Dr. Benzion Sorotzkin, Psy.D.
Clinical Psychologist
Brooklyn, NY
www.DrSorotzkin.com
bensort@aol.com

CHEMICAL IMBALANCE, GENETIC MALFUNCTION, OR PROBLEMS IN LIVING? *

Not too long ago psychologists and other behavioral scientists prided themselves for their ability to understand emotional problems in depth. They didnôt limit their perspective and analysis to the proximal, superficial causes of peopleôs difficulties. Rather, they looked for the underlying causes of these difficulties by exploring early childhood experiences that shaped the developing psychic structures (e.g., self-image) and the current interpersonal conditions that interact with the influences of those psychic structures. This helped them and their patients understand what made this particular person vulnerable to particular stressors where others wouldnôt have been so affected. They therefore, understood that current distressful events do not bring about emotional disorders by themselves. Rather, they interact with the personôs emotional makeup and especially with the vulnerabilities that resulted from his early life experiences (Barlow, 2002, Chap. 8).

Therapists often had to contend with the resistance of individuals, families, and even communities, to acknowledge these deeper and often subconscious causes of problematic behaviors. This was especially true when it involved a negative assessment of parenting.

In recent years, perhaps as reaction to the pressure to solve problems quickly, many therapists have moved away from this ñin-depthò perspective, both in therapy and in regard to understanding community wide problems. Technical innovations that promise quick results, with little need to understand the personal meaning of symptoms or the historical reasons for their development, became increasingly popular.

Cognitive – Behavioral Therapy

A short-term therapy that has become the treatment of choice for many, if not most, young therapists is Cognitive-Behavioral Therapy (CBT). CBT is held up as the paradigm of modern, evidence-based therapies that are effective, short term, and focused on the present. It is often contrasted with what the proponents of CBT consider the old fashioned, unscientific and

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ineffective, long-term psychodynamic psychotherapy (or depth psychology) that ñunnecessarilyò focuses on the past.[1]

Much of what is assumed to be true about CBT has been questioned by serious researchers, but deeply held convictions seem to die hard. This is especially true regarding convictions that fill the emotional need for quick and easy fixes. Drew Westen, Ph.D., Director of the Laboratory of Personality and Psychopathology at Emory University has published numerous research articles (available at www.psychsystems.net/lab) on the effectiveness of various forms of psychotherapy. I believe he is considered to be a relatively objective scientific observer. I would like to cite some of his comments from his recent extensive review article in the *Psychological Bulletin* (Westen, Novotny, & Thompson-Brenner, 2004) on another related trend in psychotherapy - empirically supported therapies (ESTs).

In recent years there has been a movement to use, and to train therapists exclusively in the use of, empirically validated or supported therapies. This movement has led to manualized practice guidelines for various emotional disorders. Most often, these treatment manuals advocate the use of Cognitive-Behavioral Therapy (CBT). ESTs are often ñdistinguishedé from the less structured, longer term [psychodynamic] treatments conducted by most practicing cliniciansò (Westen et al., 2004, p. 632). Psychodynamic therapists who do not adhere to these EST guidelines are portrayed as old fashioned incompetents who refuse to conform to scientific data.[2]

Among their many criticisms of ESTs Westen et al. (2004) point out that:

> Many of the assumptions underlying the methods used to test psychotherapies were themselves empirically untested, disconfirmed, or appropriate only for a [limited] range of treatments and disorders. (p. 632)

Westen et al. (2004) discuss a monograph commissioned by the American Psychological Society (APS) on the treatment of depression. The monograph cites numerous studies that show that CBT, and a number of lesser known brands of 16-session psychotherapies produce initial results comparable to those obtained with medication. Over the course of 3 years, however, there is an unacceptable high rate of relapse for those treated with these brief therapies as compared to those maintained on medication. An honest appraisal of these results would be that brief therapies are ineffective for treating depression and perhaps the traditional long-term therapies are indeed necessary for lasting gains. Yet the authors of the monogram came to a very different conclusion, that only long-term ñmaintenanceò versions *of these short-term treatments* are empirically supportable!

Westen et al. (2004) also highlight major shortcomings in many of the studies that purport to prove the superiority of CBT over psychodynamic psychotherapy. Many of the studies, for

[1] Contrary to popular perception, modern research has, in fact, confirmed most of Freudôs core propositions (Westen, 1998).

[2] Westen et al. (2004) relate the following incident: The national licensing examination in psychology now includes a series of questions about the ñcorrectò treatment for disorders such as depressioné . [O]ne colleague who indicated that his theoretical orientation was other than CBT was asked why he practiced ñan outmoded form of treatment.ò (p. 642)

example, compare CBT to treatments purported to be similar to psychodynamic therapy (e.g., ñsupportive-expressive therapyò) but, in fact, they are not constructed to maximize their efficacy (what he calls *intent-to-fail* conditions). In one widely quoted study that supposedly demonstrates that CBT is superior to psychodynamic psychotherapy for bulimia nervosa, the clinicians utilizing the ñpsychodynamically inspiredò therapy were forbidden to discuss the bulimia with the patient! Can one imagine a competent psychodynamic psychotherapist treating a bulimic patient without discussing bulimia with him or her?

Westen et al. (2004) cite a study where researchers reviewed transcripts from cognitive and short-term psychodynamic therapies for depression. The study found that therapists from both groups use techniques from each otherôs approach and that ñpositive outcome was associated with the extent to which the treatment matched the empirical prototype of psychodynamic psychotherapy [p. 639].ò In fact the extent that the cognitive therapists used cognitive techniques was found to be unrelated to the success of the therapy.[3]

"Innovations in CBT"

Our field has so distanced itself from depth psychology, that when CBT advocates realize that an in-depth understanding and a focus on the past is indeed necessary in order to truly help patients, it is presented as a ñnew innovationò in CBT. One example was noted above from Westen et al. (2004) when it was discovered that short term CBT leads to an unacceptable high rate of relapse, the solution was long term ñmaintenanceò ï as long as the forbidden phrase, ñlong-term therapy,ò isnôt used.

In an article discussing the cognitive-behavioral treatment of those who experienced chronic childhood trauma, Goldsmith, Barlow, and Freyd (2004) advocate ñadopting a contextual-ecological perspective whereby symptoms and problems must be evaluated in historical and current environmental and interpersonal contexts in which they developed and are maintained [p. 457].ò This is presented as a new innovation in CBT when, in fact, this was always standard practice for any in-depth psychological treatment.[4]

Jeffrey Young has introduced ñSchema Therapyò in order to address:

> personality disorders and other enduring patterns of relational and emotional difficulties [which do not respond as well to CBT]é . Schema Therapy is an integrative approach, bringing together elements from cognitive therapyé attachment and object relations theoriesé [and] unlike more traditional CBT approaches,Schema Therapy is explicitly

[3] See Shedler (2010) for a recent scientific review of the evidence that shatters the myth that CBT is more ñevidence basedò than psychodynamic psychotherapy. In fact there is compelling evidence for the superiority of psychodynamic psychotherapy. As reported in the *Monitor on Psychology* (03/2010, p. 13) ñPsychodynamic psychotherapy, which focuses self-reflection and self-examination to get at the root of suffering, is at least as effective as symptom-oriented treatments like cognitive behavioral therapy or psychoactive medicationé According to one major meta-analysisé psychodynamic psychotherapy was about three times more effective per treatment than the most popular antidepressant medication. The benefits of psychodynamic psychotherapy seem to persist and even grow larger over timeé

[4] The emphasis on cognitive ideations, which is considered a major innovation of CBT, has also always been an important focus, implicitly or explicitly, of psychodynamic therapy (Gabbard & Westen, 2003, p. 835).

concerned with the development (etiology) of current symptoms, and not only the factors that maintain them. Second, it places a great emphasis on the therapist-patient relationship, and on providing within it both a corrective emotional experience and empathic confrontationé [Rafaeli, Bernstein, & Young, 2011, pp. 1-2]

Substance abuse/addiction

The Clinicianôs Research Digest reviewed a recent study by Gray & Montgomery (2012) on substance abuse:

> Studies show that 60% of adolescent girls in alcohol and/or other drug (AOD) use treatment programs report histories of maltreatment. Maltreatment may increase girlsô risk for AOD problems because of resulting or lingering posttraumatic stress symptomsé . **This suggests that AOD problems may be the result of self-medication in an attempt to suppress the aversive effects of posttraumatic symptoms….**
>
> Results of this study indicated that 135 (80%) girls reported 1 or more forms of abuse or neglect. Of the girls endorsing abuse, 60% reported emotional abuse, 37% reported physical abuse, and 20% reported sexual abuse.

The reviewer concluded that:

> These results suggest that adolescent AOD use interventions may be inadequate for maltreated girls if they are not combined with therapy specifically targeting maltreatment experiences. This underscores the importance of assessing for trauma histories when adolescents present with AOD problems. **Therapists need to feel comfortable conducting assessments of traumatic experiences in mental health settings where such inquiries may not be commonplace (e.g., alcohol abuse clinics)….** [CRD, Vol 30, no. 9, Sept 2012 p. 5, emphasis added]

A previous study (Hogue, Liddle, Dauber, & Samuolis, 2004) researched the connection between the actual focus of two treatments for adolescent substance abuse (cognitive-behavioral and multidimensional family therapy), and treatment outcome. The authors report that success in therapy was related to the degree that the sessions focused on family-related themes, regardless of the treatment modality. According to the authors ñthese findings are in accord with the consensus that family conflict, parent-child detachment, and deficient parenting skills are primary etiological factors for adolescent substance abuse (Repetti, Taylor, & Seeman, 2002, p. 93).ò

Here again is recognition of the critical importance of exploring the early relationship with parents and other family related themes for successful therapy. Yet, there seems to be a reluctance to associate this research finding with the psychodynamic therapies that many contemporary theorists are trying to distant themselves from.

The average person suffering from an addiction of any sort is commonly told by his therapist, implicitly or explicitly, that addiction is an ñillness.ò The implication is that it is a medical/chemical/genetic disorder. The personôs personal history is considered basically

irrelevant to understanding the ñillness.ò This is proclaimed in spite of the fact that researchers have failed to find any evidence for such an illness.

In my experience working with patients suffering from addictions I have found that many of them have experienced neglect or abuse in their formative years. This makes them feel undeserving of pleasure or of enjoying life in any way. When they engage in regular enjoyable activities their feelings of guilt and unworthiness inhibits any pleasurable feelings. This results in a desperate hunger for pleasure. Addictive behaviors always involve pleasures of such intensity and magnitude that it overrides all inhibitions. For anyone who is incapable of any other form of enjoyment it can easily be understood why they would become addicted. In situations where this formulation is accurate, wouldnôt it be important for the patient to have this information rather than to be told that he has an ñillnessò?

Depression

Cognitive therapists treating depression have similarly discovered that focusing on current dysfunctional cognitions while ignoring early childhood developmental issues results in short lived change at best. Consider the following from Hayes, Castonguay and Goldfried (1996):

> Another unexplored area that has received increased theoretical attention in the CT [Cognitive Therapy] literature is a focus on patientsô attachment experiences with their parentsé . According to these theories, a developmental focus can facilitate lasting change because it activates the cognitive-affective network and interpersonal patterns that are central to the individualôs depression. Although the patientôs attachment patterns are not a direct focus of CT, Beck et al. (1979) recommend a developmental focus to identify the core assumptions that form the foundation of negative belief systems. *An exploration of patients' experiences with their parents should not be a primary focus of CT* but is likely to facilitate recovery and lasting changeé (p. 624, emphasis added)

This newfound acknowledgement of the importance of the ñpatientsô attachment experiences with their parentsò has not resulted in the recognition of the validity of dynamic psychotherapies that have always emphasized these developmental issues. Rather, the focus on early developmental issues is now presented as an innovation in Cognitive Therapy. However, even this concession is not presented as a focus of the treatment itself. Rather, it is presented as a technique for preventing relapse!

"Expressed emotion [EE]"

Another example I have previously cited (Sorotzkin, 2002) is research done in the area of ñexpressed emotion [EE]ò and psychiatric illness. Years of research clearly show that psychiatric patients released from the hospital to live with their high EE family are twice as likely to relapse and return to the hospital than patients returning to low EE families are. As noted by a prominent researcher in this area (Hooley, 1998); ñThe term EE [expressed emotion] is rather misleading since EE is not a measure of how willing a relative is to express emotion or to vent

feelings. Rather EE is a reflection of the extent to which the relative expresses critical, hostile, or emotionally over-involved attitudes toward the patientò (p. 631).

Logic would seem to dictate that if returning to a critical and hostile family can have such a devastating impact on a person suffering from an emotional disorder, it is quite plausible that living in such a family could perhaps be the origin of the disorder in the first place. The EE literature is rather open about its aversion to even consider this very plausible idea.

When researchers (Kershner, Cohen & Coyne, 1996) found compelling evidence that ñhigh levels of critical attitudes expressed toward children play a role in the development of childhood problems,ò they felt compelled to add that thisé ñdoesnôt exclude the possibility that high EEé might be a reaction by parents to childhood disturbanceò (p.103). They seem to be putting the responsibility of maintaining a familyôs healthy emotional environment on the children instead of the parents!

Chambless et al. (2001) take this a step further. They state:

> It is hardly surprising that relatives living with patients with serious behavioral disorders often have negative feelings about the patients, given the strain such disorders place on family lifeé . It is perhaps, more remarkable that some relatives remain low in EE. (p. 226)

The authors themselves then go on to point out all the contrary evidence:

> [S]everity of patientôs symptomsé typically fail to predict relativesôé critical comments or hostility scoresé and in one study, parents were found to be as critical of their well off offspring as of their schizophrenic childé . EE researchers have been slow to investigate the possibility that relatives may have personality traits that predispose them to be hostile to or critical of patientsé . [e.g.], high EE relatives described themselves as more concerned with social convention than low EE relativesé . (p. 227)

Unfortunately, these findings have not led researchers to adopt the logical, common sense conclusion that high parental EE is probably a major factor in their children developing emotional disorders. In fact they ñhave been slow to investigateò this possibility! In addition, contrary to the researcherôs assertion noted above, there **is** evidence that children in highly critical and hostile families are more likely to go on to develop serious emotional disorders (Nelson et al., 2003; Read et al., 2005: See also studies cited in Barlow, 2002, Chap. 8, and in Karon & Widener, 1994).

DEPTH PERSPECTIVE ALSO LACKING IN OUR UNDERSTANDING OF COMMUNITY ISSUES

One would expect mental health professionals to be in the forefront of the effort to help the community to develop a deeper understanding of the psychological factors in community problems. They certainly shouldnôt collude with the tendency to blame all of our communityôs

ills on outside factors. As a community, we usually prefer explanations that attribute the causes for our deficiencies on factors as distant from us as possible.[5] The preferred scapegoat is the outside culture. When that doesnôt work, we blame the schools and other institutions. We try our hardest to avoid attributing problems to parental factors so we can maintain the emotionally satisfying image of the benevolent parent (Moses, 1989). When that is unavoidable we try to finesse the issue by explaining that the parental error was that of permitting too much exposure to the outside environment. If even that is untenable, we will accept ñobjectiveò family problems as reasons for problems, (e.g. divorce, financial problems). Family emotional factors, such as abuse and neglect by parents, are resisted at all costs (for reasons that I have elaborated on elsewhere [Sorotzkin, 2002]).

I characterize this tendency to attribute psychological problems to outside societal factors as ñoffering sociological explanations for psychological phenomena.ò I will illustrate with a few examples.

The Internet

Much has been written in the Orthodox press regarding Internet addiction, especially in regards to pornography. Many horror stories have been recounted of supposedly well adjusted teens who, after a chance encounter with Internet pornography, became swept up in its web and developed serious emotional and/or behavioral problems as a result. It is often stated or implied that the vast majority of teens who have ñgone off the *derech*ò have done so primarily as a result of exposure to the Internet. This is a commonly held belief by most people in our community, even among many mental health professionals. The obvious question is; if the exposure to the outside culture is the primary culprit, why are there just as many rebellious teens in the very insular communities as there are in the more ñmodernò ones. This question is never addressed.

A recent posting on a NEFESH website regarding the Internet described it as a ñscourge that is wreaking havoc in many many homesò and contained a letter from a young man who claimed to be the epitome of mental and spiritual health until he became addicted to Internet pornography. My concern is that many people who read this will in fact assume that this is the case, rather than wonder what made this particular young man so vulnerable to such a drastic turnaround. In fact, if one reads his letter carefully one can see clear evidence of a young man suffering from unhealthy perfectionism (Flett & Hewitt, 2002; Sorotzkin, 1985) which often has the paradoxical effect of bringing the perfectionist to the most depraved behaviors (Sorotzkin, 1998, 1999). In discussing this issue with colleagues I often find that they also believe that a well-adjusted young man with an open and comfortable relationship with emotionally supportive parents can easily become addicted to Internet porn. When I suggest that in order for that to happen there usually has to be preexisting risk factors, they feel that I am underestimating the dangers of the Internet.

I want to make it clear that I am well aware of the dangers to oneôs spirituality that can result from exposure to the seamier side of the Internet and other ñculturalò media. But I believe we are misleading parents when we imply that it is this exposure that is the main (if not only) cause of teen rebelliousness and other emotional disorders. Why should parents struggle to improve

[5] When children do this they are chastised for avoiding responsibility.

their parenting skills and resolve their own emotional issues so that they can be better parents if they are told that the parent-child relationship is not a major factor in success in parenting?

I came across a superb article on the dangers of the Internet [available at: www.aish.com/societywork/society/escaping_the_cyber-slums.asp] written by Rabbi Leib Kelemen (from Neve Yerushalayim; author of *To Kindle a Soul*). This article is an extensive and in-depth review of the research on the subject. It is comprehensive and well balanced. After methodically documenting all the dangers associated with the Internet, Rabbi Kelemen notes (under the heading of ñ*The necessity of identifying risk factors*ò):

> Ultimately, restricting Internet access is a necessary but insufficient solutioné . What is needed is healing the personality weaknesses that virtually guarantee some individuals will fall victim to Internet temptations. *Studies show that those most likely to get into trouble are not deterred by limits on Internet access*é Therefore, a key challenge to parents and educators is identifying the risk factorsé Researchers describe *four pre-existing conditions that put an individual at high risk for getting into trouble on the Internet. They are lack of family bonds; low self-esteem; inability to express opinions and questions; and inability to socialize.* [Emphasis added]

This is a good example of utilizing an in-depth psychological perspective to better understand a problem affecting the community at large. Based on this understanding Rabbi Kelemen is able to give parents cogent advice rather than just state the obvious, more superficial advice of limiting or supervising childrenôs access to the Internet.

Rabbi Kelemenôs article was subsequently printed in a prominent Orthodox publication. Unfortunately, the section on identifying personality risk factors was omitted from this printed version of the article. The mistaken impression a reader of the printed article would be left with is that the danger is totally external, and that the **only** defense is protection from the outside world. Is it any wonder that parents who are very careful to protect their children from the outside environment, but neglect the family environment are then shocked when their child goes off the *derech r"l*. Because they did everything that they were told to do in order to avoid such tragedies, to no avail, the only possible conclusion is that ñit can happen to anybody.ò In their minds, therefore, there is nothing one can do to reduce the risk other than to protect their family from **external** influences.

Monitoring

It is common practice for therapists to encourage parents to forcefully monitor their adolescent children. In fact, a government agency runs ads (ñParents - the anti drugò) in the various media encouraging parents to question their teenage children regarding their friends and activities even at the cost of aggravating them and provoking an argument. This is presented as a very effective method - supposedly backed by 2 decades of extensive research - to prevent drug abuse and delinquency in oneôs children.

On a superficial level this approach would seem to be logical. After all, these youngsters are getting into trouble when they are ñhanging outò unsupervised with unsavory peers. If we can prevent them from doing those things, it is assumed, then we have solved the problem. It requires a more in-depth perspective to ask what it is that drives them to prefer the company of unsavory friends. I have found that it is most often the result of the following circumstances (simplistically put). When parents are excessively critical and controlling, it impacts negatively on their childrenôs self-esteem. Once this negative self-image solidifies, these youngsters only feel comfortable with peers who they see as being similar to themselves.

I was always baffled by these public service messages, because clinical experience has shown that being overly controlling of children (and especially teens) and questioning them in a provocative manner is usually what undermines the parent-child relationship and **drives** them to rebellious and dangerous behaviors. I decided to review the research literature myself.

I discovered that the conventional wisdom related to monitoring has long ago been convincingly and decisively refuted in a series of studies by Kerr and Stattin (e.g., Kerr & Stattin, 2000). These authors reviewed the many studies cited to support monitoring and were surprised to discover that the studies did no such thing. The teens in those studies were asked **if** their parents knew where they went in the evening and who their friends were, etc. They were not asked **how** their parents knew! It was simply **assumed** that the parents must have found out by questioning their children or by snooping. In their own studies Kerr and Stattin did ask this question. They discovered that a positive correlation with better adolescent adjustment existed only when the teens volunteered the information to their parents (reflecting a positive relationship with their parents). In contrast, when parents had to question their children or ñsnoopò to get the information, thereby making the children feel controlled, there was an association to poor adjustment![6] While no one has refuted Kerr and Stattinôs findings, the government continues to run these misleading ads, encouraging parents to take a course of action that is more likely to exacerbate than to solve the problem they are trying to resolve.

David Barlow (2002), in his recent comprehensive review on the treatment of anxiety disorders, similarly deplores assumptions deeply held by clinicians when ñfacts that have been available for years simply do not support these assumptionsò (p. 67).

Many therapists are more likely to hear the governmentôs ads than to have the time to keep up with the latest research findings on monitoring, so they encourage parents to tighten the reins (ñtough love,ò setting limits, imposing consequences, etc.) with little consideration for how these tactics impact their relationship with their children. There is little disagreement among researchers that a positive parent-child relationship is the most effective means to promote children and teensô positive behaviors.

> *A few years ago I met a well-respected therapist from out of town and we started "discussing shop." He related the following clinical intervention on his part. A 16 year old teenager was referred to him by a Yeshiva high school because of acting out issues. This student was constantly getting in trouble with teachers because of classroom*

[6] Reiss et al., 1995 (Cited in Barlow, 2002, p. 271) found that ñparental óattempts at controlô over an adolescent, was found to have an observable influence on depressive symptoms in that adolescent.ò

misbehavior, cutting classes and the like. The therapist insisted on first interviewing the parents. He related to me his impression of them. "They were from the most disorganized and ineffectual parents I ever met. They didn't understand the first thing about parenting!" The therapist wisely told the parents that he would only consent to work with their son if they agreed to concurrently see a guidance counselor to help them develop parenting skills. When the therapist called the guidance counselor to arrange for the referral he suggested that the first task he should attend to is to teach the parents to set limits with their son. While I suspect that many therapists would concur with this approach, I had a different reaction. "You very clearly indicated that these parents have never successfully parented their son," I told the therapist. "It is obvious that the son has lacked appropriately caring and supportive parents. Much anger, resentment and conflict have developed as a result. Now you want the counselor to help them learn to be parents. Is this going to be their son's introduction to parenting? The setting of limits? How about first teaching them how to develop a pleasant and supportive relationship with their son, and then perhaps they'll be able to set appropriate limits without setting off a destructive firestorm." To his credit, this therapist was open to other perspectives and he changed his suggestions to the counselor.

Resistance to acknowledging the role of parenting

I have elsewhere discussed at length societyôs resistance to recognizing the role of poor parenting in the development of childrenôs emotional and behavioral difficulties (Sorotzkin, 2002). It seems to me that this is one of the factors that motivate therapists to seek psychological theories and therapeutic techniques that do not require a scrutiny of the past.

After speaking at a public forum, I was approached by an 18 year old boy who wanted to discuss with me his history of anxiety and panic disorders. He was intrigued with my connection of these disorders to early life experiences (See Barlow, 2002, Chap. 8; Diamond, 1985; Gassner, 2004). He then came for a consultation where he revealed that he had previously seen two other psychotherapists and a psychiatrist. Their approach was that his disorder was a result of a "chemical imbalance" and/or genetic factors and, therefore, the treatment of choice was medication and behavioral techniques for dealing with anxiety and panic. During my initial intake, he revealed, in response to my in-depth questioning regarding his relationship with his parents, that he did not look forward to going home on his off Shabbosim. This was because of ongoing conflict with his overly critical father and intrusive mother. When I asked him what his previous therapists said about this issue, he informed me that this wasn't discussed at all, since they did not consider it relevant to his condition!

Unfortunately, this was not an unusual event. All too often I do an intake on a patient who has seen previous therapists even in relatively long-term therapies where obvious and long standing conflict with parents were rarely discussed. This usually happens when the presenting problem is a specific symptom, such as OCD, anxiety, or panic disorders where there is no obvious connection to the relationship with the parents. Even when patients bring up family issues in therapy, the reaction of the clinician is often that it isnôt very relevant to their condition! (What I

find even more surprising is when youngsters are referred for Oppositional Defiant Disorder and the therapist relates to it as a disorder that exists purely in the patient and doesn't explore what should be, at least, a probable connection to the parent-child relationship). Even when family issues are addressed it is usually for management purposes rather than for understanding the development and etiology of the disorder.[7]

Chemical imbalances

The epitome of etiological explanations that can safely ignore past history is the genetic/chemical imbalance explanation for psychological problems. There are many studies that highlight the serious shortcomings in many of the chemical imbalance explanations (see Valenstein, 1998), yet their emotional appeal (and the self-serving interest of the pharmaceutical companies) serves to maintain their popularity. The genetic explanations are likewise often dramatically overstated. A noted genetic researcher stated in a special issue of *Science*: "é the interaction of genes and environment is much more complicated than the simple 'violence genes' and 'intelligence genes' touted in the popular pressé . The same data that show the effect of genes, also point to the enormous influence of non-genetic factors" (Mann, 1994, p. 1687).

The fact that the lay public and popular press misinterpret scientific findings isn't astonishing - but the fact that trained clinicians do the same is somewhat surprising. A recent *Jerusalem Post* article (Jpost.com ï 2/19/05) regarding the opening of a psychiatric center in Bnei Brak quoted the head of a psychiatric clinic:

> Professionals agree that psychiatric illnesses are in essence brain diseases ï disorders that result from an imbalance in brain chemicals (neurotransmitters such as dopamine). But deep-seated cultural prejudices and fears caused discrimination against the emotionally disturbedé . Patients who are thus stigmatized feel shame, suffer from denial and are reluctant to get treatmenté .

In fact, many mental health professionals tell their patients that their emotional disorders are purely the result of biological causes when there is probably not a single serious researcher who believes that "psychiatric illnesses are in essence brain diseases!" There may be an imbalance of neurotransmitters, but it is widely acknowledged by researchers that this is most often the result of traumatic life experiences rather than the initial cause of psychiatric disorders.

> [R]esearch by leading neuroscientists has been madeé intellectually satisfying by a clear recognition that we must go beyond the brain to fully understand the workings of the brain. In fact, it is from these leading neuroscientists that we are coming to appreciate more fully the influence of psychological and environmental factors on brain functioningé .
> [T]here is dramatic evidence that early stressful life events may effect rather permanent alterations in brain functioné that may mediate the neurobiological vulnerability to develop chronic anxiety and depression later in life. (Barlow, 2002, pp. 216, 217)

[7] A randomized controlled clinical trial recently demonstrated the superior effectiveness of psychoanalytic psychotherapy for panic disorder (Milrod et al., 2007).

In a similar vein, Pariser (2005) cites the work of Eric Kandel -

> who won the [2000] Nobel Prize in Medicine for his discoveries demonstrating the impact of life events on the timing of protein synthesis in the cellular nucleus. The implication of Kandelôs work, that experience impacts not just behavior, or even brain structure, but the fundamental underlying genetics, demolishes the hoary nature-nurture conflict and replaces it with a deep understanding of the indissoluble system that includes brain, mind, and the surrounding environment. (p. 123)

Even the most extreme proponents of biological explanations for emotional disorders (with the possible exception of the paid consultants to the pharmaceutical companies) concede that these biological factors are best described as vulnerabilities that require negative early life experiences to develop into a disorder. As emphasized by Barlow (2002):

> At presenté there is no behavioral or emotional disorder for which aé single-gene heredity seems applicable. Even for the major psychotic disorders, where genetic links have long been suspected [note the use of the term ñsuspectedò and not ñprovenò], almost all investigators (including geneticists) believe that an underlying vulnerability interacts with a variety of psychological and social factors to produce the disorderé (p. 193)

Barlow (2002) dedicates an entire chapter in his book (Chap. 8) to the extensive research evidence on how early parent-child relationships can create the psychological vulnerabilities for various emotional disorders. One brief example:

> When parents are insensitive to their childôs expressive, exploratory, and independent behaviors, the child is at risk of developing inhibition and a sense of uncontrollability over his or her world, which may contribute to anxietyé . [A] ñmalfunctioning relationshipò involving an intrusive, overprotective, or controlling parenting style could be expected to make a strong contribution to a cognitive vulnerability for anxiety [disorders]. (p. 268)

Yet patients and their families are frequently told by their clinicians that long-standing conflicted parent-child relationships, for example, are irrelevant to the development of their ñchemicalò and/or genetic disorders! This is both misleading and a disservice to the patients. This is especially so because countless of surveys have shown that ñwhen given a choice, the public prefers psychological interventions to pharmacological interventions, even at sites known primarily for expertise in pharmacological interventions [Barlow 2004, p, 873].ò

Part 2*

Postpartum depression

It is an article of faith among the vast majority of mental health professionals that postpartum depression is caused by a chemical (hormonal) imbalance resulting from pregnancy, and there is therefore little, if any, need for in-depth psychodynamic psychotherapy. In truth, however, this belief is not based on proven science. In fact, as reported in the journal, *Social Psychiatry and Psychiatric Epidemiology:*

> Aside from anecdotal reports, we have not been able to locate credible research evidence which indicates that major depression is more frequent in women who have recently given birthé . It isé clear that many of the cases of depression noted in the postnatal period represent exacerbations or continuations of a pre-existing set of symptoms of depression. (Najman et al., 2000, pp. 19-20, 25)

Najam et al. (2000) proceed with a fascinating discussion of how postpartum depression as a solely hormonal disease became so widely accepted in our society.

Blum (2007, p. 47) cites a *Psychiatric Annals* report that ñdespite extensive investigations, there has been no major study demonstrating a direct association between these [hormonal] changes and subsequent major depression.ò Blum (2007) also cites studies reporting postnatal depression in adoptive mothers and in fathers. He likewise reviews the many studies highlighting predisposing factors in developing PPD such as prior depression, poor social support, stressful life events, poor relationships with their own mothers, and unrealistic expectations to be a perfect mother. Blum (2007) asserts that:

> [t]he typical psychological situation in PPDé is of conflicted [and] denied wishes to be taken care of, often with a feeling oh having been unsatisfactorily cared for by oneôs own mother [p. 49]. [Yet] despite the paucity of paucity of biological findings and increasing evidence for psychological factorsé the medical and psychiatric literature emphasizes the former and frequently overlooks the latter [pp. 48-49].

Heron et al. (2004) reached similar conclusions based on a prospective longitudinal study of a community sample in England. They note that ñAnecdotal and clinical experience indicates that there may be some specific concerns of expectant mothers that may make them more vulnerable to anxiety or depressionò (p. 72). In my own clinical experience I found that for women who have had a long history of difficulties with depression and anxiety (often sub-clinical or untreated), the experience of childbirth, with its accompanying responsibilities, may result in an intensification of these underlying issues to the point of requiring clinical attention. This is

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I wish to express my appreciation to my fellow members of our peer supervision group - Dr. Gail Bessler, Dr. Lawrence Bryskin, Dr. Rashi Shapiro, Dr. Elin Weinstein and Dr. Meir Wikler - for their important contribution to the development of the ideas expressed in this paper and for their friendship and support.

especially true of women with perfectionistic tendencies who demand of themselves to be perfect mothers (see Flett & Hewitt, 2002; Sorotzkin, 1985, 1998).[8]

Countless postpartum women are told that their depression is purely hormonal and they are thus deprived of the in-depth psychotherapy they truly need. Now of course, it is reasonable to presume that hormonal and physiological stressors and changes play an important factor in the emotional health of the mother, however it is equally important to consider psychodynamic and family systems issues.

Obsessive-Compulsive Disorder (OCD)

To illustrate some of the issues discussed above I will describe what I heard a few years ago in a workshop on the treatment of Obsessive-Compulsive Disorder (OCD). The presenter was a well-known clinician from the west coast who specializes in the treatment of OCD.

He stated that OCD was a ñbrain biological disorder.ò He described how PET scans of the brain can show the part of the brain that ñmisfiresò in OCD and how it ñsettles downò after successful treatment. He then described how, by the end of the first session with an adolescent patient, he knew that he was dealing with a ñbiogenic OCD.ò Just to be certain, he met the parents for a single session ñto rule out any dynamic problems that may have caused the OCD.ò Although the presenter noted a great deal of perfectionistic tendencies in the parents he was convinced on the basis of one session with the patient and one session with the parents that he was dealing with ña typical picture of biological OCD.ò The presenter described how he explains to the patient and the parents that the patient ñisnôt crazy.ò ñThere is nothing wrong with them on the emotional level but there is a part of their brain that gets stuck.ò[9]

It wasnôt clear to me if the presenter meant that OCD is always a ñbrain biological disorderò and if so why he had ñto rule out any dynamic problems that may have caused the OCD?ò And if dynamic problems can cause OCD in a vulnerable child, as clearly indicated by all the research (see Barlow, 2002, Chap. 8 & 15), how was he able to rule it out in two sessions?!

I was especially perplexed because this same presenter had, in an earlier lecture, highly recommended Daniel Siegelôs work on ñinterpersonal neurobiologyò (Siegel, 1999; Siegel & Hartzell, 2003). Siegel integrates attachment theory with neurobiology. He states:

> It is unhelpful to pité experience versus biology, or nature versus nurture. In fact, experience shapes brain structure. Experience *is* biology. How we treat our children changes who they are and how they develop. Their brains need our parental involvement. Nature needs nurture. (Siegel & Hartzell, 2003, p. 34)

[8] Interestingly, I have seen symptoms very similar to postpartum depression in emotionally vulnerable men who are given their first responsible job. See also Mazzeo et al., 2006, on the association between perfectionism, PPD and eating disorders.

[9] To me it always seemed that a patient would feel crazier believing that his brain ñgets stuckò for no reason! More on this below.

How does one reconcile the enthusiastic endorsement of that statement with the simplistic, one-dimensional proclamation that OCD is a ñbrain biological disorder?ò [10]

The certainty with which many clinicians tell their patients that OCD is a ñbrain disorderò is not at all consistent with the research literature which clearly points to unhealthy attitudes and beliefs learned during childhood as an important contributing factor to the development of OCD. For example, Barlow (2002) states that:

> [The] negative self-evaluations [common to patients with OCD] appear to be commonly derived from excessive responsibility and the resulting guilt, usually developed during childhoodé . It seems likely that extremely high standards imposed during childhood and/or excessively critical reactions from authority figures may also contribute to perfectionistic attitudes, feelings of guilt, and extreme beliefs in responsibility. [p. 533]

The PET scans referred to above actually prove nothing, since the changes in the brain are more likely to be the result of the disorder than the cause. Likewise, new positive experiences (especially psychotherapy) can repair the damage to the brain. Unfortunately, this is not what most patients are hearing from their therapists, who usually minimize or even dismiss the significance of their early childhood experiences in the development of OCD and the role of psychodynamic therapy in the treatment of OCD.[11]

More recently, Dr. Jonathan Grayson, one of the leading experts on OCD today, states in his book: ñit would be wrong to accept the neurobiological aspect of OCD as a complete explanation of the disorder. Unfortunately, many people, including professionals, make this mistake.ò (Grayson, 2014, p.15).

Misguided good intentions

While some clinicians may promote the idea of brain disorders and ñchemical imbalancesò as the cause of emotional disorders in order to help parents of emotionally disturbed patients avoid feelings of shame and guilt, the resulting lack of insight on the part of patients and their families surely hinders the progress of the therapy. At the most obvious level, it often results in the parents continuing with the maltreatment that contributed to the development of the disorder in the first place. Clinicians have also come to believe their own well-intentioned message of ñno-faultò disorders so that they donôt seriously explore the possibility of parental maltreatment, with unfortunate consequences.

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[10] Siegel and Hartzell (2003) start their book with the comment: ñHow you make sense of your childhood experiences has a profound effect on how you parent your own children [p. 1].ò

[11] Barlow (2002) reports on ñthe findings from several studies that successful treatment [either psychotherapy or medication] has resulted in normalization of activity iné the brain, with changes in OCD symptoms correlated with changes in brain functionsé [p. 521]. Interestingly, Barlow, Allen and Choate (2004) note that while for most emotional disorders ñpsychological and pharmacological treatments achieve approximately equal efficacy immediately after treatment is concludedé for OCDé psychological treatment seems more efficaciousé [p. 208].

> Unfortunately, there are some situations that arise in which the practitioner may not know that the child is continuing to live in traumatizing circumstances even while being treated. (Faust & Katchen, 2004, p. 430).

Another message these clinicians are promoting is that the reason patients shouldn't be embarrassed to seek treatment for psychological disorders is because they are purely brain disorders. The implication of this supposedly reassuring message is that if they are (even partially) emotional disorders then there **is** a reason to be ashamed! The idea that the problems are purely biological doesn't resonate true with patients and their families (otherwise the parents wouldn't get so angry at their children for their dysfunctional behavior). Subconsciously, they know what researchers have consistently said, that it is **not** purely a biological disorder and, in that case, according to what they are told, they have every reason to be embarrassed to seek treatment. That, in my opinion, is one source for the stigma in seeking treatment for emotional disorders.

It is especially unfortunate that clinicians promulgate the ñbrain disorderò myth as an attempt to decrease the stigma of emotional disorders, since research clearly indicates that this approach actually increase stigmatisation! As Read and Harré (2001) summarized this issue:

> Research indicates that the ómental illness is an illness like any otherô approach to destigmatisation has failed to improve attitudes. This studyé . confirmed previous findings (contrary to the assumptions on which most destigmatisation programs are based) that biological and genetic causal beliefs are related to negative attitudes, including perceptions that ómental patientsôare dangerous, antisocial and unpredictableé [p. 223]

A more honest and effective approach would be to say the following to prospective patients:

> *You obviously didn't ask to have these difficulties. It is also irrational to attribute your troubles to laziness or other such explanations, since even a lazy person would go a long way to avoid the suffering you are experiencing. It is much more likely that your early life experiences make many tasks, which others find easy, unusually difficult for you. Psychological pressures can be as compelling as biological forces. This was never explained to you. Rather you may have been told by your parents and teachers that it was because of your moral deficiencies ("laziness" or "not caring"), and this caused you to hate yourself. Some professionals, in a well-meaning attempt to improve your self-image, told you that your problems are due to a chemical imbalance. This only served to make you feel defective and despondent. It also made you wonder why some of your therapists may have gotten angry at you when you couldn't follow through on their recommendations. If they really believe that your problems are purely the result of the chemical imbalance why do they get so upset at you?*
> *I will try to help you make sense of why you have these difficulties. There were specific events that happened in your life that, together with whatever temperament you were born with, shaped how you experience events, yourself, and other people. When we figure all this out together, we will be able to use this understanding to figure out how to slowly alleviate many of your difficulties.*

Therapist criticalness

There is another hidden detrimental impact of therapists not focusing on underlying historical causes of patientôs troubled behavior.

Excessive criticalness and lack of acceptance on the part of parents has long been implicated in the development of psychopathology (e.g., Repetti, Taylor & Seeman, 2002).[12] An important factor in the healing power of psychotherapy is the non-judgmental acceptance of the patient on the part of the therapist. Yet, many patients feel judged and criticized by their therapists. At times this is undoubtedly, a projection of the patientôs own self-criticalness but too often it is an accurate assessment of the therapistôs feelings. Anita E. Kelly (2000a, 2000b) developed a controversial ñself-presentational view of psychotherapy [that] challenges current assumptions about the benefit of high levels of clientôs openness in therapy [2000b, p. 505].ò She cites research evidence that patients conceal information from their therapist in order to make a good impression as they are certain that if they reveal the unsavory truth about themselves their therapists would feel negative about them even though they will often attempt to hide this reaction. The unfortunate reality, according to Kelly, is that they are often right. She refers to studies that report that:

> [T]herapists formed very negative clinical conjectures about their clients, conjectures that they then hid from their clientsé . [and] that therapistsô perceptions of a target person are consistently less favorable than laypersonsô perceptionsé . [which] should not be surprisingé given that they are trained to use the *Diagnostic and Statistical Manuel (DSM)*.... [This is problematic] because clients who are more liked by their therapists tend to show more progress in therapy. [p. 509]

Kelly concedes that patients would be much better off if they believed and if indeed it was true that their therapists would still think favorably of them even if they told the therapists about specific transgressions or humiliating events. ñSuch clients might benefit immensely from telling the therapists about these events and then hearing the therapistsô challenges of their negative self-views surrounding the events [Kelly, 2000a, p. 486].ò However, according to Kelly, therapists often do form negative assessments of their patients in these situations and therefore patients are better off not being so open. In response to her critics, Kelly suggests:

> Perhaps the é researchers [who insist that patients do better in therapy when they are more open] have in common a sense of optimism about the psychotherapy process [so they recommend] that clients fully describe their very negative behaviors so that their therapists can help them see their behaviors as separate from the broader implications of who they are. [They also believe] that therapists can and do truly hold their clients in high regard, even when the clients reveal heinous details. I have seemed somewhat less optimistic in suggesting that being judgmental is part of human natureé [Kelly, 2000b, p. 510].

[12] See also my comments regarding ñexpressed emotionsò (EE) in Part 1. Citing child abuse researchers, Thomas (2005) makes the important point that abusive caregivers are often ñmisguided protectorsò (p. 30).

I would suggest that these different viewpoints may be a function of different approaches to therapy rather than differences in optimism and pessimism. When therapists focus on pathology without an emphasis on the underlying historical/developmental causes of the problem (à la the DSM) it is understandable that they would develop a negative perspective of patients who are doing very bad things.[13] When therapists do focus on the developmental causes it makes it easier not to feel negative toward patients in spite of their unsavory behavior.[14] As I tell my patients when they feel excessively self-critical and ashamed over their disturbed behaviors and emotions, ñConsidering what you went through it was virtually inevitable that this would happen.ò[15]

> *A 25 year old man came for treatment because of voyeurism. He had seen three previous therapists who recommended medication, twelve-step programs and various behavioral techniques for overcoming his impulses. There was very little exploration of his early childhood or even his current relationship with his parents. The message he got was that he has an unfortunate biologically/genetically-based defect and the most he could hope for is to learn behavioral techniques to control his impulses. When he found it difficult to follow through on the "homework" the therapist assigned to him the therapist became annoyed at him and exclaimed "How do you expect to get better if you don't show responsibility?" He felt despondent and unmotivated for treatment. When we explored his early life experiences, it was ascertained that the relationship with both his parents was extremely conflicted. They were both very critical and his mother was quite controlling. Over time, we developed an understanding of the psychological meaning of his symptom. He was very hungry for the intimacy that he was clearly deprived of in his relationship with his parents. Since a girl would normally allow someone to see her unclothed only if she had a close, intimate relationship with him, he superficially imitated this intimacy by looking at women when they were undressed. This seemed to also, at least partially, explain his excessive interest in pornography. (Of course, he conveniently blocked out the fact that he was seeing a girl unclothed without her consent or knowledge). The understanding of the meaning of his symptom was a significant factor in helping both of us not to be overly critical of his difficulties. This was the first step in helping him begin the long process of overcoming his problems.*

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[13] In his discussion of psychotherapy with child abuse survivors, Thomas (2005) takes this a step further. In their sincere efforts to help their patients, Thomas writes, therapists of child abuse survivors sometimes inadvertently become guilty of ñtherapist abuse.ò ñDespiteé their best intentions, therapists find themselves acting in a way that is likely to match the clientôs internal abuser roleé . They may be irritated by what seems to be client resistanceé ò (p. 25). I would contend that this is more likely to happen when the therapy doesnôt focus on the historical events that cause the patient to be resistant.

[14] This is similar to the method by which one is able to judge others favorably (*dan lekaf zechus*), i.e., by thinking of environmental/historical factors that could have caused the person to be more susceptible to that particular misbehavior, so that the misbehavior is not seen as reflecting an inherent defect in the person (see *Chasam Sofer, Shabbos* 97a). See also Rav Henoch Lebovitz, *Chidushei HaLev, Bamidbar,* (33:1), where he discusses how reminding someone about his past misdeeds can have a dramatically different impact on that person depending on the speakerôs perspective on the problem (see also Kirzner, 2002, p. 64, fn.).

[15] Contrary to what many people think, avoiding excessive self criticism will make it **more** likely that a person will strive to overcome his negative impulses (see Rav Chaim Shmulevitz, *Sichos Musser*, *Maamar* 55 ï 5731:13; Rav Eliyahu Dessler, *Michtav MeEliyahu*, Vol. 2, p. 161, Vol. 4, p. 263; Rav Henoch Lebovitz, *Chidushei HaLev, Vayigash,* 45:3).

Part 3*

The demise of the biological model?

Since the discovery of effective medications for psychiatric disorders it has become the accepted wisdom among most clinicians that many, if not most, psychiatric disorders (e.g., schizophrenia, OCD) are ñbiologically based.ò This perception has been strongly promoted by the pharmaceutical companies, for obvious reasons. The effectiveness of medications in alleviating psychiatric symptoms is seen by some as clear and conclusive evidence of biological causality.

This accepted wisdom is now being challenged as never before.[16] Dr. Yaacov Rosenthal called our attention (via the Nefesh listserv, 12/9/05) to:

> an earth shattering review of schizophrenia research in the most recent edition of the prestigious journal *Acta Psychiatrica Scandinavica* [that] provides evidence that at least two-thirds (in some studies up to 97%) of the individuals suffering from schizophrenia suffered childhood physical or sexual trauma.

The authors of this study (Read, van Os, Morrison, & Ross, 2005)[17] cite many studies that point to a significant overlap between the diagnostic constructs of schizophrenia, dissociative disorders and post-traumatic stress disorder (PTSD). Since many contemporary clinicians are biased in their perception of schizophrenia as a biological disease, they donôt ask the questions that would uncover the history of abuse that would allow the diagnosis of PTSD. This bias has serious clinical implications as effective, evidence-based psychosocial treatments for psychosis are abandoned for exclusively psychopharmacological treatments. The authors report on ña large, multi-centre study [that found] that psychological approaches are more effective than medication for psychotic people who suffered childhood traumaé . For some, simply making a connection between their life history and their previously incomprehensible symptoms may have a significant therapeutic effect [p. 344].ò Unfortunately, the traumatic history underlying the psychosis is so often left undiscovered, depriving the patients of needed psychological treatment.

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* [Published in the *Nefesh News*, Dec. 2006 as: ñChemical imbalance, genetic malfunction or meaningful behavior?ò]

[16] The challenge is not to statements that assert an **association** between biological markers and emotional disorders. Rather, it addresses statements that imply an **exclusively** biological cause. For example, a book on psychological issues very popular in the *frum* community states: ñThe fact that medication, even without psychological therapy, is often effective supports the theory that many types of OCD are due to some physiological imbalance in the body chemistry **rather than** to psychological causesò (Twerski, 2005, p. 140, emphasis added). The author further asserts that this is often the case in even less severe disorders: ñ[T]here is reason to believe that anxiety may occur for **purely** physiologic reasons, perhaps because of a genetic factor. In such cases, searching for the órreasonô the person is anxious is inappropriate and may be counterproductive [p. 34, emphasis added].ò Interestingly, on the very next page, the author indicates that poor self-esteem and marital disharmony among parents are frequent causes of anxiety, and, more recently he acknowledged that the chemical imbalances associated with emotional disorders can be the **result** of emotional distress rather than the original cause. ñIt is important to be aware that severe stress can cause a chemical imbalance, resulting in a depression that may require medical treatment,ò Abraham J. Twerski, *Jewish Action,* Winter 2011 ñThe Power of Positive Thinkingò p. 39.

[17] Available at www.blackwellpublishing.com/journals.

This study was widely reported in the lay press. *The Guardian* (London) reported on 10/27/05: ñThe psychiatric establishment is about to experience an earthquake that will shake its intellectual foundations.ò *Newsweek* reported (12/12/2005) that ñthe cumulative impact of this research has swayed opinion in the professionôs highest echelons.ò The *Newsweek* article also reports that the president of the American Psychiatric Association noted that ñanti-psychotic medicines now generate $6.5 billion in sales a year, and registered concern that mental disorders are being over-medicalized: óAs a profession, we have allowed the bio-psychosocial model to become the bio-bio-biomodelô.ò

In a lengthy review article recently published in the *Bulletin of the Menninger Clinic,* Seidel (2005) also cites compelling empirical evidence that seriously challenges the concept of ñbiologically based mental illness.ò Most patients are told by their clinicians that chemical imbalances play the major causal role in many, if not most, mental disorders with the pharmacological companies supplying the full color illustrations of these purported chemical imbalances. It is now abundantly clear that this formulation is, at best, very misleading and most likely simply false.[18]

The relationship between brain biology and psychological states is bidirectional. As Seidel (2005) reports:

> The construct of BBMI [Biologically Based Mental Illness] presumes a directional, causal relationship between biochemical function and behavior, or that biological process is the foundation of mental disorders. Current research does not support this view. On the one hand, placebo studies suggest that in many instances, medication may exert effects on behavior at a psychosocial (expectancy) level rather than a biochemical level. On the other hand, brain-imaging studies indicate that psychosocial interventions affect biochemistry. These studies in particular show that the biology of mental disorders is a level of expression, not the basis, of psychological problems [pp. 163-164].... Research evidence, to date, supports a ñbiological expression of mental phenomenaò construct,[19] not that particular mental disorders are biologically based [p. 166].

In a similar vein, Kendler (2005) wrote a powerful article in a recent issue of the *American Journal of Psychiatry* challenging simplistic conceptions of the relationship between genes and psychiatric disorders - what he calls the ñGeneTalkò - common in lay and professional writings (e.g., ñscientists have discovered a gene for alcoholism, violence, homosexuality, depression, etc.ò). Kendler states:

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[18] I would like to emphasize that my comments should not be understood as negating the use of psychopharmacological interventions. I have a close working relationship with a number of psychiatrists and I do not hesitate to make a referral for a psychopharmacological consultation when clinically indicated.

[19] See Cappas, Andres-Hyman and Davidson (2005) for an interesting discussion of using neuroscience to enhance clinical practice.

In a recent study published in the *Proceedings of the National Academies of Science* (reported in ScientificAmerican.com on 11/22/05) Pollak et al. report that orphaned babies from Eastern Europe, where they did not receive loving care, still ñsuffer from depressed levels of hormonesé linked to bonding, caring, communicating and stress regulationé ò even after as many as three years in their new adoptive homes in the United States.

> The strong, clear and direct causal relationship implied by the concept of ña gene foré ò does not exist for psychiatric disorders. Although we may wish it to be true, we do not have and are not likely to ever discover ñgenes forò psychiatric illness [p. 1250].
> Twin and adoption studies suggest that the impact of aggregate ñgenesò for major depression are altered by exposure to stressful life events, and for schizophrenia and conduct disorder by exposure to a dysfunctional rearing environment [p. 1248].

Kendler notes a ñcurious featureò of GeneTalk. While we find it easy to use the phrase ñX is a gene for Y,ò it feels odd to say ñA is an environment for B.ò For example, a large body of empirical work supports the hypothesis that severe life events such as being maltreated as a child is an important environmental risk factors for conduct disorder. The magnitude of this association is far greater than that observed for any of the genes. Yet we are not comfortable saying that abuse is an environment for conduct disorder.

I have personally experienced this ñcurious featureò of GeneTalk. I have been criticized for being ñtoo simplisticò when I attribute most of the emotional problems children suffer from (especially problems associated with rebellious adolescents) to problems in parenting (e.g., see letter in the *Nefesh News*, November 2005 ï also reprinted at the end of this article). In spite of the great deal of research evidence supporting the importance of this etiological connection (e.g., the research on Attachment Disorders), clinicians seem to prefer to minimize the significance of this factor. Instead, they emphasize the multiplicity of causal factors giving equal weight to every associated feature (contemporary research attempts to tease out the relative contribution of each contributing factor).

Ironically, most of these critics of my ñover-simplificationò do not seem to have similar criticism of over-simplicity of those who attribute emotional disorders almost exclusively to chemical imbalances or genetic malfunctions, for example clinicians who state that ñOCD is a brain biological disorder,ò as cited above.[20]

A recent Nefesh listserv entry (Jan. 13, 2006) by Dr. Yaacov Rosenthal cites a host of experts challenging the concept of ñchemical imbalancesò as a cause for emotional disorders. The following are two of the quotes:

- "No single reproducible abnormality in any neurotransmitter or in any of its enzymes or receptors has been shown to cause any common psychiatric disorder."

[20] Another example of this biological over-simplification was a recent article in a *chareidi* publication by a well-known *frum* psychiatrist. Discussing Obssesive-Compulsive Disorder (OCD), he wrote: ñé obsessive compulsive disorder is as physical as having fever or high glucoseé . OCD occurs because of biochemical interactions in the brainé This condition can be seen on PET scans in specific areas of the brainé Usually, OCD symptoms have no clear cause or trigger...ò Besides the fact that world-class experts cited above in the section on OCD do not agree that OCD is ñas physical as having fever,ò equating our ability to trace the neuro-chemical pathways of the disorder in the brain with understanding the underlying cause is an extreme case of over-simplification. It is similar to atheists using our modern-day understanding of the **process** of nature as a substitute for understanding the **cause** of natural events. For example: In response to a pastor saying that the Haiti earthquake was an act of G-d, Kathleen Parker responded in the Washington Post: ñWe long ago learned that earthquakes are caused not by vengeful deities but by the shifting of Earthôs tectonic platesò [reported in *The Week*, Jan. 29 2010]. As if the idea that G-d sets in motion natural events is incompatible with understanding the mechanisms of those events!

Stephen Stahl, MD, Ph. D., *Essential Psychopharmacology.* Cambridge Univ. Press, 2nd ed., 2000, p.100.

- "Hypothetical biochemical imbalances have been presented to the public as established fact. In every instance where such an imbalance was thought to have been found, it was later proven false." Joseph Glenmullen, M.D., Harvard Medical School, *Prozac Backlash.* Simon & Schuster, New York, 2000, p. 198.

In spite of the total lack of evidence for chemical imbalances **causing** emotional disorders, the vast majority of patients are fed this line by their clinicians. This isn't just a minor detail, since our understanding of etiology has a substantial impact on treatment and prevention.

The fact that medications can alleviate psychiatric symptoms should certainly not be cited as evidence that the original cause of the disorder was chemical. Most tax accountants probably have splitting headaches on April 15th. The fact that the pain is alleviated by Tylenol certainly doesn't prove that the original cause of the headache was a mysterious depletion of acetaminophen in the brain!

Frick and Loney (2002) address the relationship between inborn temperament and modes of psychotherapy with the following perceptive comment:

> There is often a tendency to assume that, if a behavior pattern is related to a biologically based temperament, the pattern is unchangeable or best treated through biological interventions. The fallacy of this assumption is well documentedé . Temperaments place a child at risk for certain behavior patterns but these behavior patterns are shaped by the child's psychosocial contexté Therefore, changes in a child's psychosocial context can clearly alter how his or her temperament is manifested. (p. 122)

As cited above from the study reported in Read, van Os, Morrison, and Ross (2005), simply making a connection between their life history and their previously incomprehensible symptoms may have a significant therapeutic effect even on patients diagnosed with schizophrenia. This is what therapy was all about before the advent of biological explanations and treatments for emotional disorders and short term CBT whose main innovation seemed to be that therapy could safely ignore a patient's early history (Spiegel, 2006).[21] In this context, it is interesting to note John Norcross' (2005) recent report in the *American Psychologist* that only 8% of behavior therapists choose behavioral treatment for themselves when they seek therapy. The overwhelming majority (92%) preferred psychodynamic, eclectic and humanistic therapies. It seems that behavior therapists also seek meaning when they are dealing with their own emotional issues.

[21] This remains the popular perception of CBT even among clinicians, in spite of the fact that the founders of CBT have reluctantly conceded that while "an exploration of patients' experiences with their parents should not be a primary focus of [CBT, none-the-less it] is likely to facilitate recovery and lasting change [Beck et al., 1979, cited in Hayes, Castonguay, & Goldfried, 1996, p. 624]".

A new awareness of the impact of chronic childhood trauma

In a recent special issue of *Psychotherapy: Theory, Research, Practice, Training* (Winter, 2004, Vol. 41, No. 4) on ñThe Psychological Impact of Traumaò there are a number of superb articles on the treatment of those who suffered the chronic trauma of childhood abuse. These articles reflect an increasing awareness of the traumatic nature of the early lives of patients who suffered parental maltreatment in early childhood. I would like to quote a few paragraphs which underscore the points that I have been emphasizing regarding the importance of understanding the meaning of symptoms by connecting them to past experiences, especially within the family.

Many researchers discuss the diagnosis of Post-traumatic Stress Disorder (PTSD) as it may apply to those who suffered maltreatment as children.

> [A] number of researchers and clinicians argued that the diagnosis of PTSD was not a perfect fit for the reactions experienced by victims of child abuseé where traumatization occurred repeatedly and extensivelyé . Individuals exposed to trauma over a variety of time spans and developmental periods suffered from a variety of psychological problems not included in the diagnosis of PTSD. (Courtois, 2004, p. 413)
>
> After facing an ongoing trauma, children sometimes do not display óvert diagnosable disorders,ô yet they profoundly distrust people, expect betrayal, and lose faith that life holds any justice or meaning. (Faust & Katchen, 2004, p. 427)

The diagnoses of ñComplex PTSD (CPTSD)ò (Herman, 1992) or ñDisorders of extreme stress not otherwise specified (DESNOS)ò (Pelcovitz et al., 1997) have been proposed for the complex reactions that occur in response to repeated traumatization, such as chronic abuse in childhood.[22]

The hidden nature of childhood trauma

Young, et al. (2001) discuss at length the challenge of ascertaining whether patients suffered maltreatment during their childhood. On the basis of their study, Dill et al. (1991) also concluded that; ñData suggest caution in accepting at face value, initial denials of abuse historiesò (p. 166).[23] A number of authors in this special issue likewise discuss the difficulty clinicians face in uncovering childhood maltreatment, since the victims are often unaware that what they experienced - and perhaps are even currently experiencing - is considered abuse. This is why clinicians are often mistakenly convinced that their patientsô home life was reasonably emotionally healthy and so they attribute their difficulties to other factors (e.g., ñchemical imbalanceò). Patients also have a strong emotional need to remain unaware of the abusive nature of their upbringing, as emphasized by many researchers and clinicians:

[22] More recently, ñdevelopmental trauma disorder (DTD)ò has been suggested (Deangelis, 2007).

[23] See also Tajima et al., 2004; Julich, 2005 (on the Stockholm Syndrome); and Bradely, Jenei and Westen, 2005. Another factor to take into consideration is that many abused children exhibit ñsleeper effectsò i.e., the development of serious psychological problems some times after the termination of the abuse (Finkelhor & Berliner, 1995).

> Briereôs (1992) construct of ñabuse dichotomyò proposes that children living in abusive situations are faced with a cognitive conflict: Either their parentsô abusive treatment of them is unwarranted and reflects parental inabilities, or it is a justifiable response to their own badness. The former cognition is more threatening because children depend on their parents. (Goldsmith, Barlow, & Freyd, 2004, p. 454)
>
> The clinician should not assumeé that asking about traumaé will automatically result in disclosure. Some individuals with positive histories of trauma are unwilling or unable to disclose early in the processé . Additionally, many traumatized individuals know nothing about trauma, may not label what happened to them as traumatic, and have little or no understanding that their symptoms may be related to their past experiences. (Courtois, 2004, pp. 416, 420)
>
> Williams (1994) [interviewed] 136 women 17 years after emergency room visits resulting from CSA [child sex abuse]. Thirty-eight percent of participants did not report the trauma, although they disclosed other personal information. (Goldsmith, Barlow, & Freyd, 2004, p. 451)

Liotti (2004) describes a common phenomenon when interviewing patients with an unrecognized history of childhood maltreatment. There is often a glaring discrepancy between their global description of their early family life and specific childhood memories. ñThis discrepancy takes the form of maintaining an idealized view of oneôs parents despite recollections that suggest a childhood marked by unhappiness and an unsatisfactory relationship with oneôs parentsò (p. 473). Unfortunately, many clinicians miss these discrepancies.

I have found evidence of the emotional need many patients have to maintain an idealized image of their parents in a common phenomenon I have observed in my practice. Patients will resist characterizing their parentôs blatant mistreatment of them as ñabuseò but will easily use that term to characterize that exact same parental behavior toward a sibling. I was pleased to find research confirmation of this observation in this special issue of *Psychotherapy*:

> In a sample of 1,526 university students, Rausch and Knutson (1991) found that although participants reported receiving punitive treatment similar to that of their siblings, they were more than twice as likely to identify their siblingôs experiences as abusive as they were to label their own in this wayé [This was because they interpreted] parental [maltreatment] toward themselvesé as deserved and therefore not abusive. (Goldsmith, Barlow, & Freyd, 2004, p. 451)

Cultural resistance to acknowledging parental maltreatment

Many of the authors in the special issue discuss the pervasive cultural denial of abuse and chronic trauma within families and the impact of this denial on treatment:

> For individuals who experience chronic trauma and whose posttraumatic social environments may act to discourage awareness of trauma, recovery from the adverse

> impact of trauma may not be adaptive and thus may be rendered difficulté . There is a great deal of cultural denial regarding trauma and its effectsé which is likely to influence individual levels of awareness. (Goldsmith, Barlow, & Freyd, 2004, pp. 449, 451)[24]

Clinicians' lack of awareness of parental maltreatment

In spite of the renewed emphasis on the impact of early childhood experiences on later emotional disorders, as reflected in the burgeoning research on attachment disorders, many mental health clinicians continue to overlook, or downplay the significance of, early childhood maltreatment. One of the examples I have cited elsewhere (Sorotzkin, 2002, p. 34) relates how researchers have found clear evidence of the high degree of childhood sexual victimization among severely mentally ill women. Yet these researchers openly acknowledge their reluctance to report these figures.

> At the same time, clinical researchers working in the area of severe mental illness have been understandably wary of focusing on the problem of early abuse in this population. There has been a reluctance, for example, to disinter the theoretical trend of blaming families for causing major psychiatric disorders. Current treatment models emphasize enhancing current adjustment rather than understanding past eventsé (Rosenberg, Drake, & Mueser, 1997, p. 261).

It is difficult to imagine trying to treat emotionally disturbed adults without relating to the sexual abuse they suffered as children. How effective can such treatment be? Yet this is what some experts are recommending! This again is an example of misguided good intentions, where the attempt to protect parentsô feelings results in revictimizing their children by denying their abuse, and thereby denying them effective treatment. In fact, the parents also end up being victims because they too will also suffer from their childrenôs lack of effective treatment.

Many of the authors in the special issue of *Psychotherapy* on trauma also emphasize how clinicians overlook trauma history.

> [R]esearch demonstrates that most mental health services do not detect childhood trauma historiesé primarily because mental health workers often fail to ask about trauma experiencesé . Mainstream approaches to trauma are shaped by traditions within psychology that emphasize single-incident trauma and responses such as fear and anxietyé . Consequently, psychologists have lower levels of awareness for aspects of trauma such as chronicity, fear, shame, and betrayalé . [T]he study ofé child maltreatment may be met with more resistance, even within the professional community, than the study of traumas such as natural disasters, which pose less of a threat to the

[24] See also Firestone (2002). A vivid example of this denial could be found in a recent interview with a famous actress in a popular magazine (Davidson, 2005). The interviewer reports that when the actress was 15 years old ñher father arrived [home] in a drunken rage, and in self-defense, her mother shot him dead.ò Later in the interview, the actress states, ñBut you know what? I had a wonderful childhood.ò The interviewer didnôt seem to find this statement incongruous with the reported history!

> status quoé . Trauma is a topic rarely included beyond the most cursory level in most therapistsô trainingé . Because it is not usually the trauma itself that causes individuals to seek help, rather it is often the distress from its subsequent effects and interpretation, most abuse survivors seek therapy because of complaints about themselves, their interpersonal relationshipsé or as a result of depressioné (Goldsmith, Barlow, & Freyd, 2004, pp. 449, 456) [25]
>
> Lack of awareness of the markedly different impact of single versus chronic traumatization among practitioners has often resulted in failure to focus on the most relevant areas for interventioné . *Misdiagnosis in the form of conduct, depressive, and attention deficit disorders frequently occurs, often resulting in the core traumatic issue never being fully examined or treated.*ò (Faust & Katchen, 2004, p. 427, emphasis added)

Even when patients report childhhod abuse, there is the question of how much credence to give to these accounts. After all, maybe they are exaggerating or even making it all up? The research, however, indicates that traumatic memories are accurately remembered in their central details (i.e., the core features of the abuse), whereas peripheral details may involve some distortion or inaccuracy (Brewin et al., 1993)

Attention-Deficit/Hyperactivity Disorder (ADHD)

ADHD is a good example of a disorder where clinicians jump to premature conclusions on the etiology of the disorder. The official DSM-IV diagnostic criteria for ADHD clearly specify that: ñThe symptomsé are not better accounted for by another mental disorder (e.g., Mood Disorder, Anxiety Disorderé).ò And, in fact, there is a great deal of research evidence indicating that many emotional disorders result in symptoms similar to those of ADHD. Yet many clinicians seem to ignore this specification, assuming the diagnosis of ADHD without exploring other possible causes. Jones (2002), for example, pleads with clinicians to consider the possibility of an attachment disorder before possibly misdiagnosing with ADHD and Halasz et al., (2002) explore the societal pressures that prompt contemporary clinicians to diagnose ADHD and recommend medication without considering family dynamics as a possible cause of the symptoms.[26] Galves (2004) likewise protested the American Psychological Associationôs misleading brochure that states that ñADHD is generally considered a neuro-chemical disorderò

[25] I recently found a glaring example of clinical myopia in an online speech and language pathology journal article. The author first posited that the majority of people who stutter do not have psychological problems underlying their stuttering. He then presents a case to back up his claim. He described how when R. was 8 years old he stuttered in front of his father who laughed at him and angrily ñshouted and demanded with cruel reproaches that he speak well immediately é . R.ôs father is a violent and authoritative man who imposed his law on the whole family and continued his criticism every time R. stuttered. In other aspects R.ôs father is revered and beloved by R. and the family.ò How can a clinician believe that this violent, abusive and hypercritical man was truly beloved by his family?! And this is supposed to be the convincing evidence that psychological problems do not underlie stuttering!

[26] In my experience, family dynamics are often ignored as possible etiological factors even when clinicians are aware of severe family pathology!

when there is a great deal of scientific evidence that would require at least some qualification of that over simplistic, if not misleading, statement.[27]

Regarding the general issue of understanding ADHD, Bruce Perry, in his book on traumatized children, writes:

> The aggression and impulsivity that the flight or flight response provokes can also appear as defiance or opposition, when in fact it is the remnants of a response to some prior traumatic situation that the child has somehow been prompted to recall. The 'freezing' response that the body makes when stressed - sudden immobility, like a deer caught in the headlights - is also often misinterpreted as defiant refusal by teachers because, when it occurs, the child literally cannot respond to commands. While not all ADD, hyperactivity and oppositional-defiant disorder are trauma-related, it is likely that the symptoms that lead to these diagnoses are trauma-related more often than anyone has begun to suspect [p. 51].

Dr. Perry laments the fact that many contemporary mental health professionals - assuming that the symptoms they are observing are biologically based - feel that they don't need to get a comprehensive history. In the case that his book is named after (ñThe boy who was raised as a dogò), he meets a 6 year old boy with a slew of strange symptoms and many different DSM diagnoses. This boy had been seen by countless mental health professionals but Dr. Perry was the first to ask the father about his child-rearing practices and so he was the first to discover that the child was literally "raised as a dog" (p. 130). Dr. Perry (a neurological researcher) emphasizes throughout the book that the biological and chemical abnormalities found in the brains of those who suffer from various emotional disorders are most often the **result** of traumatic experiences and not present at birth.

In summary, clinicians are subject to societal pressures to find quick solutions to their patientôs troublesome symptoms. As a result, there is little incentive to explore the personal meanings of behaviors and the childhood relationships and traumas that shaped the developing psychic structures. This is besides whatever personal and emotional resistances the clinician may experience in confronting the issue of child abuse. Yet, trying to help patients deal with their symptoms without dealing with the underlying issues is like treating a fever while neglecting the infection that is causing the fever. This is especially true for those who experienced chronic maltreatment as children. As Faust and Katchen (2004) assert:

> Herman (1992)é argued that complex trauma [resulting from childhood maltreatment] routinely results in major alterations in several fundamental areas of functioning such as affect regulation, consciousness, self-perception, and relations with othersé . [She] maintained that it is only when the treatment provider addresses these multiple areas of impairment that the client is able to effectively confront the traumatic origins of his or her symptoms. As survivors of complex trauma become aware that their psychological difficulties stem from their extensive traumatic background, they are less likely to

[27] See www.academyanalyticarts.org/galvesealker.htm. See also the Internet report (9/26/05) on a study by Dr. Seth Pollak that found that abused children have a tendency to focus to even subtle signs of anger which may help explain why they may be especially distracted in the classroom. www.news-medical.net/print_article.asp?id=13313)

attribute their symptoms to an inborn defect in the self. Herman argued that by failing to include a diagnosis that subsumes the wide range of difficulties resulting from complex traumatization, the *DSM* conceptually fragments the effects of trauma. For example, somatic complaints that frequently are experienced by survivors of complex trauma are diagnosed as somatic disorders; their interpersonal problems often are categorized under the borderline personality diagnosis; changes in consciousness are demarcated as a dissociation diagnosis; and intrusive thoughts about and recollections of traumatic events are categorized under the current heading of PTSDé .The consequence of diagnosing complex trauma survivors with these multiple divergent syndromes is that the traumatic origins of their various difficulties are obscured. This, in turn, renders the adverse effects experienced by them as inconsequential, fostering self-blame and stigmatization by others. (pp. 427-428)

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Addendum

Following the publication of Part 1 in the Nefesh News, the editor received the following letter from the president of Nefesh (The International Network of Orthodox Mental Health Professionals). Since he raises the two most common criticisms of my approach, I am including it [slightly shortened], followed by my response

To the Editor:

Kudos to Dr. Benzion Sorotzkin on his excellent articleé . in the last Nefesh Newsletter. It is a very impressive, valuable piece of work. I would like, however, to register alternative views regarding two aspects of the article.

The first relates to Dr. Sorotzkinôs apparent lack of regard for limit setting as a primary parental function. I am one of those therapists who believe that limit setting is an absolute prerequisite for success with any child, and is sorely missing in contemporary child-rearing. No matter how much affection is shown, the absence of limits will inevitably lead to disaster. Many parents cannot bring themselves to suffer the inconvenience and angry responses of their children, to watch as the childôs narcissistic strivings are frustrated (believing that everyone should have whatever he wants) in order to set limits. They cannot see such limits as expressions of love, representing sacrifice on the part of parents and child for the benefit of the latter. Even children who bridle at limits crave them and understand their necessity.

On the other hand, while many of the patients I have seen suffer well into adulthood from the lack of a meaningful, validating, and limit-providing relationship with a parent, I cannot agree with Dr. Sorotzkinôs almost exclusive focus on poor parenting as the cause of our childrenôs problems. In my view, this is far too simplistic and unwisely disregards dramatic changes in our culture, which, from its very inception, has been inexorably evolving toward complete disregard for authority. It also fails to address the overwhelming influence of peer culture during adolescence. The most arduous parenting cannot change this.

Notwithstanding these qualifications, I wish to express my thanks to Dr. Sorotzkin for this very thought-provoking and informative article.

Sincerely yours,

Nosson Solomon, Ph.D.

My response: [The paragraphs in brackets were not published due to space considerations].

Dear Editor:

I sincerely appreciate Dr. Nosson Solomonôs comments as it gives me an opportunity to correct possible misperceptions of my position.

Dr. Solomon feels that my article (1) shows insufficient regard for limit setting as a primary parental function and (2) almost exclusively and simplistically emphasizes poor parenting as a cause of childrenôs emotional problems.

I, of course, agree that limit setting is an important parental function and that there are many factors, other than faulty parenting, involved in the development of emotional problems. My article, however, was a critique of what I see as an imbalance in the prevalent approach to emotional disorders rather than a

parenting manual or therapy primer. I, therefore, didnôt feel it was necessary for me to discuss all aspects of the issues involved.

[This reminds me of the conservative talk show host who was criticized for not giving equal time to the liberal point of view on his show. ñI **am** the equal timeò he responded. Since the media is overwhelmingly liberal he didnôt feel it was necessary for him to present the liberal perspective. Rather, he presented the conservative perspective in order to provide balance. I, likewise, feel that the current zeitgeist is tilted toward proximal causes of behavior and emotions and I am, therefore, emphasizing what I consider the deeper and more crucial causes. I do not intend to deny the other factors, just to put them in perspective.**]**

[It seems to me that logic dictates that from all the various influences experienced by children, the relationship with their earliest caregivers would have the strongest impact on their emotional makeup. The impact of later experiences (such as the impact of friends and schools) will themselves be strongly moderated, for better or for worse, by those earlier familial experiences. My position is that saying that a personôs OCD is purely the result of a chemical imbalance and/or genetic factors or that his acting out behavior is exclusively the result of the influence of bad friends or exposure to the internet (the impression many patients seem to get from speaking to doctors and *mechanchim*) is the simplistic approach. Acknowledging that the various factors that may contribute to the development of OCD or ODD are strongly influenced by the existing psychic structure formed by the early home environment seems to me to be the more comprehensive approach. My point was not to disregard these other influences but rather to decry the lack of sufficient attention being paid to a most basic and primal factor. (I cite similar sentiments made by leading experts in parts 2 and 3 of the article).**]**

[Similarly, my assumption is that readers of the *Nefesh News* are well aware of the importance of limit setting in parenting and so I (perhaps mistakenly) didnôt feel it was important to emphasize that point. I, instead, focus on the danger of overly harsh discipline or when the attitude underlying the discipline causes a child to feel rejected (i.e., the distinction between authoritarian parents and authoritative parents discussed in the child development literature).**]**

While our community is undoubtedly influenced by the anti-authority attitude of the general culture, my experience is that the majority of the *frum* patients I see suffer from emotional disorders resulting, to a significant degree, from early familial experiences with excessive criticism, overly harsh discipline and overly restrictive and unreasonable limit setting. In those situations where the discipline was inconsistent or inadequate it was most often due to parental neglect resulting from emotional shortcomings rather than to an ideological embracing of societyôs laissez faire attitude to educational discipline (a rare occurrence, in our community, in my experience). Even our generationôs purported legions of spoiled children who ñgot everything they wanted,ò were not truly spoiled. They, most often, got too much of what they didnôt need (e.g., expensive toys) but alas, got too little of what they did need (e.g., attention, respect, acceptance, and consistent, *Halachicly* sanctioned, discipline).

Benzion Sorotzkin, Psy.D.