



Nefesh News

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

October 2005

In the Shadow of the Net:

Understanding Internet Addiction and Problematic Online Sexual Behavior

Rachel C. Sarna, Ph.D., M.S.W.

Sarah walked into her therapist's office slowly, with her head bowed and tears streaming down her face. She approached the chair slowly, and it seemed as if she was collecting her last ounce of strength in order to sit down.

"Now I know it all! I have an answer to all the problems Mayer and I are having all this time that we have been coming here. He doesn't love me, he doesn't find me attractive, I caught him..."

She paused and burst into tears, a deep and painful cry that left the therapist dumbfounded, and her eyes too began to well with tears. Sarah kept bawling, unable to stop.

"Caught him with what? With another woman?" asked the therapist finally, trying to help Sarah complete her thought.

"No, no, no. Much worse! I caught him sitting at his computer, surfing the Internet, watching hard-core pornography, and talking animatedly to someone. I stood quietly behind him," continued Sarah, as her cry changed to a rapid-fire stream of words, "and watched him talking to someone, viewing pornographic pictures. He also posted some of his own, and was smiling, obviously enjoying himself. Now I know what he has been doing all these hours when he said he was working in the basement, claiming that he had deadline after deadline. I stupidly believed him. He has become an Internet sex addict," continued Sarah, with tears still streaming down her cheeks.

More and more therapists in the Orthodox community find themselves hearing similar stories, again and again. Same story. Different names and faces. Orthodox mental health professionals have started talking to each other seeking assistance, support and guidance as to how to deal with this new plague called cybersex addiction, a topic that, with all their years of training and experience was not in their repertoire. We discovered that all of us have one and mostly more than one patient/client who has become an Internet sex addict.

At Nefesh, we listen to the needs of the Orthodox community, and the leaders of Nefesh have begun to take action. On September 14, 2005, Nefesh sponsored a workshop for mental health professionals and rabbis on understanding Internet addiction and problematic on-line sexual behavior. The workshop, entitled "In the Shadow of the Net: Understanding Internet Addiction and Problematic Online Sexual Behavior," attracted about 70 participants. After introductory remarks by Rabbi Dr. Abraham Twerski, a well-known psychiatrist who specializes in addiction, the workshop was led by David Delmonico, Ph.D. and Elizabeth Griffin, M.A. who are leaders in the field of Internet addiction and the authors of several books on this topic. One of the books also served as the title of the workshop and is available from Amazon.com or Barnes and Noble as ISBN 1592851495.

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Message from the Editor

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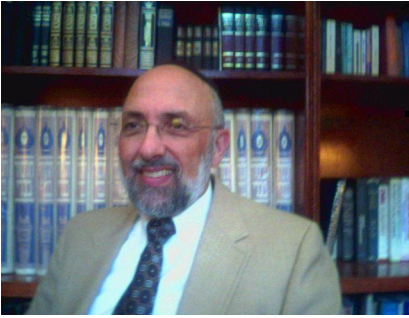
The past few newsletters have spurred some lively debate and discussion around treatment and the origins of mental illness. This issue promises to continue in this tradition, and I am proud to be submitting an article of my own, which I hope the readers will find informative and enjoyable.

I gratefully acknowledge the assistance of several individuals who have helped produce this newsletter. Hadassah Lowy, 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.

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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.



From The President's Desk

Nosson Solomon, Ph.D.

Since the last *Newsletter*, developments at NEFESH have continued to lay the groundwork for a more comprehensive, professional organization. Behind the scenes, dedicated Board members are busy exploring and planning new facets of a more complex NEFESH to meet the needs of professionals and lay community alike. These will unfold as the year moves along, IY”H.

Lisa Twerski, CSW, has treated us to two excellent professional seminars on coaching and on internet addiction. She and her committee worked hard and successfully, and the result was first-rate professional training available to the New York metro membership.

As NEFESH wades into the field of community education in new ways, we look toward collaborating with other organizations and agencies. Leading this very important and complicated initiative is Miriam Turk, LCSW. She is hard at work to fashion education and training opportunities for the Torah community, and we look forward to some important announcements in this area.

Meanwhile, preparations for the International Conference in February of next year continue apace. Abe Worenklein, Ph.D., and Chana Kahn, LCSW, are putting together an event to remember. Everyone is likely to find something special to appeal to his particular interest at this gathering. Those of you who know Chani and Abe know to expect an outstanding Conference featuring world-renowned experts. Once again, Mrs. Nina Glick will favor us with excellent accommodations and arrangements to make the Conference run smoothly and beautifully.

Phyllis Mayer, CSW, has given us great cause for celebration. Her considerable efforts have culminated in the certification of NEFESH International as a CEU provider to social workers for all NASW-approved programs.

Norman Blumenthal, Ph.D., and Rabbi Shimon Russell, LCSW, are close to completing the fourth edition of the widely acclaimed NEFESH publication, *Children in Crisis*. It will feature four new chapters based on the contributions and feedback of participants in the CIC retreats. We are very proud of Norman and Shimon’s groundbreaking work in this area.

Taken together, the foregoing suggest a growing, relevant, professional organization poised to serve the lay and professional Torah communities. I look forward to reporting on further initiatives in coming *Newsletters*.

Best Wishes,

Nosson



The Psychopharm Consultant

Shalom Feinberg, M.D.

The Use of Medication in the Treatment of the Bipolar Pregnant Patient

This issue's column will discuss the use of psychopharmacologic agents for the treatment of bipolar disorder during pregnancy. While some studies have suggested that pregnancy is a protective factor against bipolar disorder related episodes, Viguera et al have reported that the risk of relapse is no different in pregnant and non-pregnant patients who discontinue their medication (1). Clinicians treating women with bipolar disorder who desire to conceive or who are already pregnant are faced with a complex challenge. How does one balance the potential exposure of a developing fetus to medications with variable but real teratogenic risk (i.e. risk of congenital organ malformation) versus the threat to mother and unborn offspring of not treating, or discontinuing pharmacotherapy for a potentially life threatening psychiatric illness.

Unlike treatment of a bipolar patient in the secular community where a psychiatrist may readily recommend that the patient either forego any attempt to conceive or terminate a pregnancy, this is not as simple with an Orthodox patient. She may feel great pressure to have a large family regardless of her psychiatric status, and is forbidden to abort except in limited circumstances. (In my experience, I would also add that frequently Frum couples dealing with pregnancy and bipolar disorder do not want to ask a *Shaila* about abortion, even in a potentially life threatening circumstance where there may, in fact, be grounds for such a *heter*.)

Thus understanding the teratogenic risks of the available medications for bipolar illness can help the clinician and the patient/couple make a more informed therapeutic decision. The use of antidepressants in pregnancy was the subject of an earlier column and thus this discussion will focus on mood stabilizers and antipsychotics agents.

The original gold standard of mood stabilizers, Lithium, has been off patent for many years, receives very limited public promotion, and is reportedly declining in use, particularly in the United States (2). In contrast, anticonvulsants, such as Valproic Acid (Depakote) and Carbamazepine (Equetro, Tegretol), which have been more recently approved for mood disorders, are well publicized and aggressively detailed to physicians by their respective pharmaceutical companies. Accordingly, prescription of these latter agents is significantly increasing in comparison with that of lithium. One may ask why this is relevant to a discussion of medication use during pregnancy?

The answer is that all older, commonly used anticonvulsants have been associated with significant teratogenicity as well as a greater than random risk of major birth defects (3, 4). While the research on this class of medicines involves pregnant patients with seizure disorders and not mood disorders, most feel that the specific illness is not the more relevant variable in looking at congenital risk data and is thus applicable to psychiatric illness as well (3). Multiple studies suggest that Valproic Acid offers a considerable risk of many congenital malformations, notably neural tube defects, such as spina bifida (5). This risk of birth defects for the latter has been estimated to range as high as 16% in recent studies (6), in comparison with a risk of approximately 1-4% of congenital malformations in any pregnancy in the general public. Similarly, the research around Carbamazepine suggests a risk greater than random of congenital malformations such as craniofacial abnormalities, cardiac defects, neural tube defects, though apparently less than that associated with Valproic Acid (5,7).

Lithium, since the early days of its use was felt to be associated with a significant risk of congenital malformations, in particular a considerable incidence of Epstein's anomaly, a serious cardiac congenital defect. More recent data suggests a risk of Epstein's anomaly of only approximately .05% to .1%, (1/2000 to 1/1000)

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compared with a risk of this birth defect in the general population of 1/20,000(4,8). Additionally, while there are a smattering of case reports connecting lithium with other types of congenital fetal abnormalities, the one prospective study of lithium use in pregnancy did not find a greater than random risk of congenital abnormalities (9). While there are reported complications during the neonatal period associated with lithium use later in pregnancy (10), again the risk of toxicity is felt to be small in comparison to the risk of untreated bipolar disorder (3). Additionally, a recent study uniquely found long term cognitive deficits in children following fetal exposure to Valproic Acid (11). Similar studies involving Lithium found no such long term sequelae (12). These facts and the relatively low absolute risk of congenital defects has led to the recommendation that lithium should be considered as a first line treatment of bipolar disorder in pregnancy (4). Despite their popularity, anticonvulsants carry a significant risk to female patients attempting to conceive. Yet on the other hand the risks associated with lithium are not negligible, and close monitoring of mother and her lithium levels and the developing baby by physicians experienced in this area is mandatory if lithium is to be prescribed during pregnancy.

What about the newer anticonvulsants? Lamotrigine (Lamictal) is rapidly growing in popularity as a mood stabilizer, primarily for the treatment and prevention of bipolar depression and mixed episodes. Studies to date suggest Lamictal's risk of congenital defects is no greater than random, though more data is required for confirmation (13). One anticipates this data will be forthcoming in the not so distant future due to a combination of its increasing use and the manufacturer's interest in the collection of this information.

One study to date suggests that Oxcarbazepine (Trileptal), a derivative of Carbamazepine, offers a risk of congenital defects no greater than random, though clearly it is too early to draw a conclusion about this medication (14). With all mood stabilizers the literature is clear that one prescribes the minimal necessary dose as the incidence of birth defects increases with increasing dose (7).

The older so-called typical antipsychotics (e.g. Haldol, Thorazine) have been used as treatments for acute mania for decades. Due to their impact on serum prolactin they were often associated with infertility and amenorrhea (disruption of menses), as is the newer antipsychotic Risperdal. Based on retrospective studies and only rare

reports of congenital defects associated with it, Haldol has been the drug of choice from this group when an antipsychotic was clinically required (14).

The newer atypical antipsychotics (i.e. Risperidone, Zyprexa, Geodon, Abilify, Seroquel, Clozapine) have largely supplanted the older antipsychotics in clinical practice due to a combination of factors including their manufacturers' receiving FDA approval over the last few years for mood disorder related indications, and their company's aggressive marketing campaigns. Unfortunately, controlled data for their use in pregnancy, for any indication, is limited. While there are case reports and case series describing their safe use in pregnancy, the only controlled research consists of early data from Lilly's Zyprexa data base and a small prospective study involving most of the atypical agents. Both found no greater incidence of birth defects versus the general population (15,16) . The lack of reported congenital defects and the high risk of relapse in discontinuing these medications has led reviewers to recommend maintaining any atypical antipsychotic agent in a pregnant patient with a history of psychosis (15). What is not clear is which specific agent to choose in a pregnant woman who becomes acutely ill. Does one choose a mood stabilizer, such as Lithium, or an atypical antipsychotic? Which of the latter does one select if that is what is clinically indicated?

Two other pharmacologic related options to be noted in a review of bipolar treatments in pregnancy is the reported safe use of Electroconvulsive Therapy in pregnancy and reports that calcium channel blockers, such as verapamil and nimodipine may in fact be safe and effective for the treatment of a pregnant manic patient (12,17). The latter class of drugs have been used for years by obstetricians for other clinical reasons (e.g. maternal hypertension) in pregnancy.

In summary, this is obviously a complex topic and each patient and their clinical situation needs to be carefully thought through. All clinical decisions should be processed in a collaborative fashion with patient and spouse. Hopefully this short review (and the references included below) give the reader useful information in addressing the issues involved in medicating bipolar illness in pregnancy.

(continued on page 34....)

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To the editor of Nefesh News:

Kudos to Dr. Benzion Sorotzkin on his excellent article, “Whatever Happened to Depth Psychology? Part 1” in the last Nefesh Newsletter. It is a very impressive, valuable piece of work. I would like, however, to register alternative views regarding two aspects of the article.

The first relates to Dr. Sorotzkin’s apparent lack of regard for limit setting as a primary parental function. I am one of those therapists who believe that limit setting is an absolute prerequisite for success with any child and is sorely missing in contemporary child-rearing. No matter how much affection is shown, the absence of limits will inevitably lead to disaster. Many parents cannot bring themselves to suffer the inconvenience and angry responses of their children, to watch as the child’s narcissistic strivings are frustrated (believing that everyone should have whatever he wants) in order to set limits. They cannot see such limits as expressions of love, representing sacrifice on the part of parents and child for the benefit of the latter. Even children who bridle at limits crave them and understand their necessity. Some of my most strikingly successful, professional moments have come, when I placed the children in charge of families previously led by ineffectual, frightened parents.

On the other hand, while many of the patients I have seen suffer well into adulthood from the lack of a meaningful, validating, and limit-providing relationship with a parent, I cannot agree with Dr. Sorotzkin’s almost exclusive focus on poor parenting as the cause of our children’s problems. In my view, this is far too simplistic and unwisely disregards dramatic changes in our culture, which, from its very inception, has been inexorably evolving toward complete disregard for authority. It also fails to address the overwhelming influence of peer culture during adolescence. The most arduous parenting cannot change this.

Notwithstanding these qualifications, I wish to express my thanks to Dr. Sorotzkin for this very thought-provoking and informative article.

Sincerely yours,
Nosson Solomon, Ph.D.

Benzion Responds:

I sincerely appreciate Dr. Nosson Solomon’s comments as it gives me an opportunity to correct possible misperceptions of my position.

Dr. Solomon feels that my article (1) shows insufficient regard for limit setting as a primary parental function and (2) almost exclusively and simplistically emphasizes poor parenting as a cause of children’s emotional problems.

I, of course, agree that limit setting is an important parental function and that there are many factors, other than faulty parenting, involved in the development of emotional problems. My article, however, was a critique of what I see as an imbalance in the prevalent approach to emotional disorders rather than a parenting manual or therapy primer. I, therefore, didn’t feel it was necessary for me to discuss all aspects of the issues involved.

While our community is undoubtedly influenced by the anti-authority attitude of the general culture, my experience is that the majority of the *frum* patients I see suffer from emotional disorders resulting, to a significant degree, from early familial experiences with excessive criticism, overly harsh discipline and overly restrictive and unreasonable limit setting. In those situations where the discipline was inconsistent or inadequate it was most often due to parental neglect resulting from emotional shortcomings rather than to an ideological embracing of society’s *laissez faire* attitude to educational discipline (a rare occurrence, in our community, in my experience). Even our generation’s purported legions of spoiled children who “got everything they wanted,” were not truly spoiled. They, most often, got too much of what they didn’t need (e.g., expensive toys) but alas, got too little of what they did need (e.g., attention, respect, acceptance, and consistent, *Halachicly* sanctioned discipline).

Benzion Sorotzkin, Psy.D.

Homosexuality: Innate or Developmental, and Can it be Changed?

Rabbi Simcha Feuerman, LCSW

As Orthodox mental health professionals, many of us have been confronted by clients who either report experiencing homosexual feelings, or fear they may be homosexual, or feel compelled to act on these homosexual compulsions, and in each case are troubled by it. The operative phrase is “troubled by it”, because our concern as therapists is to protect our clients from counter-transferential feelings so that we do not impose our agenda or values upon our clients. This article refers to the client who expresses discomfort with his homosexual yearnings or tendencies and is seeking some way to remedy it. Also, please note this paper will only discuss male homosexuality. Female homosexuality requires a completely separate discussion, and has its own unique halachic, ethical, social and treatment dynamics.

Unfortunately, in the professional clinical community not much attention has been given to the idea that it is possible to help homosexuals change their orientation. The mainstream media often lumps together legitimate professional and clinicians who work in this field with primitive, bible-thumping homophobes. In our current political climate it is difficult to harness societal resources and sanction to investigate a cure for something that society at large does not consider a disease. Today, considering homosexuality as a pathological condition is equated with bigotry or homophobia, even though one does not have to follow from the other. Considering a condition to be a result of certain dysfunctions does not diminish the rights of those suffering from the condition nor does it automatically invite societal discrimination. The focus of this article is to explore this issue from a Torah, sociological and psychoanalytical perspective in the hopes of fulfilling the following objectives:

1. To provide Orthodox mental health practitioners with a theoretical and philosophical framework to understand homosexuality that is compatible with Torah values and common sense.
2. Although this article will not serve as a “how to” guide for treatment, the author hopes that it will help provide a framework that may spur practitioners to learn more about forms of treatment and available resources.
3. To serve as an “inoculation” against the immoral and family-destructive values that have been foisted upon us, and our clients, by secular culture in the name of science and mental health.

Science and Politics

Unfortunately, we know that scientific findings can be affected by the bias of the investigators.¹ And even without any bias, scientific theories and evidence change quite frequently. Additionally, it is important to note the degree to which public sentiment influences science and research. For example, the American Psychiatric Association originally scheduled a conference for their annual meeting of year 2000 to debate and discuss reparative therapies (that some claim can cure homosexuality.) The planned conference caused tremendous backlash and negative publicity that arose from the gay community, who in a full page newspaper advertisements, incorrectly stated that the APA was going to revert from its 1973 decision to no longer consider homosexuality to be a mental illness. Ultimately, due to the storm of controversy, the APA called off the conference, ostensibly because there was “no new scientific evidence” showing that such sex orientation therapies work. (WebMD Medical News, By Daniel J. DeNoon and Darryl Gossett, May 19, 2000. Url: “http://www.humana.com/webmd/men_sxorient.asp”.)

This ostensible reason represents a circular argument. Of course there was no new evidence, because there was not enough opportunity for clinicians to share and discuss research. This is why the conference was originally scheduled! Apparently, there were people of science out there who wanted to open up this matter for further exploration and

¹ (Similar criticisms of modern scientific research are made by proponents of the liberal social view as well, such as feminist scholars who refute “scientific theories” that confirm certain aspects of femininity. For example, see Newsweek, October 30, 2000, pp 70-71. In addition, NARTH (The National Association for Research & Therapy of Homosexuality) has published an excellent critique on many of the studies that have been misused by researchers to prove homosexuality to be of a genetic nature. See <http://www.narth.com/docs/istheregene.html>.)

discovery. This process seems to have been squelched for social reasons, not scientific reasons. Of course, countless diseases would never have been cured if serious investigations were never conducted. Such unfortunate antics and goings on weakens the credibility of contemporary "scientific" research.

In addition, one must also consider that even when it is "proven" that there is a biological, hormonal, or neurochemical basis for a particular mental process, it does not necessarily prove that it is innate or due to a strictly biological cause or that psychotherapy cannot influence or change it. If you think about it, all mental processes must have a chemical and hormonal basis, otherwise how would our bodies act upon them? For example, someone tells you something that makes you happy, and you then smile. Surely, one day, brain researchers will be able to trace the exact hormonal and neurological paths that occur. Perhaps they may even be able to artificially induce the same exact response via electrical stimulation or certain chemical agents. But that does not mean that the process was not originally psychological. It may very well be that the psychological and emotional processes cause the biological response and not the other way around. In addition, even if ultimately some genetic basis were found for homosexuality, it would likely be no different to the mainstream clinical approach in regard to alcoholism, which does seem to have a genetic component; that is, certain genetic factors may predispose individuals with certain pathological developmental experiences to alcoholism.

Further supporting this assertion that today's "scientific" views on homosexuality have been distorted by both personal and social politics is a New York Times interview of Dr. Anne Fausto-Sterling, a developmental biologist and professor of Biology at Brown (NYT, page F3, 1/2/01, italics mine.):

“Q: Among gay people, there is a tendency to embrace a genetic explanation of homosexuality. Why is that?

A: I think gay men...face a particularly difficult psychological situation because they are seen as embracing something hated in our culture – the feminine – *and so they'd better come up with a good reason for what they are doing....*It provides the disapproving relatives with an excuse: “It’s not my fault, I didn’t raise ‘em wrong.” *It’s bad science and bad politics....*The biology is poorly understood. The best controlled studies performed to measure genetic contribution to homosexuality say that 50 percent of what goes into making a person homosexual is genetic. *That means 50 percent is not.*”

In 1973, the DSM completely removed references to Homosexuality, no longer considering it a disease. However, the DSM does leave a, shall we say, “remez” to homosexuality in the category of “Other Sexual Disorders Not Otherwise Specified”, partially described by “persistent and marked distress over one’s sexual orientation.” Joseph Nicolosi, PhD. in “The Reparative Therapy of Male Homosexuality” (1991, Jason Aronson, p. 9) reports a written correspondence to Robert L. Spitzer, chairman of the DSM Nomenclature Committee. Nicolosi asked Spitzer, “In the history of psychiatry, has a heterosexual ever sought treatment for distress about his heterosexuality and wished to become homosexual?” Spitzer is reported to have replied, “The answer, as you suspected, is no.” This would seem to indicate a possible diagnostic category for unwanted, or ego-dystonic same-sex attraction.

Innate or Developmental?

It is difficult to know whether homosexuality is innate and biological, or a result of certain developmental issues. The reader should also be aware that it is not clear whether the Torah considers homosexuality to be a mental illness either. The fact that it is forbidden as an abomination tells us nothing about its status as a mental illness. There are many forbidden behaviors and acts described by the Torah that would seem to stem from character flaws, but also have an origin in, or be exacerbated by, personality disorders and psychiatric syndromes. For example, narcissism, jealousy, infidelity, and grandiosity are moral problems but clearly have origins in childhood developmental experiences.

Traditional Psychoanalytic Thought

It is illuminating and refreshing to find that Freud wrote about homosexuality not only with great insight and clarity, but also with fairness and compassion. He notes that whether or not homosexuality is a result of some deviance or not, it certainly does not indicate any other psychological abnormality because:

"Inversion [homosexuality] is found in people who exhibit no other serious deviations from the normal...It is similarly

found in people whose efficiency is unimpaired, and who indeed are distinguished by specially high intellectual development and ethical culture." (Standard Edition, Three Essays on Sexuality, 7:138-139.)²

Freud himself was undecided about whether sexual orientation was something that a person was born with, predisposed toward, or developed as a result of subsequent psychological dynamics. He suggests that there may be several categories, with a certain percentage having an innate biological factor and others having developed it, but he also does bring several points that completely argue against the innateness of homosexuality:

"(1) In the case of many inverts, even absolute ones [meaning they never have or had any attraction to objects of the opposite sex], it is possible to show that very early in their lives a sexual impression occurred which left a permanent after effect in the shape of a tendency toward homosexuality.

(2) In the case of many others, it is possible to point to external influences in their lives...which have led to a fixation of their inversion. (Such influences are exclusive relations of persons of their own sex, comradeship in war, detention in prison...celibacy, etc.)

...In view of these considerations it is even possible to doubt the very existence of such a thing as innate inversion." (Ibid:140.)

Amazingly prescient, and as if in response to today's gay community, Freud responds to the claim that many homosexuals make that their earliest memories are of having homosexual longings, thereby proving that their homosexuality is innate. He states:

"It can be argued that, if the cases of allegedly innate inversion were more closely examined, some experience of their early childhood would probably come to light which had a determining effect upon the direction taken by their libido. This experience would simply have passed out of the subject's conscious recollection, but could be recalled to his memory under the appropriate influence [i.e. the psychoanalytic technique of free association.]" (Ibid. For more information see *ibid*:137.)

However, in the final analysis, Freud remains uncertain and makes the following closing remark:

"[This conclusion is]...completely countered by the reflection that many people are subjected to the same sexual influences (e.g. to seduction or mutual masturbation which may occur in early youth) without becoming inverted or without remaining so permanently. We are therefore forced to a suspicion that the choice between 'innate' and 'acquired' is not an exclusive one." (Ibid.)

Freud also gives an intriguing proof to the psychological nature of homosexuality, which goes as follows: If it is innate, one would assume that the innateness would cause an attraction to the person of the same sex. Presumably, the more masculine the object, the more attraction it would generate for a male homosexual. However, Freud observed that at least many homosexuals look for a male partner who is effeminate in manner or physical quality.

"The sexual object is someone who combines the characters of both sexes; there is, as it were, a compromise between an impulse that seeks for a man and one that seeks for a woman." (Ibid:144.)

This observation then suggests that the homosexual seeks a man with feminine characteristics because, on a deeper level, he is still drawn to and attracted to femininity. We can then theorize that he has repressed his attraction toward females out of some fear or defense against sexuality with women. Therefore, his homosexuality is an unconscious compromise and formed out of psychological defenses and not biological tendencies.

Current Developmental Theory

Nicolosi, (1991) makes a convincing argument for the developmental nature of Homosexuality and sees it as an outcome of insufficient development of a masculine identity. The father plays a key role in a child's development of his

² The term "invert" or "inversion" means homosexual or homosexuality.

personality. The mother represents nurturance and merger. From the earliest moments of life, even conception, the mother is the source of nurture and protection. But eventually, in order to grow, a child must venture beyond the safe domain of Mother and take risks. First by crawling, then by toddling, and ultimately by going to school and becoming his own person. Who is the model for such behavior? Who can the child turn to for precedent? Who blazes the trail showing it is safe to explore, roughhouse, even make a little mischief? In comes this tall dark stranger, the other. Someone who is not around all day but seems to have so much influence over the house, which in a child's eyes, might as well be the Universe. Where did this stranger come from? How does he get his power?

This is Father. The young boy at an early age begins to intuitively recognize that this man is someone who he can learn from, someone who can give him power. But father is as scary as he is strong. His love is not unconditional like Mommy's. He makes challenges and endorses risks. "Come on, throw the ball, you can do it!" Or, "Let's race to the bottom of the hill."

A successful father-son bond allows a child to gradually identify with the father, to borrow strength from his father's personality, and eventually incorporate it into his own. But this happens best if a father balances his expectations of performance with warmth and love.

However, if a father is unreceptive toward his son, if he is cold, harsh, distant, too controlling, or even ineffective, this can disrupt the normal process of childhood development. The father needs to be a strong enough presence that the son feels compelled to identify with him, but not too harsh and distant that the son feels uncomfortable and unsafe. In other words, a father who validates and respects his son, but also challenges him to explore the outside world of men that lies beyond Mamma's arms. The Gemara (Sanhedrin 107b) speaks about this balance between firmness and love when it states regarding a young child, "The left hand should push away, and the right hand should draw near." The Gemara also recognizes the unique emotional bond inherent in the father-son relationship in that a son who is pining for his father at times may be considered to be in mortal danger (see Shabbos 66b).

Nicolosi documents, via dozens of case histories, similar childhood experiences of clients who were not able to feel comfortable identifying with their fathers, leading to what is called a defensive detachment. Essentially, the child rejects masculinity because his father does not provide a safe model to become attached to. In addition, the mothers often colluded with the child against the abusive father, further undermining the authority and value of masculinity. Some homosexuals exhibit exaggerated masculinity as an overcompensation against feelings of inadequacy, while the actual homosexual behavior is an attempt to incorporate masculinity via the sexual act, but of course ultimately never actually corrects the developmental dilemma.

But Can it Be Cured?

Our next question is that if homosexuality is not innate, or at least some forms are not innate, what is the theoretical psychodynamic cause for this sexual orientation? First we will review Freud's comments on this matter which are somewhat pessimistic, and then discuss some of the current research which does show grounds for optimism.

According to Freud, there is an inherent bisexuality in all people (ibid:141-144.) Meaning, that on some level there is sexual attraction for both sexes. From a Jewish philosophical view this also makes sense, since the Torah usually does not take the time to forbid that which people have no desire to do. Thus, the Torah must have recognized that people may have homosexual temptations, at least at certain times. (This view, that there can be a natural desire for homosexual acts, is apparently not supported by Rabbi Feinstein, and we will discuss this matter a bit later in greater depth.)

Though a person may feel utterly repulsed by homosexuality, that does not contradict the innateness of bisexuality. The revulsion is a conscious thought and does not reflect what occurs on an unconscious level. In fact, often times a strong revulsion toward anything is indicative of the presence of an unconscious attraction. The revulsion is actually a defensive stance taken by the ego to protect the personality from the pain of the conflict, which in this case is the attraction to homosexuality versus the moral and social demands against it. Such ego defenses are known as reaction formations. One can readily observe this in small children, such as child trying to be brave who says, "I am not afraid." Or when someone, literally or figuratively, "Whistles past the graveyard." This is why we often find homosexual experiences or incidents in the psychological histories of those who commit violent crimes against homosexuals. They beat up other

homosexuals as a way of externalizing their self-hate and revulsion of their own homosexual tendencies. This is similar to the Talmudic dictum, "Kol Haposel Bemumo Posel (a person criticizes others with his own flaws.)" (Kiddushin 70a.)

However, despite there being an innate bisexuality in all people, it is not of equal force. Thus, there is a somewhat stronger drive in the direction of the opposite sex (S.E., *ibid*:226.) This also makes sense biologically, since it is only through heterosexuality that the species can continue. But there are many points in development where the child's sexuality can be either steered toward homosexuality or away from it. A child's earliest love objects are his/her parents. The son is naturally drawn to the mother, and the daughter to the father. However, the jealousy and competitiveness of the spouse of the same sex may drive the child toward identification and attraction to objects of the same sex, since as we have said, humans are bisexual. Even though, to some extent, this rivalry is normal and an important part of all children's sexual development, there may be a minority of cases where this contributes to a misdirection of the sexual instinct. For example, in cases where either the intensity of the jealousy and rivalry is too strong, or there exists an innate weakness in the child's drive toward heterosexuality, it may lead to a permanent homosexual object choice. Such a sexual orientation may present a satisfactory outlet for the subject's libidinal instincts while avoiding the danger implicit in competing with the parental rival. A key factor is the quality of the father-son relationship, in that the father be a strong enough presence that the son feels compelled to identify with him, but not too harsh and distant that the son feel uncomfortable and unsafe. In other words, a father who validates and respects his son, but also challenges him to explore the outside world of men that lies beyond Mamma's arms.

Thus Freud states:

"The frequency of inversion among the present day aristocracy is made somewhat more intelligible by their employment of menservants, as well as the fact that their mothers give less personal care to their children. In the case of some, it is found that the loss of one of these parents, whether by death, divorce or separation, with the result that the remaining parent absorbs the whole of the child's love, determines the sex of the person who is later to be chosen as a sexual object, and thus may open the way to permanent inversion." (*Ibid*:230.)

Whether there are psychodynamic causes for homosexuality or it is innate or it is combination of both factors, it still does not imply that once the fixation is present that it can easily be changed or corrected. Although Freud noted that there are definitely individuals who experience homosexual desires for selected periods in their lives, or during certain circumstances (*ibid*:137,241), and can revert back to heterosexuality, there also is a portion of the homosexual population that remain more or less permanently fixated. Below are some of Freud's key observations about the possibility of effecting a change in a person's sexual orientation:

"Such an achievement -- the removal of genital inversion or homosexuality -- is in my experience never an easy matter. On the contrary, I have found success possible only in highly favourable circumstances, and even then the success essentially consisted in making access to the opposite sex (which had hitherto been barred) possible to a person restricted to homosexuality, thus restoring his full bisexual functions. After that it lay with him to choose whether he wished to abandon the path that is banned by society, and in some cases he has done so." (S.E. "A Case of Homosexuality in a Woman", 18:151.)

Freud is making an important point, namely, even if a person's sexual orientation is changed, since that person has already experienced homosexuality as a satisfactory form of sexual expression, it will at best always remain a matter of choice. Put simply, you can teach someone who likes vanilla to eat chocolate too, but you can never make him hate vanilla!

To help the reader understand the magnitude of the difficulty in changing sexual orientation Freud very cleverly asks one to imagine how difficult it might be to achieve the opposite, that is, for a heterosexual to change into a homosexual. He states:

"In general, to undertake to convert a fully developed homosexual into a heterosexual does not offer much more prospect of success than the reverse, except that for good practical reasons the latter is never attempted." (*Ibid*.)

Freud goes on to comment on some hidden obstacles that are present in the treatment of homosexuals, even in cases where the homosexual person expresses a strong desire and motivation to change. Specifically, though there may be a conscious

motivation and need to change, unconsciously the person may have other motivations for seeking treatment:

"The number of successes achieved by psycho-analytic treatment of the various forms of homosexuality, which incidentally are manifold, is indeed not very striking. As a rule the homosexual is not able to give up the object which provides him with pleasure, and one cannot convince him that if he made the change that he would rediscover in the other object the pleasure that he has renounced. If he comes to be treated at all, it is mostly through the pressure of external motives, such as the social disadvantages and dangers attaching to his choice of object, and such components of the instinct of self-preservation prove themselves too weak in the struggle against sexual impulses. One then soon discovers his secret plan, namely, to obtain from the striking failure of his attempt a feeling of satisfaction that he has done everything possible against his abnormality, to which he can now resign himself with an easy conscience." (Ibid.)

However, regarding the class of homosexuals who have not yet fully fixated on this form of sexual orientation, Freud paints a more optimistic picture:

"It is only where the homosexual fixation has not yet become strong enough, or where there are considerable rudiments and vestiges of a heterosexual choice of object, i.e. in a still oscillating or in a definitely bisexual organization, that one may make a more favourable prognosis for psychoanalytic therapy." (Ibid)

We see from the above, that according to Freud, treatment for homosexuality was difficult, but not impossible.

Jewish Ethics

From the halachic perspective, we find a responsa of Rav Moshe Feinstein ZT'L written to someone who sought guidance on how to repent for having committed the sin of a homosexual act. Rav Moshe writes:

"The first thing you should know is the severity of the transgression, [which is] stoning [in biblical and ancient Israel if warned in advance by two witnesses and convicted in a rabbinical court] and kares [see chapter one where we define this term.]...Even non-Jews are commanded in this prohibition...Secondly, it does not make sense why there should be a desire for this, for in creation there is no natural drive toward homosexuality...and even wicked people [who commit other transgressions] do not have an urge for [homosexuality] per se. Rather the entire attraction is based merely on it being forbidden and therefore the evil inclination spurs him on to rebel against the will of his creator. Keeping this fact in mind will be of great assistance in fighting against his evil inclination that has already won him over [in the past.]...Third,...The whole world, even the wicked people, disdain homosexuals....The best strategy for success is to study Torah in-depth, for it saves and protects one for all sexual sins...Behold I close with my blessing that your repentance be whole and complete, and you grow in Torah and fear of God." (Igros Moshe, O.C. IV, 115, pp. 205-206.)

As the reader can see, Rabbi Feinstein does not consider this homosexual to be suffering from an innate condition. Indeed, one of the three points that Rabbi Feinstein enumerates is that the person must recognize that his urge is not natural. A very careful reading shows that Rabbi Feinstein is aware that this person, nonetheless, subjectively feels a desire for homosexuality. But rather Rabbi Feinstein seems to be suggesting a cognitive therapy approach and that he change his cognition so that he can convince himself that his desire is illusory in nature. While this may be helpful, the potential downside of such kinds of behavioral treatments is that the client is being asked to repress various feelings and change cognitions instead of addressing underlying developmental deficits that are inducing the behavior and the cognitions.

Reparative Therapy

In terms of current practice, recent findings show significant cause for hope. There are therapists and organizations that do provide treatment for homosexuality, and some programs conduct follow up studies claiming impressive results. This treatment is known as either reparative therapy or gender affirming therapy. It is based on helping clients strengthen their masculine identity via individual and group treatment to address their underlying deficits. There are indeed many impressive studies that document relatively successful outcomes from reparative therapy. One such study was conducted by Robert Spitzer, (the same fellow quoted earlier in regard to DSM). Spitzer's concluding comments included the following statement:

“Mental health professionals should stop moving in the direction of banning therapy that has, as a goal, a change in sexual orientation. Many patients, provided with informed consent about the possibility that they will be disappointed if the therapy does not succeed, can make a rational choice to work toward developing their heterosexual potential and minimizing their unwanted homosexual attractions.”³

It also is important to note, that since the DSM and the APA no longer considers homosexuality per se to be a disease, technically speaking, providing treatment may put one at risk in terms of professional licensure and unprofessional conduct. From a secular perspective, one might consider providing therapy for a non-disease to be malpractice similar to a surgeon performing procedures on a patient who has imaginary ailments. On the other hand, given the DSM diagnosis “Other Sexual Disorders Not Otherwise Specified” that we discussed earlier, it might be justifiable to provide treatment for an individual experiencing marked distress about his or her sexual orientation. And, such treatment does not have to involve affirming a client’s “gayness” or encouraging him to “come out of the closet” if the client identifies a goal of heterosexual function. Therapists who do wish to provide this kind of therapy should consider various forms of documentation and waivers to protect them from liability.

For those interested in studying more about reparative therapy, I recommend “The Reparative Therapy of Male Homosexuality” by Joseph Nicolosi, PhD., as mentioned previously in this article. In addition, I also recommend the international organization JONAH “www.jonahweb.org”, which offers education and support group for Jewish persons suffering from “Same Sex Attraction”.

Concluding Thoughts

When I was still a pulpit rabbi, I remember once being asked by a congregant, “How come women aren’t taught Gemara?” The answer I came up with was different than the stock apologetics that my colleagues often gave, and I think is relevant to this discussion as well. I informed the person that in my belief, the only reason why such a question was asked is because men have neglected Talmud study to such an extent that it is open for any ordinary person to casually entertain the idea of engaging in this sacred pursuit. In reality, the rabbis considered the study of Talmud to be deadly serious, requiring extreme dedication and deprivation.⁴ If it were not for the fact that men had a Biblical obligation to study Torah, given the lack of studiousness and intellectual laziness exhibited by men in our times, the rabbis might have forbidden them from studying Talmud too! So, it is not that women are being barred from Talmud study because they are women per se, but rather Talmud study required a level of intensity and dedication that was not practical for a woman with child bearing responsibilities to achieve at the time that this ban was enacted. Perhaps if the rabbis had the power today, given the laxity that many men regrettably show toward Talmud study and the zeal and competence shown by some women, a different ban would have been enacted. (Of course, these comments are somewhat tongue-in-cheek, so please do not extract a philosophy about women and Torah study from this article.)

In any case, the point here is that modern attitudes have completely eroded our respect for sacred family values. These influences have plagued us with rising divorce rates, infidelity, increased personal selfishness and focus on immediate gratification, and lack of modesty and moderation. It is only because we live within such a context, that the idea of homosexuality can be entertained as a healthy and productive alternate lifestyle. If society had a real appreciation for the sanctity and commitment that a real marriage requires, what it takes for two people of the opposite gender to learn how to respect each other, to raise children together, to understand and care for each other over a lifetime, to honor obligations that require maintaining sexual intimacy throughout the lifetime of the marriage, the idea that a relationship of two men could ever come near that, or be considered morally equivalent, would seem ludicrous.

³ *Archives of Sexual Behavior*, Vol. 32, No. 5, October 2003, pp. 403-417. Also reprinted on the NARTH website: “<http://www.narth.com/docs/evidencefound.html>”.

⁴ Some examples: “Rabbi Yaakov said: One who walks on the road while reviewing [a Torah lesson] but interrupts his review and exclaims, ‘How beautiful is this tree, how beautiful is this plowed field!’-Scripture considers it as if he bears guilt for his soul.” Avos 3:9.” Rabbi Dostai bar Yannai says in the name of Mabbi Meir: Whoever forgets anything of his Torah learning, Scripture considers it as if he bears guilt for his soul, for it is said: ‘But beware and guard your soul exceedingly lest you forget the things your eyes have seen’ (Deuteronomy 4:9).” Avos 3:10 and “This is the way of Torah: Eat bread with salt, drink water in small measure, sleep on the ground, live a life of deprivation...” Avos 6:4

In the Shadow of the Net... (Continued from Page 1)

What is cybersex addiction? Cybersex addiction has become a specific subtype of Internet addiction. It has been estimated that one in five Internet addicts are engaged in some form of sexual activity, primarily viewing cyberporn and/or engaging in cybersex.

Early studies show that men are more likely than women to engage in cyber porn, while women are more likely to engage in erotic chat. Ms. Griffin and Dr. Delmonico pointed out that cybersex addicts are not only deviant individuals engaged in acting out but, to our surprise, people who have never had problems with sex addiction are also becoming addicted to on-line sex. The presenters went on to explain why this plague has spread like wildfire. One of the reasons is the anonymity of on-line interaction that helps people to increase their activity without being caught, so to speak. The anonymous context of the Internet allows users to act out hidden or repressed sexual fantasies without fear of being caught (except by a spouse standing quietly and looking over their shoulder...). Another reason is the convenience and ready availability of cyberporn and sexually-oriented chat rooms, making it easily available to users 24/7 in the convenience of their own homes or offices.

The workshop included an on-line presentation that taught the participants about the dark side of the Internet. Looking around the room, one could see how shocked, unfamiliar, and uncomfortable most of us were to actually view these realities in action and on a magnified screen. It seemed as though most of the participants were unfamiliar with the language and terminology of cybersex and were quite enlightened by the excellent presentation. The presenters were very sensitive to the religious audience and tried as hard as they could to cover up or censor certain pictures that they ordinarily show to a non-religious audience. Their sensitivity to the audience and the concerns of the Orthodox mental health professionals was greatly appreciated by all workshop participants.

While it may appear that addictions are pleasure-seeking behaviors, the roots of any addiction are usually traceable to suppression and avoidance of some kind of emotional pain. Addiction, the presenters said, is a way to escape from reality, either something that is either too full of sadness (such as an abusive relationship) or too devoid of joy (an emotionally empty life). Emotional trauma in early life may be at the source of most addictions.

Internet addiction is a fantasy world in which there are endless people who appear to be interesting and interested in the person. Ms. Griffin mentioned that once when she was in a chat room and was complimented repeatedly by a man, she thought to herself, "Ah. That felt real good." So you can imagine how people who are not professionals find it easier to engage in Internet "relationships" than risk face to face rejection from a real person and beyond that, get positive feedback and compliments. As the addict becomes immersed in this shadow world, denial starts to take place and he or she starts to view the "cyberfriends" or "partners" as more real than the actual spouse or family. This causes increased distance between husband and wife, and poses a grave danger to the family.

Everyone is at risk! However, people who suffer from low self-esteem, distorted body image, and persons diagnosed with ADHD are even at greater risk than others. In addition, concern was expressed about our children, teens, and young adults who engage in cybersex.

Most of the workshop participants said that they were attending because they have encountered Internet addictions in their practices, and more and more therapists are seeing cases of Internet addiction. The problem has not passed the Orthodox community by.

It is a problem that affects all ages. Generally, women complain that their husbands spend too much time on the computer and are finding pornography and cybersex. This can destroy family life. Women feel that men obtain "effortless pleasure." Sex on the Internet is so easy to access and so prevalent that it does not feel like it is committing adultery, because it is virtual and not real. Women blame themselves, believing that they are not pretty enough or good enough, and because of that, their husbands have to resort to the Internet. They are afraid to discuss the problem, because of fear of stigmatization in the community. The women, like Sarah, then experience feelings of low self-esteem and sadness and come crying into the therapist's office.

The therapists who participated in the workshop pointed out that there are no guidelines for addressing the problem in the Yeshivas, because it is so new. Clearly there are different levels of addiction.

One recommendation from the workshop was for Nefesh to appoint a committee to establish guidelines, develop a curriculum, and then conduct mandatory educational workshops in the Yeshivas for parents, to teach their children proper and appropriate behavior in the cyber world. It was also felt that there is a need to continue to educate mental health professionals, rabbis and educators. In the 9th Annual Nefesh International Conference to be held February 8 – 12, 2006 in Baltimore, MD, Nefesh is planning to have Dr. Delmonico and Ms. Griffin present their workshop to a wider Nefesh audience.



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**THE 9TH ANNUAL NEFESH INTERNATIONAL CONFERENCE
FEBRUARY 8-12, 2006**

**“WORKING TOGETHER FOR TZORCHEI TZIBBUR:
GAINING STRENGTH FROM UNITY AND DIVERSITY”**

Speakers for the 9th Annual Nefesh International Conference

We have an exciting and distinguished roster of invited presenters (see below) for the upcoming 9th Nefesh International Annual Conference. This is only the short list. You will be receiving an extended list in the mail of all the presenters and the titles of their workshops. Many of you have submitted excellent abstracts for which we are grateful. It is obvious to us that you have given a great deal of thought and time to your proposals and for this we thank you. It is a confirmation of our belief in the expertise, and professionalism of all of you who devote your energy towards helping those in need. Your spirit and dedication is what contributes to the success of our conferences. We hope this list will encourage you to attend and avail yourselves of the opportunity to be inspired by your colleagues, our distinguished guests and educational workshops.

Chana Kahn, LCSW

Abe Worenklein, PhD

Presenters (in Alphabetical Order)

Paul S. Appelbaum, M.D. is former president of the American Psychiatric Association, Chairman, Department of Psychiatry, and Director, Law and Psychiatry Program, University of Massachusetts Medical School. He is a nationally acclaimed expert on legal and ethical issues in psychiatry. He will speak on boundary issues in the practice of psychotherapy.

David Brent, M.D. is Professor of Child Psychiatry, Pediatrics & Epidemiology, at the University of Pittsburgh School of Medicine, and Academic Chief, Child and Adolescent Psychiatry, Western Psychiatric Institute. He is an internationally distinguished expert in suicide research and the treatment of adolescent depression. He will be speaking on “SSRI’s and Suicidality: Cause or Cure?”

HaRav Dovid Cohen is Morah D’Asrah of Congregation Gevul Yaavetz, Brooklyn, N.Y. Rav Cohen is halachic consultant to Ohel Children’s Home and Family Services and the Morah D’Asrah of Nefesh International.

David Delmonico, PhD is an associate professor at Duquesne University. He is co-author of *In the Shadows of the Net* and *Cybersex Unhooked*. Dr. Delmonico conducts trainings across the nation on Internet and sexuality. He is the director of the Online Behavior Research and Education Center, and Editor-in-Chief of the *Sexual Addiction and Compulsivity Journal*. Dr. Delmonico and Ms. Griffin (see below) led a one day workshop “In the Shadow of the Net: Understanding Internet Addiction and Problematic Online Sexual Behavior” in New York City which received excellent reviews by the participants. They will be leading a pre-conference institute titled “The World of Cybersex and Its Impact on the Family”.

Hinda Dubin, M.D. is Clinical Assistant Professor of Psychiatry at the University of Maryland School of Medicine and, Director, Psychotherapy Education, University of Maryland School of Medicine.

Mr. Joseph Friedenson, Editor of “Dos Yiddishe Vort”, Author and historian of Modern Jewish History.

Merle Cantor Goldberg, LCSW has specialized in treating eating disorders for over thirty-five years. Over this period, she has served as training leader for the International Association of Eating Disorders. Currently the Executive Director of Associates in Psychotherapy, she has appeared on many radio and television shows, and her articles have been published in numerous newspapers and magazines. She is co-author of *Weight Loss Surgery, My Thin Excuse and The Human Circle*.

Fredrick Goodwin, M.D. is past Director of the National Institute of Mental Health. He is one of the leading international authorities on Bipolar Disorder and co- author of the definitive textbook on this subject. He will speak on advances on the diagnosis and treatment of Bipolar Disorder.

Elizabeth Griffin, MA is a licensed Marriage and Family Therapist with over twenty years of experience treating sexual offenders and those with sexually compulsive behaviors. Ms. Griffin is co-author of *In the Shadows of the Net* and *Cybersex Unhooked*. Ms. Griffin is a director of *Internet Behavior Consulting*, a company whose focus is on issues related to problematic online behavior.

Mr. Richard Joel is President of Yeshiva University. Mr. Joel served as president and international director of Hillel: The Foundation for Jewish Campus Life, was an assistant district attorney in New York, and an associate dean at YU's Benjamin N. Cardozo School of Law.

Otto F. Kernberg, M.D. is Director of the Personality Disorders Institute at the New York Presbyterian Hospital, Westchester Division and Professor of Psychiatry at the Weill Medical College of Cornell University. Dr Kernberg is an internationally distinguished expert on the treatment of borderline and narcissistic personality disorders and the author of ten books and co-author of nine others on psychopathology, object relations and the treatment of borderline and narcissistic personality disorders.

Harvey Kranzler, M.D. is Professor of Psychiatry and Director of the Division of Child and Adolescent Psychiatry at the Albert Einstein College of Medicine in the Bronx, New York, and will discuss the treatment of social phobia and other anxiety disorders.

David N. Neubauer, M.D., M.A. is associate director of the Johns Hopkins Sleep Disorders Center, and a nationally renowned speaker on sleep disorders.

David Pelcovitz, PhD, Professor of Psychology and Education at Yeshiva University and Vice President of Nefesh International. He is an internationally recognized expert on Post Traumatic Stress Disorder and an expert of Developmental Psychopathology.

Rabbi Dr. Aaron D. Twerski is the Dean and Professor of Law at the Hofstra Law School. He is the first Chasidic Jew to head a major law school in the United States and is a preeminent authority on both secular legal issues and the Chassidic community. He has decades of experience with Orthodox Jewish communal mental health concerns.

Rabbi Dr. Abraham Twerski is the founder and Medical Director Emeritus of Gateway Rehabilitation Center, a nationally recognized not-for-profit drug and alcohol treatment center in western Pennsylvania. He is recognized as an international authority in the chemical dependency field.

Rabbi Tzvi Hersh Weinreb, PhD is Executive Vice President of the Orthodox Union. Rabbi Weinreb has extensive training in group psychotherapy and object relations theory.

Rabbi Chaim Dovid Zwiebel, Esq. is Executive Vice President of Government and Public Affairs of Agudath Israel of America.

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A Joint Project of **NEFESH**, Ohel Children's Home and Family Services, and **Yitti Leibel Helpline**
With the Generous Support of **TARGUM SHLISHI**, a
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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, click [Click here to add your agency to our directory.](#)

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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Clerical Intervention in Psychological Treatment

Seymour Hoffman, Ph. D. and Rabbi Naftali Bar-Ilan

Abstract

Several cases are presented of the intervention of a rabbi in the treatment of psychiatric patients. The rabbi was requested to intervene by the therapist when the issue of pathological guilt was encumbering further therapeutic progress.

In the psychological literature, several cases have been reported by mental health practitioners describing the collaborative efforts of (orthodox) rabbis and clinicians in the treatment of psychiatric patients where the outstanding elements were maladaptive behavior and reactions to extreme guilt feelings (Witztum, Buchbinder and van der Hart, 1990, Rapaport, 1991)

In her study on orthodox rabbinic attitudes to mental health professionals, Slanger (1996) makes the following points: "It is important for the mental health profession to assume responsibility for initiating contact with the rabbis and engaging in extensive case recruitment efforts"; "...it is essential to acknowledge areas of rabbinic expertise and to harmonize closely with the rabbis in a mutually working alliance"; "Therapeutic approaches which may include participation of the rabbis should be considered".

Below are presented five abbreviated case reports describing the collaborative efforts of a rabbi and a clinical psychologist in the treatment of psychiatric patients.

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Jonah, a 28 year old bachelor who several years ago became a "baal teshuva" (repentant), has lived in a hostel for discharged psychiatric patients for the last two years. During the past ten years he has been in psychiatric treatment, which included several hospitalizations. His diagnosis is Schizophrenia, Unspecified Type and Obsessive-Compulsive Disorder, Mixed Obsessional Thoughts and Acts. He is presently receiving psychopharmacological and psychological treatment at a local mental health clinic.

Jonah was described by his therapist as a highly anxious, insecure, dependent, depressed, suspicious, immature, rigid and perseverative individual who was involved in a compulsive manner with issues of religion, dietary laws, cleanliness and food. These preoccupations severely encumbered his daily functioning, both vocationally and socially. His religious obsessional and compulsive preoccupations included excessive concern regarding observing the dietary laws (e.g. dairy and meat products were compromised as a result of their being in close proximity to each other, etc.) concern that he inadvertently deleted several words from his prayer which prompted him to repeat the prayer and excessive concern regarding the cleanliness of his hands and body, especially before partaking of food and praying.

Jonah had approached several local rabbis about his religious questions and concerns who patiently explained to him the halacha in an attempt to reassure and calm him. However, the intricate explanations only prompted more questions and doubts and increased his anxiety. At the request of the patient, the therapist acceded to the patient's wish to discuss his concerns with a rabbi. Before the meeting, the rabbi met with the therapist to discuss the strategic approach to be taken with the patient.

In the three-way meeting, the rabbi, after hearing the patient's questions and concerns for a half-hour, told the patient that because of his difficult emotional situation, he would be granted a special dispensation, and therefore, for him there were no questions and therefore no need for clarifications or explanations. As of today he did not have to worry if the food he eats has been compromised, and need not concern himself whether he skipped some words in his prayers or whether his body was

adequately clean before doing a religious ritual. He was told to repeat this “mantra”- “There are no questions and therefore there is no need for answers”. He was also informed that this special dispensation was in force for three months and to be renewed only after prior consultation between the rabbi and therapist. The rabbi wrote out his opinion, dated it, and gave it to the therapist to keep. At the conclusion of the session the rabbi wished the patient a speedy recovery and success in his endeavors.

In the following therapy session with the therapist, the patient reported a significant reduction in his religious obsessions. Whenever the patient attempted to raise religious concerns in the session, the therapist reminded him of the “mantra” and the discussion was refocused on other non-religious issues. Several years later, the patient’s present therapist reported that the patient continues to use this “mantra” when plagued by religious obsessions, with partial success.

Case-2

Joseph is a 50 year old haredi (ultra-orthodox) man who three years ago married a divorcee with two children. He has three children from his first marriage whom he sees at rare occasions. For the last ten years he has run a large haredi school in Jerusalem with considerable success.

In the first meeting, he informed the therapist that he is a closed person, doesn’t have many friends, doesn’t trust people including his wife, and that he will not reveal personal information to the therapist. When asked about his marriage he responded that it was fine, his wife was a good woman and he took all the blame for all the difficulties between them. When pressed, he acknowledged that he feels like a guest in his home, he has no say regarding the discipline of his wife’s children and because of his generosity with money (buys presents for his children and their mother), the bank account is in his wife’s name. He doesn’t have his own telephone because his wife objects that he speaks to his former wife.

When asked why he decided to go for psychological treatment, he explained that he is not living a meaningful and productive life, lacks desire and energy to cope with life’s everyday problems, and feels depressed and pessimistic about the future. When the therapist commented that it was understandable in light of his marital situation, Joseph insisted that he was to blame and that he had to work on himself to accept the situation for the sake of “shalom bayit” (domestic peace). He added that he had to work on his “middot” (attributes), “bitul hayesh” (“annihilation of the self”) and learn to accept his situation with grace and tolerance. He denied that he harbored any angry feelings towards his wife and added that angry feelings are prohibited by halacha. Upon inquiry, he acknowledged that angry feelings were unacceptable in his house since he can remember. When asked if he discussed the above mentioned halachic-philosophical issues with a rabbi, he answered in the negative and explained that there wasn’t any rabbi that he respected and trusted enough to confide in. At this point, the patient enquired if the therapist would arrange a meeting with a rabbi that the latter respected and trusted in order to discuss these issues.

At the following session (fifth), the rabbi met with Joseph together with the therapist at the latter’s office and related to the halachic-philosophical issues raised by the patient. The rabbi opined that the patient’s understanding and interpretation of the hassidic concept “bitul hayesh” was inaccurate as it had to be balanced and not create negative consequences. He also took issue regarding the patient’s understanding of the halacha’s view of anger. According to Rabbi Kook, the rabbi explained, when anger is a mode of life or when it is unjustified, it is prohibited. When a person is wronged, he is permitted to express his natural feelings. At this point the psychologist turned to the rabbi and stated that in his opinion Joseph was hiding behind a “halachic- philosophical smokescreen” in order to avoid acknowledging and dealing with his pent-up angry feelings and fears of behaving in an honest, forthright and assertive manner. He believes that by acting as a “doormat”, he is acting in a righteous manner. The rabbi turned to the patient and encouraged him to start taking small steps toward assertiveness and suggested that the next meeting that he schedules with the therapist be done with his new telephone, even though he may jeopardize “shalom bayit”. Joseph unexpectedly responded that if the rabbi rules such, he will do it.

Several days later, Joseph called for an appointment with his new telephone. At the meeting, Joseph seemed more relaxed and in a positive mood. He reported that he is more assertive at home and was surprised that he met less resistance from his wife than expected. At the end of the session, he mentioned that the previous meeting with the rabbi was very helpful and asked the therapist to again thank the latter for his help.

Case-3

David, a 29-year-old single man from a religious family, is the youngest of six children and the only one who had not completed a high school education. At the age of 19 he was hospitalized with a diagnosis of chronic paranoid schizophrenia. In the past, Dan had worked in the post office and in sheltered workshops. He is presently involved in a rehabilitation program that involves occupational and social therapy and individual supportive therapy. In one of the therapy sessions, David raised the issue of masturbation. On the one hand he felt extreme conflict and guilt indulging in this behavior: on the other hand, he had no other avenue to release his strong sexual impulses. The guilt caused him considerable distress, depression and preoccupation with thoughts of punishment and suicide. The therapist suggested to David to discuss this issue with a rabbi and after receiving his consent, a meeting was arranged with a rabbi with wide experience in pastoral counseling.

After listening to the patient explain his conflict and dilemma, the rabbi, using appropriate halachic texts, counseled the patient to attempt to control his masturbatory activity since it was against Jewish law. He pointed out, however, that it was not possible to judge him since others could not know what he is feeling and experiencing. Because of his serious psychological problems he could be considered an *anoos* (legal term for a person who has limited or no self-control and free choice regarding his behavior) by society and especially, by his family. The rabbi added that David knew himself best: if he tried to control his behavior and did not succeed, it was an indication that he is an *anoos*. Therefore, there is no reason for guilt feelings. David mentioned to the rabbi that several years ago he had consulted a rabbi about the same issue and was told that his behavior was terrible and sinful, and that if he continued, an accident would befall him. The rabbi pointed out to the patient that since the dire predicted consequences did not occur, it proved that he might be considered an *anoos*. The rabbi terminated the meeting with a quote from the Talmudic text, "Ethics of the Fathers": "You are not called upon to complete the work, yet you are not free to evade it". A week later, the therapist contacted the rabbi and informed him that following the meeting there was a noticeable improvement in the patient's mood and general functioning and thanked him for his help. (5)

Case-4

Dinah, a thirty year old married woman and mother of three children requested an immediate appointment as she was afraid that out of desperation, she will do harm to herself. The patient appeared tense and anxious as she described her fragile emotional state. For the last two years, after a religious friend of hers in whom she confided, told her that in the Talmud it states that the punishment for not keeping vows is the premature death of children, she has been obsessed with guilt feelings, fears and thoughts of making vows and receiving divine punishment for not fulfilling them. Her emotional stability has been further aggravated as a result of marital tension and conflict.

Following the initial session, Dinah felt less anxious and tense and in more control of her emotions. In the fourth meeting when she again raised the issue of her obsessional thoughts and fears, the therapist suggested a meeting with a religious authority in order to discuss further this issue, to which the patient enthusiastically agreed.

In discussing the case with the rabbi, the therapist suggested that the former arrange a religious ceremony of "Hatarat Nedarim" (Annulment of Vows)* as a means of aiding the patient to free herself from the oppressive bonds of her obsessional fears.

The meeting was held in the rabbi's synagogue and was attended by the therapist and another man. The rabbi, after listening to the patient's story, explained that it is a sin to make vows and not fulfill them but thoughts of making vows are not prohibited. The Torah, however, realized that man is only human and is not capable of controlling all the time his speech and, therefore, provided a way to annul vows that were made impulsively and now regretted. After explaining the form and purpose of the above mentioned religious ritual, the rabbi conducted the ceremony with the participation of the other two men. At the conclusion of the meeting, the patient, visibly relieved, thanked the rabbi for his help. The latter wrote out what transpired at the meeting, signed the note and asked the other two participants to do likewise and handed it to the patient for future reference.

In the following therapy session, the patient reported a marked decrease in her obsessional thoughts and a significant improvement in her mood and overall functioning.

*It is considered a fearsome sin for one to violate vows and oaths ("He shall not desecrate his word"-Numbers, 30:3) and the mainstream rabbinic view was against making vows in general ("Do not form the habit of making vows"-Babylonian

Talmud, Nedarim, 20,a). However, Jewish law provides the possibility of annulment of vows if the vow involves only oneself. One remedy is the ceremony of "Hatarat Nedarim", recited on the eve of Rosh Hashana, the Jewish New Year. In this ceremony, three individuals band together and take turns in constituting a quasi- ecclesiastical court. The petitioner recites a formula whereby he renounces all oaths and promises made and not fulfilled. He expresses regret in taking upon himself vows and requests that they be annulled. The "judges" then declare that there "does not exist any vows"... "but there does exist pardon, forgiveness and atonement". The ceremony is concluded with the petitioner declaring for the final time that "he cancels from this time onward all vows and all oaths". The ceremony is declared proactive so that if an oath is made subsequently and then regretted, it too is declared totally null and void.

Case-5

The patient, a 25 year old bachelor who immigrated to Israel with his mother and older sister five years ago, appeared at the clinic with the following complaints: severe depression, poor concentration, pains in the chest and legs, decreased functioning at work, and an overpowering feeling that he was "going crazy" from his constant thoughts regarding the death of his father. Though he had suffered for the last ten years, he refused to seek psychiatric aid until his mother pleaded with him to do so.

His father, who suffered from several serious physical illnesses and who had a long psychiatric history, expressed a desire to end his life. One day the patient found him attempting to hang himself from a basement rafter. The father asked the son to move the table upon which he was standing so that he could die, but the son refused. After repeated taunting and pleading the son in an attempt to appease his father, moved the table from under his father's feet and immediately returned it to its original place. The father, enraged at his son's action, began cursing and yelling at him to move the table. The son again moved the table, but this time was unsuccessful in returning it to its original place because of the father's frantic kicking movements. The patient immediately ran to his mother for help, but on their return, the father had already expired.

A year before seeking psychiatric help, the patient established a relationship with a woman, with whom he was presently sharing an apartment, but not his "awful secret." The patient felt that he could not marry and bring children into the world because of his fear of not being able to function as a husband and father and "going crazy."

In the therapy sessions, an attempt was made to relate to and deal with the patient's intense and overwhelming guilt feelings regarding the "patricidal" act and his self-punishing behavior, but with little success. At one point, the therapist suggested consulting a rabbi regarding the possibility of atonement for the patient. The patient, who came from a traditional background, agreed. However, he requested that the therapist speak to the rabbi first, in order to prepare him for the "shocking" story. In the meeting with the rabbi, the psychologist presented briefly the patient's history and the purpose and goals of the upcoming meeting.

The meeting with the patient was held in a synagogue in the presence of the psychologist. After hearing the patient's story, the rabbi stated that the offense committed was indeed very serious. He proceeded to explicate on Judaism's view of the sanctity of life and then read several select portions from Maimonides on repentance. The rabbi then concluded:

"According to the Torah, you are obligated to believe that nothing stands in the way of repentance and this includes even the serious offence that you committed. I am also not convinced that all the responsibility falls upon you, in view of your father's erratic condition and disturbed behavior. The Torah requires that the penitent go through a process of experiencing and suffering guilt feelings and regret for the offense committed, a process that you have undergone more than is required and it is a pity that it has continued for so long. You are now required to pass on to the second stage of identity change* and doing good and charitable deeds. It seems to me that you can realize identity change by getting married and having children. By naming your child after your deceased father, you will be perpetuating his memory for generations. You should also take upon yourself to donate money to a worthwhile charity in your father's name, visit his grave and in the presence of family members pronounce the new path that you have taken upon yourself and say the Kaddish. God's mercy will never cease and may he provide you with a complete recovery and forgive your sins."

The patient was given the written opinion of the rabbi as he had requested and instructed to take it home to study. He was told it might take him a while to digest the significance of the meeting and the content of the letter and that he should contact

the therapist when he felt ready for a meeting. A half-year later, the patient's girlfriend telephoned to invite the therapist to their wedding and requested that he ask the rabbi to officiate as he had offered in his initial meeting with the patient. In response to the therapist's inquiry, she reported that her fiancé was doing well and there was a significant decrease in his somatic complaints. The meeting and letter of the rabbi had a profound influence on him, as it forced him to face reality. She mentioned that several weeks ago, he had visited his father's grave, where he had announced his intention to marry and asked his father for his blessing. A week before the wedding, the couple had a premarital consultation meeting with the rabbi and the following day the patient donated several volumes of religious books, including the writings of Maimonides, to the synagogue, in his father's memory.

*Part of the therapeutic process in cases of Post-Traumatic Stress Disorder of "accident killers" is "to forgive themselves and move on to **redefinition and acceptance of the self**". See, Janoff-Bulman, *Shattered Assumptions: Towards a New Psychology of Trauma*, 1992, New York: The Free Press.

Conclusion

In the above cases, the rabbis' role and interventions aided the patients to extricate themselves from the guilt-ridden quicksand which imprisoned them. The result was a considerable remission in their suffering and symptoms and a freeing of their energies and thoughts toward change and growth.

While the psychotherapist can explore the subject of guilt, morality, conscience, etc., he cannot participate with the guilty person in repentance, confession, and atonement or offer dispensations. Here, only that person whom the "guilty" man "acknowledges as a hearer and speaker who represents the transcendence believed in by the "guilty" man", can speak. (Buber, 1965)

In the first case described above, the Orthodox Rabbis through their good intentions, by explaining and analyzing the halachic intricacies of the patient's questions, inadvertently reinforced the patient's obsessive-compulsive behavior, and in the third case, the Orthodox Rabbi, unintentionally, increased the patient's anxiety and guilt feelings and aggravated his unstable mental condition, because of their unfamiliarity and ignorance of psychopathology.

Rabbi Shlomo Wolbe, a prominent haredi rabbi, author and educator from Israel, wrote, "There is an urgent need to organize courses for practicing rabbis and educators, in order to disseminate basic knowledge of the symptoms of neurosis and psychosis and their treatment, in order that they will know to refer mentally ill people immediately to the psychiatrist. Basic knowledge will remove many prejudices". (Wolbe, 1989)

It is strongly recommended that the recommendations of Slinger and Wolbe be adopted by mental health practitioners and clergymen of all faiths, for the benefit of the people they serve.

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What Ever Happened To Depth Psychology?¹

Part 2

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Benzion Sorotzkin, Psy.D.

In part 1 (June 2005), I deplored the movement away from depth psychology in favor of short-term therapies and the tendency to downplay the significance of childhood familial experiences, both in therapy and in our understanding of societal problems. I especially lamented the propensity of many clinicians to tell patients that their emotional difficulties are purely the result of genetic factors and chemical imbalances, in spite of the lack of credible evidence for such positions. (A copy of Part 1 is available on my website, www.DrSorotzkin.com).

I received quite a few emails in response to my article. Most applauded my efforts but others expressed reservations. One friend and colleague wrote the following: “You seem to have failed to emphasize the importance of taking responsibility for your actions once you’re an adult. How long can a 54 year old, for example, blame her parents for her failures in life?” I should have indeed mentioned this issue. I do discuss this topic at length in my articles “The Denial of Abuse” (The Journal of Psychohistory) and “The Role of Parents in the Current Crises of Rebellious Adolescents” – both available at www.DrSorotzkin.com.

Two articles published in the same issue of the Nefesh News dovetailed nicely with my article. In Dr. Shalom Feinberg’s report from the recent American Psychiatric Association’s meeting, he relates, “I was struck by the increased focus on the value of cognitive behavior therapy [for the treatment of schizophrenia]... This emphasis on the talking to our patients and working within their inner world... feels [like] “Back to the Future.” I would recommend reading Bertram Karon’s research on the value of psychodynamic therapy for this population (e.g., Karon & VandenBos, 1981; Karon, 2003).

Dr. David Pelcovitz’s comments regarding the “Kiddush Clubs” - as reported in the Nefesh News reprint from The New York Times - also resonates with my comments on the lack of depth perspective regarding community issues. I share his doubt that eliminating Kiddush Clubs would affect our community’s substance abuse problem. (There are, of course, many other good reasons to eliminate Kiddush Clubs).

Postpartum depression

It is an article of faith among the vast majority of mental health professionals that postpartum depression is caused by a chemical (hormonal) imbalance as a result of pregnancy, and there is therefore little, if any, need for in-depth psychodynamic psychotherapy. In truth, however, this belief is not based on proven science. In fact, as reported in the journal, *Social Psychiatry and Psychiatric Epidemiology*:

Aside from anecdotal reports, we have not been able to locate credible research evidence which indicates that major depression is more frequent in women who have recently given birth.... It is... clear that many of the cases of depression noted in the postnatal period represent exacerbations or continuations of a pre-existing set of symptoms of depression. (Najman et al., 2000, pp. 19-20, 25)

Najman et al. (2000) proceed with a fascinating discussion of how postpartum depression as a solely hormonal disease became so widely accepted in our society.

Heron et al. (2004) reached similar conclusions to those of Najman et al. (2000) based on a prospective longitudinal study of a community sample in England. They note that “Anecdotal and clinical experience indicates that there may be some specific concerns of expectant mothers that may make them more vulnerable to anxiety or depression” (p. 72). In my own

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

clinical experience I found that for women who have had a long history of difficulties with depression and anxiety (often sub-clinical or untreated), the experience of childbirth, with its accompanying responsibilities, may result in an intensification of these underlying issues to the point of requiring clinical attention. This is especially true of women with perfectionistic tendencies who demand of themselves to be perfect mothers (see Flett & Hewitt, 2002; Sorotzkin, 1985, 1998).²

Countless postpartum women are told that their depression is purely hormonal and they are thus deprived of the in-depth psychotherapy they truly need. Now of course, it is reasonable to presume that hormonal and physiological stressors and changes play an important factor in the emotional health of the mother, however it is equally important to consider psychodynamic and family systems issues.

Obsessive-Compulsive Disorder (OCD)

To illustrate some of the issues discussed above I will describe what I heard a few years ago in a workshop on the treatment of Obsessive-Compulsive Disorder (OCD). The presenter was a well-known clinician from the west coast who specializes in the treatment of OCD.

He stated that OCD was a “brain biological disorder.” He described how PET scans of the brain can show the part of the brain that “misfires” in OCD and how it “settles down” after successful treatment. He then described how, by the end of the first session with an adolescent patient, he knew that he was dealing with a “biogenic OCD.” Just to be certain, he met the parents for a single session “to rule out any dynamic problems that may have caused the OCD.” Although the presenter noted a great deal of perfectionistic tendencies in the parents he was convinced on the basis of one session with the patient and one session with the parents that he was dealing with “a typical picture of biological OCD.” The presenter described how he explains to the patient and the parents that the patient “isn’t crazy.” “There is nothing wrong with them on the emotional level but there is a part of their brain that gets stuck.”³

It wasn’t clear to me if the presenter meant that OCD is always a “brain biological disorder” and if so why he had “to rule out any dynamic problems that may have caused the OCD?” And if dynamic problems can cause OCD in a vulnerable child, as clearly indicated by all the research (see Barlow, 2002, Chap. 8 & 15), how was he able to rule it out in two sessions?!

I was especially perplexed because this same presenter had, in an earlier lecture, highly recommended Daniel Siegel’s work on “interpersonal neurobiology” (Siegel, 1999; Siegel & Hartzell, 2003). Siegel integrates attachment theory with neurobiology. He states:

It is unhelpful to pit... experience versus biology, or nature versus nurture. In fact, experience shapes brain structure. Experience *is* biology. How we treat our children changes who they are and how they develop. Their brains need our parental involvement. Nature needs nurture. (Siegel & Hartzell, 2003, p. 34)

How does one reconcile the enthusiastic endorsement of that statement with the simplistic, one-dimensional proclamation that OCD is a “brain biological disorder?”⁴

The certainty with which many clinicians tell their patients that OCD is a “brain disorder” is not at all consistent with the research literature which clearly points to unhealthy attitudes and beliefs learned during childhood as an important contributing factor to the development of OCD. For example, Barlow (2002) states that:

[The] negative self-evaluations [common to patients with OCD] appear to be commonly derived from excessive responsibility and the resulting guilt, usually developed during childhood.... It seems likely that extremely high standards imposed during childhood and/or excessively critical reactions from authority figures may also contribute to perfectionistic attitudes, feelings of guilt, and extreme beliefs in responsibility. [p. 533]

² Interestingly, I have seen symptoms very similar to postpartum depression in emotionally vulnerable men who are given their first responsible job.

³ To me it seems that a patient would feel crazier believing that his brain “gets stuck” for no reason!

⁴ Siegel and Hartzell (2003) start their book with the comment: “How you make sense of your childhood experiences has a profound effect on how you parent your own children [p. 1].”

The PET scans referred to above actually prove nothing, since the changes in the brain are more likely to be the result of the disorder than the cause. Likewise, new positive experiences (especially psychotherapy) can repair the damage to the brain. Unfortunately, this is not what most patients are hearing from their therapists, who usually minimize or even dismiss the significance of their early childhood experiences in the development of OCD and the role of psychodynamic therapy in the treatment of OCD.⁵

Misguided good intentions

While some clinicians may promote the idea of brain disorders and “chemical imbalances” as the cause of emotional disorders in order to help parents of emotionally disturbed patients avoid feelings of shame and guilt, the resulting lack of insight on the part of patients and their families surely hinders the progress of the therapy. At the most obvious level, it often results in the parents continuing with the maltreatment that contributed to the development of the disorder in the first place. Clinicians have also come to believe their own well-intentioned message of “no-fault” disorders so that they don’t seriously explore the possibility of parental maltreatment, with unfortunate consequences.

Unfortunately, there are some situations that arise in which the practitioner may not know that the child is continuing to live in traumatizing circumstances even while being treated. (Faust & Katchen, 2004, p. 430).

The message these clinicians are promoting is that the reason patients shouldn’t be embarrassed to seek treatment for psychological disorders is because they are purely brain disorders. The implication of this supposedly reassuring message is that if they are (even partially) emotional disorders then there **is** a reason to be ashamed! The idea that the problems are purely biological doesn’t resonate true with patients and their families (otherwise the parents wouldn’t get so angry at their children for their dysfunctional behavior). Subconsciously, they know what researchers have consistently said, that it is **not** purely a biological disorder and, in that case, according to what they are told, they have every reason to be embarrassed to seek treatment. That, in my opinion, is one source for the stigma in seeking treatment for emotional disorders.

A more honest and effective approach would be to say the following to prospective patients:

You obviously didn’t ask to have these difficulties. It is also irrational to attribute your troubles to laziness or other such explanations, since even a lazy person would go a long way to avoid the suffering you are experiencing. It is much more likely that your early life experiences make many tasks, which others find easy, unusually difficult for you. Psychological pressures can be as compelling as biological forces. This was never explained to you. Rather you may have been told by your parents and teachers that it was because of your moral deficiencies (“laziness” or “not caring”), and this caused you to hate yourself. Some professionals, in a well-meaning attempt to improve your self image, told you that your problems are due to a chemical imbalance. This only served to make you feel defective and despondent. It also made you wonder why some of your therapists may have gotten angry at you when you couldn’t follow through on their recommendations. If they really believe that your problems are purely the result of the chemical imbalance why do they get so upset at you?

I will try to help you make sense of why you have these difficulties. There were specific events that happened in your life that, together with whatever temperament you were born with, shaped how you experience events, yourself, and other people. When we figure all this out together, we will be able to use this understanding to figure out how to slowly alleviate many of your difficulties.

Therapist criticalness

There is another hidden detrimental impact of therapists not focusing on underlying historical causes of patient’s troubled behavior.

⁵ Barlow (2002) reports on “the findings from several studies that successful treatment [either psychotherapy or medication] has resulted in normalization of activity in... the brain, with changes in OCD symptoms correlated with changes in brain functions... [p. 521]. Interestingly, Barlow, Allen and Choate (2004) note that while for most emotional disorders “psychological and pharmacological treatments achieve approximately equal efficacy immediately after treatment is concluded... for OCD... psychological treatment seems more efficacious... [p. 208].

Excessive criticalness and lack of acceptance on the part of parents has long been implicated in the development of psychopathology (e.g., Repetti, Taylor & Seeman, 2002).⁶ An important factor in the healing power of psychotherapy is the non-judgmental acceptance of the patient on the part of the therapist. Yet, many patients feel judged and criticized by their therapists. At times this is undoubtedly, a projection of the patient's own self-criticalness but too often it is an accurate assessment of the therapist's feelings. Anita E. Kelly (2000a, 2000b) developed a controversial "self-presentational view of psychotherapy [that] challenges current assumptions about the benefit of high levels of client's openness in therapy [2000b, p. 505]." She cites research evidence that patients conceal information from their therapist in order to make a good impression as they are certain that if they reveal the unsavory truth about themselves their therapists would feel negative about them even though they will often attempt to hide this reaction. The unfortunate reality, according to Kelly, is that they are often right. She refers to studies that report that:

[T]herapists formed very negative clinical conjectures about their clients, conjectures that they then hid from their clients.... [and] that therapists' perceptions of a target person are consistently less favorable than laypersons' perceptions.... [which] should not be surprising... given that they are trained to use the *Diagnostic and Statistical Manual (DSM)*.... [This is problematic] because clients who are more liked by their therapists tend to show more progress in therapy. [p. 509]

Kelly concedes that patients would be much better off if they believed and if indeed it was true that their therapists would still think favorably of them even if they told the therapists about specific transgressions or humiliating events. "Such clients might benefit immensely from telling the therapists about these events and then hearing the therapists' challenges of their negative self-views surrounding the events [Kelly, 2000a, p. 486]." However, according to Kelly, therapists often do form negative assessments of their patients in these situations and therefore patients are better off not being so open. In response to her critics, Kelly suggests:

Perhaps the ... researchers [who insist that patients do better in therapy when they are more open] have in common a sense of optimism about the psychotherapy process [so they recommend] that clients fully describe their very negative behaviors so that their therapists can help them see their behaviors as separate from the broader implications of who they are. [They also believe] that therapists can and do truly hold their clients in high regard, even when the clients reveal heinous details. I have seemed somewhat less optimistic in suggesting that being judgmental is part of human nature... [Kelly, 2000b, p. 510].

I would suggest that these different viewpoints may be a function of different approaches to therapy rather than differences in optimism and pessimism. When therapists focus on pathology without an emphasis on the underlying historical/developmental causes of the problem (a la the DSM) it is understandable that they would develop a negative perspective of patients who are doing very bad things.⁷ When therapists do focus on the developmental causes it makes it easier not to feel negative toward patients in spite of their unsavory behavior.⁸ As I tell my patients when they feel excessively self-critical and ashamed over their disturbed behaviors and emotions, "Considering what you went through it was virtually inevitable that this would happen."⁹

⁶ See also my comments regarding "expressed emotions" (EE) in Part 1. Citing child abuse researchers, Thomas (2005) makes the important point that abusive caregivers are often "misguided protectors" (p. 30).

⁷ In his discussion of psychotherapy with child abuse survivors, Thomas (2005) takes this a step further. In their sincere efforts to help their patients, Thomas writes, therapists of child abuse survivors sometimes inadvertently become guilty of "therapist abuse." "Despite... their best intentions, therapists find themselves acting in a way that is likely to match the client's internal abuser role.... They may be irritated by what seems to be client resistance..." (p. 25). I would contend that this is more likely to happen when the therapy doesn't focus on the historical events that cause the patient to be resistant.

⁸ This is similar to the method by which one is able to judge others favorably (*dan lekaf zechus*), i.e., by thinking of environmental/historical factors that could have caused the person to be more susceptible to that particular misbehavior, so that the misbehavior is not seen as reflecting an inherent defect in the person (see *Chasam Sofer*, as cited in the *ArtScroll, Shabbos* 97a). See also Rav Henschel Lebowitz, *Chidushei HaLev, Bamidbar*, (33:1), where he discusses how reminding someone about his past misdeeds can have a dramatically different impact on that person depending on the speaker's perspective on the problem (see also Kirzner, 2002, p. 64, fn.).

⁹ Contrary to what many people think, avoiding excessive self criticism will make it **more** likely that a person will strive to overcome his negative impulses (see Rav Chaim Shmulevitz, *Sichos Musser*, Sec. 1, pp. 41-43; Rav Eliyahu Dessler, *Michtav MeEliyahu*, Vol. 4, p. 263; Rav Henschel Lebowitz, *Chidushei HaLev, Vayigash*, 45:3).

A 25 year old man came for treatment because of voyeurism. He had seen three previous therapists who recommended medication, twelve-step programs and various behavioral techniques for overcoming his impulses. There was very little exploration of his early childhood or even his current relationship with his parents. The message he got was that he has an unfortunate biologically/genetically-based defect and the most he could hope for is to learn behavioral techniques to control his impulses. When he found it difficult to follow through on the “homework” the therapist assigned to him the therapist became annoyed at him and exclaimed “How do you expect to get better if you don’t show responsibility?” He felt despondent and unmotivated for treatment. When we explored his early life experiences, it was ascertained that the relationship with both his parents was extremely conflicted. They were both very critical and his mother was quite controlling. Over time, we developed an understanding of the psychological meaning of his symptom. He was very hungry for the intimacy that he was clearly deprived of in his relationship with his parents. Since a girl would normally allow someone to see her unclothed only if she had a close, intimate relationship with him, he superficially imitated this intimacy by looking at women when they were undressed. This seemed to also, at least partially, explain his interest in pornography. (Of course, he conveniently blocked out the fact that he was seeing a girl unclothed without her consent or knowledge). The understanding of the meaning of his symptom was a significant factor in helping both of us not to be overly critical of his difficulties. This was the first step in helping him begin the long process of overcoming his problems.

A new awareness of the impact of chronic childhood trauma

In a recent special issue of *Psychotherapy: Theory, Research, Practice, Training* (Winter, 2004, Vol. 41, No. 4) on “The Psychological Impact of Trauma” there are a number of superb articles on the treatment of those who suffered the chronic trauma of childhood abuse. These articles reflect an increasing awareness of the traumatic nature of the early lives of patients who suffered parental maltreatment in early childhood. I would like to quote a few paragraphs which underscore the points that I have been emphasizing regarding the importance of understanding the meaning of symptoms by connecting them to past experiences, especially within the family.

Many researchers discuss the diagnosis of Post-traumatic Stress Disorder (PTSD) as it may apply to those who suffered maltreatment as children.

[A] number of researchers and clinicians argued that the diagnosis of PTSD was not a perfect fit for the reactions experienced by victims of child abuse... where traumatization occurred repeatedly and extensively.... Individuals exposed to trauma over a variety of time spans and developmental periods suffered from a variety of psychological problems not included in the diagnosis of PTSD. (Courtois, 2004, p. 413)

After facing an ongoing trauma, children sometimes do not display ‘overt diagnosable disorders,’ yet they profoundly distrust people, expect betrayal, and lose faith that life holds any justice or meaning. (Faust & Katchen, 2004, p. 427)

The diagnoses of “Complex PTSD (CPTSD)” (Herman, 1992) or “Disorders of extreme stress not otherwise specified (DESNOS)” (Pelcovitz et al., 1997) have been proposed for the complex reactions that occur in response to repeated traumatization, such as chronic abuse in childhood.

The hidden nature of childhood trauma

Young, et al. (2001) discuss at length the challenge of ascertaining whether patients suffered maltreatment during their childhood. On the basis of their study, Dill et al. (1991) also concluded that; “Data suggest caution in accepting at face value, initial denials of abuse histories” (p. 166).¹⁰ A number of authors in this special issue likewise discuss the difficulty clinicians face in uncovering childhood maltreatment, since the victims are often unaware that what they experienced - and perhaps are even currently experiencing - is considered abuse. This is why clinicians are often mistakenly convinced that their patients’ home life was reasonably emotionally healthy and so they attribute their difficulties to other factors (e.g.,

¹⁰ See also Bradely, Jenei & Westen, 2005. Another factor to take into consideration is that many abused children exhibit “sleepers effects” i.e., the development of serious psychological problems some times after the termination of the abuse (Finkelhor & Berliner, 1995).

“chemical imbalance”). Patients also have a strong emotional need to remain unaware of the abusive nature of their upbringing, as emphasized by many researchers and clinicians:

Briere’s (1992) construct of “abuse dichotomy” proposes that children living in abusive situations are faced with a cognitive conflict: Either their parents’ abusive treatment of them is unwarranted and reflects parental inabilities, or it is a justifiable response to their own badness. The former cognition is more threatening because children depend on their parents. (Goldsmith, Barlow, & Freyd, 2004, p. 454)

The clinician should not assume... that asking about trauma... will automatically result in disclosure. Some individuals with positive histories of trauma are unwilling or unable to disclose early in the process.... Additionally, many traumatized individuals know nothing about trauma, may not label what happened to them as traumatic, and have little or no understanding that their symptoms may be related to their past experiences. (Courtois, 2004, pp. 416, 420)

Williams (1994) [interviewed] 136 women 17 years after emergency room visits resulting from CSA [child sex abuse]. Thirty-eight percent of participants did not report the trauma, although they disclosed other personal information. (Goldsmith, Barlow, & Freyd, 2004, p. 451)

Liotti (2004) describes a common phenomenon when interviewing patients with an unrecognized history of childhood maltreatment. There is often a glaring discrepancy between their global description of their early family life and specific childhood memories. “This discrepancy takes the form of maintaining an idealized view of one’s parents despite recollections that suggest a childhood marked by unhappiness and an unsatisfactory relationship with one’s parents” (p. 473). Unfortunately, many clinicians miss these discrepancies.

I have found evidence of the emotional need many patients have to maintain an idealized image of their parents in a common phenomenon I have observed in my practice. Patients will resist characterizing their parent’s blatant mistreatment of them as “abuse” but will easily use that term to characterize that exact same parental behavior toward a sibling. I was pleased to find research confirmation of this observation in this special issue of *Psychotherapy*:

In a sample of 1,526 university students, Rausch and Knutson (1991) found that although participants reported receiving punitive treatment similar to that of their siblings, they were more than twice as likely to identify their sibling’s experiences as abusive as they were to label their own in this way... [This was because they interpreted] parental [maltreatment] toward themselves... as deserved and therefore not abusive. (Goldsmith, Barlow, & Freyd, 2004, p. 451)

Cultural resistance to acknowledging parental maltreatment

Many of the authors in the special issue discuss the pervasive denial of abuse and chronic trauma within families and the impact of this denial on treatment:

For individuals who experience chronic trauma and whose posttraumatic social environments may act to discourage awareness of trauma, recovery from the adverse impact of trauma may not be adaptive and thus may be rendered difficult.... There is a great deal of cultural denial regarding trauma and its effects... which is likely to influence individual levels of awareness. (Goldsmith, Barlow, & Freyd, 2004, pp. 449, 451)¹¹

Clinicians’ lack of awareness of parental maltreatment

As mentioned above, mental health clinicians often overlook, or downplay the significance of, early childhood maltreatment. One of the examples I have cited elsewhere (Sorotzkin, 2002, p. 34) relates how researchers have found clear evidence of the high degree of childhood sexual victimization among severely mentally ill women. Yet these researchers openly acknowledge their reluctance to report these figures.

¹¹ See also Firestone (2002).

At the same time, clinical researchers working in the area of severe mental illness have been understandably wary of focusing on the problem of early abuse in this population. There has been a reluctance, for example, to disinter the theoretical trend of blaming families for causing major psychiatric disorders. Current treatment models emphasize enhancing current adjustment rather than understanding past events... (Rosenberg, Drake, & Mueser, 1997, p. 261).

It is difficult to imagine trying to treat emotionally disturbed adults without relating to the sexual abuse they suffered as children. How effective can such treatment be? Yet this is what some experts are recommending! This again is an example of misguided good intentions, where the attempt to protect parents' feelings results in revictimizing their children by denying their abuse, and thereby denying them effective treatment. In fact, the parents also end up being victims because they too will also suffer from their children's lack of effective treatment.

Many of the authors in the special issue of *Psychotherapy* on trauma also emphasize how clinicians overlook trauma history.

[R]esearch demonstrates that most mental health services do not detect childhood trauma histories... primarily because mental health workers often fail to ask about trauma experiences.... Mainstream approaches to trauma are shaped by traditions within psychology that emphasize single-incident trauma and responses such as fear and anxiety.... Consequently, psychologists have lower levels of awareness for aspects of trauma such as chronicity, fear, shame, and betrayal.... [T]he study of... child maltreatment may be met with more resistance, even within the professional community, than the study of traumas such as natural disasters, which pose less of a threat to the status quo.... Trauma is a topic rarely included beyond the most cursory level in most therapists' training.... Because it is not usually the trauma itself that causes individuals to seek help, rather it is often the distress from its subsequent effects and interpretation, most abuse survivors seek therapy because of complaints about themselves, their interpersonal relationships... or as a result of depression... (Goldsmith, Barlow, & Freyd, 2004, pp. 449, 456)¹²

Lack of awareness of the markedly different impact of single versus chronic traumatization among practitioners has often resulted in failure to focus on the most relevant areas for intervention.... *Misdiagnosis in the form of conduct, depressive, and attention deficit disorders frequently occurs, often resulting in the core traumatic issue never being fully examined or treated.*" (Faust & Katchen, 2004, p. 427, emphasis added)¹³

In summary, clinicians are subject to societal pressures to find quick solutions to their patient's troublesome symptoms. As a result, there is little incentive to explore the personal meanings of behaviors and the childhood relationships and traumas that shaped the developing psychic structures. This is besides whatever personal and emotional resistances the clinician may experience in confronting the issue of child abuse. Yet, trying to help patients deal with their symptoms without dealing with the underlying issues is like treating a fever while neglecting the infection that is causing the fever. This is especially true for those who experienced chronic maltreatment as children. As Faust and Katchen (2004) assert:

Herman (1992)... argued that complex trauma [resulting from childhood maltreatment] routinely results in major alterations in several fundamental areas of functioning such as affect regulation, consciousness, self-perception, and relations with others.... [She] maintained that it is only when the treatment provider addresses these multiple areas of impairment that the client is able to effectively confront the traumatic origins of his or her symptoms. As survivors of complex trauma become aware that their psychological difficulties stem from their extensive traumatic background, they are less likely to attribute their symptoms to an inborn defect in the self. Herman argued that by failing to include a diagnosis that subsumes the wide range of difficulties resulting from complex traumatization, the

¹² I recently found a glaring example of clinical myopia in an online speech and language pathology journal article. The author first posited that the majority of people who stutter do not have psychological problems underlying their stuttering. He then presents a case to back up his claim. He described how when R. was 8 years old he stuttered in front of his father who laughed at him and angrily "shouted and demanded with cruel reproaches that he speak well immediately R.'s father is a violent and authoritative man who imposed his law on the whole family and continued his criticism every time R. stuttered. In other aspects R.'s father is revered and beloved by R. and the family." How can a clinician believe that this violent, abusive and hypercritical man was truly beloved by his family?! And this is supposed to be the convincing evidence that psychological problems do not underlie stuttering!

¹³ See Jones (2002) on the danger of misdiagnosing children suffering from attachment disorder with the diagnosis of ADHD since they both result in similar symptoms.

DSM conceptually fragments the effects of trauma. For example, somatic complaints that frequently are experienced by survivors of complex trauma are diagnosed as somatic disorders; their interpersonal problems often are categorized under the borderline personality diagnosis; changes in consciousness are demarcated as a dissociation diagnosis; and intrusive thoughts about and recollections of traumatic events are categorized under the current heading of PTSD....The consequence of diagnosing complex trauma survivors with these multiple divergent syndromes is that the traumatic origins of their various difficulties are obscured. This, in turn, renders the adverse effects experienced by them as inconsequential, fostering self-blame and stigmatization by others. (pp. 427-428)

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The Psychopharm Consultant....(Continued from Page 5)

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Nefesh Members at Large & What They're Up To

Sol Herzig and Sheri Degani led a workshop on "Integrating Psychodrama Into Individual Psychotherapy" on February 13, 2005 for the Association of Cognitive Therapists of the New Jersey Psychological Association.

Rabbi Simcha Feuerman, LCSW will be presenting at the upcoming BJE conference (Dec 7) on the topic of Motivating the Unmotivated Child

Mazal Tov:

Rabbi & Mrs. Shimon Russel on the marriage of their daughter, Elisheva to Koby Schikman.

Dr. Barry and Mrs. Chani Holzer on the marriage of their daughter Aliza to David Stern.

Dr. & Mrs. Yosef Geliebter on the bar mitzvah of their son Pinchas.

Drs. Shalom and Karyn Feinberg on the birth of a grandson.

Irene Preiss on the recent marriage of her son Eli Julian to Michal Lowenstein.

Condolences:

Condolences to Mrs. Chava Weinreb on the passing of her father.

Seminars and Programs of Interest

Chicago Nefesh Book Group, a monthly activity of Nefesh celebrates its fifth year of study. In honor of the occasion the group donated their participation fees to the Chicago chapter for future programming. The book group selects classical and current literature both fiction and non-fiction. All material is interpreted as clinical material. We supplement the reading with psychological topics that are the themes demonstrated in each selection of literature. In reading Anna Karenina, the theme of shame was presented, while in reading the Odyssey, the theme of dreams in the developmental process was explored. Our goal is to increase the clinical skills of the participants through expanding our knowledge of literature.

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1368 East 18th Street, #1F, Brooklyn, NY 11230
718-645-2286

Member Type: Full
Areas of Expertise: Depression, anxiety, stress, interpersonal relationships, illness/disability
Languages: Hebrew

Work:

Jewish Board of Family & Children's Services, Administrative
1273 53rd Street, 4th Floor, Brooklyn, NY 11219
718-435-5700 ext 211 * (F) 718-854-5495
sliberman@jbfcs.org

Private Office:

1921 Avenue 12, #A5, Brooklyn, NY 11230
Degree: MSSW * Degree Year: 1983 * Institution: Columbia
Theoretical Orientation: Integrative/Eclectic
718-645-2286

Price, Richard Louis Rabbi Psychiatrist, Rabbi

Member Type: Full
Areas of Expertise: Adults, teens, couples psychotherapy and psychopharmacology
Degree: Rabbi/M.D. * Degree Year: 2005/1999 * Institution: Or Somayach (Monsey), Yale Medical School
Theoretical Orientation: A mind-body-spirit approach to healing
Languages: Some Hebrew, Yiddish, Spanish

Work:

Cornell Medical School/New York Presbyterian Hospital, Psychiatry

Private Office:

441 Route 306, Suite 3, Monsey, NY 10952
845-893-4538 (F) 845-364-9118
richard.price@yale.edu

Sassoon, Janette Mrs. Social Worker

Member Type: Professional/Family
Areas of Expertise: Relationships; abuse; teen issues; children's issues;
Degree: BA, MSW * Degree Year: 1998, 2000
Institution: Brooklyn College; Columbia University School of Social Work
Languages: Hungarian, Hebrew

Work:

Board of Jewish Education of Greater New York, Project Coordinator - Dept. of Student Health Services
520 8th Avenue, 15th Floor, New York, NY 10018
646-472-5336 * sassoonj@bjeny.org

Weinberg, Miriam Mrs. Social Worker

Member Type: Professional/Family
Degree: MSW * Degree Year: 2003
Institution: NYU
Languages: Hebrew

Work:

Jumpstart Early Intervention, Service Coordinator
3914 15th Avenue, Brooklyn, NY 11218
718-853-9700 x246 * (F) 718-853-5533

Work:

Counterforce, Social Worker
601 Ocean Parkway, Brooklyn, NY 11218
718-854-7730

Weinberg, Yonah Mr. Social Worker

Member Type: Professional/Family
Degree: MSW * Degree Year: 2005
Institution: Fordham – Lincoln Center
Theoretical Orientation: Cognitive
Languages: Hebrew, Yiddish

Work:

JBFCs, Social Worker
2020 Coney Island Avenue, Brooklyn, NY 11223
718-676-4280

Grunfeld, Yeshaya Rabbi Counselor UK

41 Richmond Ave., Prestwich, Manchester M25 0LZ
01617730912 * (C) 07908801343 * (F) 01617730912

Member Type: Associate
Areas of Expertise: Adolescent, teens-at-risk, LSE
Degree: Dip. Counseling * Degree Year: 2005
Institution: Refua Institute, Israel
Theoretical Orientation: Rogers Therapy/Choice Therapy

Work:

Our Kids Manchester, Counselor/Therapist
The Basement, 4 Upper Park Rd., Salford,
Manchester M7 4HL UK
0161 795 2000 * (F) 0161 795 2000

Leigh, Yvonne Counselor

99 Bridge Lane, Golders Green, London NW11 0EU
02-08-458-6460 * (C) 07-95-637-4564

Member Type: Full
Areas of Expertise: General; cancer support; bereavement
Degree: CPCAB Certification – Advanced Diploma
Degree Year: 2002, 2005 * Institution: MST
Theoretical Orientation: Person Centered

Work:

Schonfeld Square Residential Home, Counselor
Schonfeld Square, Stamford Hill, UK

OMITTED FROM THE DIRECTORY

Rosenthal, Yaacov Rabbi Psychologist Israel

Nachal Revivim, 12/3, Ramat Beit Shemesh 99641
02-992-0514 * (C) 057-311-1924 * (F) 02-992-0514
jacobrosenthal@yahoo.com

Member Type: Full
Areas of Expertise: Psychotherapy of schizophrenia and psychosis





LITSERV AND WEBSITE INFORMATION

If you haven't been receiving the listserv, you are missing out on a wonderful forum to share ideas, find out about resources, participate in lively discussions, and much more! To join the listserv, simply send a blank e-mail with the word "subscribe" in the subject line to nefeshint@nefeshisrael.com. There is no charge to be signed up on the listserv - it is one of the benefits of Nefesh membership.

If you are looking for a place to advertise a product, program, jobs available, etc. the listserv is a great venue! The cost is only \$50 per insertion and generally gets great results. If you would like to place an ad, contact the Nefesh secretary (secretary@nefesh.org) and arrange for payment. Then simply send the ad as you would post any item to the listserv (by sending it to nefeshint@nefeshisrael.com). The following does not constitute advertising and may be sent in at no charge:

- a) any member may post notices about services for clients or professionals as long as the services are provided at no charge and are not offered to induce people to eventually use services or items that they will have to pay for;
- b) members looking for jobs, office space, etc. may post queries at no cost. Responses, however, must be made only to the sender and not to the entire listserv;
- c) *On a case by case request basis*, members offering office space to share, and/or making practice announcements, and/or offering a unique service may be allowed to do so free of charge in cases where there is a compelling value and interest to Nefesh's community of therapists (for example, some unusual course offering or unusual area of specialty, or low cost, etc).

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.

If you would prefer to receive postings once a day, rather than as they come through one by one, you can receive the listserv in digest format. To do so, just send a blank e-mail to the same address (nefeshint@nefeshisrael.com) with "digest form" in the subject line.

The listserv is one of the many benefits of Nefesh membership -SIGN UP NOW!!

If you haven't checked out our website (www.nefesh.org) recently you are in for a pleasant surprise. It has a new face and new features and will continue to be updated. Keep posted with updated information on the conference and all Nefesh events. Note that the links page is for your benefit only. We have not and can not verify the reliability or usefulness of the websites listed. If you feel that a link that is listed is not appropriate for Nefesh, or would like to suggest a website that you feel should be listed, contact me at (mordechaiglick@videotron.ca). (Note that private, for profit, websites are not acceptable.)

I hope to see all of you at the conference in February!

Mordechai Glick

**Please send us any changes to your information so that
we can keep your file current**

E-Mail to: secretary@nefesh.org

**Nefesh
P.O. Box 3027
Teaneck, NJ 07666**