VIEWS OF MENTAL ILLNESS, TREATMENT, AND STIGMA IN THE ORTHODOX JEWISH COMMUNITY

A DISSERTATION SUBMITTED TO THE FACULTY
OF
PSY.D. (DOCTOR OF PSYCHOLOGY) PROGRAM IN CLINICAL PSYCHOLOGY
OF
WILLIAM PATERSON UNIVERSITY OF NEW JERSEY
BY
CHANA B. BECHER
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE DEGREE
OF
DOCTOR OF PSYCHOLOGY

APPROVED

______ August, 2024____(diploma date)

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Abstract

Stigmatization of mental illness and treatment is associated with ostracization and avoidance which puts individuals and communities at risk primarily due to lack of care. People stigmatized due to mental illness may face extreme discrimination and difficulties integrating into vocation, housing, interpersonal aspects, and academic opportunities, among other problems. Although the stigma of mental illness is alive in many communities across the globe, religious communities may be particularly vulnerable to this stigma and stereotypes of mental illness. Due to the interconnectedness of religious communities and spiritual guidelines for health and healing, individuals with mental illness may resort to secrecy and underutilization of mental health services and resources in the community. Previous research has demonstrated this avoidance or underutilization of mental health treatment in Orthodox Jewish communities. The study's main goal was to assess the views of community members through semi-structured qualitative interviews to assess opinions and perceptions of the stigma of mental illness in the community. Data analysis uncovered several important factors and barriers to discussing and seeking mental health care within the community. Some factors included social ramifications, religious and financial concerns as well as cognitive dissonance regarding stigma amongst participants. Data from this study also included participant recommendations for decreasing stigma, primarily through appropriate psychoeducation, and increasing available services in the community through proposed recommendations, as well as future directions.

Acknowledgments

The work and progress for this dissertation were expertly guided by Aileen Torres, Ph.D. and Pei Wen-Winnie Ma, Ph.D. at William Paterson University's Culture & Resilience Lab. I am deeply appreciative of their expert knowledge, assistance, and unwavering support throughout this process. I could not have completed this milestone without their championship. My deep appreciation extends to Jan Mohlman, PhD, for her expert directorship and guidance.

I am also extremely thankful and grateful to Kathleen Torsney, Ph.D. for her everlasting encouragement, advice, and sensitivity during my time at William Paterson University and beyond. The impression of her genuine care will always be with me.

I would like to honor the memory of my dear father, Abraham Wolfson, whose vision and philanthropy helped multitudes in need, specifically in the most trying times and situations. His gentle guidance, modeling of exceptional character, and unconditional devotion will always serve as a beacon of light in my life.

Lastly, my everlasting thanks belong to my family, my husband, Yechiel, my mother, Tovie and my children, Yaakov, Yitzchak, Shimon, Eliyahu, Moshe, Mordechai, Tziporah, and Zev. They have stood by my side throughout this process, supporting me with encouragement, understanding, and patience. For that, I am forever grateful.

Views of Mental Illness, Treatment, and Stigma in the Orthodox Jewish Community

Mental health is a crucial facet of healthy and productive living. Unfortunately, barriers to wellness may be embedded in various societal and religious expectations, myths, and points of view (Mannarini & Rossi, 2019; Schnall et al., 2014). Individuals and groups of people with mental illness have long been stigmatized and labeled with stereotypes such as "alien," "strange," “stupid” and "dangerous" (Rosen et al., 2008). Prefabricated opinions and stereotypes of mental illness activate generalized ideas about individuals suffering from this illness (Rossler, 2016). These phenomena create stigma, which is defined as beliefs and negative attitudes that increase fear, avoidance, and rejection of those with mental illness in our society (Parcesepe & Cabassa, 2013).

Stigma related to mental illness is a social issue associated with harmful effects such as ostracization within communities and families, reluctance to seek appropriate help, and withdrawal from society. Although the dissemination of information about and/or the provision of treatments for physical illnesses is socially acceptable, these same practices addressing mental disorders may be considered taboo and unacceptable in certain communities. A lack of awareness in communities, worry about revealing mental diagnoses, and the belief that symptoms will remit without treatment are all associated with the avoidance of mental health care (Mannarini & Rossi, 2019; Rossler, 2016).

Additionally, the biases of danger and unpredictability that are attributed to people with mental illness maintain the cycle of stigma and the public’s general avoidance of mental health issues. Current research reveals that religion often shapes the perception of mental illness and help-seeking norms. For example, there may exist extreme religious and traditional beliefs which promote the suffering of mental illness as a form of punishment or cleansing from sin (Peteet, 2019). Consequently, individuals who need mental health treatment in religious communities and do not receive adequate assistance may experience a lower quality of life, social ostracism, unemployment, and other disadvantages (Mannarini & Rossi, 2019). Additionally, a deep concern about one’s reputation and the threat of being perceived negatively due to mental illness may cause individuals to be reluctant to seek help, even from close family members (Hays & Iwamasa, 2006).

Overall, stigma related to mental illness may be amplified in minority groups worldwide, as noted, particularly among more tightly-knit religious communities such as the Orthodox Jewish community (Schnall et al., 2014). Additionally, the lack of knowledge pertaining to mental illness and treatment contributes to the avoidance of mental health care and results in stigma (Bineth, 2017; Jorm, 2000). Studies have found that stigma toward mental illness is a central reason for the avoidance of mental health treatment in religious communities (Mackenzie et al., 2006).

Religion, religious beliefs, practices, and strong community values may further affect the stigmatization of mental illness (Rosen et al., 2008; Schnall et al., 2014). The Orthodox Jewish community may experience this stigma due to the interconnectedness of the community, the importance of genealogical pedigree, as well as marriage arrangements, and Jewish laws and customs. Rosen and colleagues (2008) found that within an Orthodox Jewish community in Jerusalem, clients with a more religious upbringing reported more stigma towards mental illness than patients who had embraced religious practice and community more recently in life**.** Therefore, the complexity of the role of religion and stigma in Jewish communities needs to be further explored.

Approximately one in five adults in the United States may suffer from a mental illness. According to the Department of Mental Health and Human Services Report, the assumption is that Jewish individuals are just as likely to suffer at the same prevalence rates of mental illness (U.S.Department of Health and Human Services, 2018). Possibly due to the stigma of reporting mental illness, there are no available statistics for the overall prevalence of particular mental illnesses in Orthodox communities in the United States (Hays & Iwamasa, 2006). However, some specific differences reported include higher rates of major depressive disorder in Jewish men and lower rates of substance use disorders than in non-Jewish men. Although similar proportions of individuals are suffering from mental illness in the Orthodox Jewish community as compared to the general population, the mental health services available to this community are greatly underutilized (Levav et al., 1997; Schnall et al., 2014).

Research reveals that closely related marriages within the community with a more homogenous genetic pool may increase the prevalence of specific disorders. It is interesting to note that research on the mental disorders of mainly endogamous groups, such as the Old Order Amish community, showed specific, prevalent illnesses, such as bipolar one diagnosis in families with at least one parent with bipolar disorder. While not explicitly identified in the Orthodox community, it may be hypothesized that similar gene pools, while not completely endogamous, may increase the likelihood of specific disorders (Levin, 2005).

Judaism, one of the oldest monotheistic religions, supports the belief that G-d is omnipresent and the source of the world's creation (Corrigan et al., 2016). Orthodox Jews, a subgroup of Judaism, adhere strictly to the *Torah* (Jewish Code of Law), which Orthodox Jews believe was received from G-d and passed down to Moses at Mt. Sinai and guides daily life, including relationships and behavior. Orthodox Jews are encouraged to show kindness and holiness and place significant importance on family and community unity. Due to specific Jewish Law guidelines and propensity and obligation to do *Mitzvot* (commandments of the *Torah*), Orthodox Jews may distrust secular attitudes and opinions. The *Talmud* (Oral Jewish Law) does not ostracize individuals with mental illness and promotes seeking help; however, individuals from closely-knit communities have heightened concerns about mental problems affecting marriages, leading to stigma and alienation (Loewenthal, 2006; Margolese, 1998). Additionally, religiosity may exacerbate latent or masked mental health issues due to guilt or scrupulosity regarding religious practices (Loue, 2010; Siev et al., 2011).

The stigma attributed to mental illness drives higher secrecy about mental illness and treatment. Greater urgency for secrecy and the necessity for treatment options have created alternative avenues of help-seeking (Baruch et al., 2014). Specifically, the literature has revealed that many religious people and even the general population (non-religious communities) reach out to clergy in times of crisis or other distress. Therefore, the attitudes of religious leaders to mental health problems and treatment are influential to their constituents and communities. Because rabbis frequently interpret or facilitate religious and secular experiences and phenomena, the rabbi's opinion may be greatly valued. His guidance is highly influential and trusted in many aspects, including mental illness (Slanger, 1996).

Interestingly, behavioral, emotional, and cognitive practices of self-help are encouraged by rabbinic leadership, including prayer, study, and acts of kindness (Bushong, 2018). In more complex cases of mental illness, talk therapy with a therapist is encouraged, with medication as a last resort due to the stigma of medication and seeking the services of a psychiatrist (Slanger, 1996).

Furthermore, as noted above, specific aspects of religion and culture may contribute to the challenges of Orthodox Jews seeking mental health care. Orthodox Jews may have specific issues that can create misunderstandings that impede receiving quality mental health care. Potential issues can include a lack of trust between religious minority groups and mental health providers and a lack of understanding of cultural nuances (e.g., dress codes, standards of modesty related to print and visual media, religious ceremonies, importance and hierarchy of religious leaders, and marriage arrangements; Greenberg & Witztum, 2013; Rosen et al., 2008).

A 25-year follow-up on the status of mental health needs in the Orthodox Jewish community included mailed questionnaires distributed to approximately 450 members of NEFESH, an organization devoted to the mental health needs of the Orthodox Jewish community. One hundred twenty-two members responded about the Orthodox Jewish community's present attitudes and mental health needs. Although respondents reported a greater awareness and acceptance of mental health services within the community, 60% of participants concluded that the community's mental health needs were not being met (Schnall et al., 2014). Specific issues with seeking help include concerns about trusting a therapist who is not a part of the community. As noted above, common concerns include a lack of understanding of sensitive Jewish laws and values. Additionally, worry about disclosing personal information, awareness of the restriction of social behaviors between men and women, and anti-Jewish or anti-religious attitudes may decrease seeking mental health services (Hays & Iwamasa, 2006).

Overall, there has been recent progress in the quality of psychoeducation information about mental illness and treatment in the Orthodox Jewish community. For instance, recent efforts have included psychoeducational training for non-religious therapists as well as for religious therapists. In addition, educational programs for laypeople and community members highlighting the importance of quality assessment and mental health treatments facilitate important liaisons between community leaders and mental health professionals serving the Orthodox Jewish community. This progress, coupled with an increasing number of religious Jews being trained as mental health providers, has created a positive shift towards mental healthcare utilization and psychoeducation, compatible with religious faith and practices. However, mental health services and help-seeking levels are still not adequate, and many in the community may be suffering in silence and secrecy (Greenberg & Witztum, 2013; Schnall et al., 2014).

Moreover, noted in the literature is the idea that Jews have missed out on the profusion of support for cultural diversity services, specifically cultural knowledge, and sensitivity surrounding tolerance of religious beliefs and practices of Jewish people. Therefore, recent research and policymaking have emphasized removing the barriers to adequate support, information, and culturally sensitive services recommendations (Langman, 1999; Schall et al., 2014).

Future research aims to explore important emotional and social components of mental illness in the community. Due to the relevant literature, there are some assumptions about Orthodox Jewish communities pertaining to mental illness and a culture of stigma. These assumptions hypothesize that Orthodox Jewish communities may stigmatize mental illness, and additionally, Orthodox Jews are hesitant to seek mental health treatments.

The current study aims to add to the limited body of research by generating in-depth qualitative information about the views on mental illness and treatment and the stigma of mental illness in the Orthodox Jewish communities. Although there have been several quantitative studies examining mental health in the community, a large portion has focused on the experiences of community therapists and other mental health service providers. No identified in-depth qualitative studies based on the personal experiences of members of Orthodox Jewish communities have been conducted in the US. Thus, the purpose of the study is to explore the Orthodox Jewish views on mental illness and its relationship with stigma in the community. Continued research in this area may lead to understanding the interaction of religious adherence and mental illness, leadership, and other influences on mental health decision-making. Additionally, the data aims to elucidate and understand barriers to seeking mental health services and factors that help increase effective psychoeducation and utilization of mental health services. Finally, ideas for the dissemination of information and interviews throughout the Orthodox community are proposed, based on interview responses.

Methods

Participants

Participants in this study all self-identified as members of the Orthodox Jewish community within the northeast metropolitan area (NY, NJ, CT, PA) and currently belong to an Orthodox Jewish community. Orthodox Jews adhere to the *Torah* (Jewish Law) and follow its authoritative rabbinic translation (Margolese, 1998). Orthodox Jewry includes four main subgroups: Litvish, Sephardic, Hassidic, and Modern Orthodox. Although there are other subgroups in Orthodox Jewry, all self-identified Orthodox Jews were welcome to participate. Participants were between 18-65 years of age at the time of participation in this research. Additionally, participants were not limited to any gender identification or sexual orientation. Demographic data was assessed and reported below (Appendix A, Table 1). The number of participants for this study was based on responses to social media recruitment invites and word of mouth. Qualitative research's gold standard for the number of participants in studies ranges from 12 to 15 individuals (Hill, 2012). This study included 12 participants. Exclusion criteria include individuals who have been treated for moderate or severe mental illness.

Measures

All participants were interviewed with the same semi-structured interview protocol. The full interview protocol is provided (see Appendix B). Participants were interviewed via password-protected Zoom sessions or phone call sessions. Demographic information was also collected (age, gender, language, current place of residence, highest degree earned, religious affiliation category- Litvish, Sephardic, Hassidic, Modern Orthodox).

Consensual Qualitative Research (CQR) uses open-ended questioning to collect data about specific phenomena, experiences, attitudes, and beliefs using observing, interviewing, and assessing context through inductive analysis with a team of trained researchers (Hill et al., 1997). CQR includes three steps for a research study: developing coding domains, assembling core ideas, and constructing specific categories or themes across analyzed data (Hill et al., 1997). Interviews were conducted by the principal investigator who is a member of the Orthodox Jewish community, with adequate knowledge of the Orthodox Jewish community, and is trained in CQR. There were multiple raters for the coding and thematic process (research assistants (RAs), masters, and doctoral students). The raters assessed the reliability and validity of the CQR measure through mutual consensus on coding and categorizing themes. Coders were trained with the steps outlined by Hill (2012). Specific modules in Hill, 2012 describe the coding and thematic process.

Training

There was a formal training process in which the study team learned about general aspects of qualitative research and data collection. Interviewers and coders were required to read the first edition of *Essentials of Consensual Qualitative Research* (Hill & Knox, 2021). Furthermore, under the supervision primary of a faculty member trained in CQR, the lead investigator reviewed important concepts in detail, during two training sessions, and determined that there was an adequate understanding amongst the study members, specifically regarding data collection and analysis. The team conducted practices, using a transcript, to reach a consensus on research materials, domains (codes), and categories (themes) via cross-analysis of data from a completed study. Upon completion, this training included all necessary topics relating to developing domains, categories, and data analysis.

Although the primary investigator conducted the interviews, the team was also trained to anticipate issues during an interview, in order to understand added validity and reliability in this qualitative research. This includes anticipated specific questions and responses of participants in the study. The interview questions included five broad, open-ended questions. Each broader question had additional probing and follow-up questions. If a participant's response included "I do not understand the question" or "What do you mean," interviewers would then ask if there are words or phrases that are not understood and re-ask the question. Due to the inherent bias in CQR of individual experiences (both the interviewee and interviewer), the interviewer did not paraphrase or change the wording of the questions. If the participant did not respond or had difficulty, the interviewers will move to the follow-up questions. The team members were trained to efficiently complete an interview session within the allotted amount of time. This can be accomplished by informing the participant at the beginning of the interview of the maximum length of time the session will extend and that they will receive a prompt approximately five minutes before the session ends.

Before the team used their training for the current study, a pilot interview was conducted to assess the usefulness of the semi-structured interview. Discussion and consensus amongst the interviewer, faculty supervision, and coders of the pilot study materials determined that training goals were met.

In anticipation of the process of a CQR study, each team member independently read through approximately two transcripts of interviews and constructed possible domains which were discussed and then returned as a group to reach a possible consensus on all the transcripts used in general domains. This training increased the team's probability of producing quality consensus and data analysis.

Coding

The interviews were transcribed at the conclusion of the interviews. Accuracy was established by reading the transcript and simultaneously listening to the audiotape. A minimum of three trained coders (masters and doctoral-level RA’s) met to create a consensus of codes and themes and resolve any differences for coding purposes. Interrater reliability was established in practice rounds (pilot study) before coding the participant data. An interrater reliability/agreement was constructed by study members separately coding data and then returning to create a consensus between raters to assess rater agreement. As the CQR may lend itself to biases, study team discussions related to potential biases transpired before coding (Hill et al. 1997) to improve the team’s objectivity.

The consensus amongst the interviewers and coders of study materials served to determine specific codes (domains) and themes (categories) for analysis. After collection, the data was analyzed through a rigorous CQR process, which included the use of auditing and cross-analysis (detailed later in the data analysis section). The independent auditor, who is trained in CQR but less directly involved with this study, provided feedback to incorporate into coding.

Procedure

Participants were invited to join the study after the Institutional Review Board (IRB) of William Paterson University (WPU) reviewed and granted permission for this study. All participants were recruited through email, social media, and word of mouth. Participants signed a consent form. The informed consent included specific permission for an audio-recorded virtual interview through Zoom. At the start of each interview, participants' demographic information was collected via short questions (i.e., age, gender, language, education level, community affiliation). Participants were then asked a series of open-ended interview questions by a trained interviewer during the interview. Demographic short questions (see Appendix A) and open-ended interview questions (see Appendix B) are provided. Responses and dialogue were audio-recorded and transcribed for later analysis. Participants were asked to share their opinions, thoughts, and beliefs and have the option to end the interview at any time. Additionally, participants were given the option to skip any questions which made them feel uncomfortable or unwilling to answer. Participants were debriefed at the close of the session.

Data Analysis

The semi-structured interview sessions were transcribed and coded to provide qualitative data. The research team was trained to use the Consensual Qualitative Research (CQR; Hill, 2012) method of data analysis. The CQR for analysis involves the following steps when using interview data—development of domains and categories, construction of core ideas, auditing, and cross-analysis. During the development of domains and categories, the team first read each transcript independently. They then met to discuss codes that are repeatedly mentioned in the data. The meetings assisted the team in deciding on domains (which are the central topic ideas, e.g., reasons for stigma) that were the foundations of final codes for discussion in the study. The team of researchers collaborated to reach a consensus on domains (final codes) (Table 2).

Next, the team met to come to a consensus about the wording of each core idea (categories) from the transcripts. The team also met to come to a consensus about each core idea's wording from the transcripts. The team then used the core ideas in individual statements and summarized the statements for domains in each transcript.

After the core ideas (categories) were constructed and summarized per domain, an external auditor (a researcher with expertise in qualitative research, not directly involved with the current study) assisted in determining that the data from the interview was coded in the correct domains and that the categories sufficiently portray the responses of the study's participants. The auditor provided feedback to the team; the team then made changes based on the reviewed suggestions.

The last step of cross-analysis brought together interview transcripts to check for consistency of analysis. Domains and categories were compared for homogeneity. Categories for each domain are critical to be looked at for consistency. The modifications included combining categories under domains to include all participant responses or ideas. After the cross-analysis concluded, the team met to verify the final categories for each domain. The final data analysis of the domains and categories is detailed and reported (see Table 3).

The data was also checked for any missing responses to the interview questions. This is done to check for differences between those participants who answer all the questions and those who decline to answer specific or multiple questions. This documentation assists in ensuring that if there are problems with the interview questions as a measurement tool for the study, they will be noted and addressed. The pilot interview also assisted in improving the quality of the interview questions.

Results

The results of this study included findings related directly to the interview questioning and resulting qualitative data collection. The data analysis of interview materials produced domains and categories. There were no questions in the interview protocol that participants purposely skipped or refused to answer. Demographic data is included in charts below (Table 1). Eight distinct domains emerged from the analyzed data. (Data Tables 2,3).

Perception of Mental Health and Mental Illness

The domain of mental health as understood by participants included responses delegated to core ideas for both mental wellbeing and mental illness in the first domain. Participant data described five categories for mental wellness and six categories for mental illness. At least half of the participants (*n*=7, 58%) described mental health as an ability to adapt and cope with challenges and bounce back in difficult circumstances. Additionally highlighted was an individual's consistency within interpersonal relationships and personal responsibilities.

> We all have feelings that change with situations, and circumstances, if a person is upset over a certain event the natural tendency is to be upset, or sad, it's all part of the human condition, if a person has good mental health, after a certain amount of time he bounces back to good mental health; if he has a mental illness he can't bounce back to initial state of equilibrium (Participant #8, 38, Male).

> Mental health is consistency in life, understanding people, themselves, and understanding relationships with people around them (Participant #4, 45, Female).

In addition to describing mental health in a general sense, the theme relating mental stability and the ability to practice religious beliefs was supported by participants. This is interesting given the amount of time Orthodox Jews devote to prayer, *Torah* (Jewish Law) learning, and acts of *Chessed* (charity and good deeds). Since they are surrounded by religious practices, usually every day, there appears to be an important interaction as was relayed by one participant.

> Good mental health is not going to the extreme, basic healthy function in a community, one's family and one's place of work, being able to get on with one's friends, spouse, children, employee/ employer, friends and family, in addition feeling a sense of accomplishment, inner piece, a sense of happiness and worthiness of life, proper mental health of course will also go hand and hand with religious observance and religious requirements, my feeling is that proper ability to live as a practicing Jew coming from a place of love, happiness and desire is contingent and so dependent on one's proper emotional state of being (Participant #9, 47, Female).

As mentioned above mental illness was described by participants as being unable to function properly or cope with difficulties, an inability to sustain relationships and responsibilities as well as showing extreme unhappiness exhibiting symptoms causing an inability to enjoy life.

> Mental illness will vary, different people are born with different levels of emotional strength ability and capacity. When one fails to produce and to live and function according to their basic normative emotional functioning and begins to not function according to their capacity and ability that's when there is a problem- but its relative to how they are born, their G-d given strength and community and family around them,

> when one begins to drop these things there may be a concern of an emotional illness at play (Participant #8, 38, Male).

Experiences with Mental Health

The experiences the participants had with mental health and illness varied. This domain provided four categories regarding experiences. Multiple (*n*=6, 50%) participants discussed experiences they had from within the community; that is communal interactions with those suffering from mental illness, which included witnessing those suffering from psychiatric symptoms to hearing about another's relative or significant other dealing with a psychiatric crisis or long-term situation. Most participants did not discuss a personal situation (i.e., self, family member etc.), whether that is coincidental or a product of the stigma in the community is difficult to ascertain. Some participants (*n*=4, 33%) related experiences they encountered while caring for non-relatives or within an occupational framework.

> As I stated earlier with my students coming in with varying levels of emotional unhealthiness and mental illness, in some case it's a child of as the suffering person, neighbor, child or part of the community and we deal with the repercussions, as part of a support group as part of people impacted by mental illness. Specifically, what I have seen and noticed is a dip and a strong impact of many people who fought valiantly and very different times of COVID, some immediately post COVID and post COVID effect which caused mental illness (Participant #5, 39, Female).

> I have dealt with it like... I had two foster girls living in my home that both suffered from severe mental illness at different times, it was a big exposure that I had…(Participant #4, 45, Female).

Likelihood to Seek Mental Health Services

The third domain captured the likelihood of individuals reaching out for mental health treatment. The responses to this domain fell along a continuum. At least half of the participants (*n*=7, .68%) responded that they would seek mental health services if needed (i.e., if the situation was serious and the symptoms warranted treatment). Some of these participants were more enthusiastic while others were more nonchalant as reported by one participant. "…If I thought I needed it I would probably go- why not?" Only one participant noted they would defiantly not get help,

> I would avoid it like a plague…I have seen a lot of issues; I feel a lot of people are misled with unprofessional help (Participant #4, 45, Female).

Another participant noted her experiences with others reaching out for help as well as her own.

> I am going to say it runs the gamut- most people feel it's a tremendous resource, but some people feel "I must be crazy," and that's sad. (but) I would, to be honest I have a couple of instances because I am lucky enough to be exposed to the best (therapy resources) I have reached out and said can I have a slot? I'm lucky because I don't need so many sessions, but I can pay for it thankfully. I think people are hesitant because of the commitment and the time it takes to get results, it's not a magic pill (Participant #7, 55, Female). It depends how serious it is, if I am not functioning I probably would be hesitant, but I would follow the advice of my physician (Participant #3, 65, Female).

Some participants reported their worry about practitioners being suitable, capable, and qualified to provide mental health services for patients. This included their ability to assist those with mental illness, especially with understanding the unique beliefs and customs within the Orthodox Jewish community.

> I understand, when necessary, it is such an amazing resource, that being said I would be very cautious. In my experience of sending people for assistance I have not always seen the practitioners being suitable or worthy 100% very infrequently, at time jeopardizing their religious beliefs and mental health therefore for my personal search I would do much research by means of asking people in my community, mental referral services and trusting my gut when meeting (Participant #5, 39, Female).

Not surprisingly, all the participants who reported they were less likely or hesitant to reach out for mental help if needed as stated by a participant,

> It depends how serious it is, if I am not functioning I probably would be hesitant, but I would follow the advice of my physician (Participant #3, 65, Female).

These followed up with the reasoning that they would be stigmatized or feel uncomfortable due to mental health treatment which leads to the domain number four.

Personal and Community Feelings Towards Mental Health Care

Specific fears, worries, or general attitudes and feelings towards mental healthcare initiated rich responses of specific issues and personal situations related to mental illness throughout this study. Data analysis of this domain pointed towards the personal and social levels of the general acceptance of issues regarding mental illness. This was classified by personal or communal acceptance, stigmatization, or mixed feelings towards this subject. It appears that people’s experience, whether personal or within the community, has a direct impact on their views and perceptions regarding mental illness and treatment.

Participants also appeared to be on the fence about whether mental illness, or talking about mental health was accepted, this included their supposed comfort to speak about or seek treatment but worry about other’s knowing as a participant noted,

> I would say I am very open (speaking about mental illness), but immediate family and some, extended family not as much I guess….If it would be public I'm too embarrassed to do it, what if people find out what will people think and how people will react? so not the same as stigma, stigma is being labeled as or I have something private (Participant #9, 47, Female).

Or as another participant when asked if others would share information, the participant responded,

> I would be very comfortable, but most people would keep it quiet- but someone else would believe that it's better to be quiet (Participant #7, 55, Female).

Overall, this domain highlighted the individualistic vs. collectivistic views that may be present in insular or religious communities. This may be due to more centralized religious beliefs, customs, laws and community leaders. Although participants endorsed personal opinions about mental illness in the community, they also endorsed views about community values and perceptions.

Barriers to Mental Care

Participants described six major barriers to obtaining mental health care. Participants related obstacles related to religious concerns and an overall sense of shame. At least half of the participants reported cost or financial issues and lack of confidence in mental health services as a barrier to reaching out or receiving help. To complicate the financial issue, many participants described privacy as a core issue. Due to issues of privacy, community members may seek private services to minimize public exposure, but costs are high and may be difficult to manage financially. As described by a participant,

> It's also so expensive (private therapy) I think it's way too expensive, so there is going to

> a clinic (but) I would be very embarrassed (Participant #12, 38, Female).

The idea of perfectionism and wanting to appear problem-free within social circles and the community was raised by a participant. It appears privacy may be a way to decrease the way others can view imperfections and in this case, the issues related to mental or emotional symptoms. The participants homed in on this idea of perfectionism.

> There is a certain sense of perfection, so certain groups of people would look down at abnormalities and sickness. Mental illness is a newer imperfection that showed up on the screen, so stigma refers to you're missing something, there is a sense of weakness, the more people realize it's not a sense of weakness but part of the human condition, same as a heart disease, it's a human condition, more we come into that, the stigma goes away (Participant #8, 38, Male).

As noted above several participants (*n*=3, .25%) concluded that shame could come from having mental illness and also be a barrier to seeking help. One participant addressed the interactions of addictions and shame. It appears from participant's responses that shame is not only a reason for stigma but more specifically also a barrier to getting mental health care.

> There is an enormous amount of shame generally in addition which are contrary to *Torah* (Jewish Law) and that shame will hold people back from going to mental help. Obviously that shame helps people stay away from things, but it is a big component (Participant #8, 38, Male).

Reasons for Stigma

The results of the data analysis captured reasons for stigma in four main categories. At least half the participants (*n*=7,.58 %) endorsed social and family ramifications and issues related to secrecy and judgment from others around them as the main reasons for stigma, which appears to create a better understanding of the preoccupation with privacy and secrecy in insulated communities like the Orthodox Jewish community. A major societal and familial concern addressed issues related to marriages and making shidduchim (marriage arrangements) for their children. The closeness of the community and interrelatedness of Jewish communities, even throughout the world increases the stigma of problems, including mental illness, which may impede the culmination of a good marriage suggestion and culmination. As related by a participant concerning discussing/disclosing mental health information with worry about marriage arrangements for their children and family health status.

> No, I personally wouldn't, but there is a fear for matchmaking to present themselves as free from illness for their children and since there is not 100 acceptance (about mental illness) people will shy away knowing there is mental illness, personally I would shy away for family who doesn't accept (Participant #1, 64, Female).

Two participants concluded that the lack of psychoeducation in the community may increase the stigma of mental illness and cause community members to fear mental illness and individuals who may display psychological symptoms. This is evident in a participant's response.

> Just lack of knowledge, misinformation, support and guidance and the lack of appropriate information, beliefs that all people are crazy and will be institutionalized. For some people the only access, exposure is to serious illness (severe mental illness) so they have a stigmatized view (Participant #7, 55, Female).

On a different note, three participants (25%) reported on ideas expressed by individuals and leaders in the community, specifically about new school vs. old school attitudes of how to address mental illness, with or without outside help. Participants noted that some in the community feel,

> We can handle it on our own, we don't bring in outsiders, professionals are outsiders. (Participant #4, 45, Female).

Age was also an important stigma-related factor discussed by at least two participants. Due to issues of marriage and status as mentioned above parents of children and younger adults would be less likely to share information about mental illness (or shared by their parents). As reported by a participant,

> I don't think it's anyone else's business because people might misunderstand and have a negative attitude or misconstrue……or may not be true and ruin another's life (Participant #1, 64, Female).

However, in older age, participants reported it may be slightly more likely to share and give support to younger people as older individuals risked less with ideas mentioned above by sharing information.

Sources for Seeking Help

Participants' responses for the seventh domain provided a comprehensive list of the six. categories of various sources most selected for help with mental illness and emotional difficulties by community members. Most participants included more than one avenue of help-seeking they would pursue if needed. The majority of the participants endorsed the use of referral organizations or mental health professionals. While other participants reported they would reach out to their physician, rabbi, or spiritual leader. Still, others stated they would seek help through a teacher, a respected other, or a family member. Some participants appeared to combine ideas in their responses as one participant noted "I would turn to my physician, who is a religious person" (Participant #3, 65, Female).

Projected Interventions in the Community and Appropriate Facilitators.

The last domain addressed the factors that can increase or decrease the likelihood of receiving mental health treatment and services in the community. Present or currently occurring interventions include three main categories. Participants noted there is some community outreach and psychoeducation catering to the Orthodox Jewish community to increase knowledge and understanding of mental illness, as well as some communal training of clinicians and community stakeholders. Additionally, participants (*n*=6, .50%) endorsed that there appears to be increased acceptance to seek and receive psychotherapy.

> My community, I think we are much more open to the idea of getting professional help, very much so…slowly but very much so. I think the community is very open to hear about mental health issues. But I think there are many not open and they may not want to know about it (Participant # 1, 64, Female).

In addition to psychoeducation and training, participant responses for future recommendations were discussed in four categories. These include increasing information in print and social media, creating peer support programs for those suffering from mental illness, creating organizations to provide financial support for therapy services as well as creating a way to assist with matching clients to appropriate therapists to increase the sense of security and reliability within the mental health care services.

> If it’s affordable and easy and we are able to erase the stigma then people will go if they need to go, who would otherwise not be able to. The hardest thing to realize is that people think that we are in control of mental health, they we can stop ourselves from worrying etc. but it’s not always the case, and that may be a reason for the stigma (Participant #9, 38, Male).

Participants also suggested the use and potential benefits of responsible, safe, and appropriate sharing of experiences related to mental illness and treatment in the community as presented by a participant.

> I think they only have to gain by sharing their experiences and not affect their future. If people don't understand it, they might create stereotypes in a way that is unnecessary (Participant #4, 65, Female).

Overall, the main ideas appear to highlight the importance of psychoeducation and communal sharing to increase awareness, not just information but accurate information that addresses sensitivities and worries directly related to the issues mentioned above.

Discussion

Findings from this study's data point to existing literature regarding religious communities' perception and pervasive attitudes around mental illness in general, as well as behavior and projection toward individuals suffering from a mental illness (Mannarini & Rossi, 2019; Schnall et al., 2014; Rossler, 2016; Parcesepe & Cabassa, 2013).

Consistent with the literature, participants endorsed different degrees of the stigma of mental illness, including worries and perceptions related to mental illness and interactions with people who suffer mental health challenges. The social repercussions of identifying as an individual with mental illness were also identified. Some prominent concerns related by participants as barriers to seeking mental care include worry about secrecy due to family image, the importance of appropriate social interactions, and future marriage arrangements. Some participants reported a decreased concern for privacy regarding mental health treatment as they aged due to lessening worry about personal marriage arrangements and personal interactions.

Interestingly, although there may be a stigma and lack of accurate information about mental health, participants had largely homogeneous ideas about what constitutes mental health and mental illness, which most describe similar personal and social characteristics. Most endorsed ideas included the ability or lack of ability to cope with life challenges, interpersonal interactions, and personal responsibilities.

Participants reported concerns about the ability of clinicians from outside the community to understand the community's unique needs and customs. On the other hand, community members are reluctant to use professionals in their communities due to familiarity and lack of privacy. Previous data reports that mental health professionals within the community endorse the underutilization of mental health services (Schnall et al., 2014), which in turn gives a greater understanding of specific nuances that may prevent or delay seeking services.

It is interesting to note that participants alluded to the connection between stigma and shame on multiple occasions. One participant explained the connection and cycle between shame and avoidance of helping services, particularly regarding addictions or self-sabotaging behaviors; where the possibility of the therapist or other mental health professional knowing about unhealthy or inappropriate behavior would keep a person from getting the help, they need due to embarrassment and stigma.

Although past research suggests that people from both religious and non-religious communities may turn to clergy members during times of crisis (Slanger, 1996), data from this study did not conclude that all participant’s first avenue would be to would turn to their Rabbi or other religious leaders for help. Although some participants endorsed the likelihood of turning to a spiritual leader, most reported they would approach a referral service or professional as a front-line avenue of assistance. It is intriguing to note the hypothesis that the possibility of the passage of time since the research mentioned above, advances in psychoeducation in the community, and more readily available referrals and hotlines may influence the turn towards medical and psychiatric help-seeking.

Participant responses above suggested the importance of protecting their children’s future by refraining from discussing mental health; participants also suggested that the younger generation (participants' children) appeared more comfortable asking for help or their desire to speak with a therapist regarding personal issues. As reported by a participant “... my daughter straight out asked me to get her help but we are supportive (of mental health services) in a private way…” (Participant #12, 38, Female). On the other hand, other participants stated the opposite that there is less stigma for the older generation because there is less concern once they are married and have raised families as reported “Depends which stage of life and I will pass if you are young there is no reason to share mental issues, but an older person like I think they only have what to gain by sharing their experiences and it will not affect their future (Participant #4, 65, Female). The younger generation may be more open to accepting therapy, however, their parents are not comfortable sharing their children’s information due to worry regarding their children’s reputations and future social ramifications. These ideas may lend themselves to further research regarding stigma issues per age group.

During the interview process, the researchers identified social desirability or socially appropriate responses; participants sometimes appeared hesitant to say what they felt, and the interaction with the interviewer showed some participants' apparent cognitive dissonance. For example, participants attempted to normalize mental illness and the importance of receiving treatment but over-stressed the importance of no one knowing about illness or mental health services. According to this study's current qualified data, there were no significant differences in opinion by identified religious sub-group per the use of specific help-seeking or reasons for stigma.

Because one in three people may experience mental illness in their lifetime (Vigo et al., 2016; Javed et al., 2021), it behooves us to look for ways to decrease the stigma of mental illness so that individuals suffering from symptoms can receive appropriate and adequate care. Even more so in the religious and the Jewish Orthodox community, where the stigma appears to be more profound due to various societal concerns, there is an urgency to tackle this matter.

Clinical Implications

There are several clinical implications identified through the data collected. The stigma of mental illness and treatment has been analyzed and identified in the literature pertaining to general and religious groups. However, in-depth perspectives of individuals from within the Orthodox community appear to have specific concerns that differ in scope and reason. Understanding the cause and root of stigma in the community can help researchers, lay people, and clinicians understand and take appropriate action to assist members in seeking and utilizing mental health services.

Judaism, and Orthodox Judaism in particular, does not shun helping others, whether they have a physical, emotional, or mental illness, but instead encourages community members to care for one another. This care is evident in the vast number of helping and charity networks doting all Orthodox Jewish communities worldwide. This includes organizations helping the sick, infirm, emergency services, those that assist with financial concerns, as well as helping families with orphans, widows, divorcees, and a myriad of other charities that function daily mainly on communal donations, widespread support, and focused care. So clearly, the need to assist and support is present. Although various organizations are also dedicated to assisting those with mental illness and emotional distress, the stigma of mental illness remains. It appears the importance of psychoeducation directed for the community about mental illness, specifically the causes, trajectory, and range of treatments, may give family, friends, and the community at large a better and clearer understanding of individuals with mental illness and increase confidence in care and treatment. Once in treatment, therapists working with this population may need to use reframing techniques that focus on Jewish values at the outset of treatment to explore the benefit of help-seeking for mental health services and enhance treatment adherence.

The literature suggests that a social group with power has a greater ability to create or endorse stigmas (Knaak et al., 2017). This idea further suggests the importance of getting community leaders and stakeholders to understand and agree to assist in decreasing stigma through psychoeducation and other identified methods. According to research, in order to create effective and positive results, it is essential to have the ability of open dialogue to discuss ideas, fear, and confusion regarding mental health (Staurt et al., 2014; Stuart, 2016). Additionally, it is imperative to tailor psychoeducation about mental illness specifically to the specific group, whether it is directed at youth, care workers, or other sectors of the community.

According to qualitative data conducted in religious countries where stigma related to mental illness is more pronounced, participants endorsed the importance of including psychoeducation at much younger ages, particularly in school-age children (Taghva et al., 2017). Earlier psychoeducation appears to have an impact on decreasing stigma earlier in life. According to the data mentioned above, adolescents may be more likely now to ask their parents for assistance in getting mental health assistance, while this data does not include reasons for this endorsement. Overall, the importance of younger children being more comfortable discussing mental health may prove to be a big factor in increasing stigma in the community.

On a technical level, the cost of mental health treatment and therapy, in particular, appeared to be a significant concern for participants. Worry about free or low-cost clinicians from clinics and other organizations possibly being less qualified to treat disorders combined with, on the other hand, the onerous burden of paying private but highly rated therapists may be a number one concern a barrier to utilization of mental health services. Participants voiced various opinions about the solutions to this issue with subsidizing private services, communal funds for private therapy, and vetting of clinic therapists.

Limitations and Future Directions

This study is not without its unique limitations. Participants in this study were from within the tri-state metropolitan area. They expressed perceptions that may be particular to an insular group from within large and interconnected communities where stigma may be decreased or more substantial and have more significant repercussions than in other parts of the country that are less populated or metropolitan. Most of the study's participants identified as a member of the Litvish Community, a subgroup of Orthodox Jewry discussed above. It would be interesting to compare more data from the other identified communities (i.e., Hassidish, Sephardic, Modern Orthodox) to note differences in the levels of stigma, particularly concerning secrecy and privacy. The participants were made up of a larger number of women than men. This may lead to an unbalanced view of the data provided due to the possibility of different interactions and the social concerns of men and women in the community. The interviews were conducted by a member of the Orthodox Jewish community, which may have attributed to some social desirability answering due to possible concern about negative evaluation or judgment. The interviewer was a female, which may have suppressed more candid answers from male participants.

Aside from the lead investigator, the research team members were not from the Orthodox Jewish community and had limited knowledge about customs and concerns, which may prove to be both an advantage and some limitation to this study. As a general note, as discussed above, qualitative studies can help researchers gain highly valuable in-depth information and perception about societal issues; the investigator's and participants' personal biases are present and may be a limitation to the study and data findings.

Future directions endorsed by participants and study investigators point heavily to psychoeducation and the use of community outreach to encourage the accumulation of knowledge and effective help-seeking. This should be accomplished with the input of community leaders, educators, religious leaders, and others who may positively affect the direction of decreasing stigma within the community. An important takeaway of this study may be to propel other data collection from different groups in the community which have not been reached through this effort. Some groups within the Orthodox Jewish community may not have access to social media and may require other methods to collect data. These groups may also require similar or different techniques or skill-building to elicit information and act on data gleaned from the community. The possibility of sharing information and stigma-decreasing techniques may be a future direction for community leaders and mental health providers. Additionally, it may be interesting to note the similarities between this community and other non-religious communities regarding the cycle and complications of the stigma of mental illness.

Conclusion

There is a sparsity of research information relating to the perceptions, beliefs, and attitudes about mental illness and wellness from within the Orthodox Jewish community. The data from this study helps capture the magnitude of effects regarding issues of mental illness in the community and how it poignantly affects many social, interpersonal, and communal concerns. Understanding the main concerns, worries, and barriers, who the community currently turns to for help-seeking, and the concerns regarding mental health providers will increase the effectiveness of working with communal and religious leaders.

Overall, the current data, which have begun to uncover the views related to the how and why of stigma in the community, will assist us in future work by providing enhanced data to community leaders and other stakeholders as to how to begin to work on decreasing the stigma of mental illness, primarily through community outreach and the appropriate psychoeducation with care to age, stage, and social group.

In closing, this study's data, particularly through participants' perceptions, beliefs, and views, combined with past and current literature on the stigma of mental illness, particularly in religious or insulated communities, underscores the cycle that leads to the stigmatization of individuals or groups of people living with mental illness and its accompanying symptoms. Elucidation of the specific attitudes, barriers, and causes combined with future directions and suggestions, will provide a highlighted path toward improvement and the fulfillment of important goals related to decreasing the stigma of mental illness in the Orthodox Jewish community.

Table 1

Demographic Characteristics

Characteristic	*n*	%
Gender		
Men	5	42
Women	7	58
Age		
18-38	6	50
39-54	3	25
55-65	3	25
Religious Affiliation		
Litvish	10	84
Sephardic	0	0
Hassidic	1	8
Modern	1	8
Highest Level of Education		
High School	5	42
Trade School	0	0
College	5	42
Graduate	2	16
Doctoral	0	0
Native Language		
English	12	100
Hebrew	0	0
Yiddish	0	0

Note. *N*=12.

Table 2

Domains and Descriptors

Domain	Description
Definition/Perception of Mental Health	Participant understanding of the characteristics attributed to mental wellness
Definition/Perception of Mental Illness	Participant understanding of the characteristics attributed to mental sickness
Experiences with Mental Illness	Participant experience with mental illness, self, family, community, and other experiences
Likelihood to Seek Mental Health Services	Participant report of willingness to seek mental care
Personal and Community Feelings Towards Mental Health Care	Participant feelings of stigmatization including both personal and community
Barriers to Mental Health Care	Specific obstacles to receiving mental health care per participant report
Reasons for Stigma	Participant perception of reasons for the stigma of mental illness
Sources for Seeking Health	Sources to turn to for mental health care per participant report
Projected Interventions in the Community and Appropriate Facilitators	Present and Future intervention to decrease stigma and improve mental health care in the community

Table 3

Domains and Categories of Twelve Cases and Classification

Domain and Categories of Classification	Number of Cases	Classification
Definition/Perception of Mental Health		
1. Ability to adapt; Bounce back in difficult circumstances	7	Typical
2. Consistency and understanding within interpersonal relationships	5	Typical
3. Keeps personal responsibilities; Functioning person	5	Typical
4. Being happy and upbeat	3	Variant
Definition/Perception of Mental Illness		
1. Unable to function properly or sustain relationships	6	Typical
2. Exhibiting symptoms causing severe distress, loneliness and inability to enjoy happy life	4	Variant
3. Biological Basis	2	Variant
4. Someone who has a mental illness of feeling and emotions	8	General
Experiences with Mental Illness		
1. Familial/Personal	4	Variant
2. Caring for non-family in home (foster)	1	Rare
3. Community based	6	Typical
4. Occupation based	3	Variant
Likelihood to Seek Mental Health Services		
1. Enthusiastic	2	Variant
2. Nonchalant; Likely	7	Typical
3. Hesitant/Worried	2	Variant
4. Would Decline/Avoidant	1	Rare
Personal and Community Feelings Towards Mental Health Care: Society vs. Individual		
1. Personally		
a. Accepted	7	Typical
b. Stigmatized	2	Variant
c. Mixed	2	Variant
2. Societally		
a. Accepted	2	Variant
b. Stigmatized	1	Rare
c. Mixed	7	Typical
Barriers to Mental Health Care		
1. Cost or Financial Issues	6	Typical
2. Resistance Due to Lack of Confidence of	7	Typical

Mental Services		
3. Shame	3	Variant
4. Privacy Concerns	8	General
5. Sense of Perfection	2	Variant
Reasons for Stigma- (psychological- personal)		
1. Social and Family Ramifications	7	Typical
2. Cognitive Dissonance- try to normalize endorse stigma	3	Variant
3. Secrecy and Judgement	6	Typical
4. Inadequate Psychoeducation	2	Variant
Sources for Seeking Help		
1. Referral or Hotline	8	General
2. Physician	5	Typical
3. Mental Healthcare Professional	6	Typical
4. Rabbi or Spiritual Leader	5	Typical
5. Teacher or Respected Other	3	Variant
6. Parent/Family	1	Rare
Projected Interventions in the community and appropriate facilitators.		
Present		
1. Some Community Outreach and Psychoeducation noted	8	General
2. Increased acceptance to receive therapy	5	Typical
3. Communal training of clinicians and community stakeholders and religious leaders	2	Variant
Future		
1. Increase of print and social media where appropriate	2	Variant
2. Peer support programs	3	Variant
3. Creating a subsidized fund or monetary support or making it free	5	Typical
4. Assistance with matching clients to Appropriate therapists	4	Variant

Note. Domain/Core idea descriptors: General if applied to at least 8 out of 12 participants, Typical if applied to 5-7 participants, Variant if applied to 4 or less participants, Rare if applied to only 1 participant.

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Appendix A
Demographic Questionnaire

Participant:
Age:
- 18-38
- 39-55
- 55-65

Gender:
- Male
- Female
- Other

Area of Living:
- NY
- NJ
- CT
- PA
- Other

Religious Affiliation:
- Litvish
- Sephardic
- Hassidic
- Modern Orthodox
- Other

Education Level:
- Primary- 3rd

4th - 8th

9th- 12th

Trade School

College Degree

Masters Degree

Doctoral Degree

Native Language:

English

Yiddish

Hebrew

Other

Appendix B

Semi-Structured Interview Questions

A. Have you always practiced Orthodox Judaism?

How do you identify in terms of religiousness?

B. What are the experiences of mental health in the Orthodox Jewish community?

What do you understand good mental health to mean?
What is mental illness? How would you describe it?
How do you feel about discussing this topic?
What are your experiences with mental illness?
Have you known anyone with mental illness?
Have you ever received information about mental illness from your community? Can you tell me more about it? Are there any specific sources of information in your community?

C. How likely would you be to seek mental health care?

How do your friends and family feel about getting mental health services?
How does your community view mental illness?
How does your community view psychotherapy?
How would you feel about getting services?

D. Where do Orthodox Jews turn to for mental health needs?

Where would you turn to if you had a mental health crisis?
Are there any similarities or differences between mental crisis and spiritual experiences?
What are the benefits or downsides of turning to your rabbi (other religious people) for help?
Are there specific types of treatment that are recommended in your community?

E. What would stop you from getting mental health services?

Are there specific worries or fears regarding getting mental health services/treatments?
Would you be worried about others (family, friends, etc.) knowing that you reached out to a mental health professional and/or received treatment?
Do you find it important to keep issues regarding mental or emotional health private?
Who would you share this with?
Are there any specific factors that would increase your getting mental health care?
Anything else you would like to add or that you would like the community to know?