HaRofei LeShvurei Leiv:
The Contemporary Jewish Legal Treatment of Depressive Disorders in Conflict with Halakha

Senior Honors Thesis

Presented to
The Faculty of the School of Arts and Sciences
Brandeis University

Undergraduate Program in Near Eastern and Judaic Studies
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In partial fulfillment of the requirements for the degree of Bachelor of Arts

by
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December 2018

Accepted with Highest Honors

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A Brief Word and Acknowledgments

In the preparatory stages of this project, when I first began reaching out to rabbis and clinicians to discuss my research, I received the following response from a psychiatrist I had emailed in the hopes of arranging a meeting: “My personal opinion about that kind of research…(is) that it’s a waste of time…entirely futile. Why not use your time to help some special need (sic.) children or adults?” Needless to say, I did not heed the advice of that reputable physician. It is my firm belief that this topic is of genuine import, both because of depression prevalence rates and an absolute dearth of previous (published) attention among rabbis and academics alike. This is the most expansive—if not the only—formal survey on the contemporary operation of halakha in the face of depression to date. Though it is an academic paper, I have endeavored to keep the religious and clinical reader in mind, knowing that perhaps my most valuable contribution is the mere presentation of sources that will allow depressed individuals, rabbis, and practitioners to make informed decisions in cases of conflict between depression and Jewish law. In this way, the thesis is intended as both a practical guide and a serious academic piece. I begin by providing background information, including a historical overview of the treatment of depression in conflict with halakha and a survey of contemporary definitions of depression. Then, I explore several areas of Jewish law where conflicts between depression and halakha are especially endemic. (However, it should be noted that one or two issue domains were ultimately excluded from the final paper because of space constraints and inadequate or dilatory responses from some decisors.) Finally, I identify patterns in the texts analyzed and draw conclusions. The last section also contains a glossary of terms and a references list for transparency and further study. My ultimate hope is that this thesis illustrates the importance of acknowledging and addressing conflicts between observance and psychological wellness, sheds light upon just
how diverse and numerous these struggles can be, shows individuals who struggle with depression a halakhic aspect of their disorder that they may not have considered, and urges the Jewish community to continue engaging this topic proactively and pronouncedly.

* * *

This manuscript is the culmination of almost a year of exhaustive and exhausting research, of writing and rewriting, (and rewriting again,) and of hours spent in conversations with prominent religious decisors, clinicians, and depressed individuals. I would like to extend my deepest gratitude to several people who have invested significantly in this project and in me as an individual. First of all, a great many thanks to my two primary advisors, Professors Reuven Kimelman and Zvi Zohar, who allowed me to tap into their wisdom and scholarly reserves, and provided critical guidance throughout the development of this project. I would also like to thank Professor Lynn Kaye for serving as a reader and equipping me with thoughtful and immensely helpful insights and feedback, Professor Jonathan Krasner for providing clarity and crucial advice during the early stages of this project, and Professor Jonathan Sarna for helping me understand my potential as a researcher. This thesis was significantly enhanced by the Eizenstat Grant, a scholarship funded by Stuart Eizenstat and distributed through the wonderful Schusterman Center for Israel Studies at Brandeis, that funded my research trip to Israel. I am also indebted to specific individuals who provided invaluable perspectives and positions, including Rabbi Yuval Cherlow, Rabbi Yigal Shafran, Rabbi Shlomo Riskin, and Dr. Seymour Hoffman. More generally, but just as importantly, I would like to thank my family (especially my father and mother), friends, and longstanding spiritual mentors (especially Rabbis Judah
Dardik and David Pardo), for inspiring and supporting me in ways that thoroughly transcend the limitations of this brief acknowledgment. Most importantly, thank you G-d.

“Although you intended me harm, G-d intended it for good: in order to accomplish-it is as clear as this day- that a vast people be kept alive (Genesis 50:20).”

*HaMevin Yavin*

Ezra Pesaḥ Cohen

Kislev 5778/November 2018
NB: This paper discusses Jewish legal concepts that can be obscure and complicated to the unacquainted reader. It proved difficult to provide a sufficient background while working with deadlines and space restrictions, and while remaining concise. To balance these factors, additional background information and sources are located in the footnotes. Additionally, because it is often impossible to discern the Gregorian year when only the Hebrew year is provided (as is the case with many volumes of responsa), the dates given in this paper should be taken as general estimates.

Furthermore, I would be remiss if I did not thank Google, Inc. and the Google Books program for providing access to, and information regarding the citation of, many of the books discussed in this paper.
Chapter I: Setting the Stage
Why This Thesis is Important Right Now

Our endeavor should be framed in the context of several contemporary patterns and problems that converge to render this project exceptionally opportune. The question of rising prevalence rates of depression has been a hotbed psychological question for some time. Research is somewhat mixed, but a greater number of longitudinal studies suggest that the rate of depression has risen. However, this debate is of little importance to us, because even if static levels are assumed depression is highly prevalent; recent global estimates place the incidence rate at 4.4%. The percentage is even higher in Jewish men (but not Jewish women), potentially because Jewish men are less likely (than non-Jews) to use alcohol as a coping mechanism. Moreover, a 2014 study of stigma attitudes towards depression among Orthodox and non-Orthodox Jews suggested that the former group harbors a greater amount of stigma towards depressive disorders. Elevated prevalence rates of depression and depression-related stigma in the Orthodox community demand both an exploration of the relationship between depression and halakha, as well as the dissemination of any findings in a direct and unapologetic manner.

A second phenomenon that renders this project important is a dearth of preexisting research. The reader will soon realize that the vast majority of our sources are primary; this is, in large part, because there is no secondary literature. The lack of research on depression and halakha contravenes a growing trend of attention to the intersection of Jewish law and certain other mental disorders, especially obsessive-compulsive disorder (OCD). Given that depression is more prevalent and typically more debilitating than many other mental illnesses, this paucity is unexpected and disappointing. Finally, our project is impelled by the nature of the role of the contemporary rabbi. Rabbis are often conceptualized as mental health resources by the laity. This reality, especially when the aforementioned depression prevalence estimates are considered, suggests that rabbis in community roles are commonly approached for guidance by depressed individuals. It urges that rabbis be acquainted with the legal background necessary to provide psychologically- and halakhically-sound advice.

In conclusion, four trends are clear. Depression is highly prevalent, especially within the Orthodox Jewish community. Orthodox communities harbor more stigmatizing attitudes towards depression than other Jewish denominations. There exists a deficiency of research on the Jewish legal relationship to depression. Rabbis are called upon to provide psychological and spiritual guidance in ways that necessitate their familiarity with the treatment of depression in

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6 The terms mental disorder and mental illness are used interchangeably throughout this paper for readability.
conflict with halakha. These factors converge to demand a clear and thorough presentation of the relationship between depressive disorders and Jewish law.
Defining Key Terms

Prerequisite to any discussion about the relationship between Judaism and mental health (or mental health generally) is an operationalized definition of relevant key terms. The importance of applying sound nosology and arriving at stable working definitions may be evidenced by the following examples:

Ezra, a newly orthodox young man, married and the father to one baby girl, was brought to the clinic by his older brother, himself a long-time penitent who became a rabbi, because of “bizarre behavior.” He appeared unkempt, uncooperative, severely depressed, and only partially oriented to place and time... Psychodynamically, the source of Ezra’s problems could be traced back to the traumatic death of his (sick) father… Underestimating his father’s deteriorating condition, he refused to stay by his side during what turned out to be his father’s last night, and this irrevocable negligence made him guilt-ridden and despondent… He started hearing voices which he identified as coming from a vengeful angel who was sent to punish him for the neglect that had led to his father’s death. To absolve himself, the angel ordered him to afflict himself by fasting frequently and otherwise eating minimally, by abstaining from sexual relations, and by wearing old and tattered clothes. Aside from these behaviors, Ezra immersed himself in various mystically-based practices to obtain forgiveness; he frequented the sanctuaries of popular saints all over the country and engaged in nightly rituals to mobilize their assistance.9

The author…was initially contacted by the grandchildren of the patient, an elderly male who did not seek medical intervention for himself. The patient’s grandchildren presented the author with a description of a unique and bizarre pattern of insomnia. According to the grandchildren’s report… the patient would arise most nights at approximately midnight. The patient would then go to his fireplace, pick up some ashes, and put them on his forehead (the patient would light a special fire even in the summertime, in order always to have ashes in his fireplace for this purpose). Then he would sprawl underneath a doorway with his face on the floor, muttering unintelligibly. After a while he would return to bed and sleep until dawn. The grandchildren reported that they had confronted the patient about this behavior, and that they had received the explanation that their grandfather was mourning for the Temple…The patient obsessed over the loss of his “Temple” …and he constantly hoped to get it back. One day the author happened to be present while the patient was finishing his meal. After he finished eating, the patient carefully removed, or covered, every knife on the table. When asked why he did so, the patient replied that he was about to recall the loss of the Temple, and

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that he had to cover up all the knives before doing so, because if he saw a knife while recalling the loss of the Temple he might stab himself.¹⁰

Determining which aspects of Ezra and the grandfather’s behaviors are rooted in mental illness and which are normative religious activities requires a thorough understanding of Jewish law’s relevant tenets and an ability to differentiate between robust religious fervor and psychopathological symptoms. Properly operationalized classifications that enable differentiation between these two poles permit objectivity and thus underlie the entire discussion. Yet, the task of arriving at precise and representative definitions is as difficult as it is necessary; two individuals may behave identically, but the actions of only one is sourced in mental illness. Hopefully, the above case studies shed light on the elusive nature of halakhic and psychopathological classification; in any case, this dilemma is further documented in religious Jewish writings.¹¹ To sum, defining both halakha and depression can be difficult; nevertheless, proper classification is a necessary first step towards understanding the interaction between them. Now that both necessity and difficulty have been demonstrated, we may turn towards developing a set of essential working definitions.

**Defining Depression**

“Depression” is often informally employed as a catchall term for any psychological syndrome featuring depressed or irritable mood as the distinguishing feature. However, there exists no condition in any prominent diagnostic manual formally labeled “depression.” Instead, the clinical operationalization of the informal phrase “depression” is the term “depressive


¹¹ For example, the work *Meged Givot Olam*, a two-volume repository of stories about several renowned religious scholars from the past century-and-a-half, records the tale of an unnamed Kohen who would continuously touch the bed of his deceased father in fulfillment of the obligation to become ritually impure for immediate relatives (Rabbi Michel Zalman Shorkin, *Meged Givot Olam* - vol. 1 [Jerusalem: Yefe Nof- Y. Posen, 5765 (2004/2005)], p. 71). This behavior somewhat aligns with standard definitions of obsessive-compulsive disorder.
disorder,” a blanket name for several conditions linked by the presence of negative affect as the defining and eminent symptom.\(^\text{12}\) We must be clear about what constitutes a “depressive disorder” and what does not. To do so, we will examine the two most prominent and relevant diagnostic manuals for the treatment of depression in Orthodox Jewish populations,\(^\text{13}\) the fifth-edition Diagnostic and Statistical Manual of Mental Disorders (DSM-5) and the eleventh-edition International Classification of Diseases (ICD-11) handbook.

The DSM-5 is the fifth iteration\(^\text{14}\) of the original Diagnostic and Statistical Manual of Mental Disorders, published in 1952 as the “first official manual of mental disorders to focus on clinical use.”\(^\text{15}\) Though its structure has evolved somewhat, the current Diagnostics and Statistical Manual of Mental Disorders (DSM-5) is divided into three sections, and provides a list of acknowledged mental disorders accompanied by a description and a set of possible symptoms and additional qualifications. Because the DSM-5 is very commonly employed in the contemporary treatment of mentally ill individuals, its definition of depressive disorder is particularly relevant and consequential. According to the DSM-5, “the common feature of all of these disorders is the presence of sad, empty, or irritable mood, accompanied by somatic and cognitive changes that significantly affect the individual’s capacity to function. What differs

\(^{12}\) Depressive disorders include: “Disruptive mood dysregulation disorder, major depressive disorder (including major depressive episode), persistent depressive disorder (dysthymia), premenstrual dysphoric disorder, substance/medication-induced depressive disorder, depressive disorder due to another medical condition, other specified depressive disorder, and unspecified depressive disorder (American Psychiatric Association [APA], *Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition*, [Arlington, VA: American Psychiatric Association, 2013]), 155. The APA’s listing (as opposed to that of another diagnostic manual) is mentioned here because of considerations mentioned below.

\(^{13}\) Other taxonomies, such as the Chinese Classification of Mental Disorders (CCMD) and the Research Domain Criteria (RDoC), are hardly used in our target population.

\(^{14}\) Though the DSM-5 is the formal fifth iteration of the DSM (as its name suggests), if revised versions of earlier DSM manuals (such as the DSM-III [R]) as well as revisions to the DSM-5 itself are accounted for, there have been more than five iterations.

among them are issues of duration, timing, or presumed etiology.”¹⁶ In other words, the DSM-5 defines a general depressive disorder as a melancholy mood associated with disruptions in normal and healthy psychosomatic functioning. Specific depressive conditions are differentiated from one another by temporal and causal factors.

This definition is somewhat ambiguous. More specifically, the barometer of requisite severity for a set of symptoms to be termed a depressive disorder is not immediately clear: How depressed a mood is depressed enough? What is considered a “significant” abrogation of functioning? These questions are surely important; however, it is critical to acknowledge that a certain amount of definitional opacity is actually necessary for accurate diagnoses. Many mental disorders lack a means of empirical measurement;¹⁷ one cannot, for example, test for depression the same way that one can verify the presence of a given medical illness through bloodwork or biopsies. Consequently, the mental health practitioner must engage in a diagnostic process resembling more of a best-guess effort than a sound scientific determination. It can be difficult to tell when someone’s poor mood crosses a clinical line, especially when the symptom(s) in question is (are) mild.¹⁸ Moreover, different people experience emotions differently, and so the presentation of a given symptom in two individuals might signal a mental disorder in one and not the other.¹⁹ A black-and-white, universal definition of “depressive disorder” that inherently assumes negative affect becomes a depressive disorder at the same point in every individual, discounts consequential individual differences and therefore leaves genuinely depressed

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¹⁷ Ibid., 21.
¹⁸ Ibid.
¹⁹ Ibid.
individuals outside the margins of a formal diagnosis (and vice versa). Therefore, a gray
definition that leaves space for the clinician’s own judgment is important.20

The first International Classification of Diseases (ICD) manual was published in 1990. It
has already undergone ten revisions, with an eleventh (ICD-11) due in 2018. The beta version of
ICD-11 is already available online, and defines a depressive disorder using terminology similar
to the DSM-5’s description: “Depressive disorders are characterized by depressive mood (e.g.,
sad, irritable, empty) or loss of pleasure accompanied by other cognitive, behavioural, or
neurovegetative symptoms that significantly affect the individual’s ability to function.”21 The
overlap in philosophy and phraseology between the two manuals is both elucidative and
unhelpful. On the one hand, that two influential and widely-used systems of classification in
many ways share a definition of depressive disorder means that such a definition is better-backed
should we choose to apply it. On the other, because of the striking similarities, the ICD-11
description fails to provide a sufficient contrast by which we may evaluate the DSM-5.

In conclusion, several things are clear. Understanding what is meant by “depression” is
prerequisite to any attempt at bringing the former into dialogue with halakha. When individuals
colloquially employ the term “depression,” they typically refer to a “depressive disorder.” To
ensure both objectivity and that the findings of this paper are actionable, two widely-used
definitions of “depressive disorder” have been presented. Because it is the most ubiquitous
diagnostic tool among clinicians in countries with a substantial number of observant Jews,
because its definition of “mental disorder” is mimicked by an independent and widely-respected
organization’s own diagnostic manual, and because it offers a clear and concise description of

20 Ibid.
21 World Health Organization, The ICD-10 Classification of Mental and Behavioural Disorders: Clinical
Descriptions and Diagnostic Guidelines (Geneva: World Health Organization, not yet published), available at
https://icd.who.int/browse11/l-m/en#/http%3a%2f%2fid.who.int%2fcd%2fentity%2f1563440232.
the illness at hand, the DSM-5 definition of “depressive disorder” will be used as the operationalized term for depression throughout this paper. Included in this orientation is the ability to flex diagnostic criteria to accommodate mentally ill individuals who do not technically meet the conditions of a diagnosis. For readability’s sake, we use “depression” and “depressive disorder” interchangeably; both refer to the definition of a depressive disorder in the DSM-5. Descriptions of specific depressive disorders (such as “postpartum depression” or “major depressive disorder”) will be attempted where relevant. The reader is encouraged to review this chapter and reflect on the classifications contained within it as they explore the responsa, case studies and interviews presented later. Finally, the emphasis we have placed on proper classification in this chapter demands that we acknowledge a serious limitation of our research: When exploring responsa on depression, it is sometimes too difficult to discern whether the subject meets the criteria for a formal depressive disorder. This is usually either because the case description provided is too brief, or because of somewhat inconsistent usage of terminologies among decisors. There is, unfortunately, little that can be done about this, other than to strive for accurate judgments and keep in mind that our findings may be consequently more fallible.

Defining Halakha

Different rabbis and Jewish communities harbor divergent and sometimes conflicting understandings of how to apply or observe Jewish law (halakha). These disparate perspectives derive largely from contravening attitudes about the weight of certain meta-legal influencers, such as the value of stringency and leniency, the malleability of established practice, the binding nature of halakha, and the weight of contemporary ethics or social norms in determining acceptable practice. For example, a religious decisor who values stringency is likely to rule

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\[22\] Though “Jewish law” is a relatively straightforward translation of halakha, it is important to note that “law” here encompasses legal theory, methodology and practice (including ritual).
prohibitively in cases where the legal conclusion is unclear and leaves room for both a permissive and a prohibitive ruling, whereas a religious decisor who values leniency is wont to do the opposite. Similarly, a community that accepts halakha as binding will react more skeptically and rigidly when a given halakha conflicts with a serious emotional or ethical imperative than a community that does not accept halakha as binding.

Therefore, a proper exploration of halakha’s approach towards the treatment of mental illness necessitates answering the question, “Who’s definition of halakha?” General length restrictions preclude an exhaustive exploration of our topic from the perspectives of all three of contemporary Jewry’s major movements (Reform, Conservative, and Orthodox). Moreover, focusing on the relationship between Jewish law and mental illness in just one community from the outset seemed the best way to guarantee a thorough and deep treatment. We have elected to explore the themes and issues at hand with a deliberate concentration on the Orthodox perspective.23 At the same time, efforts are made to incorporate the positions of other Jewish denominations when noteworthy or consequential. Suggestions for further reading are included where topical or spatial constraints preclude a sufficiently thorough elaboration. The reader is

23 There are several reasons that Orthodox Jewish law warrants greater analysis. First of all, there is more to explore; Orthodoxy possesses a much greater amount of responsa and other legal literature. Second, because both Reform and Conservative responsa frequently utilize (or at least acknowledge) the decisions of prevenient Orthodox scholars, the Orthodox position is an important part of the legal fabric of other movements. Third, because Orthodox halakha is more encompassing and generally more observed by its adherents than Reform or Conservative halakha, we theorize that it practically presents the most challenges to depressed individuals.

Additionally, it is critical to acknowledge that even within the Orthodox ambit, there exists (sometimes profound) differences of opinion and practice among legal decisors and within different communities. The fact that we have adopted Orthodox halakha as the legal lens through which the interaction between depression and Jewish law will be explored in this paper should not be taken to mean that all Orthodox halakhists and communities possess homogenous philosophies, practices, or methodologies. Indeed, many of the halakhic issues we discuss are not issues at all according to some Orthodox legalists. While we endeavor to represent the most mainstream and consensus-driven position (when it exists) in our presentation of various halakhic problematics, we cannot completely control for the fact that many of the decisors quoted in this paper do not speak on the same terms. In some cases, when decisors respond differently to the same exact same question and when their philosophical-methodological underpinnings are clear, it is indeed possible to understand the impact of a given halakhist’s approach on their psak (see Glossary). However, such is usually not the case. This poses a challenge to our analysis that is not easily remediated. Similar to our conclusion regarding depression, we must proceed with the understanding that this reality potentially limits the cogency of our ultimate findings.
advised to remember that legal perspectives on the relationship between mental illness and halakha in the multi-denominational Jewish community can vary considerably, even though our decision to concentrate on Orthodoxy prevents these disparities from being fully reflected in the paper.
A Brief History of Depression in Halakhic Literature

A historical overview of the treatment of depression in halakha is prerequisite to our analysis. Such a synopsis is for our purposes necessarily general, because a full recounting of the historical development of depression and Jewish law is too lengthy and anyways lies beyond the scope of our basic objective, which is to analyze contemporary legal literature. Therefore, many elements of a thorough discussion must be omitted. Nevertheless, we endeavor here to provide a sufficient background of the subject, beginning with the relevant Biblical and Scriptural texts.

There are Pentateuchal verses that discuss mood, and several Scriptural characters are beset with negative affect at one time or another. However, the circumstance of Saul ben Kish, the first King of Israel who reigned in the eleventh century BCE, receives the most attention from both scholars and rabbis for his protracted maladaptive state. According to the Scriptural narrative, a young lad named David is anointed King in place of the then-reigning Saul. G-d’s spirit (ruah) seems to transfer from Saul to David. Seemingly in place of the spirit of G-d, Saul is gripped with a “ruah ra’ah (evil spirit),” which begins to “terrify him.”

24 For example, there is a considerable amount of antecedent literature on the depressed individual’s status as a shoteh (a mentally incapacitated individual who is exempt from all commandments because of their condition). These writings are touched upon in our later chapter titled, “The Depressed Individual as a Shoteh (below, pp. 89-91).” Another example is the full extent of Maimonides’ interaction with depression, which is dealt with in this chapter only summarily. Cf. Ezra Cohen, “Psychologizing Maimonides: Exploring the Impact of a Sibling’s Death and Clinical Experience on Maimonides’ Understanding of Halakha.”

25 I.e., Genesis 42:38; Deuteronomy 16:14 and 28:47.

26 Such figures include Hannah (I Samuel 1:10), and Barukh, servant of the prophet Jeremiah (Jeremiah 45:3). That the latter figure was beset by negative affect is posited by Ephraim Nissan & Abraham Ofir Shemesh, “King Saul’s ‘Evil Spirit’ (ruach a’ah): Between Psychology, Medicine and Culture,” La Ricerca Folklorica, No. 62 (2010): pp. 149-156.


29 I Samuel 16:12-14. Cf. Rabbi David Altshuler’s commentary to the latter verse (ibid., I Samuel 16:14) for why “terrify” is a proper translation.
have translated *ruaḥ raʿah* as a psychological syndrome,\(^{30}\) arguing on the basis of symptoms subsequently described in the text or Saul’s treatment (music therapy)\(^ {31}\) that he suffered from any one of several specific psychological conditions.\(^ {32}\) Although the details of Saul’s apparent syndrome are largely hypothetical, his disorder has one relevant halakhic ramification. The Mishnah in Shabbat records that “if one extinguishes a flame (on Shabbat) because they fear non-Jews, bandits, (or) because of *ruaḥ raʿah*… (that individual) is exempt.”\(^ {33}\) In his *Peirush HaMishnayot*,\(^ {35}\) Moshe Maimonides (1138-1204) identifies *ruaḥ raʿah* with a group of psychological illnesses called “*melancholiot*.”\(^ {36}\) The extent to which these disorders include or are similar to contemporary depression is unclear; however, there is (an admittedly tentative) reason to suggest that (some) “*melancholiot*” are at least tangentially associated with depression.\(^ {37}\)

\(^{30}\) See, for example, Martijn Huisman, “King Saul, Work-related Stress and Depression,” *Journal of Epidemiology and Community Health* 61, no. 4 (2007): p. 890; and George Stein, “The Case of King Saul: Did He Have Recurrent Unipolar Depression or Bipolar Affective Disorder?” *The British Journal of Psychiatry* 198, no. 3 (2011): 212–212.  

\(^{31}\) I Samuel 16:15-16.  

\(^{32}\) However, the theologian Christopher C. H. Cook wisely urges that “extreme caution be exercised” in assuming that antecedent religious texts present accurate representations of the thoughts or behaviors of particular individuals (cf. Christopher C. H. Cook, “Psychiatry in Scripture: Sacred Texts and Psychopathology.” *The Psychiatrist* 36, no. 6 [2012]: 228).  

\(^{33}\) Mishna Shabbat 2:5.  

\(^{34}\) According to the commentary of Rabbi Ovadia of Bartenura (1445-1515), this is because such an individual is in danger of dying (Ovadia of Bartenura, *Mishnayot Zekher Hanokh* [Israel: H. Vagshel Publishing Ltd., 5759 (1998/1999)], Shabbat 2:5). Maimonides, however, is not explicit about the causal reasoning behind the Mishnah’s statement. Tangentially, Maimonides’ own son, Rabbi Avraham, discusses King Saul as well (cf. Avraham ben HaRambam, *Teshuvot Rabbi Avraham ben HaRambam* [Jerusalem: Friedberg ed., 2006], no. 22 [Acc. Bar Ilan Responsa, https://www.responsa.co.il/default.aspx]).  

\(^{35}\) *Peirush HaMishnayot* (lit. “Explanation of the Mishnas”) is a commentary to the Mishnah written by Moshe Maimonides between the years 1161 and 1168 (Joel Kraemer, *Maimonides: The Life and World of One of Civilization’s Greatest Minds*, [Doubleday Religious Publishing Group, 2008], 164).  

\(^{36}\) Moshe Maimonides, *Masekhet Shabbat im Peirush Rabenu Moshe ben Maimon*, trans. Rabbi Yitzḥak Shilat (Maaleh Adumim: Yeshivat Birkat Moshe, 2004), 41 (2:5). Importantly, in many standard editions of Maimonides’ *Peirush HaMishnayot*, the collection of psychological disorders called “*melancholiot*” is replaced by a single disorder termed “*malconia*.” We have adopted Shilat’s version because it was copied (and translated, for Maimonides originally wrote this work in Judeo-Arabic) from a manuscript that, according to many scholars, was written by Maimonides himself.  

\(^{37}\) At the end of Maimonides’ comments about “*melancholiot*,” he remarks that “this is very common among *‘ba’alei hamara’*.” Shilat (Shilat, 41 n. 1) understands this as a reference to *Mara Shechorah*, an illness which Maimonides elsewhere (Moshe Maimonides, *Pirkei Moshe b’Refuah*, trans. Rabbi Natan Hamati [Jerusalem: Mossad HaRav Kook, 5766 (2005/2006)], 37) associates with melancholia.
The Babylonian Talmud never refers specifically to depression, even though it contains stories of individuals experiencing sadness or despondency and remarks about the virtue of restrained joy, as well as discussions of other mental dysphoria like psychosis. In fact, besides the aforementioned Mishna (according to Maimonides’ understanding), depression is basically absent from all early halakhic rabbinic texts. It does not reappear until the writings of Rishonim (sing. Rishon), rabbis who lived between the eleventh and fifteenth centuries. By far the most prolific Rishon on the subject of depression and halakha (and halakha in general) was Maimonides. It is important to note that Maimonides potentially suffered from depression himself, and treated it in others in his capacity as a physician. In addition to his understanding of Mishna Shabbat 2:5, Maimonides makes other statements that pertain to depression. For example, the Talmud remarks that a condemned individual may not be put to death because of their own testimony. The Talmudic text provides no reasoning for this verdict; however, Maimonides posits the following explanation: “perhaps (the individual who confessed) …was one of those who are in misery, bitter in soul, who long for death, thrust the

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38 See, however, Avraham Steinberg, Encyclopedia of Jewish Medical Ethics-vol. 1, trans. Fred Rosner (Jerusalem: Feldheim, 2003), 660.
39 See, for example, the reaction of Rabbi Yohanan to the death of Rabbi Shimon ben Lakish (B.T. Bava Metzia 84a) and the sentiment of Nakdimon (B.T. Taanit 20a).
40 See the statements of Rabba and Rabbi Zeira recorded in B.T. Berakhot 30b-31a.
41 See the position of the Sages recorded in B.T. Ḥagiga 3b.
42 There are references to the term ruah ra’ah in the writings of the Geonim, (e.g., Halakhot Gedolot (Jerusalem: Makhon Yerushalayim, 1992), no. 1- Hilkhot Berakhot Chapter 7; Rabbi Aḥai Gaon, She’eltot d’Rav Aḥai Gaon (Venice: 1546), Parashat Beshalah She’elta 48 & Parashat Metzora She’elta 88. However, context makes it relatively clear in each of these instances that they refer to other mental illnesses or metaphysical spirits, not cases of depression.
43 Harvey N. Kranzler, “Maimonides’ Concept of Mental Illness and Mental Health,” in Moses Maimonides: Physician, Scientist, and Philosopher, ed. Fred Rosner & Samuel S. Kottek (Jason Aaronson, Inc., 1992), 50. Similarly, the seminal Maimonides’ biographer Joel Kraemer defines Maimonides’ state as “melancholy (Kraemer, 257). Maimonides’ seeming depression was triggered by his brother’s untimely death, and he writes about it at some length (see S.D. Goitein, Letters of Medieval Jewish Traders [Princeton University Press, 1973], 207).
45 B.T. Sanhedrin 9b.
sword in their bellies, or cast themselves down from roofs..." In other words, Maimonides suggests that depressed individuals attempting relief through death are the impetus behind the ruling. This is Maimonides’ original interpretation. Other Rishonim ultimately have little to say about depression and halakha, though it does receive a small amount of attention.

This relative silence continues in the ensuing systematic legal codes, the Arba’ah Turim (by Rabbi Yaakov ben Asher [1269-1343]) and Shulkhan Arukh (by Rabbi Yosef Karo [1488-1575]), where no legal references to depression are made. These texts, however, do contain references to general mental illness with varying degrees of explicitness. For example, both codes discuss restrictions on mourning for an individual who dies by suicide (which is forbidden), a common consequence of depression. Rabbi Moshe Isserles (1530-1572), the preeminent Ashkenazic codifier of Jewish law who composed glosses to Karo’s Shulkhan Arukh, wrote a relatively sparse commentary to these passages; one may reasonably deduce from Isserles’ silence his implicit agreement. Another example is a series of discussions in both the

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47 Harvey Kranzler suggests that it developed from Maimonides’ own clinical experience treating depression ([Kranzler, 52-53]).

48 The remaining material from the period of the Rishonim is comprised mostly of rabbis corroborating Maimonides understanding of ruah ra’ah as some potentially depressed state (though it is admittedly unclear whether the mara shehorah that he, and other Rishonim refer(s) to is some form of depression [see below, note 64]). See, for example, Rabbi Ovadia of Bartenura quoted supra, note 34. Other Rishonim do mention depression, but not in a formal halakhic context. I.e., see, Rabbenu Yona of Gerondi’s (1200-1263) comments to B.T. Berakhot 21a, (Talmidei Rabbenu Yona al haRif, [Vilna ed.], Berakhot 21a (s.v. “lo savar lei b’hol etzev yihye motar”). [Acc. Bar Ilan Responsa, https://www.responsa.co.il/default.aspx]). These comments are quoted by other prominent Rishonim (such as Rabbi Yom Tov Asevilli [Ritva], in Hiddushei HaRitva- Masekhet Berakhot [Jerusalem: Mossad HaRav Kook, 5766 (2005/2006)], 192.

49 Based on Genesis 9:6 and the opinion of Rabbi Elazar quoted in B.T. Bava Kama 91b.


51 Yaakov ben Asher, Arba’ah Turim (Jerusalem: Ḥemed, 1981), section Yoreh De’ah (YD) 345; Yosef Karo, Shulkhan Arukh (Lemberg: P Balaban, 1893), Orah Hayim (OH) 345:1-3.

Tur and Shulkhan Arukh about the legal status of the shoteh.\textsuperscript{53} While depressive disorders are occasionally relevant to questions of mental incapacitation\textsuperscript{54} and suicide, neither topic intrinsically entails depression.

As a result, depression entered the seventeenth century without substantial precedent in Jewish legal texts. By this point, a large number of prominent rabbis resided in Europe. At the same time, intra-European conceptual understandings of depression began to evolve immensely. This process probably began with English scholar Robert Burton’s publication of The Anatomy of Melancholy in 1621, a watershed work that posited several causes for depression (such as loneliness) and suggested treatments (including exercise and primitive forms of talk therapy) that are still advocated today.\textsuperscript{55} 56 57 In any case, the general geographic proximity of Jewish scholars to advancements in the understanding of depression seems to have generated newfound Jewish legal attention to the disorder. Indeed, it is in the centuries following Karo’s Shulkhan Arukh that mention of depressive disorders began trickling into the relevant literature in the form of responsa and commentaries to Karo’s work. A majority of these treatises were devoted to addressing the severely depressed individual’s status as a shoteh;\textsuperscript{58} within this category, a

\textsuperscript{53} Le., Arba’ah Turim Hoshen Mishpat (HM) 35; YD 1; Shulkhan Arukh, CM 35:8; YD 1:5
\textsuperscript{54} See our chapter titled, “The Depressed Individual as a Shoteh,” pp. 89-91.
substantial number pertained to the ability of a severely depressed male to provide his wife with a Jewish document of divorce,\(^{59}\) an action that requires lucidity on the part of the husband.

One important exception to the pattern of *shoteh*-dominant questions, and perhaps the first known remark about a conflict between depression and halakha outside the discussion of *shoteh*, was made by Rabbi Ḥayim Yosef David Azulai (Palestine; 1724-1806), in his commentary to Karo’s *Shulkhan Arukh* titled *Birkei Yosef* (pub. 5537 [1776/1777]).\(^{60}\) \(^{61}\) Specifically, Azulai vindicates the behavior of seemingly observant individuals who nevertheless pursued activities that were considered religiously vacuous or frolicsome\(^{62}\) by suggesting that these individuals did so to alleviate an illness called *sheḥorah* [שחורה]. One later authority\(^{63}\) translates Azulai’s *sheḥorah* as depression.\(^{64}\) If this is an accurate reading, the implication of Azulai’s ruling is that certain activities normally prohibited because of frivolity are permitted when performed to facilitate wellness. However, Azulai’s remark is ultimately too brief to be more helpfully elucidative for our purposes.

It was not until 1928\(^{65}\) that the conflict between depression and halakha outside the aforementioned discussion of *shoteh* was taken up in an extensive fashion, in a responsum by

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\(^{59}\) I.e., Halberstam, *(Divre Ḥayim)* EH 2:75.

\(^{60}\) Ḥayim Yosef David Azulai, *Birkei Yosef* (Bne Brak: Yahadut HaTorah, 5750 [1989/1990]), OH 338 *siman katan* no. 1. Though Azulai was from Palestine (not Europe), he made several lengthy trips to Europe (Meir Benayahu, *Rabbi Ḥayim Yosef David Azulai*- vol. 1 [*Toldot Ḥayav*] [Jerusalem: Mossad HaRav Kook, 1959], which perhaps explains his familiarity with depression.

\(^{61}\) Publication date based on Benayahu, 107.

\(^{62}\) Rabbinic decisors view the wasting of time and engagement in time-wasting, pointless, or frivolous activities, as negative and sometimes prohibited (see below, pp. 76-77). The specific activity Azulai discusses is chess.


\(^{64}\) Depression is often referred to in classical religious Jewish texts as *mara sheḥorah* (because depression was thought to develop from an accumulation of black bile [cf. Evan Balmuth, “From Black Bile to the Brain: Tracing Melancholia and Depression,” PhDnet, May 29, 2017, https://www.phdnet.mpg.de/27403/20170529_From-Black-Bile-to-the-Brain]), this contention is reasonable.

\(^{65}\) Often, the dates provided in responsa and other Jewish religious texts are Hebrew calendrical dates. Each Hebrew year overlaps with two Gregorian years. (For example, the Hebrew year 5768 occurred during part of both 2007 and 2008.) Therefore, it is difficult or impossible to determine the specific corresponding Gregorian year when only the Hebrew year is provided. When faced with this dilemma, we utilize the later year. In some cases, we do so even when the Hebrew month is given, which would render a more specific calculation possible. See p. vi.
Rabbi Shimon Gruenfeld (alt. Greenfeld) (1860-1930) of Bűdszentmihály, Hungary.66

Gruenfeld discusses whether a depressed individual who utilized a phonograph to play songs with lyrics borrowed from Scriptural verses (for therapeutic purposes) violated the prohibition to turn Scripture into song.67 This responsum marks the starting point for our discussion, and, save for Azulai’s comment, serves as the earliest depression-specific piece of literature in our analysis. Now that a general overview has been provided, we may turn to the contemporary sources on depression and halakha.

66 “This Day in History (19 Shevat),” Hamodia, 2013, https://hamodia.com/columns/2591/. Gruenfeld was a student of the venerable Rabbi Moshe Schick and headed the Bűdszentmihály rabbinical court (Yitzhak Yosef Kohen, Ḥakhmei Hungaria v’Ha’Sfraot HaToranit Ba [Jerusalem: Makhon Yerushalayim, 5757 (1996/1997)], 172). Kohen also records that Gruenfeld was “of the great(est) rabbis and pillars of (halakhic) guidance in the entire country (Kohen, 172).”

67 See B.T. Sanhedrin 101a. For a fuller analysis of this responsum and the prohibition in question, see below, pp. 21-24.
Chapter II: The Contemporary Legal Treatment of Depressive Disorders in Conflict with Halakha

Depression and Music Therapy

Music as a form of therapy possesses a rich, lengthy history in many major cultures, including Judaism. It bears reference in texts at least four-thousand years old, and held unique sway in the minds of prominent Greek philosophers and Jewish theologians alike. Though the nature and extent of its usage has varied over time and across societies, music therapy has entered the contemporary clinical era as an important alternative to, and supplementary treatment for, variegated mental illnesses. The American Music Therapy Association defines “music therapy” as “the clinical and evidence-based use of music interventions to accomplish individualized goals within a therapeutic relationship by a credentialed professional who has completed an approved music therapy program.” A 2014 survey of twenty-one studies on music therapy found evidence that music therapy harbors

68 Peregrine Horden, introduction to Music as Medicine: The History of Music Therapy Since Antiquity, ed. Peregrine Horden (Oxon & New York: Routledge, 2017), 1 (page numbers not given [p.n.g]).
73 Actually, music therapy has been used to treat physical illness as well. Cf. Suzanne B. Hanser, “Music Therapy in Cardiac Health Care: Current Issues in Research.” Cardiology in Review 22, no. 1 (February 2014): 37–42.
74 American Music Therapy Association, “Frequently Asked Questions (FAQ’s),” American Music Therapy Association, https://www.musictherapy.org/faq/#267. While this definition is certainly helpful, it is perhaps overly formalistic; for example, most of the cases we will describe probably do not involve “a credentialed professional who has completed an approved music therapy program.” We will nevertheless proceed with the understanding that even cases lacking in this criterion are valid forms of music therapy.
observable therapeutic potential; a 2017 study reached the same conclusion for depressive disorders in particular.

Orthodox Jewish law regulates the creation and consumption of music in specific circumstances and at various times of year. For example, certain mourners are proscribed from listening to music, and musicians are discouraged from performing during two annual several-week cycles dedicated to commemorating Jewish communal tragedies. According to some authorities, Jews are prohibited from enjoying music year-round as a form of mourning over the destruction of the Second Temple around 70 CE. In addition to time-bound musical restrictions, normative Orthodox halakha imposes several standalone regulations that apply perennially and bear no connection to mourning or remembrance. For example, Jewish males may not actively listen to a woman singing, and Scriptural verses may not be used as song lyrics. While a full exploration of the intersection of music and halakha lies beyond the scope of this paper, the reader is encouraged to generally familiarize themselves with the relevant laws and customs to better understand the halakhic context of the below-mentioned responsa.

Probably the first rabbinic figure to discuss the legal ramifications of music therapy is Rabbi Avraham Yitzḥak Glick (b. 1909) of Toltšesva, Hungary. Though his responsa are quoted by contemporary rabbinic decisors, relatively little is known of Glick’s life. In a responsum likely written no later than 1909, Glick permits an individual struggling with severe

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77 The rabbinic ban on music in response to the destruction of the Temple is the subject of much research and dispute, and lies beyond the scope of our analysis. For a thorough legal analysis, see Rabbi Aharon Kahn, “Music in Halachic Perspective,” The Journal of Halacha and Contemporary Society 14 (1987): 7-46.
78 Based on B.T. Berakhot 24a and B.T. Kiddushin 70a. It should be noted that there are several potential exceptions to this dictum, and some contemporary decisors significantly limit the extent of its applicability.
79 Based on B.T. Sanhedrin 101a.
80 Kohen, 26 n. 1.
anxiety to enjoy music from a phonograph on Shabbat with the goal of easing his anxieties, provided the machine was operated by a non-Jew instructed to do so before the Sabbath began.  

Ultimately, however, he recommends that a G-d-fearing individual refrain. While Glick dealt with an individual afflicted by serious anxiety, his logic may be tentatively applied to other mental illnesses responsive to music therapy.

As noted earlier, the first rabbinic figure to discuss the relationship between music therapy and depression is Rabbi Shimon Gruenfeld (1860-1930), former head of the rabbinical court in Bűdszentmihály, Hungary. Like Glick, Gruenfeld’s responsa are quoted with relative frequency, but surprisingly little is known of his life. In any case, Gruenfeld was asked whether an individual who used a phonograph to play songs with lyrics borrowed from Scriptural verses violated the aforementioned prohibition to turn Scripture into song. In a 1928 responsum, Gruenfeld writes: “The (answer to the) question…posed varies by place and time, and also by person. Many times, there lies (within the abovementioned act) a very great prohibition; many (other) times, it is completely permissible and (even) a possible mitzva.”

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81 In the responsum, Glick discusses more extensively the potential prohibitions involved in such an activity. He concludes that listening to a phonograph is rabbinically prohibited because of noise-making (based on B.T. Shabbat 18a), but argues that there is room to be lenient when such an activity is engaged in for the sake of a sick individual by a non-Jew. The idea of requesting a non-Jew to perform a rabbinically prohibited activity on Shabbat involves two rabbinic prohibitions (asking a non-Jew to perform a forbidden activity on behalf of a Jew and the actual rabbinic prohibition that the non-Jew performs). According to normative halakha (Shulkhan Arukh OH 307:5), one is permitted to ask a non-Jew to violate a rabbinically-imposed Shabbat restriction for the sake of a sick individual, a great need, or a mitzva (such as turning on certain types of lights to allow one to study Torah). It is to this caveat (referred to as shevut d’shevut) that Glick appeals in his responsum. He also discusses whether turning on and tuning the instrument is problematic.

82 Avraham Yitzhak Glick, Yad Yitzhak- vol. 2(2) (Vale: 5662[1901/1902]-5669[1908/1909]), she’eilot v’tshuvot no. 322.

83 Glick expresses concern that utilization of this leniency will lead individuals to violate the prohibition (of asking a non-Jew to perform a rabbinically forbidden activity on Shabbat) even when no significant need exists (under the misimpression that it is permissible).

84 Glick’s responsum is more extensively discussed below, pp. 29-30.


86 See, however, supra, note 66, for a brief background.

87 See supra, p. 20 note 79.

Gruenfeld proceeds to note that according to Rabbi Ḥayim Vital, sadness, among other tendencies, is a root cause of negative character traits. He then continues:

Sadness…brings one to a number of transgressions, and even sadness over the transgressions (themselves)…can result, G-d forbid, in suicide. Such have you heard, and I have seen this a bit with my own eyes. And if so, one who inclines towards sadness as a result of their nature, G-d forbid, obviously bears no sin listening to a phonograph to alleviate their suffering…But one who…is not sad (but instead suffers from another of Vital’s negative tendencies) …is of course forbidden from listening to a phonograph, and additionally the prohibition of “your children have rendered me like a harp” applies. And therefore, what I mentioned before is proper—that this (question) varies by person, place, and time, and one cannot make broad statements of principle—for an individual is not aware of the concealed (dispositions) of their fellow.

Gruenfeld’s response is significant on several accounts. First, he argues that a theoretical ban on making song of Scripture does exist, and that it seemingly applies to all individuals barring extenuating circumstances. More specifically, persons matching a description quite similar to those of several depressive disorders may disregard the prohibition to facilitate their well-being. Second (and perhaps more implicitly), Gruenfeld’s utilization of the clause “and if so” creates a connection between potential for suicide and permission to utilize the phonograph, suggesting (albeit implicitly) that the abovementioned leniency flows from a concern for the individual’s life. Third, Gruenfeld demonstrates awareness that depression can engender suicide. Fourth, he emphasizes the importance of acknowledging individual differences when determining psak.

Slightly after Gruenfeld penned his responsum on music therapy, and similar to the responsum of Rabbi Avraham Yitzḥak Glick above, Rabbi Mordekhai Yaakov Breish (1895-

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89 Rabbi Ḥayim Vital (Safed, 1542-1620) was a prominent Kabbalist and student of the Kabbalist Rabbi Isaac Luria.
90 It is unclear whether Gruenfeld is quoting this point from Rabbi Shneur Zalman of Lyadi’s Tanya. Either way, cf. the remark of Rabbi Moshe Dov Wilner in the name of Rabbi Yehuda HaHasid (below, p. 83).
91 This word (שמעתי) (“I heard”) seems more correct.
93 I.e., the prohibition to turn scripture into song. Cf. supra, p. 20 and note 79.
1976) of Switzerland was asked about the permissibility of utilizing a radio to soothe a highly anxious individual on Shabbat, provided the device was turned on and tuned before the holiday began. In an undated multi-letter correspondence with the asker, he answers:

…I was inclined to sanction (the abovementioned activity), for even regarding all (healthy) individuals there are bases for leniency… Regarding… (the idea that) one suffering from anxiety is merely suffering (tza’ar) and not in pain (ka’ev)… (Behold!) Anxiety and depression\(^95\) are bona fide illnesses, tied to the arteries\(^96\) and the senses…and when (the illness reaches) an advanced stage, (such an individual) is possibly also considered a holeh she’yesh bo sakana\(^97\)… (But) even if it is not decidedly true (that an individual suffering from anxiety or depression can be definitively defined as a holeh she’yesh bo sakana), it is certainly true that an individual with anxiety is considered a holeh she’ein bo sakana.\(^98\) And in the Torah is spoken a full verse, “He heals the brokenhearted, and binds their wounds.”\(^99\) If so, (such individuals) require remedy, very similar to (the writings of) Rabbi Moshe Isserles, (who noted that)\(^100\) one possessing a painful ailment that sickens their entire body even though this person still walks (i.e., is not bedridden), it is considered as if their entire body is sick.\(^101\)

Breish considers depression a legitimate debilitation, legally equivalent to a medical disorder; in fact, he is probably the first decisor to explicitly draw a medical equivalence between depression and physical illness. Breish also demonstrates an understanding of the somatic elements involved in depression and anxiety (“veins” and “senses”), even though they are not necessarily consonant with medical concepts at the time of this thesis’ writing. Finally, Breish (like Gruenfeld) suggests that depression harbors a life-threatening capacity.

The date of Breish’s responsum is unclear, but it was probably several years later that the issue of music therapy and depression was taken up again in responsa form, this time by Rabbi Menashe Klein (1924-2011). Klein was a Holocaust survivor who served as a rabbi in the

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95 The relationship in Breish’s mind between anxiety and depression, as well as the then-prevalent understanding of these illness upon which his conception was reasonably based, are unclear. It is possible that Breish understood these as interrelated, and that this is the reason why he refers to them in tandem here.
96 The term Breish uses,עורקין, may potentially also be translated as “nerves.”
97 A sick individual whose illness places them in danger of death. See Glossary.
98 See Glossary.
99 Psalms 147:3.
100 Rema OH 328:17.
101 Yaakov Breish, Helkat Yaakov- vol. 1 (Tel Aviv: Seder-Kol, 5752 [1991/1992]), (Oח) 64.
United States before emigrating to Israel around 2009. The responsum, issued to a young yeshiva student in 1971, discusses the permissibility of enjoying music in light of the abovementioned ban on musical expression as a form of mourning over the destruction of the second Temple in Jerusalem. Klein begins by affirming the presence of an active prohibition and emphasizes the severity involved in its violation. He then continues: “…it is obvious that the Sages of blessed memory only forbade music for the sake of enjoyment and playfulness, which brings one to kalut rosh (lightheadedness/frivolity); however, (if the activity is performed) for curative reasons, the Sages of blessed memory did not extend the prohibition (to apply in such cases).” Klein quotes the aforementioned position of Rabbi Avraham Yitzḥak Glick as proof for his conclusion, but expresses a separate concern that therapeutic music containing lyrics from Torah verses contravenes a prohibition to use words of Torah to facilitate healing. He leaves this question unresolved.

The next authority to take up the question of depression and music therapy was Rabbi Shmuel Wosner (1913-2015), a prominent ultra-Orthodox rabbi from Bne Berak, Israel. He discusses the issue in two separate responsa about five years apart. In the first (written in 1984), Wosner reaffirms the injunction against enjoying music as a form of mourning over the second Temple’s destruction, and expresses disappointment in the seemingly common practice to ignore what he believes is a veritable restriction, before briefly discussing music therapy:

…In practice, to our shame and sorrow, this simple and clear halakha has been almost forgotten, and we possess no conclusive limud zḥut; however, at any rate…one who listens (to music) to control their sadness, which might be considered a mitzvah, as

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103 Cf. supra, note 77.
105 Avraham Yitzhak Glick, Yad Yitzhak- vol. 2(2) (Vale: 5662[1901/1902]-5669[1908/1909]), no. 322.
106 Cf. B.T. Shevuot 15b and Shulkhan Arukh YD 179:8, 10 & 12.
107 See Glossary.
the great teacher and rabbi Shimon Gruenfeld has already written\textsuperscript{108} (incurs no sin) …And obviously, this is not to permit learning an instrument and improving one’s skills “just because,” in order to sing “just because…”.\textsuperscript{109}

In a similar vein, Wosner’s second responsum (written in 1989) discusses the annual three-week period dedicated to lamenting the Second Temple’s destruction (often colloquially referred to as the “Three Weeks” in English). According to many authorities, these three weeks bear enhanced restrictions on musical expression and enjoyment. Wosner writes:

Nowadays, even those normally scrupulous (to avoid music during the “three weeks”) are lenient regarding recorded acapella music,\textsuperscript{110} and it is worth attempting to judge them favorably (\textit{lelamed alehem zhuṭ}), for many times, individuals engage (in such activity) to control their sadness, which is acceptable. This is especially common regarding women…\textsuperscript{111}

Several important elements of Wosner’s two responsa demand acknowledgement. He believes that individuals liable to depression are permitted music despite the imperative to refrain from musical expression as a form of mourning. Like Klein, this ruling stems from an understanding that the enactment never included music employed to alleviate sadness in the first place, rather than a circumstantial override of the prohibition. Additionally, Wosner seems to understand that a significant percentage of individuals struggle with depression, or at least enough that he felt comfortable using depression to suggest a favorable means of understanding widespread tendencies to ignore the prohibition. Third, Wosner expresses awareness of the empirical reality\textsuperscript{112} that depression affects more women than men.\textsuperscript{113}

\textsuperscript{109} Shmuel Wosner, \textit{Shevet HaLevi}- vol. 6 (Bne Brak: 5762 [2001/2002]), no. 69.
\textsuperscript{110} Recorded acapella music is treated more leniently by some (but not most) decisors, bcause it is dissimilar to “bona fide” music (i.e., with instruments).
\textsuperscript{112} See the study by Myrna M. Weissmann and Gerald L. Klerman. “Gender and Depression.” \textit{Trends in Neurosciences} 8 (January 1, 1985): 416–20, which was published shortly before Wosner’s responsum.
\textsuperscript{113} Interestingly, this statistic is also mentioned in a series of published letters between Wosner and Rabbi Eliyahu Schlessinger (Eliyahu Schlessinger, \textit{Shoalin v’Dorshin}- vol. 4 [Jerusalem: 2001], no. 39).
One final work for analysis here is *Hilkhot Ḥag b’Ḥag*, a fourteen-volume compendium of holiday-related halakhot written by Rabbi Moshe Mordekhai Karp (b. unknown; Modi’in, Israel). In his section dedicated to the laws and customs surrounding the period of mourning between Passover and Shavuot typically referred to as *Sefirat HaOmer*, Karp affirms a custom to refrain from listening to both live and recorded music during this time, but offers the following directive: “If there exists a great need, such as someone with depression and much sadness and the like, and that individual is wont to violate more serious prohibitions as a result of their condition, that individual should ask a qualified authority (for advice on how to proceed).” He then adds:

Since the (individual’s intention) …is merely to remedy their psychological state and calm their nerves and the like. (In such a case,) there is room to be lenient in private. Such have I heard from…Rabbi Ḥayim Kanievsky…and I have also heard that this advice is standard among those qualified and employed to dispense religious legal guidance.

Karp’s position departs in several significant ways from the approaches examined prior. In three regards, it is more stringent: Firstly, he potentially implies that only depression coupled with the undesirable prospective for serious sin warrants leniency. Secondly, Karp directs those suffering from depressive disorders to consult with a qualified legal authority before availing themselves of music, instead of granting permission directly and outright. Thirdly, Karp rules that one who meets the necessary criteria may only listen to music in private. These conditions are not explicit in any of the aforementioned responsa, which is more surprising given that Karp himself

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114 This period of mourning commemorates the death of 24,000 students of the sage Rabbi Akiva (see B.T. Yevamot 62b).

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seems to adopt (the normative position) that refraining from music during the period of *Sefirat HaOmer* is a matter of custom rather than official code.\(^{117}\)

In conclusion, several things are clear. Music therapy intersects with Jewish law at several significant junctures. Rabbinic authorities have made scientifically-accurate comments about depression in recent history; in several cases, the personal exposure to depression or scientific awareness of the authors explicitly affected the legal decision. Perhaps most importantly, and to the extent that the views explored above are representative, most rabbis are consistently lenient despite addressing these questions at different points in recent history and regardless of the disparate halakhic problems they identified in their responsa.

Depression and *Shabbat/Holidays*

Because *Shabbat* occurs frequently and is heavily regulatory in nature, the interplay between Shabbat observance and depression is particularly robust. This chapter outlines some of the halakhic challenges that individuals with depressive disorders may encounter on *Shabbat* as addressed in Jewish legal literature. It is critical to acknowledge that the laws of *Shabbat* are especially complex; while we endeavor to provide appropriate context and introductions, concision demands that the reader approach this chapter with a general understanding of the relevant laws. Furthermore, because Sabbath prohibitions apply to a great many activities, and because cases are often unique and demand nuanced treatment and tailored religious accommodations, the chapter cannot be completely comprehensive. In any case, supplementary information and sources may be found in the footnotes. Finally, while most challenges that Sabbath observance presents to depressed individuals arise also on *Yamim Tovim ([s. Yom Tov])*, cases *specific* to *Yamim Tovim* do arise. They, too, are included in this chapter.

**Amira l’Nokhri**

Jews are proscribed by rabbinic decree from instructing non-Jewish individuals to perform Sabbath prohibitions on a Jew’s behalf (even though Jewish law permits non-Jews to perform such activities on their *own* behalf). This prohibition is commonly called *amira l’nokhri* (instructing a non-Jew), or *amira l’akum* (instructing an idol worshipper). If a non-Jew *did* perform some forbidden action on behalf of a Jew, all Jews are prohibited to benefit from that action.

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119 For readability we alternate between *Shabbat* and Sabbath, and intend these terms interchangeably.

120 See Glossary. Fasting on *Yom Kippur* is dealt with below, on pages 75-76.

121 *Shulchan Arukh* OḤ 307.

122 “Idol worshipper” here refers to any non-Jew, even one who does not worship idols.
In the previous chapter, one pertinent ramification of this law was already discussed:

Writing in the early twentieth century, Rabbi Avraham Yitzḥak Glick of Toltsesva, Hungary, discusses whether an individual with severe anxiety was permitted to listen to a phonograph on Shabbat to ease his nerves, provided the device was operated by his non-Jewish servant who was instructed to do so before the Sabbath began. Working under the assumption that utilizing a phonograph in this case is only rabbinically prohibited, and in acknowledgment of the general caveat that Jews may indeed request a non-Jew to perform a forbidden activity if (a) the forbidden activity is used to heal or alleviate the pain of a sick individual and (b) the forbidden activity is rabbinically (and not Biblically) prohibited, Glick writes:

“Even regarding an individual who is slightly sick (miktzat ḥoli), we are lenient (and permit such an individual) to instruct a non-Jew on Shabbat (to violate rabbinic prohibitions of Shabbat) on the (sick) individual’s behalf… If the individual is classified as miktzat ḥoli, there is room to permit (the above activity) because it is (a case of) shevut d’shevu. (Furthermore, in our) specific (case), where the non-Jew is instructed before the onset of Shabbat [as opposed to on Shabbat itself], (the law is) even more lenient…”

Ill individuals whose condition warrants the suspension or abrogation of standard Jewish law are judged according to the severity of their symptoms and assigned to one of five legal categories. As chaplain Jason Weiner notes, each category possesses disparate rules regarding how halakha applies to individuals within them. In ascending order of severity, miktzat ḥoli is

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123 Because non-Jews are not obligated to observe Shabbat, there is greater leniency when the prohibited action is performed by a non-Jew.
124 See Shulkhan Arukh OḤ 307:5
125 See, however, Rabbi Moshe Isserles, who notes that some rule leniently even when the activity in question Biblically forbidden (Moshe Isserles, quoted in Yosef Karo, Shulkhan Arukh [Lemberg: P. Balaban, 1893]), 307:5.
126 Shulkhan Arukh and Rema to OḤ 307:5.
127 See supra, note 81.
128 See Shulkhan Arukh OḤ 338:3
129 Avraham Yitzḥak Glick, Yad Yitzḥak- vol. 2(2) (Vale: 5662[1901/1902]-5669[1908/1909]), no. 322.
130 This is obviously not Weiner’s original perspective; it derives from the Talmud and ensuing legal codes. However, we utilize Weiner’s synopsis because it is straightforward and concise.
the second of these five labels. It “describes a patient with a minor illness, aches or pains…which does not affect the entire body or cause a person to be confined to a bed.”

Apparently, Glick believed that an individual with severe anxiety belongs in this category, though a definitive determination of his position is unclear. Furthermore, Glick was not describing the halakha relative to an individual with depression, despite the fact that extrapolating to apply his conclusion to depressed persons is probably reasonable.

There exists a second, though admittedly bizarre, case in contemporary halakhic writings about the relationship between depression and amira l’nochri. In the work Tiferet HaShabbat, a compilation of Shabbat-related legal articles by affiliates of the Kedushat Tzion seminary in Bat Yam (Israel), Rabbi Yitzḥak Schiff writes:

An individual without hands or feet who is otherwise healthy like all other human beings, may not instruct a monkey to perform an action forbidden on Shabbat. [However], when there exists a concern that the individual will become sick or depressed etc., even when there is no danger –the monkey may be instructed to perform rabbinically prohibited activities. When there exists a threat of danger, it is permissible even when the [monkey’s] action involves a Torah prohibition.

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132 Weiner, ibid.
133 Presumably due to amputation or an illness or genetic disorder.
134 Perhaps surprisingly, Jewish legal texts bear a relatively substantial amount of material on monkeys. See, for example, Moshe Sofer, Hiddushe Hatam Sofer HaShalem al HaShas- Gittin- vol. 1 (Jerusalem: Makhon HaTam Sofer Yerushalayim, 5768 [2007/2008]) 22b. On the specific topic of a trained monkey’s capacity to perform forbidden activity on behalf of a Jew on Shabbat, see also Rabbi Yitzḥak Zilberstein, Melakhim Omanekha (Bne Brak: 5752 [1991/1992]), 37.
136 In attempting to understand the context behind Schiff’s ruling, it is worth noting that Rabbi Yitzḥak Yosef (in Yitzḥak Yosef, Yalkut Yosef Shabbat OH 9 [Shabbat vol. 2] [Jerusalem: 5752 (1991/1992)], ha’arot to 308:6- Dinei Muktzat maḥamat gufo) describes a somewhat similar case, in which a handicapped man purchased a well-trained monkey to assist him with daily tasks. The monkey escaped, and Yosef was asked whether one who returned the monkey to its owner on Shabbat violated the Sabbath prohibitions on trapping animals and moving muktze items (see Glossary). He responds that, regarding the violation of muktze, one is permitted to return the animal on Shabbat lest the individual become depressed and despondent and develop mental health issues that may endanger his life. Yosef is more stringent regarding the prohibition of trapping. Yosef and Schiff’s cases, however, are more different than they are similar; therefore, the relationship between them is therefore unclear at best.
Unlike Glick, Schiff does not expressly state the reason why normative halakha is waived for his subject liable to melancholy, and so explanatory suggestions are conjectural. Moreover, it is unclear whether Schiff refers to formal, diagnosable depressive disorders, though the juxtaposition of depression and sickness implies the presence of a genuine clinical condition. Additionally, the Hebrew word he uses דיכאון – is the clinical term for depression, though (like the English term “depression,”) it is not exclusively used in a formal-clinical context. If we assume that Schiff indeed refers to clinical depression, it is worth further noting that he apparently understands depressive disorders can manifest in both a life-threatening and non-life-threatening capacity, and that these disparate presentations carry divergent halakhic ramifications.

Uvdin D’ḥol

Uvdin d’ḥol is a highly elusive and difficult-to-define rabbinic prohibition that forbids performance on Shabbat of activities that are either similar in nature to one of the forbidden acts of labor on Shabbat, render one liable to transgress the latter, or are determined to be excessively burdensome. In our chapter on music therapy, a responsum of Rabbi Yaakov Breish (1895-1976) permitting the use of a radio on Shabbat to calm a depressed individual under limited circumstances was explored. Breish analyzed the issue from a number of vantage points, but uvdin d’ḥol was not one of them. We may reasonably deduce that Breish did not consider uvdin d’ḥol an operative restriction in this case. His position, however, is not universally shared: Rabbi

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137 According to most authorities. See, however, the opinion of Moshe Nahmanides (Ramban) in his commentary to Leviticus 23:24, s.v. “yihyeh lakhem Shabbaton.” Available in Moshe Nahmanides, Perush Ramban al HaTorah- Vayikra (Jerusalem: Makhon Yerushalayim, 5768 [2007/2008]), 23:24. See also the opinion of Rabbi Yuval Cherlow, below (p. 32).

138 These definitions are taken from Rabbi Israel Lifschutz, a European Rabbi famous for his commentary on the Mishna titled Tiferet Yisrael, quoted in Rabbi Tzuriel Ohayon, Uvdin D’ḥol (Elad: 5774 [2013/2014]), 245. The unsatisfied reader is directed to this latter source for a fuller exploration of the topic.

139 Breish’s responsum was addressed to someone struggling with anxiety, but he juxtaposes anxiety and depression in his analysis.
Yuval Cherlow, a prominent Israeli Orthodox legal authority and ethicist, was asked whether a depressed individual may listen to music on Shabbat, provided that whatever device the individual used was set up before the onset of Sabbath. Cherlow responded:

Here… (the situation) is more stringent…. When (the issue being) discussed (requires the violation of) halakhot kalot (minor infractions), it is easier for me to rule permissively…but I am very, very stringent regarding the prohibition of uvdin d’ḥol. And in my opinion, this is a Torah prohibition, not some rabbinic custom….Therefore…on Shabbat…it depends on the individual’s disposition…If (the disposition) is (one of) depression… (which is) hard to bear, but is not a deep, clinical depression…I would not permit music on Shabbat.

Cherlow’s remarks are both consonant with, and depart from, other rabbinic perspectives. For example, his understanding of uvdin d’ḥol as a Torah (and not a rabbinic) prohibition is not shared by most legal authorities. At the same time, he echoes Schiff’s abovementioned remark that depression exists on a spectrum, and that halakhic treatment depends upon severity and symptoms.

In an interview, Cherlow informed the author that several years ago he was asked to provide a ruling for a boy struggling with serious clinical depression. The child had adopted an Orthodox theology and lifestyle despite residing in a thoroughly secular neighborhood. He lacked local friends. As a result, Shabbat was especially lonely and difficult to endure. A psychologist aware of the child’s situation claimed he was in danger, and asked Cherlow whether the boy was permitted to use a computer to communicate with friends on Shabbat. Cherlow responded affirmatively, out of a concern for the child’s life. In conclusion, uvdin

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140 Yuval Cherlow in discussion with the author, August 2018. Translated from Hebrew by the author.
141 Examples of halakhot kalot in Cherlow’s opinion include listening to music during Sfrat HaOmer and the three weeks before the Ninth of Av, two annual periods of mourning that carry enhanced restrictions regarding the creation and consumption of music. (Yuval Cherlow in discussion with the author, August 2018. Translated from Hebrew by the author.)
142 Yuval Cherlow in discussion with the author, August 2018. Translated from Hebrew by the author.
143 Presumably, suicidal.
144 Yuval Cherlow in discussion with the author, August 2018. Translated from Hebrew by the author.
d’ḥol interacts with depression in variegated ways, but, because of significant disputes regarding its applicability to specific treatments and status as a rabbinic or Torah prohibition, the circumstances under which uvdin d’ḥol may be waived for the sake of treatment is unclear. In other words, there seems to exist both a disagreement of principles and a disagreement in application of principles. Expectedly, however, when the condition presents a threat to life, all relevant prohibitions become permitted.

Refuah (Medication/Healing)

Grinding substances is Biblically prohibited on Shabbat. Out of a concern that individuals will grind medication (a common practice in Talmudic times), the Sages banned Jews from consuming medication on Shabbat and holidays under certain circumstances. Medication here is defined very broadly; the proscription comprises both typical remedies like pills and creams, as well as activities that generally enhance physical wellness, like exercise and vigorous massage. However, exercise is an effective tool in managing clinical depression and a staple in the contemporary practitioner’s arsenal of management techniques for depressive disorders. This tension is the subject of a very brief SMS exchange between Rabbi Shlomo Aviner (b. 1943, Bet El, Israel) and an anonymous individual concerned about the permissibility of “exercise on Shabbat (sic.) if it saves me from depression and lying in bed the entire day…”

145 Mishna Shabbat 7:2; Shulkhan Arukh OḤ 321.
146 B.T. Shabbat 53b; Shulkhan Arukh OḤ 328:1-49.
147 Smearing creams may violate additional Shabbat restrictions, cf. Mishna Shabbat 7:2; Shulkhan Arukh OḤ 316:11 and commentaries.
Aviner responded with just one word, “certainly.” While it is prudent that we include this interaction, the conversation’s brevity makes it difficult to understand the logic behind his ruling; as a result, we must withhold a legal analysis.

**Being Joyous**

There exists a unique commandment to be joyous on Jewish holidays. This Biblical law presents obvious challenges to depressed persons whose illness definitionally engenders sadness. Rabbi Yitzḥak Zilberstein (b. 1934; Bene Break, Israel), in an undated responsum to an anonymous individual, was asked whether one who suffers from depression possesses a legal obligation to consume antidepressants on religious holidays in fulfillment of the requirement of joy. Zilberstein delves into a lengthy discussion of the purpose behind the commandment, ultimately concluding that “according to all opinions, one should take the medication in order to fulfill the commandment of holiday joy…” It is worth pointing out that all the responsa examined prior involve exempting certain individuals from normative practices or permitting typically prohibited activities; Zilberstein’s responsum is unique because it argues that depression also bears the capacity to incur *positive legal obligations* specific to the depressed individual.

**General Principles**

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Some aspects of the halakhic relationship between depression and Shabbat are more general and therefore do not fit within the abovementioned categories. For example, Rabbi Re’em HaKohen (b. 1957), Rabbi of the Israeli settlement Otniel and author of the multi-volume set of responsa titled *Badei HaAron* (2013), discusses extensively the permissibility of violating Shabbat to settle the mind (*yishuv hadaat*)\(^{154}\) of an individual with mental illness. A full accounting of HaKohen’s responsum lies beyond the scope of this chapter, but his conclusion is highly relevant:

> It is worth pointing out, that (in our exploration) of this entire topic, we have not found permission to (violate the Sabbath) to facilitate *yishuv hadaat* for its’ own sake, rather, (one may only violate *Shabbat*) for a sick individual in danger of dying (*ḥoleh she’yesh bo sakana*) whose mental state renders them liable to physical danger.\(^{155}\)

According to HaKohen, one may not violate *Shabbat* to calm an individual with depression unless the depression is life-threatening.\(^{156}\) However, Rabbi Shlomo Riskin (b. 1940), the Chief Rabbi of Efrat, Israel, seems to disagree:

> “Depression is one of the most serious illnesses…and *safek*\(^{157}\) *pikuaḥ nefesh* is a very big deal. In other words, people don’t begin terribly depressed, but if they are mildly depressed and (it) continues, it becomes severe depression.”\(^{158}\)

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\(^{154}\) “*Yishuv hadaat*” (Heb. יישוע ה אתה) is a common term in halakhic literature that refers to restoring calm and serenity to an individual in distress. Its legal origin is probably B.T. Shabbat 128b, where the Talmud uses the Aramaic version of the term to explain why extinguishing a candle on *Shabbat* for the sake of a blind birthing woman is permissible.


\(^{156}\) Importantly, see the responsum of Rabbi Moshe Feinstein (Igrot Moshe- vol. 5 [YD 2, OH 3, EH 3] [New York: Moriah Offset Company, 1973], OH 18), in which he discusses the permissibility of violating *Shabbat* to prevent one from going insane. Due to space constraints, because the illness in question there is significantly different than depression, and because Feinstein deals with prevention (and not the treatment of an existing malady), we have not included it in our examination; however, prominent rabbinic decisors have indeed discussed it in their analyses of questions about other mental disorders. (See Naḥum Rabinovich, *Siah Naḥum* [Jerusalem: Ma’aliyot, 2008], OḤ no. 22 [p. 61] and the responsum of HaKohen, quoted supra, note 155).

\(^{157}\) See Glossary.

\(^{158}\) Based on a contradiction between B.T. Yoma 84b and B.T. Yevamot 12b, Rabbi Yaakov Etlinger (*Binyan Tzion* (Altona: Gebrüder Bonn, 5628 [1867/1868]), no. 137) writes that one may not violate commandments to save an individual’s life if the element of danger does not yet exist, but may very well exist in the future. For example, one would be permitted to board a ship when the weather forecasts potential for dangerous, stormy seas, provided the sea has not yet become dangerous. (This is the example given by Rabbi Yitzhak Zilberstein in his work *Shiurei Torah la Rofim* (Hemed, 5772 [2011/2012]), no. 230.) On the basis of this point, one may be tempted to argue that, provided one has not yet entered the dangerous territory of a serious, life-threatening depressive disorder, no prohibitions should be violated. However, Rabbi Moshe Feinstein was asked about the permissibility of violating...
Certainly, certainly *pasken* (rule) that as far as a *mitzvat aseh* (positive commandment) is concerned, without a question its (depression is) *mevatel* (nullifies) a *mitzvat aseh*… It’s very much life-disruptive, and it’s important to get out of it as quickly as you can get out of it… There’s a general principle in halakha… (held by) many *poskim* (decisors)… that if you’re in a hospital, it’s always considered *pikuah nefesh*. Whatever the issue is, if you’re in a hospital it’s always considered *pikuah nefesh*, even against the *lo taaseh* (negative commandment[s]) of Shabbos. And I think if you were in a syndrome of depression, the same thing applies.¹⁵⁹

According to Riskin, because even mild (and therefore non-life-threatening) depression runs the risk of devolving into something more serious, one may unhesitatingly neglect the fulfillment of a positive commandment if it is necessary for the mildly depressed individual’s betterment. Riskin appears more reticent to permit the active violation of a negative commandment, but then suggests that the Torah-ordained Shabbat prohibitions may be waived in such a case as well.

In conclusion, several important trends must be noted. First, rabbinic decisors have been summoned to adjudicate variegated and diverse cases in which *Shabbat* observance poses a challenge to the treatment of depressive disorders. Second, rabbis appear to disagree about the prognosis of depressive disorders, which results in disparate positions regarding the classification of depression on the aforementioned severity spectrum, as well as the circumstances under which depression warrants the suspension or alteration of normative Shabbat laws. These barriers exist

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¹⁵⁹ Shlomo Riskin in discussion with the author, August 2018.

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prohibitions to prevent an existing but non-dangerous medical condition from deteriorating into a dangerous medical condition. He writes: “Because the current illness causes a life-threatening illness, there is good reason to consider this (first) illness dangerous, too, even if it is known that the patient’s original condition will not worsen, and there is no threat to life in the current illness, for if the patient is not healed from the first illness, it is possible that they will contract the second, dangerous one. Behold- in such a case, the first illness is considered a danger to the sick individual… *(Igrot Moshe*- vol. 5 [*YD* 2, *OH* 3, *EH* 3] [New York: Moriah Offset Company, 1973], *OH* 3:91). It seems to Riskin that same case can be made for mild depression (i.e., that in some cases it is reasonable to consider mild depression a gateway towards serious depression, and that, as a result of this connection, even mild depression warrants the abrogation of halakha in certain instances). We should nevertheless note that some research demonstrates mild depression often resolves without treatment (G. E. Simon and M. VonKorff, “Recognition, Management, and Outcomes of Depression in Primary Care,” *Archives of Family Medicine*, vol. 4, no. 2 (1995): 99–105). However, more recent findings have suggested that untreated mild depression is indeed a liability (Myrna M. Weissman et al., “Positive Screens for Psychiatric Disorders in Primary Care: A Long-Term Follow-up of Patients Who Were Not in Treatment,” *Psychiatric Services*, vol. 61, no. 2 (2010): 151–59; Robert Preidt, “Untreated, Mild May Become Major Depression,” HealthDay, Feb 4, 2010, https://consumer.healthday.com/mental-health-information-25/depression-news-176/untreated-mild-may-become-major-depression-635574.html).
in addition to disputes regarding the nature of specific prohibitions (such as *uvdin d’hol*) that can further complicate treatment. Perhaps most importantly, this chapter suggests that programming for rabbis about the nature and course of depression be implemented to ensure that all rabbis harbor scientifically accurate understandings of depressive disorders.  

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Depression and Abortion

Depressive disorders are more common in females than males, though female-specific disorder rates may vary across intra-Orthodox Jewish communities. The former reality has generated a substantial amount of causal research, though a comprehensive explanation remains elusive. One paper suggests that hormones related to the menstrual cycle predispose women towards depressive episodes, but this connection has not been sufficiently articulated or studied. In any case, the fact that some depressive disorders (such as postpartum depression and premenstrual dysphoric disorder) apply predominantly or exclusively to women, compounded by the fact that menstruation is “halakhically” complex, justifies the relatively high volume of responsa pertaining to women-specific issue areas when depression is a factor. Increased attention to questions of women and halakha is perhaps another influencer. These next two chapters deal heavily with women-specific legal issue areas of depression. We turn first to the topic of abortion, which includes perhaps the largest body of relevant responsa.

The relationship between abortion and halakha enjoys a rich history in Jewish legal literature; however, the concept of deliberate abortion is scarcely mentioned in the Pentateuch and Babylonian Talmud. Perhaps because of this paucity, there exists a variety of positions regarding the permissibility of abortion, ranging from unqualified permission to severely

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165 According to some rabbinic understandings of Tosafot, there exists no prohibition of abortion at all (See, for example, Tzvi Hirsh Hayes, *Maharatz Hayes- Masekhet Nidda* [Acc. Bar Ilan Responsa Project, https://www.responsa.co.il/default.aspx], 46b [publishing information not provided]).
restricted homicide. The majority of decisors advance stringent prohibitive positions, so abortion has effectively become forbidden according to normative Orthodox Jewish law, barring extenuating circumstances. However, this qualification is incredibly consequential, because the decision to abort is often driven by extenuating factors. Three variables are particularly impactful in determining the religious permissibility of a given abortion: the age of the fetus, its condition, and the impact of pregnancy or birth on the mother’s health. Generally, abortions are more legally justifiable in the early stages of prenatal development, or when uninterrupted fetal development, birth, or child-rearing poses a significant health risk to the mother. This latter principle forms the basis for responsa when depression is involved.

For our purposes, relevant literature should be divided into two categories: those discussing the legal parameters of abortion in the face of depression, and those about abortion in the face of other mental illnesses or mental illness in general. However, two confounds problematize our analysis. First, ambiguous phraseology or incomplete case descriptions sometimes make it challenging to determine whether a given responsa belongs in this or that category; in other words, it is not always clear whether the illness in question is a depressive disorder. Second, responsa about abortion are typically highly specific to the case, and psychological distress is often one among several factors that influence the ultimate rabbinic decision. It can therefore be difficult to determine the isolated clout of mental anguish; as a

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result, the generalizability of some responsa to other cases of psychological distress is potentially quite limited.\textsuperscript{169} Both because the specific mental illness in question is not always discernable from a given responsum’s description, and because limited generalizability demands that we explore more responsa for a fuller picture, we include below both depression-specific responsa and those relating to mental illness in general.

Perhaps the first rabbi to write about the relationship between abortion and the mother’s mental health was Rabbi Mordekhai Winkler (1845-1932) of Madd, Hungary.\textsuperscript{170} In an undated responsum, he permitted an abortion in which parturition generated serious risk of teruf hadaat\textsuperscript{171} for the mother, on the basis that psychological insanity is indeed legally considered life-threatening.\textsuperscript{172} Several decades later, in 1975, Rabbi Eliezer Waldenberg (1915-2006), a prominent legal decisor from Jerusalem frequently consulted in questions of Jewish medical ethics and more commonly referred to by the title of his magnum opus Tzitz Eliezer, explored the permissibility of aborting a fetus with Tay-Sachs disease.\textsuperscript{173} 174 Based on antecedent rulings by Rabbis Yosef Trani (1538-1639) and Yaakov Emden (1697-1776), Waldenberg departs from Winkler’s position by suggesting that even non-life-threatening distress may legitimate abortion

\textsuperscript{169} This point is also noted by Rabbis Moshe Sternbukh, Teshuvot v’Hanhagot- vol. 1 (Jerusalem: 5752 [1991/1992]), no. 880, and Eliyahu Schlessinger, Shoalin v’Dorshin- vol. 3 (Jerusalem: 1997), no. 58.
\textsuperscript{171} “Teruf hadaat” is a Hebrew phrase typically employed to refer to general psychological insanity or craziness. It is, however, not completely clear what specific mental disorder Winkler was referring to with this term.
\textsuperscript{172} Mordekhai Leib Winkler, Levushei Mordekhai (Mahadura Hadasha)- EH, HM (Brooklyn: 5771 [2010/2011]), HM no. 39.
\textsuperscript{173} Tay-Sachs is a genetic disease in which nerve cells involved in locomotion are destroyed. It is common among Ashkenazi Jews, hence its extensive mention in Jewish literature.
under certain circumstances. In another, later responsum, he argues that psychological anguish is a legitimate form of duress:

Is there a greater case of pain and suffering than what will be caused to the mother in giving birth to this child, which everyone says will suffer and surely die within a few years? ... It makes no difference whether the suffering is physical or psychological-emotional, because in many instances psycho-emotional suffering is greater than physical suffering...

Waldenberg expresses similar (albeit more hesitant) sentiments elsewhere. It is also important to note that his position in the above case about Tay-Sachs disease was openly criticized by Rabbi Moshe Feinstein. An intermediate approach was advanced by Rabbi Moshe Tendler (b. 1926, New York), a prominent Jewish medical ethicist and decisor, in a 1989 interview. He sanctioned theoretical abortion a) during any stage of gestation, if the mother is at risk of suicide because of her pregnancy, or b) within the first forty days of gestation, if the situation renders the mother at risk for non-suicidal but serious depression and the mother possesses a history of depression. The strictest approach is quoted in the analysis of (but not necessarily adopted by) Rabbi Avraham Steinberg (b. 1947), a prominent religious medical ethicist and author of the three-volume Encyclopedia of Jewish Medical Ethics. Steinberg seems to posit that, according

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176 Eliezer Waldenberg, Tzitz Eliezer- vol. 13 (Jerusalem: 5745 [1984/1985]), no. 102:1. Translated by Alan Jotkowitz in the following citation, with the author’s own minor alterations. The juxtaposition of this source and the previous one in the we have done it here copies Jotkowitz’s own presentation of the sources (see Jotkowitz. 99).
178 Rabbi Moshe Feinstein wrote: “I was shocked when I saw the responsum of a certain sage [R. Waldenberg] in Israel who permitted abortions in fetuses greater than three months who according to the tests of doctors had Tay-Sachs disease ... and one should not err and rely on the responsum of this sage (Moshe Feinstein, Igrot Moshe-vol. 7 [EH 4, HM 2] [Brooklyn: Moriah Offset Co, 1985], HM 69:3. This translation and parenthetical reference to Rabbi Waldenberg are copied from Jotkowitz, 98.
179 Such situations may occur when the fetus is the result of an illegitimate sexual relationship (between two independently married spouses, for example), which can generate awful shame, or when the fetus is diagnosed with serious life-limiting defects that cause the mother significant distress.
180 This is perhaps implicit, not explicit. The reader is encouraged to review the text of the interview cited below to draw their own conclusions.
to Rabbi Yitzḥak Shor (b. unknown; author of Resp. *Koah Shor*), aborting in the face of mental health challenges is prohibited *even* when the mental distress presents a threat to the mother’s life. ¹⁸² (One must note that Steinberg is merely providing sources and this perspective does not necessarily represent his own position.)

A practical ramification of the above debate is found in the writings of Rabbi Moshe Sternbukh (b. 1928), a highly-regarded legal decisor and *Haredi* community leader in Jerusalem (originally from South Africa). He was asked by an ultra-Orthodox physician about the halakhic feasibility of performing an abortion for a pregnant woman who threatened to commit, and had attempted, suicide because she felt ashamed of the circumstances surrounding her pregnancy. ¹⁸³ The patient was also professionally diagnosed with a genuine, albeit undisclosed, mental illness. Sternbukh writes the physician informed him that threatening suicide is a relatively common technique utilized to obtain abortions and typically goes unfulfilled. However, because this patient had actually attempted a lethal overdose, he was inclined to take her warning seriously. Sternbukh begins by highlighting the possible prohibitions involved in aborting, and notes the aforementioned principle permitting abortion when the fetus poses a risk to the mother’s life. He then argues that in this case the patient herself, and not the fetus, generates the life-threatening danger, but contends that even when the fetus is not the *cause* of danger but feticide will save the mother, many rabbinic authorities nevertheless rule permissively. As a result, permissibility depends upon the extent to which the patient is genuinely suicidal. Sternbukh concludes:

> Everything depends upon her mental state...If, according to the physicians, refraining from abortion renders it very likely that she will remain mentally ill, it is proper to permit the abortion out of concern for [the patient’s] life. However, it is


impossible to utilize this case to establish a general principle; rather in every instance one should leave the decision to a qualified rabbi… 184

Sternbukh’s writing here places him in the abovementioned category of decisors who permit abortion only in case of threat to the mother’s life. As an aside, the anonymous physician’s sociological observation that many (presumably Haredi) patients threaten suicide to obtain abortion is remarkable.

A similar situation is discussed in the responsa of Rabbi Eliyahu Schlessinger (b. unknown), a Rosh Yeshiva185 in Jerusalem, as well as a haver186 of the official Jerusalem Rabbinical court. Schlessinger was approached in-person by a pregnant woman wishing to abort a mamzer,187 who informed him that she was significantly depressed because of the circumstances surrounding her predicament, and that if she was denied a heter188 to abort in a safe and professional environment, she would abandon the halakhic system and pursue abortion through potentially dangerous methods and without religious regard.189 Schlessinger explicitly mentions a desire to permit the abortion ab initio.190 His undated response is extensive and detailed, and centers on two key issues: Whether a mamzer fetus warrants different treatment than a non-mamzer fetus, and whether the woman possesses a valid, life-threatened status that would legitimate abortion. According to Schlessinger’s analysis, an individual who deliberately places themselves in danger (i.e., by doing something harmful) does not merit the abrogation of Jewish law to preserve life; however, if the individual is seriously psychologically unwell, they

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184 Sternbukh, 1:880.
185 See Glossary.
186 See Glossary.
187 A mamzer is a child conceived out of certain prohibited sexual relationships. Such an individual is prohibited from marrying most Jews.
188 See Glossary.
189 Eliyahu Schlessinger, Shoalin v’Dorshin- vol. 3 (Jerusalem: 1997), no. 58.
190 Eliyahu Schlessinger, Shoalin v’Dorshin- vol. 3 (Jerusalem: 1997), no. 58 (p. 389).
may be legally considered “onuss (coerced)”\textsuperscript{191} and indeed warrant the aforementioned. Perhaps most interestingly, Schlessinger writes: “It might be worth adding…that she was in a state of depression according to her claim (and had received treatment for this in the past)\textsuperscript{192}, and this is how she acquires the status of a shotah.”\textsuperscript{193} Based on his wording, one may reasonably argue that the woman’s clinical history of depression somehow impacts Schlessinger’s understanding of this her disposition and consequent status in Jewish law. In any case, he ultimately concludes:

“It appears in my humble opinion that despite the existence of a concrete prohibition involved in feticide, and even a mamzer fetus appears to be clearly included in the prohibition of feticide according to the writings of (most) aḥaronim,\textsuperscript{194} which is (a) simple and clear (prohibition), at any rate in our case it appears in my humble opinion that one may rely on those decisors that are lenient regarding (the abortion of) a mamzer fetus, specifically when there exists danger that the mother will jeopardize herself. And even though currently there is no life-threatening situation…we have already proven that also in our case [the woman possesses] the status of onuss, specifically when she is in a hysterical and –according to her claim—depressed state, and has decisively decided to undergo an abortion herself if she is not granted permission to do so through medical means, in which case she would definitely endanger herself. Because of this, it appeared in my humble opinion proper to permit the abortion here, and [may] G-d, His name should be blessed, rescue us from error.\textsuperscript{195}

A third and final manifestation of the aforementioned debate is found in the writings of Rabbi Pinhas Toledano (b. unknown), the Chief Rabbi of Amsterdam and author of three volumes of responsa titled Berit Shalom. He was posed the following question by Rabbi Shmuel Riccardo De Signi, the current Chief Rabbi of Rome:

A married woman was raped by a non-Jew and conceived, and now, out of great depression, she wants to abort the fetus. The physician says that [because of her] great aggravation and depressed spirit, she is not capable of caring for the fetus. Moreover…a family blemish (also exists).\textsuperscript{196} And now she is engrossed in the question, that in order to forget all of this, she wishes to have an abortion. May she be permitted this, or not?\textsuperscript{197}

\textsuperscript{191} See Glossary.
\textsuperscript{192} Emphasis ours.
\textsuperscript{193} Eliyahu Schlessinger, Shoalin v’Dorshin (Jerusalem: 1997), 3:58. (Shotah is the feminine conjugation of shoteh.)
\textsuperscript{194} Aḥaronim (sing. aḥaron) is a blanket term used to refer to all rabbinic decisors from roughly the late sixteenth century through today.
\textsuperscript{195} Eliyahu Schlessinger, Shoalin v’Dorshin (Jerusalem: 1997), 3:58.
\textsuperscript{196} Because the child was conceived via rape.
\textsuperscript{197} Pinhas Toledano, Berit Shalom- vol. 2 (Jerusalem: 5766 [2005/2006]), HM no. 17.
Toledano divides his undated responsum into eight subsections; for brevity, we will concentrate only on those elements directly relevant to our topic. First, he argues that a fetus is categorically different than a born human; as a result, it possesses differential status as a living being and abortion is permitted if it is genuinely needed by the mother.\textsuperscript{198} Toledano continues:

\begin{quote}
Therefore...where the mother is depressed to the extent that she lacks sanity, abortion is considered healing the mother...and if you would assert that (abortion is only permitted when the fetus threatens the life of the mother) ...there is reason to say that such would apply in our case, where there exists depression and the physician testifies that her depression renders her liable to psychological danger. Moreover, any psychological danger is liable to bring one to physical danger, for such an individual is not capable of guarding themselves... If we do not permit her to undergo an abortion (she will be in a melancholic state), and the depression is liable to bring her to danger...\textsuperscript{199}
\end{quote}

Toledano is statistically correct in noting that psychological danger begets physical danger;\textsuperscript{200} however, he discusses a case of serious depression, in which it is relatively easy to understand the imminence of suicide or self-harm. Many instances of mental illness in general and depressive disorders in particular are less life-threatening; as a result, the extent to which we may extrapolate on the basis of Toledano’s assertion is unclear.\textsuperscript{201}

Several conclusions emerge from our discussion. To the extent that the abovementioned responsa are representative, halakhic questions arising from the interplay between abortion and psychological health in general and depression in particular are somewhat common. The answers, however, are highly tailored to the specific case and subject to significant disputes regarding both the nature of the prohibition of abortion and the extent to which psychological wellness is a legitimating factor. Regarding the latter, we have identified three main positions:

\textsuperscript{198} The implication at this point in the responsa is that it would also be permitted even when no threat to life exists.
\textsuperscript{199} Pinhas Toledano, \textit{Berit Shalom}– vol. 2 (Jerusalem: 5766 [2005/2006]), HM no. 17.
\textsuperscript{200} According to the 2015 Centers for Disease Control and Prevention (CDC) Data & Statistics Fatal Injury Report, quoted by The American Foundation for Suicide Prevention (AFSP) at https://afsp.donordrive.com/index.cfm?fuseaction=ems.page&id=1226&eventID=5545 (acc. November 11, 2018), over 50% of suicides were committed by individuals who suffered from major depressive disorder.
\textsuperscript{201} See the remark of Rabbi Shlomo Riskin, \textit{supra} p. 35 as well as note 158.
permission only when the mental anguish poses a danger to the mother’s life,\textsuperscript{202} permission in the face of serious emotional distress \textit{even when} the abortion does not pose a danger to the mother’s life,\textsuperscript{203} and ostensible \textit{proscription} regardless of whether the psychological suffering threatens the mother’s life.\textsuperscript{204} The most common position is the first one,\textsuperscript{205} but its advocates fall short of representing a genuine consensus. Therefore, the general implication of our analysis is that sometimes serious prohibitions may be abrogated or suspended to facilitate the betterment of depressed individuals, though whether this applies outside the margins of a life-threatening situation is a matter of dispute. Finally, it is worth noting that these responsa are innovative in that they apply old and well-used principles (such as aborting in the face of maternal danger) to relatively nascent issue areas (such as depression in its contemporary understanding). As an aside, we should acknowledge that threats of suicide or self-harm appear unnervingly common among women in certain communities, though this sociological observation has little bearing on our discussion.

\begin{footnotesize}
\textsuperscript{202} Mordekhai Leib Winkler, \textit{Levushei Mordekhai (Mahadura Ḥadasha)- EH, ḤM} (Brooklyn: 5771 [2010/2011]), ḤM no. 39; Moshe Sternbukh, \textit{Teshuvot v’Hanhagot- vol. 1} (Jerusalem: 5752 [1991/1992]), no. 880. Importantly, Rabbi Shmuel Wosner, \textit{Shevet HaLevi}- vol. 7 [Bne Brak: 5762 (2001/2002)], no. 208 forbade an abortion when the mother harbored adverse psychological symptomology because he believed in that specific case, there was no legitimate concern of danger. However, Wosner does imply that if there were, an abortion might then be permitted. Also, see the position and subsequent analysis of the position of Rabbi Isser Yehuda Unterman, the former Chief Rabbi of Israel, in Moshe HaLevi Spero, “Psychiatric Hazard in the Disposition Towards Birth Control and Abortion: The Role of the Case Worker,” \textit{Journal of Jewish Communal Service} 53 (1976): 158.


\textsuperscript{204} Rabbi Dr. Avraham Steinberg’s understanding of Rabbi Yitzḥak Shor, \textit{Koah Shor} (Kolomyya: 5684 [1887/1888]), no. 20, quoted in Avraham Steinberg, \textit{Encyclopedia of Jewish Medical Ethics- vol. 1} trans. Fred Rosner (Jerusalem: Feldheim, 2003), p. 10. Again, this is not necessarily the opinion of Rabbi Steinberg; rather, it is merely his understanding of the position of an antecedent decisor.

\textsuperscript{205} Cf. Wosner, (vol. 7), no. 208.
\end{footnotesize}
Depression & Contraception

Depression and birth control possess a complicated relationship. There exists very limited and heavily disputed evidence that the use of common contraceptives correlates with depression; however, pregnancy prevention may be necessary when the presence of a depressive disorder in one member of a sexually active relationship renders that individual unfit or unready to bear or raise children. The latter reality can be especially difficult to navigate for partners who believe they are religiously obligated to produce children, and for whom the use of contraceptives is often proscribed by Jewish law. This chapter analyzes responsa about the interplay between depression and contraception in an attempt to ascertain and understand rabbinic perspectives on this complex issue area.

Prerequisite to any meaningful discussion is a brief overview of the Jewish laws surrounding use of contraceptives generally, which we provide now by drawing heavily upon Fred Rosner’s article “Contraception in Jewish Law” and Rabbi David Feldman’s seminal book, Birth Control in Jewish Law. It is basically prohibited to employ contraceptive

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206 Abortion is discussed in the former chapter, “Depression and Abortion.”
methods. The interdiction is essentially present in the Talmud, and derives from several key verses in Genesis discussing the commandment to procreate, among other passages. Therefore, contraception may be understood as the failure to fulfill a Biblical injunction. Importantly, the mitzva of procreation devolves upon men, but it should be acknowledged that women obviously play a fundamental role in its fulfillment. When the contraceptive method involves impeding or preventing the expulsion and flow of semen (such as coitus interruptus, a condom, or even abstinence), the prohibition to waste sperm also applies. (In any case, the wife’s conjugal rights render male abstinence generally impermissible.) Under duress, or sometimes for the sake of family planning, specific forms of contraception may be admissible or even required. In such cases, “a hierarchy of acceptability” determines which method of birth control should be employed, dependent upon the circumstance compelling contraception and the gravity of differential prohibitions that apply to various forms of birth control. Generally, oral contraceptives are the most preferred from a Jewish legal standpoint.

Only a relatively limited number of responsa discuss questions of Jewish law and pregnancy prevention with regards to depression in particular. However, the responsa of Rabbi Moshe Feinstein (1895-1986), a highly influential and prolific American decisor, are perhaps an exception; from 1960 to 1980, Feinstein published five treatises dealing with contraception and mental illness. In most of them, anxiety or depression is the operative mental disorder. Because

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211 See B.T. Yevamot 12b, as well as the statements of Rabbi Eliezer, Rabbi Ya’akov, ben Azzai and Abba Ḥanan in the name of Rabbi Eliezer, in B.T. Yevamot 63b-64a. It should be noted, however, that these latter remarks (in B.T. Yevamot 63b-64a) seem to refer to refraining from procreation and not necessarily delaying it.
212 Mishna Yevamot 6:6.
213 See Feldman’s book (cited above) and Hiddushe HaRan to Kiddushin 41a, both quoted in Rosner, 95.
214 Abstinence is seen as a “double-destruction” of seed: “Not only is the seed prevented from fulfilling its function of procreation, but it also fails to fulfill the commandment of onah, one of the wife’s conjugal rights (Rosner, 97).”
215 See Rosner, 97.
216 Rosner, 102.
217 Ibid.
anxiety is often comorbid with depression, because there exists a paucity of responsa focused exclusively on depressive disorders qua (non-abortive) contraception, and because Feinstein’s rulings in cases of anxiety are probably generalizable to those of depression, we will explore his responsa on anxiety as well. Feinstein’s first relevant responsum (from 1960), discusses contraception for a woman with suicidal ideation stemming from an unclear (or at least undisclosed) mental illness. Her suicidal tendencies may be taken as inconclusive evidence for the presence of a genuine depressive disorder. Feinstein writes:

Regarding the woman who has a neurological disorder...and is very afraid of conceiving, there is reason to permit her to refrain from conception, because she possesses serious neurosis; (for example), she once mentioned that she does not wish to live and even (wishes) to commit suicide. Therefore, this (case is) clearly one involving a threat of danger, and there is reason to permit her to use even an absorbent (mokh) for a period of time, until her condition improves. The heart knows the bitterness of her spirit, but because drugs…also work…there is no need for an absorbent, and she should be permitted to use (contraceptive) drugs for two years.

In summary, Feinstein argues that her suicidal condition essentially renders all necessary preventive methods permissible, but when a variety of contraceptive mediums fulfill the need, she should pursue oral contraceptives, the least halakhically problematic alternative. Feinstein applies his ruling for two years, after which the situation must presumably be reappraised. His leniency is clearly motivated by danger to life, though it is worth acknowledging that the specific disorder generating the suicidal circumstance behind his decision is unclear.

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218 The language Feinstein uses here is [mahalat atzavim (nerven)].” Mahalat atzavim is a Hebrew phrase that literally means a sickness of nerves, but which more accurately translates as “neurosis.” Nerven is a Yiddish word, translated with a slight variation in spelling as “nervous, neurological” in S. Beinfeld, Harry Bochner, Isidoro Niborski, Bernard Vaisbrot, & Simon Neuberg, Arumnmik Yidish-English Verterbukh (United States: Indiana University Press, 2013), Verterbukh.org. We have translated Feinstein’s phraseology here as “neurological disorder.”

219 Rosner (p. 100) translates mokh as an absorbent.

220 See Proverbs 14:10.

221 Moshe Feinstein, Igrot Moshe-vol. 7 [EH 4, ḤM 2] [Brooklyn: Moriah Offset Co, 1985], EH 4:74.
Feinstein’s second responsum (from 1961) discusses whether a woman who developed postpartum psychosis following the births of her two children and whose physicians forbade her from conceiving a third time was permitted to use an absorbent during sexual intercourse:

Of course… insanity is a danger not only to herself but also to her small children, for even though one whose insanity does not currently impel them to do evil (is technically not dangerous in the here and now), it is possible (for the illness) to invert and the individual will desire to do evil to herself and her children. Therefore, she should be permitted to utilize an absorbent…

Feinstein’s analysis is shrewd and scientifically-backed; indeed, medically speaking, postpartum psychosis is ordinarily treated as an emergency because severe psychotic symptoms that endanger mother and child can develop precipitously. It is important to point out that Feinstein describes the subject of his question with the term, “shtut (שטות),” often translated (with adjustment for context) as “insanity,” and notes that the individual had received electroconvulsive therapy (ECT) for a previous episode. In a 2011 article, Rabbi Barukh Finkelstein and Michal Finkelstein argue that this woman’s history of ECT compelled Feinstein to employ the term “insanity” rather than depression. It is important to clarify, however, that “insanity” is not necessarily a more “extreme” version of depression. While depressive disorders can manifest with psychotic features, postpartum psychosis can present as a

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222 The specific disorder in question at this point in the responsum is unclear; Feinstein uses the term נשתטה, which generally means, “she went crazy.” However, the general thrust of the responsum strongly suggests the presence of postpartum psychosis. In truth, there is no clinical condition in the DSM-5 called “postpartum psychosis;” instead, psychotic episodes triggered by parturition are formally diagnosed as a “brief psychotic disorder with peripartum onset.” For a fuller definition of what constitutes such a condition, see American Psychiatric Association, “Brief Psychotic Disorder,” Psychiatry Online, https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.dsm020#CIHDFIHA. Nevertheless, we use the term postpartum psychosis to maintain consistency with the literature discussed in this chapter.

223 Emphasis ours.


226 A prominent Rabbi and the author of several publications on Jewish law, pregnancy and fertility.

227 A survivor of postpartum depressive disorder and an advocate.

distinct and independent psychological condition (without depressive qualities).\textsuperscript{229} Comparative suicide and filicide rates for postpartum psychosis and postpartum depression are difficult to assess,\textsuperscript{230} but given Feinstein’s first responsum, it is reasonable to contend that his permission here extends to depressive disorders. Feinstein expresses generally similar sentiments in three additional responsa from 1966,\textsuperscript{231} 1972,\textsuperscript{232} and 1978.\textsuperscript{233} In all cases, his leniencies derive from a concern for the life of the mother and/or children. As Finkelstein and Finkelstein note, Feinstein is prepared to permit contraceptives for any mental endangerment meeting that criteria.\textsuperscript{234}

In the aforementioned article, Finkelstein and Finkelstein differentiate between four intensities of postpartum depression and argue that different stages generate disparate legal exemptions. The first, “sadness associated with parturition,” refers to melancholy mood swings that typically resolve two to three weeks after childbirth but do not meet the criteria for formal postpartum depression.\textsuperscript{235} The second, “postpartum stress syndrome,” is characterized by a more pervasive depressed mood that may linger up to three months after parturition.\textsuperscript{236} The third is formal, official postpartum depression, and the fourth is postpartum psychosis.\textsuperscript{237} 238 It is important to point out that only the latter two disorders are formally recognized by the DSM-5.\textsuperscript{239}

\textsuperscript{229} This is implied by Ian Brockington in Ian Brockington, “Suicide and Filicide in Postpartum Psychosis,” \textit{Archives of Women’s Mental Health} 20, no. 1 (2017): 63–69.
\textsuperscript{230} Brockington (above, note 217) explicitly presents the filicide rate in individuals with postpartum psychosis, and the filicide rate for postpartum psychosis with depressive symptoms. V. Lindahl, J.L. Pearson, and L. Colpe note that suicides “account for up to 20% of postpartum deaths,” but do not state the overall suicide rate (V. Lindahl, J. L. Pearson, and L. Colpe, “Prevalence of Suicidality During Pregnancy and the Postpartum,” \textit{Archives of Women’s Mental Health} 8, no. 2 [2005]: 77–87).
\textsuperscript{232} Moshe Feinstein, \textit{Igrot Moshe-vol. 7 [EH 4, HM 2]} [Brooklyn: Moriah Offset Co, 1985], EH 4:72.
\textsuperscript{233} Moshe Feinstein, \textit{Igrot Moshe-vol. 7 [EH 4, HM 2]} [Brooklyn: Moriah Offset Co, 1985], EH 4:68.
\textsuperscript{234} This not explicit, rather, it implicitly emerges from the general thrust of Finkelstein and Finkelstein’s paper.
\textsuperscript{235} Finkelstein and Finkelstein, p. 112.
\textsuperscript{236} Ibid., 112.
\textsuperscript{237} See the descriptions provided by Finkelstein and Finkelstein in ibid., 112.
\textsuperscript{238} As noted before, this author does not agree that postpartum psychosis should always be seen as a more serious version of postpartum depression, because it can manifest without depressive symptoms (thus suggesting it may exist as an independent clinical entity).
\textsuperscript{239} Though neither postpartum psychosis nor postpartum depression is given this exact name in the DSM-5. See note 222.
Based on Feinstein’s responsa, Finkelstein and Finkelstein argue that postpartum depression and postpartum psychosis warrant the utilization of contraceptives, but sadness associated with parturition and postpartum stress syndrome do not unless they engender more serious conditions. They add that rabbinic permission is prerequisite to permit contraception in all four circumstances, but that rabbis should obviously rule leniently when there are potential suicidal and feticidal liabilities.240

The Golda Koschitzky Center for Yoatzot Halakha in Jerusalem, Israel241 operates a telephone hotline for women with halakhic questions pertaining to women’s health. The endeavor is driven by a desire “to meet the needs of women who seek a woman-to-woman address,” 242 243 and is therefore manned by women trained specifically in matters of family purity, sexuality, and related issues (titled Yoatzot Halakha, sing. Yoetzet Halakha).244 In addition, the organization responds to halakhic inquiries submitted via a form on their website, and maintains a public archive of previously answered questions. In one posting (from 2009), a thirty-three-year-old mother of two in psychological counseling and under medication,245 received a heter to employ contraception after an episode of postpartum depression snowballed into a long-term clinical depressive disorder. She contacted the organization for guidance after her husband expressed a desire for more children and her rabbi told her it was time to reassess the validity of the heter. She writes: “I honestly can’t think of having more (children) now.

240 Ibid., 116.
241 This is an organization that trains women to answer questions in women-specific areas of Jewish law. For more information, see “About Us,” Nishmat Women’s Health and Halacha, http://www.yoatzot.org/about-us/.
242 I.e., as opposed to consultation with a male rabbi.
244 Ibid.
245 Presumably, for depression.
Doesn’t halacha take these factors into account when making a decision? … We are stretched emotionally and I am exhausted.”

The answerer, an anonymous Yoetzet Halakha, first points out that the rabbi’s desire to reappraise the heter does not necessarily mean the asker will indeed be required to refrain from contraceptives. She then continues:

Halacha certainly does take emotional and psychological factors into consideration. We urge you to discuss these issues with your Rav and make it clear that your emotional and medical state are serious factors that necessitate continued use of birth control until your situation improves. It is important for you to personally discuss this with your Rav (and not have your husband speak to him for you) so he can fully understand the gravity of your concerns. We suggest that you also ask your physician or therapist to discuss your situation directly with your Rav and explain to him the medical need for you to continue using contraception.

To summarize, the Yoetzet advises consultation with the woman’s personal rabbi. Importantly, she also urges the subject to speak with the rabbi directly. This response implies that the Yoetzet personally believes that contraception is appropriate in this instance, but wants the ultimate decision to be made by the asker’s own halakhic authority.

A second posting (operating under the same framework of anonymity) deals with the utilization of oral contraceptives to treat premenstrual dysphoric disorder (PMDD). The asker writes that she was prescribed oral birth control to reduce depressive symptoms associated with the onset of her period. The intervention was largely effective, but the asker expresses concern

247 The author was informed of this by Ariella Gentin.
248 Hebrew for Rabbi.
250 Neither the asker nor the Yoetzet refer to the malady described in the question by this clinical term, but its presence is reasonably clear from the conversation. The DSM-5 describes PMDD as follows: “The essential features of premenstrual dysphoric disorder are the expression of mood lability, irritability, dysphoria, and anxiety symptoms that occur repeatedly during the premenstrual phase of the cycle and remit around the onset of menses or shortly thereafter. These symptoms may be accompanied by behavioral and physical symptoms (American Psychiatric Association, Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition. [Arlington, VA: American Psychiatric Association, 2013]), 172.
that her upcoming marriage will limit the extent to which she may avail herself of such medications: “Will I have to go off the birth control after my marriage? My hope is that I will go off the birth control when we want to conceive and then go back on it after each baby's birth, but now I'm worried it's not halachically acceptable.”

The Yoetzet writes:

Indeed, you need not go off contraceptive pills until you are trying to conceive. Since procreation is a mitzvah, there is a halachic question of the permissibility of delaying conception. Different rabbis give different rulings about contraception at the beginning of marriage. Rav Yehuda Henkin, our site's halachic supervisor, permits all couples to use contraception for six months after marriage. That permission may be extended for longer periods of time depending on each couple's unique situation. When you are ready to try to conceive, it will be important for you to consult your physician about alternate options for managing your pre-menstrual symptoms.

Several key elements of this response should be noted. First, the Yoetzet writes that according to Rabbi Yehuda Henkin, all couples are permitted to employ contraception for up to six months post-marriage. In certain situations, this time limit may be extended. Precise examples are lacking, but it is reasonable to assume that depression may warrant such a postponement. However, in our case, the depression is tied to the woman’s menses, and is therefore a recurring issue; as a result, while temporary time extensions may be legitimate, each allowance is a matter of “kicking the can down the road.” Therefore, the Yoetzet recommends exploring alternative treatments that do not preclude conception.

In conclusion, depressive disorders and birth control are intertwined on several levels. Contraception is prohibited by Jewish law, but may be permitted or required in extenuating circumstances.

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253 Rabbi Yehuda Henkin (b. 1945) is a prominent Orthodox decisor living in Israel.
254 Presumably, oral contraception.
255 The Yoetzet implies that the decision to conceive is ultimately inevitable, but does not state whether this stems from a religious obligation or the assumption that the couple in question will elect to pursue children sooner or later. Either way, this unknown is, for our purposes, mostly irrelevant.
circumstances. Generally, responsa are highly specialized to the particular case. Rabbi Moshe Feinstein engaged the topic extensively; in each circumstance, and across several types of puerperal afflictions, he views the sufferer as liable to suicide or feticide and therefore permits contraception. Nonetheless, when a lesser problematic form of contraception (such as oral medication) is available, Feinstein prioritizes it over other forms of birth control. Rabbi Barukh Finkelstein and Michal Finkelstein use the responsa of Rabbi Feinstein to argue for a four-tiered halakhic classification of postpartum afflictions. The first two categories are least serious and only legitimate contraception when they render the individual liable to more severe problems. The latter two sets are categorically life-threatening and warrant the utilization of contraceptives. The issue of depression and pregnancy prevention also receives attention from Yoatzot Halakha who are members of the Golda Koschitzky Center for Yoatzot Halacha. In one case, a clinically depressed woman who felt unready to conceive despite pressure from her husband and rabbi was told to engage in a direct conversation with the rabbi. In another, a Yoetzet responding to a woman who took oral birth control to alleviate depressive symptoms related to the onset of her menses, implied that limited post-marriage permission to utilize contraceptives may be extended in cases of depression.
Depression & Romantic Relationships

Depression and marriage are intricately interconnected. For observant partners who adhere to the detailed laws of family purity and/or the religious regulations surrounding who can marry whom, the coupled presence of Jewish law and a depressive disorder in one or both members can be overbearing and superbly challenging to navigate. This chapter explores how normative halakha accommodates the distinct requirements of a romantic relationship in which one or more partners suffers from a depressive disorder. With exception, our conversation is relevant to heterosexual partners formally married according to Jewish law. Some elements of discussion are also applicable to individuals in non-marital or homosexual romantic relationships. A discussion of contraception and abortion can be found in the previous two sub-chapters.

It is worth beginning this discussion by exploring religious legal sources that contribute to a general understanding of how individuals should relate to a depressed spouse from the perspective of Jewish law. In a 2011 article, Rabbi Barukh Finkelstein and Michal Finkelstein provide general guidelines for marriages in which one partner suffers from postpartum depression:

The husband is obligated to be especially attentive to his wife when she suffers from depression…It is prohibited for him to be critical, and upon him to be a source of encouragement. It is upon him to be ready for the task (at hand) also at the expense of his daily routine, (and) even (at the expense) of prayer with a quorum. For performing kindness for his wife at this time takes precedence over the beautified forms of other commandments… (So too) we have seen regarding Elkana who attempted to offer words of support to Hannah his wife when she was depressed because of her

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257 See supra, note 226
258 See supra, note 227.
259 That is, a quorum of ten adult Jewish males required for communal prayer, also called a minyan. A legal overview of this topic is provided on the following page and in its footnotes.
260 See note 263.
infertility... There are circumstances (they should not occur to us), indeed rare, in which the woman will require constant supervision. In such a case, it is upon the husband to interrupt his normal work and to utilize all his strengths for her sake... 

Several elements of Finkelstein and Finkelstein’s writing must be acknowledged. First, it is abundantly evident that the husband bears responsibility to attend to his ailing wife. It is further apparent that at times this obligation may necessitate forfeiting the performance of certain “lesser” commandments, such as prayer with a quorum of ten males. This does imply, however, that “genuine” or “greater” commandments (such as the basic requirement to pray, even without a quorum) are less readily abrogated for the sake of a depressed spouse. Precise guidelines are not given regarding the temporary suspension of such directives, perhaps because cases are highly specific and necessitate nuanced and diverse guidance that are not conducive to a general protocol.

The idea that Judaism mandates caring for a depressed spouse even when it involves notable sacrifice is actualized on a new level in a responsum of Rabbi Yitzḥak Zilberstein (b. 1934; Bene Berak, Israel). In a letter, Zilberstein discusses whether a woman may divorce from her depressed and suicidal husband, provided the latter’s condition renders him legally capable of providing a bill of divorce. He writes:

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261 See I Samuel 1:10.
263 Finkelstein and Finkelstein’s language is likely gendered because they discuss a case of postpartum depression, which affects women disproportionately. However, it is reasonable to contend that the advice provided is intended to apply to all depressive disorders and in either spouse.
264 We use the term “lesser” here because it is unclear whether prayer with a quorum is obligatory or not for males. The wording of Rabbi Yosef Karo in the Shulkan Arukh, “A man should try his utmost (ישתדל) to pray with a quorum,” implies the absence of an absolute obligation (Yosef Karo, Shulkhan Arukh [Lemberg: P. Balaban, 1893] [Maginei Eretz], OḤ 90:9). Others, however, disagree (see the notable responsum of Rabbi Moshe Feinstein, in Igrot Moshe- vol. 6 [OH 4, YD 3] [New York: n.d.], OH 4:68. Based on Finkelstein and Finkelstein’s language, it appears they believe, contrary to Feinstein, that prayer with a quorum is a “lesser” obligation.
265 It is highly possible or likely that this responsum was originally published in a Hebrew manuscript (which may contain a date), but the author has been unable to locate it.
266 According to Orthodox Jewish law, the husband must give the wife a document of divorce (and not vice versa) (see. Deuteronomy 24:1 and Sefer HaḤinukh [Jerusalem: Mossad HaRav Kook, 1990], mitzva no. 579).
If the wife recognizes all her husband’s problems (his great depression and suicide attempt) and therefore asks for a bill of divorce, it would seem to be proper to try and appease her and to impress on her the great merit she will have if she continues to live with him and she thereby will save his life, and that she clearly understand that in her merit of remaining with him, she will be blessed with long life and reach a ripe old age. But by all means she should remain with him for the moment and try to live with him for another year and then we can reevaluate the situation…

Zilberstein explicitly contends that the marriage bears potential to save the depressed husband’s life. Despite this, his tone implies the absence of a clear obligation necessitating the wife’s fealty, even though it might reduce the risk of suicide. To generalize, Zilberstein apparently believes that remaining with a depressed spouse when one’s presence is possibly life-saving is incredibly meritorious and respectable, but not necessarily an obligation. In any case, our analysis is regrettably conjectural because the short case description, as well as the lack of definitive statements regarding the woman’s obligation in either direction, leave us without the resources for a firm understanding.

Now that we have explored perspectives on the religious-legal parameters of caring for a depressed spouse, we may proceed to study how specific laws of marriage are impacted by the presence of a depressive disorder. Unsurprisingly, most of the relevant literature centers around hilkhot nidda (laws of family purity). Because this topic is difficult to engage without a firm understanding of its tenets, we digress briefly to provide a general overview. Judaism possesses an elaborate system of ritual purity and impurity; all Jewish individuals268 are born “pure,” but may become “impure” through certain activities or circumstances (such as menstruation or ejaculation). The terms “pure” and “impure” here are effectively labels for intangible and

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268 On a Biblical level, non-Jews cannot become impure (B.T. Nazir 61b). (However, the Sages decreed that all non-Jews transmit a certain level of impurity [cf. B.T. Avoda Zara 36b; B.T. Shabbat 17b].).
humanly undetectable inner spiritual states. A tentative analogy may perhaps be made to a student “in good standing” or “not in good standing,” though the comparison is misleading because impure individuals are not necessarily contaminated through the commission of a misdeed. There are also different severity levels of impurity; impure individuals are restricted from participating in certain activities according to the gravity of their ritual contamination. The re-purification process varies for each level, but almost always requires the lapse of a certain time period and immersion in a ritual bath. As noted above, Jewish women are rendered ritually impure (nidda) upon the egress of blood during menstruation. Their period of impurity ends after fulfillment of the two aforementioned conditions.

Women are sometimes required to proactively test for the presence of blood, in order to determine whether any has exited the reproductive complex and rendered them impure. This process is called a bedika (pl. bedikot), more specifically defined as “a self-performed internal examination of the vaginal canal done with a cloth.” The Shulkhan Arukh rules that bedikot of a mentally incapacitated woman, or a woman rendered psychologically insane due to the presence of an illness, must be performed by a woman who is mentally well. It is worth attempting to understand the implications of this ruling for women with a depressive disorder.

In reference to the abovementioned ruling, Rabbi Shmuel Wosner (1913-2015) of Bene Berak, Israel, writes: “Regarding the illness of depression, the seriousness of the illness should be approximated (to determine) whether [the woman] is fit to perform the bedikot.” Several important nuances of Wosner’s sparse comment warrant discussion. Clinically speaking,

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270 Shulkhan Arukh YD 196:8.
271 Based on Mishna Nidda 2:1 and B.T. Nidda 13b.
depressed persons may have difficulty performing highly routine and relatively insignificant tasks—such as household chores. In this light, it is easier to understand his contention that a depressed woman may struggle to execute proper bedikot. The phrase “illness of depression” instead of simply “depression” was perhaps deliberately formulated to express that only a genuine mental disorder is subject to the requirement of an assessment of faculties (and not normal sadness or non-clinical depressed mood). This understanding is convincing considering the passage of Shulkhan Arukh on which Wosner comments discusses individuals who are significantly mentally impaired. Moreover, Wosner demonstrates awareness that depression exists on a spectrum of debilitation in which disparate levels of incapacitation warrant differential halakhic treatment.

Rabbi Zekharia Ben Shelomo, a prominent Israeli legal authority who has written extensively about the laws of family ritual purity, suggests a novel reason why women struggling with depression may be incapable of performing proper bedikot. Generally, bedikot should be conducted after experiencing physical sensations (hargashot [sing. hargasha]) in the vaginal area that indicate the potential egress of blood. In his work Orot HaTahara, Ben Shelomo writes:

“It appears, aside from [Rabbi Wosner’s concern regarding a depressed woman’s fitness to perform] the technical action of the bedikot, such women are required to discern [the sensation of] ‘hargashot’, and one should investigate, even if they are [technically] capable of performing a bedika, the possibility that [depressed women] are incapable of discerning hargashot…”

In other words, Ben Shelomo suggests that some depressed women are incapable of properly detecting and identifying the physical sensations that would demand a bedika. While there is no

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direct evidence for the idea that depressive disorders inhibit the detection of physical stimuli,\textsuperscript{275} it is worth suggesting that depression may nevertheless indirectly impact the perception of a hargasha. For example, depressed individuals sometimes ruminate excessively; constant preoccupation with obsessive thoughts can reasonably engender difficulties in noticing minute physical sensations. Furthermore, persons whose depression is accompanied by lethargic symptoms may engage in practices of cognitive dissonance and downplay or rationalize suspect vaginal sensations to absolve themselves of responsibility for following up with a bedika. In any case, Ben Shelomo concludes: “It appears in my humble opinion that because many circumstances are unclear, and bedikot are merely rabbinically-ordained, therefore, the rabbi may be lenient in times of need.”\textsuperscript{276} We should point out that ben Shalom specifies the “rabbi may be lenient,” perhaps suggesting that he believes depressed individuals with questions regarding hargashot should not self-determine proper halakhic recourse.

In his work Torat Haim v’Ḥesed, Rabbi Eliezer Rot (b. unknown) of Bene Berak, Israel explores the legal repercussions of a case in which a depressed woman rendered impure by menstrual blood engaged in sexual intercourse with her spouse after deliberately neglecting to disclose to him her impure status.\textsuperscript{277} The woman eventually informed her husband, but the original decision brought her future trustworthiness into question. Based upon consultation with Rabbi Yosef Lieberman (b. unknown), a Jerusalem-based rabbi and Rosh Yeshiva, Rot writes: “The woman is believed from here on out, provided that she presents each hefsek tahara\textsuperscript{278} to her

\begin{footnotes}
\item[275] In fact, there exists an unfortunate dearth of research on the relationship between depressive disorders and reaction to physical stimuli in both directions.
\item[276] Zekharia Ben Shelomo, Orot HaTahara (5773 [2012/2013]), (mevo,) p. 57.
\item[277] Sexual relations between a man and woman are prohibited when the latter is impure (cf. Shulkhan Arukh YD 195).
\item[278] “In order to confirm that all uterine bleeding has ceased… (the woman) must do an initial internal examination, or bedikah. This examination is called a hefsek taharah, and means that she has stopped bleeding. The hefsek taharah initiates the process of exiting the niddah status and becoming tehorah (pure). From “Hefsek Taharah,” Nishmat Women’s Health and Halacha, http://www.yoatzot.org/articles/?id=527. Parenthetic remarks ours.
\end{footnotes}
husband and he assumes responsibility for the *bedikah* (instead of her), and that she takes oral medication to remedy [her condition].” It is unclear from this conclusion whether, in Rot and Lieberman’s estimation, a depressed woman may perform her own *bedikot*, and it is only because she misled her husband (presumably somehow as a result of her state) that her reliability is dubious, or whether depression renders women inherently incapable of performing *bedikot*.

Until now, our chapter has sought to clarify two things: how individuals should relate to a depressed spouse from the perspective of Jewish law, and the impact of depression on a woman’s ability to perform *bedikot*. The latter topic, however, represents a relatively small segment of the corpus of *nidda* laws. As mentioned earlier, women (and their spouses) are required to refrain from certain activities when impurity due to menstruation renders the former impure. For example, a woman in *nidda* and her husband may not engage in sexual intercourse or any other form of physical contact. However, for depressed individuals, bodily intimacy can serve as a powerful form of support. Understandably, these competing realities generate significant potential challenges. They have been recently addressed, to varied extents, by rabbinic authorities. Rabbi Peretz Moncharsh, a Haredi rabbinic decisor living in Betar, Israel, operates a website with a question-and-answer forum open to the general public. In 2011, he posted the following exchange:

*Question:* Is there a leniency for hugging his wife niddah when both are fully dressed (sic.). The wife is very depressed almost non functioning (sic.) because of the separation and she just need a hug (sic.) to feel alive. Thank you (sic.)

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280 Rot notes later in the responsum that physicians noted that oral medication bore potential to eliminate her depression.
281 It is not clear how the woman’s depressive disorder caused her to lie. This author is not aware of any known, empirically-backed scientific connections between depression and trustworthiness.
282 See Shulhan Arukh YD 195.
**Answer:** I'm afraid not. It is certainly forbidden miD'Rabanan and possibly Biblically. However, it is certainly praiseworthy that you want to help. Giving a gift is permitted as are many other demonstrations of appreciation. Also, if her depression is so severe, she may need professional counseling.284

We must qualify our analysis by noting that the sparse nature of an informal question-and-answer webpage does not permit a thorough understanding of the subject’s condition nor the legal reasoning behind Moncharsh’s response. Nevertheless, on a most basic level, his decision seems to derive from the understanding that prohibitions of physical contact are impervious to the presence of depression in one spouse. Interestingly, a similar question was posed through a parallel online forum for halakhic questions-and-answers, Din.org.il. This website is operated by the Makhon Yerushalayim l’Dayanut, a Jerusalem-based institution for the study of Jewish monetary law. Inquiries posted on its forum are answered by rabbis affiliated with the program.

In a 2016 exchange, someone anonymously inquired whether an unmarried and mentally unstable woman was permitted to participate in touch therapy285 to facilitate her wellbeing. A member of the website’s faculty anonymously published the decision: “Clearly, it is prohibited in all circumstances,”286 basing this ruling on a passage of Talmud in which a concupiscent male was denied physical and even verbal contact with an unmarried woman by rabbis, at the expense of his life.287

In contrast to these two perspectives is a 2016 responsum by Rabbi Yonatan Rosensweig, a community rabbi in Bet Shemesh, Israel and the author of two volumes of responsa titled Yishre Lev. In an online article, Rosensweig discusses whether the abovementioned restrictions

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285 For a background on touch therapy, see J. Robinson, F. C. Biley, and H. Dolk. “Therapeutic Touch for Anxiety Disorders.” The Cochrane Database of Systematic Reviews, no. 3 (July 18, 2007): CD006240.
287 B.T. Sanhedrin 75a.
on physical intimacy between spouses when the wife is ritually impure may be relaxed when one partner suffers from depression and the physical touch possesses therapeutic value. After a lengthy discussion, he argues for a lenient position that permits direct physical contact even in cases where there is decidedly no danger to life:

“It appears to me…(that) there is room to be lenient…regarding a mentally dysphoric individual who requires support from his wife (or vice versa)…in a default situation, we would obviously not rule leniently. However, here the individual is sick and…therefore, spousal touching related to treatment and support is by default given the status of a “loving touch” (that arouses [asexual] sentiments similar to touching his daughter and son-in-law), with which we are not concerned in the face of a pressing need…288 Even if we were in doubt that perhaps this touch…would bring one to ruminations about sexual contact, we have already seen in the responsum of the Batei Kehuna289 that we are not (to be) concerned… (for such a possibility). Furthermore, one should add that the individual is involved in the performance of a duty (and will therefore not come to sin) …290 Moreover, according to a multiplicity of decisors…a woman in a state of ritual impurity is not included among the forbidden sexual relationships for which one must die rather than transgress (by engaging in sexual intercourse). Moreover, it should be recalled that it is preferable to engage in caressing rather than hugging and kissing, for some explain291…[that] Rambam [Maimonides] only prohibited hugging and kissing on a Torah level292… Regarding a sick individual in danger of death, it is of course possible to be lenient… [so too] for a sick individual regarding whom the physicians say that he will engage in self-harm if he does not receive a certain type of support…Regarding an individual whose life is not in danger, we have arrived at a dispute…Here, in my humble opinion, one should judge each case independently, in consultation with psychiatrists, to ascertain whether the sick individual’s specific situation is one of non-life-threatening sickness.293 294

288 Because there is no concern that the touch will generate sexual ruminations, it is permitted according to several authorities (cf. Shabatai HaKohen, Siftei Kohen [Shakh], quoted in Yosef Karo, Shulkhan Arukh- YD [vol. 2] [Lvov/Jerusalem: Ḥ. Vagshal, n.d.], p. 316 [195:20]).

289 Yitzḥak Rapoport, Batei Kehuna- vol. 3 (Izmir: n.d.), bet din, bayit 12 (pp. 32-42).

290 The phrase Rosensweig uses for “involved in the performance of a duty,” is עליה בعبادתיה, a term employed by the Babylonian Talmud (Avoda Zara 20b) as part of a discussion regarding whether males who wash women’s clothing or individuals facilitating the mating of animals (acts which are understood by the Talmud to generate illicit sexual thoughts) are permitted when the individual engages in such activities on a strictly professional level. The idea is that, because that individual is preoccupied with their professional duties, they will not come to sin by having improper thoughts.


292 I.e., it is only the specific acts of hugging and kissing that are prohibited by Maimonides on a Torah level, but not other forms of physical contact.


294 In which case, it would be permissible. This is as opposed to a non-clinical condition, which is less serious.
Rosensweig provides several additional qualifications for his ruling, such as a preference for non-direct physical contact (i.e., by using a glove), and limits the leniency to physical contact between two partners married according to Orthodox Jewish law. Furthermore, Rosensweig only advocates leniency in cases where a physician and rabbi together agree that physical intimacy is the proper recourse. It is worth noting that Rosensweig’s ruling is more lenient than a previous decision of his published in 2011 that permitted physical contact only over clothing.295

Now that we have charted the proper religious approach towards caring for a depressed spouse and explored the relevant literature discussing depressive disorders in conflict with the observance of family ritual purity, it is worth turning to miscellaneous questions of depression and romantic relationships that do not fit neatly into either of these two categories. Rabbi Michael Broyde (b. 1964), a professor of law at Emory University and the author of numerous works of halakha, was asked to weigh in on the religious ramifications of providing couple’s therapy for two homosexual male partners,296 one of whom was severely depressed and whose condition greatly worsened after a serious fight with his lover. The depressed subject’s psychologist was concerned for the individual’s life, but was wary that successful therapy would prompt increased sexual activity. Broyde responded:

I confess that my basic mindset and orientation is to be very lenient in cases where someone’s life is in danger…I see reason to be lenient here and permit inviting his male lover in to therapy in the hopes that this will prevent a suicide…There is no sin at all being encouraged. The patient’s partner is being brought in to prevent suicide and not to encourage prohibited sexual relations. Of course it is true that prohibited sexual relations might be restored but such is not the goal…Suicide is a terrible sin…This is not a case of healing through sin…as there is no sin here and now. What you are doing now is saving the life of a person who will sin in the future. That is completely proper and appropriate. Would anyone suggest not doing CPR on this man if he needed it?297

296 Homosexual anal sex is prohibited according to Orthodox Jewish law. (Based on Leviticus 18:22 and 18:13; cf. Moshe Maimonides’ Sefer HaMitzvot, [Israel: H. Vagshal/Hemed, 1990], lo taasei no. 350.).
297 Michael Broyde, quoted in Seymour Hoffman, “Piskei Halakha l’She’elot Miktzot iyyot Shel Psychologim Datiyim,” p. 22. Available at https://www.hebpsy.net/books/CXq5IZL5Sd9WxGzqXYjA.pdf. See also Seymour
In short, Broyde acknowledges the potential for restored prohibited homosexual activity, but feels the risk of suicide supersedes these concerns. He advances two additional arguments for leniency that are directly relevant to depression: One, the depressed man might be so severely mentally ill that he is ultimately exempt from the performance of mitzvot.\(^{298}\) Second, in Broyde’s own words, “I am uncertain if this specific patient’s mental illness is a cause or an effect. Maybe curing him of his mental illness will have other positive effects and lead to diminution in sin. Maybe not, I agree. But not treating his depression will not have any change in his homosexual feelings, for sure.”\(^{299}\) This latter consideration—that depression potentially engenders transgression (aside from suicide and self-harm)—is highly consequential, because it theoretically intimates that depressive disorders can be so religiously detrimental that treatment which will potentially result in spiritual misbehavior is not necessarily worse than the misbehavior that depression already causes. It is important to note that another religious scholar (under the pretext of anonymity) was presented with this case and forbade the therapy, based upon a ruling of Rabbi Moshe Sofer prohibiting the marriage of a Kohen and a divorcee\(^ {300}\) who were deeply in love, even though the breakup generated risk of danger.\(^ {301}\)

This latter ruling serves as a good bridge to another responsum (from 2003) by Rabbi Shalom Mesas (1909-2003), the former Chief Rabbi of Morocco and later, of Jerusalem. Mesas

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298 The term Broyde uses is *shoteh*. More specifically, Broyde writes, “I am not sure if the man at hand is obligated in mitzvot at this moment as he might very well be so severely mentally ill that he is exempt from mitzvot, and certainly there is no obligation to separate him from sin of any type. The type of clinical depression that leads to suicide is not exactly a shotah (*shoteh*), but not exactly far from it (in Hoffman, 22).” See our chapter titled, “The Depressed Individual as a *Shoteh*,” pp. 89-91.

299 Hoffman, 22.

300 A Kohen (Jewish Priest) and a divorcee may not marry according to Jewish law (see Leviticus 21:7 and Mishna Makkot 3:1.).

was asked whether a *Kohen* who was romantically involved with a female convert before becoming observant, was permitted to marry her.\(^{302}\) The asker noted that “there exists concern that if permission is not granted for them to marry, deep depression will seize her and G-d-forbid, she will abandon *mitzvah* (observance) entirely.”\(^{303}\) Mesas ultimately permits the marriage because of technical considerations regarding the laws of marriage between a *Kohen* and a convert, and out of concern that a negative decision would lead the woman to abandon observance; however, the potential for depression is not mentioned in his response. Because there are several possible explanations for Mesas’ omission, offering conclusive suggestions is irresponsible. For example, perhaps Mesas felt he possessed enough arguments that there was no need to appeal to depression, or perhaps he did not believe the risk of depression was a valid argument at all.

We should discuss one final responsum about the interplay of depression and romantic relationships. In a 1983 piece, Rabbi Yitzḥak Zilberstein was asked whether a clinician treating the child of two parents with an internecine marital relationship was religiously obligated to intervene in the latter’s difficulties even though it had nothing to do with the treatment of the child.\(^{304}\) In response, Zilberstein balances the negative consequences of marital conflict and the importance of facilitating peace with the prohibition to embarrass another.\(^{305}\) Partially quoting (or at least partially paraphrasing) Rabbi Yosef Shalom Elyashiv (1910-2012; Jerusalem, Israel), Zilberstein writes:

\(^{302}\) A *Kohen* and a female convert may not marry according to Jewish law (see Leviticus 21:7 and Mishna Yevamot 6:5).

\(^{303}\) Shalom Mesas, *Sheme”sh uMagen- vol. 4* (Jerusalem: 5767 [2006/2007]), EH no. 73.

\(^{304}\) Marital harmony (typically termed *shalom bayit* in Hebrew) is considered a religious value (see B.T. Shabbat 23b), in addition to the general value of interpersonal peace (see Mishna Peah 1:1). The clinician wanted to know whether they bore a religious duty to attempt to facilitate the value of marital harmony in this case.

\(^{305}\) The source for this commandment is somewhat complicated. See Moshe Maimonides, *Sefer HaMitzvot*, (Israel: H. Vagshal/Hemed, 1990), *lo taasei* no. 303 (based on Leviticus 19:17).
There only exists a question when the partners are not interested in having strangers treat their problems, because of embarrassment... However, a serious fight is liable to generate danger and we cannot initially predict where the argument may lead, and the fighting previously led to serious depression, which possesses the status of (a) life-threatening (condition), and also to aggravation, which can negatively impact health and shorten the length of life... (Therefore,) the prohibition to stand idly by while your fellow’s blood is shed applies. And even if there is no concrete concern for (loss of) life, behold, even saving one from pain is a mitzvah, and is (also) included in the (general) injunction of do not stand idly by while your fellow’s blood is shed... (Therefore, regarding) a serious conflict between spouses that is liable to result in danger, we are obligated to intervene and make peace between them even when they do not want it...One should not take their embarrassment and their opposition into account...because such embarrassment is nonsense.

In summary, Zilberstein (and Elyashiv) argue(s) that one should intervene in spousal conflicts when the fallout generates a risk for depression. The prohibition of embarrassing another is sidelined out of a concern for the health of the partners and their relationship, based partly upon the potential depressive repercussions and the understanding that their embarrassment is illegitimate. In any case, Zilberstein concludes by obligating the clinician to engage the couple gently to avoid embarrassment.

In conclusion, several things are clear. There exists a substantial amount of halakhic literature on the intersection of depression and romantic relationships. We have identified two rabbinic figures who discuss the general religious-legal approach towards a depressed partner; both emphasize fidelity and support at great sacrifice. Because the laws of family ritual purity devolve mostly upon women, and because depression rates are higher in women, observant woman are especially disposed towards conflicts between religious marital law and depressive

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307 Rabbi Yitzhak Zilberstein, Shiurei Torah la’Rofim (5772 [2011/2012]), no. 268 (pp. 404 & 407). It is unclear whether part of this was written by Rabbi Elyashiv or just paraphrased.
308 Zilberstein, citing Elyashiv, writes “One should not at all consider embarrassment, because it is an embarrassment of foolishness that has no justification, and therefore their objections are invalid (Zilberstein, 407).” This is interesting, because it conveys that some forms of embarrassment are illegitimate and therefore carry less halakhic weight.
309 Zilberstein, 407.
disorders. Rabbinic decisors express concern that some depressed women are incapable of performing *bedikot* either because their illness renders them too handicapped to do it properly or because they are unable to detect the physical sensations that might necessitate one. Regarding the question of physical contact between two spouses when one suffers from depression, we have identified a position that prohibits and a position that permits such contact. Rabbi Michael Broyde permitted couple’s therapy that would likely restore prohibited sexual activity when one partner suffered from life-threatening depression, but another (anonymous) scholar forbade it. Broyde’s assertion that depression can generate its own transgressions is noteworthy. In a case where refusal to permit the wedding of two individuals normatively prohibited from marrying one another (according to Orthodox Jewish law) might generate depression, Rabbi Shalom Mesas did not include risk of depression as a consideration in his arguments for leniency. Finally, Rabbis Yitzchak Zilberstein and Yosef Shalom Elyashiv permitted one to intervene in serious spousal conflicts lest the situation degenerate into a danger such as depression. Both rabbis were unconcerned for the religious prohibition to cause embarrassment in such a case.
Depression and Prayer

The topic of mental illness and Jewish prayer (tefila) receives the most attention in two areas: First, with respect to obsessive-compulsive disorder and its tendency to sometimes inhibit proper tefila either through word-repetition behaviors or excessive fixation on religious laws pertaining to bodily excretion that generally preclude prayer. Second, and perhaps less directly, with respect to the approach charted by Rabbi Naḥman of Bratslav that emphasizes the importance of capitalizing upon profound emotional anguish to facilitate meaningful and effective supplication. The halakhic complications that arise from depressive disorders and the religious commandment to pray is an important component of the more general interplay between mental illness and prayer that has not received sufficient notice. This dearth is reflected in the reality that much of this chapter’s material derives from interviewer-directed questions instead of published responsa. Here, we explore some of the legal challenges that manifest when depressed individuals navigate the numerous everyday requirements and restrictions that prayer imposes.

Jewish women are required to pray to G-d once daily and Jewish men thrice. The origins of this commandment and its status as rabbinic or Torah-ordained lie beyond the scope of this article; however, it is important to note that Jewish prayer carries several auxiliary

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311 Such as wiping properly after defecating before praying, and constantly checking to see if one needs to use bathroom during prayer. One is generally prohibited from praying if they are not properly clean in the anal area, or if they feel the need to relieve themselves. Cf. Rabbi Yisrael Kanievsky, *Karyana d’Igarta*- vol. 1 (Bne Brak: 5746 [1985/1986]), nos. 373, 374, 375, & 376.
312 The Mishna (Berakhot 3:3) writes that men and women are obligated in prayer. How often individuals must pray, however, is a matter of dispute. According to Moshe Maimonides (in *Mishne Torah*- Sefer HaMada [Jerusalem/Bne Brak: Shabtai Frankel, 2001], *Hilkhot Tefila* 1:2) the Biblical commandment to pray requires all Jews of age to engage in prayer once daily. Men are required to pray twice more each day by rabbinic decree.
313 See previous note (312).
regulations, such as ablutions and time-bound restrictions. Importantly, Jewish males are instructed to pray in a quorum (minyan) of ten adult Jewish men. Most of the literature explored in prior chapters discusses individuals who suffer from depression but nonetheless maintain general mental functioning. However, severe depression may render some individuals physically inactive; such a condition appears to grip the subject of an undated responsum by Rabbi Moshe Sternbukh (b. 1928), a leader of the Eidah Haredit rabbinical court in Jerusalem and a prolific decisor of Jewish law. Sternbukh was asked whether a man apparently so incapacitated by severe depression that he would not respond upon being spoken to may be included in a minyan. The man was described as “completely disconnected from the world as a result of his illness.”

Sternbukh writes:

In our case, where he is in a state of depression where (others) speak with him and he does not respond at all in a relevant way…he is considered a shoteh and it is improper to include him in (the requisite count of ten males necessary for) a minyan, even though he essentially possesses a developed mind… I am inclined to be stringent and consider him a shoteh; however, if he…feels ashamed about this, even though a shoteh cannot legally be embarrassed, in our case it appears that he is considered a minor, regarding whom one is liable for embarrassing…and this stringency whereby he is (considered) a shoteh is a leniency G-d forbid, for people who will (thereby) come to disparage him, and “great is kavod haberiyyot (human dignity) which pushes aside a negative commandment of the Torah,” (therefore) we must conceal that (this individual) possesses the status of a shoteh and find minyanim with ample attendance…and not spill blood in his embarrassment(,) which carries a very serious punishment.

In summary, Sternbukh argues that depression renders this individual so mentally incapacitated that he is exempt from the entirety of Jewish law. However, out of concern that this classification will embarrass the subject, he necessitates large prayer quorums so that a communal service not be invalidated on account of the depressed individual in a way that would

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314 See notes 259 and 264.
316 Cf. B.T. Bava Kama 86b.
317 B.T. Berakhot 19a.
318 Sternbukh, 2:61.
reveal his status. Importantly, Sternbukh quotes the Talmudic dictum of *kavod haberyiot*, a Talmudic concept in which rabbinic commandments may be suspended for the sake of human dignity. The original Talmudic discussion of this topic records a dialogue regarding whether the principle may be used to abrogate Torah-ordained commandments (נוהל נבוי מברית שוהות לא, והך נוהל אשת נביה) or merely rabbinic laws (נוהל אשת נביה של שונים) (תנושת שביחד). The latter possibility is vindicated by the Talmud and codified as normative halakha; however, Sternbukh quotes the original, rejected and more expansive possibility (נוהל נבוי מברית שוהות לא, והך נוהל אשת נביה) instead of the accepted position. This phraseology is presumably intentional, probably to accentuate the importance of sensitivity towards the subject. In any case, though Sternbukh indeed appeals to the dictum of *kavod haberiyot*, his insistence that efforts be made to locate at least ten additional Jewish men for a *minyan* at which the depressed individual is present renders the extent to which he would apply this maxim ultimately unclear.

While Sternbukh’s responsum is significant, most depressed individuals do not experience such severe symptoms; therefore, the majority of legal questions regarding depression and prayer are less intense. Rabbi Yuval Cherlow was asked whether a depressed individual who was calmed by the sunset, but lived in a town where the only available *minyan* for afternoon and evening prayers occurred during this time, was permitted to forego prayer with a quorum to watch the sunset. He responded: “I would say the best thing to do…in such a situation…is to plan it… Pray the afternoon service before going to the park (where the sunset is watched). And

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319 For example, if the subject were to attend a prayer quorum with just nine other adult Jewish males, the prayer service would not be permitted to continue because, although there are technically ten Jewish men present, there are only nine individuals who qualify towards the requirement of ten. Such a prayer service would therefore be impermissible, and the other participants would presumably become aware of the depressed individual’s disposition.


even if this would not constitute prayer with a minyan, my answer would be (yes).”

In other words, Cherlow advocates proactive planning to eliminate conflict and allow the individual to partake in prayer with a quorum and watch the sunset; however, in the event that such a conflict is unresolvable (i.e., the only minyan nearby meets during sunset), Cherlow is willing to waive the former value.

The Ohr Somayach Yeshiva in Jerusalem maintains an anonymous online question-and-answer forum. In an undated posting, one questioner disclosed that pervasive sadness arising from his struggle with depression had engendered lachrymose, emotive, and ultimately more meaningful prayers. However, the individual subsequently lost this enriched connection upon beginning antidepressants. He asked whether he should cease medication so that depression would return and a more soulful and evocative prayer experience could resume. The anonymous responding rabbi answered:

G-d has decided that you’re ready for a new challenge: Find spirituality as a healthy person…The Sages taught that wealth makes it harder to be spiritual, so perhaps the same is true of health. The challenge is, can you seek inspiration when things are OK? I think you can, because I believe that people are given only challenges that they are capable of overcoming.

The rabbi’s response is interesting because it adopts a decidedly non-halakhic approach towards the issue. Still, he makes clear that one should not cease antidepressants for the sake of more impassioned prayer. Though to the reader this question may seem foolish and its answer obvious, we should point out that individuals struggling with comorbid depression and obsessive-compulsive disorders encounter such questions regularly, and these inquiries should be treated with sensitivity and due attention.

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322 Yuval Cherlow, in discussion with the author.
In conclusion, several things are clear. Despite its importance, the topic of depression and prayer lacks sufficient attention. Rabbi Moshe Sternbukh classified an individual seriously incapacitated by depression as a *shoteh* and ruled accordingly regarding the individual’s ability to count as one of the ten adult Jewish males necessary for prayer with a quorum. However, it is unclear whether Sternbukh would waive the individual’s *shoteh* status in favor of human dignity when there are *only* ten such men available and the former’s exclusion would generate shame and embarrassment. Rabbi Yuval Cherlow ultimately permitted the neglect of prayer with a *minyan* for the sake of a therapeutic sunset, but explicitly advised planning ahead to prevent a mutually exclusive decision.
Depression & Miscellaneous Issues

There are, of course, variegated issue areas that do not fit neatly into any of our topic-specific chapters. Such miscellaneous fields of halakha are the subject of this chapter.

Fasting

There exists a considerable amount of Jewish legal literature on depression and fasting. Rabbi Yitzḥak Zilberstein writes in a 1984 book:

A woman with diabetes, who is treated through insulin injections, should not fast (on Yom Kippur), so that she not endanger herself… So too one who suffers from…a mental illness, such as serious depression and the like…must seek counsel with a physician and legal decisor, for there are cases in which she is permitted to eat a full shiur, and there are cases in which she is permitted to eat “ever so slightly less than a shiur.” And there are cases in which she is permitted to drink and not eat. And vice versa.

Zilberstein repeats the contention that certain individuals may be obligated to consume food and drink on Yom Kippur in a published letter to a family physician in Rehovot, Israel. Though he only explicitly discussed pregnant women, the notion that depressed individuals should be generally cautious about fasting is relatively well-founded in halakhic literature. As discussed below, in our chapter on the proactive prevention of depression, Rabbi Daniel Goldschmidt of Modi’in, Israel writes that depressed individuals should not fast on the Ninth of Av. He does not, however, discuss whether a depressed individual may fast on Yom Kippur; because the

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324 The Jewish holiday of atonement, on which eating and drinking are forbidden by the Torah.
325 Jews only violate the Torah injunction to refrain from eating on Yom Kippur if they eat a certain amount of food within a limited time frame (see Mishna Yoma 8:2). The specific quantity of food required to violate the prohibition is called a shiur. Nevertheless, it is prohibited to ingest even less than a shiur (see B.T. Yoma 73b-74a), though one who does so is not liable to the penalty that normally applies to one who eats or drinks a shiur on Yom Kippur.
326 This is so as not to violate the prohibition (see above note).
injunction against eating and drinking on Yom Kippur is more serious,\textsuperscript{330} no conjectural extrapolations should be attempted. However, the medical reasoning behind these rulings is not immediately apparent. Reduced energy is a common symptom of clinical depression;\textsuperscript{331} this can reasonably be exacerbated by reduced food consumption. While no studies have demonstrated that lower caloric intake worsens depression, perhaps these rabbis believe that the weakness doubly engendered by depression and fasting may cause individuals to behave unpredictably. Interestingly, however, sparse research suggests that decreased caloric intake may enhance the effectiveness of antidepressants.\textsuperscript{332}

**Bitul Torah (Wasting Time that Should Be Spent Studying Torah)**

Adult Jewish men are required to reserve time for Torah study twice daily;\textsuperscript{333} however, such individuals are also instructed to study Torah whenever they are not occupied with other important activities.\textsuperscript{334} Failure to do so is referred to as *bitul Torah* (neglect of Torah study), and incurs harsh criticism in classical Jewish sources.\textsuperscript{335} Naturally, however, depressed individuals may need to devote more time towards feel-good activities at the expense of general productivity or Torah study. Rabbi Mordekhai Ashkenazi (1943-2015), the former Chief Rabbi of Kefar Ḥabad, Israel and a leader of the Ḥabad-Lubavitch Hasidic community, discusses in a book the

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{330} Meaning, it is Biblically-ordained rather than Rabbinically-ordained.
\item \textsuperscript{331} American Psychiatric Association, *Diagnostic and Statistics Manual- Fifth Edition (DSM-5)*, 161 & 172.
\item \textsuperscript{332} Yifan Zhang, Changhong Liu, Yinghao Zhao, Xingyi Zhang, Bingjin Li, and Ranji Cui, “The Effects of Calorie Restriction in Depression and Potential Mechanisms,” *Current Neuropharmacology* 13, no. 4 (2015): 536–42.
\item \textsuperscript{333} B.T. Menahot 99b; *Shulḥan Arukh* YD 246:1.
\item \textsuperscript{334} Based on Deuteronomy 5:1, Maimonides rules that Jewish men are obligated to learn the entire written and oral Torah (Moshe Maimonides, *Mishne Torah- Sefer HaMada* [Jerusalem/Bne Brak: Shabtai Frankel, 2001], *Hilkhōt Talmud Torah* 2:1). This concept applies in addition to the minimum daily requirements cited in note 332. It is the impetus behind the idea that men should spend their free time learning (Rabbi Hershel Shachter, quoted in: OU Torah, “Rabbi Hershel Shachter: Balancing Torah with Other Obligations,” filmed [Jan 15, 2017], YouTube video, posted [Jan 19, 2017], https://www.youtube.com/watch?v=oOtKOit-ILg).
\item \textsuperscript{335} A full background of the concept of *bitul Torah* is unreasonable here, but it is worth noting that the term appears early, in Tanaitic works (e.g., Tosefta Shabbat 8:2). See also the statement of Rabbi Nehorai in B.T. Sanhedrin 99a.
\end{itemize}
\end{footnotesize}
permissibility of playing chess on Shabbat. He quotes various authorities who ruled stringently, but notes that their objections stemmed from “bitul Torah” and concerns of general vacuousness rather than Shabbat-specific prohibitions (such as muktzeh). Noting that many great rabbis indeed played chess, he quotes the work Birkei Yosef, a prominent commentary on Shulkhan Arukh by Rabbi Ḥayim Yosef David Azulai (1724-1806): “The great [rabbis] of Israel [who played chess] of course acted for the sake of Heaven [l’shem shamayim], for it is possible that they were holei shechorah (depression) and for the sake of healing…they acted.” These words are Azulai’s, but the parenthetic “depression” insertion is Ashkenazi’s. Apparently, at least according to Ashkenazi, it is permissible for depressed individuals to engage in activities otherwise forbidden because of bitul Torah, in order to facilitate mental wellness. Interestingly, Rabbi Barukh Finkelstein and Michal Finkelstein, in a 2011 article discussed more extensively in our chapter on depression and contraception, provide similar guidance for women suffering from postpartum depression: “(Such an individual)...possesses a halakhic obligation to emerge from the depression because happiness is an utmost Jewish value…it is upon her to…pursue activities that will return happiness to her life, whether this involves merely listening to happiness-inducing music and taking walks in nice gardens…” Finkelstein and Finkelstein do not write that these activities are normatively problematic because they are a waste of time (like Ashkenazi does regarding chess); however, they clearly convey that individuals struggling with depression

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336 Ashkenazi originally approaches the issue from the perspective of muktzeh (a rabbinic prohibition on moving certain objects on Shabbat. (The word “muktzeh” may be best translated as “set aside.”) He discusses whether chess is forbidden to be moved (because a chess set is muktzeh), and therefore forbidden to play, on Shabbat.

337 Cf. note 335.


should make special efforts to engage in activities that generate pleasure and well-being. The implication is that this directive applies even when it incurs lost study time.

_Honoring Parents_

Certain maladaptive parental behaviors correlate with depression in children exposed to such conduct.⁴⁰ Rabbi Naftali Bar-Ilan (b. unknown), a Rabbi from Rehovot, Israel, frequently consulted regarding questions of halakha and psychology, was asked to rule in a case in which treatment for depression necessitated violation of the commandment to honor one’s parents.⁴¹ The specific phraseology is important, so we will recall the question here.

In situations where the psychologist diagnoses that the patient suffers from dysfunction, self-directed anger, self-hatred, extreme lack of self-worth, or depression, (all of which are) sourced in the pernicious behavior on the part of one or both of the individual’s parents, (and) the treatment necessitates that the patient realize that their problems and suffering stem from parental abuse on some level or another. In certain situations, the psychologist finds it proper to encourage the patient to express their unconscious anger toward their parents, and sometimes the psychologist instructs the patient to rebuke their parents regarding their behavior. Is this method of treatment permissible according to Jewish law?⁴²

Bar-Ilan responded in a 2014 article with six relevant points:

A) (The) psychologist with a license from the government is permitted to heal.⁴³ B) Children are permitted to disclose to the treating psychologist every detail of their parents’ behavior. C) (The) psychologist is permitted to encourage the patient…to express their anger towards their parents. D) (The) psychologist is permitted to bring to the patient’s attention their parent’s shortcomings and those aspects of their (the parents’) behavior that generated the child’s distress. E) (The) psychologist is commanded to assist the child in dealing with the distress in a way that will render it possible to fulfill the commandment to honor one’s parents in the best way in the given circumstances. F)

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⁴¹ Cf. Exodus 20:12; Leviticus 19:3; Deuteronomy 5:16; Moshe Maimonides, _Sefer HaMitzvot_, (Israel: Ḥagshal/Ḥemed, 1990), ase1 no. 210.

⁴² Rabbi Naftali Bar Ilan, “_Tipul Psychologi v’Kibud Horim_,” _Assia_ 95-96 (24, 3-4) (2014): 111.

⁴³ Cf. the statement in the name of the school of Rabbi Yishmael quoted in B.T. Bava Kama 85a. The Talmud there remarks whether human medical assistance is religiously proper, for one could theoretically argue that it contravenes trust in Divine intervention (Rashi [Rabbi Shlomo Yitzḥaki printed in _Talmud Bavli- Bava Kama_ (Vilna: HaAlmana v’Ha’Aḥim Reʾem, 1882), 85a].
Patients who suffer from very difficult distress are legally considered sick individuals whose lives are in danger, with all the implications that flow from such a condition. That a decisor seasoned in the intersection of halakha and psychology felt compelled to publish an article on this topic perhaps suggests the question arises with some frequency. Indeed, it is worth acknowledging that a significant number of prominent rabbis have published statements on the relationship between mental illness and the commandment to honor one’s parents. Bar-Ilan is the only one to explicitly discuss depression in particular (as opposed to other mental disorders), so we have limited our analysis to his treatise. Nevertheless, readers are encouraged to explore the writings of other rabbinic decisors on this subject, many (but not all) of whom draw different conclusions than Bar-Ilan.

Geneivat Daat (Artifice)

As noted above, depression (like many other mental disorders) carries a significant amount of stigma, which can make individuals reluctant to seek treatment. This reality likely forms the impetus behind a question posed to Rabbi Yitzḥak Zilberstein regarding the permissibility of administering to “a civilian injured in an enemy attack a medication for depression without his knowledge…” Presumably, the operative conflict is geneivat daat, a prohibition to engage in artifice, and the individual did not wish to take medication because of

344 I.e., potential disparate halakhic treatment (especially leniencies).
345 Bar Ilan, 123.
347 See supra, note 332.
351 See B.T. Ḥullin 94a; Shulkhan Arukh HM 228.
the stigma associated with mental illness. Zilberstein answers by recording a very similar case that was brought before Rabbi Elazar Shakh (1899-2001), a prominent religious leader in Bene Berak, Israel:

…A young man from the Ponovez Yeshiva\textsuperscript{352}…went into a deep depression from fright and terror during the Gulf War…The young man absolutely refused to be labeled as having a mental illness. His friends went to consult with Rabbi Shach…about what to do. He said: there is medication available for this illness, and he consulted with a specialist physician…The psychiatrist heard the whole story and prescribed a medication. One problem remained. How to convince the Yeshiva student to take it? Rabbi Shach replied: whoever is sitting next to him during meal times can slip the pill into his tea without him noticing it.\textsuperscript{353}

Zilberstein concludes: “Logic tells us that it is permissible to give a patient the pills he needs without his knowledge since an expert physician (the psychiatrist) determined that he needs it and is obligated to accept it and take it.”\textsuperscript{354} In short, Zilberstein and Shakh permit one to deceptively administer medication at the behest of a physician; importantly, no threat to life was explicitly mentioned as a contributing factor. However, because Zilberstein does not provide the legal background for his ruling, a more comprehensive analysis is impossible.

Several conclusions emerge from our analysis. Under certain circumstances, persons who struggle with depression may be exempt from fasting even on Yom Kippur. Depressed individuals are also encouraged to pursue happiness-generating activities that would otherwise be frowned upon as an inappropriate waste of time. According to Rabbi Naftali Bar-Ilan, children whose depressed disposition stems from maladaptive parental behaviors are permitted to speak poorly about their parents for the sake of treatment. Rabbis Yitzḥak Zilberstein and Elazar Shakh opine that one may violate the prohibition of geneivat daat to administer medication to a

\textsuperscript{352} A prominent yeshiva in Bne Brak, Israel, headed by Shakh.
\textsuperscript{353} This is listed as quoted in the work Toratcha Sha’ashuai (p. 159) (though our quote was probably translated from Hebrew by Fred Rosner). However, there are several books with that title and this author was unable to locate the specific passage quoted by Zilberstein. In any case, the above quotation was taken from Zilberstein, 179.
\textsuperscript{354} Zilberstein, 179.
depressed individual. More generally, the diverse areas of halakha explored in this chapter demonstrate the expansive surface area upon which depression and Jewish law interact. Our findings here summate to suggest the presence of a rabbinic leadership that readily applies lenient rulings and legal justifications to facilitate the wellness of depressed individuals.
The Proactive Prevention of Depression

Depression is often perceived as an unending, debilitating condition in which individuals are condemned to a lifetime of negative mood swings.\footnote{Jonathan Rottenberg, Andrew R. Devendorf, Todd B. Kashdan, and David J. Disabato, “The Curious Neglect of High Functioning After Psychopathology: The Case of Depression,” Perspectives on Psychological Science 13, no. 5 (2018): 549–66.} In reality, however, some sufferers recover from a single depressive episode and proceed to live robust and lengthy lives;\footnote{Cf. F. Hardeveld, J. Spijker, R. De Graaf, W. A. Nolen, and A. T. F. Beekman, “Prevalence and Predictors of Recurrence of Major Depressive Disorder in the Adult Population,” Acta Psychiatrica Scandinavica 122, no. 3 (2010): 184–91.} still others who experience depression more chronically enjoy significant periods of uptime between incidents. For such individuals, proactive prevention is perhaps more important than treatment.\footnote{For a general background to the topic of preventive mental health care, see World Health Organization, Prevention of Mental Health Disorders: Effective Interventions and Policy Options (France: World Health Organization, 2004), https://www.who.int/mental_health/evidence/en/prevention_of_mental_disorders_sr.pdf.} Whereas previous chapters have concentrated on the halakhic ramifications of an already-present depressive disorder, this chapter explores how halakha treats individuals who are liable to depression but do not presently suffer from the condition. Several important examples were discussed in prior sections of this thesis because they were immediately relevant to another topic; others will be introduced now.

A healthy sense of regret is an essential aspect of repentance for the transgression of Judaism’s commandments.\footnote{See Moshe Maimonides, Mishne Torah- Sefer HaMada (Jerusalem/Bne Brak: Shabtai Frankel, 2001), Hilkhot Teshuva 2:2.} However, religious individuals liable to depression may have difficulty experiencing remorse in a healthy and constructive manner. For these individuals, guilt over misbehavior can devolve into serious depressive illnesses.\footnote{For powerful examples of the psychological fallout of excessive remorse, see the anecdotes recorded in Yoram Bilu and Eliezer Witzum, “Culturally Sensitive Therapy with Ultra-Orthodox Patients: The Strategic Employment of Religious Idioms of Distress,” in Case Studies of Unorthodox Therapy of Orthodox Patients, ed. Seymour Hoffman and Benni Feldman (New York: Golden Sky, 2012), 12-19, and Seymour Hoffman and Brurit Laub, “Brief Intervention of a Rabbi in a Case of Matricide,” in Case Studies of Unorthodox Therapy of Orthodox Patients, eds. Seymour Hoffman and Benni Feldman (New York: Golden Sky, 2012), 73-81.} When confronted with

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wrongdoing, depressed or depression-liable persons must navigate a narrow chasm between productive regret and maladaptive guilt. The former possibility is a concrete religious obligation, but the latter may be explicitly prohibited. For example, Rabbi Moshe Dov Wilner (1912-2007), the former Chief Rabbi of Ashkelon, Israel, writes in a responsum published in 1974: “It is brought in the Sefer Hasidim\textsuperscript{360}…if one performs a…(pietistic) action\textsuperscript{361} (as a form of repentance)…which engenders depressed spirit, (such activity) is included in (the prohibition of) “But the blood of your souls I will demand (Genesis 9:5) …\textsuperscript{362} 363 364 For individuals liable to depression, the development of a proper and balanced approach towards repentance is an important step in the proactive prevention of depressive disorders. While this endeavor does not necessarily demand the intrinsic abrogation of halakha, religious authorities must take the potential for depressive fallout seriously, to the extent that rulings may sometimes necessitate sacrificing abundant regret or pietism for the sake of mental health.

Rabbi Moshe Feinstein (1895-1986; New York) published several rulings in which the potential to arrive at a psychologically unhealthy state factored explicitly into his decision.\textsuperscript{365} One, written in 1985, explicitly discusses melancholia. He writes:

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\textsuperscript{360} Rabbi Yehuda ben Shmuel HaHasid, Sefer Hasidim (Israel: Mossad HaRav Kook, 2004), no. (ot) 676.
\textsuperscript{361} I.e., fasting or some other presumably ascetic activity.
\textsuperscript{362} According to Rabbi Elazar (quoted in B.T. Sanhedrin 91b), this verse refers to the prohibition of suicide. Cf. supra, note 49.
\textsuperscript{365} Moshe Dov Wilner, She’elat Hemdat Tzvi- vol. 2 (Tel Aviv: 5734 [1973/1974]), 19:5.
\textsuperscript{364} See also the responsum of Rabbi Shimon Gruenfeld, quoted above (pp. 21-22).
A heresh (deaf-mute) who is technically not a heresh because he speaks (i.e., is not actually mute), may receive aliyot (s. aliya) if he reads together with the one reading from the Torah… However, a (genuine) heresh (i.e., who cannot hear or speak) …may only receive aliyot when it is necessary, for example, for his bar mitzvah, for his aufruf, and the like. And similarly, in isolated cases one may give him an aliya so that he not feel humiliated or depression G-d forbid.

In short, Feinstein permitted one usually ineligible to perform a certain ritual to do so when depressive fallout exists. It is worth noting that Feinstein appears to be discussing situational despondency rather than a formal depressive disorder; however, one may reasonably argue that Feinstein’s ruling would apply to a genuine depressive disorder via an argumentum a fortiori.

Proactive prevention is especially important for at-risk individuals who suffer the loss of a close friend or family member, because the death of a loved one has been associated with heightened risk for several psychological disorders. For many mourners, visiting and praying by the deceased individual’s grave is an important memorial exercise. Jewish law and custom dictate times during which cemetery visits are encouraged, permissible, or forbidden.

Individuals are generally instructed to refrain from visiting the cemetery on joyful days, such as

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366 According to Jewish law, individuals are sometimes permitted to fulfill a particular commandment by proxy. For example, one who wishes to eat bread and recite the appropriate blessings may fulfill their obligation by listening to another individual make the blessing for them (cf. B.T. Sukkah 38b; Shulhan Arukh ᪩ 214). However, a deaf-mute (heresh; Heb. הַרְשֶׁה) is proscribed from fulfilling the obligation of another (Mishna Rosh HaShana 3:8). For a more comprehensive background to the deaf-mute in Jewish law, see Tzvi C. Marx, Disability in Jewish Law (London & New York: Routledge, 2003), 114-127.

367 The Torah is read in the synagogue several times each week. Because these readings constitute the fulfillment of a commandment and blessings are recited on the fulfillment of many commandments, the reader is required to recite certain blessings. In contemporary times, this is accomplished via a system of proxy in which a second individual recites the blessings and the reader fulfills their obligation by listening to them (see note 346, above). The process of approaching the Torah and reciting the requisite blessings for the reader is called an aliya. Because a heresh is proscribed from fulfilling others’ obligations (see note 346, above), such an individual cannot receive aliyot.

368 Aufruf is a Yiddish term that literally means “call” or “appeal (S. Beinfeld, Harry Bochner, Isidoro Niborski, Bernard Vaisbrot, & Simon Neuberg, Arumnenik Yidish-English Verterbukh [United States: Indiana University Press, 2013], Verterbukh.org).” In this context, it refers to the aliya a groom traditionally receives at the Torah reading on the Sabbath preceding his wedding (i.e., he is “called up” to the Torah).

369 Moshe Feinstein, Igrot Moshe-vol. 8 (OH 5, YD 4) (Jerusalem: Ḥemed/Rabbi D. Feinstein, 1996), YD 4:49 (siman katam no. 6).

Ḥanuka and the first of every Jewish month (Rosh Ḥodesh). This limitation engenders potential emotional challenges for mourners, who may assign grave visitation supreme importance. Such tension is the partial subject of an undated responsum by Rabbi Ezra Batzri (b. 1937), a prominent Sephardic religious judge in Jerusalem. He writes:

…Ideally, one should not go (to a cemetery on Rosh Ḥodesh), as I have written (above), however, there exist individuals of bitter spirit and if we prevent from them this matter, it will generate depression. Therefore, such individuals may rely on the testimony of the Rabbi (Salman Hagi Aboudi, who would visit the cemetery on Rosh Ḥodesh), provided they do not eulogize and only recite kaddish...

In summary, Batzri permits graveside visitation on Rosh Ḥodesh, an activity normally proscribed, to prevent individuals from developing depression. He does not specify mourners in his writing, but it may be reasonably asserted that they are the group most impacted by his ruling.

In a 2008 book, Rabbi Yitzḥak Zilberstein was asked to adjudicate a unique and complicated case: A young male in speech therapy for a significant stutter was instructed by his pathologist to practice speaking by telephoning various businesses and ordering products. The pathologist contended that speaking with strangers in particular was important; however, the patient was merely telephoning for practice and did not intend to make a purchase. The question arose whether such an activity violated geneivat daat (perhaps best translated as

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371 This position is mentioned in the Kol Bo (an anonymous early halakhic text), as quoted in Moshe Rivkes’ Be’er HaGolah commentary on the Shulkhan Arukh (printed in Yosef Karo, Shulkhan Arukh (Lemberg: P Balaban, 1888), YD 344:20. The earliest source for refrainment on Hanuka is less clear.

372 The late Chief Rabbi of Baghdad.

373 Eulogizing is prohibited on Rosh Ḥodesh (based on Mishna Moed Katan 3:9; cf. Yosef Karo, Kesef Mishne (printed in Moshe Maimondes, Mishneh Torah- vol. 14 [Shoftim] [Jerusalem: 5767 (2006/2007)], hilkhot aveilut 11:3).

374 Kaddish is a special prayer recited in memory of the deceased.


376 This last sentence is implied by the context, but is not explicit in the responsum.
“thievery of the mind”),377 the religious prohibition to deceive and mislead.378 In his response, Zilberstein notes a passage in the Babylonian Talmud that permits deception in cases where refraining from artifice could generate danger to life.379 He then writes:

From (that Talmudic passage) …one may extrapolate to our case, for if there exists a concern that (the individual) will reach a state of depression…(which) is suspect to be a danger…Genuine (emphasis mine) thievery380 is obviously prohibited to facilitate healing…however, mere artifice (i.e., thievery of the mind), such as in our case, where the vendors…think that someone wants to make a purchase…in our case is not considered genuine thievery, and is permissible for the sake of healing, when there exists concern that he will reach a state of danger to life, and the matter requires more study…381

To summarize, Zilberstein argues that depression is potentially lethal, and geneivat daat is permissible when danger to life exists. As a result, he allows artifice even when the individual is not currently depressed, to prevent them from developing such a condition. Zilberstein’s responsum is important because it demonstrates one case in which individuals at risk of depression may avail themselves of the same leniencies as those who are already depressed.

Let us explore another example. Rabbi Daniel Goldschmidt, the head of an advanced religious study program (kollel) in Modi’in, Israel and the author of four books on Jewish law, writes: “Regarding depression, one does not fast (on the Ninth of Av [a Jewish fast day commemorating the destruction of the Second Temple in 70 CE]), even (out of concern) for a minor level of depression, out of concern that (the depression) will return (to a serious level), and

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377 Presumably because geneivat daat includes the Hebrew word for thievery (geneiva; גניאה) and because some decisors derive the proscription of geneivat daat from the prohibition to steal (cf. the positions quoted in Rabbi Yom Tov Asevilli [Ritva], Hiddushei HaRitva- Hullin [Jerusalem: Mossad HaRav Kook, 1982], 94a (p. 126), Zilberstein dichotomizes genuine stealing and genevat daat.
378 See B.T. Hullin 94a and supra, pp. 79-80.
379 B.T. Shabbat 129a.
380 I.e., physically seizing an object that belongs to another.
this applies even to a sick individual stabilized by pills." His remark clearly indicates that the law may be abrogated to prevent serious depression in this circumstance.

Jewish men are generally proscribed from dressing like women or imitating traditionally feminine behaviors. In most circumstances, and according to certain decisors, plucking gray hairs as a form of beautification falls under this rubric. Rabbi Moshe Fried (b. unknown), an Israeli rabbi and the author of *VaYishma Moshe*, a three-volume compendium documenting the responses of prominent rabbis to questions of Jewish law, examined the case of a student who removed his friend’s gray hair while the graying individual was asleep. (The friend was presumably distressed by his loss of pigment and wanted the gray hairs removed.) The student argued that the prohibition applies only to one who cuts his own hair, and so his actions were wholly in accordance with halakha. Fried paraphrases the responses of five decisors, including Rabbi Shmuel Eliezer Stern, the halakhic authority for *Hatzolah* (a volunteer Jewish ambulance corporation):

Rabbi Stern said that one needs a proof to prohibit the matter, but in any case one should not permit such an action *lekhatila*… A man once told of his graying son, and he (the son) was greatly embarrassed, and did not want to be seen publicly, and he lay on the brink of depression and broken-spiritedness. And out of this great need Rabbi Stern permitted him to have his hairs removed in the individual’s sleep, specifically by a non-Jew and not by a Jew.

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383 See supra, p. 75, for a fuller discussion on the relationship between depression and fasting.
385 We have qualified our ruling with the word “most” because there are select instances in responsa literature where males are permitted to engage in such a behavior.
386 I.e., and not the hair of another.
387 I.e., Stern did not perceive a clear reason to prohibit the action.
388 See Glossary.
389 I.e., because the prohibition only applies to one who removes the hairs (not the one who has them removed), and because non-Jews are not obligated to observe this commandment, no prohibition would be violated if the action were performed in this way.
Fried adds that Rabbi Shamai Gross (b. unknown), a judge in the Belz Hasidic rabbinical court, permitted the above action even by a Jew.\(^{391}\)

Several conclusions are clear. For individuals predisposed towards depressive disorders, excessive guilt over transgressions poses a significant risk. According to some, persons who engage in pietistic behaviors that can cause depression are likened to those who commit suicide. Rabbi Moshe Feinstein permits a deaf-mute to be called up to the Torah in situations where refraining would generate embarrassment and depression. Bereaved individuals are at heightened risk for depression; seemingly in recognition of this, Rabbi Ezra Batzri allows persons at risk to pay cathartic cemetery visits at times of year when such visits are generally proscribed. In discussing an individual with a distressing stutter, Rabbi Yitzchak Zilberstein argues that depression is life-threatening and therefore even potential depression warrants the same halakhic treatment as depression itself. Rabbi Daniel Goldschmidt permits one suffering from minor depression to eat on a rabbinically-ordained fast day out of concern that the illness would devolve into a more serious condition. More generally, this chapter demonstrates that rabbis feel comfortable allowing potential emotional fallouts to factor into the ultimate decision. Their responsa summate to suggest the presence of a veritable tilt towards leniency when dealing with the proactive prevention of depressive disorders.

\(^{391}\) Fried, 320. However, Fried does not provide the legal reasoning behind this position.
The Depressed Individual as a Shoteh

Our most fundamental question—how halakha is applied to individuals with depression by contemporary rabbinic decisors—has been explored thus far under the assumption that persons who suffer from depression are obligated to observe halakha in the first place. There is, however, a category of individual who is totally exempt from the performance of all commandments as a result of mental incapacitation. Such a person is termed a shoteh (fem. shotah,)\(^{392}\) perhaps best contextually translated as a mentally incapacitated individual. Rabbis debate the extent to which an individual with depression is considered a shoteh. Our goal is to provide a brief historical background of the legal concept of shoteh and attempt to discern whether depressed individuals may ever be appropriately classified as such. A brief passage in Tosefta Teruma (1:3) is the inception of the relevant literature:

Who is considered to be mentally incapacitated? One who goes out alone at night, and one who stays overnight in the cemetery, and one who tears their garment, and one who destroys things that people give to them. [For one who is] sometimes insane, sometimes sane, this is the general rule: Whenever they are insane, regard them as someone who is insane in all respects, and [whenever they are] sane, regard them as someone who is sensible in all respects.\(^{393}\)

This passage is picked up by the Babylonian Talmud in tractate Hagiga (3b), where only the first three examples (going out alone at night, remaining overnight in a cemetery, and garment-tearing) are recalled by the Sages.\(^ {394}\) The Talmud (ad. loc.) also records a debate between Rav Huna and Rabbi Yoḥanan regarding whether all three of these qualities are necessary to render one a shoteh (Rav Huna) or whether just one symptom suffices (Rabbi Yoḥanan).\(^ {395}\) It is worth

\(^{392}\) We will use the male conjugation throughout this thesis to maintain consistency with the language of the texts we explore.
\(^{394}\) B.T. Hagiga 3b.
\(^{395}\) The fourth condition (destroying what one is given) is then raised by Rav Pappa, who argues that Rav Huna was unaware of this requirement, and had the latter known, he would have ceded to Rabbi Yoḥanan. The Talmud
Rishonim debate whether these bizarre behaviors are mere indicators of the status of shoteh (a siman) or whether they are intrinsically necessary for a diagnosis (a siba). More specifically, the former group argues the conduct described in Tosefta Teruma was intended only as an example, and that a shoteh refers more expansively to any individual suffering from any psychological aberration that compromises lucidity. Within this framework, whether a depressed individual is a shoteh should depend upon the extent to which they retain awareness and normal functioning. According to the second position, however, the stereotypical depressed individual cannot be classified as a shoteh because contemporary depression does not manifest through the peculiar symptoms mentioned in Tosefta Teruma (unless the depression is accompanied by psychotic features or is comorbid with a psychotic or neurocognitive disorder). While some relatively contemporary decisors rule in accordance with the latter position and necessitate the specific symptomology described in Tosefta Teruma, the majority adopt the former perspective implicating depressed individuals in the event of restricted lucidity. Our thesis, which has documented voluminous rabbinic responsa that implicitly assume depressed individuals without serious sanity handicaps are obligated to observe halakha is testament to the questions whether Rav Pappa intended that Rav Huna would have ceded exclusively regarding the fourth condition (that it alone is enough to render one a shoteh, but the other three must manifest together), or whether he would have ceded entirely (and all four qualities need not present collectively).

398 Moshe Maimonides, Mishne Torah (Jerusalem: ḤVagshal, 1990), Hilkhot Edut 9:9; Menahem Meiri, Bet HaBehira (Zikhorn Yaakov: 1978), Ḥagiga 3b.
400 See Steinberg, 663; Moshe Sternbukh, Teshuvot v’Hanhatot- vol. 2 (Jerusalem: 5754 [1993/1994]), no. 61.
widespread acceptance of this position. Of course, when depression *does* raise questions of sanity or lucidity, the sufferer may indeed be considered a *shoteh*. However, because such cases are the exception rather than the rule, we operate under the rubric that halakha *does* apply to depressed individuals barring fringe cases.

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401 Such as the case described in Moshe Sternbukh, *Teshuvot v’Hanhagot* - vol. 2 (Jerusalem: 5754 [1993/1994]), no. 61.
Chapter III: Conclusions and Additional Information

Conclusions

This thesis examined contemporary responsa and other Jewish legal literature on the topic of depression in an attempt to understand how Orthodox halakha approaches the depressed individual, as well as to discern the sociological, legal, and methodological implications of that approach. The time has come to organize and present our final findings, and to acknowledge some salient patterns that have emerged from our exploration. In his seminal forward to the Supreme Court’s 1982 term, Robert Cover argued that law cannot be conceptualized as an abstract system of rules and principles divorced from its *nomos* - the sociocultural context that shapes these laws and imbues within them meaning.  

403 404 Our thesis corroborates Cover’s assertions in several ways: Most importantly, this paper establishes that depression is being discussed in responsa and other Jewish legal literature at an unexpectedly high level. The reality that this trend is probably reflective of growing attention to, and awareness of, depression in general demonstrates the dependency of Jewish law upon the psychological *nomos*. Moreover, we have identified a general rabbinic consensus regarding the circumstances under and the extent to which Jewish law applies in an altered fashion to facilitate the wellness of depressed persons, except regarding questions of sexuality. In this area, there is often a significant divide between ultra-Orthodox (who tend to rule stringently) and more moderately-identifying legalists (who tend to rule leniently). The disparate conclusions reached by rabbis steeped in communities with

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404 In a similar vein, Barry Wimpfheimer contends that the intrinsically dialogical nature of Talmudic legal narrative renders the Talmudic text unamenable to strictly legal outcomes; in other words, the Talmud’s legal conclusions result sometimes from the interplay between law and psychological, political, ethical, or scientific concerns (Barry Wimpfheimer, “Love and Law: The Dialogical Nature of Talmudic Legal Narrative,” [2005]: https://ssrn.com/abstract=813849).
disparate religious philosophies regarding questions of sexuality and depression intimates that contemporary Orthodox Jewish law is dialogical and connected to the social context.

Additionally, this thesis is an exercise in understanding how Jewish law approaches budding issue areas. To be sure, prevenient psychologists and rabbis demonstrated at least a conceptual awareness of depression many centuries ago; however, the notion of depression as a concrete clinical construct with normalized diagnostic features and detectable neurobiological abnormalities is relatively nascent. Such major advancements in the understanding of depression have demanded from rabbis a reconceptualization and consequent legal reappraisal. At the same time, Jewish law systematically relies on antecedent proof-texts and rulings as criteria when legal decisions must be made. Because of the significant gap between “then” and “now” conceptualizations of depression, contemporary legalists must address the relationship between depression and halakha without direct legal precedent. From this challenge emerges a powerful meta-question: How does Jewish law deal with the unprecedented in a legal system that demands precedent? The writings explored in our thesis do not lend themselves to an easy or straightforward answer to this question. For example, sometimes Talmudic and other rabbinic proof-texts are used extensively, but other times the answer to a given question is developed without the traditional progression through sources. Furthermore, that different decisors possess disparate approaches, writing styles, and literature formats all serve as confounds that render a determination difficult. Perhaps more than demonstrate a model for how the precedent-based legal system of Jewish law approaches nascent issue areas lacking in said precedent, the methodological diversity of our sources suggests that no such model exists.
A significant proportion of the literature is directed towards women. The reasons for this trend are probably threefold: One, more women suffer from depression than men. Two, women are responsible for the performance of rituals and laws that happen to intersect with depression more than those rituals and laws pertaining exclusively to men. Three, our trend reflects a growing emphasis on women and women’s issues in Judaism.

Moreover, and most basically, we have demonstrated that contemporary Orthodox halakhists typically resolve conflicts between depression and halakha by suspending the latter to facilitate alleviation of the former. These implications are greatest for observant individuals who struggle with depression and the rabbis and clinicians who are called upon to service them. They also suggest that normative Orthodox law understands depression as a genuine and concrete illness. Finally, our thesis underscores the importance of ensuring that rabbis harbor accurate and up-to-date conceptions of depression and other mental disorders.

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406 One may well argue that halakha is never “suspended” per se, rather, it possesses built-in caveats such that the utilization of leniencies in cases of depression is actually as full an application of halakha as any other. According to this philosophy, because the halakhic system carries within it the propensity for disparate applications according to the circumstance, it can never truly be abrogated. Importantly, abrogation should not be confused with violation, which is possible; in other words, one can go against the halakha, but one cannot contend that it does not apply. In any case, it is not the place of this author to assume a stance on this distinction here.
<table>
<thead>
<tr>
<th><strong>Dayan</strong></th>
<th>A rabbinical judge who serves on a Jewish court of law.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Haver</strong></td>
<td>A member of a rabbinical court.</td>
</tr>
<tr>
<td><strong>Heter</strong></td>
<td>A statement of permission.</td>
</tr>
<tr>
<td><strong>Ḥoleh she’ein bo sakana</strong></td>
<td>A sick individual whose illness does not endanger their life but who nevertheless warrants potential differential halakhic treatment as a result of their illness.</td>
</tr>
<tr>
<td><strong>Ḥoleh she’yesh bo sakana</strong></td>
<td>A sick individual whose illness endangers their life.</td>
</tr>
<tr>
<td><strong>Lekhatḥila</strong></td>
<td>Ideally; permitted from the outset (as opposed to <em>a posteriori</em>, or after the fact).</td>
</tr>
<tr>
<td><strong>Limud ḥṭut</strong></td>
<td>Lit. “learning favor;” The vindication of individuals who engage in a potentially irreligious practice by providing that practice with legal justification or ascribing to those who engage in it more noble motives.</td>
</tr>
<tr>
<td><strong>Muktze</strong></td>
<td>Lit. “set aside;” any object that is forbidden to be moved on Shabbat; a rabbinic restriction forbidding the movement of certain objects on Shabbat.</td>
</tr>
<tr>
<td><strong>Onuss</strong></td>
<td>Coerced; forced.</td>
</tr>
<tr>
<td><strong>Psak</strong></td>
<td>A decisor’s understanding of how to apply the halakha to a particular situation.</td>
</tr>
<tr>
<td><strong>Rosh yeshiva</strong></td>
<td>The head of a Jewish seminary</td>
</tr>
<tr>
<td><strong>Safek</strong></td>
<td>Lit. “doubt;” used in texts discussed in this to describe the factor of the unknown.</td>
</tr>
<tr>
<td><strong>Shabbat</strong></td>
<td>The Jewish Sabbath, occurring from sundown Friday through sundown Saturday.</td>
</tr>
<tr>
<td><strong>Shoteh</strong></td>
<td>An individual who is deaf and mute.</td>
</tr>
<tr>
<td><strong>Yom tov</strong></td>
<td>Any holiday on the Jewish calendar that is accompanied by Shabbat-related prohibitions</td>
</tr>
<tr>
<td>Acronym</td>
<td>Description</td>
</tr>
<tr>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>EH</td>
<td>Even HaEzer</td>
</tr>
<tr>
<td>OḤ</td>
<td>Orah Hayim</td>
</tr>
<tr>
<td>Ḥemed</td>
<td>Haser Makom Dafus (Location of publication unknown).</td>
</tr>
<tr>
<td>ḤM</td>
<td>Hoshen Mishpat</td>
</tr>
<tr>
<td>P.N.G</td>
<td>Page Numbers Not Given</td>
</tr>
<tr>
<td>Resp.</td>
<td>Responsa</td>
</tr>
<tr>
<td>YD</td>
<td>Yoreh Deah</td>
</tr>
</tbody>
</table>
References

*= Author unknown.

Ḥemed= Abbreviation for Ḥaser Makom Dafus (Eng: location of publication unknown).
Resp. = Responsa.


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Kol Bo. Quoted in Rivkes, Moshe Be’er HaGolah. Printed in Yosef Karo, Shulkhan Arukh. Lemberg: P Balaban, 1888.


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*“Should I Be Happy.” Ohr Somayach. https://ohr.edu/ask_db/ask_main.php/326/Q1/.


*Toratcha Sha’ashuai.* See p. 81, note 353.


Weissman, Myrna M., Yuval Neria, Marc J. Gameroff, Daniel J. Pilowsky, Wickramaratne, Rafael Lantigua, Steven Shea, and Mark Olfson. “Positive Screens for Psychiatric Disorders in Primary Care: A Long-Term Follow-up of Patients Who Were


Chapter I: A Brief History of Depression in Halakha

Note 33:
Mishna Shabbat 2:5
œuvre. שבעי כל תקופה של שיעור, פעוט. אם על טמנים את מבט ראשי על החלטות מסוים, מפרים לרחב, יאמ

Note 46:
Moshe Maimonides, Mishne Torah Hilkhot Sanhedrin 18:6

Chapter II: The Contemporary Legal Treatment of Depressive Disorders in Conflict with Halaka

Note 88:
Depression and Music Therapy
וכו

א"ש.Validate the function with the following input:


Note 109:

Note 111:

Note 115:

Depression and Shabbat/Holidays


Note 153:

Cohen 114
Depression and Abortion

Note 183:

Note 193:

Note 197:
Depression and Contraception

Note 221:
Moshe Feinstein, Igrot Moshe-vol. 7 [EH 4, ḤM 2] [Brooklyn: Moriah Offset Co, 1985], EH 4:74.

Note 224:
Depression and Romantic Relationships

Note 262:

Note 272:

Note 274:
Zekharia Ben Shelomo, Orot HaTahara (5773 [2012/2013]), (mevo.) p. 57.
Note 279:

Note 307:
לשאלה א: סכסוך רציוני בין בני אדם על שלטונות בسكوיה,HEY ו russafa, ÈY של אחרים. הבוחנים, שיש בוвро ללא תועדו "לא תועדו על דברים" ו aggi להבעה בכורה.

בנ_acquireים, של ביוטה משוערה, שגייה אותה על פי הבוחנים.

דברים אל נאמרים עם כשרי אדםlettesינו על דברים, על כך כותב המיתר載ש שלם כשל wollen ישים בין ליליאם, השכירות measפוקר. והיה לאמצע בהם בדך הזדה מבעד לכנסאים.

לﻧגורים יהלום בוזה. אם הסכסוך אין של מבשלforder.

Depression and Prayer

Notes 315, 318:

וכ"כ שבדינו דירי ושוהה במעט מעורב שתחדשו שמייברarious על יואר, מיי מדיה של כל ס menuItem. עד שמוסרימש שאינה ראו למסל, BE.

והנה נשבעו יאני לזרג ט_reviews או ששלפעוס אוהג ענה לעוף במעט. ביקוד ועד פלונית אין להזדה במעט, listsשתרפויים ממנון עדין סומר קפן שאינו ראו הולחן.

אף על האנשים. ראני לזרג למסל. מי שדריאי לאשפוז במעט של - ובש אוף ידנ, BE.

לתחזיר עליה שוהה בשתייה, שכזב אפי מוגדר תמיל גרר,trees שאיני נשבעה בזות מקפה ברוב המיתר载ש. פ"א: بم. נראת

שדונן כפנט שחייבין על בורשת בسكوיה, יהאمنظم חונן שווה או חלון א"כ. רazı"א שיביאו למסל, BE, לבין ברוד déבורה של"מ שמרותה, ציריכים לשזרי י🎞 שנותו וספרים פנים ברזות ולא בקטינה ולא-imgir.

Depression and Miscellaneous Issues

Note 327:

. ה. הזוהל צליל התומפלעל של ידי וירית יאנכפורל. אינ הל אצומ, יכלו כתמַתת. כאשר בני הסובלת ממנה החל לחיים בו, מי להזדה של שחר试管婴儿, לשות ורומץ במיל, BE, של כריך תעודה להזדה שלאת שלה, מי מערית שCharArrayær של临ך להאבה של"מ. יrophic צורת מפקחה, ציריכים לשזרי י엽 שנותו וספרים פנים ברזות ולא-imgir.

Note 338:
Mordekhai Ashkenazi, Ashmora Shabbat, 2:4:308 (pg. 190), quoting Birkei Yosef to Shulkhan Arukh OḤ 338 sk 1.
Notes 342, 345:

Proactive Prevention of Depression

Note 363:
Moshe Dov Wilner, She’elat Ḥemdat Tzvi- vol. 2 (Tel Aviv: 5734 1973/1974]), 19:5.
Note 369:

Note 375:

Note 381:

Note 382:
Note 390: