Clinical Social Work with Orthodox Jews: A Relational Approach

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Introduction

Relational theory is an update and integration of the various psychoanalytic approaches to clinical theory and practice. As initially developed and elaborated by Greenberg and Mitchell (1983), relational theory addresses the centrality of the interpersonal exchange as the therapeutic medium and the co-construction of meaning as the means of pursuing in-depth understanding across the individual differences that inform interpersonal relating. This position of mutual discovery and problem definition in the treatment process reflects the stance of clinical social work both historically and contemporaneously (Tosone 2004). The social work clinician in today's complex practice environment finds special relevance for the application of relational theory principles as he or she encounters the diverse racial, ethnic, religious, sexual, and other self-defining dimensions of client populations. This chapter applies relational theory to direct clinical practice with Orthodox Jews, a population that brings the challenges of interpersonal connection across differences to many clinical social work practitioners. The specific features, needs, transference and countertransference evocations, and parameters of effective treatment of Orthodox Jews are explored both to inform the worker of unique issues and to illustrate their solutions through the relational application of established clinical social work practice models.

The subject of religion has a long and controversial history among theorists beginning with Freud, who considered religion a form of obsessional neurosis (Freud 1907, 1913). His contemporary, Jung, saw religion as a universal need (Jung 1954). Relational theorists, who are by definition less dogmatic and are at odds with a priori

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assessments, focus on the individual and his or her unique experience, thereby approaching religion as a dimension of the clinical social work client's worldview. The role of religion for the social work clinician who encounters a client for whom religion plays a dominant role in their daily life is the subject of this chapter. In particular, I will look at the factors influencing the relationally oriented treatment of the Orthodox and of the ultra-Orthodox Jewish client.

This chapter provides background about the kinds of issues that may arise in clinical work with Orthodox Jews and the way the relational model can guide the clinician by applying the principles of mutually co-constructed clinical social work practice. It will provide a necessarily limited introduction to the belief system and practices of Orthodox Judaism and be followed by a discussion of how relational theory has evolved and interfaces with Jewish traditions. Principles of engagement and practice for practitioners and supervisors dealing with Orthodox Jews in their practice are illustrated by a number of clinical examples that demonstrate the application of these principles. Finally, it will demonstrate how relational concepts can be functionally applied in clinical social work with this population, as well as identifying areas of theoretical incompatibility that need to be acknowledged and addressed in the theoretical field.

Relational theory, which provides an orientation to engagement, assessment, and treatment planning that allows the practitioner to recognize, respond to, and demonstrate meaningful cultural competence with the client and his or her immediate service needs, serves the practice guidance needs of all clinicians. This includes the clinician who is not identified as Orthodox, who represents a different sect within Judaism, or who may himself or herself be Orthodox. Those less familiar with the Orthodox may experience concern about understanding the detailed teachings that shape the lives of the Orthodox. Conversely, the Orthodox clinician who can identify with and understand this client population may over-identify, develop countertransference responses, and fail empathically in other dimensions of his or her clinical work. Clinical social work clients are, after all, seeking help with problems of living. A religious context of practice determines perspective, treatment options, and relational parameters but may also require culturally sensitive deconstruction of its interaction with human struggles of all kinds.

Judaism and Relational Social Work

The history of Judaism and relational practice captures the often conflicted relationship between the individualism of a psychodynamically informed theory of experience and functioning and the tradition of hierarchical and collective perspectives on living that define membership in a defined population. The relationship between clinical theory and Judaism begins with Freud himself, with his intense rejection, first of his own Orthodox Jewish background, and then with rejection of all religions. The early practitioner, following Freud's drive theory, considered religion a type of pathological defense mechanism (Jones 1957). While there were prominent

early defectors from this psychoanalytic orthodoxy, notably Jung and Adler, the hostility to religious practice as opposed to the Freudian "scientific" model continued well into the 1950s (Greenberg and Witztum 1991, 2001; Rubin 2004).

The emergence of object relations theories introduced by Fairbairn (1952); Guntrip, Winnicott (1958), and Klein in Europe and the interpersonal theories of Sullivan, Horney (1942), and Fromm in the United States emphasized the importance of relationship as a fundamental human motivation and thus challenged the primacy of drive theory and infantile sexuality as drivers of behavior with a model based on interpersonally co-constructed relationships (Greenberg and Mitchell 1983).

This broadening perspective provided a new realm for consideration of religious motivation. Indeed, "spirituality" has become increasingly recognized as an aspect of mental health. The desire for spiritual connectedness (Welwood 1996; Rubin 1999, 2004) is now viewed as a legitimate and valuable aspiration. The religious orientation that has gained the most acceptability is Eastern spirituality, which emphasizes meditative practices and is decidedly not monotheistic (Rubin 2004). Nevertheless, clinical social workers still encounter a wide range of clients who are members of faith-based communities. Like others affiliated with faith-based communities, followers of Orthodox Judaism are highly sensitive to perceived criticisms of their customs, which lie outside the frame of mainstream American culture, which are linked with political turmoil past and present, and which may be unfamiliar to most clinical social work practitioners.

Just as the relational theory privileges relationships, particularly parent–child relations, over drive theory's emphasis on instincts as the root of psychological development, it also reclaims the important role of social relationships in contrast to Freud's disdain of sociological explanations. Relational theory reminds us of social work's original emphasis on the bio–psycho–social framework and the person-in-situation framework for understanding self experience and current functioning (Tosone 2004). While the movement toward inclusion of cultural factors has been met with resistance in psychoanalytic theory, clinical social work has readily embraced relational theory as an outgrowth of psychoanalytic thinking. With its constructivist roots, relational theory unifies in-depth individual dynamic understanding with the sociocultural forces surrounding and shaping the past, present, and future contexts for that individual (Goldstein 1995; Hollis 2000; Berzoff et al. 2008).

The notions of relationship seeking as a primary driver of behavior, and the importance of being part of an interpersonal group giving meaning to and organizing the thoughts, feelings, and values that guide the individual's behavior, are congruent with relational theory and with the roots of clinical social work (Tosone 2004). Even Winnicott (1945, 1948), among the psychoanalytic theoreticians, emphasized the power of membership as an interpersonal holding environment. Following this paradigm, the individual's connection to his or her God can be understood as a meaningful relationship that is part of the internal object relation world (Meissner 1984). This would similarly be true for a member of a Christian or Muslim believer who interprets their sacred text literally and bases their daily activities on a relationship with the God of their understanding.

Clinical social work practice with a person for whom religion plays a prominent role requires an acceptance of and sensitivity to how that person lives his or her religion and how it affects his or her relationship to others. McWilliams (1994) observes that "a deeply religious person of any personality type will need first for the therapist to demonstrate respect for his or her depth of conviction" (p. 17). While there are many ways to become familiar with a specific population, it is important to introduce this group descriptively, to cognitively prepare for engagement with Orthodoxy. The challenge is to conduct clinical practice with Orthodox Jews without making assumptions based on shared religious beliefs or to impose their beliefs on clients in the guise of clinical advice. To the non-Orthodox practitioner, ritual observances of Orthodox Jews may seem mystifying and atavistic and thereby entwined with the pathological. This intersection of the community and individual becomes a dominant factor particularly when working with members of ultra-Orthodox groups. The natural extension of the relational orientation includes the importance to observant Jews of being part of a community as well as the seeking of God as an object that meets the legitimate needs of individuals.

Orthodox Judaism: Some Central Practices and Beliefs

Judaism is the oldest monotheistic religion. There are currently 14,824,000 Jews worldwide and 5,720,000 Jews in North America (World Almanac 2012, p. 699). American Judaism is divided into four primary branches – Orthodox, Conservative, Reform, and Reconstructionist. These branches vary in degree of liberalism in interpretation of the guiding texts of Judaism. Orthodox Judaism is the most strict and traditional branch, encompassing those who interact with the larger community and those who stay apart. The "modern Orthodox" wear ordinary clothing, generally go to college, and work in many professions. By contrast, the "ultra-Orthodox" generally keep themselves separate from the influences of outside culture, avoiding television, movies, and the Internet. For the men in this group, study of Torah is considered a legitimate full-time professional pursuit. Although many Orthodox find the "modern" and "ultra" categorizations culturally insensitive, they are commonly used to describe real differences.

Key Observances

The most traditionalist ultra-religious group is called *haredim*, which include Hassidim. The majority of this group migrated to the United States after World War II and is the most easily identifiable, insular, and segregated. They have recognizable differences in customs and clothing, maintained since the mid-1700s, and continue to use Yiddish as their language. Their communities are organized around the leadership of a rabbi, or *rebbe*, who is the final arbiter of all issues, religious and nonreligious. They consider their goal in life to be the perpetuation of Jewish

laws, practices, and observance, and conduct is defined by extreme religious dogma and principle (Poll 1962). Orthodox Judaism maintains sharp gender-role distinctions (Levine 2003). Males and females who are not related cannot touch each other, even to shake hands, and gender-specific religious rituals shape daily life. Their world is often full of drama, intensity, and, for some, a craving to break the rules (Levine 2003). Such clients therefore present a rigid yet often conflicted picture for the social work clinician, who must help the client sort out the individual from the group expectations without violating religious imperatives.

Most Jewish observance is outlined in numerous holy texts beginning with and extending from the Torah (the Old Testament) and other texts, including the Talmud (a codification of laws) and various responses. These codify for Jews how and what to eat, rules regarding sex and procreation, rituals around death and mourning, and how generally to behave in relationship to others, including family, strangers, and even animals. The genesis of these laws is the bargain God offers the Jews that He will care for them if they obey His commandments. Rules of daily living are spelled out with great specificity and are strict and binding, with severe punishments, including ostracism from the community, for noncompliance. One example of this is the set of instructions in the bibllcal book of Deuteronomy that deal with food and food preparation. Orthodox Jews are only permitted to eat kosher food (Hertz 1981). They do not mix meat and milk products or eat "unclean" animals, such as pig, and are constrained from involvement with people who do not follow these laws. Thus familial, social, and professional experiences are impacted, and the most observant would not go outside the Orthodox community, including to seek professional clinical help. When social realities (access, fees, presenting problem) do cause the Orthodox to make compromises, awareness of these issues requires the relationally attuned clinician to take care to avoid deviations from prescribed practices as much as possible. For example, patterns of greeting would not include a handshake, and assessment might include such questions as, "What might your rabbi say about…?"

Clinical practice of any kind is forbidden on the Sabbath. The Ten Commandments state: "Remember the Sabbath day and keep it holy. Six days shall you labor and do all your work, but the seventh is a Sabbath of the Lord your God" (Exodus 20:8, Hertz Second Edition). Orthodox Jews do no work of any kind on this day, and work is defined broadly, including earning of wages, traveling, pushing an elevator button, cooking food, or even tearing toilet paper. Asking another Jew to violate the Sabbath by any such actions is equivalent to violating the law personally. Similarly, suggesting an appointment on a Friday night, when the Sabbath begins, through Saturday night would be a significant breach, demonstrating insensitivity to the most important of all religious practices. This would not necessarily be the case for many Conservative or Reform Jews, who have more liberal practices, but the clinician needs to assume observance applies unless informed otherwise. While it is unreasonable for every clinical social worker to have expert knowledge in all dimensions and variations of any population of diversity, it is not unreasonable for his or her to have a method of discovery and connection with his or her client that includes the client's freedom to express and adhere to specific belief constraints. The relational principles of inquiry, not knowing, and mutuality in establishing practice orientation serve this purpose well.

Gender, Sexuality, and Family Life

Another aspect of Orthodox Jewish practice has to do with laws relating to sexuality, sexual purity, and sexual modesty. There are extensive rules relating to purity and modesty. One example is the instruction for married women to wear a head covering, a cap or wig, after marriage. Orthodox rules of modesty also can affect open and frank discussion and even problem solving in couples. Guilt and shame, recurring religious motifs, can create resistances to self-disclosure which the relational clinician will be able to understand not as unconscious conflict per se, but as reflections of internalized identifications with a religious reference group.

The Orthodox Jew as Client

In some communities, specifically including Hassidic, the rabbi is consulted on all matters, not only religious. In other Orthodox communities, the rabbi is consulted on religious issues and sometimes about crises not pertaining to religion, such as marital and sexual problems, addiction, violence and abuse, and severe psychopathology. The social work clinician, working relationally, can be open to collaboration or referral to rabbinic counsel. The client's preference for addressing different problems with different professionals can effect positive connections to clinical experiences.

Orthodox Jews come to the attention of clinical social work practitioners in a wide variety of settings, from mental health clinics to domestic violence services to all forms of medical and health-care centers and every other arena of social services. For an Orthodox Jew, seeking clinical or other social work services outside of his or her sect may represent a break from traditional modes, and a bridge must be built through respect for religious observances as well as the emotional quality of the relationship, so highly correlated with positive outcome of treatment (Strupp 1989).

Engagement, from the outset, requires reference to Jewish law. For example, while it is unusual for an ultra-Orthodox man to be in treatment with a female clinician, the female clinician should not extend a handshake and may need to accommodate the prohibition of being alone with a female, and vice versa, by leaving a door ajar. Speaking ill of others and all forms of gossip is considered sinful, so telling a clinician about specific relational problems is violating this restriction. Assuring a client that these problems are confidential and their conveyance is for no other purpose than alleviating pain helps clients understand that this is not "idle gossip." This is an ideal opportunity for the clinical social worker to demonstrate the principles of openness about his or her own knowledge or lack thereof, mutuality of problem definition, and exploration of resistances as instances of conflict that contain critical religious and personal information. Since the Orthodox client accepts constraint on personal choice by religious doctrine as a value in itself, a clinician must not confuse defensive structures with religiously determined rigidity. In this person-in-situation perspective, religious aspects of the situation are

largely immutable, and the area of clinical focus must be on the individual client's experiences and range of options within that situation.

A particularly complex exception to the social worker's acceptance of Orthodox rules is the Orthodox client who is struggling with his or her religious convictions. This delicate issue, often implicit rather than stated, must be allowed room to emerge, in the spirit of "potential space" (Winnicott 1967; Bollas 1987), constructed of the clinician's empathic attunement to and reflection of the client's communications. This is particularly true when the individual questions how an all-powerful God can permit seemingly needless suffering and tragic natural disasters. Whether the social work clinician is Orthodox or not may shape discussion of such questions of conviction. This is one reason that non-Orthodox social workers need preparation to work relationally with the Orthodox: their outsider status may facilitate potential space if they can demonstrate respect and understanding of what is at stake, including membership in a closed community as well as religious observance.

For example, a gifted supervisee reported a first meeting with a potential Orthodox client who initially asked, "Are you religious?" "No," she answered authentically, adding "I was never able to have that experience but I do believe that I am a spiritual person." A successful clinical experience followed from that meeting of the Orthodox client and nominally Catholic clinician based on this opening of shared space. The Orthodox clinician, likewise, must demonstrate respect for the client's individual relationship to his or her religious membership, even if deviating from the group rules in some ways. The relational stance of constructing the client's meanings and feelings by interactive search for clarity will offer assurance that judgment or ignorance of the issues will not interfere with a commitment to the client's trajectory of clinical exploration. The utilization of mirroring (Winnicott 1967) by the relational clinician can help the client to see the role religion plays in his or her life and how it shapes the way he or she relates, including the way he or she relates to the clinician.

Individuals seeking clinical social work services may be struggling with conflicts about religious adherence and subsequently go beyond the traditional system of seeking rabbinic counsel. Some Orthodox rabbis will refer their congregants to trusted clinicians who they feel confident will support religious practices. Conflict with a too strict or abusive parent, for example, would be a difficult subject for a rabbinic authority, but could be handled in the holding environment with a relational clinician. Orthodox clients do develop strong attachments to non-Orthodox clinicians who are empathic and do not pathologize or undermine religious practice. An Orthodox colleague once shared, "I will only work with my Italian Catholic analyst because he does not pathologize my religion."

One arena of clinical practice that is particularly complex for Orthodox and non-Orthodox practitioners alike is that of Orthodoxy and homosexuality. A 2007 National Survey of American Jews reported by Ariel (2007) shows that 7% of American Jews are lesbian, gay, or bisexual. Orthodox homosexuals, particularly the youth, feel shame and fear of exposure and often suffer severe ostracism if they reveal their homosexuality (Ariel 2007; Davis 2008). Disclosure of homosexuality, as well as many other issues, affects marital prospects of siblings and casts shame on the entire family.

In 1973 the American Psychiatric Association voted to remove homosexuality from their list of sexual pathologies, and this was included in the revised Diagnostic and Statistical Manual (American Psychiatric Association 1980). While this opened the door for all homosexual men and women to seek clinical services to deal openly with issues in living rather than to change or conceal their sexual orientation, Orthodox clients report catastrophic experiences of rejection by family and community, feelings of alienation and marginalization, and continued wishes for inclusion. A still current explicit Orthodox position states that homosexuality is a choice and can be either suppressed or "cured" using conversion therapies (Ariel 2007). Relational theoreticians reject "cure" out of hand, along with the Freudian definition of maturity as mature heterosexuality. Rather, in the relational perspective maturation is reflected in self-cohesion that includes sexual identification (Mitchell 1988; Kohut 1984; Berzoff et al. 2008). Still, acceptance by the clinical world does not translate into acceptance by Orthodoxy.

Judaism and Relational Theory

Judaism, while prescriptive and laden with consequences for transgressions, is nonetheless a religion that contains teachings about tolerance and higher-order principles of righteous living. In few other religions does one find a God portrayed as so punitive, exacting, and jealous as the God of the Jews. Jews see themselves as having an authority-driven relationship with a God who offers the ultimate reward, punishes severely for transgressions, yet commands the people to live justly, have mercy, and to show compassion. Sorting this out is an individual process and occurs in a relational matrix. Buber (1937) asserts that man's relationship to God is a personal one. He stated that God, who is presumably both spirit and personal, is clearly and unequivocally object seeking and has both direct and indirect relationships with His people. They, in turn, are always seeking expressions of their relationship with Him.

The whole conceptualization of good self-development and the sources of personal happiness or suffering are defined, for Jews, as the products of being in the right or wrong relationship with God. There are no intermediating factors or abstractions: healthy self must be a self without conflict with God's rules, and rabbis function to interpret situations according to those rules. The clinician should stay attuned to this representation of the core relationship: mutual construction of meaning and behavioral adaptation supports the validity of the client's quest for a unique solution to problems that align the client with his or her religious convictions.

Eigen (1981), in *The Area of Faith in Winnicott, Lacan and Bion*, introduced religion into the relational sphere, stating that "By the area of faith I mean to point to a way of experiencing which is undertaken with one's whole being, all out, with all one's heart, with all one's soul, and with all one's might" (p. 3). Here, even partially quoting words from the Sh'ma, the central prayer of the Jews, Eigen admits

religious faith into the fabric of relational theorizing: "In transitional experiencing, the infant lives through a faith that is proof to clear realization of self and other differences…." (Eigen 1981, p. 4). Fromm (1950) developed his own position that some obsessional rituals can be viewed as a private religion, but he clearly added that religious belief does not need to be "cured." Eigen's position can help doubtful clinicians sort through some of their own religious questions in preparation for challenging clinical situations.

Relational Theory and Practice: Congruence with Orthodox Judaism

What does working within relational theoretical frameworks offer the clinician working with Orthodox Jews and the clients themselves over more traditional schools of social work theory or psychoanalytic thought? Freud himself was an atheist who communicated often his understanding that religious belief was an illusion and that belief in God was a projection of early wishes for protection by an omnipotent parent figure (Freud 1927). This bias affects many traditional psychoanalysts and psychoanalytically oriented clinicians who also see themselves as grounded in "science" and view science as antithetical to religious belief and faith. Applying a relational theoretical model offers Orthodox Jews a framework which does not, out of hand, reject basic belief. A number of relational theoreticians offer a view of religious belief and a bridge between traditional psychoanalytic positions and social work positions that favor adaptation and behavior over internal self-cohesion.

According to McWilliams (1994), "Longings for the omnipotent caregiver naturally appear in people's religious convictions" (p. 106). Goldman (1993) cites Winnicott as speaking of the therapist in the transference as an omnipotent holding object, but not rejecting a belief in a supernatural God. He also quotes Winnicott (1985) as stating "Psychotherapy does not prescribe for a patient's religion, his cultural interests or his private life, but a patient who keeps part of himself completely defended is avoiding the dependence that is inherent in the process" (Goldman 1993, p. 75).

Emmanuel Ghent (1990) develops another position, viz., that there is a universal need or wish for an experience of surrender that takes multiple forms, including religious surrender. He supports the religious position without interpreting belief in God as a wishful myth. Relational social workers, embracing their understanding both of early transference manifestations and other early archaic experiences of the infant and child, are in a good clinical position to understand and truly empathize with an "I–Thou moment" and its importance for Orthodox Jews. In understanding the earliest interpersonal encounters, the clinician can demonstrate his or her attunement to the power of religious force and its place in human experience.

Engagement: Starting Where the Orthodox Client Is

A question for clinical consideration in working with Orthodox clients begins with the impetus for seeking clinical help. What change is desired and how can change be achieved? The immediate client/clinician relationship offers a nonjudgmental arena for the client to explore deeper layers of meaning about his or her presenting problems so long as the framing of conflicts is congruent with the religiously informed definition of self-in-relation. Is he or she struggling with relationship problems or what Sullivan (1954) called problems of living in the present or with issues reemerging from and complicated by early childhood struggles? The question of why the client is seeking out a social work clinician rather than a rabbi is a fruitful point of engagement. If a clinician works in a Jewish social service agency, the client population may receive a variety of services from that agency in a venue that would be acceptable to the community. In other settings, the question may have particular salience. Receptivity to an interest in the patient's religion as well as the circumstances of religious conviction that surround the clinical encounter must be accomplished lest the client reject the treatment and perhaps internalize or reenact discriminatory relationships from his or her own life.

The religious orientation and self-presentation of the social worker and of the client are often obvious in their first encounter, by the dress or other physical presentation, evoking transference and countertransference reactions from the outset. Active work with this nexus is a relational theory expectation and contrasts with the classical psychoanalytic position of the blank screen clinician onto which the client projects. Silence about points of apparent similarity and difference is not constructive with most Orthodox clients. The clinician needs to be more accessible as a real person interested in two people coming together in a shared therapeutic encounter (Greenberg and Mitchell 1983). Bowlby's (1969) formulation that good clinicians use the language of feeling and emotion to communicate with clients is germane: it utilizes common ground for the relational social worker's proactive inquiry and pursuit of mutual understandings and treatment goals.

Emphasis on the real relationship illuminates transference concerns and is a significant departure from the non-relational models that emphasize more distance, abstinence, and neutrality. The aim of such openness is to establish a positive working alliance as well as a positive transference and countertransference relationship, seeking to illuminate and dispel any earlier negative experiences, including clinical experiences that would affect the establishment of a beginning bond for the work. A stance of openness to listen and understand, rather than to evaluate and interpret, is a proactive one for the relational clinician. Once a bond has been established, transference issues beyond those relating to Orthodoxy can be investigated or revisited.

The role of the supervisor is crucial for clinical social work practitioners working with Orthodox clients. Ideally the supervisor would be at least somewhat familiar with the practices, beliefs, and customs of the Orthodox community in order to educate supervisees accurately. The supervisor is charged with encouraging the worker to be as frank as possible regarding their reactions, thoughts, and feelings. In supervision, the social work clinician can be invited to acknowledge areas of uncertainty

of understanding, responses, confusions about how to work with religiosity in connection with presenting problems of daily life, and the like. The relational aspects of the supervisor/supervisee are the model for the work and require the supervisor to have a real relationship with the supervisee. This can include a tactful exploration of the clinician and supervisor's religious orientation and its relationship to treatment.

A Case of Relational Social Work Practice with a Female Orthodox Client

An Orthodox female, Amy, presented for treatment wearing a snood, the traditional headscarf worn by ultra-Orthodox women. While she seemed easily identifiable in this way, I had to resist quick assumptions about her, knowing that assumptions, even if they prove correct, are relationally counterproductive. Though I had expected that I was meeting an Orthodox client, based upon the source of the referral, I had worn a sleeveless top rather than more modest dress. It was one of those steamy summers, but nonetheless I was giving a message about my position on Orthodox rules of dress. I quickly felt self-conscious about being sleeveless and wearing dramatic nail polish. I was intensely aware of how I appeared. Following the relational principle of ongoing self-reflection in the treatment setting, I asked myself why I was inviting assumptions by the client that I knew could be provocative.

As is the case when beginning with all clients, mutual scrutiny was occurring. With Orthodox clients, this scrutiny reflects the expectation of relational misalignment that they live with in daily life as a visible minority. In the earliest part of our meeting, the client asked if I understood her background. I responded authentically but with neutral affect, offering information without persuasion: I said that I was familiar with traditional Jewish practice. I also said that I wanted to be able to understand her experiences. Despite this overt exchange about whether I was sufficiently attuned to the Orthodox culture, her noticeable reaction to my manner of dress, indicating I was not as observant a Jew as she was, was a transference and countertransference moment not to be wasted. While this unspoken "collision" (Bromberg 2011) no doubt contained developmental precursors (Why had I chosen not to dress according to Orthodox rules? Why had she chosen to maintain her dress observance?), an interpersonal exchange was occurring in the present and shaping the mutual exchange process, where relational practice directs its primary focus. I contained any tendency to be defensive and tested the capacity to have open and authentic exploration of religiously prescribed matters. I stated that I sensed her reacting to my way of dressing. She responded with "I noticed your green nail polish; I wore that once and my mother objected." I continued the here-and-now relational exchange, inquiring what my deviations from the strict rules meant in terms of our working together on her concerns. She stated, "I do sense that you are sympathetic and sincere." I did not pursue this response except to nod in acknowledgement, seeing it as an example of co-constructing a shared space in

the client-with-clinician relationship where variation could exist (from Orthodoxy, from mother's authority) without it being a violation that led to flight. She had asked, rather than judging silently, about my capacity to be informed about her orientation, and she responded to my question about our differences with reflection on her own experience. As Bromberg (2011) notes, the "collisions" that bring dissociated material into conscious interaction are key relational treatment elements in themselves: creating in the interpersonal exchange a shared space that contains variations expands tolerance for internal dissonance.

The client's response added to my assessment that, despite a physical presentation of hesitant uncertainty, this woman possessed an intact self, adequate to be expressive and assertive about her concerns. She also communicated an emotional intuitiveness, attentiveness to relational issues, and an ability to discriminate between people on the basis of human rather than solely religious criteria. The practice knowledge gained in this simple exchange, preliminary but highly informative, demonstrates the strategic and relationship-building self-disclosure that is one of the distinctive principles of relational approaches (Aron 1991). It also demonstrates how this kind of openness addresses the sensitivity of Orthodox clients, and other marginalized clients, to having a real need to know about safety in the clinical social work process.

While this client and I were not both Orthodox Jews, we were co-participants in this sharing of perceptions of ourselves as mutually engaged, working on the edge of intimacy (Mitchell and Aron 1999) as we established other areas of similarity. We communicated a considerable amount in this exchange. She talked about her mother, about awareness of the impingement of her Orthodoxy on her choices, about her attunement to differences as raising valid questions of understanding. By airing those questions about encompassing diversity in traditional Jewish background, we were able to create a mutual exploration process. The exploration is not a questioning of the centrality of cultural identity for the client's well-being. Rather, it is an entry into discussion of how the client's cultural identity informs her thinking about the many issues that may arise. Many Jews "return" to Judaism, especially to Orthodoxy, after being raised in less religious or nonreligious families. Some of these *baal teshuva* (returnees) do so for spiritual reasons; others make this choice unconsciously as expressions of difficulty in the family of origin. At this point, with Amy, the relevance of her Orthodoxy to the core problem that brought her to treatment was not yet spelled out. However, the need to establish an interpersonal connection wherein problems or concerns could be examined in context of religious observance had been established.

This greater degree of self-disclosure is consistent with most relational approaches and is generally indicated with Orthodox clients, who need to know that you understand, or wish to understand, the rules by which they live. The relational stance is one that can include the sharing of relevant information, as compared to a client giving information to a more traditional clinician, who receives manifest and latent details, lying in wait to interpret unconscious motivations. As Goldstein (1995) states, "In ego-oriented intervention the worker generally permits his or her personal qualities to enter the client-worker relationship in a disciplined way based on his or her determination of the client's need and therapeutic goals" (p. 201).

A Case of Sexual Issues with a Male Orthodox Client

Ari, a highly sexual Orthodox male, adhered to the religious requirement to have sex for only two "clean" weeks of the month, when his wife was not menstruating and only after she returned from the ritual cleansing bath. Ari came to treatment with a particular struggle: it was both an internal conflict and one between him and his wife. He was beset and disturbed by his sexual preoccupations, with a sex drive he felt demanded gratification by having sex "off schedule" or alternatively by masturbating. Though conflicted about these alternate routes to gratification, they were for him stopgap measures. Ari reported craving regular sexual encounters in order to feel emotionally reassured by and connected to his wife. At times he spent hours negotiating with himself before masturbating, feeling intense shame and weakness about his inability to control this behavior which had been expressly religiously forbidden and pathologized by his rabbinic teachers. Sometimes he pressured his wife for sex during her unclean weeks. Living in this constant bind led to frustration, anger, and bargaining with himself and others, including many debates with God. Ari even sought loopholes to express or to get around his "bestial impulses." Simultaneously, he seemingly self-righteously, perhaps defensively, justified these urges that competed with his mostly pious, religious observance.

In this clinical example, employing both a Darwinian and Freudian perspective, Ari could be viewed as a man plagued by normal impulses that strive for gratification to achieve his own satisfaction. To live in civilization, Freud (1930) posited that man, through the internalization of the superego, in this case religiously defined, must force himself to resist natural, understandable sexual urges. This theoretical model fits neatly if problematically with Ari's conception of self-regulation by religious laws. The Talmud states that man has two opposing inclinations, a good inclination (*yetzer hatov*) and an evil inclination (*yetzer hara*), and mastering and balancing these two inclinations is ongoing through life. Freud's drive theory bases civilization on requiring repression and suppression of sexual and aggressive drives for the survival of the social group. Jewish law attempts to solve the same problem by codifying and prescribing sexual behavior.

As Ari requested, I consulted first with an ordained Hasidic rabbi who was also a social work professional, asking him to research any possible exceptions to the laws of sexual abstinence, which provisionally would allow Ari to masturbate or to have sex with his wife during her unclean weeks. The rabbi moved around the question respectfully but deftly, saying that there were some obscure references to the possibility of masturbation under special circumstances. However, he related, interpretations relating to these abstinent periods had to do with the importance of creating space to enhance a couple's nonphysical intimacy.

This emphasis on the interpersonal ramifications moved the issue back into the clinical social work practice sphere, placing sexual expression in a relational perspective. The social work clinician can validate the client's attention to his urges as a good dynamism, worth holding, but simultaneously underscore the significance of his relational needs. The relational model communicates the formative impact of early childhood experience as the source of disconnection between the biological and relational drives. In this larger clinical context, Ari's dilemma was created not only

by his basic maleness but by how he internalized complex parental, rabbinic, and scriptural messages. If parents and rabbis communicated many complex messages about his phallus and his sexuality, his urges have not only pressure but also meaning, perhaps aimed at reassuring him, diminishing his anxiety, and otherwise being compensatory for relational longings. Ari could be helped to delay gratification and sustain connection by expanding his understanding of himself as a person who was not solely infantile in nature, but rather moving progressively through stages of development toward integration of primitive and more mature forms of meeting his needs. In this symbolic way, the relational model unified Ari's struggle religiously and clinically, one shoring up the other. Specifically, it moved Ari from viewing himself as less primitively constructed and significantly impacted his marital relationship.

Conclusion

In groups classically under siege, as has historically been the experience of Jews, the probability of developing a bunker mentality is high. This mentality leads naturally to an "us against them" position and a "we will take care of our own problems" stance. This self-protective orientation can lead to insularity and repetitive experiences where pathological scenarios are repeated and reenacted without transformation. An empathic attunement to the complex experience, including the outsider status of such a group, promotes a respect for the stress created by being a stranger in a strange land. The clinician can potentially utilize this knowledge in clinical engagement by assuming and dealing with a position of mistrust and by creating levels of safety. The relational clinician employs distance as well as self-disclosure, maintenance of a positive transference relationship, and expressions of affirmation and approval to reinforce the mutuality of the task of therapy. "Mutuality involves being engaged in a growing connection with another person. As the relationship unfolds, honoring the uniqueness of each other becomes integral to the growth of mutual respect" (Freedberg 2009, p. 87).

In revisiting and comparing relational theory to clinical social work and traditional casework theory, we see that there are few differences. Both employ a generally accepting relationship with the client, working within a person–situation and environmental fit and informed by a bio–psycho–social matrix without being limited to, or excluding, an explanation based on infantile sexuality. Working with Orthodoxy parallels working with familiar concepts of family hierarchies and models of relationship. The social work clinician is not pursuing changing religious convictions, but instead decoupling them from residual familial conflicts. Ultimately, the issue for clinicians is the stance of co-construction that focuses on the person-in-situation matrix, a bio–psycho–social history, and the existential facts of each person's life. The clinician's empathic response, rather than their theoretical orientation, is the crucial factor in helping the individual find their way out of the pain that brought them to treatment in the first place. The crucial dimension of cultural competence in dealing with clients from various backgrounds highlights the importance of being in a relationship with the client that honors their lived experience. Relational theory is where traditional social work has always been.

Study Questions

1. What have you learned about Orthodox Jews that alters preconceived notions about what a relational clinician would need to bear in mind in practice?
2. How does a secular bias in psychotherapy impact on working with religious Jews? Give an example and generalize about ways in which secular bias can have an impact on practice.
3. How might a relational clinician approach a client who ascribes to the authority of a religious figure, such as a rabbi? What role may this person play, and how could it affect the role of the clinician?
4. What part does countertransference play when working with clients who have strict customs to which they adhere? Give an example of a time when you have had such a reaction and what relational skills you used to manage the situation.
5. What relational social work principles were illustrated in the cases of Amy and Ari? Identify one in each case, and explain how the case material demonstrated the principle.
6. What might you begin to do to prepare for work with Orthodox Jews? As a relational clinician, what are your feelings about needing to incorporate previously unfamiliar cultural information into your practice?

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