Nefesh News

The International Network of Orthodox Mental Health Professionals

www.nefesh.org

MARCH 2007

Tenth Annual Nefesh Conference

The tenth annual Nefesh conference this past December was great! The workshops were really exciting. Most of the time, I found myself torn between two or even three choices of presentations.

The workshops on dealing with crises in the frum community were priceless. It was amazing to see the protocols and program that the communities in California set up in order to identify and eradicate sexual abuse in the Yeshiva system. Debbie Fox was terrific in presenting this system to the audience. Within the same lines, Dr. Rona Novick's powerful presentation on the prevention and treatment of bullying demonstrated how to teach children to say "NO". These workshops were a windfall of information.

Other workshops included: gambling addictions in children and adolescents presented by Dr. Jeffrey Derevensky, a full day workshop in practical applications of CBT by Dr. Hinda Dubin, and a psychopharmacological panel moderated by Dr. Shalom Feinberg.

One of the highlights of the conference was the question and answer session with the NEFESH Morah D'asrah, Rav Dovid Cohen. Through his characteristically unique humor and straightforward responses, Rav Dovid provided his attentive crowd of hundreds with responses to mental health and halachic dilemmas.

Special thanks to Joe Lowy, Nefesh Board members and volunteers who contributed their time and effort to make this conference such an outstanding success.

I look forward to next year's conference. One where I can once again learn, collaborate and network with my colleagues from across the continent and globe.

Chaim Sender, LCSW
Administrative Director
Crown Heights Center
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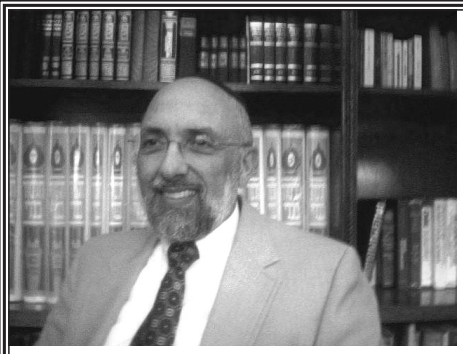

From the President

Nosson Solomon, Ph.D.

By now it is clear to almost everyone that NEFESH International has entered a new era of phenomenal growth and scale. Fed by the rich programming for both professionals and lay public, membership continues to climb. The most recent examples are the wonderful International Conference in Lawrence, NY, and the three-session teachers' institute in Brooklyn. Our dedicated officers and Executive Board have turned out a series of events that have brought important education and training to the Torah community and prestige to NEFESH International.

For those of you who want to be more involved as NEFESH moves forward, I list below the roster of committees currently operating in the organization. To volunteer, contact me at nas1@optonline.net.

Advertising (selling ads in NEFESH publications, etc.)
CEU's (providing educational credits at events)
Development (fundraising and financial planning)
International Referral Directory (gathering agency data and publishing on line)
Membership (recruitment and service provision)
Newsletter (writing and gathering articles)
Programming (planning and implementation)
Publicity (placing ads, etc.)
Student Division (student member recruitment and services)
Website (design and management)

Our expanding role in the community creates new opportunities for individual fulfillment.

Kol tuv,

Nosson

Message from the Editor

Rabbi Simcha Feuerman, LCSW-R

I confess that I am a Rav Dovid Cohen "Groupie". For as long as I have been able to ask and follow halachic questions, I have sought Rav Dovid's counsel and recorded his answers for my own safekeeping. At this years' NEFESH Conference, I made sure to transcribe his Question and Answer session as well.

The thing about Rav Dovid, Shlit"a, and I would imagine most poskim, is that you have to listen very carefully and read between the lines. In any given response, there is a goldmine of ideas about hashkafa and mussar, which require careful study. Because halacha is complex, one can never quite predict what a posek will say. Sometimes, even when you are sure of the answer, you get exactly the opposite of what you expected. If you can resolve the apparent inconsistency, then a new and deeper understanding can be achieved. (This is the style of analysis taught to us from the Talmud: The best way to master subject matter is to find contradictions and then resolve them.)

I really wanted to print the entire session, but Rav Cohen requested that I refrain from doing so, due to the sensitive and context-dependent nature of the questions. However, Rav Cohen did permit me to print the questions, and I can assure you that his answers where compassionate, inspirational and thought provoking.

Here is a selection of some of the more relevant and timely questions asked during the session:

Q. From a halachic perspective, does one need a special "heter" vis a vis the taboo against "mesirah" to report child abuse, or is it sufficient to know that there is a serious concern?

Q. Is there an obligation of an Orthodox therapist to steer the person toward observance?

Q. Sometimes case conferences really just seem to be gossip, and border on loshon hora. What are the guidelines for discussion about a person, does one have to be careful to make sure every detail is exactly l'to'eless?

Q. What are the general guidelines for Yichud in therapy rooms and offices?

Q. What concerns should there or should there not be in regard to Chilul Hashem and talking about serious community problems publicly, such a molestation or embezzlement?

Q. If a person is suffering from mental illness and extreme anxiety, is it permitted to violate Shabbos in order to put his or her mind at ease.

Q. Does a woman with anorexia have to reveal this to her fiance?

Q. Can a person who participates in Overeaters Anonymous, and who experiences sugar and flour to be addictive substances that can cause binging, abstain from eating Challah at the Shabbos Seudah?

Q. Does a person need to divulge in a shidduch that they are on SSRI'S?

These questions will have to serve as teasers so that you will come to next year's conference to learn Torah Sheb'al Peh directly from the source.

Special thanks once again to those who have submitted articles to this newsletter, and to Karyn Feinberg for her assistance in producing this newsletter.

Best wishes,

Simcha

The following Dvar Torah by Dr. Joseph Geliebter was originally delivered at the Tenth Annual NEFESH Conference (& National Council of Young Israel Rabbis' Council) on December 25th at Congregation Beth Sholom, Lawrence, NY. The first part of the Dvar Torah was said in loving memory, l'ilui nishmas Esther bas Avraham Solomon. Esther, the wife of our president, and my good friend, Dr. Nosson Solomon, tragically was taken from us while carrying flowers in honor of Shabbos.

With the permission of our *morah d'Assrah* and my Rebbe, HaRav Dovid Cohen, *sh'lita, maranan, v'rabbanim, v'rabosai:*

We learn in the Chumash that when Yaakov and his son Yosef met after they had been separated for 22 years, he did not embrace his son, nor did he even kiss him. He was reciting the *Shema.*

This is a puzzling thing for Yaakov to have been doing at that crucial and emotionally charged moment in his life. Even as a child, I wondered why Yaakov had to recite the *Shema* at this exact moment. Couldn't he first have embraced his beloved son, greeted him, and only then recited the *Shema*?

And in fact, Ramban disagrees with Rashi. He brings a number of proofs to show that, to the contrary, it was Yaakov who appeared to Yosef, fell on his neck, and who cried. And Ramban does not mention that Yaakov chose that exact moment to recite the *Shema.*

Yet how can we explain Rashi's position?

To do that, let us go back in time—22 years prior to the dramatic meeting between father and son.

When Yaakov first learned from his sons of Yosef's ostensible death, he mourned. And he continued to mourn for the following 22 years. For 22 years, Yaakov's sons and daughters tried to console him—but they failed. And this was, Rashi states, because Yosef was still alive, and as a result, on a spiritual plane the process of mourning could not come to an end. There could be no closure, no resolution—the special Blessing of *consolation* could not take effect.

Consciously, Yaakov may have believed that Yosef was dead. Still, Yaakov realized that something was wrong. He should have been able to resolve his mourning, he should have at long last been comforted, he should have regained his *ruach hakodesh*—yet none of these things happened. Was Yosef truly dead or was he alive? And if he was alive, had he fallen spiritually? Either way, had Yaakov lost Yosef forever?

When, toward the end of these 22 painful years, Yaakov's sons returned from Mitzrayim to tell him that Yosef was alive, at first *vayofog libo ki lo he'emin lohem.* Yaakov grew fainthearted because he did not believe his sons.

Vayedabru eilav. They spoke to him. They pleaded with him; they reported Yosef's words to him.

And at last, Yaakov saw the wagons that Yosef had sent him. Then *vatechi ruach Yaakov avihem.* Yaakov's spirit was revived—because, Rashi explains, G-d's Presence, which had left Yaakov for the 22 years of his unresolved mourning, once again rested on him. Chazal teach us that *ruach haKodesh* and *nevuah* (prophesy) can only occur while a person is in state of happiness.

The midrash teaches that with these wagons Yosef was sending his father a coded message. Yosef was alive—and more: although he had been living in Mitzrayim for 22 years, he remained spiritually pure. *Od Yosef chai.* Yosef was still alive, both physically but spiritually.

That night, Hashem came to Yaakov in a dream and told him not to be afraid to go down to Mitzrayim. Hashem assures Yaakov that He will descend with him to Mitzrayim and that He will personally take his children out of Mitzrayim. In the middle of that dream, in an apparent non sequitur, Hashem assured Yaakov that Yosef would place his hand over his eyes—the Midrash interprets this to mean that Yosef would take care of Yaakov when Yaakov died and physically close his father's eyelids.

Although this dream was a type of prophecy, it was inferior to the prophecy that a person experiences when he is awake, the level that both our other *Avos* Avraham and Yitzchak regularly experienced.

At any rate, why was Yaakov so afraid? *Chazal* explain that he was fearful of going into *galus.*
But I would like to add an additional thought. Perhaps Yaakov was still afraid to learn, once and for all, what had happened to his son. Perhaps he did not yet fully believe that Yosef was alive. And so he needed Hashem's reassurance and healing from his extended mourning.

With that assurance, Yaakov traveled to Mitzrayim, where *Vayeira alov*—"he appeared to him"—Yaakov and Yosef at long last met.

Interestingly enough, this is not the first instance in the Chumash of the phrase *Vayeira eilav*. It appeared earlier when Hashem came to Avraham to heal him on the third day of his bris— the most painful day and in *k'Chom haYom*—the heat of the day. *Vayeira eilav Hashem b'Eilonei Mamre.* "Hashem appeared to him in Elonei Mamrei." Hashem came to pay Avraham a Bikkur Cholim visit—a sick call, as it were, because, although Avraham's spirit was elevated, his body needed to be healed—*refuas haGuf*.

Yaakov too needed to be healed—in his case, not his body, but his broken spirit—*refuas haNefesh*.

We can see that Hashem took Yaakov through a gradual healing process. First Yaakov's sons told him that Yosef was alive—these were mere words of fallible human beings. Then Yaakov saw the wagons—a tangible reality before his eyes. He also received a coded message from Yosef that that he had not changed spiritually as when he had last seen him. That night Yaakov experienced prophecy—G-d Himself spoke to him and reassured him that the *Shechinah* would accompany him. But because his spirit was not yet completely healed, that prophecy occurred in a relatively lower level, in a dream.

Now, at the moment that Yaakov at long last met his son face to face, the final stage of this healing process occurred. Yaakov's spirit was filled with such exaltation that he experienced a high level of prophecy, as he saw Hashem's Presence—the *Shechinah* —directly before him.

And so now we can understand why Yaakov chose this moment to recite the *Shema.* It was his spontaneous response to the revelation of G-d's Presence.

And perhaps this explains the apparent non sequitur in Yaakov's dream, when Hashem told Yaakov that Yosef would cover his eyes. In a veiled way, Hashem was promising Yaakov that his mourning would come to a complete end when he met Yosef.

How is that?

We are not allowed to gaze upon G-d's Presence. Moshe could only see the Back of the *Shechinah,* as it were. The Jews in the Beis Hamikdash were not allowed to gaze directly when the Cohanim blessed them.

When Yaakov and Yosef met, perhaps Yosef realized the spiritual experience that his father was going through: an overwhelming awareness of G-d's Presence. And so, in order to protect his father, Yosef put his hands over his eyes.

Some support for our interpretation of the phrase *Vayeira eilav* actually derives from a question contained in the Sefer *Shaarei Aharon.* Rav Aharon Rotter proposes an emendation in our text of Unkelos in regard to the phrase, *Vayeira eilav* as he points out that throughout the *Chumash,* Unkelos uses two specific terms for the verb, "to appear." When G-d appears or is revealed to someone, Unkelos uses the verb *v'isgali.* When one person appears to another, Unkelos uses another verb: *v'ischazi.*

When Yaakov and Yosef met, *vayeira eilav* – "he appeared to him." Unkelos should, of course, have translated this as *v'ischazi*—one person appeared to another. Yet most of our texts have *v'isgali*—meaning that G-d revealed Himself to someone.

That leads Rav Rotter to state that our standard text of Unkelos is corrupt. And indeed, he points out that there exist alternate versions of Unkelos that use the word *v'ischazi.*

But perhaps we do not have to say that. Perhaps *v'isgali* is in fact the proper verb to use. It is possible that Unkelos is telling us that when that Yosef appeared to Yaakov, at the same time Hashem Himself appeared to Yaakov as He had assured him before leaving Eretz Yisrael. When Yaakov and Yosef met, first, Yaakov was at last healed of his broken spirit. Thus, joy suffused him. And so in consequence he experienced the highest level of closeness and revelation of Hashem's Presence. And thus Yaakov felt the need to say *Shema* at that moment of ecstasy.

Yaakov was healed of his 22 years of mourning, 22 years of uncertainty, 22 years of not knowing what happened to Yosef. When *Vayeira eilav,* when Yaakov met Yosef, all of his psychic wounds were resolved, all of his pains were healed. And so, shortly afterwards, Yaakov came before Pharaoh and stated: "Now I can live." Now I am truly alive, for now I have Yosef once more.

All of Yaakov's worries, all of his fears, had come to an end.

May Hashem grant the Solomon family and our extended Nefesh community *nechama* for the great loss of our beloved Esther who so selflessly cared for others in her unassuming approach to *gemilas chasadim*, including her tireless work on *shidduchim* and in *kiruv*. I am pleased to have made a pledge to start a fund within NEFESH in Esther's memory.

Atypical Antipsychotics: *They Ain't Just for Schizophrenia Anymore*!

Shalom Feinberg MD
Associate Clinical Professor of Psychiatry, Albert Einstein College of Medicine

Wait. Don't immediately turn to the next article saying to yourself, "I don't treat psychotic patients and therefore I don't need to know about atypical antipsychotics." As the expression goes "the times they are a changin'." Let me explain. The use of atypical antipsychotics (also known as Second Generation Antipsychotics (SGAs)) is being extended way beyond their sole initial intended use for the treatment of psychosis and schizophrenia into a broad array of other clinical issues.

For those unacquainted with the group of drugs they are; Risperdal (risperidone), Zyprexa (olanzapine), Seroquel (quetiapine), Abilify, (aripiprazole), Geodon (ziprasidone) and Clozaril (clozapine). (The latter drug, clozapine, while an extremely beneficial medication for refractory patients, is not easily or popularly used, and therefore will not be a focus of this article.)

The first medicine of this class to reach the US market for treating schizophrenia was Risperdal in 1991, with the other SGAs subsequently becoming available over the next decade. Primarily, there were two initial arguments made for their use in comparison with the older, first generation antipsychotics (FGAs) (e.g. drugs such as Haldol or Trilafon) to treat schizophrenia. First, they caused far less neurological side effects, particularly tardive dyskinesia (TD), (a chronic, involuntary movement disorder primarily due to long term exposure to older antipsychotics) and secondly, they were somewhat better than the FGAs for the treatment of the so-called negative symptoms of schizophrenia. These include affective flattening, the lack of or decline in emotional response, alogia, the lack of or decline in speech, avolition, the lack of or decline in motivation, and asociality.

Aware that the older antipsychotic drugs had some useful role for treating the symptoms of acute mania in bipolar disorder, the pharmaceutical industry began performing double blind controlled studies of the SGAs for this role. This resulted, beginning with Zyprexa in 2000, in all medications of this class now receiving FDA approval for the treatment of acute mania in bipolar disorder, either as monotherapy or in combination with a traditional mood stabilizer such as lithium or Depakote. The SGAs are frequently used in this role as they are somewhat easier to prescribe than mood stabilizers (e.g. it is easier to quickly titrate them to a therapueitc dose and they require less blood work). Additionally, Zyprexa and more recently, Abilify have also received approval for maintenance therapy for the prevention of future bipolar episodes. One suspects that while the double blind data is lacking, the other SGAs are also effective in this latter role. One critical question, though, is whether the SGAs are *as* effective as lithium, Depakote, or Tegretol in treating and preventing future mood episodes? One certainly hears much hype from SGA drug company representatives as well as in their promotional literature for their use in bipolar disorder . But in my view the existing research data, as well as clinical experience, favor the traditional mood stabilizers versus the SGAs in preventing future mood episodes.

Additionally, when prescribing the SGAs for whatever the indication, one also has to factor into the equation two problematic health concerns. First, there are risks of metabolic side effects such as weight gain, hyperglycemia and hypertriglyceridemia (somewhat more so with Zyprexa and probably less so with Geodon and Abilify.) Secondly, the fact is that while the risk of TD and other neurological side effects are clearly LESS with these newer SGAs versus the older antipsychotics, the actual risk is not zero. We simply do not know what the long term incidence will be for TD with these newer SGA' s, particularly after 10 to 20 or more years of exposure for chronic maintenance therapy as is required to prevent future bipolar episodes.

But the pharmaceutical industry has not yet stopped in exploring the potential uses of SGAs, and one aspect of their reasoning is clear. There is a greater market

for medicines to treat mood disorders such as mania in bipolar disorder or depression than schizophrenia. For example, SGAs produced 2.7 billion dollars in sales last year for the treatment of bipolar disorder *alone*, 50% more than the sales generated for their initial indication, schizophrenia (1). Any additional FDA indications, such as for the treatment of depression, will further swell these profits.

There is a rich literature from the 1960s and 1970s looking at the role of the older antipsychotics for depression and anxiety (2). But the quality of that research was inconsistent at best, with numerous methodological limitations. The concern for the risk of TD associated with these drugs has already been noted. I may add that what increases the confusion in interpreting the older literature is the fact that there is data noting that in at least a subgroup of patients FGAs may actually *cause* depression (3,4) It is for these reasons that FGA's are drugs not generally used for any form of depression.

But, bringing the question into the 21st century, Seroquel (an SGA) was recently compared to placebo as a monotherapy to treat bipolar depression in two large eight week DB controlled well done studies (nicknamed by its manufacturer with the catchy acronym the BOLDER studies from BipOLar DEepRession)(5,6). Its success in these studies led to FDA approval for this use. While certainly FDA approval reflects a reasonable likelihood of their short term benefit, idealy studies providing long term data on relapse prevention and safety, as well research not specifally supported by the manufacurer are needed. Zyprexa, when combined in a fixed dose pill with fluoxetine (Prozac) was also found to be useful for bipolar depression (7). While some suggest that all the SGAs will treat bipolar depression, we certainly don't know that yet, particularly as Zyprexa, when used alone in this latter study, was not better than placebo in treating the core depressive symptoms (8). We also really don't know why any of the drugs of this class *may* work as antidepressants though theories include their effect on the serotonin and dopamine related neurotransmitter systems. Seroquel can be somewhat sedating when it is initially prescribed and it is important to support patients early on until the body accommodates to this nuisance effect which does diminish.

At this time in an attempt to further widen the range of SGA uses there are double blind controlled studies in progress (for better or worse funded by its manufacturer) to assess whether monotherapy with Seroquel will treat unipolar major depression, generalized anxiety disorder, posttraumatic stress disorder, social anxiety and insomnia in the same vein as they it appears to treat bipolar depression. In particular, this research, in addressing major depressive disorder, includes a study comparing it to a known antidepressant drug, Cymbalta.

There have been many open studies and 2 DB studies over the last few years finding that the SGAs, when added to one of the newer antidepressant drugs (e.g. SSRIs) are beneficial in treating otherwise refractory depressed patients. Many clinicians have found this augmentation strategy useful and it is frequently used in clinical practice for depressions nonresponsive to an antidepressant alone. Interestingly, seven DB studies were presented in the last year at various psychiatric meetings and were all positive. As they were all sponsored by their respective pharmaceutical manufacturer we await their publication so one can better evaluate their findings. One question to be answered here, as well, is whether one SGA is better than another in this role?

So what do we see from here? Yes, for the cynics, we are seeing capitalism at work. And, yes, reemphasizing the health cautions stated above, these drugs should not be used in a careless or casual fashion. But, clinically, there is growing data to support that calling this class of medicines "antipsychotics" is becoming more and more of an anachronism. More importantly, labeling them as such may prevent patients who are fearful of being stigmatized for taking an "antipsychotic" from accepting medication which may potentialy be useful for their mood disorder.

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Why It Is Often Helpful To Raise a Patient's Fee

Yisrael Feuerman, LCSW

"I won't do it. I just won't do it," Anna, a seasoned therapist and a close friend, recently told me. "I know I could raise my fees, I know I *should* raise my fees, but I can't – I won't."

For most people the idea of costs going up, of having to pay more -- for anything -- causes anxiety – even *deep* anxiety for some. *How will I be able to keep up? Will I have enough money for what I need for myself, for my family?*

So it is no wonder that the thought of raising our *patient's* fees, presumably individuals we nurture and care about, makes many therapists anxious as well. For a religiously observant therapist who has a community practice, the situation is compounded. First, there is a deep cultural expectation for compassion on the part of the therapist. This cultural imperative is powerful and frequently unarticulated. It runs as a profound undercurrent beneath relations with "our own kind" – even when this compassion is neither particularly helpful nor progressive. In this situation, when a fee is raised it can be seen as a double betrayal -- a breach of empathy with the patient, and a break from the hallowed tradition of *rachmones.* In fact, one observant therapist I know has gone many years without raising fees. Rochel confided in me that there is one young woman that she has been treating for 7 years at the same fee ($90) though she certainly could afford to pay much more.

Additional factors that inhibit setting and raising fees

The question then that begs further exploration is why does the idea of *raising* fees unsettle some therapists – even when patients can afford more? One suspects that it is neither completely about *rachmones* nor about money. What lies behind this reluctance?

For one thing, many therapists think of themselves as healers. In fact, Anna built a considerable practice on the idea that if she communicated her desire to heal people and nurture them, they will come and keep coming and their lives will get better. "I love my patients," Anna is fond of saying.

This did in fact happen. Anna built a thriving practice. It should have been no surprise. She is a great clinician. She communicates wisdom and empathy. And yet, as Anna tells it, she will not raise a fee. "I would never do anything that would seem blatantly self-serving as to increase a patient's fee. It seems hostile, even mercenary."

"Are you sure that raising fees is self-serving?" I asked her

She thought for a moment. "I have always thought so. My supervisor always told me: we must forever be guided by what is best for the patient -- what will heal them, what will help them make progress. Patients are not here to gratify our needs -- certainly not our need to have more money."

Anna is saying something true. We are sacredly bound to do what is in the best interests of our patients. This is precisely why I would argue that in some instances, at least, to *not* raise fees, is harmful to the patient.

Here's why: patients come to treatment usually with a consciously stated wish for us to help them in a certain aspect of their lives. There are also *unconscious*, *unstated* messages and wishes that flow back and forth between therapist and patient. Often, among these unconscious wishes are: *you will never leave me, you will treat me better than my mother/father/wife/husband treats me.* Part of that may translate into *you will not cause me pain or make my already hard life harder by making me pay more.*

Do we go along with or gratify all wishes? Certainly not, our role is often simply to understand them. Whether or not we accede to them is determined by what would be most helpful to the *relationship*.

By that yardstick, if the therapist were rich enough, he could treat a patient gratis – or alternately charge an exorbitant fee -- providing that would be helpful to the patient.

As an illustration of this concept, the famous analyst Hyman Spotnitz, a man known for his creative use of aggression, wrote how a depressed unemployed patient used to complain about "all the money he had to pay" for treatment. Sensing perhaps that the patient would benefit from a dose of "reality," Spotnitz promptly

doubled the fee. Shortly afterward, the patient found a well-paying job. Spotnitz also wrote how he occasionally treated people to a free session when he thought it would be helpful to them.

The self-worth myth

Unfortunately, many therapists use a less helpful measure in assessing what and when to charge. One colleague recently said at a therapist's meeting. "I know I should charge what other therapists in my area charge, but I always go to the lowest fee. I think it has something to do with my self-worth."

How selfish I thought. Here is an intelligent, talented therapist. Why would she be charging based on her own idea of *her* self-worth? What does a *therapist's* self-worth have to do with the patient?

Furthermore, one could argue, that keeping a fee artificially low could be dangerous. It could, believe it or not, potentially depress a patient or serve to maintain a depression.

She thought for a moment. "I have always thought so. My supervisor always told me: we must forever be guided by what is best for the patient -- what will heal them, what will help them make progress. Patients are not here to gratify our needs -- certainly not our need to have more money."

The nature of the fee and the dynamics of fee setting

Though the fee carries all kinds of symbolic meaning, it might be best viewed as a kind of concession to reality – the therapist's reality and the patient's. The therapist as we all know, whatever we represent to patients, is a human being, a citizen who must pay taxes to the IRS and buy groceries and pay for living expenses. So the therapist must make money in exchange for his service. The fee is not a product of arbitrary impulse. It is a reflection of and a concession to outer or *external* reality, not *inner* reality. When understood this way, it is possibly a *disservice* to base a patient fee on our own self-worth.

On a deeper, dynamic level, when a therapist undercharges or avoids raising fees, it could be interpreted as an activity that is designed to put off or store rage. The therapist's rage is bottled and whatever anger the client carries over the course of treatment, is avoided. Anger that is stored tends to accumulate and gather steam. It may also be expressed destructively in withholding words or missing appointments or in refusing to "get well."

Interestingly, as Anna and I continued to talk, she confided that every time a long-standing patient leaves her, she goes into a depression. She will do anything to avoid having anyone leave her. She charges low fees in order to keep patients coming and avoids raising them to keep them from leaving.

"Why," I wondered aloud to her, "will patients leave because she asks for more money?"

"Because Yisrael," she said, blowing her bangs into the air, "they get angry. And when they get angry, they leave."

"Let's be honest then, Anna. It's not that you don't want to raise fees because it's good for them. You don't want to raise fees because you do not want to anger them and because you are fearful that they might leave."

"I suppose that sounds silly," Anna said. "They really ought to be able to leave and I really ought to be able to get paid. And yet," she said, sheepishly, "I don't want to be left and I hate it when people are angry at me – especially long-standing, loyal patients. I would do anything to avoid that feeling."

Anna, like many people, finds it difficult to tolerate other people's rage. Her mother raged at her often and then would withdraw. She learned early on, that she must operate on an empathic level in order to get nurturance.

Anna thanked me for our discussion and our conversation ended on that note. Last week Anna called. "After we spoke something clicked inside me. I decided to tell my long-time patient gently, that as of January my rate for her will go up to $125. She raged and said all the things that I feared she would say: how worthless I was as a therapist and that all these years she never got her money's worth. 'I thought you were my friend,' she told me. But then the following session she surprised me, 'I felt so angry at you. I felt you betrayed me and I wanted to punish you, but in fact, I took the energy and demanded a huge promotion and a raise in a company where I had been neglected for years. Who knows? Raising my fee may have been the most helpful thing you ever did for me."

News from NEFESH Chicago

Sheldon Schaffel

NEFESH Chicago has had a very busy fall. We organized and conducted four programs for our members, the rebbetzins in our community, a joint program with the Chicago Rabbinical Council and a shadchonis program with Congregation Bnei Ruven.

1. Dr. Blair Skolnick presented an in-depth program on "Post Partum and Other Depressions." He discussed the causes and current treatment programs available. He also explained the latest drugs available to help patients. Rebbetzin Malka Schick, who recovered from depression, shared her journey back to health.

2. We conducted our second annual program for the Rebbetzins in our community, helping them understand their role as individuals who are often the first line of communication when troubled people call their Rabbis. The topic, "Understanding the Anxiety that Families Feel", was explored by Dr. Miriam Gutman, Psychiatrist; Dr. Esther Shkop, Dean, Teacher Institute, Hebrew Theological College; Dr. Vivian Skolnick, PhD Psychologist. Rivkah Eichenstein, daughter of a Rabbi, explored the issues she faced growing up.

3. NEFESH presented a program in conjunction with The Chicago Rabbinical Council on "Clergy Counseling, What are the Legal Restraints Rabbis have to Consider." Presenters were Rabbi Gedaliah Dov Schwartz, Av Beis Din, CRC and RCA; Dr. Naftali Klafter, PhD, and E.L. Pasik, Esq.

4. NEFESH and Congregation Bnei Ruven of Chicago presented a program titled, "Understanding Shadchonis in Our Community." Presenters included Dr. Roy Weiss, M.D, PhD, University of Chicago Medical School, who discussed genetic considerations; Dr. Nosson Solomon, PhD., Psychologist, President of NEFESH International, who discussed emotional issues and Rabbi Gedaliah Dov Schwartz, Av Beis Din, CRC and RCA, who reviewed halachic issues.

TENTH ANNUAL INTERNATIONAL CONFERENCE ON ORTHODOX JUDAISM AND MENTAL HEALTH

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