rebelliousness and other emotional disorders. Why should parents struggle to improve their parenting skills and resolve their own emotional issues so that they can be better parents if they are told that the parent-child relationship is not a major factor in success in parenting?

I came across a superb article on the dangers of the Internet [available at: www.aish.com/societywork/society/escaping_the_cyber-slums.asp] written by Rabbi Lawrence Kelemen (from Neve Yerushalayim; author of *To Kindle a Soul*). This article is an extensive and in-depth review of the research on the subject. It is comprehensive and well balanced. After methodically documenting all the dangers associated with the Internet, Rabbi Kelemen notes (under the heading of "*The necessity of identifying risk factors*"):

> Ultimately, restricting Internet access is a necessary but insufficient solution…. What is needed is healing the personality weaknesses that virtually guarantee some individuals will fall victim to Internet temptations. *Studies*

[6] When children do this they are chastised for avoiding responsibility.

> *show that those most likely to get into trouble are not deterred by limits on Internet access…* Therefore, a key challenge to parents and educators is identifying the risk factors… Researches describe *four pre-existing conditions that put an individual at high risk for getting into trouble on the Internet. They are lack of family bonds; low self-esteem; inability to express opinions and questions; and inability to socialize.* [Emphasis added]

This is a good example of utilizing an in-depth psychological perspective to better understand a problem affecting the community at large. Based on this understanding Rabbi Kelemen is able to give parents cogent advice rather than just state the obvious, more superficial advice of limiting or supervising children's access to the Internet.

Rabbi Kelemen's article was subsequently printed in a prominent Orthodox publication. Unfortunately, the section on identifying personality risk factors was omitted from this printed version of the article. The mistaken impression a reader of the printed article would be left with is that the danger is totally external, and the **only** defense is protection from the outside world. Is it any wonder that parents who are very careful to protect their children from the outside environment, but neglect the family environment are then shocked when their child goes off the *derech r"l*. Because they did everything that they were told to do in order to avoid such tragedies, to no avail, the only possible conclusion is that "it can happen to anybody." In their minds, therefore, there is nothing one can do to reduce the risk.

Monitoring

It is common practice for therapists to encourage parents to monitor their adolescent children. In fact, a government agency runs ads ("Parents - the anti drug") in the various media encouraging parents to question their teenage children regarding their friends and activities even at the cost of aggravating them and provoking an argument. This is presented as a very effective method - supposedly backed by 2 decades of extensive research - to prevent drug abuse and delinquency in one's children.

On a superficial level this approach would seem to be logical. After all, these youngsters are getting into trouble when they are "hanging out" unsupervised with unsavory peers. If we can prevent them from doing those things, it is assumed, then we have solved the problem. It requires a more in-depth perspective to ask what it is that drives them to prefer the company of unsavory friends. I have found that it is most often the result of the following circumstances (simplistically put). When parents are excessively critical and controlling, it impacts negatively on their children's self-esteem. Once this negative self-image solidifies, these youngsters only feel comfortable with peers who they see as being similar to themselves.

I was always baffled by these public service messages, since clinical experience has shown that being overly controlling of children (and especially teens) and questioning them in a provocative manner is what usually undermines the parent-child relationship and **drives** them to rebellious and dangerous behaviors. I decided to review the research literature myself.

I discovered that the conventional wisdom related to monitoring has long ago been convincingly and decisively refuted in a series of studies by Kerr and Stattin (e.g., Kerr & Stattin, 2000). These authors reviewed the many studies cited to support monitoring and were surprised to discover that the studies did no such thing. The teens in those studies were asked **if** their parents knew where they went in the evening and who their friends were, etc. They were not asked **how** their parents knew! It was simply **assumed** that the parents must have found out by questioning their children or by snooping. In their own studies Kerr and Stattin did ask this question. They discovered that a positive correlation with better adolescent adjustment existed only when the teens volunteered the information to their parents (reflecting a positive relationship with their parents). In contrast, when parents had to question their children or "snoop" to get the information, thereby making the children feel controlled, there was an association to poor adjustment![7] While no one has refuted Kerr and Stattin's findings, the government continues to run these misleading ads, encouraging parents to take a course of action that is more likely to exacerbate than to solve the problem they are trying to resolve.

[7] Reiss et al. (1995: Cited in Barlow, 2002, p. 271) found that "parental 'attempts at control' over an adolescent, was found to have an observable influence on depressive symptoms in that adolescent."

David Barlow (2002), in his recent comprehensive review on the treatment of anxiety disorders, similarly deplores assumptions deeply held by clinicians when "facts that have been available for years simply do not support these assumptions" (p. 67).

Many therapists are more likely to hear the government's ads than to have the time to keep up with the latest research findings on monitoring, so they encourage parents to tighten the reins ("tough love," setting limits, imposing consequences, etc.) with little consideration for how these tactics impact their relationship with their children. There is little disagreement among researchers that a positive parent-child relationship is the most effective means to promote children and teens' positive behaviors.

> *A few years ago I met a well-respected therapist from out of town and we started "discussing shop." He related the following clinical intervention on his part. A 16 year old teenager was referred to him by a Yeshiva high school because of acting out issues. This student was constantly getting in trouble with teachers because of classroom misbehavior, cutting classes and the like. The therapist insisted on first interviewing the parents. He related to me his impression of them. "They were from the most disorganized and ineffectual parents I ever met. They didn't understand the first thing about parenting!" The therapist wisely told the parents that he would only consent to work with their son if they agreed to concurrently see a guidance counselor to help them develop parenting skills. When the therapist called the guidance counselor to arrange for the referral he suggested that the first task he should attend to is to teach the parents to set limits with their son. While I suspect that many therapists would concur with this approach, I had a different reaction. "You very clearly indicated that these parents have never successfully parented their son," I told the therapist. "It is obvious that the son has lacked appropriately caring and supportive parents. Much anger, resentment and conflict has developed as a result. Now you want the counselor to help them learn to be parents. Is this going to be their son's introduction to parenting? The setting of limits? How about first teaching them how to develop a pleasant and supportive relationship with their son, and then perhaps they'll be able to set appropriate limits without setting off a destructive firestorm." To his credit, this therapist was open to other perspectives and he changed his suggestions to the counselor.*

Resistance to acknowledging the role of parenting

I have elsewhere discussed at length society's resistance to recognizing the role of poor parenting in the development of children's emotional and behavioral difficulties (Sorotzkin, 2002). It seems to me that this is one of the factors that motivate therapists to seek psychological theories and therapeutic techniques that do not require a scrutiny of the past.

> *After speaking at a public forum, I was approached by an 18 year old boy who wanted to discuss with me his history of anxiety and panic disorders. He was intrigued with my connection of these disorders to early life experiences (See Barlow, 2002, Chap. 8; Diamond, 1985; Gassner, 2004). He then came for a consultation where he revealed that he had previously seen two other psychotherapists and a psychiatrist. Their approach was that his disorder was a result of a "chemical imbalance" and/or genetic factors and, therefore, the treatment of choice was medication and behavioral techniques for dealing with anxiety and panic. During my initial intake, he revealed, in response to my in-depth questioning regarding his relationship with his parents, that he did not look forward to going home on his off Shabbosim. This was because of ongoing conflict with his overly critical father and intrusive mother. When I asked him what his previous therapists said about this issue, he informed me that this wasn't discussed at all, since they did not consider it relevant to his condition!*

Unfortunately, this was not an unusual event. All too often I do an intake on a patient who has seen previous therapists even in relatively long-term therapies where obvious and long standing conflict with parents were rarely discussed. This usually happens when the presenting problem is a specific symptom, such as OCD, anxiety, or panic disorders where there is no obvious connection to the relationship with the parents. Even when patients bring up family issues in therapy, the reaction of the clinician is often that it isn't very relevant to their condition! (What I find even more surprising is when youngsters are referred for Oppositional Defiant Disorder and the therapist relates to it as a disorder that exists purely in the patient and doesn't explore what should be, at least, a probable connection to the parent-child relationship). Even when family issues are addressed it is usually for management purposes rather than for understanding the development and etiology of the disorder.

Chemical imbalances

The epitome of etiological explanations that can safely ignore past history is the genetic/chemical imbalance explanation for psychological problems. There are many studies that highlight the serious shortcomings in many of the chemical imbalance explanations (see Valenstein, 1998), yet their emotional appeal (and the self-serving interest of the pharmaceutical companies) serves to maintain their popularity. The genetic explanations are likewise often dramatically overstated. A noted genetic researcher stated in a special issue of *Science*: "…the interaction of genes and environment is much more complicated than the simple 'violence genes' and 'intelligence genes' touted in the popular press…. The same data that show the effect of genes, also point to the enormous influence of non-genetic factors" (Mann, 1994, p. 1687).

The fact that the lay public and popular press misinterpret scientific findings isn't astonishing - but the fact that trained clinicians do the same is somewhat surprising. A recent *Jerusalem Post* article (Jpost.com – 2/19/05) regarding the opening of a psychiatric center in Bnei Brak quoted the head of a psychiatric clinic:

> Professionals agree that psychiatric illnesses are in essence brain diseases – disorders that result from an imbalance in brain chemicals (neurotransmitters such as dopamine). But deep-seated cultural prejudices and fears caused discrimination against the emotionally disturbed…. Patients who are thus stigmatized feel shame, suffer from denial and are reluctant to get treatment….

In fact, many mental health professionals tell their patients that their emotional disorders are purely the result of biological causes when there is probably not a single serious researcher who believes that "psychiatric illnesses are in essence brain diseases!" There may be an imbalance of neurotransmitters, but it is widely acknowledged by researchers that this is most often the result of traumatic life experiences rather than the initial cause of psychiatric disorders.

> [R]esearch by leading neuroscientists has been made… intellectually satisfying by a clear recognition that we must go beyond the brain to fully understand the workings of the brain. In fact, it is from these leading neuroscientists that we are coming to appreciate more fully the influence of psychological and environmental factors on brain functioning….
> [T]here is dramatic evidence that early stressful life events may effect rather permanent alterations in brain function… that may mediate the neurobiological vulnerability to develop chronic anxiety and depression later in life. (Barlow, 2002, pp. 216, 217)

In a similar vein, Pariser (2005) cites the work of Eric Kandel -

> who won the [2000] Nobel Prize in Medicine for his discoveries demonstrating the impact of life events on the timing of protein synthesis in the cellular nucleus. The implication of Kandel's work, that experience impacts not just behavior, or even brain structure, but the fundamental underlying genetics, demolishes the hoary nature-nurture conflict and replaces it with a deep understanding of the indissoluble system that includes brain, mind, and the surrounding environment. (p. 123)

Even the most extreme proponents of biological explanations for emotional disorders (with the possible exception of the paid consultants to the pharmaceutical companies) concede that these biological factors are best described as vulnerabilities that require negative early life experiences to develop into a disorder. As emphasized by Barlow (2002):

> At present… there is no behavioral or emotional disorder for which a… single-gene heredity seems applicable. Even for the major psychotic disorders, where genetic links have long been suspected [note the use of the term "suspected" and not "proven"], almost all investigators (including geneticists) believe that an underlying vulnerability interacts with a variety of psychological and social factors to produce the disorder… (p. 193)

Barlow (2002) dedicates an entire chapter in his book (Chap. 8) to the extensive research evidence on how early parent-child relationships can create the psychological vulnerabilities for various emotional disorders. One brief example:

> When parents are insensitive to their child's expressive, exploratory, and independent behaviors, the child is at risk of developing inhibition and a sense of uncontrollability over his or her world, which may contribute to anxiety…. [A] "malfunctioning relationship" involving an intrusive, overprotective, or controlling parenting style could be expected to make a strong contribution to a cognitive vulnerability for anxiety [disorders]. (p. 268)

Yet patients and their families are frequently told by their clinicians that long-standing conflicted parent-child relationships, for example, are irrelevant to the development of their "chemical" and/or genetic disorders! This is both misleading and a disservice to the patients. This is especially so because countless of surveys have shown that "when given a choice, the public prefers psychological interventions to pharmacological interventions, even at sites known primarily for expertise in pharmacological interventions [Barlow 2004, p, 873]."

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Nefesh Members at Large & What They're Up To

Mazal Tov to Rabbi Shimon and Mrs.Yocheved Russell on the engagement of their daughter Elisheva to Kobi Shickman.

Rabbi Dr. Mordechai Glick led a marital enrichment weekend program at the Adath Israel Synagogue in Montreal on June 10-11. The program was entitled: "Turn a Good Marriage into a Great One."

Rabbi Glick facilitated sessions on "Communication Strategies That Really Work," Romancing Your Marriage," and "Men are from Minsk, Women are from Pinsk - Understanding Gender Differences."

Congratulations to Dr. David Pelcovitz on his recent appointment as Straus chair of Psychology and Education, Azrieli Graduate School; and Special Assistant to the President, Yeshiva University

Congratulations to Dr. Neal Goldberg and Miriam Lieberman, CSW upon the publication of their book, "Saying Goodbye" which is a handbook for Teens on is loss and mourning, published by Targum/Feldheim.

Congratulations to Rabbi Simcha Feuerman, LCSW and Chaya Feuerman, LCSW upon the publication of their new book, "Direction: Finding your way in Relationships, Parenting and Personal Growth" published by L'chaim press.

Congratulations to Nefesh member Rabbi Ronny Greenwald on being profiled in a recent feature article in the Yediot Achronot, recounting his international efforts past and present on behalf of Jewish communal and world affairs. It is quite a read, detailing the role he played in freeing Shransky, and somehow, even being brought in on a peacemaking mission between warring factions of the Russian and Italian Mafia. Now, that's bringing social work and applied psychology to a whole new realm!

Seminars and Programs of Interest

The School of Social Work at Bar-Ilan University has started a two-year **Sex Therapy Training Program**, the only such program in Israel (and almost certainly the Middle East), Now completing its first year, the course work and internships emphasize cultural diversity, focusing on intimate issues facing not only the general population, but on ethnic groups such as the Dati/Haredi community. Admission requires an M.A./M.S.W./M.D. degree and two years of therapeutic experience. Dr. David S. Ribner, founder and director, is a sex therapist certified by The American Association of Sex Educators, Counselors and Therapists (AASECT) and by the Israel Society for Sex therapy (ITAM/ISST). For further information, please call him in Israel at 052-3414294 or 02-6513447.

Regesh Family and Child Services (Toronto, Ontario Canada) is pleased to announce the opening of **Chezi's Corner** as a Residential Safe House for four (4) Jewish youth (ages 16-24) for up to a six-month period. The residence is a strictly kosher, nurturing, help oriented home in a community within Toronto. During their residency, residents will participate in skills training, including self-esteem enrichment, anger management, conflict resolution skills, peer communication skills and more. More suitable housing arrangement are sought for the residents for them to move into upon graduation from the Program. Leaning modules for skills training will be run within the residence. After learning more appropriate means of dealing with their own issues, the youth could be trained to mentor their newly acquired skills with other youth. The residence is limited to only males or only females for each residential period. An individual assessment is conducted with the applicant to determine his/her individual needs and level of functioning regarding social skills, life skills, work/employment skills, family involvement and community skills (including education and employment).

"Chezi's Corner" is named in memory of the legacy of Chezi Scotty Goldberg. Chezi, who grew up in Toronto, was a victim of a tragic bus bombing in Israel in January 2004. He had become a renowned expert in his work with youth at-risk from both Israel and North America. Chezi's Corner will become a legacy of his great work.

Information can be obtained from me at Regesh Family & Child Services, 149 Willowdale Ave, 416-495-8832

The **Family Institute of Neve Yerushalayim** is a unique Post-Graduate Family Therapy training center for religious therapists wishing to enhance their clinical skills. The Institute's Machon L'Mishpacha clinic provides the Dati/charedi community of greater Jerusalem with individual, couple's, and family therapy at low subsidized fees.

We are currently experiencing an inordinate number of client referrals, and our waiting list has grown to a point of concern to us. Our 30 therapists are carrying maximum caseloads and we are simply unable to meet the overwhelming demand for our services.

In order to meet this growing need, we have decided to increase the number of clinical interns at our institute next year. We will therefore consider a limited number of additional applications to our two year Internship program.

If you are a mental health professional with at least a Master's degree in a mental health related field, and supervised clinical experience, you are invited to take advantage of this unique opportunity to develop yourself professionally while at the same time, serve a very needy segment of Israel's religious community.

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In addition to our psychotherapy library of audio/video tapes, books and professional literature, you will experience a warm, supportive and collegial environment within which to learn and grow into the best therapist you can be.

For further information and applications, please call The Family Institute at 02 652 7893 between 9:00 am and 2:30pm Sunday through Thursday, or respond to this email at FamilyInstitute@neveyerushalayim.org.il

Application will be considered until June 30, 2005.

Dr. Yisrael Levitz, Director, Family Institute, Neve Yerushalayim

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Article reprinted from The New York Times, 4/2/2005

A Push to Curb Drug Abuse Among Orthodox Youths

By Naomi Schaefer Riley

Last weekend, many Jews celebrated Purim, which commemorates their salvation from the hands of a wicked king's minister, Haman, in .ancient Persia, by getting drunk. In fact, it is considered a mitzvah to drink immoderately on the holiday, one of the happiest in the Jewish calendar. So why was the Orthodox Union, the umbrella group for Orthodox synagogues in North America, sponsoring advertisements in Jewish publications that said, "Friends don't let friends drink irresponsibly on Purim"? Rabbi Tzvi Hersh Weinreb, the executive vice president of the Orthodox Union, said the advertisements were part of a new program, called "Safe Homes, Safe Shuls, Safe Schools," that seeks to curb substance abuse among Orthodox youth. "It's not something we're proud of," Rabbi Weinreb said of the problem of substance abuse, "but we're proud that we're trying to deal with it."

In addition to advertisements like the ones for Purim, the effort includes seminars to teach families the signs of drug and alcohol abuse and, most controversially, a request that synagogues do away with "Kiddush clubs." Named for the blessing Jews make over wine, Kiddush clubs are formed when a group of men leave services at the start of me Haftarah (the reading from the prophets) on Saturday morning to have some liquor, usually Scotch in another room, and return about a half hour later. It is hard to estimate the number of these groups because they are largely informal and attendance is determined by invitation only, but they are widespread, say people who attend Orthodox shuts. The Jewish Center on the Upper West Side of New York has one, as does Kesher Israel in Washington, the synagogue that Senator Joseph J. Lieberman, Democrat of Connecticut, attends. But many rabbis see these clubs as insidious and say they interrupt services, introduce a sense of elitism into a congregation (because only a few select men are invited to join), disrespect the person reading the Haftarah and foster unhealthy attitudes toward drinking.

Rabbi Hershel Billet banned not only the Kiddush club, but also all hard liquor from the premises of his synagogue, Young Israel of Woodmere on Long Island, two years ago.

"Children like to experiment and their experiments end in tragedy," Rabbi Billet said. "The adults can't even stay awake on Saturday afternoon and eat the Shabbat meal with their family." Rabbi Daniel Korobkin, of Kehillat Yavneh in Los Angeles, believes that many rabbis allow the clubs because "there is a lot of competition in attracting congregants to a synagogue." What brings people in, Rabbi Korobkin said, "might be the social atmosphere or the food, and not the rabbi's sermon."

Rabbi Billet said that he lost some members as a result of his decision, but that "many of them have, now returned." The clubs have bothered Orthodox rabbis for years, but with the recent death of a yeshiva student in Israel from a heroin overdose and arrests last year of 42 teenagers, including many yeshiva students in Livingston, N.J., on charges of under-age drinking and drug abuse at a party, Rabbi Weinreb said it seemed like time to act against substance abuse. Amie Goldfein, the president of Jewish Alcoholics, Chemically Dependent Persons and Significant Others, or JACS, said he believed that the rates of substance abuse among Jews had recently risen to those of the population at large, "around 8 to 10 percent."

Rabbi Dr. Abraham Twerski, the founder of the Gateway Rehabilitation Center in Pittsburgh, agreed, saying: "Twenty-five years ago, country clubs would refuse to host Jewish weddings because Jews didn't drink and that's how the clubs make their money. Nowadays they clamor for that business." But others wonder whether substance abuse is a growing problem among Jews. Dr. David Pelcovitz, a professor of psychology and education at Yeshiva University, disputes Mr. Goldfein's numbers, though he said that a comprehensive survey had not been done. "There still seems to be a considerably lower rate in the Orthodox community, but it sticks out in a community which is so tight-knit," said Dr. Pelcovitz, who has treated Orthodox young people for substance abuse. Yehudah Rosenblatt, a 17-year-old from the Bronx who attends an Orthodox high school in Manhattan, said he did see a problem among his peers, which he attributed to academic pressure and the fact that he and his fellow students did not spend much time with their families. Jewish and secular studies can run as late as 6 p.m. during the week and extracurricular activities until after 9 p.m. "Your friends become your family, and sometimes they can influence you more," Mr. Rosenblatt said. But Rabbi Twerski suggests there might be more specifically religious issues behind the problem, saying that one cause of alcoholism is a yearning for spirituality. He points out that spiritual fulfillment is the basis for 12-step programs. Rabbi Weinreb agrees that many Orthodox youths are turning to substance abuse on the one hand or "more stringent and often more exotic Jewish lifestyles" on the other to make up for a dearth of spirituality. But Rabbi Weinreb and others say the Orthodox Union's pronouncement on Kiddush clubs was largely symbolic. The Orthodox Union has asked that rabbis ban the clubs, but has no power to enforce the request. The leaders are hoping that even if the rabbis do not ban the clubs, members will be shamed out of attending and the clubs will disappear.

But others doubt that eliminating the clubs would affect any substance abuse problem. Dr. Pelcovitz said that "very often it's responsible drinking" that goes on at Kiddush clubs, and that "modeling responsible drinking has been shown to lower rates of alcoholism."

Mr. Rosenblatt agrees. "I see adults who are drinking responsibly at shul, so alcohol is not something I would use as a tool for rebellion," he said.

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If you haven't been getting the listserv postings - you are missing out on important information, ideas in answer to your questions, advertisements regarding positions available, and much much more! If you have recently become a member, you can subscribe to receive the international listserv by sending a blank e-mail to nefeshint@nefeshisrael.com and write "subscribe" in the subject box. You will automatically be added to the Nefesh Israel ListServ as well. (If you aren't on the listserv because you don't have e-mail, maybe this is the time to join the 21st century!)

To post messages to the listserv, simply send an e-mail message to the listserv address, nefeshint@nefeshisrael.com. (When you send in a message, make sure to include your name and credentials at the end of the message, and make sure to indicate concisely the topic of your post in the subject line.) When you post a message or a reply to the listserv address, the message goes to everyone receiving the listserv. If you want to reply only to the person who sent a particular post, select "reply" and send your e-mail. It is extremely important that those of you who use "AOL" are careful not to report us for spam in error.

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