A Clinical Note on the Therapeutic Management of "Religious" Resistances in Orthodox Jewish Clientele

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"Religious" resistances are almost always encountered during the beginning stages of therapeutic involvement with the religiously committed client. However, once these resistances are appropriately managed and the therapeutic alliance is firmly established, the patient's resistances should no longer take a uniquely religious form.

The continuous exploration of the therapeutic interaction with religiously committed Jewish patients is intended to create an ever-narrower gap between the technical constraints imposed by a patient's religious beliefs and practices and the attitudes and goals of contemporary psychotherapy. Specifically, one of the purposes of such exploration is to develop Halachically appropriate techniques of intervention which simultaneously preserve the integrity of the clinician's practice procedures, his Halachic obligation not to place a "stumbling block" before the patient, and which respects the value of both the therapist's and patient's healthy religious beliefs.

In my own philosophical and clinical writings on this topic, I have maintained that the interaction between psychotherapy and Jewish ethics (Halachah) can be preserved through the use of Halachic models for therapeutic procedures and practices (Linzer presents an approach similar to mine, but uses it for different purposes).[1] In these papers, which I will presume do not need review here, I elaborated upon such models as "psychotherapy as *teshuvah* (repentance)," "psychotherapy as *viduy* (confession)," "therapist as *mokhiah* (ethical rebuker)," and others. I have been careful to explain that such Halachic models are not intended to supplant contemporary technique. That is, *viduy* or *hokhahah* cannot be substituted for psychotherapy or casework as they are not *identical* processes. Rather, these models represent heuristic *analogies* between Halachah and psychotherapy, allowing the mental health professional to draw useful Halachic guidelines for practice from the relevant Halachic paradigm.[2]

It has been my view that the professional can safeguard Halachic propriety during the therapeutic endeavor by recognizing the intrinsic Halachic qualities and characteristics of his or her work and by implementing these guidelines in practice. In this brief report, I wish to illustrate clinical applications of this approach to the specific problem of managing the initial resistances of Orthodox Jewish patients or clients.

Workers who have had experience with the Orthodox Jewish patient in psychotherapy or casework are aware of the tendency of such patients to make direct or indirect appeals to their religious beliefs, and to specific laws and customs, in the effort to avoid certain topics or content.[3]

[1] M.H. Spero, *Judaism and Psychology: Halachic Perspectives* (New York: Ktav/Yeshiva University Press, 1980), chap. 1; see also N. Linzer, "A Jewish Philosophy of Social Work Practice," *Journal of Jewish Communal Service 55* (1979): 309-317.

[2] *op. cit.*, Spero, 1980.

[3] See M. Wikler, "Fine-Tuning: Diagnostic Techniques Used by Orthodox Jewish Clients," *Journal of Psychology and Judaism 3* (1979): 184-194; S. Ostrov, "A Family Therapist's Approach to Working with Orthodox Jewish Clientele," *Journal of Jewish Communal Service 53* (1976): 147-154; Spero, *op. cit.*, 1980, chap. 3 and also M.H. Spero, "Countertransference in Religious Clients of Religious Therapists," *American Journal of Psychotherapy* (1981), to be published.

Frequently, there will be direct appeal to—or confrontation with—the mutual religious beliefs shared by therapist and patient in the effort to draw some pact of nonbelligerence from the therapist. And as I have stated elsewhere, the Orthodox religious therapist may have numerous neurotic and nonneurotic motivations to allow such collusion to occur. However, such collusion will always be counterproductive. Indeed, as Loomis and Pruyser have observed, the areas the patient wishes to hold from scrutiny are always of extreme importance and belie conflict.[4] Indeed, the very process of resisting is an element of the patient's pathology inasmuch as it tends to preserve conflict and opposes the development of a therapeutic alliance. The manner in which the development of a therapist manages his patient's initial resistances is often decisive of the course of his psychotherapy.

By specifying "religious" resistances we are denoting resistances couched in the language of normative or idiosyncratic religious attitudes and beliefs.[5] In the case of the alliance between a religious therapist and patient, the patient's appeal to dogma as a shield against the free associative process actually involves the patient's *and the therapist's* normal religious beliefs (e.g., that rabbinic law forbids wanton phantasizing about illicit sexual content[6]), as well as those aspects of the religious parties' personalities currently in conflict. This latter category refers specifically to the neurotic ways in which normative beliefs are co-opted in the service of the ego.

No less than other resistances, "religious" resistances must be managed in ways which reflect to the patient how the therapist will interact with the patient and his technical approach to their shared or conflicting religious beliefs. Management of resistance represents an opportunity to interpret magical hopes and fantasies or deep-seated mistrust and hostility, and other elements which have unique implications in the case of religious individuals and may contribute to uniquely complicating forms of transference and countertransference.[7] The religious therapist, on one hand, wants to free his patient of pathologic inhibition yet, on the other hand, does not wish arbitrarily to denounce religious beliefs or laws which *in the case of his patient* are utilized for conflict-based purposes. In other words, the Halachically-committed psychotherapist is in search of a Halachically valid distinction between uses of religiosity which cannot be challenged and those which he can and perhaps must challenge. While resistance is usually viewed as a

[4] E. Loomis, "Religion and Psychiatry," in *Encyclopedia of Mental Health*, eds. A. Deutsch & H. Fishman, 1963, 5, p. 1750; P. Pruyser, "Assessment of the Patient's Religious Attitudes in the Psychiatric Case Study," *Bulletin of the Menninger Clinc 35* (1971): 272-291.

[5] The term "religious" resistance was coined by R. Lovinger, "Therapeutic Strategies with 'Religious' Resistances," *Psychotherapy: Theory, Research, and Practice 16* (1979): 419-427.

[6] In fact, even such forbidden fantasies, or *hirhurim*, can be incorporated in a Halachically valid way into psychotherapeutic practice, following an approach I have suggested elsewhere; see Spero, *op. cit.*, 1980, chaps. 10 and 11, and also M.H. Spero, "Homosexuality: Clinical and Ethical Challenges," *Proceedings of the Associations of Orthodox Jewish Scientists 6* (1980): 177-199.

[7] Spero, *op. cit.*, 1980, chap. 13.

behavior of the patient,[8] any display of resistance calls into play the therapist's personal dynamics and his management of resistance is carefully monitored by the patient's ego. Thus, the strength of the "religious" resistance partially rests on the therapist's manner of response.

Typically, the initial "religious" resistances are displayed while establishing the therapeutic relationship and bear the tacit message, "If you are truly religious, you, too, will accept my religious interpretations and allow me to avoid certain topics or content." Indeed, the initial insistance by the religious patient on securing a therapist of like-religious belief or a specific, perhaps well-known *frum* professional is very often itself a resistance motivated by a wish for special treatment, and indicates a passive attitude toward therapeutic work. Such requests are part of the patient's pathology *despite* the fact that the professional may feel that such patients should optimally be interviewed by a religious therapist. In many cases, the religious therapist's need to be accepted and trusted by the religious community, and perhaps his ambivalence about his own professional and religious views, adds motivation to be entrapped into misalliance. The religious therapist who is flattered by such requests and accepts the patient without critically exploring the patient's motivations for such a request may find himself up to his neck in unmanageable transference and countertransference reactions.[9]

As stated elsewhere, therapeutic work between religious therapists and patients will be constructive only if both participants recognize at the outset that (1) their shared religious beliefs include shared but potentially distorting expectations stemming from their individual psychological needs for religion, (2) that the phenomenon of shared religious belief is not a legitimate basis for any additional positive or negative regard for each other, and (3) that such beliefs will be included as a subject of analytic focus and (4) that the therapist will regularly submit his and the patient's religious feelings and beliefs to rigorous examination.[10]

In the excerpt that follows, I will illustrate a religious patient's initial resistance to treatment, and what I consider one productive management approach to such resistance. I consider this approach productive in that it keeps the two participants' mutual religious beliefs in the proper perspective during this beginning phase of psychotherapy.

The patient, an intelligent 19-year-old obsessive-compulsive male with depressive trends, had just recently graduated from high school and elected therapy to deal with depression and "certain fears and worries about death and punishment." His concerns at intake included frequent rage reactions and emotionally violent outbursts during class and with his family, and an inability to suppress "certain disturbing thoughts and such." The patient belonged to a religiously observant family and had attended yeshiva for several years. He informed me after our first encounter that the rabbis with whom he had earlier discussed his problems managed to assuage temporarily his depression and anxiety, but he soon found them unhelpful. He then turned to psychology to find "relief from some typical problems of adolescents," but soon felt that psychologists did not express concern for his religious sensitivities.

The illustration is taken from the third therapeutic hour during the evaluation stage. The patient had been hinting that his outbursts might be in someway related to

[8] R. Greenson, *The Technique and Practice of Psychoanalysis* (New York: International Universities Press, 1967), pp. 132-139.

[9] See a related discussion in M.H. Spero, "Casual Encounters for Off-the-Cuff Advice: Managing a Professional Problem," *Journal of Jewish Communal Service 56* (1979-1980): 190-192.

[10] Spero, "Countertransference in Religious Patients of Religious Therapists, *op. cit.*

"certain things which perhaps occur prior to the outbursts." After a few moments of his struggling with this thought, the patient muttered that when he was alone he often "found" himself "doing certain things that" he "would later regret . . . things that, uhm, I find very hard to, uh, talk about." As the therapist continued to support the patient's efforts to bring out clearly what was on his mind, the dialogue proceeded as follows.

Therapist: It seems that whatever is on your mind is very difficult for you to talk about with me.

Patient: Yeah, uh . . . yes, you might say so.

Therapist: Why don't you try to pick up the trend of thought again.

Patient: [Shifts uncomfortably in his seat] Well . . . I, uh, was saying that there are certain thoughts that I have and certain things which, uh, happen that, uhm, are pretty troublesome to me.

Therapist: Certain thoughts?

Patient: Yes, and I have been assured by my teachers that these thoughts are normal, but they still bother me.

Therapist: I'm still unsure of what you mean by "certain thoughts" and "things that happen." Do your own expressions here not have a distant tone about them?

Patient: Well, maybe so . . . I mean, uh, by "thoughts," uhm, I mean having to do with certain sexual matters and, uhhm [voice trails off] . . .

Therapist: Are you referring to things that happen between you and some other person, or when you are alone?

Patient: [leans forward] Uuh, yes . . . [clears throat] yes, that's essentially what I mean.

Therapist: Essentially, but not exactly.

Patient: That's really about all I wish to say about the matter.

Therapist: Is there anymore detail to what you are thinking about?

Patient: Uh, you know that there are specific laws, and, uhm, morals about talking about such matters. You understand the main thing so, so that's all I need to say.

Therapist: You are very uncomfortable with discussing your obviously troubling thoughts.

Patient: I can discuss that I'm upset about these types of things, but I don't see why we have to dig for details.

Therapist: Yes, it is hard to see why I am interested in details, especially about such a sensitive topic.

Patient: [Looks distantly out of the window.]

Therapist: I have the following impression. I'm getting the sense that while you are trying valiantly to maintain a "pure tongue" as we talk to each other here, the thoughts in your head are not what you would call "pure." Is that about right?

Patient: [Laughs self-consciously] Yes.

Therapist: Then it seems that your mind doesn't wish to accept the Halachot that you live with in everyday life.

Patient: Maybe. But I'm trying to have my mind, uh, cooperate, OK?

Therapist: Is the problem that the thoughts are, let's say, sinful, and yet talking about them in order to get help may be just as sinful. Yes?

Patient: Yep, that's just how it is. Now you understand?

Therapist: I think I appreciate the difficulty. Now, you came to me to get some help, which means I'm going to soon be facing the same problem in our work as you are. But let me suggest something which may help us both. You know, in my own efforts to place my professional work somewhere within Halachah, I have found it helpful to view it as something like *viduy* or *teshuvah* in the sense that you wish to rid yourself of thoughts and feelings which cause you to sin, as you have expressed it to me. Can you see this?

Patient: That's a *chidush* [novel exposition]! But, uhm, I mean, I am admitting that there are things which bother me. Everyday I say all kinds of special *tefilot* [prayers] for this problem.

Therapist: [Recognizing that the patient has accepted the Halachic paradigm, but is interpreting the model of "therapy as *viduy*" literally.] Perhaps I'm less concerned in having you "admit" things. As you have said, this alone hasn't been of much help to you. I am, however, interested that you feel free to allow your thoughts and feelings unfold here—and nowhere else—so that you and I can explore them and confront them. You may recall that

this is exactly what Halachah demands in *viduy: pirut ha-het,* the requirement that one specify every detail of one's sin and the intensity of his involvement with sin. Whatever is held back is kept out of *viduy.* Here, too, whatever you hold back does not benefit from therapy. We call this holding back "resistance." It is my job to point out this holding back and label it as "resistance" whenever I notice it. What do you think about all this?

Patient: [Thoughtful for a moment] Well . . . you put it rather clearly, uhm, so what can I say. I have thoughts about sexual matters, sometimes in dreams, too, and I do certain, ahm, things that I regret.

Therapist: "Sexual matters," "doing things;" Is this how you experience it or is this how you talk about it to a *rosh yeshivah* [dean]?

Patient: [suppresses a smile] OK, uh . . . I, ahm, a couple of times, uh, what they call, masturbated.

Therapist: You masturbated a couple of times.

Patient: [obviously relieved] Yes. Uh, it was probably more than occasionally that I did it while I was having these thoughts.

Therapist: "Thoughts"?

Patient: [Leaning back in chair] Ohh . . . uh, I think of people in positions of sexual intercourse . . . There.

Therapist: It is still uneasy for you to be able to express these facts. However, we are now really talking about your experience in the way that it happens.

Patient: [Looking almost exhausted] Yes.

The patient went on to discuss troublesome sexual fantasies and other compulsive habits. The patient's problems included the obsessive manner in which he used words and ideas in a futile attempt to control sexual fantasies. Thus, encouraging him to "disinhibit" the associative process was a significant early step in bringing him closer to the conflict-laden content which lay below the surface.

This brief case selection illustrates one approach to dealing with so-called religious resistances which avoids unproductive confrontation between the therapist and patient over dogma and faith. I attempt as early as necessary to introduce the patient in a forthright and simple manner to the conceptual scheme which governs my work, and to the demands it imposes upon both of us, in much the same manner as the psychoanalyst or other specialist briefly introduces the patient to the "fundamental rules" with which the patient is expected to comply. I do not "lecture" the patient on *viduy* or *teshuvah per se* as these are not the immediate functions of psychotherapy and because I do not wish to encourage the patient to adopt compulsive breast-beating or intellectualization as substitutes for psychotherapy. Contrary to the approach suggested by Beit-Hallahmi and Lovinger, I stay clear of challenging the patient's religious interpretations and beliefs with my own formulations.[11] Such challenge unnecessarily and unproductively reveals the therapist's personal religious preferences. Like any other aspect of the professional's personal life, knowledge of the therapist's religious beliefs, beyond the degree unavoidable due to extra-therapeutic or communal familiarity, only provides the patient with additional material for rumination and manipulation. Revelation of personal religious beliefs—and certainly offering religious advice—generally elicits from the patient additional contentiousness and argumentiveness and encourages disdain and mistrust for the therapist's presumptuous attempt to wear two hats.

Of course, my imparting to the patient my conceptualization of therapy as *viduy* may be considered an interpretation, and the reader will perforce call me to account for failing to follow my own recommendations. In response, I would first assert that the analogy between psychotherapy and *viduy* is readily established in Halachic

[11] B. Beit-Hallahmi, "Encountering Orthodox Religion in Psychotherapy," *Psychotherapy: Theory, Research, and Practice 12* (1975): 357-359, and Lovinger, *op. cit.,* 1979, p. 424.

literature,[12] and as such I present it to the patient as an *a priori* rather than as something I wish to debate or spar with. Second, and more important, I am essentially utilizing this analogy as a springboard to introduce the patient to the general concept of resistance *in language he or she can readily understand.* For this reason, even when I do consider it beneficial to mention the *viduy* analogy, I do not present a detailed Halachic discourse, but rather, through the suggestion of analogy, emphasize the "disvalue" of holding back. In the illustration offered here, breaking through the resistance actually began with pointing out to the patient the paradox between his "pious tongue" and "impious mind."

I recognize that presenting the patient with a religious framework for psychotherapy is only one approach to managing resistance, perhaps best utilized when the worker is reasonably sure that the patient will not offer too much resistance to the analogy itself. On other occasions, a more oblique approach should be used, one which addresses the same concepts and points out resistance, but does not make any mention of the therapist's Halachico-psychological framework. That is, while the therapist still operates with the *viduy* format in mind, this framework itself is not directly appealed to during dialogue.

The following illustrates the oblique approach. The material is excerpted from the second hour of therapy with an 18 year-old, devoutly religious *ba'al teshuvah* (penitent) whose presenting problems were general unhappiness in his studies at yeshiva, deeply conflicted feelings about his irreligious parents (who lived out of town), inability to form friendships, and complaints of generalized anxiety, headache, and other somatic symptoms. The patient was referred by a close but not religious relative acting *in loco paternis.* The relative advised that the young man had of late been exhibiting various "primitive religious beliefs and practices." The patient's religious practices were in fact not pathological, but the well-intentioned relative had actually reacted to the contrast between the affected or "protested" quality of this *ba'al teshuvah's* newly adopted faith and practice and its inability to make his life any more conflict-free or productive.[13] The patient, however, did have distinctly negative attitudes toward psychotherapy, partially reinforced by the archaic views of his religious community, partially by his teacher's and peers' mistrust of the superiority of psychotherapy over other home-spun "approaches" to unhappiness, and of course partially motivated by his own conflicts.

We join the dialogue as the patient attempts to manipulate the psychotherapist into granting a "no pain contract," thereby rendering the therapist nonthreatening and ineffective.

Patient: What are we going to do today?

Therapist: I prefer to leave this up to you.

Patient: . . . Well, I already discussed the types of things that are bothering me. But, uhm . . .

Therapist: But . . . ?

Patient: Well, I frankly don't know if this whole business is such a good idea, because I don't think we share the same *hashkafot* [religious-philosophical views].

Therapist: Do your problems involve these *hashkafot*?

Patient: [Defiantly] No, no, there is nothing wrong with my *hashkafot.* . . . I'm very satisfied, thank God, with being religious and everything, but how can I be sure that you won't do something to, uh, change these *hashkafot*?

Therapist: You seem very concerned that I might subtly attempt to influence your

[12] E.G., Maimonides, *Mishneh Torah: Hil. Teshurah* 7:3 and *Shmoneh Prakim,* end chap. 3 to Prov. 4:19; and see also Spero, *op. cit.,* 1980, chap. 1.

[13] See M.H. Spero, "The Penitent Personality: Diagnostic, Treatment, and Ethical Considerations," *Journal of Psychology and Judaism 4,* no. 3 (1980): 131-190.

hashkafot and perhaps introduce you to some unacceptable *hashkafot.*

Patient: Well, yeah. I mean, you know that psychologists have many *farkrumpt* [distorted] ideas about *hashkafah* and they reject the validity of God.

Therapist: Is this true of every psychologist or only of some who have gained infamy in our circles?

Patient: Well, OK, uhm I'm sure many psychologists are quick to assume that *ba'alei teshuvah* are crazy.

Therapist: I'm aware of rabbis and other *frum* people who would jump to the same erroneous generalization.

Patient: True, but it's certainly true of psychologists.

Therapist: Why so, do you think?

Patient: [Reflects] . . . maybe because they see many who do have some slight problem or difficulties.

Therapist: Uhm. Perhaps you are afraid that I'm deeply concerned about your sanity?

Patient: [Laughs] Maybe.

Therapist: Maybe.

Patient: OK, yes, I've been warned about that possibility.

Therapist: Well, you said earlier that your *hashkafot* are not the cause of your problems. So maybe your problems have to do with troubles or feelings that preceded your new religious commitments? Maybe these earlier troubles actually prevent you from enjoying a less conflicted religious life? Is this possible?

Patient: Uhm, no, I'd have to say that most of these problems have surfaced since I've been at the yeshiva.

Therapist: Then are you yourself pinning the blame on your new religiosity?

Patient: [Looks pained yet thoughtful] I don't know if I want to say that . . . but then . . . maybe they've just surfaced now because of all the new things I've been experiencing . . . or because my parents and I no longer see eye-to-eye on a lot of things we used to.

Therapist: This sounds like a very realistic perception. If we could explore it in more detail, with the same openness you've just demonstrated, I could learn more about your *hashkafot* and perhaps help you to separate these from the things that are really problems to you.

Patient: . . . But what about my Torah beliefs?

Therapist: You want some sort of guarantee from me that these will not be challenged.

Patient: And you cannot do that, can you?

Therapist: I think that everything that is meaningful to you should be shared here in complete confidence, and explored by us without reservation. The fact that you are a *frum* yeshiva student cannot influence me positively or negatively about your problems for which you are paying me to help your resolve, the same way that *your* being religious has not helped you to eliminate your troubles, and the same way that my personal *hashkafot* will neither help nor hinder your emotional pain.

Patient: . . . I think I am feeling a little more comfortable with your approach now. Maybe a little cautious, but more comfortable.

Therapist: Let's explore this feeling of caution and see where it takes us.

From this point, therapist and patient enjoyed a very useful and successful alliance, lasting for 12 months, at which point therapy, 'religious' resistances surfaced but were readily resolved. For example, during the third week, as the patient neared some very significant sexual topic, he requested to be allowed to review the therapy sessions with his religious mentor. This request was not flatly denied, but rather was painstakingly analyzed in the manner illustrated above. The patient was helped to see how this request could undermine the fundamental trust necessary for an effective therapeutic relationship and was itself an indication of hesitance to approach the dangerous but critical source of his problems.

Conclusion

I have illustrated two examples of successful management of "religious" resistance. I have explained that such resistances are "religious" primarily by virtue of their expression through superficial or even intensely-held religious beliefs or mannerisms. Their counterproductive potential lies in the combination of general psychodynamic factors and the religious therapist's neurotic and non-neurotic motivations for collusion with his fellow religionist. "Religious" resistances are almost always encountered during the beginning stages of therapeutic involvement with the religiously committed client. However, once these resistances are appropriately managed and the therapeutic alliance is firmly established, the patient's resistances should no longer take a uniquely religious form. If such resistances persist, one must assume that basic trust has not been successfully established and that countertransferential distortion has interfered with the practitioner's ability appropriately to resolve the latent motivations behind such resistances. If managed appropriately, on the other hand, the psychotherapist prevents one major opportunity for misalliance with the religious patient.

"A Fantastic Experience"

"A Fantastic Experience" is how David Lewis, Chairman of the Jewish Blind Society and Vice-Chairman of the Central Council, the EC's UK affiliate, described his impressions of the General Assembly of the Council of Jewish Federations in Detroit in November, which he attended as one of three European observers. There were 2,700 participants in the 4-day conference. What impressed him most in this "gathering of people from every facet of Jewish life" was the presence of intellectuals and academics in the workshops and panel sessions on Israel, the Soviet Union, the Family, Education and "every type of organized Jewish activity." Mr. Lewis, who was reporting to the EC Executive Committee, recommended that more European lay leaders and professionals be encouraged to attend the annual General Assemblies.

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