HEBREW UNION COLLEGE - JEWISH INSTITUTE OF RELIGION
California School

in cooperation with

UNIVERSITY OF SOUTHERN CALIFORNIA
School of Social Work

GROUP APPROACHES TO MENTAL HEALTH PROGRAMMING IN LOS ANGELES SYNAGOGUES

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CHAPTER I

INTRODUCTION

Statement of the Study Problem

Traditionally, the Jewish family and the sense of identity within the Jewish community have represented two major emotional and social support systems which have been available to Jews over the years. The synagogue has served a complementary role to the family and the sense of community. However, changes have taken place in the family's functioning.

> The processes of social and technological change have contributed to obsolescence of traditional values, secularization of religion, role diffusion, identity crises, generation gaps in youth's lack of communication and identification with parents, compartmentalization of family responsibilities and their relegation to surrogate institutions. Jewish families today are not as closely knit as heretofore, have less authority over their members, serve ineffectively as role models and protective socialization units as a result of having experienced acculturation to the larger society.[1]

No one knows the extent to which synagogues are involved in sponsoring or conducting activities which deal with the individual's and the family's emotional stability and

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[1]Norman Linzer, The Jewish Family (New York: Commission on Synagogue Relations, 1970), p. 73.

coping capacities in today's society.

There are four ways in which synagogues can be active in promoting the mental health of its members:

1. Individual and family counseling around problems.
2. Group counseling around common problem areas. This is the corrective or therapeutic model.[2]
3. Group education for preventive and developmental needs.[3]
4. Modifications in regular synagogue functions to meet the needs of members with special problems. This may be done through affiliative groups such as the sisterhood or havuroth.[4]

For a number of years now the educative/preventive and corrective programs have been assumed to be the province of other institutions. It now appears that synagogues are increasingly active in these areas. This study

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[2]Child Study Association of America, Education and Therapy: Similarities and Differences (New York: Wel-Met, 1974), p. 1.

[3]Ibid.

[4]A havurah (plural: havuroth) is a small group of people who meet together for study, celebration of holidays, social activities, etc.

proposed to explore this issue by surveying a cross-section of synagogues in the Los Angeles metropolitan area to determine the nature and types of group counseling and education programs that are being offered.

Significance of the Study

Synagogues are major religious and communal institutions with which a great many Jews regularly interact. Sklare estimates that in a large Jewish community approximately 50% affiliate with synagogues.[5]

As an important institution in their lives, it is also the place where Jews may well bring their questions and problems relating to personal, family and social adjustment. In fact, for many people the synagogue may represent a stigma-free resource. For others who don't know where else to go, the synagogue may be the first place to which they reach out. In the Action for Mental Health series, it is estimated that 42% of the American people consult their clergyman when problems arise.[6] It would be

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[5]Marshall Sklare, Conservative Judaism (New York: Shocken, 1972), p. 123.

[6]Joint Commission on Mental Health and Illness, Action for Mental Health (New York: Basic Books, 1961), p. 78.

valuable to know whether the rabbis view personal problems of congregation members as an area in which they can be active in providing some assistance. The findings are therefore important in terms of seeing the potential of what synagogues can do in the area of mental health.

This study will determine the extent to which educative/preventive and corrective mental health programs are offered in Los Angeles synagogues and ascertain whether there are differences among synagogues related to their association with the Reform, Conservative, and Orthodox movements.

The findings should be significant to the Jewish community by helping it determine current trends in this area of synagogue programming. It should also be useful to agencies of the Jewish Federation Council by providing an awareness of what exists in synagogues in the Los Angeles community. This has implications for future planning for programs and for the orientation and training of personnel.

Many people would not consider a synagogue to be a viable setting for mental health programs. However, much of the literature on preventive mental health suggests that various settings in the community can be effectively utilized. As there are different criteria for defining

mental health, the following chapter explores various aspects of mental health prevention.

CHAPTER II

PREVENTIVE MENTAL HEALTH

Definition of Mental Health

In dealing with the nebulous issue of mental health, there are implicit assumptions which many authors have recognized. Marie Jahoda holds that:

> Mental health is a value judgment, not necessarily an ultimate good, in which standards differ among various cultures. In American culture, it is a value for an individual to cope with life without imposing harsh demands on others.[1]

Furthermore, Jahoda contends that good physical health is a necessary but not sufficient condition of good mental health.[2]

Gurin, Veroff, and Field[3] agree with Jahoda in using multiple criteria in approaching a definition of mental health.[4]

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[1]Marie Jahoda, Current Concepts of Positive Mental Health (New York: Basic Books, 1958), p. x.

[2]Ibid.

[3]Gerald Gurin, Joseph Veroff, and Sheila Field, Americans View Their Mental Health, Monograph #4 of the Joint Commission on Mental Illness and Health (New York: Basic Books, 1960).

[4]Jahoda, Current Concepts of Positive Mental Health, pp. 25-64.

(1) Variables which Jahoda takes into account begin with the attitude of the individual towards himself. Jahoda uses this concept in its broadest sense, stating that this means, "feelings about the total configuration of the self-concept, rather than any single attribute of it."[5] In developmental terms, one can place this in Erikson's fifth stage, ego identity, from which real intimacy develops. This means that an individual has confidence that his own perceptions are matched by the meaning he has for others, forming a true sense of his basic identity.

(2) The second variable is self-actualization which includes the motivational processes in addition to self-concept. Positive tension is maintained by concern for others, significant objects and activities, one's work and avocation, and interest in distant goals. This is the degree to which one's potentialities are realized through action.

(3) An additional variable is the unifying forces which guide the functioning power of the individual. The forces include frustration tolerance, the ability to delay gratification, a guiding purpose with which to shape

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[5] Ibid., p. 28.

actions, and an ability to be flexible.

(4) Internal regulation of behavior through self-direction and control, self-respect, and self-reliance comprises the fourth category. Implicitly this includes the degree of individual autonomy from social influences.

(5) Jahoda's next variable is a "freedom from need-distortion."[6] This is the individual's ability to perceive and test reality without making distortions based on wishes. In addition, empathy and social sensitivity to others are included.

(6) Adaptation and adjustment combine with adequacy in interpersonal relations to make up the last variable in Jahoda's scheme. This is the ability to take life as it comes. It is the ability to problem-solve, meet situational requirements and to experience love.

In a general adjustment survey, Gurin, Veroff, and Field have found that gratification and distress in the above areas stem from economic or material circumstances and from central life relationships.[7] Donald Klein defines prevention (of distress) as that which modifies or

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[6]Ibid., p. 51.

[7]Gurin, Veroff, and Field, Americans View Their Mental Health, p. 49.

eliminates the troublesome element or acts as a safeguard to help those who are exposed to cope.[8] He says further that "communities can be influenced to provide more healthy environments and supports that will contribute to the growth and development of their inhabitants."[9]

Preventive Approaches

In recent years a new approach to dealing with the mental health needs of a community has developed which focuses on prevention. There are different types of approaches to preventive mental health. Primary prevention aims at reducing the incidence of new cases of mental disorder in the population by combatting harmful forces which operate in the community and by strengthening the capacity of people to withstand stress.[10] By dealing with the conditions of life which affect the entire population, this approach deals with the whole field of community activity. It seeks to reduce the intensity of crises

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[8]Donald Klein, Community Dynamics and Mental Health (New York: John Wiley & Sons, 1968), p. 6.

[9]Ibid., p. 16.

[10]Gerald Caplan, Support Systems and Community Mental Health (New York: Behavioral Publications, 1974), p. 190.

among the members of a population in order to increase their spontaneous chances of healthy adaptation. It also provides preparation before, and help during crises so that a healthy outcome is more likely.[11] Secondary prevention has as its goal the reduction of the duration of cases of mental disorder which occur in spite of programs of primary prevention. By shortening the duration of existing cases, the prevalence of mental disorder in the community is reduced. This is accomplished by organizing case finding, diagnostic, and remedial services so that mental disorders are detected early and are dealt with effectively.[12] Tertiary prevention aims at reducing the community rate of residual defect which is a sequel to mental disorder. It seeks to ensure that people who have recovered from mental disorder will be hampered as little as possible by their past difficulties in returning to full participation in community life. It works at fighting alienation from work, family, and social groups during and after mental illness, and by organizing programs to rehabilitate expatients.[13]

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[11] Ibid., p. 193.

[12] Ibid., p. 190.

[13] Ibid.

All three types of preventive mental health focus on the total population and seek to reduce the community rates of mental disorder and its effects.

Many mental health professionals today believe that primary prevention should be the focus of mental health programming. McGee writes that mental health programming beginning in the 1960s began to adopt the philosophy that instead of concentrating all of the limited professional energies on treating mentally ill people, more attention should be devoted to eliminating those conditions in homes, schools, businesses, and communities which are inimical to the development of positive mental health.[14] Foley and Gorham agree:

> Revision is needed in service delivery and training to emphasize primary prevention, which requires social action on two levels: redirection of national priorities and development of a new philosophy of care founded in service and committed to prevention.[15]

A survey conducted among directors of mental health programs regarding their opinions on the role of primary prevention brought findings which concur with the positions

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[14]Richard McGee, Crisis Intervention in the Community (Baltimore: Uni Park Press, 1974), pp. 35-36.

[15]A. R. Foley, and P. Gorham, "Toward a New Philosophy of Care: Perspectives on Prevention," Community Mental Health Journal 9 (1973):99.

of the authors cited above. Ninety percent of the directors felt that primary prevention should be an integral part of programming. The author concludes that if a common thrust toward primary prevention could be developed by professional associations, citizen mental health movements, and local communities, this goal could be accomplished.[16]

Models in Community Mental Health

Caplan writes that several complementary models in community mental health need to be developed which will provide, in toto, a comprehensive guide for fact finding and action.

The nutritional model is based on the fact that the achievement of adequate personality development depends on the availability of appropriate opportunities and supplies, in the same way that a body needs physical nutrients for adequate bodily development. One type of supplies is psychosocial. An example might be that there are inadequate opportunities for satisfying interpersonal needs due to broken families. Another type of needed supplies is sociocultural. For example, poor educational provisions

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[16] M. Van Antwerp, "The Route to Primary Prevention," Community Mental Health Journal 7 (1971):188.

may cause children to be ill-equipped to function well in a technologically advanced society. The nutritional model provides a guide for programs of primary prevention through identifying and remedying long-term damaging factors in the life situation of population groups.[17]

The developmental adjustment or crisis model has a short-term focus on the events and reactions involved at transitional periods of an individual's development.[18] This model contrasts with the disease model under which professionals in mental health have generally operated. The disease model views breakdowns in psychological functioning as a manifestation of underlying disease. It implies that psychological distress requires treatment by altering the defective personality.[19] Crisis theory assumes that an individual's resistance to stress is finite, and that any person will at times find his coping mechanisms inadequate to maintain his psychological

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[17]Caplan, Support Systems and Community Mental Health, pp. 245-6.

[18]Ibid., p. 247.

[19]Thomas S. Szaz, "The Myth of Mental Illness," American Psychologist 15 (September 1960):113-18.

equilibrium.[20] The developmental and accidental stresses and events are viewed as pivotal points for the mental health of an individual. If the person is able to manage the crisis well, he will learn new coping behavior and will strengthen his emotional problem-solving ability. If it is handled poorly, there will be a deterioration in psychological adjustment.[21] People in crisis are more susceptible to influence than during periods of stable equilibrium. Therefore, the intervention of different kinds of care givers--educators, helping professionals, clergymen, administrators, and others with authority and influence--is crucial.[22] This intervention could be developed through the use of groups formed around lifecycle crisis, such as birth, adolescence, marriage, middle age, retirement, and death. These are periods in life which can be stressful for any individual or family. The crisis model offers a guide to primary prevention by enhancing healthy

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[20]Gerald A. Specter and William L. Claiborn, Crisis Intervention (New York: Behavioral Publications, 1973), p. 2.

[21]W. G. Smith, "Critical Life Events and Prevention Strategies in Mental Health," Archives of General Psychiatry 25 (1971):73.

[22]Caplan, Support Systems and Community Mental Health, p. 247.

personality development. It is useful in secondary prevention since it suggests an approach which uses therapeutic workers more efficiently. Much of the work can be done on a widespread scale by interested key people and usually does not demand the specialized psychological knowledge that would restrict its use to a small number of highly trained experts.[23]

The community organization and development model focuses on the state of development of a community as a problem-solving organization for the prevalence of mental disorder. It theorizes that the prevalence of mental disorder will be lower if the community has a well-developed pattern of leaders and followers, good communication, an effective control system, an efficient system for the identification of problems and for mobilizing resources, and a value system which accepts the importance of satisfying the human needs of its members. This is a higher order model that provides a guide for all types of prevention through non-specific community development.[24]

The socialization or effective role performance model emphasizes the significance of the complementary role

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[23]Ibid., p. 248

[24]Ibid., p. 240.

functioning of an individual in a social structure. Mental disorder is seen as a condition of the deviant functioning of a person who doesn't conform to social expectations of appropriate behavior in his roles as a member of his family, work, cultural, or religious groups. The model provides a guide to re-educating or resocializing the "deviant" back into a socially productive and self-satisfying set of roles in the community. The disordered person is not viewed as sick and in need of medical treatment, but as a student or trainee involved in an educational program staffed by educators. Issues such as communication and motivation are salient.[25]

Support Systems

From the perspective of an ecological systems model, the individual is viewed as an integral part of a succession of open systems, each of which is a subsystem of a larger unit. Mental disorder in an individual may be one manifestation of strain in some or all of those systems. Remedial actions may take place in related caregiving and control systems in the community such as health, mental health, welfare, corrections, manpower, religion, and law.

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[25]Ibid., p. 249.

Unfortunately, each of these systems is likely to identify those signs of strain which are categorized as appropriate for it to deal with. The ecological systems approach attempts to design a comprehensive system of caregiving units and attempts to orient them to the broad view of the strains and maladjustments on a variety of levels of the client system.[26]

Studies by Caplan have shown that the individual's responses during crises indicate that the outcome is influenced not only by the nature of the stress and the current ego strength of the individual, but most important, by the quality of emotional support and task-oriented assistance provided by the individual's social network. A support system:

> . . . implies an enduring pattern of continuous or intermittent ties that play a significant part in maintaining the psychological and physical integrity of the individual over time.[27]

One aspect of a support system might be what is termed a <u>natural</u> mental health delivery system. It is defined as:

> . . . a set of naturally occurring, spontaneously activated mechanisms which are always a part of the

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[26]Ibid., pp. 252-54. [27]Ibid., p. 7.

person's phenomenal environment.[28]

The actors in the system don't generally see their role as primarily related to a mental health function. The family or the clergyman are such actors. A principle in preventive mental health utilizing the natural system is to enhance or extend the natural system and to keep the contrived external intervention system to a minimum, reserved for persons for whom the natural service delivery system fails.[29]

Caplan further delineates the type of support systems which exist. There are spontaneous support systems which are not planned by professionals, such as marital or family groups.[30] These support systems are crucial. One study of a middle-sized American city examined what sources of assistance would be relied on in crisis situations. Relatives and friends were commonly listed as sources, but few reported that they would go to a social service

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[28]Leo Levy, "The Role of a Natural Mental Health Delivery System in Dealing with Basic Human Problems," in Crisis Intervention, eds. Gerald A. Specter and William L. Claiborn (New York: Behavioral Publications, 1973), p. 19.

[29]Ibid., p. 22.

[30]Caplan, Support Systems and Community Mental Health, p. 25.

agency.[31] A second type of support system is organized support not directed by caregiving professionals, such as youth service organizations, charity groups, mutual help associations, and organizations like Alcoholics Anonymous.[32] A third type is the organized support system, such as the religious denominations provide. Caplan writes:

> Religious denominations are the most widely available organized support systems in the community and probably cater on a regular basis to more people than all others.[33]

Caplan feels that a major effort of professionals interested in preventive mental health should be to foster the development of all kinds of support systems. He sees four ways of doing this. First of all, the professional can work towards organizing a new support system inside an existing institution. He gives the example of a consultation program developed by the Harvard Laboratory of Community Psychiatry and the Episcopal Church. What began

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[31] B. Lebowitz, J. Fried, and C. Madaris, "Sources of Assistance in an Urban, Ethnic Community," Human Organization 32 (1973):23.

[32] Caplan, Support Systems and Community Mental Health, p. 25.

[33] Ibid.

simply as a mental health consultation to bishops developed into a program that helps all clergy in the parish to deal with the mental health dimensions of their jobs. A network of individual, group, and administrative supports was built within all levels of the church structure.[34] Another way of developing support systems is to organize a new support system in the "open community" as a visible alternative to traditional institutions. Consultation to an already organized support group is an approach, as well. In this case, the professional is an outsider invited to fulfill a requested role within an organized informal community support group. The example Caplan gives is of a group of amateur volunteer counselors without professional direction who called in a consultant to set up a training program. The last approach he deals with is to foster already existing unorganized supportive services. An example of this was in helping an unorganized day care system in a neighborhood organize and become more effective.[35]

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[34]Ruth Caplan, Helping the Helpers to Help (1972), cited by Caplan, Support Systems and Community Mental Health, p. 32.

[35]Caplan, Support Systems and Community Mental Health, pp. 32-38.

Family Life Education

As the industrial revolution and the transition to an urban society challenged the social institution of the family, a range of mental health services evolved as support systems to help families cope with the stresses of a changing environment. FLE was among them.[36]

Bronfenbrenner, in a paper prepared for the 1970 White House Conference on Children, spoke of the institutional supports that are necessary to help the family perform its function. He sees FLE as one of these supports.[37] "As a result of the current threat to families, there has been a resurgence of interest in FLE."[38]

Auerbach reported that it is only recently (1950s) that casework agencies have gotten involved in FLE programs. Previously, unskilled persons had served as

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[36]Bernard Reisman, The Emerging Jewish Family (New York: Institute for Jewish Life, 1974), p. 33.

[37]Child Study Association of America, The Scope of Family Life Education Programs (New York: Wel-Met, 1974), p. 3.

[38]Ibid., p. 5.

group leaders in many programs.[39] As the agencies provided more intensive treatment and recognized that fewer clients were served, they began to use preventive programs as outreach mechanisms to a broader constituency. Cooperation with clinics, hospital social services, neighborhood centers, and youth boards provided different populations and settings for service.[40]

The Family Service Association of America Committee on FLE defines this type of programming as "a process by which people are helped, through group discussion, to broaden their understanding of family relationships."[41] This is distinguished from therapy in its emphasis on normal family relationships. FLE deals with the ego and its capacity to deal rationally with various problems.

While there are similarities between education and therapy, different emphases exist, and unless clarified, there may be an adverse effect on the achievement of client and worker expectations. A primary distinction arises at

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[39]Aline B. Auerbach, "Family Life Education as a Service of the Casework Agency," Jewish Social Service Quarterly (Spring 1955):316.

[40]Ibid., p. 319.

[41]Gertrude Pollack, "FLE: Its Focus and Techniques," Social Casework 34 (May 1953):148.

the point of initiation of services. Therapy begins with the client's awareness of a problem. The therapeutic process is an attempt to eliminate the problem--to correct some deficiency in the person. In contrast, education addresses itself to the person in his normal phases of development, highlighting strengths and providing resources to maximize individual potential. While both therapy and education acknowledge the centrality of the affective domain, education makes more use of the cognitive.[42]

Both approaches aim towards change and involve learning. However, therapy is based on a medical model, beginning with the identification of a dysfunction, and focusing on deficiency needs. Education focuses on strengths and growth needs. The educative approach deals with recent history, as opposed to the psychoanalytically influenced therapeutic model. Education deals with those areas of functioning identified as being subject to volitional control. There is a focus on specific behaviors with a view of developing more productive alternatives. While it might result in personality restructuring, this is not a goal of family life education.

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[42]Reisman, The Emerging Jewish Family, pp. 45-46.

The therapeutic approach makes interpretations on a personal level. While there is interpretation done in FLE, it is done on an impersonal level, and there is not as much personal risk or exposure for participants. Feelings are dealt with in FLE, but the focus is on the interpersonal, as opposed to the intrapsychic. Education and therapy are not polar opposites, but rather are two approaches that overlap and borrow from each other.[43]

Cantoni describes FLE as education of the whole person. "Learning about families is learning about relationships."[44] Through the relationships one forms in a group, a participant learns about how he functions in general. Kiefer, Levine, and Rosenthal say that FLE adds to an individual's knowledge of his own behavior as an individual, in addition to being part of a family and society.[45] In work with parents of day care children, they

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[43]Child Study Association of America, Education and Therapy: Similarities and Differences, pp. 1-4.

[44]Lucile Cantoni, 18 FLE Groups Conducted for Parents by the Family Service of Metropolitan Detroit (Detroit: Family Service, 1970), p. 111.

[45]E. Kiefer, N. Levine, and C. Rosenthal, "Family Life Education for the Parents of Day Care Children," Journal of Jewish Communal Service 48 (1972): 304.

found that FLE is a positive preventive approach which helps families "establish, strengthen, fortify and reinforce the precepts of healthy relationships."[46] This finding addresses goals that are similar to Hefter's Program Aids for Jewish Community Centers. The focus of her FLE programs is on individual members, the family, and the relationship to the community.[47] Hefter defines FLE as:

> . . . a preventive and educational service dealing with understanding of human relations, encompassing intellectual growth, involving feelings and attitudes, the dynamics of interpersonal relationships and personality development.[48]

Place describes the purpose of FLE to be a way:

> . . . to modify attitudes, to practice human relations more beneficial to mental health (so that) some of the potentially negative family patterns can be altered and there can be some positive influence for healthier family functioning in coming generations.[49]

Pollack comments that the aim of FLE:

> . . . is not treatment but prevention of disturbances in personality development or family relationships . . .

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[46]Ibid.

[47]Felicia Hefter, "FLE Program," Jewish Community Center Program Aids (Summer 1971):17.

[48]Ibid., p. 18.

[49]Francis Goodall Place, "A New Look at Family Life Education and Community Mental Health," FLE: Philosophy and Content (St. Louis: Family and Children's Service of Greater St. Louis, 1965), p. 2.

the group members are predominantly normal individuals with capacity for object relationships.[50]

More explicitly, Hefter elucidates seven goals for Jewish Family Life Education programs:

1. Increase participants' knowledge in human relations and personality development
2. Alleviate anxieties in relation to human interaction
3. Develop a wider range of choices in problem solving and decision making situations
4. Promote awareness of and support an individual's potential in breaking an unsatisfactory pattern of behavior
5. Sensitize participants to behavior patterns of people with whom they interact
6. Cultivate a sense of self-confidence
7. Reinforce a sense of belonging to the Jewish community.[51]

In the past fifteen years there has been a wide range of FLE programs in operation. While the authors found that most of these have centered upon parent-child relationships, the goals and purposes of such programs have great importance for all areas of preventive service.

An experimental community program out of the Nathan W. Ackerman Family Institute in New York provided service to three groups of "well" families before their problems escalated to disruptive levels. This emphasized an

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[50]Pollack, "FLE: Its Focus and Techniques," p. 198.

[51]Hefter, "FLE Program," p. 18.

educational rather than a treatment bias. Goals were to teach families ways of observing their own interaction, defining problems in terms of relationships, and developing an awareness of family themes.[52]

After conducting a study of eighteen FLE groups for parents in Detroit, Cantoni reports that FLE is an effective method of service.[53] Furthermore, FLE groups, according to Cantoni, should be developed for people at each stage of life. The groups in the Detroit study were a series of discussion meetings for people with similar problems or life tasks. The goals were to increase the competence of the participants in dealing with life situations. The primary goal was to teach mental health concepts related to human growth and development and human interaction, and relate these concepts to day-to-day life experiences. Group leaders universalized experiences, reducing anxiety and tensions, but always clarifying the difference between group education and individual

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[52]P. Papp, O. Silverstein, and E. Carter, "Family Sculpting in Preventive Work with 'Well Families'," Family Process 12 (1973):197.

[53]Cantoni, 18 FLE Groups Conducted for Parents by the Family Service of Metropolitan Detroit, p. 4.

treatment.[54] Kiefer's groups also emphasized through the group process that others are going through similar experiences. Conscious and preconscious material was used with parents looking at the meaning of their own and the child's behavior and age appropriateness.[55] It is the position of the writers that FLE groups would make an important contribution to people at all stages of the life cycle.

The FLE groups in Detroit were all conducted in host organizations whose primary function was religion, education, fellowship, etc. In the Jewish community FLE groups are often developed in coordination with synagogues, fraternal service organizations, and Jewish social service agencies.[56] A recent Jewish Family Service brochure on FLE included topics such as choosing a mate, marriage, sex, divorce and separation, the single parent, the challenge of children's behavior, dealing with adolescents, the empty nest, and the golden years.[57] Other topics from Hefter's

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[54]Child Study Association of America, Education and Therapy: Similarities and Differences, p. 5.

[55]Kiefer, Levine, and Rosenthal, "Family Life Education for Parents of Day Care Children," p. 304.

[56]Reisman, The Emerging Jewish Family, p. 38.

[57]Ibid., p. 34.

program aids include family living and sex education, adolescence and the new morality, the role of the Jewish woman in family and society, self-awareness, husband/wife communication, etc.[58]

The St. Louis Jewish Community Center and Jewish Family Service share a belief in FLE as a preventive or early detection device. These two agencies work together to "promote and endorse education for good family living"[59] Parents in these groups work to develop self-knowledge, understanding and a perspective of their own feelings. It is programs such as the above that Reisman refers to when he remarks:

> . . . that the Jewish Family Service Association has taken the initiative in collaborating with other Jewish organizations (and) is in itself a positive contribution to enrichment of the Jewish community.[60]

Auerbach comments on the validity of FLE as showing "that casework agencies can make and are making an important and special contribution to the mental health of the community

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[58]Hefter, FLE Program, p. 17.

[59]Kiefer, Levine, and Rosenthal, "Family Life Education for the Parents of Day Care Children," p. 305.

[60]Reisman, The Emerging Jewish Family, p. 39.

in this work."[61]

Summary

Family Life Education services are an important development in preventive mental health. As professionals began to realize the stresses modern living places on the family, Family Life Education was increasingly used as a means of strengthening coping mechanisms. Other approaches such as counseling groups, were used for similar purposes, but were more focused on the intrapsychic processes. Both the education and therapy models are viable responses to crisis theory which states that the individual's coping ability is influenced by his ego strength, the nature of the stress, and his support systems. These approaches have been found to be effective programs which can be integrated into the existing support systems of the individual, such as schools, churches, synagogues, and other community settings. In the following chapter, the synagogue will be discussed as a possible resource for mental health programming.

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[61]Auerbach, "Family Life Education as a Service of the Casework Agency," p. 319.

CHAPTER III

THE SYNAGOGUE AND MENTAL HEALTH:

A REVIEW OF THE LITERATURE

The Role of the Clergy in Mental Health

There are some generalizations that are relevant in discussing the role of the clergy in mental health. First of all, there are large numbers of people who receive no help from mental health professionals. Second, in American culture, asking for and receiving help is difficult due to taboos against becoming dependent.[1] A study conducted by the Joint Commission on Mental Illness and Health investigated where people turned when they needed help. While 25% of those surveyed claimed that they had had a problem in which professional help could have been useful, only 14% actually sought out help. Of those, 42% consulted clergymen, 29% spoke with a physician, 18% sought out psychiatrists or psychologists, and 10% went to social service clinics. The authors believe that a critical factor that led to some individual's seeking help was its availability

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[1]Joint Commission on Mental Health and Illness, Action for Mental Health (New York: Basic Books, 1961), p. 115.

and the client's awareness of it.[2] They conclude that most Americans turn to clergymen before going to anyone else for help.[3]

Many mental health professionals agree that there aren't enough clinical services to meet the problem of mental illness in the society. Place writes:

> The alternative is prevention: preventive services under our (mental health professionals) own auspices and in collaboration with other community institutions.[4]

Many agree that the church is prime among these community institutions. Chikis states that the focus on community supports and rehabilitation rather than providing custodial care will inevitably involve the church as a resource. He suggests that there must be extensive collaboration between mental health professionals and clergymen.[5]

Seward Hiltner gives four reasons for the increasing importance of the pastoral counseling role.

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[2]Klein, Community Dynamics and Mental Health, p. 111.

[3]Joint Commission on Mental Health and Illness, Action for Mental Health, p. 132.

[4]Place, "A New Look at Family Life Education and Community Mental Health," p. 3.

[5]Tibor Chikis, "New Hope for the Mentally Ill," Concern 5 (1963):2-3.

(1) More church members are faced with personal needs and problems which they present to the clergyman. (2) Knowledge gained from the disciplines of psychiatry, psychology, and anthropology cannot be ignored. (3) Without proper understanding, people will not follow the faith. (4) Theological tradition is endangered if not made relevant to modern life and its problems.[6]

In a study of the clergy's involvement in mental health endeavors, it was found that most clergymen felt that one of the most important functions of religion is to provide a feeling of security.[7] They saw their maximal effectiveness in the area of prevention, rather than treatment, since group or individual counseling can often be a stabilizing factor. It was concluded that clergymen must capitalize on certain built-in aspects of their role, such as accessibility.[8] Klink writes:

> The method of effective pastoral work is to use the situations of ministry to increase, support, supplement, and preserve the ego functions of the persons served.[9]

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[6]Richard McCann, The Churches and Mental Health (New York: Basic Books, 1962), p. 58.

[7]Ibid., p. 180.

[8]Ibid., pp. 239-240.

[9]Thomas Klink, Depth Perspectives in Pastoral Work (New York: Prentice Hall, 1965), p. 32.

He makes the point that even among the increasing number of specialists in the helping professions, pastors:

> . . . must not abandon more than two centuries of distinctively American pastoral leadership and church involvement in meeting human needs.[10]

Group Approaches to Pastoral Counseling

Most of the pastoral counseling which takes place is on an individual basis. Clinebell feels that group approaches must not be ignored:

> Group counseling methods constitute the most promising resource for major creative advances in pastoral counseling: Group counseling approaches, applied to a wide spectrum of problems of living, can release a Mississippi-like stream of help in a congregation's life together. They can allow a church to become an increasing force for preventing personality problems by stimulating growth toward wholeness. Although exciting developments are occurring in the use of group pastoral counseling in many different places, most churches have scratched only the surface of the rich possibilities in this direction.[11]

He lists some of the advantages and values of group counseling in the church:

1. Most of pastoral counseling done individually can be done more effectively in small groups
2. It increases the number of those who can be served
3. Group counseling methods can be used to stimulate the growth of many who would not come for "formal"

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[10] Ibid., p. 62

[11] Howard J. Clinebell, Basic Types of Pastoral Counseling (Nashville: Abingdon Press, 1966), p. 206.

counseling
4. It allows counselees to help each other. It is good especially for people who fear dependency, since it allows them to give of themselves
5. The small group is the natural milieu for short-term educative counseling.[12]

Clinebell notes that counseling groups are a major new frontier for churches and that:

> . . . paralleling its conventional groups, every church should have one or more groups with specific counseling goals--dealing openly with feelings and attitudes; giving support during personal crises; seeking solutions to problems of living; increasing mental and parental effectiveness; growing in spiritual strength, interpersonal awareness, and self-acceptance. Some of these goals can be achieved as byproducts in creatively led non-counseling groups. But a need-oriented church should have certain groups in which these goals are the groups's explicit raison d'etre.[13]

The training of the pastoral counselor

While the clergyman may be in the ideal position to deliver mental health services to his constituents, a major drawback lies in his training. The Joint Commission on Mental Illness and Health voiced the fear that the clergyman may have difficulty in recognizing the complexity of the problems presented to him, and suggests that more

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[12]Ibid., p. 20.

[13]Robert C. Leslie, "The Uniqueness of Small Groups in the Church," Pastoral Psychology (June 1964):33.

clinical training is needed.[14]

The movement towards clinical pastoral counseling education is found primarily among the Protestant denomination. The 212 Protestant seminaries in the United States reported in a survey that they now have 343 courses in clinical pastoral training, counseling, or psychology. Amorg the 500 Catholic seminaries there were few courses or programs in supervised clinical training, although many academic courses were offered in psychology or related areas. There are also seven centers specifically geared for training in more extensive clinical experiences. The only clinical program which is associated with the three major Jewish theological schools (Yeshiva University, the Jewish Theological Seminary, and Hebrew Union College) is the Institute for Pastoral Psychiatry of the New York Board of Rabbis.[15] Rabbi Hollander of the New York Board of Rabbis stated:

> The clergyman needs a religious concept of man which could be applied to the needs of man and help him to meet them better (in such areas as belonging, security, purpose, and regarding basic institutions such as the

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[14]Joint Commission on Mental Health and Illness, Action for Mental Health, p. 119.

[15]McCann, The Churches and Mental Health, pp. 115-15.

> family). He needs a psychiatric understanding which will communicate this. Finally he needs a technique . . . Many clergymen . . . have no picture of how they should come to a focus on a problem.[16]

Anderson voices the concern that clergymen are not up to date in their approaches. He writes that mental health concepts have changed in the past ten years, and that the pastoral counselor may tend to be unaware of the changes. Most courses still tend to be heavily psychoanalytic in their orientation. He feels that if this continues, the pastoral counselor will be excluded from healing teams. He predicts that in the next twenty years psychiatrists will become more interested in philosophy and morality, and that religion can offer a lot to this search. He thinks that the turmoil in organized religion could be ameliorated through closer collaboration between mental health and religion.[17]

The Role of the Rabbi

The rabbi has long filled the role of the spiritual and temporal counselor for the Jew. The rabbi

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[16] Ibid., p. 128.

[17] G. C. Anderson, "Pastoral Psychology: the Next 20 Years . . . in Relation to Mental Health," Pastoral Psychology 21 (1970):63-68.

traditionally played the role of an arbitrator in personal and social problems, which gave rise to a body of responsa literature addressing itself to the solution of problems in the spirit of appropriate religious practices.

Kertzer writes:

> . . . (that) "the rabbi will surely advise and help" was the perennial hope of countless Jews who depended on him in times of personal or family crisis.[18]

As Jewish immigration to the United States swelled at the end of the nineteenth century, the rabbi served as an agent of social service, helping families deal with problems of adjustment to a new land. The synagogue was not only responsible for the religious and educative needs of its members, but was responsible for the health and welfare of its congregants as well.[19] The rabbinical duties of educator, preacher, confidante, mental healer, psychologist, administrator, public relations man, and pastor developed when the Jewish community had not begun to train

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[18]Morris Kertzer, ed., The Rabbi and the Jewish Social Worker (New York: Commission on Synagogue Relations, 1964), p. 8.

[19]Ibid., p. 11.

specialists in fields other than the rabbinate.[20] However, as the secular institutions developed in the twentieth century, the social services were removed from the synagogue. Trained professionals displaced the rabbi as leader in many areas.[21]

The rabbi in America today is seen by some as more of a functionary-administrator than a scholar-saint. He must be prepared to live in two worlds--the secular, as well as the religious.[22] Sklare sees the modern rabbi filling several roles. He is a priest who conducts public worship. He is a preacher who delivers sermons. He is a cleric who, as an arm of the state, performs certain rituals. As a rector, he is an administrator. In a psychological sense, he is a father who heads the congregation. He is a parson, a communal leader. Finally, he is a pastor who offers counsel and guidance. Sklare notes that "in this role, lack of orientation is felt to be even more

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[20]Stuart Rosenberg, "Synagogue, Community, and the Rabbi: After 300 Years," Reconstructionist 21 (November 18, 1955):14.

[21]Kertzer, The Rabbi and the Jewish Social Worker, p. 11.

[22]David Golovensky, "The Rabbi as a Counselor and his Relationship with Professional Social Workers," Journal of Jewish Communal Service 35 (Winter 1958):219.

serious."[23] Changes have occurred in the role of the modern rabbi. In his role as a congregational leader, the ritual and spiritual emphasis has declined, while the role of counselor has grown.[24]

Many see the rabbi as being in an ideal position to promote the mental health of his congregants. The rabbi has long been seen as playing an important role in the Jewish community and in implementing harmonious relationships. Rabbi Jeshaia Schnitzer, who conducted a study of the mental health functions of the rabbi, wrote:

> In the American Jewish community, the rabbi has a two-fold task. He must help his people become positive Jews and to develop into wholesome and integrated personalities.[25]

Rabbi Earl Grollman agrees: " . . . the aim is the restoration of the person to wholeness--emotional, spiritual, and social."[26] Jews approach the rabbi in relation to the entire range of difficulties which occur throughout the

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[23]Sklare, Conservative Judaism, p. 21.

[24]Kertzer, The Rabbi and the Jewish Social Worker, p. 77.

[25]Jeshaia Schnitzer, New Horizons for the Synagogue (New York: Bloch Publishing, 1956), p. 5.

[26]Earl A. Grollman, Rabbinical Counseling (New York: Bloch Publishing, 1966), p. 23.

life span:

> Jewish people do find their way to the rabbi at a time of grief, in moments of anxiety relevant to adolescence, at times when the miracle of birth of a child comes into their lives, when they seek premarital consultation, help at a time of marital difficulty, tranquility from fear or guilt, and when they want the help of an interested individual to guide them in making great decisions.[27]

Rabbi Edward Klein further corroborates this:

> Experience and at least one recent survey indicate that the majority of people with problems consult their clergymen first. This is certainly true of Judaism, for the Rabbi has served traditionally as teacher and judge, not merely in ritual matters, but also in interpersonal relationships and moral problems.[28]

Schnitzer concludes that the rabbi is an ideal facilitator for positive mental health programming:

> The rabbi, because of his prestige in the community, and his many relationships, can go far in developing a program for the growth of the individual and the family.[29]

Schnitzer's nationwide study of rabbis from the Orthodox, Conservative, and Reform movements found that 90% said that they engaged in counseling.[30] However, this role

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[27]Kertzer, The Rabbi and the Jewish Social Worker, p. 33.

[28]Jacob Freed, ed., Judaism and the Community (New York: Barnes & Co., 1968), p. 231.

[29]Schnitzer, New Horizons for the Synagogue, p. 3.

[30]Ibid., p. 8.

is not without its problems. He found in interviews with rabbis that they were not ready or prepared to "accept the implications of the pastoral counseling role." Many felt that common sense, maturity, or experience were sufficient, yet he notes, "One must not base a counseling approach only on common sense and experience." He felt that there are ambivalent feelings among rabbis about their role in direct counseling, and that many saw the responsibility as threatening.[31] Segalman points out some other problems. He suggests that the role and status of the rabbi may prevent the development of a good counseling relationship. In addition, the lack of structure and function as a counselor may be problematic.[32]

The training of rabbis

Rabbis Roland Baxt and Walter Wurzburger of the New York Board of Rabbis wrote:

> At a time of mounting social upheaval and family conflict it becomes increasingly important for the spiritual leader in a community to be equipped to offer sensitive guidance in effecting happier relationships

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[31] Ibid., p. 15.

[32] Robert Segalman, "Rabbi-Caseworker Cooperation," CCAR Journal 20 (Fall 1973):22.

within the framework of the Jewish home.[33]

Berman implies that this means changes in the training curriculum of rabbis:

> Can the reconstruction of Jewish family life be a job for a new breed of counseling rabbis? . . . They will be men as vigorously trained and as deeply committed to unfolding a theory and practice of counseling as their forebears were committed to the understanding and implementation of Halachah (Jewish law).[34]

The Joint Commission on Mental Illness and Health found that most courses in human relations in Jewish seminaries were theoretical and did not prepare the rabbi for the institutional aspects of counseling.[35]

Liebman wanted to find out how rabbinic students evaluated their own education. A survey conducted at Yeshiva University (Orthodox) found that the curriculum is almost exclusively related to the Talmud--a vast body of law, theology, philosophy, and history. Sixty percent of the students felt that there was too little emphasis on human relations, while 40% felt that the emphasis was about

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[33]Samuel Spiegler, "Fact and Opinion," Journal of Jewish Communal Service 49 (Winter 1972):169.

[34]Louis Berman, "The Need for a Change in Jewish Family Life," Jewish Digest 17 (November 1971):66.

[35]Joint Commission on Mental Health and Illness, Action for Mental Health, p. 25.

right.[36]

The Jewish Theological Seminary (Conservative) stresses Talmud also but offers additional courses in Bible, philosophy, history, homiletics, speech, education, and pastoral psychology. The pastoral psychology program was initially funded by a grant from the National Institute for Mental Health. However, in a Seminary report to NIMH, they report that the students don't take it seriously and feel threatened by studies which " . . . by emphasizing the . . . psychological, undercut moral, ethical, and religious views of life and behavior determination."[37] Instructors questioned the value of the course despite administration approval. One teacher commented that the emphasis on scriptural studies is justified because counseling skills are acquired "primarily through experience and common sense. They cannot, in fact, be taught, nor are they particularly worthy of being taught."[38] The students at the Seminary seemed to agree that further training was unnecessary. Sixty-seven percent felt that the emphasis on human relations courses was about right, while 33% felt

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[36]Charles Liebman, Aspects of the Religious Behavior of American Jews (New York: KTAV, 1974), p. 31.

[37]Ibid., p. 34

[38]Ibid., p. 50.

that there was too little emphasis.[39]

Hebrew Union College (Reform) has more emphasis on the practical rabbinate, with 15% of its courses devoted to human relations, homiletics, education, and speech.[40] A survey of Hebrew Union College rabbinic students showed an unexplained difference of opinion between the Cincinnāti and New York schools. In New York, 77% felt the emphasis on human relations was about right, and 23% felt it was too little. In Cincinnati, 36% felt it was about right, and 64% felt it was too little.[41]

Liebman concludes that seminaries are neither vocational nor professional institutions, but are closer in character to graduate schools in the liberal arts with scholarship more highly valued than professional training. He perceives rabbis as: 1) knowing Jewish textual tradition, 2) possessing basic skills in preaching and officiating at religious and quasi-religious functions, and 3) possessing a minimal ability to do counseling.[42]

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[39] Ibid., p. 49.

[40] Ibid., p. 54.

[41] Ibid., p. 59.

[42] Ibid., p. 105.

The relationship between rabbis and other professionals

Ostow, who heads up the pastoral psychiatry sequence at the Jewish Theological Seminary noted some points of contact between the disciplines of the rabbi and the psychiatrist. There are common interests in: understanding human behavior, influencing behavior for the "better," helping people in trouble, preventing and alleviating illness, assisting the individual to live as a member of society, and strengthening family life.[43] One writer has suggested that:

> . . . the time may be right for making available in the American synagogue, as specialized clergy have already appeared in certain churches, some Rabbis . . . who may cooperate with the other scientific members in the team of modern therapists.[44]

However, as discussed above, there is some question as to the rabbi's ability to engage in counseling. Golovensky suggests that where the rabbi's skills are such that he can't help the client he should be able to refer him to a qualified professional: "The rabbi can, and indeed

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[43]Mortimer Ostow, "Rabbinic Counseling," Conservative Judaism 21 (Fall 1966):23.

[44]Kertzer, The Rabbi and the Jewish Social Worker, P. 73.

should serve as a valuable catalyst."[45] Segalman agrees, and in addition, suggests that more programs of mutual consultation be established.[46] However, in a study of the interactions of rabbis with other helping professionals, Aronoff found that rabbis tended to have negative feelings toward social work agencies. The negative reactions were based on: 1)isolated negative experiences with agencies, and 2) the fear that social workers would not respect the rabbi's religious Weltanschaung.[47]

The Function of the Synagogue

A Brief History of the Synagogue and Its Relationship to the American Jewish Community

With the large wave of Jewish immigration in the late 1800's, the New York Jewish community depended on the congregations to meet the needs of the many groups. The synagogue was not only responsible for the religious and educative needs of its members, but was responsible for the

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[45]Golovensky, "The Rabbi as a Counselor and his Relationship with Professional Social Workers," p. 219.

[46]Segalman, "Rabbi-Caseworker Cooperation," p. 30.

[47]Nina Aronoff, "Rabbis as Counselors Interacting with Other Helping Professions," Smith College Studies in Social Work (October 1957):100.

health and welfare of its congregants as well.[48] The leaders of the synagogues were the founders of social agencies to meet these needs. Sisterhoods and brotherhoods became the organizations which developed social service activities. Groups organized through the synagogue included, "Upbringers of Orphans," "Clothers of the Naked," "Crown of the Aged," and "Comforters of Mourners." These were all voluntary associations of lay persons inspired by Jewish law, the synagogue-community and traditional notions of obligation.[49]

By 1930 the professionalization and availability of social work leadership separated the synagogue from many aspects of its linkage to social service agencies. The synagogue played less of a role as an institution for providing social service leadership in the community. Many laymen assumed that social problems should be dealt with by social agencies. Social workers emphasized professionalism, thereby discouraging the synagogue from playing an active role in social service. In addition, many social

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[48]Kertzer, The Rabbi and the Jewish Social Worker, p. 11.

[49]Synagogue Council of America, A Guide to Aging Programs for Synagogues (New York: Synagogue Council of America, 1975), p. 2.

workers no longer saw value in sectarian service. The synagogue until the late 1950's was relegated to the circumference of many aspects of Jewish community life, concerning itself only with religion and education.[50]

With the disappearance of the extended family, the nuclear family has greater dependence on societal institutions.

> Stresses are experienced by Jewish individuals and families in attempts to maintain their own cultural identity in a society which really doesn't provide reinforcement.[51]

The synagogue has an important role in maintaining and strengthening Jewish family cohesion.[52] For the sake of its own and for Jewish survival, the synagogue has recently joined other communal institutions in showing an increasing interest in Jewish family life and in the individual lives of its members.

Schnitzer sees a shift in the role of the synagogue due to the growing interest in the social sciences and the links made between religion and psychology. In the past,

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[50]Sidney Goldstein, Synagogue and Social Welfare (New York: Bloch Publishing, 1955), p. 62.

[51]Hefter, "FLE Program," p. 4.

[52]Segalman, "Rabbi-Caseworker Cooperation," p. 21.

says Schnitzer, "religion was practiced not so much for the sake of man on this earth, as it was for the sake of his place in heaven."[53] Sklare takes this one step further by declaring that synagogues had to make compromises in order to maintain themselves in a secular society.[54] The growth of social and recreational programs, according to Sklare, stems from a desire for self-maintenance. "The creation of the multifunctional role of the synagogue is an attempt to fortify the institution."[55]

The writers have found that throughout the literature there is evidence that synagogues which play an important part in the total life of its members have remained the most vibrant. Those which have concentrated on their role as a house of worship to the exclusion of other types of function appear to be going through an identity crisis as the needs of the constituency change.

> The novel approaches in adult education, the introduction of social action programs and concern for the social and personal integration of human beings are the new trends in synagogue functioning.[56]

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[53]Schnitzer, New Horizons for the Synagogue, p. 2.

[54]Sklare, Conservative Judaism, p. 130.

[55]Ibid., p. 79.

[56]Schnitzer, New Horizons for the Synagogue, p. 1.

It is the contention of these writers that synagogues are following their traditional function as the center of Jewish life by becoming intricately involved with the emotional and social lives of its congregants. In addition, the synagogue is making a contribtuion to Jewish survival by maintaining the emotional and physical health of its members. This will be further examined in the section on the synagogue as a resource for mental health.

The Synagogue as a Resource for Mental Health

"One of the fundamental principles of Judaism is the sacredness of human life."[57] In the Bible, laws of health and codes of behavior begin a long tradition in Judaism of activity in health-related areas. Trends have gone from treatment of the sick, to prevention of disease, to the promotion of health.

Kertzer outlines the psychological values of classic Judaism in a book on the rabbi and the Jewish social worker:[58]

1. Judaism has always exhibited insight into the

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[57]Goldstein, Synagogue and Social Welfare, p. 187.

[58]Kertzer, The Rabbi and the Jewish Social Worker, pp. 72-76.

therapeutic importance of talking out troubling emotions. An example is the mourning process. Clergymen were once called "physicians of the soul." The prophet Jeremiah once said, "The Torah shall not perish from the priest, nor the word from the prophet, nor counseling from Hacham, the wise."[59]

2. The appropriate roles of mother, father, and child as the children's character develops through identification has been espoused throughout Judaic literature.

3. Judaism declared hope and love to lead to personal stability, recognizing sex as an important element in the drive for love.

4. Jews have a strong sense of cohesion with a sense of independence and self-worth. It is a value that it is healthy to belong to a group where there is trust and belief in each other.

The synagogue has historically served as the center of the community and has been the focus for carrying out the mitzvot (Jewish law). Rabbi Isaac Trainin, the Religious Director of the New York Federation said: ". . . the philosophy of Jewish social work and synagogues . . .

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[59]Ibid., p. 72.

must be concerned for the individual."[60] Reisman agrees with this concept, believing that "one level of conceiving of Jewish objectives is that of servicing the mental health needs of Jews."[61] Reisman advocates the use of Jewish Family Life Education groups in achieving this objective.

Questions asked by Shapiro bind the servicing of individuals and families to the basic values of Judaism:

> Does a Temple say in effect that if families are disintegrating, then Judaism is disintegrating? And if this is your responsibility, how will you go about fulfilling it? Clearly the old ways are not doing the job. What new ways will you adopt? . . . if we can do that we can not only make Judaism truly a family religion but also save some Jewish families.[62]

Bubis earmarks the synagogue as "a logical institution for the nuclear family."[63] In his article, "The Synagogue and the 70's," Bubis deals with the new kind of family that fulfills its needs through the synagogue.

> Synagogues of tomorrow have options before them. One road will lead them to being active partners with all

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[60]Freed, Judaism and the Community, p. 83.

[61]Reisman, The Emerging Jewish Family, p. 27.

[62]Manheim Shapiro, "Is Judaism Still a Family Religion?," Jewish Digest 17 (December 1971):12.

[63]Gerald Bubis, "The Synagogue and the 70's: What Will its Leaders Need to Know?," Reconstructionist 37 (October 15, 1971):12.

of Jewish life in serving the needs of the Jewish people.[64]

The population now being served by the synagogue, according to Bubis, consists of: nuclear families in search of substitute extended families; single parent families; mobile families seeking roots; older people and younger families. People live longer and retire earlier, having much leisure time. They turn to the synagogue for outlets. Day-to-day events are shared by friends rather than family.

Jews look to the synagogue for answers to problems. The synagogue is a ready vehicle through which to accomplish the integration of religious principles and social actio...[65] The synagogue is a local institution, with a geographic focus. That it is convenient for outreach has been proved by centers and hospitals who have conducted programs in synagogues. Synagogues in changing neighborhoods need new vitality through community involvement. The familiar atmosphere, staff, and access to volunteers makes the synagogue a more personal and less complex center for service. The Synagogue Council of America holds that the

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[64]Ibid., p. 13.

[65]Synagogue Council of America, A Guide to Aging Programs for Synagogues, p. 10.

prime duty of the synagogue and the rabbi is to be understanding of life-cycle events because the synagogue has a concern for and a responsibility to its members throughout the life-span.[66]

Examples of social service programs which have existed in synagogues

The Stephen Wise Free Synagogue in New York sees itself as a center of community service.[67] A special Social Service Department, equivalent to the Departments of Worship and Education, studies social needs and develops appropriate programs. It has a professional staff in addition to carefully trained volunteers. There is extensive cooperation with other agencies. Sample programs include film forums and discussion groups such as: Mental Hygiene; Marriage and Human Relations; Feelings of Depression; Fears of Children; Adolescence; etc.

An experiment in the Human Relations Center at Temple Shomrei Emunah began in 1951. The rabbi spoke of the relationship of counseling and Judaism in sermons and

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[66] Ibid., p. 11.

[67] Goldstein, Synagogue and Social Welfare, p. 62.

handled ten to twelve weekly cases using a crisis model.[68]

The Human Relations Program of Temple Beth Sholom[69] consists of two rabbis and an advisory board made up of a social worker, a psychiatrist, a psychologist, a doctor, and a Protestant minister. An integral part of the synagogue program includes counseling and group work.

The Commission on Synagogue Relations in New York has involved the rabbi and social worker in a series of workshops.[70] Among these were: Mental Health and Judaism; Cooperation of the Rabbi and Social Worker in Problems of Divorce and Separation; and, Problems of the Aged.

The authors view the synagogue as an appropriate setting for mental health prevention. Potential resources in the synagogue include the rabbi, teachers, men's clubs, sisterhoods, youth groups, and the general membership. Resnikoff suggests that "families in the congregation could be assisted by utilizing the specialized services of congregational members."[71] In his own congregation a

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[68]Schnitzer, New Horizons for the Synagogue, p. 121.

[69]Ibid., p. 119.

[70]Freed, Judaism and the Community, p. 83.

[71]Simon Resnikoff, "The Congregation as an Extended Family," Conservative Judaism 27 (Summer 1973):82.

Family Life Committee was formed consisting of a clinical psychologist, psychiatrist, psychiatric nurse, education counselor, psychiatric social worker, drug counselor, attorney, three interested laymen, and two young people. An occasional speaker from Jewish Family Service supplements these resources. "This program . . . provides a channel for constructive action in dealing with problems leading to family breakdown."[72] The committee also makes itself available in crisis situations.

Numerous proposals developed out of the Stephen Wise Free Synagogue. They suggest that positive programs should be instituted in which congregants build up courage to face life and cope with their problems. "It should be one of the functions of religion to cultivate in men and women a spirit of confidence and courage and faith in their own inner and latent resources."[73] Lecture courses and discussion groups led by experts both in their fields and in Jewish tradition and teachings should be conducted. Synagogues should play a part in the education of parents as to life cycle stages, leading to a better understanding

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[72]Ibid., p. 83.

[73]Goldstein, Synagogue and Social Welfare, p. 199.

of themselves and their children. The development of programs of family relationships will hopefully reduce tensions, estrangement, and alienation. People must be tuaght how to avoid and deal with frustrations and recognize their limitations. Libraries in synagogues should be developed in mental health areas. The Free Synagogue also favors consultation programs in cooperation with other agencies.[74]

It is the opinion of these writers that those synagogues which are taking steps in regard to mental health concerns are following in the tradition of Judaism. Although limitations must be realized, within the realm of preventive care, there is room for many innovative types of programs. It is recognized that although the basic tenets of this philosophy are not new, the implementation of supporting programs raises legitimate questions for each rabbi. These questions will be dealt with in this study of synagogue programs and rabbinic attitudes in the Los Angeles area.

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[74]Ibid.

The Major Denominational Movements Within Judaism

Three major denominational movements exist in the United States today. While the three movements differ in theological interpretation, the major differences between them that affect daily living arise from their different approaches to Jewish law and Jewish ritual practices. The Orthodox movement sees Jewish law as divinely revealed. Every situation in life is approached from the perspective of Jewish law--it is an all encompassing life style.[75] The Conservative movement sees Jewish law as divinely revealed, but more adjustable in its interpretation and more subject to changing conditions. The Reform group sees the moral and ethical doctrines of Judaism as divinely inspired and its ritual law as man made and, therefore, not compulsory. Hertzberg sums up the relationship between the three movements: "We are in reality, on the religious scene, confronted by a continuum . . . in which the ritual variations

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[75]Oscar Z. Fasman, "Orthodox Judaism," in Meet the American Jew, ed. Belden Menkus (Nashville: Broadman Press, 1963), p. 25.

shade from one group into the other."[76]

Reform Judaism

A study of 276 Reform Temples done by Jeshaia Schnitzer in 1958 as part of the Action for Mental Health series, found that 85% of the rabbis of these temples did pastoral counseling. Ninety-three percent answered affirmatively when asked if they felt counseling was an essential part of a rabbi's professional duties. Eighty-eight percent had read material on counseling procedures. Many of these rabbis, however, were not concerned about techniques of counseling. This was seen as an art, coming from a natural base of personal talent and experience.[77] The above statistics establish criteria to support the contention of these writers that there is a place for mental health services in the Reform synagogue.

Feldman links the function of the present day synagogue and the pattern of activity to the character and

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[76]Arthur Hertzberg, "The American Jew and His Religion," in The American Jew: A Reappraisal, ed. Oscar I. Janowsky (Philadelphia: Jewish Publication Society, 1972), p. 116.

[77]McCann, The Churches and Mental Health, p. 66.

interests of the rabbi.[78] In the study guide for the Future of the Synagogue published by the Union of American Hebrew Congregations, the national body of Reform congregations, the role of the rabbi as counselor is examined. It is stated that many congregants will go to the rabbi rather than to a psychiatrist with whom an association still carries a stigma.[79] There are a lot of people who need a range of services beyond that which a psychiatrist can offer. The future, therefore, still holds a place for these services beyond that which is offered in the social service agencies. The question remains as to how these services are to be offered.

The Central Conference of American Rabbis (CCAR), to which the Reform rabbis belong, has established a Committee on Judaism and Health. Rabbi David Saperstein, the Associate Director of the UAHC Religious Action Center and the Social Action Commission said, in a personal interview, that the Committee "supplies the rabbis with material

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[78]Abraham Feldman, "The Changing Functions of the Synagogue and the Rabbi," in Understanding American Judaism, ed. Jacob Neusner (New York: KTAV Publishers, 1975), p. 108.

[79]Union of American Hebrew Congregations, Critical Issues Facing Reform Judaism (New York: UAHC, 1972) p. 19.

that should be helpful to them as interest and concern in health matters continue to mushroom."[80] A pamphlet dealing with death, mental illness, suicide, and drugs was sent out by the Union of American Hebrew Congregations. Rabbi Saperstein continued, however, stating:

> The UAHC has never passed a resolution on mental health per se; it was alluded to in a nebulous resolution expressing concern for drug abuse. There is a fundamental presumption that people are entitled to mental health care. This made it unnecessary for the Union to delineate a concern. Secondly, there is a belief that dealing with mental health problems fell into the province of the rabbi's competence and responsibility. Therefore those programs that have been done are aimed at enriching the ability of the rabbi.[81]

This statement raises questions since the only preparatory course at Hebrew Union College, the training institution for Reform rabbis, is one in human relations. This course is aimed at recognizing symptoms of mental illness and knowing when to make appropriate referrals to other professionals. There is also some instruction in supportive therapy as opposed to treatment oriented techniques.

The UAHC publishes a manual on program priorities in order to generate discussion among its communal leaders

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[80] Interview with Rabbi David Saperstein, Union of American Hebrew Congregations, Los Angeles, California, November 1975.

[81] Ibid.

as to what directions the Reform Movement should take. Among the major priorities in the 1974-1979 manual was strengthening Jewish family life. The Union has stated an interest in the delineation of ways in which its member synagogues are fulfilling this traditional goal. Among the issues suggested for study in order to come to a consensus of "Guiding Principles for Reform Judaism" are marriage and divorce, death, the relation between men and women, aging and retirement, and single parents.[82] It is stated that:

> Our congregations and communities are filled with single parents, divorced and widowed men and women and others who stand alone in an increasing frenetic America. The Union and its congregations should begin to create programs to involve Jewishly those who do not fall into the traditional and comfortable rubrics of Hebrew life.[83]

Further questions are raised as to the specific congregational programs which can be introduced to enhance Jewish family life. The manual mentions family neighborhood groups, counseling services, and crisis counseling as examples. It appears to these authors that the Union is beginning to take a stance in support of programs which go

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[82]Union of American Hebrew Congregations, Critical Issues Facing Reform Judaism, p. 19.

[83]Union of American Hebrew Congregations, Toward Program Priorities: 1974-1979 (New York: UAHC, 1974), p. 27.

beyond the individual services of the rabbi.

The structure of the UAHC is set up so that there is a separate department for each area of congregational need. It is interesting to note that there is a Department of Gerontology. In addition, a committee on the single Jew has recently been formed which, according to Erwin Herman, the Director of the West Coast region, will probably develop into a full-fledged department. According to Rabbi Herman, who was interviewed personally, "The synagogue should be the center in which professionals can be helpful in every area in order to contribute to a more wholesome life."[84] Rabbi Herman sees the Union's growing interest to be a response to the increased demand of congregants "who are trying to find answers to specific problems in an open society."[85] The Union has sponsored various programs on death and dying and divorce in addition to a number of resolutions from the Department of Gerontology that call upon the Union to create programs through synagogues. Rabbi Herman, however, raises concern about duplication of

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[84]Interview with Rabbi Erwin Herman, Union of American Hebrew Congregations, Los Angeles, California, October 1975.

[85]Ibid.

services offered by other agencies. He sees the synagogue as an appropriate setting for programs of this nature, but these should be directed by the professional agencies.

Rabbi Sanford Shapiro, the Director of the Southeast region of the UAHC, in a letter to Rabbi Herman dated December 26, 1973, raises still another issue, specifically in regard to the aged:

> We must begin programs . . . both in religious schools and in the home . . . . It is emotionally sound to reach out towards the elderly . . . it is pedagogically wiser to spend at least as much effort on teaching the young the meaning of age.

It is the thought of the authors that this statement is generalizeable to every social stage and position, and validates the appropriateness of sensitization and prevention as a means of dealing with these issues.

Robert Mills, in an article of the CCAR Journal (the Reform Movement's Journal), states:

> Our approach is primarily prophylactic rather than crisis-oriented. We utilize Abraham Maslow's models which speak of full humanness rather than psychological health. The primary purpose of religious life is to work toward the alleviation of human suffering.[86]

Mills continues, saying:

> The synagogue will be true to its function when it

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[86]Robert Mills, "Health Care and the Synagogue," CCAR Journal 20 (Fall 1973):14.

> realizes that it is one of the few institutions equipped to transfer crisis times into growth times throughout the life span.[87]

He sees the synagogue as being able to program appropriate activities at each stage of life development--marriage, birth, change of employment, sickness, death--approaching each with an understanding of what happens at various crisis and growth stages. He goes on to say that this must be provided before the stress situations occur. This statement has implications for the seminaries, calling for increased efforts at providing proper training for future rabbis, so that they are aware of the stress involved with each change in life and can program effectively. Mills states that he is not, however, calling for therapeutic interventions on a wide scale. "We are reactivating the institution's primary obligation to concern itself with the alleviation of man's trouble and suffering."[88]

Examples of program suggestions received from UAHC literature

Jerry Fisher, the Western Regional Consultant on single's activities, in an article in the Los Angeles Times of February 16, 1975 stated:

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[87] Ibid., p. 19. [88] Ibid.

> Divorce and changing life styles are forcing rabbis and synagogue leaders to come to grips with the reality of singles in the synagogue setting.

The article suggests topics for discussion, such as: The Newly Divorced, The State of Being Single, The Empty Home 45-60, Is Marriage the Answer, Newly Widowed, For the Recently Remarried.

Rabbi Earl Grollman suggests a widow-to-widow program as an "experience in preventive intervention (which) provides necessary help and assistance to the recently bereaved" (leaflet from the UAHC). Suggested topics are: Reorganizing Your Life, Ways of Dealing with the Feeling of Being a Fifth Wheel, Interpersonal Relationships, Role of a Single Parent.

The following are suggestions for services under religious auspices from the UAHC Department of Gerontology:

1. Congregational and pastoral ministry--working with the bereaved and dying, pastoral care.
2. Counseling--pastoral and/or including the training of volunteer or congregational counselors including older persons with counseling skills.
3. Intergenerational relations--foster grandparent programs, programs designed to promote interaction between older persons and other age groups in the family and society at large.
4. Rehabilitation--retraining and assisting persons to get back into the mainstream of society through providing training workshops, classes, therapy, etc.
5. Retirement training--classes, workshops, etc. which will enable persons to adequately prepare for retirement and function in retirement.

6. Visiting-companionship--adopt an older person program for families, youth groups, regular visitation by church/synagogue visitors, etc.
7. Widowed persons--providing those services and programs which may be uniquely needed by the widowed aged.

As evidenced in the literature and in personal interviews, the Reform movement has recently begun to take strides in dealing in a concrete way with the strengthening of Jewish family life. Through various types of program intervention, it appears that Reform synagogues are directly contributing to the survival of Jewish life.

Conservative Judaism

In examining how the Conservative movement deals with the question of the synagogue's role in mental health, we find a dual picture. Some movement leaders claim that mental health should have an important place in the synagogue's program, while others choose to ignore it. As discussed above, many students and faculty members at the Jewish Theological Seminary feel that the pastoral psychiatry sequence is not needed.[89] Several articles by Conservative rabbis discuss prospects and priorities for the future. The issues they see as most pressing deal with

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[89]Liebman, Aspects of the Religious Behavior of American Jews, p. 34.

ideology, observance of Jewish law, Jewish education, Jewish identity, demographic changes affecting synagogue affiliation, and alienation of the youth from Judaism.[90] None of them dealt with mental health programming as a priority for the future.

Yet there are other indications that the Conservative movement is receptive to a mental health role for the rabbi and the synagogue. The Conservative movement views itself as being innovative as conditions change, as evidenced in a position statement by the editors of the movement's journal, Conservative Judaism:

> The discussants (the editors) reaffirmed their conviction both that the Conservative movement is the 20th century expression of normative Judaism and that Judaism itself is a growing tradition which must be made viable by interacting with the intellectual climate and needs of the period.[91]

It seems that the needs of this period are causing more Conservative Jews to turn to their rabbis for counseling. Resnikoff asks rhetorically:

> Shouldn't a congregation be concerned for the happiness of its members? . . . Where was the synagogue's humanity? Why wasn't it caring for its people? Why

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[90]Wolfe Kelman, "The American Synagogue: The Present and Prospects," Conservative Judaism 26 (S 1972):29.

[91]Editorial Staff, "Directions for the Conservative Movement," Conservative Judaism 25 (Winter 1971):2.

> wasn't it responding to human need? Wasn't the rabbi's function, among others, to provide a ministry of help and healing?[92]

Rabbi Harry Halpern, president of the Conservative movement's rabbinical body, the Rabbinical Assembly of America, deals with the question:

> More and more Jews are turning to the synagogue and the rabbi for guidance in these days of stress and tension. People who would never have thought of availing themselves of the rabbi when they are confronted by marital difficulties or the problem of bereavement, are now looking to him for advice and comfort.[93]

The author of a publication issued by the Conservative movement feels that the rabbi must be even more mindful in his planning: "The emphasis we give to preventive-maintenance the less need will there be for private psychotherapy with the problems of individuals."[94]

Rabbi Edward Tenenbaum, director of the Western region of the United Synagogue of America (the Conservative movement), feels that the synagogue must meet this need. He sees the ideal synagogue administering to the overall needs of a Jew in all aspects of his life. Since the

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[92]Resnikoff, "The Congregation as an Extended Family," p. 82.

[93]Schnitzer, New Horizons for the Synagogue, p. vii.

[94]Ibid., p. 20.

family is the basic social unit, the synagogue should be particularly ready to serve the family in all types of relationships. However, the degree to which a synagogue is involved in such programs depends on its size, and the training and amount of personnel it has. In view of these limitations, he suggests utilizing the resources within a synagogue's membership. Members who have specific expertise could be used to organize and deliver needed services. He feels that one step in the direction of meeting needs is increased cooperations between synagogues and the Jewish Family Service. The synagogue, of course, should not duplicate the Jewish Family Service but should be doing more counseling if it has the budget for it. He suggests that synagogues develop programs in which the agencies come to the synagogue to acquaint members with its services, as well as to conduct programs in the synagogue itself.[95]

One Los Angeles Conservative rabbi, Michael Menitoff, sees Los Angeles as a community whose residents are particularly needy for mental health services. He sees

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[95]Interview with Rabbi Edward Tenenbaum, United Synagogue of America, Los Angeles, California, October 29, 1975.

an unstable and transient population turning more to the rabbi for help. "Los Angeles is a psychiatric center, therefore there is a spilloff to the synagogue."[96] He, too, calls for greater cooperation between rabbis and communal agencies:

> It is time to redefine the parameters of our work. Synagogues are guilty of fostering their own vested interests rather than working together. It would do better for us to work together, as synagogues should benefit from other areas of expertise.[97]

Orthodox Judaism

The Orthodox view of Judaism has been more hesitant than have other movements to incorporate new ideas into their philosophies and actions. Rackman notes:

> Orthodoxy by its very nature compromises less easily with new environments and new philosophies, so that it could not avail itself of that flexibility which aided the growth of the Reform and Conservative movements.[98]

The more conservative Orthodox rabbis believe that to adjust Judaism to the values of today is to "forfeit the role of religion as a goal and aspiration for a more

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[96]Rabbi Michael Menitoff, address to students of the School of Jewish Communal Service, Hebrew Union College, October 6, 1975.

[97]Ibid.

[98]Emanuel Rackman, "American Orthodoxy--Retrospect and Prospect," Judaism 3 (Fall 1954):303.

spiritual tomorrow.[99] One leading Orthodox thinker put it this way:

> Orthodoxy has remained blithely indifferent to contemporary challenges by arguing that there have been similar dilemmas in the past, and that each time Judaism has met the challenge and survived by holding fast to its classical doctrines while refusing to bend with every blowing wind.[100]

What then, is the role of rabbi and the synagogue in Orthodox Judaism? Sklare states that the traditional rabbi has one basic skill--his familiarity with the literature, values, and rules concerning the social part of society, and his life as an example. "The traditional rabbi resisted changes in doctrine or procedure since innovation would have further outmoded his skills."[101] Some Orthodox Jews felt that the synagogue has come under criticism as being "outmoded and unresponsive." Bleich notes a disillusionment among the rabbinate because of congregational expectations of being a "jack of all trades." He senses that Orthodox rabbinic students feel some apprehension about serving congregations because of a lack

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[99] Ibid., p. 307.

[100] Gilbert S. Rosenthal, Four Paths to One God (New York: Bloch Publishing, 1973), p. 55.

[101] Sklare, Conservative Judaism, p. 59.

of training in areas other than classical Judaica.[102]

The synagogue is seen by Orthodox rabbis as being primarily a center for worship.[103] Rosenthal writes: "Generally speaking, Orthodoxy views the synagogue as the House of Prayer, with the study and social aspects as merely incidental to its true purpose."[104] The President of Yeshiva University, the Orthodox school of higher learning, has publicly disavowed the social center facet of the synagogue, and has stressed the worship aspect.[105] Another Orthodox leader, while recognizing the social value of the synagogue in helping to preserve the Jewish people, feels that the emphasis of the synagogue should be shifted over to study of religious texts.[106]

While Orthodox Judaism has been rather hesitant in approaching psychology, one Orthodox writer notes the similarities between Judaism and psychology:

> Man constantly seeks to understand the nature of the forces which seem to work within him and which he holds

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[102]J. David Bleich, "The Synagogue--Stagnation or Growth," Jewish Life 40 (April 1973):40.

[103]Interview with Yisrael Kelemer, Los Angeles, California, November 7, 1975.

[104]Rosenthal, Four Paths to One God, p. 74.

[105]Ibid., p. 75.

[106]Ibid., p. 313.

> responsible for his behavior. He relegates the study of such matters to the rigors of a formal discipline such as psychology. Judaism, as a religion which concerns itself with the total man, also investigates and posits theories about the structure of consciousness, personality, and the nature of various psychological mechanisms, drives, and impulses.[107]

However, another Orthodox writer, an administrator of the national Orthodox day school (parochial school) movement, states: "We accuse psychoanalysis, with no reservations, for the decay of moral standards of our society."[108] If this view is held by many Orthodox Jews, it might be expected that one would find a distrust of mental health techniques and a hesitancy in using them in Orthodox synagogues.

In reviewing all of the issues of Tradition, the Orthodox movement's journal, few articles were located dealing with concepts of mental health or psychology. All of those which were published appeared within the last three years and showed a similar approach. A psychological theory was discussed and accepted if it supported already held beliefs. For example, one article discusses logo-

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[107]Moshe H. Spero, "Thanotos, Id, and the Evil Impulse," Tradition 15 (Spring 1975):97.

[108]Abraham Amset, Judaism and Psychology (New York: Feldheim, Inc., 1969), p. 198.

therapy as presented by Victor Frankl and notes how it agrees with the Jewish values stressing the inherent meaning of life.[109] Another article, by an Orthodox rabbi who is also a social worker, discusses the similarities between the Jewish ethical movement led by Rabbi Israel Salanter and humanistic psychology as represented by Rogers, Maslow, and Moustakas.[110]

A careful review of the literature uncovered no articles written by Orthodox Jews discussing the use of the synagogue in promoting the mental health of its members. These writers conclude that this is due to: 1) the view that the synagogue's purpose is that of a House of Prayer and religious study; 2) the view that Judaism as a religion is a total system which is adequate in meeting all the needs of observant Jews; and 3) the suspicion of psychological theory held by many Orthodox Jews. Rabbi Yisrael Kelemer, president of the Rabbinical Council of Los Angeles (Orthodox) agrees that Orthodox synagogues have not done much in this area. However, he notes that if modern

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[109]Reuven P. Bulka, "Logotherapy as a Response to the Holocaust," Tradition 15 (Fall 1975):92.

[110]Mel Gottlieb, "Israel Salanter and Therapeutic Values," Tradition 15 (Fall 1975):112-128.

Orthodoxy is going to grow, more will have to be done by synagogues to meet the mental health needs of its members.[111]

The synagogue has traditionally met a variety of needs of the Jewish people. An important function of the synagogue in an increasingly stressful society has been to maintain and strengthen the Jewish family and the individual. Differences in the philosophy and daily living patterns among the three denominational movements affect how this goal is achieved. The focus of this study are the factors which affect the extent to which synagogues are creating programs which meet the mental health needs of their congregants.

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[111]Yisrael Kelemer, Interview November 7, 1975.

CHAPTER IV

METHODOLOGY

Focus of the Study

This is a descriptive-exploratory study with a two-fold purpose. First, it was designed to assess the extent to which mental health programs exist and are being planned for in the future in Los Angeles synagogues. Secondly, the researchers are interested in the difference in the occurrence of these programs among the three major Jewish denominations.

The following are assumptions leading to the hypotheses and research questions:

1. The three religious movements may be seen on a continuum in their interpretation of Jewish law and their prescriptions regarding the conduct of daily life and ritual religious practice.
2. The Reform movement has stood for innovation and change in comparison to both the Orthodox and Conservative movements.
3. Reform and Conservative synagogues are involved in a number of important aspects of their congregants' day-to-day living situations apart

from religion.

4. Orthodoxy by definition is more resistant to change and often focuses on a narrower area of interest--living a religious life.
5. The Orthodox movement believes that religion should encompass the whole life of a Jew. Therefore it is the contention of the Orthodox movement that all the day-to-day living needs can be met through religious observance.

Hypotheses Posed by the Study

I. It is anticipated that synagogues affiliated with the Orthodox movement will have significantly less community mental health oriented programs and activities than synagogues affiliated with either the Conservative or Reform movements.

II. It is anticipated that the larger the size of the congregation the more likely that the synagogue will have more formal mental health oriented programs and activities. It is expected that the larger budget and more diverse staff facilitates a range of programming.

Research Questions Posed by the Study

1. To what extent is the years of experience of the rabbi

associated with the number of formal mental health oriented programs and activities in the synagogue? The authors have reason to believe that those rabbis with more experience in the field will be serving synagogues with a greater number of mental health programs.

2. To what extent is the rabbi's past training in counseling or human relations associated with the amount of formal mental health oriented programs and activities in the synagogue? It is expected that those rabbis with training in counseling will be serving synagogues with a greater number of mental health programs.
3. To what extent is the number of years of the congregation's existence associated with the amount of formal mental health oriented programs and activities in the synagogue? The authors expect that older congregations will sponsor a greater number of mental health programs.

Operational Definitions

For the purposes of this study, observance of Jewish law, mental health concerns and formal mental health oriented programs are defined as follows:

1. Observance of Jewish law: measured by affiliation with Reform, Conservative or Orthodox Judaism.

2. Mental health concerns: marriage, sex, parenting, aging, interpersonal communication and changing roles in the family.

3. Formal mental health services: services offered to groups of members of the congregation where the manifest functions are mental health in nature.

The Research Design

The Sampling Plan

The synagogue sample was drawn from that area in Los Angeles which has a Jewish population density of 20% or higher as determined by the 1970 study done by the Research Service Bureau of the Jewish Federation Council of Greater Los Angeles. Using this study as a guide, the researchers plotted an area on the map (see Appendix A), which was used as the sample frame, from which a sample of synagogues was selected by random sampling techniques.

The researchers were interested in this geographic area as there are a greater number of synagogues located there than in other parts of Los Angeles. The final sample was selected from among those synagogues which employed a full-time rabbi and are listed in the Jewish Organizations Directory of 1975. The total population from which the

sample was drawn consisted of 50 synagogues. Of those 50, there are 15 Reform, 19 Conservative, and 18 Orthodox synagogues.

A stratified random sample of 27 synagogues was drawn. The first step in this process was to categorize synagogues according to denominational affiliation. The next step was to rank synagogues according to the size of the congregation within each of the three denominations. Size was determined by the number of member-families. Within each denomination the ranked list of synagogues was divided into thirds--small, medium and large. Within each of the nine subcategories a random sample was drawn through a table of random numbers. The final sample consisted of three small, three medium, and three large congregations for each denomination; this composed a list of 9 Reform, 9 Conservative, and 9 Orthodox congregations. A list of substitute respondents was then randomly selected to substitute for synagogues not available for study. This was necessary in four instances; this will be discussed later in this chapter under the heading, "The Research Process."

Data Collection Procedure

Initial contact with the respondent-rabbis was

through an introductory letter from the researchers, accompanied by a letter of endorsement from the Executive Vice President of the Los Angeles Board of Rabbis, and a letter of endorsement from the representatives of the respective denominations. The respondents were then contacted by telephone to set up appointments for interviews.

The rabbis of each congregation were interviewed with a structured interview schedule. The interviews were followed up by surveying synagogue bulletins to determine the range of programs held in the past year.

The Research Instrument

The researchers decided against the use of a mailed questionnaire for the following reasons:

1. A possible lack of response from the rabbis.
2. A possible misinterpretation of questions.
3. The limited ability to probe further in complex or ambiguous areas.

Therefore, a structured interview schedule was designed which includes a combination of closed ended and open ended questions (see Appendix B). In areas where the instrument may not have probed an area or issue sufficiently with closed ended questions, open ended questions were used for

further exploration.

The interview schedule is divided into three parts. The first phase of the interview schedule addresses the background and description of the congregation. Areas explored were number of member-families, average socio-economic status, educational level, occupation, place of birth, and age distribution of congregants. Further questions dealt with the professional staff employed, the group and committee structure, and duration of the congregation's existence.

The second phase of the interview schedule addresses the programs sponsored by the synagogue. One series of questions focused on the range of activities offered. The next series examined the extent to which programs were oriented to specific groups in the congregation which might have different needs. Another series of questions dealt with different topic areas which might be included in a preventive mental health program. The researchers then probed the circumstances surrounding the development of the programs such as budget, planning, leadership, and goals.

The third phase of the interview schedule addresses the background of the rabbi. This includes age, number of years in the field, number of years at that particular

synagogue, educational background, and training for and/or provision of individual and/or family counseling.

The Research Process

The researchers found that most of the respondents were receptive to being interviewed for this study. A few rabbis were quite difficult to reach and subsequently declined to be interviewed due to time constraints. Two of these rabbis were Orthodox, one was Conservative, and one was Reform.

In conducting the actual interviews, the researchers found that some rabbis were unable to answer a few of the questions posed in the interview schedule. Most rabbis experienced difficulty in quantifying the educational and occupational background of the congregation. For instance, the rabbis were unable to give percentages in the categories listed. The researchers therefore asked the respondents to report which groups were predominant. Questions which explored the quantity of programs or activities sponsored in a specific program area were difficult for some rabbis. The researchers therefore reviewed the synagogue bulletins and program literature for further information.

Analysis of the Data

The researchers tabulated the questions and used descriptive statistics to analyze the findings. Responses were cross-tabulated with key characteristics such as the age, experience, and training of the rabbi; the size of the professional staff; the size and age of the congregation and denominational affiliation.

Limitations of the Study

The present study has certain limitations.

1. The study does not establish the extent of need for mental health programs in synagogues.

2. In addition, it does not deal with the quality or effectiveness of the existing programs.

3. There is also the possibility that some of the same goals that are achieved through formal mental health programs may be reached in other recreational and social activities such as havuroth, sisterhood, etc.

4. While the researchers dealt with the perceptions of the rabbis and program coordinators, the views of the constituency served were not included.

5. The research study did not attempt to establish causality between the variables in question. Associational

patterns, however, were discussed. The findings can be generalized only to the Los Angeles area. However, there may be implications pertinent to Jewish communities elsewhere.

CHAPTER V

FINDINGS

The purpose of this study has been to determine the extent to which synagogues in Los Angeles sponsor programs with a mental health orientation. In addition, the researchers were interested in several factors related to the characteristics of the rabbi, the synagogue, and the congregation which might be associated with the presence of such programs in synagogues. Questions posed by the researchers were aimed at gathering information about the denomination, size, and composition of the congregation; background and training of the rabbi; and the range of programming offered by the synagogue. This information was then examined for associational patterns in order to determine what type of synagogue situation would be most likely to have mental health programming in addition to its other customary activities and programs.

A central purpose of this section is to report the findings of this study regarding the relationship between synagogue programming and the characteristics of the synagogue, the congregation and the rabbi.

Data on synagogue programming was recorded along

two dimensions. One dimension is the overall orientation of the synagogue's programming. A distinction is made between those synagogues whose programming is directed towards worship and study, and those synagogues which also include activities which are not necessarily religiously oriented. In other words, those synagogues whose major focus was described by the rabbi to be prayer, study of religious texts and the celebration of holidays, are considered by the researchers to have a "worship and study" orientation. Those synagogues described by the rabbi as including social events, hobby or interest groups, performing arts, or public affairs programs in addition to the religious functions, are considered by the researchers to have a "worship, study and social orientation." Defining the functions of the synagogue in this manner is consistent with the traditional functions of the synagogue as cited in the literature; a house of worship, a house of study and a house of assembly. Three out of the 27 synagogues surveyed have a worship and study orientation. The remaining 24 synagogues are rated by the researchers as having a worship, study and social orientation.

The second dimension on which synagogue programming was examined pertains to the degree to which synagogues are

concerned with and sponsor mental health oriented programs and activities. The rabbis were asked questions regarding the needs of their congregants and the programs developed in an attempt to meet those needs. These questions can be found in the interview schedule (Appendix B, Questions 20-58). A score was assigned to each synagogue by tabulating points which were given for each reported program area in which the synagogue was active. For example, zero points were assigned if there was no indication of mental health oriented programming. One point was assigned if minimal programming[1] existed. Two points signified a substantial level of programming[2] in this area. Extensive efforts,[3] in the program area, were noted by a score of 3 points. Out of a possible 57 points which a synagogue could receive by reporting extensive programming in 19 areas, the range of scores obtained was from 0 to 39. Synagogues were subsequently categorized as high (21-39), medium (9-20), low (1-8) and nothing (0). Five synagogues received a high rating, 10 synagogues received a medium rating, 7 syna-

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[1]Minimal programming: one or two programs.

[2]Substantial programming: three or four programs.

[3]Extensive programming: five or more programs.

gogues were rated as low, and 5 synagogues reported that they had no mental health programs, and obviously scored no points.

These ratings were assigned as an aid in summarizing and categorizing the extent of mental health programming which existed in the synagogues. In the following sections of this chapter the categories are used descriptively in analyzing and interpreting the association between the extent of mental health programming and the rabbis' responses to other questions posed in the study. For example, in the next section of this report, the authors compare the characteristics of the synagogue with the overall program orientation and the extent to which the synagogue sponsors mental health programs.

Synagogue Programming and Characteristics of the Synagogue

There are several characteristics of a synagogue which the authors felt might be influential factors that have a bearing on the existence of certain synagogue programs.

Size of Staff

The researchers were interested in whether the size

of the synagogue's staff is positively associated with the programs sponsored by the synagogue. It was expected that synagogues which employ a larger staff would have more resources and personnel for developing a wider range of programs. The data indicates that size of staff does appear to be associated with the overall range of programs sponsored by a synagogue. Table 1 below reveals that all of those synagogues with a large staff have a worship, study, and social orientation. Two of the three[4] synagogues which are primarily focused on worship and study have a relatively small staff.

TABLE 1

SIZE OF STAFF BY THE OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Size of Staff			
	0-2	3-5	6-9	Total
Worship/study	2	1	0	3
Worship/study/social	6	14	4	24
Total	8	15	4	27

[4]In view of the small number of synagogues which are primarily focused on worship and study, there are limitations to the associations which can be drawn from this portion of the data.

The data indicates that as the size of the staff increases there is a greater incidence of the worship, study, and social orientation. This is logical since it is expected that a synagogue with a larger staff would be able to develop and sponsor a broader range of programs.

The size of staff seems to have an association with the degree to which synagogues sponsor mental health oriented programs. Table 2 below shows that the largest number of programs were in synagogues with the largest staff; that synagogues with staffs of "6-9" had at least 9 programs; and that the synagogues with fewer than 3 staff members had no programs at all.

TABLE 2

SIZE OF STAFF BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Size of Staff			
	0-2	3-5	6-9	Total
High (21-39)	0	0	5	5
Medium (9-20)	2	6	2	10
Low (1-8)	2	5	0	7
Nothing (0)	5	0	0	5
Total	9	11	7	27

As size of staff increases, the incidence of mental health programming increases. The reason for this pattern might

be that synagogues with larger staffs are more likely to have at least one staff member who is interested in mental health oriented programming; or they can assign staff to respond to the range of interests presented by members of the congregation. It can be expected that a larger staff has a greater potential for having a wider variety of skills and interests and a larger staff will generate more programs.

Size of the Congregation

The researchers were interested in whether the size of the congregation is associated with the range of different types of programs offered by the synagogue.[5] The data seems to show that this association exists. Table 3 below shows that all the synagogues with large congregations have a worship, study, and social orientation. Two of the three congregations which have worship and study orientations are relatively small in size.

As expected by the authors, a clear trend emerges: as the size of the congregation increases, so does the incidence of the worship, study, and social orientation.

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[5]Refer to the methodology chapter for definitions of synagogue size.

It is speculated that this may be due to a larger congregation having a larger budget with which to develop the programs that are needed or requested by congregants and possibly that the "social" orientation is necessary to attract more members.

TABLE 3

SIZE OF CONGREGATION BY
OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Size of Congregation			
	Small	Medium	Large	Total
Worship/study	2	1	0	3
Worship/study/social	5	8	11	24
Total	7	9	11	27

There appears to be an association between the size of the congregation and the number of mental health programs offered by a synagogue.

Table 4 below indicates that as the size of the congregation increases so does the number of mental health programs. It is also interesting to note that the majority of synagogues with no mental health programs have relatively small congregations.

It is speculated that these reported findings reflect the generally greater resources available in

larger congregations. A larger synagogue would be expected to receive more money in membership dues which could be used for program expenditures. A larger synagogue may also employ a larger staff, the implications of which are described above. As indicated before, the availability of programs may also lead to increased membership.

TABLE 4

SIZE OF CONGREGATION BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Size of Congregation			
	Small	Medium	Large	Total
High (21-39)	0	1	4	5
Medium (9-20)	4	3	3	10
Low (1-8)	0	4	3	7
Nothing (0)	3	1	1	5
Total	7	9	11	27

Denomination

It was expected by the researchers that the denomination of a synagogue would be an important factor in the number and types of programs sponsored. For example, denomination could serve to provide a frame of reference for the kinds of programs offered by a synagogue.

The data in Table 5 reveals that all of the synagogues which are limited to a "worship and study" orienta-

tion are Orthodox. All of the Reform and Conservative synagogues are rated as having a worship, study, and social orientation.

TABLE 5

DENOMINATION BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Denomination			
	Reform	Conservative	Orthodox	Total
Worship/study	0	0	3	3
Worship/study/ social	9	9	6	24
Total	9	9	9	27

The above findings were anticipated and are consistent with the literature which indicates that there are quite different interpretations of the functions of the synagogue among the Reform, Conservative, and Orthodox Movements. The Orthodox sources stressed that the primary function of the synagogue is worship and study. The Reform and Conservative sources both stressed the social aspects of the synagogue's role and function. For example, one Orthodox rabbi commented that if a program does not have specific Jewish content, it should not be sponsored by the synagogue. In this rabbi's words, "A synagogue doesn't have to cater to clubs!"

An association between the number of mental health programs that a synagogue sponsors and denomination appears to exist in the sample studied. All of the Reform congregations have a medium or high number of mental health programs. Five out of nine of the Conservative synagogues have a medium or high number of mental health programs. Only one Orthodox congregation has a medium number of mental health programs. Of the other eight Orthodox synagogues, four have a low number of programs and the other four have no programs which could be considered to have a mental health orientation.

TABLE 6

DENOMINATION BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Denomination			
	Reform	Conservative	Orthodox	Total
High (21-39)	2	3	0	5
Medium (9-20)	7	2	1	10
Low (1-8)	0	3	4	7
Nothing (0)	0	1	4	5
Total	9	9	9	27

Therefore a trend appears in the data in which the number of mental health programs increases as the congregations increasingly become more liberal in their interpreta-

tions of Jewish law. As cited in the literature, the difference among the three denominations' interpretations of Jewish law may be seen as a continuum ranging from a more liberal to a more traditional view: Reform ⟶ Conservative ⟶ Orthodox.

The writers speculate that the more liberal interpretation of Jewish law is more conducive to the development of mental health programs in the synagogue. In addition, representatives of the Orthodox movement have expressed a greater caution regarding the validity of psychological precepts; they usually view the study and worship aspects of synagogue life as having the most validity, in that they feel that all of a person's emotional needs can be fulfilled by leading a traditionally observant lifestyle. All of these factors increase the resistance to the development of mental health programs in Orthodox synagogues.

Group and Committee Structure

The researchers were interested in whether the group and committee structure of the congregation is associated with the kinds of programs sponsored by the synagogue. These groups and committees generally consist

of sisterhoods, men's clubs, youth groups, social action groups, and various committees related to the administration of the synagogue, such as finance, education, ritual, and membership. The researchers found similar kinds of groups and committees in existence in most of the synagogues. Therefore, the data did not seem to show any noteworthy differences between group and committee structure and the kinds of programs sponsored by the synagogue. However, it should be noted that the two synagogues which have a "committee on counseling" have the highest number of mental health programs.

Age of the Congregation

The researchers were interested in whether the length of time a congregation has been in existence is associated with the kinds of programs offered by the synagogue. It was expected that a newer congregation, still in the process of organizing and struggling for survival, would have a more limited range of programs. It was thought that most of the energies of a newer congregation would be spent in developing basic programs, such as religious services, religious education, and the typical social clubs such as the sisterhood and men's club. The

older congregations, however, were expected to have developed a broader range of programs, since they had the time perspective and security that allowed for maximum use of resources.

To the surprise of the researchers, there does not appear to be an association between the amount of time a congregation has existed and the range of programs offered by the synagogue. Neither does there appear to be a relationship between the amount of time a congregation has existed and the number of mental health programs it sponsors. The report of the data can be found in Appendix C, Tables 24 and 25.

Synagogue Programming and Characteristics of the Congregation

There are several characteristics of a congregation's members which the authors felt might be influential in terms of the existence of a range of different synagogue programs. A series of questions were asked regarding the age of the members, their birthplace, education, occupation, and socioeconomic status.

Age of the Congregation Members

The researchers were interested in determining

whether the congregation was predominantly composed of families with children living at home, middle aged couples, or elderly people. It was thought that the age concentration of the congregants would influence programming. For example, a congregation with a high number of children would be more focused on youth programming.

At times the rabbi's were not able to categorize their congregations as falling within one predominant age group. In those instances, the congregation was rated by the researchers as "heterogeneous" in terms of age.

There does not appear to be an association between the predominant age of the congregation's members and the range of programs offered by synagogues. The reason for this may be that the scope of a synagogue's programming is not that dependent upon specific age groups. The data may be found in Appendix C, Table 26.

When the association between the number of mental health programs and the age of the congregation's members is examined, no clear trend emerges. However, as seen in Table 7 below, it is interesting to note that nine of the ten congregations which are predominantly composed of families with children at home, also have a medium or high number of mental health programs. A large percentage of

those congregations with varied or heterogeneous age groups have a low number of mental health programs, if they have any.

TABLE 7

AGE OF CONGREGATION MEMBERS BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Age of Congregation Members				
	Families with Children at Home	Middle Aged	Elderly	Varied	Total
High (21-39)	4	1	0	0	5
Medium (9-20)	5	2	0	3	10
Low (1-8)	1	1	0	5	7
Nothing (0)	0	2	1	2	5
Total	10	6	1	10	27

There is a possible explanation for the higher number of mental health programs in the "Family" group and the lower number of mental health programs in the "Varied" group. The authors speculate that those congregations which are more homogeneous in terms of age may be more able to identify needs and reach consensus on their need to have mental health oriented programs. In addition, the authors expected that those congregations with younger memberships would generate and be more receptive to innovative programs which helped in their efforts to cope with the complex

demands and stresses of life today.

Birthplace of the Congregants

The researchers were originally interested in knowing whether the majority of the congregation is composed of immigrants, first, second, or third generation Americans. It was felt that the needs of each generation might differ, and would be reflected in the types of programs offered by the synagogue. However, the rabbis interviewed distinguished only between the immigrant group and native born Americans. The data was therefore collapsed into these two categories. A third category is composed of those synagogues whose rabbi could not distinguish which group was predominant.

It was expected that synagogues whose membership is predominantly composed of immigrants[6] would share many of the attributes of the traditional model of European synagogues, and would therefore be more oriented towards worship and study. Two of three congregations with a predominantly immigrant membership do in fact have a worship and study orientation. Ten of the eleven congregations

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[6]It should be noted that the three congregations with predominantly immigrant memberships are Orthodox congregations.

with a heterogeneous membership have a broader range of programs beyond worship and study. All thirteen of the congregations with a predominantly native born membership have a broader range of programs. (See Table 8 below.)

TABLE 8

BIRTHPLACE OF CONGREGANTS BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Birthplace of Congregants			
	Immigrants	Native Born	Mixed	Total
Worship/study	2	0	1	3
Worship/study/social	1	13	10	24
Total	3	13	11	27

It appears that as the composition of the congregation becomes increasingly native born American, the synagogue tends to offer a wider variety of programs.

There is a similar level of association between the birthplace of the congregants and the number of mental health programs. As seen in the following table, the three congregations with a predominantly immigrant membership had no mental health programs. The association is not as clear among the twenty-four congregations with a native born or mixed membership. There appears to be a tendency in these congregations to have a higher number of mental health

programs than those congregations with a predominantly immigrant membership.

TABLE 9

BIRTHPLACE OF CONGREGANTS BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Birthplace of Congregants			
	Immigrant	Native Born	Mixed	Total
High (21-39)	0	3	2	5
Medium (9-20)	0	5	5	10
Low (1-8)	0	4	3	7
Nothing (0)	3	1	1	5
Total	3	13	11	27

Similar to the finding concerning the association between birthplace and range of programs offered by the synagogue, the three congregations predominantly composed of immigrants are Orthodox. The authors speculate that this may be the reason for the relative absence of mental health programs. All fifteen of those synagogues that have a predominantly native born or mixed membership have a medium or high number of mental health programs. Only one of these fifteen synagogues is Orthodox. The authors therefore suggest that the birthplace of the congregants may not be as much of a factor in the synagogue's decision to develop mental health programs as is the denomination of the

synagogue. The Orthodox rabbis probably view the study and worship aspect of synagogue life as having the most validity and utility; therefore any other activities are of a secondary concern. In addition, a greater caution in approaching psychology increases the resistance of Orthodox congregations to the development of mental health programs. This is discussed further in the latter section of the chapter.

Educational Level, Occupations, and Socioeconomic Levels of the Congregants

The researchers were interested in whether there are associations between the educational levels, occupations, and socioeconomic levels of the congregants on one hand, and the number of mental health programs sponsored by the synagogue on the other. A series of questions (Questions 2, 4, and 5) in the interview schedule (Appendix B) explored these characteristics. The researchers expected that such factors might have a bearing on the congregants' attitudes and receptivity towards mental health programming, and in turn, this might affect the decision to have such programs in a synagogue.

Question 4 of the interview schedule (see Appendix B) asked for the rabbi's estimate of the educational levels

of male and female congregants. Responses were stratified into the following categories: high school graduates, college graduates, those with post-graduate education, varied educational levels, and "don't know." The researchers acknowledge, based on impressions gained during interviewing, that "varied responses" may indicate either an educationally heterogeneous congregation or may indicate the rabbi's lack of knowledge about the educational levels of his congregants.

Question 5 of the interview schedule (see Appendix B) focused on the occupations of the congregants. The distinction made by the rabbis generally distinguished between business and professional people in contrast to white or blue collar workers. Therefore the data was collapsed into these two categories. An additional category, "varied," was added to indicate congregations without a predominant group. The "varied" response in this instance, too, may indicate either an actual heterogeneity in congregants' occupations, or may reflect the rabbi's lack of knowledge about his congregants in this area.

There appears to be some association between the level of education of the members, the occupations of the members, and the number of mental health programs sponsored

by the synagogue. As shown in Tables 10, 11, and 12, when a congregation has a high proportion of college graduates and business or professional people, there is also a high or at least a medium, level of mental health programming.

TABLE 10

EDUCATIONAL LEVEL OF MALE CONGREGANTS BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Educational Level (Male)					
	High School	College	Graduate Degree	Varied	Don't Know	Total
High (21-39)	0	3	0	2	0	5
Medium (9-20)	2	6	0	1	1	10
Low (1-8)	1	1	0	4	1	7
Nothing (0)	3	0	0	2	0	5
Total	6	10	0	9	2	27

TABLE 11

EDUCATIONAL LEVEL OF FEMALE CONGREGANTS BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Educational Level (Female)					
	High School	College	Graduate Degree	Varied	Don't Know	Total
High (21-39)	0	3	0	2	0	5
Medium (9-20)	1	3	0	2	4	10
Low (1-8)	0	1	0	3	3	7
Nothing (0)	2	0	0	1	2	5
Total	3	7	0	8	9	27

TABLE 12

OCCUPATIONS OF CONGREGANTS BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Occupations			
	Business/ Professional	White or Blue Collar	Varied	Total
High (21-39)	2	1	2	5
Medium (9-20)	6	0	4	10
Low (1-8)	0	0	7	7
Nothing (0)	2	1	2	5
Total	10	2	15	27

The higher frequency of mental health programs in synagogues whose congregants are predominantly college graduates and business and professional people may be attributable to two factors. These congregants may have a greater awareness of the value of preventive mental health and of their own specific needs. Subsequently, they may be more accustomed to expressing these needs and possibly suggest programs in these areas.

A question is raised concerning the association noted above when one examines the "varied" and "don't know" columns in Tables 10, 11, and 12. The authors found an unexpectedly large number of synagogues which have relatively few mental health programs in these columns. Upon further study, these synagogues are found to be the same

ones in all three tables. One speculation as to the reason for these unexpected findings is that it might reflect the rabbi's lack of specific knowledge about his congregants. Another possible explanation might be that these synagogues do indeed have a more heterogeneous membership and may not orient their programs to specific needs of the members. The heterogeneity may also interfere with concerted efforts on the part of congregants to develop pressure for such programs.

The association between occupation, educational level, and number of mental health oriented programs is further questioned when the socioeconomic level is considered. Question 2 of the interview schedule probed the socioeconomic status of the congregants. Although this was an open ended question, the researchers were able to stratify the responses into categories of lower middle, middle, and upper middle class. A fourth category, "varied," was composed of those synagogues in which the respondent did not specify one predominant group. Again, the authors speculate that the "varied" response may indicate either a truly heterogeneous congregation, or the rabbi's lack of knowledge about his congregants with respect to socioeconomic status.

As seen in Table 13, there is no clear association between the socioeconomic level of the congregants and the number of mental health programs in the synagogue. It was expected that socioeconomic level would have had a similar association with the number of mental health programs (as did educational level and occupation).

TABLE 13

SOCIOECONOMIC LEVEL BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Socioeconomic Level				
	Lower Middle Class	Middle Class	Upper Middle	Varied	Total
High (21-39)	0	2	1	2	5
Medium (9-20)	1	3	1	5	10
Low (1-8)	0	5	0	2	7
Nothing (0)	1	3	1	0	5
Total	2	13	3	9	27

There is no noteworthy association between the congregants' educational levels, occupations, socioeconomic levels, and the synagogue's overall range of programming. These findings may be found in Appendix C, Tables 27, 28, 29, and 30. The authors speculate that these findings may be better understood if one considers the importance of denomination in determining the synagogue's approach to programming. The authors suggest that denomination has a

much greater impact on a synagogue's orientation than the above mentioned factors.

Proximity of Congregants' Residences to the Synagogue

Data were gathered on whether or not congregants live in neighborhoods nearby the synagogue. It was thought that those synagogues located in the congregants' neighborhoods would be more likely to function as family support systems, and that this would be reflected in the programming. There is no apparent association found between the proximity of the congregants to the synagogue and either the overall program orientation or the number of mental health programs. These findings are reported in Appendix C, Tables 31 and 32. An explanation for these findings may be based upon the selection criteria used by people when choosing a synagogue. The reputation of a synagogue, and what it has to offer may be just as, or more important than its location. However, it should be noted that Orthodox congregants must live nearby their synagogue in order to observe Jewish laws that prohibit driving on the Sabbath and major holidays. This may explain the large number of synagogues which had most of its congregants living nearby, yet had a low number of mental health oriented programs.

Synagogue Programming and Characteristics of the Rabbi

There are several characterisitcs of the rabbi which the authors felt might be influential factors in determining the existence of synagogue programs. Questions 70, 71, and 72 of the interview schedule (Appendix B), inquired about the age of the rabbi, the number of years since ordination, and years of tenure at the synagogue. Questions 73,74, and 75 dealt with the rabbi's educational background. Questions 76, 77, 78, 79, and 80 examined the extent of the rabbi's involvement in counseling his congregants.

Associations are found between some of these characteristics and the number of mental health programs sponsored by synagogues. However, no associations are found between the characterisitcs of the rabbi and the overall range of programming in the synagogue. The data tabulations pertaining to the overall range of programming can be found in Appendix C, Tables 33, 34, 35, and 36. The authors speculate that denomination has a much greater impact on a synagogue's orientation than the personal characteristics of the rabbi.

Age of the Rabbi, Number of Years Since Ordination, and Years of Tenure at the Synagogue

The age of the rabbi was estimated by the interviewers and reported in Question 70. Few rabbis were estimated to be under 35 years old and therefore the rabbis' ages were recorded as up to 50, and 50 years of age or over.

There appears to be an association between the age of the rabbi and the number and range of mental health programs sponsored by the synagogue. When one examines those congregations with medium or high levels of mental health programming, it is found that there are twice as many rabbis under 50 years of age than 50 years old or over.

TABLE 14

AGE OF THE RABBI BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Age of the Rabbi		
	Under 50	Over 50	Total
High (21-39)	3	2	5
Medium (9-20)	7	3	10
Low (1-8)	4	3	7
Nothing (0)	1	4	5
Total	15	12	27

A possible reason for the relationship between the

age of the rabbi and the number and range of mental health programs is that younger rabbis may have more current ideas about programming than older rabbis and may have a broader view of the function of the synagogue. Younger rabbis, who have recently completed their rabbinical education, may have had more exposure in the seminary to new ideas concerning the need for mental health oriented programs. The younger rabbis therefore, may tend to sponsor programs in the synagogues which are more relevant to the many needs of the congregants.

The data gathered in Questions 71 and 72 reflected no apparent association among the number of years a rabbi has been ordained, how long he has served the congregation, and the number of mental health programs sponsored by the synagogue. The data is found in Appendix C, Tables 37 and 38. It is interesting to note that although most of the rabbis have been ordained for over 16 years, a majority of the respondents have served their present congregations less than five years. This may reflect a certain amount of instability, or perhaps upward mobility, in a rabbi's career, or a possible skew in the sample. Assuming that the sample is reflective of the population, a possible outcome of instability in one's position may be a lack of time

to develop innovative programs and the preliminary community support for them. Less experienced rabbis might not be as wary of innovation because they have not had to deal with as much congregational politics in their brief careers.

Graduate Training of the Rabbi Other than Rabbinical Preparation

The researchers were interested in the education of the rabbis, assuming that the rabbis with training in counseling-related areas would be more aware of the interpersonal needs of their congregants. Therefore, it might be expected that these rabbis would be more likely to encourage the development of mental health programs in the synagogue. In Question 73 the rabbis were asked about the graduate education they completed. Responses clustered around theology, education, and counseling-related disciplines.

In analyzing the data, the researchers distinguished between those rabbis who had pursued graduate educations other than rabbinical preparation and those who had not. The denomination of the rabbi did not seem to be associated with the existence of other graduate training. Rabbinical seminaries do not require additional graduate education of

their students. Therefore, those rabbis with other graduate education pursued it on their own initiative. The data is found in Appendix C, Table 39.

The authors expected to find a positive association between the graduate training of the rabbi and the level of mental health programming. Half of those rabbis who have graduate training other than rabbinical preparation serve a congregation which has a medium or high level of mental health programming. The remaining half of these rabbis serve congregations with a low number, or no mental health programs. Of the six rabbis who do not have other graduate training, five serve congregations which sponsor a medium or high number of mental health programs.

TABLE 15

GRADUATE TRAINING OF THE RABBI OTHER THAN RABBINICAL PREPARATION BY THE NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Graduate Training Other Than Rabbinical Preparation		
	Yes	No	Total
High (21-39)	3	2	5
Medium (9-20)	7	3	10
Low (1-8)	7	0	7
Nothing (0)	4	1	5
Total	21	6	27

In examining the areas in which the rabbis pursued other graduate training, it was discovered that several of them were in fields which the authors felt had no direct connection to mental health programming. Many of these consisted of philosophy, Judaic studies, and theology. Therefore, it is important to focus on graduate training in areas related to counseling. The data found in the table below was obtained by responses to Question 74 in the interview schedule.

TABLE 16

RABBIS' GRADUATE TRAINING IN COUNSELING OR GROUP WORK BY THE NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Graduate Training in Counseling or Group Work		
	Yes	No	Total
High (21-39)	3	2	5
Medium (9-20)	9	1	10
Low (1-8)	5	2	7
Nothing (0)	1	4	5
Total	18	9	27

Eighteen out of twenty-seven rabbis have graduate training in areas pertaining to counseling. Of those rabbis who have this training, two-thirds serve congregations which have a medium or high number of mental health

programs. It was found that two-thirds of those rabbis without graduate educations in counseling-related fields serve congregations with a low number or no mental health programs. The data supports the authors' expectation that those rabbis with graduate educations in mental health related fields would be likely to develop more mental health programs in their synagogues.

The authors realized that is was possible that some rabbis had been trained in counseling through seminars that may not have been part of a graduate program. Question 74 inquired as to whether the rabbi had attended any training seminars in counseling. Table 17 below indicates that an association exists between rabbis who have attended seminars in counseling and the number of mental health programs sponsored by synagogues. This is similar to the findings which indicate an association between graduate training in counseling and the number of mental health programs sponsored in synagogues. By and large, the rabbis who have attended seminars are the same ones who have had graduate training in counseling.

It should be noted that many of the rabbis who reported having graduate training in counseling acquired it while pursuing graduate degrees in education. Counseling,

therefore, was not the main objective. In addition, several of the rabbis had attended a seminar sponsored by the Los Angeles Board of Rabbis on pastoral counseling.

TABLE 17

RABBIS' PARTICIPATION IN SEMINARS IN COUNSELING BY THE NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Rabbis' Participation in Seminars in Counseling		
	Yes	No	Total
High (21-39)	4	1	5
Medium (9-20)	9	1	10
Low (1-8)	6	1	7
Nothing (0)	2	3	5
Total	21	6	27

The seminar, held for two consecutive years, consisted of six to eight sessions, led by a psychiatrist affiliated with Cedars-Sinai Medical Center. Rabbi Harry Essrig, Executive Vice President of the Board of Rabbis, reported that the seminar did not generate enough interest, in his opinion, to warrant further programs in this area. Several of the rabbis who participated in the seminar reported that it was their only training in counseling. The experience of these rabbis was limited to this one program; this may serve to explain the large number of

synagogues with a low number or no mental health programs, whose rabbis had participated in training seminars in counseling. If this was their only exposure, one could not reasonably expect that it would result in changes in synagogue programming.

The researchers examined whether denomination is associated with the rabbi's graduate education in counseling and attendance at seminars in counseling. It was surprising to find that there is no association, and that no noteworthy differences exist among the three denominations. The data is presented in Tables 18 and 19 below.

TABLE 18

DENOMINATION OF THE RABBI BY GRADUATE TRAINING IN COUNSELING

Graduate Training in Counseling	Denomination			
	Reform	Conservative	Orthodox	Total
Yes	6	4	5	15
No	3	5	4	12
Total	9	9	9	27

It was expected that few Orthodox rabbis would have had graduate training in counseling, or would have attended seminars in counseling. This expectation was based on Orthodox perspectives concerning the rabbi's functions and

the validity of psychology. The literature indicated the role of the Orthodox rabbi to be primarily that of a religious functionary and teacher. In addition, several Orthodox authors expressed their suspicion about psychology as a body of knowledge that had relevance for Jews. This expectation was not supported by the data.

TABLE 19

DENOMINATION OF THE RABBI BY RABBIS' PARTICIPATION IN SEMINARS IN COUNSELING

Participation in Seminars	Denomination			
	Reform	Conservative	Orthodox	Total
Yes	8	6	6	20
No	1	3	3	7
Total	9	9	9	27

Rabbi's Involvement in Counseling His Congregants

The researchers were interested in the extent to which rabbis engage in counseling their congregants, expecting that there would be an association between the rabbi's involvement in counseling and the number of mental health programs offered. In Question 76, the rabbis were asked whether they engage in individual or family counseling. Twenty-five of the 27 respondents reported that they engage in counseling their congregants. The denomination

of the rabbis did not seem to have any association with their level of counseling activity. The data is reported in Appendix C, Table 40.

Question 77 of the interview schedule dealt with the proportion of time the rabbis spent in counseling congregants. The question was open ended; however, most rabbis tended to respond in terms of "a lot" or "a little," and when questioned further, viewed this as more or less than 20% of their time. The data was therefore divided into three categories: more than 20%, less than 20%, and don't know. It is speculated that those rabbis who responded with "don't know," either were unable to quantify the amount of time spent counseling congregants, or in fact did not engage in much counseling and preferred not to indicate this fact.

The researchers reviewed the data to determine whether there is an association between the amount of counseling done by the rabbi and the number of mental health programs sponsored by the synagogue. The findings reported in Table 20 below indicate that no such association exists. It was expected that those rabbis who spend much of their time counseling would be more aware of their congregants' needs and therefore would develop more

programs. While this is true for some rabbis, others reported that the programs resulted in their having to spend less time counseling. The decrease in the amount of time the rabbi spends counseling may reflect the preventive function of such programs or may be indicative of an alternative method of dealing with congregants' personal problems. Such an alternative has implications for the rabbi in the economical use of resources.

TABLE 20

THE AMOUNT OF COUNSELING DONE BY THE RABBI BY THE NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Amount of Counseling Done by the Rabbi			
	Less Than 20% of the Rabbi's Time	More Than 20% of the Rabbi's Time	Don't Know	Total
High (21-39)	1	4	0	5
Medium (9-20)	5	2	3	10
Low (1-8)	4	3	0	7
Nothing (0)	2	2	1	5
Total	12	11	4	27

Recognizing that the majority of rabbis in the sample do in fact engage in counseling, the researchers were interested in whether the rabbis experience difficulties in working effectively in this role. An open ended question, number 78, explored the rabbis' feelings about

their difficulties. Questions 79 and 80 explored whether the rabbis find it necessary to involve other professionals either through consultation or referral, in the attempt to help their congregants.

Twenty-two of the 27 respondents reported that they do experience difficulties involved with their role as counselors. It was found, however, that difficulties could mean a variety of things. Several rabbis felt that they do not have the expertise to deal with many of the problems presented to them. Others spoke of the emotional difficulties involved in being a counselor. For instance, several rabbis expressed concern, in retrospect, with whether they had handled the situation most effectively. It is interesting to note that two of the Orthodox rabbis experienced difficulty in fulfilling the dual role of being both a spiritual leader and a counselor. The rabbis felt that quite often congregants are reluctant to discuss family problems with their congregational leader. One rabbi reported that many congregants view their rabbi as a father figure with an aura of sacredness. The respect that the congregants bestow upon the rabbi makes it difficult for some to reveal their own perceived weaknesses.

Several rabbis felt limited in their ability to

help their congregants who were in need of longer term counseling. A few respondents referred such limits to time constraints. Others held the philosophy that a rabbi should not be involved in long term counseling, and referred these individuals to other professionals after initial contacts.

Those rabbis who reported that they experience no difficulties in counseling their congregants, expressed various reasons. Some rabbis are professionally trained as counselors and feel confident in their abilities to offer assistance. One rabbi did not engage in counseling and therefore did not report any difficulties. It is also possible that a rabbi who is not trained in counseling may not have the expertise to deal with issues beyond the presenting problems, and contact may therefore remain on a superficial level. These rabbis may not be aware of some of the difficulties inherent in counseling. A fourth reason that rabbis did not report difficulties is their promptness in referring congregants to other resources.

The data did in fact indicate that 23 of the 27 rabbis, regardless of denomination, consult with other professionals about counseling with congregants. In most cases, the consultation is informal, with a congregant who

is a mental health professional. In addition, most rabbis refer congregants to other agencies and professionals when necessary. The findings are in Appendix C, Tables 41, 42, 43, and 44.

The researchers were interested in determining whether the rabbis felt that having a social worker on staff would be beneficial to their congregants. The authors were aware that this was a new idea that was being explored by one Los Angeles congregation, and expected that those rabbis who were the most involved in counseling would favor the addition of a social worker to their staff. The data collected in Question 81 of the interview schedule revealed that 18 of the 27 rabbis felt that the presence of a social worker would be beneficial to their congregation. As expected, most of the rabbis serving congregations with a medium or high number of mental health programs replied affirmatively. Most of the rabbis who did not see any need for a social worker serve congregations which have a low number, or no mental health programs.

This finding may reflect the rabbi's sensitivity to or awareness of his congregants' needs; those rabbis who serve congregations with more mental health programs are probably more aware of their congregants' needs, and

therefore feel that a staff social worker would be beneficial.

TABLE 21

RABBIS' ASSESSMENT OF THE NEED FOR A SOCIAL WORKER BY THE NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Rabbis' Assessment of the Need for a Social Worker		
	There is a Need	No Need	Total
High (21-39)	5	0	5
Medium (9-20)	9	1	10
Low (1-8)	4	3	7
Nothing (0)	0	5	5
Total	18	9	27

A clear association is found between the rabbi's denomination and his assessment of the need for a social worker on his staff. All the Reform rabbis, two-thirds of the Conservative rabbis, and one-third of the Orthodox rabbis reported a need for a social worker in their congregations. It is interesting to note that as the rabbis become more traditional in their interpretation of Jewish law, they showed a decrease in their assessment of the need for a social worker. The authors speculate that Orthodox rabbis would be more wary of hiring a social worker. This is probably related to Orthodox views of psychology and of the functions of the synagogue. As cited in the literature,

and noted earlier, representatives of the Orthodox movement have reservations about psychology and view the primary function of the synagogue to be worship and study.

TABLE 22

DENOMINATION OF THE RABBI BY RABBI'S ASSESSMENT OF THE NEED FOR A SOCIAL WORKER

Rabbi's Assessment of the Need for a Social Worker	Denomination			
	Reform	Conservative	Orthodox	Total
There is a need	9	6	3	18
There is no need	0	3	6	9
Total	9	9	9	27

Several explanations were presented by rabbis who did not think that a social worker on staff would be beneficial to the congregation. One rabbi stated, "A staff social worker is not as high on our list of priorities. . . youth and adult education is more important." Another rabbi felt that hiring a staff social worker is not advisable: "It's not our job; Jewish Family Service can handle it." A rabbi of a small congregation, who did not feel the need for a social worker, reported that he had a Masters in Social Work and could competently handle the needs of his congregation.

Rabbis had various reasons for supporting the idea

of hiring a social worker. One respondent reported his changing perception of the role as a rabbi: "(Earlier) I saw my role as dealing exclusively with ritual, but as I saw a troubled community in middle class suburbia, I realized that more was required." One rabbi viewed his synagogue as a community center and felt that a staff social worker should serve the surrounding community as well as his congregants. Several rabbis felt overwhelmed with requests for counseling: "I don't have the time or the expertise to do more than scratch the surface." Some rabbis, however, did express the need to hire a social worker who would be sensitive to Jewish values. These rabbis felt that if this condition is met, the sensitivity of social work is most appropriate for the synagogue setting: "People who have problems should feel that the synagogue can meet their emotional needs . . . rabbis are not as well trained to deal with these problems as professional counselors."

Rabbis' Opinions on the Synagogue as a Setting for Mental Health Programming

The final question of the interview schedule asked the rabbis to express any opinions or feelings they had about the inclusion of mental health programming as part of

a synagogue's activities. Nineteen of the 27 respondents indicated that they consider mental health activities to be an appropriate part of a synagogue's programming. The data presented in Table 23 below was analyzed in order to determine whether there is an association between denomination and opinions on the appropriateness of mental health programming for the synagogue.

TABLE 23

DENOMINATION BY RABBIS' OPINIONS ON THE APPROPRIATENESS OF MENTAL HEALTH PROGRAMMING IN THE SYNAGOGUE

Rabbis' Opinions on the Appropriateness of Mental Health Programming in the Synagogue	Denomination			
	Reform	Conservative	Orthodox	Total
Yes	9	6	4	19
No	0	3	5	8
Total	9	9	9	27

There appears to be an association between the rabbis' denominations and their opinions on the appropriateness of mental health programming for the synagogue. The authors expected that those congregations with more liberal interpretations of Jewish law would be more conducive to the development of mental health programs. The findings do in fact indicate that the number of rabbis who

approve of including mental health programs increase as their denominations become more liberal in their interpretation of Jewish law.

There were several reasons expressed by respondents who disapproved of the inclusion of mental health programming in the synagogue. Several rabbis felt that religious and educational programming had greater priority. In fact, one rabbi stated: "Groups are not the right way to help people out of their problems. People won't tell the truth or will be showoffs. It's just a way to kill time and gossip." Other rabbis indicated that they view psychology as harmful to modern Jewish life. One rabbi, when asked whether the synagogue is an appropriate setting for mental health programming, stated: "The synagogue isn't the place for it. Judaism is fading away because we accepted psychology. There is a clash between psychology and Jewish values. It has destroyed the idea of God and morality."

There are two general viewpoints of the function of a synagogue which are held by rabbis who agree that the synagogue is an appropriate setting for mental health programming. Several rabbis stated that the synagogue is an extended family, and it is therefore appropriate for it to service any of the congregants needs. One rabbi stated

that " . . . anything pertaining to Jews and Judaism should be dealt with." Another rabbi stated that " . . . the synagogue family, if it is to be one, must extend support from within."

Other rabbis viewed the synagogue as the center of Jewish activity. One rabbi perceived the synagogue to be " . . . a multifaceted institution; not just for prayer and academic learning." Another rabbi stated that the " . . . synagogue must reach out to people and become more relevant to their needs." One rabbi carried the thought further: "There have been changes in how people view themselves and the synagogue. The synagogue is being viewed more as a therapeutic community." The importance of the relationship between the synagogue and the mental health field was expressed by one rabbi: "I am convinced that the synagogue has a responsibility in helping its constituency understand the validity of this professional community and its ability to help."

Conclusion

The preceding discussion has reviewed the various perceptions held by our sample of Los Angeles rabbis on the role and function of the synagogue. These views range from

the perception of the synagogue as primarily a center for worship and religious study, to the broader view which includes the synagogue as an extended family and community center.

As one reviews the findings it become apparent that synagogues form two polar types with relation to their approach to programming: (1) The synagogue which sponsors little or no programs with a mental health orientation, and (2) the synagogue which sponsors a large number of different mental health programs.

Profile of Type I

Several characteristics are associated with the synagogue which sponsors few mental health programs. As might be expected, the rabbi of such a congregation does not feel that the synagogue is an appropriate institution for serving the mental health needs of the congregants. A typical synagogue with this philosophy tends to have a small staff and a small membership. The rabbi has graduate training in various fields, but not in a counseling-related area. He does not feel that a social worker on staff would be beneficial for his congregants. His lack of training in counseling apparently precludes the recognition of a need

for another staff person with this area of expertise. This type of congregation is affiliated with the Orthodox movement. The Orthodox affiliation is significant in determining the orientation of the synagogue. The rabbi and the congregants expect the synagogue to address only their worship and study needs. Programming reflects this expectation. In addition, a certain caution in approaching psychology, evident among some Orthodox leaders, may contribute to a hesitancy to develop mental health programs in the synagogue.

Profile of Type II

When one examines the typical synagogue which sponsors a relatively large number of mental health programs, certain characteristics are found. The rabbi of this type of congregation feels that the synagogue is an institution that should develop and offer mental health oriented programs. Such a synagogue tends to have a large staff and a large membership. The membership of the congregation is composed of families with children in the home. Congregants are primarily college graduates who are business or professional people. The rabbi is under 50 years of age and has had graduate training in counseling-

related areas. He feels that his congregants would benefit from having a social worker on his staff. This congregation is affiliated with the Reform movement. As in Orthodox congregations, affiliation with the Reform movement is significant in determining the orientation of the synagogue. The synagogue is viewed as an extended family and community center and sponsors programs to meet a range of needs. The development of mental health programs is in response to some of these needs.

There appears to be a definite association between the above mentioned factors and the synagogue's receptivity to mental health programming. The authors speculate that there may indeed by a relationship between the synagogue's receptivity to mental health programming and the characteristics of the synagogue, the congregants and the rabbi which were discussed above. This will be discussed in more detail in the concluding chapter.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Focus of the Study

This study explored the extent to which synagogues in Los Angeles sponsored activities which were oriented toward promoting individual and family mental health and stability. Although there are various ways in which synagogues can promote the mental health of their members, the researchers were interested in those approaches that were specifically designed to educate or assist congregants in meeting these needs. For example, this might include group counseling; discussions on common problem areas; the use of developmental or therapeutic techniques; as well as preventively oriented group education programs. The latter type of program is often referred to as Family Life Education, and focuses on helping people understand and cope with developmental or life cycle crises.

In addition to determining the extent to which mental health oriented programs exist in synagogues, the researchers were interested in examining whether various characteristics of the synagogue, the congregants, and/or the rabbi might be associated with the number of such

programs that are offered. Interviews were conducted with the rabbis of 27 Los Angeles congregations, selected by random sampling procedures. Questions about the congregants dealt with their socioeconomic status, levels of education, occupations, places of birth, and ages. Another series of questions focused on the synagogues' denomination, (Orthodox, Conservative or Reform), size, professional staff, committee structure, and types of programs offered. Information about the rabbi was sought with reference to age, educational background, number of years in the field, and the duration of his tenure at the synagogue. In addition, rabbis were asked their opinions concerning the appropriateness of mental health programs in the synagogue.

Major Findings

Analysis of the data revealed that while some synagogues have extensive programming, others had no programs. When characteristics of the synagogue, the congregants, and the rabbi were reviewed, it was discovered that several of these characteristics appear to be associated with the extent to which synagogues sponsor mental health programs.

There appears to be a positive association between

the number of mental health programs likely to be sponsored by a synagogue and the size of the congregation and its staff. Those congregations with a relatively large membership and staff appeared to sponsor more mental health oriented programs.

Three characteristics of congregants appear to be associated with the number of mental health programs offered. Those congregations which are composed predominantly of families with children at home tend to sponsor the highest number of mental health programs; interestingly the congregants were generally college graduates employed in business or professional fields.

The age of the rabbi appears to be associated with the number of mental health programs sponsored in the synagogue. Those synagogues with rabbis under 50 years of age appear to have the highest number of mental health programs. There was also a clear association between the rabbi's graduate training in a counseling-related field and the number of mental health programs sponsored by the synagogue. It was found that those rabbis who had pursued graduate training in counseling-related areas also tend to be affiliated with synagogues which offered a higher number of mental health programs. It is evident that rabbis who had

not pursued graduate training in a counseling-related area tend to serve at synagogues with a lower number of mental health programs.

Another association clearly evident in the findings relates to the synagogue's mental health programming and the rabbi's assessment of his congregation's need for a staff social worker. It was found that those rabbis who felt that their congregants would or could benefit from having a social worker on staff tend to serve synagogues which sponsor a higher number of mental health programs; rabbis who did not think that hiring a social worker would be beneficial for their congregations, generally serve synagogues which sponsor a low number, or no mental health programs.

The denomination of the rabbi and the congregation is consistently associated with the following indicators of receptivity to mental health programming: the number of mental health programs sponsored by the synagogue, the rabbi's assessment of the need for a staff social worker, and the rabbi's opinion of the appropriateness of this type of programming in a synagogue. All of the Reform congregations studied sponsored a high or medium number of mental health programs. In addition, all of the Reform respond-

ents indicated that their congregations would benefit from having a social worker on staff, and held the opinion that the synagogue was an appropriate setting for mental health programming.

The majority of Conservative rabbis reported that their synagogues sponsor a medium or high number of mental health programs. Additionally, the majority of Conservative respondents indicated that their congregations would benefit from having a social worker on staff, and held the opinion that the synagogue was an appropriate setting for mental health programming.

The majority of Orthodox congregations sponsor a low number or no mental health programs. In addition, the majority of Orthodox respondents indicated that their judgment was that their congregations would not benefit from having a social worker on staff, and felt that the synagogue was not an appropriate setting for mental health programming.

The difference among the three denominations' interpretations of Jewish law may be seen as a continuum ranging from a more liberal to a more traditional view: Reform → Conservative → Orthodox. As illustrated in the diagram below, receptivity to mental health programming in

the synagogue was associated with this continuum.

Traditional Interpretation of Jewish Law (Orthodoxy)	(Conservative)	Liberal Interpretation of Jewish Law (Reform)
→ → → → → → → → → → → →		
* No mental health programs offered. * No assessment of need for a staff social worker. * Not appropriate for the synagogue to sponsor mental health programs.		* High number of mental health programs offered. * Assessment of need for a staff social worker. * Appropriate for the synagogue to sponsor mental health programs.

Discussion and Implications

The authors speculate that a more liberal interpretation of Jewish law is more conducive to the development of mental health programming in the synagogue, and conversely, the more traditional interpretation of Jewish law is less conducive to the development of these programs. Representatives of the Orthodox movement expressed greater caution regarding psychological precepts; they felt that all of a person's emotional needs could be fulfilled through a traditionally observant life. For example, Jewish law instructs people on procedures for dealing with death through prescribed mourning processes. While the authors believe that some elements of observing Jewish law can indeed have a therapeutic effect, it is questionable

whether Jewish law and customs deal with all aspects of life in the most effective manner.

It appears that those Jews who interpret Jewish law more liberally have not found that observance of Jewish law is sufficient in fulfilling all emotional needs. Many Jews expect the synagogue, an important institution in their lives, to go beyond the primary focus of worship and study and attempt to meet a variety of needs. The synagogue is increasingly perceived as both an extended family and "a therapeutic community."[1] Synagogues have responded in several ways to these expectations: the development of havuroth,[2] professional and paraprofessional counseling committees, individual counseling by the rabbi, group therapy, and educational lectures and group discussions.

The authors feel that efforts and programs such as those listed above are necessary if the synagogue is to remain a viable and central institution in Jewish life. What can the future of the synagogue be if it does not respond to the needs and expectations of its members? From

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[1]Interview with Rabbi Harold Schulweis, February 1976.

[2]A havurah (plural: havuroth) is a small group of people, which may serve as an extended family, meeting together for study, holiday celebrations, and social gatherings.

the perspective of the authors, the synagogue is an appropriate setting for meeting congregants' needs--and it is felt that these needs go beyond worship and study.

Some rabbis indicated that their congregants have not expressed a need for programs relating to mental health Can it be assumed that no such needs exist by virtue of the fact that they have not been communicated to the rabbi? If in fact the needs exist, perhaps there is a reluctance on the part of the congregants to discuss such matters. It is also possible that congregants are reluctant to form a group that might suggest activities of this sort because this would involve sharing personal experiences or problems with others whom they may know socially.

Another possible reason for unexpressed or unheard needs may be related to the rabbi. Some congregants may perceive the rabbi to be unavailable or unapproachable for discussion of personal concerns. It is possible that a heavy schedule does not permit the rabbi to spend as much time with individual congregants as they might need. In addition, many rabbis are not sufficiently trained in counseling to be sensitive to or aware of unexpressed needs. Rabbis may also lack the background or knowledge to deal with the problems once they have been raised.

It is understandable that a rabbi who has not had much training in counseling might be reluctant to develop mental health programs in his synagogue. While some rabbis feel that there is no value in mental health programming, others may feel threatened by an area in which they have little knowledge. A rabbi may feel uncomfortable about allowing other professionals to be considered "experts" within the synagogue--a role traditionally reserved for him. There might be concern that as other professionals assume positions of expertise within the synagogue, the rabbi's role may lose some of its status.

Up to now the authors have speculated that factors associated with the rabbi's denomination, age, and training play a key role in the decision not to introduce mental health programming in synagogues. Obviously this speculation derives from the authors' own personal and professional assumptions regarding societally induced and personal adjustment stresses that confront most people today. It should be noted, though, that it is quite possible that the congregants' own expectations regarding the role of the synagogue, and the size of the synagogue may be more controlling factors. Further, in many instances it is conceivable that the religious, spiritual,

and extended family qualities of some synagogues may well play an important enough role in congregants' lives to reduce the need for programs that are focused specifically on mental health. Obviously the issue is complex and beyond the scope or resources of this study.

The authors feel, however, that attitudes of the rabbi and the congregants do play a crucial role in determining the future availability of mental health programs in synagogues. The issues which have been raised are promising areas for further research.

Recommendations

The synagogue is, and should remain, a central institution in Jewish life. To do so, it must remain relevant to the needs of its members. Furthermore, the synagogue has a responsibility to help maintain a fulfilling Jewish lifestyle for individuals and families. The authors suggest that there is an opportunity to help people cope more adequately if programs and activities are organized around life cycle developmental crises. This means that programs can be developed along three tracks: (1) those designed to meet the needs of specific age groups; (2) those designed to help people with particularly stress-

ful life situations; and (3) those which deal with developmental crises likely to be encountered by most people. For example, programs developed for specific age groups could be geared for adolescents, young adults, the middle aged, and the elderly. Programs developed around stressful life situations could be geared for persons dealing with marriage, divorce, parenthood, illness, retirement, or death. Programs which might be of interest to most people could include topics such as sex and sexuality, drug and alcohol abuse, death and dying, and retirement and aging.

In addition to formal programs, a synagogue can respond as an institution to the needs of various subgroups in the congregation. For example, Jewish tradition and congregational life have focused on the intact family. Religious leaders must become more sensitive to the increasing number of people who do not fit this pattern and may feel alienated by the family emphasis. The authors suggest that synagogues make further efforts to encourage the full participation of singles, single parent families, persons with limited incomes, and persons with physical and psychological handicaps. This would include developing sensitive ways of dealing with certain situations.

Another consideration which may appear minor, but

has implications relating to making people feel welcome, is the wording of invitations. For example, synagogues might display more sensitivity to single persons by stating that the admission price of an activity is per person, rather than per couple.

There are different approaches to programming which may serve as models for synagogues interested in developing ways of meeting the mental health needs of their congregants. A variety of these models can be found in Los Angeles synagogues. In recent years, many congregations have developed havuroth. While the focus of these groups may differ, most have the central goal of providing an opportunity to develop closer relationships with other congregants. There is a potential in these groups for creating a support system, much like that of an extended family, which can help people cope with many of the stresses of life today. The creation of this support system also serves the preventive function of reducing feelings of alienation encountered by many people in this complex and mobile society.

One synagogue developed a center specifically designed to meet the mental health needs of people in the surrounding community. The center, initially financed by a

grant from one of the congregants, was originally focused on the needs of adolescents. However, it has since expanded its programming to reach other populations, including singles and widows. The program for widows, in particular, seemed impressive in terms of its efforts to help widows deal with their new life situation. Although there is a paid staff coordinator, the leaders of rap groups are volunteer professional counselors. Members of the widows' center take an active role in developing programs for themselves and other widows.

Other synagogues in the community use resources within their congregation by developing counseling services staffed by volunteers. One approach is to have congregation members who are mental health professionals volunteer their time to aid fellow congregants. The service is provided either at no cost or at a fee set according to the client's ability to pay. Another approach is to use the congregants who are mental health professionals as trainers and supervisors of paraprofessional volunteers.

Synagogues might coordinate their volunteer counseling services on the model used by kibbutzim in Israel. In order to avoid problems of confidentiality and stigma which may arise, the mental health professional who

lives on the same kibbutz, will often be "traded" for a mental health professional on a different kibbutz. Synagogues could adopt this approach and develop joint volunteer counseling services. These volunteers would offer their services to members of another congregation in exchange for reciprocal services.

An approach used by another congregation has been to contract with Jewish Family Service for a part-time social worker. The rabbi of this synagogue had become increasingly alarmed at the number of divorces among his congregants, and felt that the synagogue had a responsibility to intervene. This synagogue has recently discontinued the contract with Jewish Family Service in favor of utilizing professionals within the congregation.

Some synagogues have found it beneficial to coordinate programs with other synagogues or agencies within the community. Advantages of this approach are the reduction of costs for the individual synagogue, and the avoidance of duplication of services. Most synagogues did not fund these programs entirely out of their program budget, but found it necessary to charge modest fees. For instance, one synagogue is able to fund its activities entirely through admission and counseling fees.

In addition to the recommendations for the development of synagogue programs, the authors suggest that efforts be made towards enriching the counseling and mental health aspects of rabbis' education. Many of the rabbis interviewed in the study reported that they did not feel adequately prepared in the seminary to deal with their counseling responsibilities. Rabbinical seminaries should reevaluate the duties of the modern rabbi and consider adapting their educational program accordingly. In addition to the education received in the seminary, the authors suggest that counseling training and consultation programs be developed for rabbis in the field. These could be offered or coordinated by the Board of Rabbis, the national movements, and/or local Jewish Family Service agencies.

With regard to the Orthodox group, further efforts need to be made to integrate modern mental health approaches with traditional practices. Law and observance have changed during the millenia of Jewish existence in accordance with contemporary needs. This can be accomplished through an exchange of ideas between rabbis and mental health professionals who are concerned with the survival of Jewish life.

Finally, the authors believe there is much to be

said in favor of locating preventive and rehabilitative programs within the context of Jewish institutions such as the synagogue. Obviously further research is indicated if the consequences and implications of such steps are to be fully anticipated and designed in a constructive and effective manner.

APPENDIX

Appendix A

N
W
E
S
Roscoe
Rinaldi
Laurel Canyon
Reseda
Lankershim
Pacific Coast Highway
Centinela
Vermont

Appendix B

Interview Schedule

THE SYNAGOGUE

Can you tell me a little about your congregation? (probe)

1. number of member families?_____
2. average socioeconomic status_____
3. age distribution of membership_____
4. educational level:

	male	female	don't know
high school graduate	_____	_____	_____
college graduate	_____	_____	_____
graduate	_____	_____	_____

5. Occupations:

   a. white collar _____
   b. blue collar _____
   c. business-professional _____

   Which professions are most representative?_____

6. Do most members live in the nearby neighborhood?_____
7. Are most members:

   a. immigrants _____
   b. first generation Americans _____
   c. second generation Americans _____
   d. third generation Americans _____

8. How long has your congregation been in existence?

   a. 1-5 years _____
   b. 6-15 years _____
   c. 16-30 years _____
   d. 31-45 years _____
   e. 46 or more _____

9. What professional staff is employed by your synagogue? What are their educational backgrounds? (If more than one, place number in category.)

   a. additional rabbi_____

b. executive staff _____
c. cantor _____
d. program coordinator _____
e. education director _____
f. youth director _____
g. religious school teachers _____
h. social worker _____
i. other _____

10. What groups or committees are active in your synagogue? (If more than one, place number in category.)

a. sisterhood _____
b. youth _____
c. couples club _____
d. men's club _____
e. social action _____
f. havuroth _____
g. other _____

11. Are there opportunities for persons other than members of your synagogue to take part in activities?

a. sponsored by your synagogue? _____
b. held at, but not sponsored by your synagogue? _____

What current programs exist in your synagogue? (Questions 12-19)

	Yes	No
12. Judaica classes Hi Med Lo		
13. Hobby or interest activities Hi Med Lo		
14. Social get-togethers (dance, games) Hi Med Lo		
15. Havuroth Hi Med Lo		
16. Performing arts Hi Med Lo		
17. Holiday celebrations Hi Med Lo		

18. Public affairs or social action lectures Hi Med Lo		

19. Interviewer's general impression of the overall range of programs:

a. worship and study orientation
b. Worship, study and social orientation

We'd like to know whether you have felt it necessary for special efforts to be made in meeting the needs of various groups in your congregation.

	Yes	No	What is done at present	Future
20. Recent widows			21.	22.
23. Recent divorcees			24.	25.
26. Single parents			27.	28.
29. Nonmarrieds			30.	31.
32. Parents			33.	34.
35. Couples (marital relationships)			36.	37.
38. Adolescents			39.	40.
41. Middle-aged			42.	43.
44. Elderly			45.	46.
47. Others, please specify			48.	49.

We are interested in two types of activities which might exist in a synagogue. These may be in the form of lectures, films or discussions which are either for the purpose of general education or to help solve a particular problem. Have you had any activities of this sort?

	Yes	No	Program Information
50. Parenting Hi Med Lo			

51. Sex and sexuality Hi Med Lo			
52. Changing roles in the family and in society Hi Med Lo			
53. Communicating with your spouse, child, etc. Hi Med Lo			
54. Marriage Hi Med Lo			
55. Divorce Hi Med Lo			
56. Retirement and aging Hi Med Lo			
57. Death and dying Hi Med Lo			
58. Consciousness-raising groups Hi Med Lo			

In which of these areas do you see the greatest need? (Circle Hi, Med or Lo above.)

59. What kinds of programs of this nature would you like to see developed further in the future?

60. If there are no lectures, films or discussion groups in any of the above areas, what do you attribute the absence to? (If more than one reason, rank in order of importance.)

a. lack of funds _____
b. no expressed need _____
c. opposition by board _____
d. opposition by members _____
e. failure in the past _____
f. should not take place in the synagogue _____
g. other, please specify _____

61. In reference to the above areas, have you had any joint programs with other agencies, synagogues or organizations?

a. Yes b. No

If yes, which organizations?

What were the programs?

62. How do you feel about having joint programs with other agencies, synagogues or organizations?

SPECIFIC PROGRAMS

63. What are the goals of these type of programs?_____

64. Who is responsible for leading them?

a. rabbi_____
b. congregant_____ What was this person's area of expertise?_____
c. staff person_____ What was this person's area of expertise?_____
d. other agency, synagogue, or organization_____ Which one?_____
e. other_____ Please specify_____

65. How is the attendance?

a. larger than expected _____
b. as expected _____
c. smaller than expected _____
Comments_____

66. Who initiated the idea for the program?

a. rabbi _____
b. board member _____
c. committee _____
d. congregants _____
e. staff _____
f. other agency, synagogue or organization _____ Which one?_____
g. other, please specify_____

67. Who participates in the planning?

a. rabbi _____
b. board member _____
c. committee _____

d. congregants _____
e. staff _____
f. other agency, synagogue or organization _____
Which one?_____
g. other, please specify_____

68. How is it financed? Identify sources.

69. Do you intend to continue these programs?

a. yes_____ b. no_____

Why or why not?

THE RABBI

70. Age as estimated by the interviewer:

a. under 35 _____
b. 35-50 _____
c. over 50 _____

71. How long have you been ordained?

a. 1-5 years _____
b. 6-10 years _____
c. 11-15 years _____
d. 16 or more _____

72. How long have you served this congregation?

a. 1-5 years _____
b. 6-10 years _____
c. 11-15 years _____
d. 16 or more _____

73. Prior to, or since your rabbinical preparation, have you had other graduate training?

a. yes _____ If yes: c. prior _____
b. no _____ d. after _____

74. Have you had any training in counseling or working with groups?

75. Have you attended any training seminars on counseling?

a. yes _____
b. no _____
If yes, please list _____

76. Do you engage in individual or family counseling?

a. yes _____
b. no _____

77. If yes, what proportion of your time is spent in counseling?

78. If yes, have any of these cases posed special difficulties for you?

79. If yes, do you have consultation arrangements with other professionals on counseling?

a. yes _____
b. no _____
From what discipline:_____
How was this arrangement made? (Is it formal or informal?)_____

80. Do you have an arrangement for referrals with another agency?

a. yes _____
b. no _____
If yes, which one?_____

81. Do you feel that your congregation has need for a professional counselor?

a. yes _____
b. no _____
Why or why not?_____

82. Now that we have completed this interview, you know that I am particularly interested in group approaches to mental health programs in the synagogue. Do you have any opinions or feelings about the inclusion of these kinds of groups as an activity sponsored by or held in the synagogue?

83. The interviewer's impression of the extent to which the synagogue has sponsored mental health programs.

a. high number _____
b. medium number _____
c. low number _____
d. none _____

Appendix C

TABLE 24

LENGTH OF TIME A CONGREGATION HAS BEEN IN EXISTENCE BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Length of Time (Years)					
	1-5	6-15	16-30	31-45	45+	Total
Worship/study	0	0	2	0	1	3
Worship/study/social	0	4	10	6	4	24
Total	0	4	12	6	5	27

TABLE 25

LENGTH OF TIME A CONGREGATION HAS BEEN IN EXISTENCE BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Length of Time (Years)					
	1-5	6-15	16-30	31-45	45+	Total
High (21-39)	0	2	2	1	0	5
Medium (9-20)	0	2	4	1	3	10
Low (1-8)	0	0	3	3	1	7
Nothing (0)	0	0	3	1	1	5
Total	0	4	12	6	5	27

TABLE 26

AGE OF CONGREGATION MEMBERS BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Age of Congregation Members				
	Families/ Children	Middle Aged Couples	Elderly	Varied	Total
Worship/study	0	1	0	2	3
Worship/study/ social	10	5	1	8	24
Total	10	6	1	10	27

TABLE 27

EDUCATIONAL LEVEL OF MALE CONGREGANTS
BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Educational Level (Male)					
	High School	College	Graduate Degree	Varied	Don't Know	Total
Worship/study	2	0	0	1	0	3
Worship/study/ social	4	10	0	8	2	24
Total	6	10	0	9	2	27

TABLE 28

EDUCATIONAL LEVEL OF FEMALE CONGREGANTS
BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Educational Level (Female)					
	High School	College	Graduate Degree	Varied	Don't Know	Total
Worship/study	1	0	0	0	2	3
Worship/study/ social	2	7	0	8	7	24
Total	3	7	0	8	9	27

TABLE 29

OCCUPATION BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Occupations			
	Business/ Professional	White/Blue Collar	Varied	Total
Worship/study	2	0	1	3
Worship/study/social	8	2	14	24
Total	10	2	15	27

TABLE 30

SOCIOECONOMIC LEVEL BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Socioeconomic Level				
	Lower Middle	Middle	Upper Middle	Varied	Total
Worship/study	0	2	1	0	3
Worship/study/social	2	11	2	9	24
Total	2	13	3	9	27

TABLE 31

PROXIMITY OF CONGREGANTS' RESIDENCES TO SYNAGOGUE BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Proximity		
	Live Nearby	Doesn't Live Nearby	Total
Worship/study	2	1	3
Worship/study/social	18	6	24
Total	20	7	27

TABLE 32

PROXIMITY OF CONGREGANTS' RESIDENCES TO SYNAGOGUE BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Proximity		
	Live Nearby	Don't Live Nearby	Total
High (21-39)	4	1	5
Medium (9-20)	6	4	10
Low (1-8)	6	1	7
Nothing (0)	4	1	5
Total	20	7	27

TABLE 33

AGE OF RABBI BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Age of Rabbi		
	35-50	50+	Total
Worship/study	1	2	3
Worship/study/ social	13	11	24
Total	14	13	27

TABLE 34

NUMBER OF YEARS ORDAINED BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Number of Years Ordained				
	1-5	6-10	11-15	16+	Total
Worship/study	0	1	0	2	3
Worship/study/social	3	5	2	14	24
Total	3	6	2	16	27

TABLE 35

NUMBER OF YEARS AT THE CONGREGATION BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Number of Years at the Congregation				
	1-5	6-10	11-15	16+	Total
Worship/study	1	1	0	1	3
Worship/study/social	14	4	2	4	24
Total	15	5	2	5	27

TABLE 36

GRADUATE TRAINING OF THE RABBI OTHER THAN RABBINICAL PREPARATION BY OVERALL PROGRAM ORIENTATION

Overall Program Orientation	Has the Rabbi Had Graduate Training Other Than Rabbinical Preparation		
	Yes	No	Total
Worship/study	2	1	3
Worship/study/social	19	5	24
Total	21	6	27

TABLE 37

NUMBER OF YEARS THE RABBI HAS BEEN ORDAINED BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Number of Years Ordained				
	1-5	6-10	11-15	16+	Total
High (21-39)	0	1	0	4	5
Medium (9-20)	1	4	1	4	10
Low (1-8)	2	0	0	5	7
Nothing (0)	0	1	1	3	5
Total	3	6	2	16	27

TABLE 38

NUMBER OF YEARS THE RABBI HAS SERVED THE CONGREGATION BY THE NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Number of Years the Rabbi Has Served the Congregation				
	1-5	6-10	11-15	16+	Total
High (21-39)	2	1	1	1	5
Medium (9-20)	7	1	0	2	10
Low (1-8)	4	1	1	1	7
Nothing (0)	2	2	0	1	5
Total	15	5	2	5	27

TABLE 39

DENOMINATION BY GRADUATE TRAINING OTHER THAN RABBINICAL PREPARATION

Other Graduate Training	Denomination			
	Reform	Conservative	Orthodox	Total
Yes	5	8	8	21
No	4	1	1	6
Total	9	9	9	27

TABLE 40

DENOMINATION BY RABBIS' INVOLVEMENT IN COUNSELING

Involvement in Counseling	Denomination			
	Reform	Conservative	Orthodox	Total
Engages in Counseling	9	8	8	25
Does not engage in Counseling	0	1	1	2
Total	9	9	9	27

TABLE 41

CONSULTATION ARRANGEMENTS BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Rabbis Made Consultation Arrangements		
	Yes	No	Total
High (21-39)	5	0	5
Medium (9-20)	8	2	10
Low (1-8)	6	1	7
Nothing (0)	4	1	5
Total	23	4	27

TABLE 42

DENOMINATION BY CONSULTATION ARRANGEMENTS

Rabbis Make Consultation Arrangements	Denomination			
	Reform	Conservative	Orthodox	Total
Yes	8	7	8	23
No	1	2	1	4
Total	9	9	9	27

TABLE 43

REFERRAL ARRANGEMENTS BY NUMBER OF MENTAL HEALTH PROGRAMS

Number of Mental Health Programs	Rabbis Made Referrals		
	Yes	No	Total
High (21-39)	5	0	5
Medium (9-20)	10	0	10
Low (1-8)	6	1	7
Nothing (0)	3	2	5
Total	24	3	27

TABLE 44

DENOMINATION BY REFERRAL ARRANGEMENTS

Rabbis Made Referrals	Denomination			
	Reform	Conservative	Orthodox	Total
Yes	9	7	8	24
No	0	2	1	3
Total	9	9	9	27

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