CLINICAL ISSUES IN INTERMARRIAGE
A Family Systems Approach
Part I: An Overview of Theoretical and Ethical Issues

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For many clinicians working under Jewish auspices, and particularly for those at the Robert M. Beren Center, which was founded on Orthodox Jewish principles, counseling individuals contemplating intermarriage evokes complex ethical dilemmas. Using a family systems model allows the clinician to help the client in a way that supports both individual autonomy and interpersonal connectedness.

Editor's Note: This article is divided into two parts. Part II, "Technical Issues in the Clinical Treatment of Intermarriage," will appear in the Fall 1994 issue.

When a Jewish child is ritually welcomed into the Jewish community, it is traditional to wish for him or her three things: Torah, Mitzvah, and Chuppah. That is, that the child should know G-d, do good deeds, and have a Jewish marriage. Torah represents the knowledge of G-d, as well as a connection to the past, a connection to Jewish peoplehood. Mitzvah represents acting ethically in the world, a connection to the needs of the present. Chuppah, the Jewish wedding canopy, represents a Jewish marriage, a Jewish family with Jewish children, and a connection to the future. One can only appreciate the pain and panic caused by intermarriage when one can envision a world without a future. For many Jewish families facing intermarriage, it is the end of history (Packouz, 1976).

For many other Jewish families facing intermarriage, however, it is just one more step on the road to assimilation and acceptance. Although the marriage may not be quite as joyful as one to another Jew, neither is it a reason to mourn. So there may be a little less Yiddishkeit in the home, but has not that been the trend for the past century at least? Intermarriage, for these families, is one more step away from the Ghetto, one less demand of Jewish law to constrain them.

These two views represent the extremes of Jewish attitudes toward religious intermarriage. Taken together they form the parameters of a debate that may be the most vital, and vociferous, controversy in modern American Jewry at the close of the twentieth century. This is a debate that will affect Jewish policy, Jewish education, and every other aspect of Jewish life. The focus of this article is on the impact of intermarriage on the Jewish family. Specifically, it examines the clinician's role he or she struggles to serve families and individuals who come for help. First, however, the full scope of the problems that intermarriage presents must be appreciated.

THE IMPACT OF INTERMARRIAGE ON THE JEWISH FAMILY

The Data

The Council of Jewish Federations reported in their 1990 National Jewish Population Survey that within the previous 5 years, Jewish intermarriage rates had reached 52% (Kosmin et al., 1991). Although these data were not surprising to anyone who has watched intermarriage statistics climb over the past twenty years, the figure of 52% seemed to represent a watershed, i.e., more

than half of all Jews who are currently marrying, marry non-Jews. Yet, sociologists remark that it is not the increase in intermarriage itself that is alarming but the *rate* of increase, quintupling over the past twenty years (Fishman et al., 1990). Nor should it surprise anyone that the intermarriage rate shows no sign of leveling off and that recent estimates are now as high as 57% (Paul, 1993).

The crucial question is not how many people are intermarrying, but what happens when a couple does intermarry? More specifically, what is the impact on the individual's and couple's Jewish identity and the Jewish identity of their offspring? These data have been surprisingly consistent over time. In the late 1970s, Mayer & Sheingold (1979) concluded that "in most mixed marriages, the born-Jewish spouse affirms a Jewish identity, but does little to act on this affirmation" (p. 29). In a more recent study, Medding and colleagues (1992) conclude that "in all, the data indicate that mixed marriage and the level of Jewish identification are strongly negatively related" and "that mixed marriage must be regarded as a virtual bar to the achievement of a high level of Jewish identification" (p. 37). In addition, it seems that these marriages are less stable, with approximately 50% ending in divorce, twice the national average for endogamous Jewish marriages (Kosmin et al., 1989). Remarriages are dramatically more likely to be to non-Jews than to Jews (Mayer, 1985).

The Jewish identity of the children of intermarriage seems to fare worse than the Jewish identity of their intermarried parents (Mayer, 1983). Of the children of intermarriage, only about one-third identify as Jewish and only one in ten will marry Jews. To illustrate some of the cause for concern about intermarriage, a simple extrapolation of these data demonstrates that for every 100 Jews who intermarry, only about 10% of their offspring will marry Jews in the second generation and, by the third generation, only 1% of the original group will have offspring who identify as Jewish.

There is some small room for optimism and it lies in the data regarding conversion (Mayer & Avgar, 1987). If the non-Jewish spouse converts to Judaism, then these marriages are actually higher in Jewish identity and practice than endogamous marriages. The children of these marriages are more likely to marry Jewish partners. Technically, these are no longer intermarriages but are conversionary marriages.

The reactions to intermarriage, which were once uniformly negative and rejecting, now can be arrayed on a continuum. Rare nowadays is the family that sits *shiva* for an intermarried member as if he or she had died. Yet, reactions can still be extremely negative, even tragic, for a family facing intermarriage. At the other extreme are families who are so tentatively connected to Judaism that they can voice no objection to a prospective intermarriage. Between these extremes lies an unspecified majority of Jewish families who still find intermarriage distasteful, unpleasant, or downright unacceptable. I would like to suggest that we refer to intermarriages in such families as *family dystonic intermarriage* to convey that the intermarriage is objectionable to at least some part of the family system.

The Robert M. Beren Center

The Robert M. Beren Center exists to help families facing family dystonic intermarriage. Established at the Ferkauf Graduate School of Psychology at Yeshiva University, the Beren Center helps families who have members contemplating intermarriage by providing psychological counseling to individuals and couples contemplating intermarriage and to their parents, siblings, and extended family. The Center targets those families for whom rabbinic intervention, when sought, has been ineffective. As a matter of policy, and when clinically indicated, the Center will refer couples who have already intermarried to services that exist for them in the community.

Although the policy of the Center is not

to encourage intermarriage, nevertheless we believe this decision is ultimately in the hands of those contemplating the marriage. These are never simple decisions, and our goal is to assist our clients to think through all their ramifications and to explore alternatives to intermarriage. The Beren Center endeavors to remain faithful to the Orthodox Jewish principles upon which it was founded, as well as to honestly help the individuals and families who seek our services.

Most parents approach us with the hope that we will help avert the intermarriage. Some approach us looking for help to accept, or make the best of, the inevitable. They may have additional concerns after the intermarriage, such as conveying a clearer message to their other children of the importance of marrying Jewishly or how to maintain Jewish traditions for their mixed-heritage grandchildren. Young people contemplating intermarriage use our services because they want to know the facts and to be prepared for the problems. Often they will come because another part of the family system, usually their parents, are in so much anguish over their plans. Regardless of outcome, most families report feeling helped by our services.

The experience that these families and individuals have of "feeling helped" is the primary justification for the existence of the Robert M. Beren Center. Yet, it would be disingenuous not to admit that there may be a conflict between simply "helping" and remaining dedicated to the Orthodox Jewish principles that are also important to the Center and its institutional sponsor, Yeshiva University. The conflict arises because "helping" is a relative term, usually defined by the person in need of help, whereas the Orthodox opposition to intermarriage is independent of individual desires.

This conflict of values is not unique to the Beren Center. Nor is it limited to problems related to intermarriage. Most clinicians and clinics function in settings that endorse some values over others. This is especially true of clinics under religious auspices, but even government clinics must be guided by certain values, i.e., the values embedded in the U.S. constitution. In addition, many clinicians have their own values, as well as professional codes of ethics, that guide them in their day-to-day work. How are these personal values balanced with institutional values, on the one hand, and clients' needs on the other?

THE CLINICAL PERSPECTIVE RE-EXAMINED

What is the "Clinical Perspective"?

Throughout history, people in pain or distress have always sought help. The helper, in his or her role as physician, healer, expert, or shaman, was able to help by dint of specialized knowledge that seemed relevant to the individual in need, their family that brought them, and the society that sanctioned the healer's role. Over the past 200 years, the clinic and the clinical perspective have evolved to include the aura of *Science*, with all the implications of omnipotence and omniscience that accompany it (Foucault, 1975).

The treatment of psychological problems in the clinic has always occupied a border region between the application of natural science, as in a case of appendicitis, and the application of moral values, as in family counseling. The application of natural science is the essence of the medical model, an approach to illness that looks for the underlying biological causes of disease. One classic case used to justify the medical model was that of dementia caused as a result of an earlier infection of the syphilis bacterium; in other words, a clear-cut case of a mental problem with roots in a biological infection. The medical model is built upon such classic cases, and many modern-day psychiatrists still search for the underlying biological causes of all psychological problems (cf. American Psychiatric Association, 1987).

Although psychotherapy borrows some

of its authorization from the medical model, the work clinical psychologists or clinical social workers do as psychotherapists is fundamentally different from the pure application of this model. Perry London has made this case eloquently in his landmark book *The Modes and Morals of Psychotherapy* (1986):

> Insofar as they are concerned with the diagnosis and treatment of illness, modern psychotherapists have grown up in the tradition of medicine. But the nature of the ailments they deal with and the way they treat them set them apart from physicians and in some ways make them function like clergymen .... [Psychotherapists] are clinicians. And much of the material with which they deal, as clinicians, is neither intelligible nor usable without thought to some system of values .... Moral considerations may largely dictate how they define their clients' needs, how they operate in the therapeutic session, and how they sometimes define "treatment" and "cure" and even "reality," (pp. 5-6).

A clinical approach to helping people with problems related to intermarriage necessarily involves some system of values, and the therapist should have an awareness of that system.

In Jewish agencies and clinics, the clinical perspective must differ from the rabbinic perspective. Not that there is necessarily a contradiction between the two but, at the very least, they represent different roles and different choices for both the help-seeker and the help-giver. The rabbi's role primarily is to help congregants interpret Jewish law and to live better Jewish lives. The psychotherapist, for the most part, seeks to treat clients without recourse to the divine, with an emphasis on human resources and social supports. The latter utilizes professional knowledge with its roots in science, whereas the former uses the justice and mercy of Jewish tradition. To use a metaphor from the marketplace, the two are "vendors," and the "consumer" is free to choose that product that most suits him or her.

The treatment goals of the clinician are by definition more relativistic than the goals of the rabbi. From a rabbinic perspective, intermarriage is wrong, and a rabbi-in-role must take that stand. The clinician may ask the more relativistic question, "Is intermarriage good for you?," and the family therapist might add, "What will be the effects on your family?" In addition, the clinician is free, indeed encouraged, to see the presenting problem as the tip of the iceberg in order to discern and treat underlying causes of conflict and unhappiness. It is the rare rabbi who will respond to a Halachic question with the query, "Is it good for you?" or "What makes that question important to you?"

The Myth of Being Value Free

Psychotherapists are taught in their training to be "value-free" so they do not inadvertently impose their will or values upon their clients. There is even a term "countertransference" that implies that the therapist has let slip the veil of professional imperturbability and may have irrational thoughts and feelings about a client. Yet as London (1986) reminded us, psychotherapy is an inherently moralistic enterprise. How can any professional steer a course in the stormy sea of a client's life without the rudder of morals and the compass of ethics?

A diagnosis often provides the initial justification to begin the work of psychotherapy. It is standard operating procedure in most clinics, especially when third-party reimbursement is sought, to provide a clinical diagnosis as justification for treatment. This diagnosis tells us, in the vernacular, what is "wrong" with the patient. Diagnoses for mental problems, other than organic disorders, are in essence value judgments about behavior and feelings masked in terms of sickness and health (Szasz, 1970).

Based on the preferred school of a given psychotherapist, entire lexicons exist for the identification and treatment of problems

with psychotherapy. Within each lexicon, there is a criterion by which "health," "improvement," "wholeness," "normal development," "ok-ness," or "functionality" is judged. Freud, for example, held the criterion to be, "Where id was, there shall ego be" (Freud, 1923/1961). Mahler, Pine, and Bergman (1975) sought the achievement of separation/individuation from the maternal object as a criterion for wholeness. The Kohutians believe in the transmutation of internalized selfobjects as the goal of psychotherapy (Kohut, 1977). Eriksonian ego psychologists look for the mastery of specific life stage tasks as a criterion for proper development (Erikson, 1950). Family therapist, Murray Bowen (1978), holds that the differentiation of self in the context of the family is the goal for which one should ultimately strive. I have suggested that it is the balance between autonomy and interdependence that is the criterion of successful psychotherapy and development (Sirkin & Rueveni, 1992).

One cannot enter into the conduct of psychotherapy without a working model of human functioning and the proper ends toward which that functioning should strive. There are some areas where the professional can fool him- or herself into believing that they are just helping a "sick" person to become "healthy"; cases involving major mental illness are such examples. Yet, in many situations, certainly in cases involving counseling people about intermarriage, the way is less clear. Many questions abound with few simple answers: Should a therapist ever encourage or discourage an action? What if a course of action is good for one person in a family, but not for another? What if a course of action is good for someone, or even a whole family, but bad for one's ethnic group? How should a psychotherapist react when a client's contemplated course of action is personally anathema to the therapist? How should one act when institutional values run counter to one's professional values?

Ethical Dilemmas in Working with Intermarriage

Not all therapists who work with intermarriage are alike; therefore, different conflicts may arise for different professionals. Neither will problems dealing with intermarriage appear in isolation, but rather will be part of the larger context of one's professional and personal life.

The first and most important principle I suggest is that a psychotherapist must be honest with him or herself. Without this standard all attempts at intervention are suspect. How does one feel about the presenting problem, how can one best help the person in need, can one therapist honestly assist the client to explore all options?

The second principle is that the therapist must strive to be honest with the client. If the therapist cannot be neutral, he or she should be able to discuss their biases, as biases, to the client. Ultimately, it is the client's decision to work with a given therapist, who by informing them of potential biases, allows the client to make an informed decision. For example, when clients ask me, usually within the first 5 minutes, what my stance is about intermarriage, I admit that I find intermarriage problematical but go on to tell them that I believe I have something to offer them despite my bias and that, ultimately I will respect their right to choose the course of action that they deem is best for them.

There are extra burdens for the halachic (religious) Jew or any psychotherapist who abides by a strict moral code. Among the many constraints on behavior that halacha imposes, it is incumbent upon the halachic Jew not to assist anyone to violate the code. Again I would invoke the first and second principles mentioned above: honesty to one's self and honesty to one's client. Ultimately, our professional obligation is to act in the best interests of the client, even if that means we cannot work with a specific person or a specific problem.

For those therapists working in institu-

tional settings, there may be dilemmas in which the goals of the institution, on the one hand, and the professional and personal values of the therapist, on the other, collide. For example, someone opposed to intermarriage may be asked to work with intermarried couples. At first, this may seem like a conflict for which the only solution is to admit to a clash of values and withdraw from treatment. However, some of my colleagues, who are opposed to intermarriage have remained to run groups for intermarried couples while rationalizing that through their help some of these couples might return to Judaism and the non-Jewish spouse will decide to convert. While I am not qualified to comment on the halachic propriety of their decision, it is clear that they have weighed the complicated moral issues and made a decision that is faithful to their professional and institutional selves. They can readily discuss these issues with group members when and if questions arise about their personal beliefs.

The ability to be honest and open about one's moral dilemmas is a good litmus test and helps keep the clinician focused. By way of contrast, I know a clinician who runs groups for interfaith couples and their parents and is himself intermarried. His intermarriage is not something he readily discusses with groups or the Jewish agencies who hire him. When I watch him run groups, I detect a hidden agenda of helping parents and couples accept the intermarriage and move on, whether or not they are ready or willing to do so. I do not think his intermarriage precludes him from running these groups. However, I do believe that his inability to be honest and open, even at the risk of alienating some, hampers his capacity to do good clinical work.

The most difficult ethical dilemma, not just for the clinician, but for rabbis and parents alike, is to watch the exercise of free choice toward ends with which we disagree. For the committed Jew to watch someone intermarry, or worse, to convert to another religion, is painful. Yet, free choice is the sine qua non of moral behavior and without it, none of us is free; without it, the work we do as clinicians is pointless. The goal of our clinical work therefore is not to subvert free choice by persuasion or guile. Our goal is to enhance free choice by providing information, by removing personal and interpersonal barriers to it, by alleviating anxiety, and by enabling our clients to see the full ramifications of all their decisions. To do this, we must help them walk the tightrope between independence and connectedness, to feel individually authorized to conduct their lives as they choose while at the same time acknowledging that they are part of a larger system, a family, an ethnic group, a culture. To which do we owe our allegiance and how do we choose among them? These are the questions of our time, and helping people find answers to them is the true goal of any psychotherapy.

A SYSTEMS MODEL FOR INTERMARRIAGE

It was Kurt Lewin who said, "There is nothing so practical as a good theory." Systems theory, or family systems theory, allows the clinician to help in a way that supports both individual autonomy and interpersonal interconnectedness.

Parameters of the Systemic Model

Autonomy and Interconnectedness

Whatever clinical model we adopt, it must allow us to be therapeutic, to provide help to the people who seek clinical services. In medicine, if a patient recovers after a treatment, then it is therapeutic regardless how the patient feels about what was done to him or her. In psychotherapy, there is no outcome independent of how the client feels, and the client is the ultimate judge of whether a therapeutic approach or technique has been successful. Yet by what criterion does the therapist or the client judge outcome? Help must be more than encouraging one to feel good, or else unmitigated

praise would be therapeutic, and although some would call it necessary (Rogers, 1951), it is not sufficient. Help must be more than encouraging selfishness; otherwise, the social value of psychotherapy would be open to question. We have returned to our question of values, to confront again the question, What are the proper goals of psychotherapy? Although admitting that these may differ somewhat from therapist to therapist and from school to school, I endorse the values that I have suggested in my previous writings (Sirkin & Rueveni, 1992; Sirkin & Wynne, 1990): *to maximize individual autonomy and interpersonal interconnectedness*, to encourage clients to walk the fine line between the two but never one to the exclusion of the other. No person is an island, but at the same time, every person needs functional boundaries.

Family as the Patient

Another parameter of the systemic model is an appreciation of the system as a whole, not one part to the exclusion of the others (Satir, 1964; Watzlawick, Weakland, & Fisch, 1974). The goal is to help the entire family system when possible, not simply to fix the presenting problem (child). This systemic view is one of the strengths of the model, and it encourages the clinician to redefine the problem in a way that includes all family members. This parameter also encourages family members to find solutions to their problems that are as acceptable as possible to the maximum number of family members. The win-lose mentality so common in family "gamesmanship" needs to be replaced with a win-win or compromise mentality. Although no one solution to a family's problem may make everyone happy, the best solutions accommodate the most people.

Respect for Religious Values

Jewish agencies and clinicians, in addition to the parameters mentioned above, must also be Halachically sensitive. They work within a Jewish framework that they should neither apologize for nor ignore. At the same time, the professional role of the psychotherapist precludes foisting our opinions and values onto our clients. Again, this is where we differ from rabbis whose professional role is to represent those values. For example, if a religious Jew tells his rabbi he is considering eating a lobster, the rabbi's role would be to remind him that such foods are not kosher. If the religious Jew tells his psychotherapist the same thing, the therapist would strive to help the individual understand the motivations, and the intrapsychic and interpersonal ramifications, of such an act. It would not be appropriate for the therapist to tell the client not to eat such foods, despite the religious and personal sensitivities of the therapist.

Characteristics of the Systems Model

Family systems theory represents a complex set of ideas that encompasses numerous schools and a variety of distinct approaches (Hoffman, 1981). It would not be appropriate, for the purposes of this article, to present a thorough overview of these theories. Rather, I present for the clinician working with intermarriage a set of guidelines based on systems concepts that I have found extremely practical.

- *Work with any part of the system*: In systems parlance, any subsystem is isomorphic to the whole, meaning that the patterns of the whole system are present in any part of the system. To insist on working with only one part of the system, such as the potential intermarrier, is to lose an opportunity to affect the system as a whole, e.g., through the parents or siblings. From a practical standpoint, often the parents are the first, sometimes the only, part of the system that presents itself for treatment. The clinician should work with any subsystem that presents itself, both to affect that subsystem and the system as a whole.
- *Strengthen boundaries*: No system is vi-

able unless it has viable boundaries. The ideal boundary is semi-permeable, it contains what is inside it while at the same time allowing information to cross it. Each person in a family is a subsystem that needs strong, semi-permeable boundaries. The parental couple in the system also needs strong but permeable boundaries. A system without strong boundaries will fall apart, but a system with impermeable boundaries will ultimately deteriorate. Families in trouble often have a confused sense of boundaries (Boss & Greenberg, 1984).

- *Encourage communication across boundaries*: This guideline is the complement to strengthening boundaries. Living systems are open systems that allow information to be exchanged across boundaries. One of the essential features of any systemic therapy is the encouragement of communication across boundaries. This exchange of information can strengthen subsystems and the identity of the system as a whole (Reiss, 1981).
- *Discourage cut-offs*: Human systems are sometimes characterized by cut-offs, which represent a total breakdown of communication. These are often present in families where one member or side has barely talked to another member or side in years. The ultimate cut-off is when a parent sits *shiva* for a child who behaves in a way in which the parent disapproves. System problems are often irreparable while cut-offs are in place, and they prevent a system from functioning as a healthy whole (Bowen, 1978).
- *Expand the system*: The solutions to family problems are often found by expanding the system to include other family subsystems. Intractable arguments can often be resolved, or at least refocused, by including people who were not part of the original argument. For example, an ongoing disagreement between parent and child may be changed by including a grandparent. Expanding the system allows the therapist to incorporate other perspectives from the same family without taking sides (Speck & Attneave, 1973).
- *Recognize key family values*: It is remarkable that such an endeavor as psychotherapy, which deals so often with people's values, has so little to say about the topic of family values. It is almost as if there is a family secret, i.e., everyone knows therapy is about values but no one wants to say so because it opens a Pandora's box of questions with no easy answers: Which values? Whose values? Why those values and not other values? Although the precise definition of "family" may differ among sociologists, economists, and anthropologists, I want to suggest that from the inside, from within the family's perspective, it is a core set of values that defines the family.

American Jewish families share a core set of human values (Herz & Rosen, 1982; Linzer, 1984). The Jewish religion itself comprises an important set of communal values. These values, such as communal worship, communal charity, and dietary and marriage customs, have strengthened the Jewish community *qua* community. Other key values are operative at the personal, family, and social levels: the importance of tolerance, equality of opportunity, and social justice; the value of family life; and the importance of education. These are the major themes, heard to a greater or lesser degree in most Jewish families, that comprise the symphony of values for Jews in America today. Intermarriage, depending on how the other themes are orchestrated in any given family, may either sound a highly discordant note or be a counterpoint in a melody that sounds like modern American assimilation.

The Therapist's Multiple Roles

Consistent with the family systems approach, it is incumbent upon the therapist to be flexible in his or her approach to intermarriage. There can be no simple "cook-

book" or "how-to" guide for the clinician working with these families. Within the family therapy literature, however, a number of metaframeworks emerge that help guide the clinician faced with the family problem of intermarriage.

Therapist as System Consultant

The consultant's relationship to the family differs somewhat from that of the therapist's. Although some would argue that this difference is only a matter of degree, that all therapeutic relationships are essentially consultative, there are important differences. In their important work on this subject, McDaniel, Weber, and Wynne (1986) note that "consultation provides a relationship in which the family and the consultant can collaboratively delineate the problem and consider options for resolution .... [Whereas] the therapist takes direct and primary responsibility for facilitating change, ... the consultee, not the consultant, retains explicit responsibility for change" (p. 17). The initial phase of any work with families struggling with intermarriage should be seen as consultation, not therapy. This gives everyone in the system, including the potential therapist, time to evaluate the many variables involved and to collaborate on a course of work together that will maximally meet the family's needs.

Multidirectional Partiality

Although this term may be little known beyond the work of Boszormenyi-Nagy (Boszormenyi-Nagy & Spark, 1973), I consider multidirectional partiality the single most essential tool for the therapist/consultant in cases of intermarriage. Multidirectional partiality is defined as "an attitude that allows a therapist to empathize with each family member, to recognize the merits of each, and to take sides because of these merits" (Simon, Stierlin, & Wynne, 1985, p. 232). It is this capacity that prevents the therapist from taking sides and from favoring one individual or subsystem in the therapy session over another. The therapist must maintain the technical freedom and empathic flexibility to side with different family members at different times in a session.

The Psychoeducational Component

Many family therapists are finding that there is a need to educate the families that come to them about the very nature of the problems for which they are seeking help (Anderson, Hogarty, & Reiss, 1980). As with consultation, it may be argued that all therapy has a component of education in it. In the case of intermarriage however, there are facts about Jewish identity (Gordis & Ben-Horin, 1991), intermarriage (Mayer, 1985; Schneider, 1989), and the changing role of religion throughout the life cycle (Fowler, 1981) that should be part of any discussion.

Engaging the Question of Jewish Identity

Like a haunting melody that one cannot seem to shake, the question of Jewish identity lies lurking in the background for every family struggling with problems of intermarriage. What does it mean to be Jewish? What are the core components of Jewish identity? What are the peripheral components of Jewish identity? Most parents approach professional help for problems related to intermarriage intent on having the professional raise these issues with their children, whereas most young adults contemplating intermarriage usually prefer to put these questions on the "back burner" or to deny their importance. Yet, the question of Jewish identity lies at the heart of a family's objections to intermarriage. The very possibility forces everyone in the family to ask themselves a most difficult question: What does it mean to *me* to be Jewish and how will this potential intermarriage affect me? This can actually be a frightening question for Jews who do not understand the strength or tentativeness of their connection to Judaism. It is incumbent

upon the therapist to ask the question again and again until each and every family member has struggled with it.

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