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Psychotherapy and Teshuvah: Parallel and Overlapping Systems for Change

Introduction

People come to mental health treatment because they are in pain. The presentations of their pain vary—they come because they suffer from symptoms that restrict or threaten their lives, because they struggle with inner conflicts that undermine and torment their integrity, or because if they don't come, they will lose their job, their spouse, or their children. People seeking mental health treatments desire change in either outlook or behavior that will result in the removal of their pain. Most people who seek mental health treatment understand – or quickly come to understand—that the alleviation of emotional pain requires active participation in a process that involves understanding the reasons for their suffering and making concrete changes accordingly.

Teshuvah, repentance, can be considered a Judaic analogue of the

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process through which one's emotional pain is linked with the requirement and inevitability of change. In *teshuvah*, the change takes the form of eradicating delinquent behavior according to the precepts and ideals of Jewish Law. Indeed, observant Jews who believe in a religiously ordered cosmos accept the responsibility to fulfill 613 commandments, *miẓvot*. Transgression of any of these commandments constitutes wrongdoing that the offender is obligated to correct. The observant Jew who commits a transgression presumably feels pain and perhaps guilt, reflecting a disturbance in his/her proper orientation in God's creation.

The religious prescription for *teshuvah* constitutes, according to many authorities, a *miẓvah* in its own right. *Teshuvah* includes several components—confession to God, remorse, restitution, and the capacity to act differently when placed in the same circumstances, including, *inter alia*, the same temptation. *Teshuvah* is a profoundly powerful moral goal in and of itself, in part, no doubt, in recognition of how difficult change can be, even if it is motivated by pain or guilt. The process of *teshuvah* is largely outlined in various halakhic texts where different sages address the nature of the transgression that has been committed. Sins against one's fellow man, for example, require that specific behavioral restitution be made. *Teshuvah* following theft, therefore, can only be accomplished after the stolen property has been returned.

Like psychiatric treatment, the process of *teshuvah* is optimally performed when a person expresses a desire and commitment for change. The individual engaging in *teshuvah* has a well defined idea of the deficiencies that must be corrected and a relatively clear picture of the optimal end result. In contrast, in psychiatric treatment, the unfolding articulation of what needs to be changed or better understood is often the transformative component of the treatment. Indeed, psychiatric treatment begins with a clinical interview, a highly specialized dialogue between therapist and patient. The therapist sits with the patient and invites him to reveal his misery: "Please, tell me what brings you here."

Most therapists will agree on the diagnosis, or the proximal cause of the suffering. The therapist's specific orientation, the theory of human behavior to which she subscribes, however, will determine the clinical formulation, along with suggestions of treatment options. Mental health treatments span the gamut from "talking cures" that delve into the distant past and explore the present situation, to those more strictly focused on cognitive/behavioral goals. Individual, family, or group therapy may be advised. Mood altering medication might also be prescribed.

In this paper we look at psychiatric treatment and *teshuvah* as sys-

tems of change. We posit that these systems are distinct, yet overlapping, and we focus on three areas where these points of convergence are manifest: locus of authority, use of the transference, and establishment of goals. We then illustrate these points using case examples. These vignettes will facilitate discussion regarding whether, and to what extent, familiarity with psychological principles might facilitate and enhance the *teshuvah* experience and, conversely, whether, and to what extent, an understanding of *teshuvah* can enrich the psychotherapeutic process.

Factors Affecting Behavioral Change in Psychiatric Treatment and *Teshuvah*

Locus of Authority:
Following the initial evaluation, the therapist helps the patient set the specific goals of the treatment designed to alleviate the patient's pain. Sometimes these goals are straightforward—for example, the reduction of symptoms such as insomnia, anxiety or depression, or the implementation of behavioral changes such as anger management or impulse control. In such cases, patients may or may not wish to understand the origin of the symptoms or behaviors that they now wish to change.

In some cases, however, patients seek to understand their current problems in the context of repeated patterns or as outcomes of earlier adversity before deciding whether it is feasible, or even appropriate, to change their behaviors or circumstances. For some patients, the creation of new circumstances might be too difficult. Instead, they seek a therapeutic process that will help them cope with circumstances as they are. For example, individuals in abusive marriages may not feel able to leave the marriage or to significantly alter their spouses' behavior. They may benefit, however, from insights regarding their own reactions and behaviors in such relationships, or from concrete suggestions of how to augment other support systems to ameliorate the damaging effects of relationships they have chosen to maintain.

Thus, the psychotherapeutic process is one in which the patient is the final arbiter of what is right or wrong for them. Although the therapist may often point out that certain behaviors or attitudes are inconsistent with the patient's articulated goals, the therapist does not direct, but more guides the process of "recovery" or change. He/she is a kind of psychological lamplighter, helping the patient illuminate his/her inner conflicts and desires without imposing or advocating any particular moral or behavioral standards.

Observant Jews presumably have a code of behavior that, if adhered to, implicitly leads to a correct and good life. When a Jew experiences emotional pain, he is taught to reflect on his actions to determine whether he has departed from a set of behaviors that would mitigate the pain, including distress arising from external adversity. Thus, the religious Jew's desire to engage in *teshuvah* may be prompted by feelings similar to those suffered by a secular person seeking behavioral change through psychotherapy.

The process of *teshuvah* in Judaism provides a powerful structure through which a person's emotional pain can be contained. The laws of *teshuvah* not only operationalize the process of change, but also offer a system of social support and destigmatization by delineating a season, the High Holy Days, in which all Jews are expected to be engaged in this activity. *Teshuvah* is also a process that allows people to participate in a dialogue with God, to take responsibility in a world where there is divine oversight.

An extension of this idea also holds great power for many religious Jews. For them, wrongdoing is directly connected with suffering – the punishment is pain. From this perspective, failure to do *teshuvah* carries with it the threat of personal and/or communal tragedy. In this emotional and religious climate, *teshuvah* may be motivated more by the fear of divine reprisal than by the primary desire to realign oneself with God.

Herein lies a major different difference between *teshuvah* and psychotherapy systems. Depending on one's understanding of *teshuvah*, the desire for change arises out of fear of, or love of, God. Religious life commends and cultivates such motivation, based, as it is, on awe of God as the ultimate authority. Psychotherapy, however, looks down on incentives primarily founded on avoiding or pleasing a powerful "other." Efforts to get a patient to change "for the therapist" would be regarded with dismay. Such technique would be criticized for serving the therapist's needs more than the patient's. Over time, fostering such dependence could be unhealthy as well as expensive. The patient would become emotionally shackled, relying on treatment indefinitely to maintain beneficial results. The locus of authority rests within the individual; ideally the patient will grow out of the therapeutic scaffolding and still maintain permanent change.

Transference:

Key to both psychotherapy and *teshuvah* is the enormous emotional power of the therapeutic relationship. In psychotherapy, much has been made of the relationship between patient and therapist, known as trans-

ference. Transference refers to a process in which the patient invests the therapist with a constellation of feelings whose origins are based on earlier relationships. The therapist may therefore be regarded by the patient as a benevolent or tyrannical parent, an approving or condemning authority, or an admiring or rejecting lover. By maintaining an initially neutral stance, the therapist comes to understand the type of salient interpersonal conflicts regularly experienced by the patient.

Whether the formal contact is through one-time crisis intervention or many year psychotherapy, the consultation room is a kind of laboratory, a microcosm of the patient's typical relationships, conflicts, and behaviors. More psychoanalytically oriented therapies explicitly set up the treatment situation to encourage transference development. The therapist chooses to maintain relative anonymity and a non-directive stance so as to maximally nurture a transference development that can then be analyzed.

The therapist interprets transference in many ways, depending on his/her particular theoretic orientation and personal style. However, the therapist must be respectful of and responsible to the power of transference, since it is the bedrock of the therapeutic relationship, as well as the patient's template for learning about the self. Therapy is a dyadic experience; the patient's emotional responses to the therapist and the therapist's awareness of feelings catalyzed by him/herself provide the emotional fuel that ignites change.

Teshuvah also depends on the power of transference. For the penitent Jew, a wide range of relationships may be involved. Another individual may have been wronged—a family member, a friend, a colleague, a stranger. The notion of restitution to a fellow human being, while at times embarrassing or difficult, would not strike any thoughtful person as strange. *Teshuvah,* however, recognizes that infraction of any commandment also damages a Jew's connection with God. That relationship must be restored as well. How, one might reasonably ask, can the power of the transference be harnessed in the absence of a human partner? We suggest that the *teshuvah* process with God also calls upon a series of transferences.

How does an individual human being create and maintain a relationship with God? The psychologist appreciates a person's inner representation of God as a composite of feelings and fantasies that originate in earliest infancy. Our liturgy reflects this multiplicity of images and emotions. We beseech God with words that we use in relationships with those we love and fear. We speak to God as we would to our mother or father, a judge, or a monarch.

The religious wrongdoer's sense of responsibility may shift between self-blame and self-justification: "Surely God, who created and understands human nature can look into my soul and understand what compelled me to behave as I do, particularly if there are untoward circumstances that affected my judgment." Presumably, the religious person feels a vibrant, immediate relationship with God. That person might feel angry or critical of God for allowing him/herself to slip into sin, just as a child might feel anger towards the parent who did not prevent the child from engaging in dangerous play that resulted in physical pain. In this context, at least part of true *teshuvah* involves forgiving God for the unhappiness that causes such people to hurt others or themselves.

On a community level, the penitent Jew may seek guidance from a trusted teacher or rabbi. He/she endows that religious authority with expectations of approval and disapproval that the psychologist would trace to earlier parental attitudes. For many individuals, the rabbi can also serve as a psychological intermediary for the sinner to approach God. The supplicant Jew might feel shame, anger, or any of a myriad of difficult feelings in front of a rabbi. Transference dynamics are activated. The rabbi is in a powerful position to call the congregant's attention to his/her responsibility for infractions and to encourage inquiry as to why that wrong behavior occurred. How much should the rabbi pressure his penitent congregant in a specific direction? We might consider such tactics in a psychotherapist to be manipulative. The extent to which the same standards of neutrality apply to the rabbi is important to consider. The rabbi, even when motivated by the most noble desire to help a Jew struggling to reconcile with God, must be aware of the powers inherent in persuasion.

Goals:

The initial goal of the mental health establishment is to relieve acute suffering. Over time, in the context of the therapeutic relationship, other goals may develop. These include cultivation of insight, empathy and other traits that might loosely be termed "character growth." The therapeutic result, however, is not measured by conformity to any one cultural convention. The predominant value of therapy is to lessen psychic conflict within the rubric of a basic ethical structure. Of course, psychotherapy is practiced by individuals who each bear the stamp of his/her own inborn temperament, upbringing and culture. Much of the work of training is to identify and analyze one's own prejudices and blind spots and to be aware of how they may enter into the therapeutic work.

A question that arises is whether we consider "character growth" that hopefully develops under therapeutic conditions to be instances of *teshuvah*. Does the relinquishing of harmful behaviors and the restoration of well-being pave the way for religious return if there is no genuine remorse? Take a case in which an abusive husband is remanded for treatment. The court-appointed psychiatrist suspects a mood disorder. The husband agrees to take a psychotropic medication and undergo anger management therapy. He no longer beats his wife, but he still believes that she is lazy, wasteful, and flirtatious and deserved every insult or smack he gave her in the past. Is this *teshuvah*?

To the extent that people have neurobiologic vulnerabilities that predispose them to cope in maladaptive ways, it is interesting to think about whether the effort to comply with treatments which are time consuming, costly, and possibly accompanied by unpleasant side effects, in itself constitutes *teshuvah*. Hopefully, the clinician participates in a process that determines the underlying source of pain so that it can be controlled or stopped permanently. Many people contribute to their own pain by using and re-using ineffective coping tools. They can take an active role in reducing their own suffering by working to expand their repertoires of responses, strategies, and solutions. The therapeutic relationship allows for this type of exploration. Some clinicians feel that emotional pain can be addressed neurobiologically, but few believe that this is all that needs to be done. For most people, how to get through life with minimal pain is not immediately obvious and requires a lifelong process of exploration and trial and error.

Case Studies

CASE 1: The Desperate Wife

Mrs. Cohen, a 40 year old married Orthodox woman and the mother of an 8-year-old son, called Dr. One to arrange an appointment to discuss her escalating anxiety, which had reached panic proportions. They agreed to meet several days later. Shortly after introducing herself at the first session, Mrs. Cohen announced that she was scheduled for an abortion that same afternoon. Dr. One was surprised that Mrs. Cohen had not mentioned this matter over the phone. The therapist inquired further.

The therapist learned that Mrs. Cohen is the second wife of an older businessman whom she met while he was separated from his first wife, the mother of their four adult children. After a lengthy divorce proceeding, the Cohens married, with the understanding that they

would have only one child together. The marriage, which had produced a son that both parents adored, was generally happy. In recent months, however, Mrs. Cohen felt her husband becoming more detached and less sexually interested. She worried that his attentions might be waning, perhaps even wandering to another woman. One night, when he seemed amorous, they had unprotected relations. Mrs. Cohen was now seven weeks pregnant.

Dr. One felt that Mrs. Cohen's hasty decision to have an abortion was fueled by overwhelming, unprocessed feelings. She urged her patient to postpone the procedure until they could discuss it at least a few more times. Mrs. Cohen adamantly refused. She returned the next week having terminated the pregnancy.

In the weeks that followed, Mrs. Cohen became more and more distraught over what she had done. She and Dr. One set up a twice-weekly psychotherapy schedule. Therapy revealed that Mrs. Cohen had told her husband neither about the pregnancy nor about the abortion. She felt rigidly bound to her promise. Though Mrs. Cohen longed for a second child, she insisted that her husband would resent the burden at this point in their life and be angry at her.

Mrs. Cohen, an intelligent and psychologically inquisitive woman, engaged in the psychotherapy deeply. She revealed that as a child, she was the designated, responsible care-taker of a large brood whose parents were self-absorbed and benevolently negligent. Mrs. Cohen alternated between relishing her authority over her siblings and resenting their ceaseless demands. She longed for her father and mother's full attentions and crafted a fantasy life in which she was the sole, beloved child.

Over the next several months, Mrs. Cohen's anxiety was replaced by a deep sadness. She was consumed with an overwhelming regret over the abortion. Together with Dr. One, she formulated a hypothesis as to the why she had become so depressed. Her wish to maintain what she perceived to be precarious status as favored wife was in conflict with her desire to have more children. She had supplanted one wife; perhaps she would be pushed aside for yet another woman. Further, her anger at her own siblings had been unconsciously ignited. Just as she craved being the sole object of her parents' attentions, she unconsciously struggled with her wish to share her husband's affection with another child. Further, even if she were to dare and ask her husband to support her desire to bear the second child, she would be upsetting her own son's privileged position and dooming him to move over for a younger child, just as she had had to do many times.

These insights enabled Mrs. Cohen to tell her husband what had happened. Mr. Cohen expressed his sincere sorrow for her suffering and his unwavering love for her. He did not, however, wish to have more children. While Mrs. Cohen did not challenge her husband's decision, she recognized that her fantasy of doing *teshuvah* by getting pregnant yet again and bearing a child was not a realistic option. The sight of pregnant women and babies on the street brought her to tears.

Mrs. Cohen remained in therapy for several years. Over that time, she achieved significant insights that allowed her to function more fully and feel more deeply in her roles as wife, mother, professional and religious woman. She felt that she had not been fully present in her earlier relationship with God due to the distractions of her inner conflicts. She recognized how the unplanned pregnancy and the abortion represented a dramatic demonstration of long standing self-hatred and insecurity. Part of the therapeutic work was learning to live with some measure of anger and remorse. Mrs. Cohen always became sad around the time that would have been her due date. She wished that she had understood herself better earlier. She would have had more choices, she might not have become pregnant unexpectedly, or, if she did conceive "by accident," she might not have excluded her husband from the dilemma; she might have even have had the baby.

For Mrs. Cohen, psychotherapy paved the way for a more full *teshuvah* experience. The insights gleaned through a classical transference analysis allowed her to take responsibility for her behavior, mourn her losses, and cultivate deeper relationships with those significant to her, including God.

CASE 2: The Guilty Bookworm

Mrs. Stern, a 38 year old Hasidic homemaker and mother of seven, came for psychiatric evaluation complaining of low grade depression of many years duration. She described her symptoms as tearfulness, sadness, and overreacting to situations in which she felt criticized. She was happily married, financially well off, and loved her children, but she felt distant from her own life and unable to fully participate in the bounty that was before her. Her one enjoyment was retiring to her room and reading fiction. There was, however, a catch. Mrs. Stern was a voracious reader whose literary curiosity strayed outside the bounds of the Yiddish language libraries maintained by her community. She wanted to read modern fiction but felt terribly guilty. Hasidic culture, according to her understanding, discouraged and even banned secular literature.

Although Mrs. Stern was a reflective and introspective woman, who had spent some time in psychotherapy previously, she found the insights gleaned from that work interesting, but not especially useful in relieving her dysphoria. This time, she wanted to try medication. Dr. Two agreed to a trial of anti-depressant.

Mrs. Stern returned to Dr. Two's office after six weeks. She reported a dramatic response to sertraline, one of the newer generation of anti-depressants in the serotinin re-uptake inhibitor family. She felt more relaxed, alive, and emotionally involved than ever before. Her husband and children remarked how much happier she seemed. Dr. Two, the psychiatrist, also noticed a pleasant brightness in Mrs. Stern's manner. She wondered if Mrs. Stern's reading dilemma was affected and asked her patient. Mrs. Stern was eager to discuss the topic.

Mrs. Stern had been a reader since childhood, when she attended a religious but non-Hasidic school that allowed some secular literature. She married a Hasidic man and began having children. When her eldest child began school, Mrs. Stern became more aware of her Hasidic sect's disapproval of secular reading material. Mr. Stern did not appear to be bothered by his wife's interest, and Mrs. Stern did not have to hide her reading from him. Still, she felt uneasy, but continued to borrow books from the local library.

When Mrs. Stern's fourth child was born, the baby had some minor medical complications. Her toddler was sick as well. Sitting in the hospital, Mrs. Stern came across her New York Public Library card and impulsively ripped it up, vowing that if *Hashem* allowed her children to recover, she would not take library books out again.

The children got better. Mrs. Stern's desire to read was as strong as ever. With a rueful smile, she told Dr. Two about her compromise. She would allow herself to buy books from Barnes & Noble, thereby not technically violating her promise. She joked that it was ridiculous to spend money when she could borrow the same books for free, but "That is how it is." Further, while her mood was sunnier on the medication, she still felt a keen sense of confinement in her life. Curling up with an English book in her bed, with the door closed, was her greatest pleasure, and, no matter how she procured that book, she felt guilty about it.

Dr. Two was certain that Mrs. Stern's chronic depression had lifted as a result of the medication. She also noted a greater availability on the patient's part to examine and reflect upon complex issues. Dr. Two understood Mrs. Stern's destruction of her library card and vow in the hospital as a kind of spontaneous *teshuvah* act, a bargain forged in the

heat of her children's illness but layered over her long-standing guilt about reading. Would it be advisable, wondered Dr. Two, to probe this further? What, at this point, should the goals of the therapy be? She suggested psychotherapy for her patient. Mrs. Stern, however, declined the invitation. While she acknowledged the potential insights that she might gain, she didn't want to rock the boat. She agreed to come in for check-ups at six-month intervals.

With a thoughtfully written prescription, Dr. Two had succeeded in alleviating Mrs. Stern's present complaint of low-grade depression. What about the long-term prognosis? Dr. Two suspected that Mrs. Stern chafed under the yoke of her rigidly defined Hasidic life. Would psychotherapeutic exploration allow her patient to make a more adaptive compromise between her private desires and the beliefs of her community? Should Dr. Two attempt to help Mrs. Stern feel less guilty about her reading? Or would energy best be spent helping the patient to adhere to the norms of her community by abandoning reading? Perhaps the most radical position Dr. Two might take would be to conclude that it was her obligation to "out" her patient, to get Mrs. Stern out of her reading "closet." She then might encourage the patient to make her reading more public and face the consequences, even if this would require altering, or even abandoning, her lifestyle.

Mrs. Stern knew that she could ask a *she'alah* about the reading. Taking that step, however, was risky. Dr. Two conjectured that the seemingly best outcome would be if the *rav* told her patient to read discreetly and not feel bad about it. However, Dr. Two was not sure if the transference power of the *rav*, the authoritative arbiter of religious law, would neutralize Mrs. Stern's guilt. Also, suspected the therapist, Mrs. Stern had an unconscious attachment to her clandestine identity as a reader. She was a Hasidic woman who was secretly different, worldlier, and more sophisticated than the rest of her community, yet was unwilling to expose herself or her family to potential criticism or scandal.

On the other hand, if the *rav* told her to stop reading altogether, she would be obligated to cease the activity that gave her the greatest peace of mind and pleasure. Better to stay in the loophole that she had created and suffer tolerable guilt in silence. Although there had been a time when the patient's emotional pain had caused her to consider doing *teshuvah*, by abandoning a behavior that was considered inappropriate in the eyes of God, once the emotional pain had lifted, she was no longer motivated to change, nor could she determine the relevance of her behavior to her ongoing mood states.

CASE 3: The Complacent Philanderer

Mr. Levine, a 42-year-old married father of 5, consulted Dr. Three on the urging of his old *ḥavruta* and good friend, Dov, who was increasingly worried about Mr. Levine's extra-marital exploits. Dr. Three had treated Dov's adolescent daughter with good results.

In the first of four visits to Dr. Three, Mr. Levine explained his situation. Since age 22, he was married to a woman he described as pious and devoted, but not sexually exciting. Some years ago, he began frequenting massage parlors and became involved with one particular masseuse. His mistress, a Columbian immigrant on an expired tourist visa, was an ambitious young woman. In exchange for sexual favors, Mr. Levine helped her with night school homework and her immigration papers.

Dr. Three was struck by the patient's nonplussed manner in telling his story. Mr. Levine seemed quite pleased with the situation—his proper wife was bringing up their children according to correct, *frum* standards, while he was satisfying his lustier drives discreetly. From his point of view, no one was getting hurt. When Dr. Three inquired as to whether Mr. Levine considered the risk of catching a sexually transmitted disease from his mistress, the patient responded, "I'm careful, and she is only seeing me anyway." When the therapist commented on the disconnect between Mr. Levine's public and private behavior, the patient shrugged his shoulders: "That's what Dov said. He's afraid I'll get in trouble, but so far, it's OK."

Mr. Levine seemed to enjoy his sessions with Dr. Three. His approach to paying bills was idiosyncratic. Although Dr. Three explained that her office policy was to bill monthly, Mr. Levine insisted on paying for each session at the end, with a check from a joint marital checking account. Dr. Three asked whether Mrs. Levine would be curious as to the expenditure. The patient laughed, "She never pays attention to these things. I take care of all the money."

Dr. Three was struck at how Mr. Levine's treatment of the finances fit right in to the transference. In Mr. Levine's eyes, the psychologist was a slightly upgraded prostitute, another interchangeable female who would take care of his immediate needs, get paid, and disappear until the next time he called her. Dr. Three felt that any mention of her insight would push Mr. Levine away from treatment. Instead, she chose to comment on the disconnect between his public and private lives and to gather more history, hoping to find a plane of alliance with her patient that would motivate him to delve more deeply into his behavior.

Mr. Levine came for one more session and then called to cancel his

next appointment. He was reluctant to reschedule, stating that he would call Dr. Three if he felt the need. She did not hear from him again.

Dr. Three realized that the essential missing ingredient in this case was anxiety. Mr. Levine's relationships with significant others in his life were generally shallow. People were important to him insofar as they helped him relieve anxiety. Mr. Levine did not feel shame about his immoral behavior. His main transference was to Dov, who served a surrogate parental authority. Mr. Levine's desire to please Dov motivated him to come for a consultation, but was not enough to propel him to go beyond a superficial encounter.

The case was a failure from both *teshuvah* and psychotherapy points of view. Mr. Levine merely went through the preliminary motions of treatment. Once the therapist began to delve into the glaring split between his professed religious commitments and his personal conduct, the patient fled. Dr. Three felt uncomfortable and dissatisfied. She wondered if her neutral, probing manner had frightened Mr. Levine. Perhaps he expected her to reprimand him for his adulterous behavior, threaten him into straightening out. Perhaps if she had treated him like a bad child, reprimanded him and given him specific prescription for correct behavior, he would have felt more connected to her and stayed in the treatment. Psychotherapeutic inquiry had certainly not provided much benefit to Mr. Levine or to his family.

Discussion

We hope that the above three cases enliven the comparison of *teshuvah* and psychotherapy. These two processes are concerned with the cultivation of maximal human potential according to the demands of these respective systems. *Teshuvah* and psychotherapy recognize that people suffer from feelings and behaviors which they are capable of changing. We begin our discussion by reviewing the frames of reference that underly the prescribed restorative and transformative processes of *teshuvah* and psychotherapy.

Observant Judaism posits a clear frame of reference as to what the proper path in life is. Torah is the blueprint. Failure to adhere to this *derekh* results in dislocation and pain. The *miẓvot* constitute the template for proper behavior, and *teshuvah* offers an authoritative way back from wrongdoing. Conflicts occur when individual desire goes outside the system.

Psychiatry is less unified in its frame of reference for achieving its

goal. There are many models of the mind and a smorgasbord of methodologies to chose from. Hence, clinicians' diagnoses and treatment depend on their orientation. There is no universally agreed upon organizing theory, and therefore, it is far more difficult to know which behaviors are "right" or "wrong." Rather, these constructs are derived on the basis of whether they cause or relieve pain, or increase pleasure. This lack of absolutes can be experienced as liberating and/or threatening. Regardless, this point probably constitutes the most salient difference between the process of psychotherapy and *teshuvah.*

Another point of divergence is *teshuvah's* notion of transference. Since the process of *teshuvah* operates fundamentally between man and God, the absence of a human collaborator can make emotional restitution a difficult, lonely task. In contrast, psychotherapeutic work deliberately cultivates the relationship between therapist and patient so that it may serve as the primary template for change.

The goals of insight oriented psychotherapy vs. *teshuvah* may also differ. In *teshuvah* the goal is not to end one's pain, but to alter one's behavior. Pain relief may occur as a secondary benefit. In classical psychotherapy, the diminution or cessation of suffering is the goal. Insight, behavioral change and medication may be employed separately or in combination. Theoretically, insight should lead to pain relief. Resultant behavioral changes are useful insofar as they maintain a better functioning system and prophylax against future suffering. *Teshuvah* posits that appropriate behavior will pave the way for higher level understanding and transformation of feeling states. Cognitive-behavior therapy, which works to correct habitual negative self-perceptions and other cognitive distortions agrees with this point of view. Classical psychodynamic psychotherapy, however, posits the reverse—properly harnessed insight will motivate correct behavior.

It is important to emphasize that there are many forms of psychotherapy, and that we have presented these processes in a simplistic form for the purposes of discussion. Our intention is not to provide a precise analysis of the processes involved in either psychotherapy or *teshuvah,* but rather to provoke some discussion about how these two processes may work in tandem, or at variance, with one another. This articulation is particularly important in light of the fact that there are numerous rabbis who are involved in pastoral counseling, as well as many religiously observant clinicians who often feel caught in a dilemma of how to honor the patient's goals, even if those goals clash with the therapist's moral code.

A clear understanding of the principles and practices of *teshuvah* and psychotherapy is valuable to rabbis providing pastoral counseling as well as to psychotherapists treating *frum* clients because it will facilitate more honest and ethical negotiations with persons seeking help. Indeed, it is particularly important for clergy and religious educators to understand and disclose the nature and limits of the work they can offer a person seeking to reduce their pain in a therapeutic process with them.

The rabbi can potentially provide enormous support for a troubled congregant. He needs to balance his dual roles as compassionate listener and religious authority. While he needs to help the supplicant Jew find comfort, he must also make clear that not all impulses, solutions, or behaviors are acceptable within the framework of Jewish law. As such, there will be limits to the type of exploration that a rabbi can be expected to engage in. Rabbis should not rely on the congregant in need to implicitly understand this, since those who knock on the rabbi's door come with multiple expectations. Some suppose that the rabbi will offer counseling akin to what they might receive from a mental health professional. Others may harbor the belief that the rabbi can offer a prescription for divine absolution.

Indeed, even in cases where a clinical result would not incur any obvious harm in secular society, a rabbi who is counseling his patient must do so in accordance with the community's understanding of Halakhah. Thus, at first response, Mrs. Stern should not read *Jane Eyre*, a husband may not physically comfort his grieving wife who is in *niddah*, a *kohen* cannot marry a divorced woman. Disclosure of his commitment to religious authority can help the rabbi clarify the transference dynamics and fully inhabit his role as a counselor. He can extend compassion by helping his congregant distinguish between a correctable "wrong behavior" and the corrosive self-hatred of feeling like a "bad person." Perhaps Dov's efforts would have gotten further if he had directed Mr. Levine to a rabbi who could invoke some of these principles. However, to the extent that there are limitations to the type of exploration a rabbi is willing to engage in, he should duly inform the congregant that a mental health professional might be able to explore issues from a more open vantage point. The merits and drawbacks of this approach might then also be discussed.

The therapist has wider latitude; his/her patient will need to chart his own course. The astute clinician respects the power of religious life. S/he recognizes the compelling pull that ancient and sacred traditions have on their adherents, even on those members who have lapsed. S/he

knows that while s/he can offer non-judgmental exploration, s/he cannot advocate one solution. At the same time, the psychotherapist understands that painful feelings may arise when the tenets of tradition collide with individual yearning. If Mrs. Stern truly wants to resolve her dilemma, she will either have to eradicate her secular aesthetic appetite or go public as a reader and reckon with official response to her literary habit.

At the core of this discussion is the idea that, for a religious Jew, the process of psychotherapy might fill a different need than that of *teshuvah*, but that there may be a real need for an individual to engage in both processes at different times in their lives. Therefore, there is a need for a greater collaboration between religious leaders and mental health professionals to ensure a deeper understanding of these processes and the ways in which they work to reduce human suffering.

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