THERAPEUTIC INTERVENTIONS WITH RELIGIOUS JEWISH PATIENTS IN ISRAEL

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A client's acceptance of a religious authority to whom he or she turns for guidance, as well as other religious issues, can have an impact on the therapeutic process. The forms that anger and resistance assume may be different in therapy with religious patients. Guidelines for working with religious clients are presented.

This article discusses insights arrived at in the course of clinical work with religious Jewish Israeli patients. It focuses on two aspects of that work: (1) the effect that the patient's acceptance of a religious authority to whom he or she turns for guidance has on the therapy and (2) the impact of the religious issue on the process of therapy. The author is a religious person, knowledgeable in halacha, and committed to the dynamic approach emphasizing the role of the unconscious. Although this article reports on work with Israeli patients, the author's therapeutic experiences with religious American Jews confirm the applicability of the insights presented to the American scene.

RELIGIOUS AUTHORITY: ITS EFFECT ON THE THERAPEUTIC ALLIANCE

A cardinal assumption of some religious groups is that therapeutic alliances are subject to review by religious authorities. Spero (1986) criticizes this position: "Once a therapeutic alliance is entered into, the therapist can no longer allow his authority to be challenged or manipulated by encouraging the patient to maintain the surveillance of third parties" (p. 204). This is true even when the therapist is knowledgeable in halacha. "On the assumption that a given religious psychotherapist has achieved both halachic as well as professional competence in his line of work, which ought to provide an ample basis for a trusting relationship, the encouragement of third party approbations is generally a resistance on the patient's part" (Spero, 1986, p. 204). Others (Greenberg, 1984; Pattison, 1978) stress the beneficial aspects of cooperation between the therapist and clergy, a position also held by Robinson (1986).

Notwithstanding the basic truth of Spero's position, it is presumptuous on the part of the therapist, even one knowledgeable in Jewish law, to expect patients to regard him or her on a par with the dean, teachers, or eminent rabbis with whom they consult. In addition, barring the rabbi from the process is likely to be perceived by patients as interfering with their value systems.

The involvement of religious authorities in the therapy should be discussed at the onset of therapy and guidelines drawn. The patient is to be permitted, and at times even encouraged, to consult with the rabbi or teacher. It should, however, be made clear to both patient and rabbi that no attempt should be made to influence the actual therapeutic process. The following vignette is an example of a situation in which guidelines were not specific, and consequently, the therapy encountered difficulties.

> A 24-year-old "baal-teshuva," one who changed his previous nonreligious lifestyle to an Orthodox orientation, married his wife on the advice and cajoling of his rather young rabbi-teacher. The marriage was foundering, and the couple entered therapy. The rabbi insisted upon playing an active role during therapy in advising the couple; at times he

sided with the husband and at other times with the wife. The therapist was not comfortable with the rabbi's intervention, but did not feel that the best interests of therapy called for him to object at this point. He sensed that his objection would result in the termination of therapy. The situation, however, changed when the rabbi attempted to influence the therapist's handling of the sessions and when he offered advice to the couple that the therapist had strongly cautioned against. The therapist became frustrated, which was sensed by the husband and interpreted as hostility directed toward him. This was correct; the therapist felt anger toward the client for not being able to leave his teacher whom the therapist did not respect. This, however, was not the only cause of the anger. Self-examination by the therapist revealed the following picture. He, the therapist, felt that his expertise and knowledge of Talmud and Jewish law were equal to those of the rabbi. This, however, was not recognized by the patient, causing frustration and self-anger for the therapist, which were then directed toward the patient.

The referral source has an important effect on the patient's motivation and expectations for therapy as well. Patients referred by a rabbi may not be motivated to seek help as understood in the therapeutic sense; rather, their application is seen as the fulfillment of a religious obligation to heed rabbinic advice. Moreover, therapy when recommended by a rabbi is often perceived by prospective patients as being of potential help only because they regard it as a branch of medicine. This is so because of the value and importance placed upon health and the respect accorded to medical practitioners in the Jewish religious tradition. This perception may cause patients to expect the therapist to "cure" them, which constitutes a frame of mind not conducive to or congenial for dynamic therapy. For example, when I worked as a clinical psychologist with the Ministry of Health, school principals and parents of children in the autonomous religious school system referred children to the Ministry, even though they had access to a school psychology clinic closer to them. They explained that they preferred the Ministry of Health clinic because it represented an institution dealing purely with health problems, whereas the school psychology clinic was suspect because it represented an educational system, many of whose principles they rejected. It is therefore incumbent upon the therapist to explore with patients their motivation and expectations in seeking therapeutic help.

When both the therapist and client are religious, some difficulties may arise in the therapeutic relationship. Apolito (1970) has suggested that analysts often encounter difficulty when treating patients with religious conflicts because their own conflicts in this area are unresolved. This difficulty is diminished when the therapist is religious. However, the shared belief system can be used by the patient as a means of avoiding certain topics and feelings (Kehoe & Gutheil, 1984). Different levels of religiosity may be regarded by the patient (or therapist) as a barrier, creating an effect similar to the situation described by Apolito (1970). In addition, when the patient perceives that the therapist has a greater level of religiosity than him- or herself, this perception may serve as a channel through which resistance to the therapy may be exhibited. For example, I saw a rabbinical student in his early twenties at my home (this being the norm in Israel), where I have a rather extensive Judaica library. At one point in the course of the therapy, the patient accused me of having this library solely to falsely impress my patients.

THE IMPACT OF THE RELIGIOUS ISSUE ON THE THERAPEUTIC PROCESS

In the therapy of religious patients, knowledge of Jewish law can at times provide the key to successful therapy for two reasons. Knowledge of law and traditions increases

the therapist's sensitivity to the patient's needs, conflicts, and aspirations. In addition, knowing what is permissible and what is prohibited—assigning the proper proportions to actions and behavior—can be an indispensable tool in assessing behavior and fantasy. Consider this case example.

> A 30-year-old man was in therapy because of certain homosexual practices. He was not a confirmed homosexual, but did form liaisons for mutual masturbation, stopping short of intercourse. Slow but certain progress was made in the therapy, but the therapist discerned the patient's dissatisfaction. The therapist's comments prompted a discussion that revealed that the patient did not regard his progress as meaningful because his homosexual practices were not completely eradicated. It seems that the patient regarded himself as a confirmed sinner due to his mistaken perception that halacha did not consider him a penitent unless he completely stamped out his behavior. The therapist pointed out the patient's error, citing appropriate references to the effect that all progress in the proper direction, as codified in halacha, is considered invaluable and edifying and confers upon the person the status of a penitent, even if he or she is not wholly so. The therapist was well aware that dynamic forces were at play. Nevertheless being made aware of the halacha was a most positive contribution.

Religious issues come into play in marital therapy as well. Referral to marital therapy is usually predicated upon the supposition that the therapist's primary function is to heal the rift and lead the couple to greater harmony. This is so because of the importance attributed in Judaism to consolidating marital harmony. Tradition ascribes this good deed to the high priest Aaron.

It is therefore mandatory that the therapist delineate carefully the difference between the rabbinical mode of dealing with marital discord and the therapeutic mode. It must be emphasized that the therapist's role differs from that of the rabbi. Not explaining this difference at the onset of therapy may cause one or both members of the couple to think that the therapist is insensitive to their pain. They may mistakenly assume that, since the therapist is a religious person, his or her overriding concern is to effect a reconciliation and is blind to their anguish. My technique is to state that, although my hierarchy of values places a high premium on marital harmony, my primary function is to facilitate communication and empathic understanding of one another. I make clear that this approach is not to be construed as denigrating the rabbinical approach, which is to minimize differences and appeal to ethical values. Rather, the approach taken by the therapist addresses different needs and situations, and the function of therapy is to delineate clearly those needs and expectations and to clarify methods of communication. I further point out that, although therapy usually leads to greater mutual understanding and reconciliation, this is not the only possible sequence of events. Greater self-awareness and understanding of one's spouse may cause the members of the couple to feel that they are not meant for one another.

The religiosity and scholarship of the therapist can be a valuable adjunct in another therapeutic situation. Some schools teach the young woman student that the ideal spouse is a scholar who will devote his life to Torah study. This ideal generates a climate wherein piety and scholarship are the qualities looked for in a prospective husband. In some instances, the young bride is of the belief that her bridegroom is a future talmudic luminary. This expectation is potentially problematic and may result in disappointment, frustration, and anger. The situation is aggravated when the woman's continued employment is necessary to provide the family with basic necessities. The wife may feel that, whereas she is doing all she can, pushing herself to

the utmost, her husband is not fulfilling her expectations by becoming a recognized talmudic scholar. The therapy must include a thorough discussion of her expectations and a realistic appraisal of her perception of the ideals she was taught in school. The character, personality, aspirations, anxieties, and difficulties faced by her husband must also be discussed in full. This is necessary so that the wife gains a truer picture of her husband, not the idealized one imprinted upon her.

This case example illustrates another conflict of idealized expectations with reality.

> A wife complained that she noticed her husband looking at other women. In addition to feeling slighted, she voiced her opinion that her husband was not spiritually inclined and that she felt "cheated." She expected to be married to a completely pure spiritual individual, and she felt that, on the contrary, he was gross and materialistic. Therapy, following the guidelines presented above, paved the way for a less distorted, more valid perception of her husband. The therapist's background, similar in some ways to that of her husband, contributed to her acceptance of the more realistic picture she now was prepared to adopt.

The final case example illustrates a problem encountered in dealing with young religious patients. It can be considered prototypical, embodying as it does elements typifying the relation between aspects of the religious issue encountered in therapy.

> A young man of 23, a respected student in a famous rabbinical institution, asked for therapeutic help. He complained of not being in touch with the world, of a feeling of strangeness. The therapy could be described as a progression from one stage to another, with termination at each stage by the client when he felt slight improvement. The therapist told him that he felt something was amiss and that he regarded the termination as resistance. The therapist's efforts to understand and explore the sexual aspects of personality and behavior were rebuffed by the client. He emphatically stated that this area was not causing him problems and that he felt competent and adequate. The client's explanation of his decision to return to therapy after the first termination was that he found it difficult to maintain friendships. He evinced a desire to feel free, not to be constrained. He fantasized about the "good old days" of his youth when he was free and open. To facilitate openness he began to engage in sports activities with nonreligious youths, an act foreign to his milieu and upbringing. The therapist explored with him the significance of the fact that the turning point in his feelings about himself occurred at about puberty. It was revealed that he did not experience sexual desire or have nocturnal emissions. In addition, he was certain that his genitalia were not developed. He was encouraged to seek a medical examination and was reassured by his examiner that he was physically normal. Therapy included explaining basic, physical, sexual facts and probing the reasons for his lack of sexual desire. The picture that emerged pointed to undue influence by one of his former teachers at the age when he reached puberty. The client perceived the teacher as accusing him of sexual wrongdoing, of masturbating. There were other predisposing factors accounting for the client's abnormal sensitivity regarding sex—his father, a Holocaust survivor whom the client adored but who was a bit aloof, and a doting intrusive mother who did not allow him privacy, both in the physical and emotional sense. At this point, hostile feelings emerged that were directed toward his former teachers, parents, and other authority figures. The therapist's religious sincerity was questioned. The therapist reflected the client's feelings and conjectured that perhaps his accusation was a method of avoiding discussing sexual problems. At this point, therapy was again terminated. The client's return to therapy was not accompa-

nied by an explanation. The therapist therefore interpreted this return as meaning that the client was now ready to discuss the sexual aspects of his difficulties. Therapy continued, and improvement and change were evident in the sexual area in that he experienced sexual desire and had nocturnal emissions.

Attention is called to the forms that the transference assumed in this example. The hostile feelings that emerged and were directed against parents and teachers were also expressed toward the therapist but in a different manner; that is, his religious sincerity was questioned, and the patient's leaving therapy and then returning seemed to typify his ambivalent feelings toward religion and parents. Anger was present, and yet the patient did not wish to and could not nullify his religious commitment. Consequently, a process of terminating and then returning to therapy was instituted and followed. Although this process was discussed in the sessions, it was unfortunately not fully resolved. Objective circumstances prevented the continuation of therapy.

CONCLUSION

The case studies and the insights presented can serve to sensitize the therapist to issues in therapy with religious Jewish clients. The basic therapeutic principles are those prevalent and at work in the recognized and familiar therapeutic encounter. However, the forms that anger and resistance assume may be different.

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