

must be openly discussed. I think the most difficult and perhaps threatening idea which the parent(s) might have to accept is that their children are clearly declaring dissatisfaction, discomfort and dislike of the parental way of life, expectations, values, etc. Thus, any advance towards compromise with such children will have to involve some degree of open willingness to change and to cooperate in some formal or informal plans for radical re-vamping of past modes of family living and relating.

Assuming that such parents now confront a deprogrammed youth: what next? Again, far too many factors would have to be considered than can be adumbrated here. Yet, it appears vital that parents do not become smug, convinced that the worst is over or that, given a few minor changes and perhaps some new family hobbies, their child is back to stay. The deprogrammed individual is frail, borderline, balancing tenuously on a tightrope between the known and the unknown—between the taste of the regressive irresponsibility of cult life and the unforeseen world of old/new family and social life. If there were fears and ambivalences and tendencies toward regression prior to an adolescent's cult involvement, the deprogrammed youth experiences these ten-fold. The upper limits of the worker's empathic potentials are called into play when accepting such individuals and their phenom-

enological perceptions of reality. If the cults have taught lessons, one is surely that opportune use of vacuums affords great power. We are slowly becoming aware of the uses to which cults have put this knowledge. The Jewish family must now also learn to fill such vacuums with whatever messages and symbols we hold dear. The period following deprogramming is one such critical vacuum into which must be gingerly replaced such missing values.

Conclusion

Hopefully, some of the elements which have emerged from this discussion can be incorporated into programs designed to fill the present lacunae in social services for adolescents involved in cults. Just why some individuals find the cult experience meaningful and cannot see through the patent superficiality of such cults is a difficult question to answer, though some clinically based speculations have been forwarded here. Perhaps Judaism and its internal community structure face in cults a test to its own ability to tolerate challenges which both damage as well as point to important weaknesses. Redefinitions, re-appraisals and restructuring are, in one way or another, all in order; especially when the systems involved concern the survival of the individual as Jew and as person.

The Torah View of Mental Illness: Sin or Sickness?

MARVIN WIKLER

Caseworker, Jewish Family Service, Inc., New York

The only conclusion which can be drawn from . . . traditional sources is that the Torah conception of mental illness is a complex, many faceted one. While this conception does include a causal relationship between mental illness and sin, the Torah sees mental illness, in some form, as the cause of sin.

Orthodox Jews have always been interested in the Torah point of view on a wide range of topics. Non-Orthodox Jews, at times, also express interest in the Torah view. A social work professional journal, for example, recently published an article on the Torah perspectives on family relationships.¹ This article will focus on the Torah view of mental illness, as well as the Torah understanding of the courses of mental illness!²

As an Orthodox Jew and a practicing mental health professional, the author has a profound interest in this subject. However, he is not the only one interested in the Torah view of mental illness. More and more Orthodox men and women are entering the mental health professions.³ The number of Orthodox clients seeking professional mental health services is also increasing. As a result, many non-Orthodox mental health practitioners are finding Orthodox Jews as their colleagues and/or clients. A consequence of these trends is that interest in the Torah view of mental ill-

ness has been stimulated in laymen as well as professionals, in Orthodox and non-Orthodox circles.

The attitude towards mental illness, its definition, and the understanding of its causes have varied from one historical period to another and from one culture to another.⁴ Around the time of the American Revolution, for example, in this country, the mentally ill were viewed as criminals. Consequently, they were *all* locked in asylums. "These early asylums, or hospitals, were primarily modifications of penal institutions."⁵

The Torah, of course, does not view the mentally ill as criminals and does not equate mental illness with criminal behavior. How *does* the Torah comprehend the phenomenon of mental illness?

There are three methods available to someone wishing to research the Torah view on any given subject. The first step should be to survey the references to the subject in *Tanach* and the *Talmud*. Another approach would be to consult the writings of current authorities who have already dealt with that subject. A third, and least precise, method would be to determine the "public opinion" of the Torah community, at large, regarding that subject. This author has attempted to utilize all three methods of inquiry in the preparation of this article.

¹ Saul Berman, "Value Perspectives on Jewish Family Life," *Social Casework*, Vol. 57, No. 6 (June 1976), pp. 366-373.

² The author has chosen not to define the term "mental illness." Any attempt to do so, within the context of this article, would require a lengthy detour from the major theme. Since the Torah recognizes different forms of mental illness, the term "mental illness," as used in this article, will carry the "common usage" meaning which includes various classifications of psychopathology.

³ Dr. Egon Mayer, "Jewish Orthodoxy in America. Towards the Year 2000," an unpublished paper delivered at the Midyear Conference of the Alumni of the Rabbi Isaac Elchanan Theological Seminary, New York, March 1976.

⁴ Joseph Giordano, *Ethnicity and Mental Health: Research and Recommendations*, National Project on Ethnic America of the American Jewish Committee, New York, 1973, p. 14.

⁵ James C. Coleman, *Abnormal Psychology and Modern Life*, Scott Foresman and Company, Glenview, Illinois, 1964, p. 37.

Public Opinion

Working exclusively with Orthodox and Chassidic clients, this author has had a unique opportunity to survey the opinions of various members of the Torah community on the subject of mental illness. The usual response to questions on this topic is to change the subject of conversation. Any discussion of mental illness, particularly within the Torah community, evokes extreme discomfort. Respondents become vague, evasive, and suddenly ignorant. One prominent Rabbinic authority, when consulted on an aspect of this paper, for example, avoided discussing the subject and advised this author *not* to write this article at all, because the subject matter is too "sensitive." In short, mental illness is an issue which is shrouded in a dark closet of fear and shame. The fear and shame associated with mental illness in the Torah community can be compared only to that associated with the most severe *Halachic* transgressions.

Looking to behavioral indicators of attitude, there are those mentally ill B'nei Torah who are treated by friends and relatives, at times, as if they were willful wrongdoers in need of rebuke and chastisement. This rebuke is often the harshest kind which is usually reserved only for a hardened sinner.

Two brief case examples will illustrate this phenomenon. Needless to say, all identifying information has been thoroughly disguised in order to protect the clients' right of confidentiality.

Mrs. A., a middle-aged Orthodox woman, requested that the author see her son, who suffers from a chronic, severe depression. The young man had been treated at a psychiatric clinic with medication and psychotherapy for the past four years. In making her request, Mrs. A. asked that the worker "talk to (her son) and convince him to behave more like a *mensch* (i.e. decent human being)." When asked to explain, Mrs. A. detailed a picture of depression which included his slackened religious observance as well as loss of appetite, increased hours of sleeping and depressed mood. She went on to describe how her Rabbi's efforts to rebuke her son for his

religious misconduct had failed, and that is why she was seeking professional help.

Mrs. A. was neither psychotic, nor severely emotionally disturbed. She was able to differentiate between mental illness, per se (a cause) and its behavior manifestations (or symptoms). Mrs. A., however, focused primarily on her son's weakened adherence to religious practice and de-emphasized the other symptoms of his depression. In doing so, she not only labeled his behavior, in general, as sinful, but she also labeled him as a sinner.

Sin and mental illness are not different conceptions of the same phenomenon. Sin represents a *value judgment* associated with a particular set of behavior(s). Mental illness represents a causal *explanation* of a particular set of behavior(s). The common denominator between sin and mental illness, for purposes of comparison, concerns the rational decision-making process. In other words, for a particular behavior to be considered sinful, an individual must have (or have had) a certain level of self-control. For a particular behavior to be considered symptomatic of mental illness, a lesser degree of self-control is assumed.

The reason Mrs. A. was treating her son as if he had complete mastery over himself was because it was less painful for her to think of him as a religious transgressor than as someone who is mentally ill. Mrs. A. saw all forms of mental illness as resulting from a genetic deficiency. If her son were mentally ill, according to Mrs. A., then that would mean that she was in some way defective, herself. In order to avoid the emotional pain of seeing herself as defective, Mrs. A. *opted* to view her son's problem in religious terms, which did not reflect on her directly. In short, Mrs. A. substituted "sin" for "sickness" because the former was the lesser of two evils.

In another Orthodox family, with a schizophrenic adolescent girl, a similar attitude prevailed. During a family interview, Mr. B. was demanding that his daughter sit in a more modest position in her chair. In response, she broke out into hysterical laughter which had a definitely bizarre quality. Enraged, Mr. B.

turned to the worker and asked, rhetorically, "Is *this* considered observing "Honor thy father and mother!?" He then proceeded to harangue his daughter for her disrespect and "violation" of the Fifth Commandment.

Mr. B. was a frightened, insecure survivor of the Holocaust. He behaved with distrust and hostility toward everyone outside his family. At home, Mr. B. struggled continually to gain absolute power and ultimate control over the actions and behavior of his wife and children. He felt so helpless in the outside world that he tried desperately to overcome this feeling at home through his authoritarian manner.

If Mr. B. accepted the fact of his daughter's illness he would be forced to accept the reality of his limitations in controlling her behavior. This he simply could not do. By viewing the symptoms of his daughter's illness as religious transgressions alone, however, he felt that he still had the right and reason to attempt to control her behavior. For Mr. B., then, as long as he substituted "sin" for "sickness" he was able to maintain the position in the family which was so vital to his self-image.

From the responses and reactions which have been noted and observed, both verbally and non-verbally, it may be inferred that *some* members of the Torah Community associate mental illness with sin, at least on some level.

Recent Publications

Turning to English publications on the subject of the Torah view of mental illness, there is quite noticeably very little material with which to work. Only two authors have dealt with this subject in recent years, in this country.⁶

Dr. Jacob Mermelstein recently discussed his conception of a Torah point of view regarding psychotherapy.⁷ In his article, Dr. Mermelstein referred to the recipient of psy-

⁶ This author welcomes any and all references, in any language, of which readers may know, that are not cited in this article.

⁷ Dr. Jacob Mermelstein, Vol. XI No. 4, "An Orthodox Psychotherapist Confesses." In the *Jewish Observer*, Teves 5736/December 1975, pp. 3-7.

chotherapeutic services as a "sufferer-transgressor."⁸ This term appeared in the following context: "The Torah Jew, who conducts psychotherapy, practices *Hoch'ach toche 'ach* ("Surely you shall rebuke . . ."),⁹ i.e. psychotherapy, utilizing *all* of his skills gleaned from *many sources*, yet with but one aim—to help the "sufferer-transgressor."¹⁰ While there was no discussion of the full implications of the term "sufferer-transgressor," it does seem to indicate that Dr. Mermelstein agrees, on some level, with the public opinion which associates mental illness with sin. Not only does the term "sufferer-transgressor" associate mental illness with sin, but the comparison of psychotherapy with rebuke also reinforces this association.

Abraham Amsel shares Dr. Mermelstein's view and takes it one step further. Amsel put it this way, "Judaism believes that the individual has only two paths to travel, the good and the evil. When he chooses characteristics such as fear or lack of trust, that eventually leads him to insanity, he has chosen the evil path."¹¹ Amsel implies, therefore, that insanity results from this "choice" of personality characteristics, such as fear and distrust.

The view which links mental illness with sin does have some basis in traditional sources. Perhaps the most famous source for this association is the following quotation from the *Talmud*: "A person does not sin, except when a spirit of *Shtus* enters him."¹² The Hebrew word, *shtus*, is found elsewhere in Rabbinic literature and refers to "madness," or at times, "folly or foolishness."¹³ Which one of

⁸ *Ibid.*, p. 6.

⁹ *Sefer Vayikrah (Leviticus) 19:17*. The translation in parenthesis is added by this author and did not appear in the original text of Dr. Mermelstein's article.

¹⁰ Dr. Jacob Mermelstein, *op.cit.*, p. 6.

¹¹ Abraham Amsel, *Judaism and Psychology*, Philip Feldheim, Inc. New York, 1966 p. 96.

¹² *Mesechta (Tractate) Sota* pg. 3A. This is my own free translation of the original text.

¹³ Marcus Jastrow, Ph.D. Litt. D. *A Dictionary*, Jastrow Publishing Co., New York.

these two translations for *shtus* should be used in the quotation cited here, is, of course, open to interpretation.

Amsel translates *shtus* as "madness,"¹⁴ and interprets this passage as follows: "A man does not sin unless he has permitted a spirit of madness to overcome him."¹⁵ In order to remove all doubt, Amsel sums up his position, based on the *Talmud*, as follows: "The individual who allows himself to sink into insanity is regarded as a sinner."¹⁶

The views outlined above must not remain unchallenged. They are simplistic and misleading. They represent neither the Torah, nor the opinion of the majority of the Torah community. Amsel, for example, has based his position on a misunderstanding of the *Talmud*. Even if his translation "madness" is accepted for *shtus*, the *Talmud* cannot be understood to suggest that any mentally ill individual should be regarded as a sinner! A more correct understanding of the *Talmud's* position would be that mental illness, in some form, leads to sin, but *not* the other way around. If mental illness leads to sin, at times, this does *not* mean that the mentally ill are equated with sinners, as Amsel suggests.

In order to arrive at a hopefully more accurate understanding of the Torah view of mental illness, this author has researched many of the references in *Tanach* and the *Talmud* to this subject. He has also discussed his interpretations of these references with Rabbinic authorities, who have agreed with the conclusions of this article.

Traditional Sources

Mental illness is associated with sin, at times, as a form of punishment. Here sin "causes" mental illness in the sense that it invokes the Wrath, so to speak, of *Ha Shem* (G-d) Who punishes the sinner by inflicting mental illness. The mental illness itself, however, is not seen as sinful, but rather as a form of misfortune, similar to physical illness,

¹⁴ Abraham Amsel, *op. cit.*, p. 93.

¹⁵ *Ibid.*, p. 94.

¹⁶ *Ibid.*, p. 95.

war, famine, and/or poverty, which serve as forms of Divine punishment. In the famous *Tochechah* (Rebuke) section of *Sefer Devorim* (Deuteronomy), this view is expressed as follows: "*Ha Shem* will strike you with *shigaon*."¹⁷ Here the word *shigaon* is used to mean "insanity," or some form of mental illness. *Shigaon* comes from the same etymological root as today's now colloquial expression "*Meshugenah*."

The word *shigaon* does not appear in the *Talmud*, but does appear in *N'veim* (*Prophets*). All of these other references clearly use *shigaon* in the sense of "insanity," but they are not associated with punishment for sin.¹⁸ The Torah, then, does seem to substantiate an association between mental illness and sin, in the same manner in which it substantiates an association between physical illness, war, famine, and/or poverty and sin. If these were the only references to mental illness, however, then the conclusion could be drawn that the Torah view of this subject consists *only* of that association. There are, of course, additional references in which mental illness is not associated with sin, at all. The Torah view, then, concludes much more than the association with sin discussed above.

Further in the *Tochechah* (Rebuke), for example, the word *m'shugah*¹⁹ appears. *M'shugah* is the adjective form of the noun *shigaon* and can be translated as "mad" or "insane." The context in which *m'shugah* appears is the following verse: "And you shall become *m'shugah* (mad) from the sight of your eyes which you shall see."²⁰ In this context, mental illness is apparently understood by the Torah as having an environ-

¹⁷ *Sefer Devorim* (Deuteronomy) 28:28. This is my own free translation of the original text.

¹⁸ In *Yirmiyahu* (Jeremiah) 29:26, *shigaon* is associated with false prophecy, which is certainly a form of sin. There is, however, no causal relationship between the two as mentioned in 29:26. The other references to "shigaon" are in *Melachim* (*Kings*) II, 9:11, and *Hoshea* (*Hosea*) 9:7.

¹⁹ *Sefer Devorim* (Deuteronomy) 28:34.

²⁰ *Ibid.*, 28:34.

mental cause. In other words, something which the individual sees and experiences is so horrible and terrifying that it causes him to become mad. This may be a reference to the emotional scars of traumatic events. While these events result from the Wrath, so to speak, of *Ha Shem*, which is directed at sinners, the mental illness per se, in this case, results *directly* from the traumatic events themselves, and not the sins.

The *Talmud*, in one reference, links mental illness with physical illness: "That is, a *shoteh*²¹ (fool or madman) whose mind became weakened as a result of physical illness."²² Here the causal relationship between mental illness and physical illness is clearly stated. In other words, the *Talmud* takes the position that mental illness, at least in this particular case, has some physiological cause.

In another reference, the *Talmud* attributes a form of mental illness (perhaps depression) to the cause of an inappropriate life style of excessive leisure time.²³ The word used for mental illness, in this case, is *shiamun*. Jastrow translates *shiamun* as "dullness, idiocy."²⁴ While this may seem to refer to some form of retardation, the context clearly indicates that this form of mental illness is not congenital, but rather is brought about by excessive leisure time. For those who would question Jastrow's definition, it should be noted that Rashi²⁵ translates *shiamun* as *shigaon*.²⁶

Other references to mental illness can also be found in the *Talmud* which carry some variation of the literal or associative meanings and causal factors discussed in this article.²⁷ Readers are encouraged to check the original

²¹ Marcus Jastrow, Ph.D., Litt. D. *op. cit.* p. 1553.

²² *Mesechta* (*Tractate*) *Niddah* 13b. This is my own free translation of the original text.

²³ *Mesechta* (*Tractate*) *Kesubos* 59b.

²⁴ Marcus Jastrow, Ph.D., Litt. D. *op. cit.* p. 1611.

²⁵ "RaShi" is a Hebrew acrostic for Rabbi Shlomo, the son of Isaac, an 11th Century commentator.

²⁶ See Rashi's commentary on *Mesechta* (*Tractate*) *Kesubos* 59b.

text and context of the references cited here and to scrutinize the author's conclusions.

Conclusions

The only conclusion which can be drawn from this review of the traditional sources is that the Torah conception of mental illness is a complex, many faceted one. While this conception does include a causal relationship between mental illness and sin, the Torah sees mental illness, in some form, as the cause of sin. When the causal relationship is reversed, according to the Torah, sin brings on mental illness *indirectly* in the same manner that sin brings on Divine Retribution, in any form (i.e. such as physical illness, war, famine, poverty, etc.). The Torah conception also includes *direct* causal relationships between some forms of mental illness and environmental factors, as well as physical illness and the condition of inappropriate life style. In short, the Torah views mental illness as neither sin or sickness alone. The Torah does, however, seem to view mental illness as having varied causes, only two of which are sin (indirectly) and physical sickness.

The Torah view of *treatment* for mental illness, however, is even more complicated than its view of mental illness, per se. One of the reasons that this subject is so complicated is that it involves numerous *Halachic* considerations.

Nevertheless, as the Torah community begins to face the realities of mental illness and psychotherapy, this subject cannot be ignored. Perhaps the only appropriate means of entering in the *Pardes*,²⁸ so to speak, of this

²⁷ For additional Scriptural references to mental illness, see "The Attitude of the Ancient Jewish Sources on Mental Patients" by Josef Hes and Shlomoh Wollstein in *Israel Annals of Psychiatry and Related Disciplines* Vol. 2., No. 1 April 1964.

The body of the Hes and Wollstein article was not mentioned here because Hes and Wollstein quoted from non-Jewish religious sources, as well as traditional Jewish sources.

²⁸ This is a reference to the mysteriously dangerous subject matter of Jewish mysticism, as described in *Mesechta* (*Tractate*) *Chagigah* 14b.

subject, would be an interdisciplinary conference of Torah scholars, practicing Rabbonim, and mental health practitioners. Certainly, the controversy generated by such a conference would be enormous. Be that as it may, the Torah community has waited far too long for

the fruits of such a public controversy. "The competition of scholars will increase wisdom."²⁹

²⁹ *Mesechta (Tractate) Baba Basra* 21a. This is my own free translation of the original text.

Some Aspects of the Selection and Training of Group Workers for After-School Programs in Culturally Disadvantaged Neighborhoods

LEA BAIDER, PH.D. and EVA ROSENFELD, PH.D.
Community-Education Program, South Talpiot, Jerusalem, Israel

This paper deals with some problems arising in the process of selection and training of young adults to become "facilitating agents" in projects designed to foster personality and cognitive development in young children in culturally disadvantaged neighborhoods. Our experience is limited to one such project, now in its third year, in which young people are trained to act as group workers with children whose parents immigrated from Muslim countries (mainly Morocco and Iraq) and received minimal school training. However, we have reason to believe that the problems we faced and studied during our intensive formative evaluation of the training process, would arise also in other cultural settings, whenever the intervention program requires genuine human interaction between a "culturally disadvantaged" child and a "facilitating adult" who had himself been an "advantaged" child.

We define "cultural disadvantage" as the absence (or inadequacy) in the child's home environment of adults who are capable of socializing the child for his present environment, mediating his experiences by socially appropriate interpretations and guiding him in social and intellectual skills which he must master if he is to fulfill the expectations of his teachers. The "disadvantaged" child is commonly identified by nurses in day care centres and, later, by kindergarten teachers and school teachers, by his lack of age-appropriate self-control, low frustration tolerance and poor capacity for delay; poor grasp and lack of interest in mental activity when separated from physical activity, absence of curiosity in general. Programmed efforts at focusing the child's attention on mental tasks tend to result in "escape from thought," either passively, by not paying attention, daydreaming, finger-sucking or masturbating, or by actually running away and hiding. Among older children, acting out in school and truancy are common.

On the assumption that these behavior patterns do not stem from organically determined limitations but are, rather, defensive reactions to the painful, shameful sense of inadequacy due to inadequate socialization and acculturation, a growing number of preventive interven-

tion projects in the United States, England and other countries are designed to provide the child with those missing experiences of human interaction with adults that are considered essential to personality and cognitive development in a highly developed urban, industrial civilization. In brief, these are interactions in which a significant adult:

1. behaves in a reasonably consistent, predictable and intelligible manner;
2. enables and encourages the child to assume age-appropriate independence and self-direction;
3. provides a flow of small increments of new experience, in a stable and well-structured environment;
4. responds with pleasure and interest to the child's exploratory excitement and enters into the child's experience;
5. interprets and explains to the child his experiences, sharing with him (when age-appropriate) his own feelings and ideas.

None of this behavior requires exceptional skills, training or even superior intelligence. In fact this is "natural" behavior observed in parents of normal, healthy and happy children.^{1,2,3} However, not all parents and not all young adults who work in child care and education are able to behave in these

See "Footnotes" on next page.