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Therapists' Attitudes to Using Spiritual and Religious Interventions with Orthodox Jewish Clients

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THERAPISTS' ATTITUDES TO USING SPIRITUAL AND RELIGIOUS INTERVENTIONS WITH ORTHODOX JEWISH CLIENTS

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Dissertation Approval

This is to certify that the thesis presented to us by Shmuel Brachfeld on the 10th day of May, 20__, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

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Abstract

Literature on Orthodox Jews and their needs in therapy is limited. However, research on approaching therapy with highly religious, or spiritual clients, shows that addressing R/S in therapy is highly recommended. Studies have shown that although acknowledging the importance of addressing R/S is important, therapists may be hesitant to bring it up with clients. Therapists' attitudes have been shown to have impact not only if R/S is addressed in therapy, but also how and when it is addressed. One of the factors that impacts if therapists address R/S is therapists' own religious identity and attitudes to R/S in general. This qualitative study looks to bridge the gap between the research and its application on the Orthodox Jewish population. Twelve Orthodox Jewish therapists were interviewed to describe their attitudes towards addressing R/S with Orthodox clients, how they go about addressing it, and how they feel their own religious identity impacts their approach to therapy with this population. Analysis of interviews found that there is a spectrum of attitudes, ranging from extremely positive to being cautious, relative to addressing R/S. All therapists did endorse addressing R/S with Orthodox clients in some way, but how they addressed it varied. Interviewees also felt that their own religious beliefs impacted therapy, and described ways they can manage to monitor it effectively. Through the coding process, themes emerged that created an overarching guiding theory of "Factors that impact therapist's attitudes towards addressing R/S with Orthodox Jewish clients." These factors are recognizing boundaries, being client-centered, and recognizing how R/S intersects with mental health needs f the community. This study concludes with exploring how these factors can help understand and meet the mental health needs of this population. Implications for future research and limitations are also explored.

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Chapter 1: Introduction

Statement of the Problem

Orthodox Jews live within a unique religious, cultural and social framework that applies to all aspects of their lives. This framework is formed according to the dictates of the Torah and Talmud, which they believe were given to them by God to live their lives by (Schnall, 2006; Loewenthal, 2006; Schlesinger, 2014; Milevsky & Eisenberg, 2012), and apply to all aspects of life, including daily routines, personal interactions, family life and business matters (Schnall, 2006; Loewenthal, 2006; Schlesinger, 2014). This worldview makes every detail in life a spiritual endeavor for the Orthodox Jew (Rabinowitz, 2000).

Religion and spirituality also impact how Orthodox Jews view, and address their mental health needs (Heilman & Witztum, 2000; Schnall, 2006; Schnall et al., 2014) and has led to challenges for the mental health professional in effectively treating this population (Popovsky, 2010; Loewenthal, 2006). Obstacles include general mistrust of mental health professionals (Schnall, 2006; Heiman & Witztum, 1999), stigma attached to mental illness and seeking professional help (Schnall, et al., 2014; Rosmarin, Pirutinsky, Pargament & Krumrei, 2009), and belief that there is conflict between religion and the mental health field (Schnall et al., 2014; Popovsky, 2010). Although research on this population is limited, literature does suggest that working within the socio-cultural framework and using religious and spiritual interventions is a way of limiting some of the barriers to effectively address the mental health needs of Orthodox Jews (Schnall et al., 2014; Levin, 2015; Rosmarin et al., 2009).

The inclusion of religion and spirituality in mental health treatment has grown over the years (Masters, 2010). Clients' mental health concerns can affect their functioning in everyday life, as well as their perspective on life and their values (Masters, 2010; Martinez, Smith & Barlow, 2007). Because spirituality and religion may intertwine with mental health concerns, it is important to address their intersection in therapy (Smith & Richard, 2005). Accurate understanding of spiritual and religious beliefs have been shown to impact treatment positively; however, ignoring these beliefs can lead to reduction in effectiveness of therapy (Smith, Bartz & Richards, 2007). Research has shown that the interventions that help enhance clients' connections with their spiritual faith have the best outcomes because it helps the clients integrate the interventions into all areas of their lives (Koenig, 2009; Smith, et al., 2007).

Although acknowledging that religion and spirituality are important to address, research shows that therapists tend to avoid bringing these matters up in session (Plumb, 2011; Khale, 1998). Reasons for the hesitancy include lack of education (Plumb, 2011; Canda & Furman, 2009), not recognizing their importance (Khale, 1998), general discomfort (Plumb, 2011; Souza, 2002), counter-transference (Walker, Gorsuch & Tan, 2004; Koenig, Larson & Matthews 1996), clients not bringing it up as a subject (Ankrah, 2002; Khale, 1998; Oxhandler & Pargament, 2014), ethical concerns (Martinez, et al., 2007; Koenig et al., 1996), and not wanting to put too much emphasis on religion and spirituality (Sprangler, 2010). There is a larger willingness of religious therapists, especially from similar backgrounds, to address the spiritual concerns of their clients (Martinez, et al., 2007; Shafranske & Cummings, 2013). However, religiously similar dyads have their own concerns that need to be addressed (Masters, 2010).

Literature on Orthodox Jews suggests that it may be best that they see professionals from similar cultural backgrounds because behaviors and feelings of Orthodox Jews are likely to be best understood by those with a full immersion in the religious and cultural values of the community (Bilu & Witztum, 1993; Spitzer, 2003; Provosky, 2010). Incorporation of religious and spiritual interventions is important with this population (Schnall, 2006; Loewenthal, 2006; Milevsky & Eisenberg, 2012). Such interventions include assessing for religious/spiritual impact on life and mental health (Rosmarin et al., 2009; Huppert & Siev, 2010), use of religious rituals that promote healing (Provosky, 2010; Loewenthal, 2006), religious and cultural idioms (Heiman & Witztum, 2000), religious prayer, use of Scripture, classic Jewish texts (Rawitch, 1997; Milevsky & Eisenberg, 2012, and collaboration with Rabbi (Schnall et al., 2014; Provosky, 2010). Suggestions in the literature highlight the idea that before addressing religious/spiritual aspects, therapists, even Orthodox ones, need to be comfortable in including these interventions, and have some level of expertise in understanding the religious texts and practices (Rawitch, 1997; Schnall et al., 2014). Unfortunately, research is limited on the inclusion of religion/spirituality in the treatment of Orthodox clients. There is currently no known research that explores Orthodox therapists' willingness in addressing these areas with Orthodox clients. Examining therapists' perspectives on the inclusion of religious/spiritual interventions in treating Orthodox clients may highlight efforts and approaches used as well as inform new therapeutic approaches for this population.

Chapter 2: Literature Review

Religion and Spirituality in Therapy

In recent years there has been a growing awareness of the importance to address religion and spirituality (R/S) (Masters, 2010), particularly when working with highly religious clients (Hage, 2006; Richards & Bergin, 2005). The increased interest in R/S in mental health can be attributed to the growing awareness of the positive relationship between religion and various indices of morbidity and mortality (Gillum & Ingram, 2006), an increased recognition of the importance of culture in psychology (Master, 2010), and the roles that values and goals play in therapy (de Mamini, Tuchman & Duarte, 2010). There is a growing body of evidence, that demonstrates that the integration R/S into health practices contributes to positive outcomes across a wide range of health and mental health issues, and R/S beliefs have been shown to influence health care decisions greatly (Koenig, King & Carson, 2012). Clients have also expressed a preference for health care providers to initiate the discussion of their R/S beliefs, stating that such integration supports their healing processes (Stanley et al., 2011; Koenig, 2009). Research shows that R/S beliefs and practices are beneficial for improving and maintaining good physical and mental health (Larimore, Parker & Crowther, 2002), and that they have benefits for people dealing with mental illness (Koenig, 2009).

R/S is integral to many clients' lives and is important to consider in practice, much like culture. In fact, Canda & Furman (2009) defined religion, and Robbins, Chatterjee & Canda (2012) defined culture as a pattern of values and beliefs that is shared by a community or social group and transmitted over time (Oxhandler & Pargament, 2014). For the religious patient, religious beliefs often form a point of integration for

other life experiences; therefore, addressing religion and spirituality helps address the holistic person (Masters, 2010). Clients in therapy often grapple not only with issues of well-being, but also with their perspectives on life, their relationships with others, and their deepest values. For many clients, religious issues intertwine with these concerns, and they may benefit from explicitly addressing religious themes or drawing from their beliefs to supplement therapeutic interventions (Smith & Richards, 2005). Because individuals with a R/S worldview typically experience comfort in their beliefs and practices during times of crisis and uncertainty, it is important that counselors encourage spiritual expression (Plumb, 2011). This is especially true during the alliance building stage because it is important for the therapists to create an environment of openness, trust and respect for clients' R/S expressions (Eck, 2002). Finally, religious struggles, or coping mechanisms may emerge, making it important to explore dimensions of religious struggle and coping (Oxhandler & Pargament, 2014).

Benefits to addressing R/S in therapy. There are many benefits to incorporating R/S into therapy. Benefits include greater strength in coping and decision making, enhanced social support and personal wholeness (Fallot, 2001). Research shows that highly religious individuals are most likely to desire R/S based interventions, and often fear that clinicians may not endorse their values, so that addressing R/S needs in therapy can help bridge the gap (Martinez, et al., 2007). Addressing clients' R/S characteristics, preferences and values is an integral component for engaging in best (Oxhandler & Pargament, 2014) and ethical practice (Martinez et al., 2007). Although clinicians may take different approaches to integrating R/S interventions, these interventions have been found to be effective across settings and enhance efficacy of treatment (Smith, et al.,

2007); they also can be effectively integrated into traditional treatments like cognitive-behavioral therapy, interpersonal therapy, psycho-analysis and marital therapy (Martinez, et al., 2007). Adaptations to psychotherapy for clients who strongly endorse religion may enhance efficacy of treatment (Smith et al., 2007), but ignoring them can lead to premature termination (Smith & Richards, 2005).

R/S carry many of the same values that are essential to the therapeutic process, and can bolster the effects of therapy (Masters, 2010). deMamani et al. (2010) cites positive uses of religion which include discussions of spiritual resources, strivings, forgiveness, intrinsic R/S values and religious coping skills. Sprangler (2010) introduces ways that exploring religious concepts and traditions can help reframe distortions and help recovery, such as highlighting discrepancies between beliefs and maladaptive coping. Research on the role of R/S in therapy often promotes the following interventions: prayer with clients, discussing sacred writings, involving resources from the religious community, engaging in meditation and religious rituals, and encouraging moralistic actions (Richards & Bergin, 2005). R/S can be integrated effectively in treatment through assessment, exploring spiritual history, and discussing concepts of forgiveness, gratitude, mindfulness, hope, meaning, connection, spiritual transformation, and ultimate reality (Martinez et al., 2007). It can also be used to explore current positive and negative coping mechanisms (Oxhandler & Pargament, 2014).

A meta-analysis of 31 studies conducted between 1984 and 2005, found an overall moderate effect size (d = .56) in integrating R/S across a variety of clinical issues, suggesting that spiritually integrated therapies may be beneficial to individuals with certain psychological problems such as depression, anxiety, stress, or eating disorders

(Smith, Bartz & Richards, 2007). Wachholtz and Pargament (2008) found that the practice of spiritual meditation leads to fewer headaches, less anxiety and higher pain tolerance when compared with the practice of secular meditation. Rosmarin, Pargament, Pirutinsky and Mahoney (2010) had 125 Jewish patients in a study comparing spiritually-integrated therapy (SIT) with Progressive Muscle Relaxation (PMR) and with waitlisted patients and they found that the SIT group had lower levels of depression, less stress, but increased tolerance for uncertainty when compared with the PMR and waitlist groups. R/S contribute to increased rates of well-being and life satisfaction, and a decrease in rates of suicide, substance abuse and anti-social behaviors (Brawer, Handal, Fabricatore, Roberts & Wajda-Johnston, 2002). Cotton, Grossoehme and Tsevat (2007) found that R/S adolescents were at lower risk of developing negative health behaviors and mental health problems compared with less R/S peers. This can be attributed to the indirect influence of R/S beliefs, such as having social support and positive role models, and direct effects such as having positive coping skills such as using prayer and religious concepts that promote coping.

Precautions to engaging in R/S in therapy. Religious interventions may not always be beneficial. Sloan and Bagiella (2002) point out many reasons why addressing R/S should be avoided in therapy. These reasons include likelihood for minimization of evidence-based practices, fears of coercion, violations of privacy, possibility of doing harm, and discrimination against individuals for whom religion is not important. When addressing R/S it may be difficult to avoid engaging in philosophical discussions that may be irrelevant to therapy (Sloan, Bagiella & Powell, 2001). For example, developing forms of therapy that specifically integrate religious perspectives may lead to the over-

emphasis of the importance of religious influences (Masters, 2010). When bringing up R/S in therapy, therapists should take into account several ethical considerations: ethical obligation, informed consent, R/S identity development of the client and clinician, dual relationships, collaboration with religious leaders, respect for client's boundaries, work setting boundaries and cultural competence in the area (Martinez et al., 2007). Individuals, even from the same religious backgrounds, experience their beliefs differently, and these individual differences tend to be overlooked by generalizing religious beliefs (Masters, 2010).

An underlying assumption in integrating R/S is the idea that R/S values are healthy and that incorporating them will bring about beneficial psychological results. Sprangler (2010) points out that there are times when religious beliefs may be the underlying cause for emotional disturbance and can serve as way to promote pathogenic cognitions related to various psychological disorders. deMamani et al. (2010) cite that anxiety related to religion can lead to obsessive engagement in religious rituals that are seen as negatives in therapy. Rigid religious beliefs based on sin and guilt may deepen mental illnesses such as depression and delusions (Fallot, 2001). Research on schizophrenia has shown that hallucinations are more likely to be accentuated by religious contact than by any other context (Fallot, 2001; deMamani et al., 2010). Cotton et al. (2007) also found that R/S can have a negative effect on the lives of teens, particularly around sexual risk behaviors.

Therapists' Attitudes to Including R/S in Therapy

There are several reasons why therapists may be cautious in addressing R/S in therapy. Most mental health professionals have not been adequately prepared in their

clinical programs to work with R/S clientele. Graduate programs are lacking when it comes to preparing clinicians-in-training to invite clients to share their R/S concerns, issues and values in the same way that they share any other areas of their lives (Eck, 2002). Lack of graduate training in R/S may lead clients to avoid discussing R/S in therapy, and counselors to avoid the topic as well. Only 13% of doctoral programs have courses in R/S (Rosmarin, Pargament & Robb, 2010). Sixty-five percent of social workers report not having received any education on integrating R/S in practice (Canda & Furman, 2009). Furthermore, Khale (1998) found that most therapists had received discouraging messages about discussing God with clients through their training, even though they were encouraged by clients to discuss God.

In addition, although many therapists acknowledge that R/S is important, they are generally fearful of bringing it up with clients, and therefore it is rarely discussed (Masters, 2010). Twenty-five percent of social workers report that they do not feel that they have the skills to assist clients in R/S matters (Canda & Furman, 2009), and the other 75% report that the quality of their skills is unknown (Oxhandler & Pargament, 2014). A study of master's level counselors revealed that most students experienced discomfort when discussing spiritual issues in counseling, mainly due to fears of offending, or of being judged (Souza, 2002). In Khale's (1998) dissertation study, therapists endorsed being concerned about imposing their own belief systems, feeling that reliance on God was disempowering to people, and fear that R/S differences would create therapeutic barriers. Many therapists' views on the positivity or negativity of spirituality were based on their personal experiences (Walker, et al., 2004), which leads to concerns of counter-transference in bringing in R/S beliefs into therapy. A study found that

religious therapists were more likely to report engaging in R/S interventions such as the use of prayer, scripture references and religious metaphors, but do so based on their own religious experiences (intrapersonal integration) (Walker et al., 2004; Spero, as cited in Koenig, et al., 1996). This can create problems of therapists imposing their own values and beliefs, or applying interventions inappropriately.

Khale (1998) found that of 151 therapists surveyed, 98% of them endorsed the concept that they would discuss R/S concepts in session only if the client brought it up. Clients, however, may hold back because they may prefer to keep the sacred from the secular (Martinez et al., 2007), or they may fear religious coercion (Masters, 2010) or judgment by their therapists when discussing R/S beliefs (Eck, 2002). Clients in therapy run the risk of having their spiritual experiences misinterpreted, or of not feeling comfortable to share that part of the self, and therefore avoid bringing it up (Ankrah, 2002). Ankrah (2002) found that 25% of clients surveyed described the counseling experience as negative because they felt their spiritual experience was either pathologized or dismissed.

Koenig, et al. (1996), stress the idea that when religion is brought into therapy, transference and counter-transference reactions may be intensified. Therapists can deal with these reactions by understanding the pathological and non-pathological use of R/S in their clients' lives (Koenig et al., 1996). Spero (as cited in Koenig et al., 1996) adds that therapists need to compare and contrast their own religious beliefs to those of their clients. For the religious therapist working with religious clients, it is important to remember that he or she is a mental health professional, with the goal of enhancing psychological stability, not a religious professional, whose goal is to enhance spiritual

development. It has been strongly suggested that therapists perform a self-assessment to determine if spiritual interventions are appropriate and compatible with their roles and the scopes of their practices (Spero, as cited in Koenig et al., 1996). The therapist must also be self-aware of their own personal beliefs and their ability to hinder their services, or impose practices that violate clients' values (Eck, 2002).

Plumb (2011) surveyed 341 clinical counselors in British Columbia about their feelings of the importance of R/S in mental health, integration of spirituality and religion in mental health practice and attitudes to their training in R/S interventions. Ninety-one percent of therapists surveyed supported the idea that conceptually there is a positive relationship between a client's spirituality and his or her mental health, yet fewer than half indicated that they use it in practice. Eighty-one percent said that it is appropriate to integrate spiritual interventions, but only 46% identified how they do. Only 48% of counselors endorsed asking clients about religion; 60% said that they wait for clients to bring it up, and 37% said that they talk to their clients about God. Counselors reported greater comfort in discussing spirituality in session, as opposed to discussing religion, a finding that may be attributed to their identities as spiritual rather than religious. Only 40% surveyed were interested in continuing education on R/S in therapy, and 40% were neutral. The majority of therapists rated themselves as comfortable and competent when working with R/S clients. Some therapists did report that they were more comfortable dealing with clients that share R/S beliefs similar to their own, making identification with clients a factor that contributes to counselor comfort.

One study found that only 14% of social workers felt that discussing personal religious beliefs with clients was appropriate, but 45% report having done it at least once

(Canda & Furman, 2009). A review of the literature found that only 25% of psychologists believe R/S is relevant to practice; however, nearly half report asking about it in assessment and 82% believe that there is a positive relationship between R/S and mental health (Shafranske & Cummings, 2013). Psychologists have also expressed the importance of being aware of the role R/S has on clients' lives (Crook-Lyon et al., 2012), but said that only 30% of clients tend to bring it up (Frazier & Hansen, 2013) . Carlson, Kirkpatrick, Hecker and Killmer (2002) found that 95% of marriage and family therapists (MFTs) said that there was a relationship between spiritual and mental health, yet only 65% of them believed that it was appropriate for the therapists to ask clients about their spirituality and only 42% agreed it to be appropriate to help clients develop their spirituality. When it came to specific R/S interventions, MFTs were less likely to use them, with only 47% indicating that it was appropriate to talk with clients about a God. Fifty-two percent of the respondents agreed that it is appropriate to use spiritual language with clients, and only 36% believed it is appropriate to use religious language in therapy. A qualitative study found that MFTs feel that they should let the client know that they are willing to talk about their spiritual lives (Carlson et al., 2002).

Across studies concerning the use of R/S in therapy certain characteristics emerged. Therapists generally agree that R/S impact mental health, and vice versa (Plumb, 2011; Martinez et al., 2007; Shafranske & Cummings, 2013) Older (Oxhandler & Pargament, 2014) and more religious therapists (Martinez, et al., 2007; Shafranske & Cummings, 2013) are more likely to consider R/S appropriate for use in practice. Therapists tend to feel more comfortable seeing clients with the same religious affiliation (Walker et al., 2004), which may lead to issues of dealing with intrapersonal religious

perspectives (Walker et al., 2004; Spero, as cited in Koenig et al., 1996). Therapists who address R/S in therapy also tend to hold more positive attitudes to R/S and therefore make greater use of interventions that integrate R/S in practice (Martinez et al., 2004; Masters, 2010). It is interesting to note that religious therapists are more comfortable with using R/S interventions; however, non-religious therapists tend to use it more effectively (Propst, Ostrom, Watkins, Dean & Mashburn, 1992). Practitioners' knowledge (or lack thereof) about how to address clients' R/S struggles, or about their coping mechanisms may also affect treatment planning and outcomes (Khale, 1998; Masters, 2010; Oxhandler & Pargament, 2014; Plumb, 2011). Although acknowledging it is important, most therapists do not bring up R/S, unless the client brings it up (Plumb, 2011; Crook-Lyon et al., 2012; Carlson et al., 2002). Practitioners also acknowledge that they did not receive professional training in dealing with R/S in therapy (Rosmarin, Pargament & Robb, 2010; Canda & Furman, 2009), but many feel comfortable with their ability to use these interventions (Khale, 1998; Oxhandler & Pargament, 2014). Professional affiliation also appears to impact the use of R/S in therapy, with social workers being the least comfortable, and less likely to address this area (Plumb, 2011), and psychologists being more comfortable exploring R/S in therapy (Shafranske & Cummings, 2013).

Jews and Impact of Religion on Health Behaviors

There are several studies that seem to suggest that religious beliefs would not be as relevant to the mental health of Jews as it is to Christians. Cohen & Hill (2007) found that for a Protestant sample, religion was expressed more internally when compared with a Jewish sample. They found that religion for Jews is about community and biological descent, and generally externally expressed, with important life experiences likely to be

more social. Jews were also less likely than Protestants to rate religious beliefs as important (Cohen, Siegel, & Rozin, 2003). Because religious beliefs are more externally based, it would lead to the conclusion that religious beliefs would not relate to psychological well-being among Jewish individuals. Indeed, Cohen (2002) found that R/S beliefs did not predict happiness and life satisfaction in Jews, compared with beliefs of Protestants and Catholic samples. Sieve & Cohen (2007) found that a sample of Christians with OCD reported higher levels of thought action fusion (TAF), a cognitive vulnerability for OCD in which occurrences of immoral thoughts is viewed as tantamount to committing immoral acts, when compared with a Jewish sample.

Although findings suggest that religion has less impact on mental health for Jews, there is reason to believe that these findings would not apply to Orthodox Jews. When comparing subgroups within Jewish samples, Sieve and Cohen (2007) did find that although not significant, compared to other Jewish denominations, Orthodox Jews were more likely to have TAF. It can also be suggested that no significant discrepancy was found, related to TAF because Orthodox Jews subscribe to the Talmudic dictum ,"God does not fuse improper thoughts with actions" (Rosmarin, et al., 2009). Studies by Rosmarin, Pargament & Mahoney (2009) did find that religious views were significantly associated with elevated happiness and lower levels of anxiety and depression in an Orthodox Jewish sample. They also found that Orthodox Jews were more likely to have an intrinsic religious orientation when compared with non-Orthodox Jews. These findings would suggest that addressing R/S in therapy would be as important for Orthodox Jews as it is for Christian samples.

In a study comparing an Orthodox Jewish sample with a non-Orthodox Jewish sample, Rosmarin et al. (2009) found belief in a benevolent God did predict lower levels of depression and anxiety. In comparing samples, they found that Orthodox affiliation was also correlated with higher religious beliefs, and thus lower levels of depression and anxiety. When an Orthodox sample was compared with a Protestant sample, there was no difference in interaction between religious beliefs and mental health between groups, with both having higher religious beliefs, and lower depression and anxiety scores. In a study of the relationship between religion and depression, Pirutinsky, Rosmarin, Pargament and Midlarsky (2011) found that religious struggle and negative religious coping were correlated with higher depressive symptoms in an Orthodox Jewish sample. Additional analysis revealed that negative religious coping may precede reports of depression, suggesting that negative religious coping may cause depression in Orthodox Jews.

Levin (2013) performed an analysis of the 2009 Israel Social Survey, in which respondents were asked questions in regard to their religious beliefs and physical and psychological well-being. He found that greater Jewish religious observance is significantly associated with higher scores on self-rated health, functional health and life satisfaction. The survey also indicated that the more "right" (i.e. conservative) one moved on the religious spectrum, the more religious beliefs mattered in well-being and happiness. It was also found that religious knowledge was most positively linked to improved well-being. Less knowledge and engagement in Judaism were found to be risk factors for poorer well-being. Levin (2015) found similar results in a survey of five urban areas in the US. In addition, the US study found that higher synagogue attendance and

faithful engagement in religious rituals, factors represented most saliently in the Orthodox Jewish sample, were positively correlated with more positive reports of health and life satisfaction.

These studies appear to suggest that there are unique aspects about Orthodox Jews R/S beliefs, in comparison with non-Orthodox Jews, that are not addressed by general studies of Jews. These findings also highlight the need to address the role that R/S plays in mental health with Orthodox Jews, and the importance of targeting spiritual struggles in mental health treatment with this population. Based on the findings of their study, Rosmarin et al. (2009) suggest that it may be particularly appropriate to take a spiritually integrated approach to therapy with Orthodox Jews because religious factors are so salient to their mental health.

Cultural Presentation of Orthodox Jews

There is a lack of studies on the Jewish population in general, and Orthodox Jews in particular. Jews have been largely attributed an invisible status in the field of counseling and in psychology in general, and within the multicultural movement in particular (Arredondo & D'Andrea, 1999). This tradition of neglect especially compromises the efficacy of the mental health professionals who treat Orthodox Jews and who, therefore, lack reliable and valid research to guide them (Margolese, 1998; Schnall, 2006). Like other faith-based communities, followers of Orthodox Judaism are highly sensitive to perceived criticism of their customs, which lie outside the framework of mainstream American culture, and may be unfamiliar to most clinicians (Schlesinger, 2014). In fact, Bilu & Witztum (1993) suggest that transcultural therapy involving Orthodox Jews can be more complex than in any other diverse group. And although the

community is starting to recognize the need to address mental health needs (Schnall, 2006), and research on the population is growing (Schnall et al., 2013), there continues to be a gap in understanding the interplay of all issues that may arise in therapy with the population, and how they are effectively addressed.

According to research by the Pew Research Center (Cooperman, Smith, Hackett, & Kuriakose, 2013) there are roughly 4.2 million adults who identify as Jews in the United States. Of those who identify as Jewish, about 10% identify as Orthodox Jews. The Pew study also found that 95-99% of Orthodox Jews consider religious practices and traditions as integral to their lives, a significantly higher proportion than other Jewish denominations. Orthodox Jews also tend to be more conservative, have larger families, are more likely to receive a religious education, engage in religious activities and display higher levels of religious commitment than other American Jews (Cooperman et al., 2013).

Orthodox Judaism is the most strict and traditional branch of Judaism (Schlesinger, 2014). Orthodox Jews tend to define themselves in terms of their religious beliefs and lives (Paradis, Cukor & Friedman, 2006). Among Orthodox Jews religion can be viewed as inseparable from life, and is a constant force in their worldview (Csordas, 1985). Within the Orthodox Jewish community there are many subgroups that vary in their cultural and familial traditions (Cooperman et al., 2013; Schnall, 2006); however, they are united by an underlying belief that God revealed His teachings, the Torah (Old-Testament), to humanity through Moses and that it was passed down and elaborated on by generations of rabbinic scholars (Loewenthal, 2006). The Torah consists of the five books of the bible, and contains the mitzvoth (divine commandments) by which

Orthodox Jews live their lives (Paradis et al., 2006). The practical application of the law and its application to modern life are elaborated on by the Talmud, a compilation of discussions about the Torah, and other commentators in the rabbinic literature through the generations (Paradis et al., 2006). These biblical precepts apply to all life matters (Schnall, 2006) and dictate relationships one has with oneself, with others and with God (Paradis et al., 2006). These laws, which include precise prescriptions for family relationships, marriage, sexual behaviors, Sabbath and holiday observance, dietary laws, financial and business relationships and religious obligations (Paradis, et al., 2006), are codified in Halachic (literally translated as "way of life") responsa (Schlesinger, 2014). Both the Torah and the Talmud also have extensive examples that reflect daily living, as well as provide insight into the meaning of life, well-being and growth (Milevsky & Eisenberg, 2012). In addition to God-given laws, there are traditions and customs, developed over the generations, which are widely accepted and practiced by all Orthodox Jews (Loewenthal, 2006). Although rules of daily living are spelled out with great specificity, they are attached to a myriad of rituals (Pirutinsky, Rosmarin & Pargament, 2009) and are viewed as binding (Schlesinger, 2006); Orthodox Jews tend to view them as a source of strength, and not as a burden (Paradis et al., 2006), and see adherence to Jewish ritual practice as the manner in which one inspires personal belief in the Divine (Rosmarin et al., 2009).

A central belief in Traditional Judaism is the existence of a unified God, Who is attentive to personal human behavior (Rosmarin et al, 2009). Awareness of God is seen as an ongoing process, and a precondition to spiritual-moral struggles; that is the main purpose of existence (Loewenthal, 2006). Conceptualization of good self-development

and sources for personal happiness are defined as the product of being in the right or wrong relationship with God (Schlesinger, 2006). For the Orthodox Jew, the soul is seen as central to personality, and its needs and spiritual realities need to be addressed. Free will is emphasized and part of human development and basic drives are seen as challenges that need to be channeled the right way (Loewenthal, 2006).

Although united by their deep respect for religious law and tradition, there is, however, a within group spectrum of varying levels of adherence to these laws and traditions (Popovsky, 2010). These differences are usually imperceptible to an outsider; however, those within the Orthodox communities tend to take them very seriously (Wikler, 2001). In broad terms, Orthodoxy can be divided into two groups, ultra-orthodox and modern orthodox. Ultra-orthodox tend to be more conservative and insular, and modern orthodox tend to be more integrated into the general society (Loewenthal, 2006; Schnall, 2006). One noticeable difference is in the manner of dress, which tends to send important signals about orthodox identity and group affiliation. Among the more Orthodox Jews, secular studies are not highly regarded because it is felt that some areas of study promote values which are antithetical to Jewish values (Loewenthal, 2006). Many Ultra-Orthodox Jews strive to isolate themselves from mainstream American society and live in close-knit communities, with their own private schools, social services and communal economy (Paradis et al., 2006). Modern Orthodox Jews tend to be more highly integrated, and are driven by the ideal of integrating Torah with modern science and ideals (Loewenthal, 2006).

Education is valued by the Orthodox community. Religious education focuses on the life-long spiritual process, and study of religious texts; the adherence to the myriad

details of Jewish law is seen as key vehicles to this process. Across sectors of Orthodox Judaism, Torah study and acuity are seen as an ideal to strive for and for many Ultra-Orthodox Jews a lifetime career in Torah study is seen as the most esteemed career. Even amongst those who do not identify with this ideal, Torah study is seen as important, and time is made for it daily. Torah study delves into all aspects of life, including science, medicine and math (Loewenthal, 2006); study of it is driven by the Talmudic dictum of "delve and toil in it (the Torah), for everything lies in it" (Heilman & Witztum, 2000). In-depth Torah study involves many levels and can be open to differing interpretations. However, although Torah study, and its interpretations, is open to everyone, only the opinions of those steeped in Torah knowledge are accepted as binding (Loewenthal, 2006).

Orthodox Jews place high value on family and community as the center for religious life (Loewenthal, 2006), and personal identification within the community can be very personal and complex (Paradis et al., 2006). Orthodox Jewish communities tend to focus less on the individual, and more on family and community, in addition to their service of God (Paradis et al., 2006). Communities are generally organized around a shul, or synagogue, where prayers, communal events and religious study take place. Leadership of a rabbi/rebbe is also important for the community and the rabbi is called upon for major life events and for religious matters (Schlesinger, 2014). In some communities the rabbi is consulted regarding all matters, in others for religious concerns and crises not pertaining to religion, and, still, some in other communities consult their rabbi only on religious matters (Schlesinger, 2014).

Orthodox Jews and Mental Health

Considering that religion and its practice play such an integral role in their lives, when Orthodox Jews fall victim to some mental or behavioral disturbance it often expresses itself in a religious idiom. The problem can be expressed or articulated in relation to particular religious beliefs and practices, or, alternatively, people try to cope with their problems via religious dogma or practice (Heilman & Witztum, 2000). It is also worth noting that traditional Jewish religious devotional texts explicitly relate that belief in God is necessary for mental health. By virtue of being more familiar with these traditional sources from the corpus of religious literature, religious beliefs may indeed be relevant to the mental health of Orthodox Jews. The therapist who serves this population must not only be aware of and understand this relationship between the religious culture and mental illness but must also make use of this relationship to be successful in a diagnosis and intervention (Heilman & Witztum, 2000).

Seeking psychological treatment can be very complex in many Orthodox Jewish circles. Orthodox Jews may see going to counseling as a sign of personal weakness because it may appear that they are admitting that "Orthodox Judaism does not have all the answers" (Strean, 1994). Many in the community tend to see themselves as high achievers who wouldn't need the assistance of mental health professionals (Zedek, 1998). Because internal struggle is generally seen as matters pertaining to the soul, they may wonder how psychotherapy can help them deal with a metaphysical entity like the soul, or their struggle with evil inclination (Schnall, 2006).

Religious and cultural views of mental health can also impact treatment. Many view mental illness as God's reproof, a divine test (Margolese, 1998), and some may see

it in multi-layered aspects including divine, social, biological and psychological forces (Popovsky, 2010). The close knit nature of Orthodox communities can sometimes create stigma related to seeking mental health treatment (Schnall, 2006). People may fear being seen as “crazy”, or “meshuga”, and it can impact their family standing and chances of marriage for oneself and family (Wikler, 1986). Stigma may lead many Orthodox Jews to participate in mental health programs outside of their neighborhoods (Popovsky, 2010). Studies of Orthodox Jewish attitudes to mental health found that stigma, especially related to the impact on family, is the leading factor in help-seeking attitudes of Orthodox Jews (Schnall et al., 2013; Pirutinsky et al., 2009).

There are also times when an Orthodox Jew may use religious observance as a pretext to avoid engaging in therapy (Popovsky, 2010). As with every therapeutic relationship mutual scrutiny occurs, and for the Orthodox Jew the scrutiny reflects the expectation of relational misalignment, and being judged as a visible minority (Schlesinger, 2014). Biblical commandments regarding honoring parents, respecting one’s spouse, treating others respectfully, and not gossiping can impact how Orthodox Jews interact in therapy (Sublette & Trappler, 2000; Popovsky, 2010), and may even make them appear resistant to therapy (Popovsky, 2010). Symptoms of mental illness may be masked by religious themes (Heilman Witztum, 2000), and vice versa. Some fear that their illness will be blamed on their religious beliefs (Popovsky, 2010). Guilt and shame around religious behaviors can create resistance to self-disclosure, and may also contribute to more complex mental health concerns with clients struggling with religious convictions (Schlesinger, 2014). Assessment tools may also need adjustment, to reflect the Orthodox Jewish worldview (Popovsky, 2010).

Cultural differences between mental health providers and receivers regularly inhibit, delay and altogether preclude proper treatment of the Orthodox Jewish population. The focus of Western culture on individual autonomy and self-fulfillment may be in contrast with the emphasis placed on community, and can create fear that mental health professionals from outside the community will not understand their worldview (Popovsky, 2010). Orthodox clients may find it difficult to trust therapists from outside their community, even non-orthodox Jewish therapists, often questioning their ability to understand their worldview (Paradis et al., 2006). Many can even see psychologists as representatives of secular values, who will challenge their values, and even attempt to "deconvert" (Heilman & Witztum, 1997, p. 523) them.

There is evidence showing that clinicians may indeed misjudge religious behaviors as evidence of psychopathology and are more likely to see religious clients as disturbed (Popovsky, 2010). The Orthodox client accepts constraint in personal choice by religious doctrine as a value in itself; clinicians must not confuse defensive structures with religiously determined rigidity (Schlesinger, 2014). To the non-orthodox clinician, ritual observance of Orthodox Jews may be seen as mystifying and even entwined with their pathology (Schnall, 2006; Popovsky, 2010; Bilu & Witztum, 1993). Even armed with value sensitive techniques, the therapist must not underestimate the vast number of core assumptions that he/she holds which may not be shared by the patient (Popovsky, 2010).

In a study of barriers to mental health in the orthodox community, Feinberg & Feinberg (1985) reported that 90% of mental health professionals serving the Orthodox Jewish community felt that mental health treatment needs were inadequately met.

Barriers to treatment were identified as stigma associated with mental health problems, mistrust of the mental health field, belief that psychology and religion are incompatible, and lack of affordable services. In a follow-up study, Schnall et al. (2013) found that progress has been made since the 1980s regarding the mental health needs of the Orthodox community; however, further efforts are still needed. The findings indicate a significant decrease in the community's general mistrust of the mental health field, belief that religion and psychology are incompatible and personal attachment to stigma of psychiatric problems. There was no significant change in stigma related to seeing a mental health professional, and this was rated as the leading factor in causing Orthodox mental health needs to be underserved in 1985 and in 2009. Although there has been a decline in the barriers to mental health services in the 25 years between studies, the sizeable number of professionals continue to report these barriers suggests that additional work to build bridges and trust with members of the community is still needed.

In a survey designed to measure Orthodox Jewish attitudes towards mental illness, Pirutinsky et al. (2009) found that Orthodox Jews expressed greater stigma towards an individual suffering from OCD that was expressed in religious activity, than to an individual suffering from non-religious OCD. However, those surveyed did express the fact that they would be more tolerant and supportive of religiously expressed OCD. Respondents differentiated between treatment choices. Those suffering from non-religious OCD were more likely to endorse conventional therapeutic intervention, as opposed to religious OCD for which rabbinic intervention was endorsed, either as an adjunct or in place of therapy. These findings led researchers to conclude that Orthodox Jews may be hesitant to bring up religious or spiritual issues in therapy. In a follow-up

study, Rosmarin, Pirutinsky & Siev (2010) found that Orthodox Jews were more likely to identify religious behaviors as OCD compared with a non-orthodox sample. These findings highlight the need for a therapist to be intimately aware of Orthodox Jewish religious practices in order to assess and treat psychological concerns of the community.

The complex issues in dealing with Jewish religious law and attitudes lead to the suggestion that these might be best managed by therapists who are familiar with Orthodox Jews, with their community and its personnel, and share similar cultural values and religious beliefs (Schnall, 2006). Spitzer (2003) regards it essential that Orthodox Jews see professionals from similar cultural backgrounds. He argues that behaviors and feelings of Orthodox Jews cannot be understood by others, and appropriate help and treatment can be developed only by those with a full immersion in the religious and cultural values of the community. However, the limited number of Orthodox therapists makes this option difficult to pursue (Schnall, 2006).

Even when available, Orthodox Jewish therapists may be a poor choice for the patient (Rabinowitz, 2000). First, university-educated Orthodox Jews may be seen as outsiders to members of the community, and even the slightest variation in religious practice may trigger suspicion (Bilu & Witztum, 1993). Countertransference arising from therapists' own unresolved religious issues may influence how R/S is addressed (Rabinowitz, 2000). Orthodox Jewish therapists can end up over-identifying with the client, and it can become challenging for the therapist to conduct therapy without making assumptions based on shared religious beliefs, or impose their beliefs on clients in the guise of clinical advice (Schlesinger, 2014). The Orthodox clinician is also expected to demonstrate respect for the client's individual relationship to his identified religious

group, even if it deviates from the group rules in some way (Rabinowitz, 2000). The use of an Orthodox clinician can also raise concern about levels of professionalism, competence, confidentiality and dual relationships (Loewenthal, 2006).

As in many religious circles, many Orthodox Jews may turn to their rabbi if they have a social or emotional difficulty (Schnall, 2006); however most Orthodox Jews in therapy were not referred by their rabbi (Weiss, 2000). Research shows that Orthodox Jews may be more likely than other Jewish denominations to prefer rabbinic counseling to mental health professionals' counseling (Weiss, 2000). Previous investigations assessing rabbinic counseling indicates that relatively few clergy members make referrals to mental health professionals, even though they lack the proper counseling training (Weiss, 2000). Schnall et al. (2013) suggest that increasing clergy education and encouraging greater communication between counselors and clergy members may advance the state of mental health treatment for Orthodox Jews.

Existing literature suggests that therapists build a trusting alliance with Orthodox clients by delivering interventions within a cultural, spiritual, family-centered framework (Popovsky, 2010). Therapists who limit the degree to which therapy impacts religious observances, but non-defensively acknowledge the ways in which it does, can help in overcoming some barriers for the Orthodox Jewish population (Schnall, 2006; Popovsky, 2010). When working with an Orthodox person from a different sect, it is important not only to explore religious customs, mannerisms and attitudes of that sect (Schnall, 2006), but also to understand how the client personally connects with those ideas and ideals. Willingness to collaborate with clients' rabbinic authority demonstrates that the therapist is willing to work within clients' value systems, and this lessens the anxiety of engaging

in therapy (Paradis et al., 2006). Consultation with rabbi is critical, especially for religious expressions of a disorder (Schlesinger, 2006) because it can provide parameters for interventions, and raise awareness to flexibility in Jewish law (Schnall, 2006). Using communal values (Paradis et al., 2006) and concepts familiar to Orthodox Jews may be useful, as well (Schnall, 2006; Heilman & Witztum, 2000). Psychopathology can be assessed by noting if and how these values and concepts exceed cultural norms, or if others in their environment express concern about beliefs or behaviors (Popovsky, 2010; Huppert & Siev, 2010).

Therapist acceptance of a client's cultural-religious framework improves client trust, and working within this framework can produce beneficial results (Loewenthal, 2006). However, clinicians should be aware that over-deference to religious concerns can occur because they may be trying to compensate for their own anxiety in reference to their own religious challenges (Popovsky, 2010; Rabinowitz, 2000). Past experiences in treating Orthodox Jews cannot substitute for direct conversation with patients about their preferences (Popovsky, 2010). It is important for the therapist to refrain from engaging in religious debate, especially when personal knowledge may be limited (Bilu & Witztum, 1993; Popovsky, 2010).

Suggested Therapeutic Approaches for Orthodox Jewish Clients

Many Orthodox Jewish clients may believe that some change in their relationships with God is necessary for healing. Therefore, interventions that serve to enhance spiritual and religious beliefs and activities can be beneficial to address in therapy (Cinnirella & Loewenthal, 1999). Exploring how particular behaviors interfere with other religious obligations can help raise awareness to the need for intervention

(Huppert & Siev, 2010; Greenburg & Shefler, 2002). In addition, treatment plans should incorporate clients' beliefs about psychopathology and its treatment. Mutual construction of meaning and behavioral adaptation supports the validity of the client's quest for a unique solution to problems that align with religious convictions (Heilman & Witztum, 2000). Therapists may want to encourage their clients to explore rituals that exist in his tradition which might support improved mental health (Popovsky, 2010). Accentuating Jewish principles such as serving God with joy may help moderately depressed patients (Schnall, 2006). Rituals that require mental focus may prove beneficial when dealing with a range of disorders. (Rabinowitz, 2000; Hielman & Witztum, 2000), Popovsky (2010) bring several cases in which engaging in Jewish rituals served as a way of achieving transcendence over psychological concerns. Religious prayer can be used as an intervention to some mental health concerns (Rosmarin, et al., 2011). In Orthodox Judaism there is an emphasis put on personal connection to prayers through focus on the words uttered, proper thought and concentration on connection with God. Using clients' thoughts attached to these prayers can open the path to understanding clients' cognitions (Milevsky & Eisenberg, 2012). Prayer can also be used as an intervention because it requires some of the same skills that mindfulness interventions do, and can help in reducing stress and anxiety (Popovsky, 2010). Proper prayer can also lead to increased religiosity and feelings of trust in God, which have been shown to increase well-being (Rosmarin et al., 2011).

Rosmarin et al. (2011) ran a study measuring how spiritually-integrated therapy (SIT) affected cognitions in regard to worry in a Jewish sample. Most participants in the study were Orthodox (67%), and the treatment drew from Orthodox Jewish teachings.

Treatment consisted of a 30-minute self-guided video that contained four components: a) an introduction informing that the purpose of the program was to strengthen trust and decrease mistrust in God; b) stories and teachings adapted from classic Jewish sources and modern anecdotes intended to reinforce trust in God and challenge negative beliefs associated with mistrust; c) a series of spiritual visualization exercises with similar goals, and d) encouraging participants to pray briefly for increased trust in God using their own words. Participants completed the video daily for a two-week period.

Results of the study found that during the two-week treatment period a decrease in mistrust in God appeared to facilitate changes in worry which was measured by a decrease in reported intolerance for uncertainty. Although there was a significant increase in trust of God, statistical analysis did not show that it was mediated by changes in tolerance of uncertainty. These results highlight the salience of religious and spiritual factions in psychological symptoms in Orthodox Jewish clients.

There are traditional Jewish texts that appear to describe a range of psychopathology and also deal with struggles that are viewed as contemporary (Loewenthal, 2006). Clients can explore these classical Jewish works and how they correspond with his or her experiences (Schnall, 2006). In addition, the Talmud contains numerous discussions about living in general, including insights into the meaning of life, emotions, dreams, internal conflicts, well-being and growth (Milevsky & Eisenberg, 2012). These discussions serve as a basis to the growing section of Jewish psychology books, and can be used to close the perceived gap between religious values and modern day psychology. It may also be helpful to recommend reading books by Orthodox Jewish clinicians as an adjunct to therapy (Paradis et al., 2006; Schnall, 2006).

Incorporating R/S with Orthodox Jews in therapy. Schnall et al. (2013) suggests that therapists consider the growing literature which posits that Jewish thought and ritual can be successfully incorporated into treatment. Some clinicians do report incorporating Jewish rituals, beliefs and worldview into therapy (Schnall, 2006; Popovsky, 2010). Using religious resources, such as engaging the rabbi and introducing religious interventions helps create an anchor for client involvement and the introduction of more clinical interventions (Heilman & Witztum, 2000). Heilman & Witztum (2000) considered three case studies in which religion was used to articulate and understand the context of mental illness; this helped those clients associate meaning with their struggle and ultimately restructure their struggles through integration of religious practices and beliefs. The authors suggest that religious idioms help create an understanding of the disorder, enhance compliance with treatment and create context for interventions. By expressing problems in religious terms, clients can integrate the disorders into their lives, and it enables them to remain within the framework of the world they feel part of, and regain some level of control over their disorders (Witztum & Goodman, 1999). Heilman and Witztum (2000) go on to argue that introducing a religio-cultural framework into therapy enables interventions on different levels and makes the client feel that his/her faith and religious practices played an important role in his/her well-being. Using religious language and coping also allows the therapist to make use of his or her own scientifically based treatment in an acceptable and efficacious manner, and helps bridge the perceived divide between religion and psychology.

Incorporating religious text into psychotherapy. Rawitch (1997) and Milevsky & Eisenberg (2012) discuss case studies in which Jewish text were introduced in therapy.

In all cases, the clients were open to explore how their clinical concerns fit the text or concepts, and the use of religiously relevant materials helped clients create different, more adaptive views of their situations. Both authors warn against making generalities based on the success they experienced, and encouraged further research into the topic. Rawitch (1997) also highlights the concept that it is important to consider several points before introducing Jewish text and prayer into session. These include clinicians' expertise and willingness to address these areas, the clients' readiness to engage in therapy on that level, and the use of text to guide context for direction in therapy. He warns that even if the clinician is ready and eager to try using text with a client, he or she must be sure that it is being done for the benefit for the client, rather than for the clinician. Rawitch also suggests that the therapist using text in therapy should use text with the clients to point them in a direction, help them feel that they are taking steps in reaching that goal and to root this directedness in a Jewish context. He suggests that there are three broad questions to consider when assessing religious factors that may affect the life of a client, and may reveal the relative importance of Judaism to the client: 1) What is the client's family history in terms of religious identity or observance; 2) Does the client express religious feelings in therapy that reveal either comfort or discomfort with their religious identity, and 3) What does seeing a Jewish clinician mean to this client. Using these questions can help the therapist frame whether, or not introducing religious concepts into the session is appropriate.

Purpose of the Study

Integrating spiritual beliefs is important in therapy. Incorporating techniques that address clients' spiritual beliefs have been found to enhance therapeutic alliance and

outcomes. Studies have found that therapists are hesitant to make use of R/S interventions for a variety of reasons. Literature on the Orthodox Jewish community highlights complex issues that the population encounters in addressing their mental health concerns. Limited studies on Orthodox Jews suggest that integrating R/S interventions in therapy can help this population access the mental health care that they may require. Because the use of R/S interventions is important in this population, it is important to know if and how therapists who serve this population use these interventions. There is currently no known research that explores the attitudes of therapists and how they actually utilize interventions with the population. Through interviewing Orthodox Jewish therapists on their attitudes and implementation of R/S interventions, this study hopes to close the gap in the research and gain a richer understanding of how the mental health needs of the community are being met.

Research Questions

1. What are Orthodox Jewish therapist attitudes to using spiritual and religious interventions in therapy with Orthodox Jewish clients?
2. Do Orthodox Jewish therapists utilize spiritual and religious interventions in therapy with Orthodox Jewish clients?
3. What are ways that Orthodox Jewish therapists address spiritual and religious concerns in therapy with Orthodox Jewish clients?
4. Do Orthodox Jewish therapists feel that their own religious beliefs influence how they approach therapy with Orthodox Jewish clients?

Chapter 3: Methods

Overview and Design Justification

This study is designed to examine the phenomenon of therapist attitudes towards the use of religious and spiritual interventions in therapy with Orthodox Jewish clients. There is currently little evidence of clinician perspectives of incorporating these interventions in therapy with Orthodox Jewish clients. Furthermore, if therapists use R/S interventions in therapy there is no clear understanding of how it is used, when it is used, and how helpful it is to use. This study attempts to gain a better understanding of how therapists view the use of R/S in therapy, and how the use of these interventions is experienced within the therapeutic alliance. To explore these concerns, this study will utilize qualitative research methods, using the grounded theory method to analyze and understand the emerging data.

The design selected for the purpose of exploring therapist attitudes toward use of R/S interventions with Orthodox Jewish clients is a qualitative design. Qualitative research is a research method that involves analyzing and interpreting information gained through interviews and observation of the research participants in order to discover meaningful patterns descriptive of a particular phenomenon (Denzin & Lincoln, 2011). This research method allows the researcher to connect with research participants and see the world from their viewpoint, and explore inner experiences of participants (Corbin & Strauss, 2014). Several of the goals that qualitative research seeks to accomplish are exploration of areas and topics not yet thoroughly researched, to discover relevant variables that can later be tested through quantitative research and to engage in a holistic and comprehensive approach to study the phenomena (Creswell, 2012; Corbin & Strauss,

2014). Given the dearth of information regarding Orthodox Jews and mental health in general, and therapists' attitudes to using R/S interventions in particular, this study will attempt to narrow the gap by exploring the experiences of therapists and use the information to develop theories to understand and measure the phenomenon. The qualitative design method chosen as the interpretive framework for this study is grounded theory.

Grounded theory, which is a qualitative design proposed by Glaser and Strauss (1967), is hypothesis-generating research, used to develop theories when partial or inadequate theories exist for certain populations (Corbin & Strauss, 2014) and predetermined information from the literature is lacking the information being sought (Auerbach & Silverstein, 2003). Grounded theory attempts to use descriptive experiences to develop common themes within a phenomenon in order to develop theories and a comprehensive understanding of the experience (Creswell, 2012). The researcher uses raw data, generated through interviews of research participants, to derive repetitive ideas that lead to the development of themes, which are then used to develop more general theoretical constructs, shaped by the views of the participants, who live through the phenomena (Corbin & Strauss, 2014). Theories generated help make sense of an issue that are open and unclear and can serve as basis for future research around the phenomena (Auerbach & Silverstein, 2003). In addition, grounded theory allows the data to be presented in a manner that permits the researcher to set aside his or her own preconceived notions and biases (Strauss & Corbin, 1998). Because there is no known generalizable understanding of therapist's attitudes to using R/S with Orthodox Jewish

clients, including how they utilize these interventions, grounded theory will be used to develop theories around their attitudes and utilization of these interventions.

Participants

The researcher interviewed 14 therapists and 12 of these interviews were transcribed; the remaining two interviews were unable to be transcribed due to poor recording quality. Participants were recruited through an email sent through a listserv to the approximately 450 members of the International Network of Orthodox Mental Health Professionals, commonly known by its Hebrew name NEFESH, an association of mental health professionals that service the Orthodox Jewish community (Schnall, 2014). Ten people responded to this email. Participants were also recruited through use of the snowballing effect, which led to 6 more respondents. Participants were chosen on a first-come basis, and there was no emphasis put on age, gender, theoretical orientation or level of religious identity for participants.

Inclusion criteria. Participants included in the study were therapists who identified as Orthodox Jews, or used to identify as Orthodox, but no longer do. Additionally, participants were required to have obtained a graduate-level clinical degree (social work, counseling, school counselors and psychologists), and have had some experience treating Orthodox Jewish clients. Participants that have dual identities, serving as therapists in one role, and rabbis, teachers or community activists in their other roles were also included.

Exclusion Criteria. Therapists who identified themselves as life coaches, mentors, peer specialists, substance abuse counselors and rabbinic counselors were excluded. Students and trainees were excluded, unless they had been licensed under a different clinical license than their current training. Therapists whose role is seen as an adjunct to religious services, such as pre-marital counselors were excluded. Interviews also excluded therapists not currently practicing in the United States or Canada.

Measures

Basic Demographic Measure. This measure was developed by the researcher. The basic demographic measure (Appendix A) asked for participant's gender, age, degree, years of practice, theoretical orientation, populations served, and number of Orthodox clients they have seen.

Brief Orthodox Jewish Religiosity Measure. To capture the religious identity of the therapists interviewed broadly, each interviewee was asked to fill out the Brief Orthodox Jewish Religiosity Measure (BOJRM; Pirutinsky, 2009). The questionnaire (Appendix B) includes 11 statements about beliefs, feelings, and meaning in Orthodox Jewish practices and is based on classic religious texts, and rituals. Items on the measure are rated on a 7-point Likert- like scale ranging from strongly disagree to strongly agree. The measure has been found to be a highly, internally consistent measure (a = .92) that successfully differentiates between levels of individuals Orthodox Jewish religious identity, F (2, 104) = 21.68, p < 0.001. The measure also established norms for those who identify as Modern Orthodox (X = 63) and Ultra-Orthodox (X = 70) (Pirutinsky, 2009).

Procedures

The researcher sent out an email to the NEFESH International listserv, requesting volunteers to participate in the study. The e-mail message included a description of the research study and goals of the research. Participants were chosen from those who contacted the researcher expressing interest in participating in the study. Ten potential participants responded directly to the listserv invitation; six others responded through the snowball effect. Potential participants were then screened to see if they met inclusion/exclusion criteria and had ability to participate in the interview. Of the 16 respondents, one did not meet criteria due to not identifying, and never having identified as an Orthodox Jew, and another one for not being able to schedule an interview. The researcher then contacted therapists individually and scheduled the interviews. Interviews were conducted in a private setting, based on participant's preference, with some interviews taking place in private offices, and others done over the phone. Prior to the interview, participants were informed of risks and benefits of participating in the study, were informed of the confidential nature of the interviews and limits to confidentiality. Participants were also given the brief demographic survey, and the BOJRM before the interview. A total of 14 interviews were performed. The interviews were semi-structured (Appendix C) and consisted of a series of open-ended questions, and lasted generally around 30 minutes, with the shortest interview lasting 20 minutes and the longest an hour. Because the goal of grounded theory research is to explore emerging phenomena, questions and areas of inquiry can change as data and patterns emerge (Corbin & Strauss, 2014). Therefore, questions in the interviews did change, based on responses to previous questions, or data from previous interviews. Interviews were audio recorded. To maintain

confidentiality, the recordings were stored as anonymous data entries, with each participant being assigned a name with the letter P, indicating participant and a numerical value given at random. The audio-recorded interviews were stored in a locked cabinet until transcribed by the researcher. However, two of the interviews were unable to be transcribed, due to the poor quality of the recording. A total of 12 interviews were transcribed. After transcription, the audio recordings were destroyed. In addition, to minimize personal bias, the researcher maintained a journal consisting of content and personal reactions related to each interview, as well as a record of procedures and study activities (Strauss & Corbin, 1998).

Coding Process. The aim of grounded theory is to move from raw data, collected through the interviews, towards the development of a new theoretical concept, through the coding process (Auerbach & Silverstein, 2003). The coding process is done in several steps, which allows for more overarching principles to emerge with each step, culminating in a refined theoretical concept (Corbin & Strauss, 2014). The first step after collecting the data and transcribing them is called open coding (Creswell, 2012). In open coding the transcripts are given to recruited coders, who individually read the raw text and begin highlighting relevant text and repeated ideas (Corbin & Strauss, 2014). The goal in this step is to find the relevant texts that best relate to the research questions, and appear to be the most salient aspects of the answer (Auerbach & Silverstein, 2003).

The coders then meet to debrief, and review their findings of relevant texts and repeated ideas (Creswell, 2012). There are several different aims accomplished by these debriefings. The peer review allows for further development of emerging themes, and helps explore unifying features of the relevant texts (Creswell, 2012). By cross-checking

relevant data, and emerging themes the researchers ensure validity of their findings (Corbin & Strauss, 2014). Inter-coder agreement also serves as a way of ensuring that the data and findings of the coders are reliable as well (Corbin & Strauss, 2014).

After repeated ideas emerge, and are agreed upon by the team of coders, axial coding is used to develop themes from those ideas. Ideas that appear to be related are grouped together into axes, and a theme is developed around these similar ideas (Creswell, 2012). After themes are developed, the researchers seek understand what is driving the theme, and use the overarching principle to develop a theory that can help explain the themes (Corbin & Strauss, 2014), exploring how the theory can be used in further research (Creswell, 2012). To ensure the reliability and validity of the findings, the final step in the grounded theory process is to describe the themes and relevant texts through the lens of the theories developed, and triangulate the findings by comparing it with existing literature around similar theories and ideas (Creswell, 2012).

To analyze the results of the interviews the researcher recruited two coders for the coding process, to assist him in the process. Coders were recruited after the data had been gathered. The researcher sent an email to NEFESH listserv to recruit coders, who were found through the snowball effect. Coders were doctoral-level students; one coder was a third year PsyD. student, and the other was a second-year medical student serving on a psychiatric rotation. Both coders had completed their CITI training, and had some level of interaction with coding in the past, either through a research class, or had assisted in other qualitative research. Researcher also provided coders with a chapter from Auerbach & Silverstein (2003), which describes the basics of the steps of coding: finding relevant texts, and identifying repeated ideas, with which the coders were involved. All

three coders coded all the interviews. Coders were given the same 3-5 interviews to code at one time. Debriefings took place via phone conference after each batch of interviews was coded; these consisted of exploring how the participants answered the research questions, in order to start identifying repeating ideas. Debriefings also helped ensure that there was intercoder agreement on the emerging themes.

After the coding process was complete, the researcher categorized the relevant text into the identified repeating ideas; the repeating ideas were then placed into emerging themes; these were then explored to identify an overarching theory related to the emerging themes. Findings were triangulated with existing information in literature reviewed in regard to existing knowledge about therapy with the Orthodox Jewish community, about the use of R/S interventions from previous studies of the community, and the general population and therapists' attitudes about the use of R/S interventions in therapy.

Chapter 4: Results

Demographic Questionnaire. Characteristics of the participant sample based on responses to the demographic questionnaire are highlighted in Table 1. In their self-identification, most therapists identified on the Ultra-Orthodox spectrum (Yeshivsh = 6; Chasidic = 1). In terms of theoretical orientation most identified as cognitive-behavioral therapists (X=7), and most (X=8) practice as licensed social workers.

Table 1.

Participant Demographics

Participant	Gender	Religious Identity	Location	Degree	Graduate Course in R/S	License	Orientation
P1	M	Yeshivish	NJ	Counseling	Y	LPC	CBT
P2	M	Yeshivish	NJ	MSW	N	LMSW	CBT
P3	M	Yeshivish	NJ	MSW	N	LCSW	Family Systems
P4	M	Orthodox	NY	MSW	N	LCSW	CBT
P5	M	Chassidic	NY	MSW	Y	LCSW	Client-Centered
P6	F	Orthodox	PA	Nurse Practioner	N	CRPN	None
P7	F	Orthodox	PA	MSW	N	LCSW	CBT
P8	M	Yeshivish	NY	PhD	N	Psychologist	CBT
P9	M	Yeshivish	NJ	PsyD	N	Psychologist	CBT
P10	F	Yeshivish	NY	MSW	Y	LCSW	Psycho-dynamic
P11	M	Orthodox	Maryland	MSW	N	LCSW	CBT
P12	M	Other	NY	MSW	N	LCSW	Insight-Based

Participant	Clincial Experience (Yrs)	Yrs working with OJ population	% of OJ client base	Place of Practice
P1	9	9	100	Private + School
P2	3	1	10	Agency + CD
P3	16	16	95	Private + Agency
P4	3	3	25	Chemical Dependency
P5	5	5	100	Private
P6	6	6	5	Private
P7	12	12	100	Private + Agency
P8	15	12	100	Private + School
P9	10	5	90	Private
P10	7	5	100	Private + Agency
P11	7	7	20	Private
P12	12	10	99	Private

BOJRM. The results of the BOJRM showed that as a group the therapists had a very strong religious leaning, with the mean score of 71.83 being above the norms for the Ultra-Orthodox sample where x = 70. The was a variety of scores, with nine falling in the 70-77 range, and three falling in the 64-66 range. The lowest scoring therapist was higher than the norm of the modern Orthodox sample where $X = 64$. It is interesting to note that none of the therapists interviewed identified as Modern Orthodox, but two of the therapists that scored in the 64-66 range, did identify as Orthodox; one identified as Yeshivish, putting one Ultra-Orthodox therapist in the below average range on the BOJRM.

Semi-structured interviews. Coding was done with the research questions in mind, and the following is a summary of the findings, based on the research question.

What are Orthodox Jewish therapist attitudes to using spiritual and religious interventions in therapy with Orthodox Jewish clients? Analysis of the relevant text led to the emerging of a spectrum of attitudes that therapists have when addressing R/S with Orthodox Jewish clients. Some therapists expressed the idea that it was an extremely important area to explore, and expressed positive attitudes towards addressing R/S with this population. P12 expressed that *"I feel that it is important to address the existential aspects of my clients, and understanding their existential framework is an important part of that."* Other therapists expressed positive attitudes based on how important R/S is for this population. P11 stated *"I feel it is important. Being that Orthodox feel religion is an integral part of their everyday lives."* Others expressed positive use from a multicultural perspective, such as indicated in the explanation provided by P9:

> "*I think it is important to be aware of it culturally. Just like if a therapist was seeing an Asian client, it would be important to be aware of the Asian culture, so too when treating an Orthodox Jew one must be aware of the cultural values, beliefs, practices, sensitivities and boundaries and take into account when treating them."*

Another aspect that may have impacted therapists' attitudes may be their approach to therapy. P3 expressed his attitude towards addressing R/S as, "*I think it is powerful. It empowers them to grow from the experience, from the difficulty they are having."* He added that he feels his entire approach to therapy is framed in a psycho-spiritual model.

Other therapists' attitudes appeared to be more cautious in using R/S. Caution ranged from fear of putting too much emphasis on R/S, such as that expressed by P2: "*On one hand I feel it is the right way to go, but as a caveat, I think before we introduce a religious perspective, we wouldn't want to mask a truly medical or mental health issue with religious behaviors."* Other therapists expressed caution by stating that they felt that the client should drive the use of R/S. This idea was best expressed by P7: "*I think if it is beneficial to the client, and the client approves of it… as long as the client approves and is aligns with the client's values then it is fine, and appropriate."*

Although it is unclear what led to this caution, it may have been influenced by the fear of crossing boundaries, and the need to be client-centered. P6 expressed positive attitudes to addressing R/S, as it "*Help[s] clients to see their life within the context of not just what they are going through, but that there is meaning in their life"* but that she was also "*…a little worried about crossing over that boundary, of being too familiar and not*

as professional as I think I should be." P1 also expressed caution stating, "*I feel like I try to maintain a safe road, and not use it at my disposal until I am confident that it will be used, and used to the person's advantage versus a disadvantage or a non-entity."*

In summary, therapists interviewed expressed a spectrum of attitudes. Some expressed positive attitudes towards using R/S based on their own approach to therapy, the R/S needs of the client base and taking a multicultural approach to therapy. Other therapists expressed caution in their attitudes. This caution was influenced by not wanting to put too much emphasis on R/S at the expense of addressing real mental health concerns. Another aspect of expressed cautions was the need to be client-centered, and maintain therapeutic boundaries.

Do Orthodox Jewish therapists utilize spiritual and religious interventions in therapy with Orthodox Jewish clients? Although the attitudes of addressing R/S interventions differed, all therapists interviewed endorsed using R/S interventions. They did differ on the emphasis of their use. P5 made sure to emphasize that "*In the vast majority of my work I am doing regular therapy, and this [R/S] is just a side part of it."* P9 also expressed hesitation to use R/S interventions because, "*It is usually a mental health disorder, that has very little to do with religion, and religion is just used as a tool to express the disorder."*

Others, like P12, expressed the idea of exploring R/S through the lens of their general approach to therapy "*I definitely get very existential in general with my clients, in discussing their inner meaning, and asking them to look beyond the simple symptoms of their experience"* and "*In those discussions, it inevitably leads to the questions about*

God, the purpose they have to a relationship with God and the meaning of their relationship with Him."

Most therapists expressed the idea that it is important to allow the client's needs and wants to drive therapy. P1 expressed this idea by saying that it depends how the client approaches therapy:

> *People who are process oriented, I believe, will probably be more inclined to their religious aspects, and even if they are not religious they may have a spiritual bending. Because they are process oriented, not just goal oriented, so they are going to have religion or spirituality play a role in their wellness.*

All therapists interviewed expressed caution, warning that R/S interventions may not be appropriate in every case. P3, who generally used a psycho-spiritual model in therapy, expressed the thought that not all clients buy into it, and before addressing R/S it is important to explore:

> *Do you want to bring in spirituality or not? Do you want to focus only on technique, that we only do DBT and that's it? Or, do you want to understand the hashkafa behind it? When a mamar chazal gets said what is the reaction? Does he embrace, ignore it, or say that we are not going there? And even that, the question becomes why do you ignore, or why don't you want to go there? And they may not know, or may not want to explore it even then.*

P11, who expressed the idea that he feels addressing R/S with Orthodox clients is important, added that it is important to follow the client's lead: "*I may feel that R/S touches on every aspect of their lives, but if the client feels it or not, it's their own*

business." P6 expressed the thought that boundaries are important and therefore, "*I rarely actually use a religious context or religious interventions, but there are other ways of sharing our shared religious experience, and connecting in a way that is still professional, and does not cross the boundary."* Awareness of boundaries leads P7 to ask herself, "*I think I look at it as is there an added value? Is it offering them anything that they don't already have?"* before going ahead and using an R/S intervention.

Analysis of the data revealed that Orthodox therapists do utilize R/S interventions with their Orthodox clients. Some use them as a cornerstone in their approach to therapy with this population, yet others use them as an adjunct, or addition to therapy, with most of their therapy focusing on traditional interventions. Therapists, however, cautioned that it is important to take the clients' expressed desires and needs into account when utilizing R/S interventions. They also discussed the need to ensure the fact that they are maintaining appropriate boundaries before addressing aspects of R/S with Orthodox clients.

What are ways that Orthodox Jewish therapists address spiritual and religious concerns in therapy with Orthodox Jewish clients? Results of coding showed that there is a spectrum of uses that therapists endorsed when approaching R/S aspects of their clients. All therapists endorsed using some sort of R/S intervention, but how they used it differed. There were therapists who endorsed a variety of approaches to using R/S. Some appeared to frame their R/S interventions through the lens of their theoretical orientation and traditional interventions. Others were more hesitant to address R/S directly, and spoke about using it as an adjunct to therapy.

Conceptualization and assessment. P10 expressed the idea that exploring R/S helps her conceptualize the client: "*When you start talking about values there are many different areas, there are family values, educational values, and spiritual values, so you ask them about all their values."* P5 also endorsed the importance of "*exploring to what extent is their religious observance affecting them, or helping them, spiritually and psychologically"* which in turn impacts the interventions that he uses in order "*to make the resource more positive, and how to reduce the negative."*

The idea of exploring the influence of R/S on mental health with clients was also discussed by others, like P9, who said he explores it by, "*Direct questioning about it. In other words, let's say that the person is involved in a compulsive behavior, 'Do you believe that this behavior is what God wants you to do?"* P8 described using direct questioning as a manner of conceptualizing not only the maladaptive behavior, but also the client: "*I would ask them… I am going to ask about their need for meaning and making sense of one's life"* and "*We would also explore spirituality, if they have, or don't have and the different ways they experience it."*

Other clinicians said that their assessment is a more internal process that they go through within themselves, and is usually guided by the client's presentation of R/S. P1 shared that "*I usually follow the way they talk and their mannerisms. If they talk more yeshivish, or they talk more ehrlich, I am more inclined to use a discussion of religion and spirituality to enhance the therapy process."* Several clinicians spoke about asking to the themselves a question similar to one asked by P6 "*Can I refer them to someone else for more spiritual guidance, will they listen to my recommendation to go to get that guidance, or am I the last stop?"*

Interventions. There were several different R/S interventions discussed by the therapists. Some, like P12, endorsed using a multifaceted approach to using R/S:

> *I will definitely look at ideas and beliefs that create the tension, and deal with it. And even in spirituality, I have had quite a number of discussions with clients that misuse spirituality as a way of avoiding life, that is a second way. And a third way is to introduce certain ideas that they might have never heard of, or certain ideas they might have a pathological view of, and if they understood it from a different angle, it might actually give them a better sense of wellbeing in the world.*

Sometimes it is the theoretical orientation, and approach to therapy, that impacted the R/S intervention of the therapist. P10 said that she uses R/S in context of attachment-focused EMDR:

> *Let us say a person is in the frum world, and they cannot resource a role model, they can't resource Moshe Rabeinu, a rebbe, a gadol, a teacher, then that is a prognostic indicator that there are severe attachment issues that need to be worked on first. I just had a girl in sixth grade and she identified Esther Hamalka as her resource.*

Other therapists indicated that they would use R/S interventions to restructure maladaptive beliefs. This idea was expressed by P9:

> *When dealing with an erroneous belief, that is irrational and self-defeating, and the person believes that is what God wants from them, and this is what the religion wants me to do. In that case, it would be helpful to pull out a religious*

source, maybe a mamer chazal, or something like that, to challenge that belief that maybe this is not what God wants you to do.

P7 described using R/S as a way of developing coping skill:

If there are pieces, or language, that the client uses to discuss their challenge, or how they're coping with the challenge, I would integrate more in the lines of using it as a coping skill, integrating their language as a way of being more reflective.

There are times where R/S can lead to psychological stress. P5 shared that in those cases "*When clients raise philosophical ideas, and/or ideas about practical adherence to religion that they're in tension, or conflict, with their psychological functioning, I will bring a discussion up about it"* in an effort to minimize the conflict. A similar idea was raised by P8:

Let's say someone who is depressed, and has on purpose, or is searching what is the meaning in life. In those cases, we would get into a discussion about God, and what God may mean to them, what He would want for them, and how they feel connected. We would also explore spirituality, if they have, or don't have and the different ways they experience it.

Using an existential perspective helps clients overcome their distress. P3 expressed the thought that exploring R/S with clients is important because "*These kinds of concepts is something that we try get them to understand, and then they realize that they can look for how can they grow or how can they from gain whatever they are facing."* P6 described using R/S concepts as a way of instilling hope in her clients:

Patients who were very depressed, and they may have been ashamed of things that may have happened to them, or what they may have done. The message I try to impart to them is that God still loves them and that they were created with a pure and holy neshama, and no matter what they have done or experienced that will never change, and is always pure.

As adjunct to therapy. All interviewees endorsed using R/S resources as an adjunct to therapy, and a way of enhancing their therapeutic interventions. These include addressing R/S secondary to an overarching mental health concern. This was P2's approach when dealing with an OCD client that touched upon his religious behaviors. "*Once we did that (understood his behaviors out of context of religion) we were able to look at religious sources… about washing his hands and see the obsessive feelings… was more comparable to his driving and locking the doors."* P9 felt that using a rabbi can help reframe a client's religious perspective in general "*They need to clarify what is Torah, what is chumra, what is culture, what is halacha, what is l'chatchila, what is b'deved, what is negotiable, these are all things that a lot of these clients are missing. So, I send them to their rebbe."*

R/S resources can be used to enhance motivation in therapy as well. P5 said, "*I would approach it by showing them different sources, like mamarie chazal, mussar sefarim, Chassidic sources, hashkafa seforim, and various different sources that can really be helpful to explain different concepts from psychology books, and therapy."* P12 described utilizing resources differently for different clients "*I have sent clients specifically to rabbis to discuss things that are not related to religious law, but have more to do with how the Torah conceptualized man and psychology. I have done this when I*

saw that the client's framework was more religious based and not psychologically based."

Using religious text and concepts as an adjunct to therapy was described by many of the therapists interviewed. P7 used prayer as an example "*For example, you can tell a person to say Tehillim, in a case you would feel it would help them, but it may not necessarily complete the treatment."* Others felt that using religious concepts and teachings can be used to enhance therapy. P2 shared

> *I feel that the religious books can give an added and greater dimension of internalizing a lot of the concepts. This is because a person can be more motivated to look into these seforim, and to implement them, because it is not just their therapist telling them, it is their creator and there is an added level of accountability.*

Results appear to indicate that there are a variety of ways that Orthodox therapists use R/S interventions. Many endorsed using it in their assessment and conceptualization of their clients, helping them understand the client's R/S needs, and how they can effectively meet them. Interventions endorsed a range of possibilities, from exploring meaning of R/S beliefs, framing problems, and interventions from a R/S perspective, restructuring maladaptive beliefs, accessing R/S coping skills, and exploring R/S conflict. Therapists also discussed using R/S resources, such as utilizing rabbinic assistance, prayer and using religious texts as an adjunct to therapy, and a way of enhancing therapeutic interventions.

Do Orthodox Jewish therapists feel that their own religious beliefs impact how they approach therapy with Orthodox Jewish clients? All therapists that were interviewed identified as highly religious. They also recognized that their own R/S impact how they approach therapy. Many, like P11, shared that their R/S influenced them in their choices to become therapists "*I feel that my own religious and spiritual beliefs impact my choice in choosing this field and wanting to help people self-actualize."* Some therapists expressed the idea that they felt there were R/S and concepts that served as an underlying attitude they had in approaching therapy. This idea was expressed by P10 as, "*I think there broad hashakfik concepts that are integral parts of therapy. Concepts of ahavas yisroel, gadlus hadam, nekudas habichara that I believe in that I feel are important for me as a person, and as a therapist."* Others expressed an idea similar to P8, that their underlying goal in therapy is driven by their own R/S perspectives:

> *I feel that my spiritual and religious experiences enrich my life and give my life purpose and meaning, and my hope is that my clients can find a similar purpose and meaning in their own lives. Without telling them how to think, I just hope they reach some level of self-actualization and find meaning in their lives through their own religious and spiritual experiences.*

When speaking about personal R/S beliefs many therapists warned about the importance of maintaining boundaries, and not making assumptions about their clients. The need for awareness was raised by P9 "*I try to remain objective, and I try to separate religion from what I am doing in the therapy room, but I am sure that it does."* P12 expressed the thought, "*The familiarity and the assumptions that I, as a therapist, make about my clients is something I need to recognize and check at the door."* Recognition of

roles is important, as P3 expressed, "*So even if the client is aligned with my own belief system, I still try to keep my belief system out. So, I need to recognize it, and not impress on the client, and not bring it into the session."* P4 shared that this is especially true when the client acts in a way that does not align with his belief system, "*I try to accept them, because it is not me, this is not my decision and it doesn't reflect me. Some of the smaller things I do, I try to view it from the view of how it is affecting their life, so it would be trying not to use my value system to judge it."*

Results of the data indicate that Orthodox therapists identify as highly religious, and they recognize that their R/S beliefs can impact therapy. Therapists' beliefs can impact therapy by leading the therapists to make assumptions about their clients, try to impose their own R/S on clients and to cross professional lines. The recognition of these challenges leads Orthodox therapists to take the steps to ensure that professional boundaries are kept, and their focus is on meeting the client's needs.

Emerging Themes

Further analysis of relevant text, and the repeating ideas, led to the emergence of three central themes that were consistent through all the interviews. These factors appear to impact the attitudes, use of R/S, types of interventions used and how personal R/S impacts therapy. These three themes can be seen as an overarching theory called "Factors impacting use of R/S with Orthodox clients."

Boundaries. One factor that therapists discussed was the need to be aware of and maintain personal, professional and religious boundaries. It is awareness of these

boundaries that appears to impact how clinicians would use R/S with their Orthodox clients.

One factor contributing to the need to be aware of boundaries is the fact that the clinicians interviewed identified as Orthodox, and they realized how their own R/S beliefs can impact the session. P4 described that challenge in this way "*Yeah (that hashkafa drives therapy) … well it is really hard to differentiate, because my personal values and Torah values are the same often."* Others echoed the sentiment of P8 "*Even within Orthodoxy there are lots of different ways of thinking and lots of different approaches. My fear is that I may impose my own values and my own way of doing things on others."* One of the struggles in developing boundaries was described by P7 "*I don't want my clients perceiving me integrating my religious belief or practice onto them, which is why I am very conscious of it coming from the client."*

When it comes to using R/S interventions, therapists endorsed needing to tread with caution, and not cross into the role of teacher or rabbi. P5 described his role when dealing with R/S "*my role in therapy would not be to make them more religious. That would be uncalled for and unethical in a therapeutic relationship to do that."* P3 said that it is important to remember that boundary and "*I don't become a teacher, or a rabbi I try not to talk it into them, or things like that."* To avoid crossing the boundary P10 shared that "*It is not my job to tell them what to do. I can't take that responsibility; it is their life. So, I would involve a ruv to help them through this."* Sometimes engaging exploring religious text can lead to religious debate. P9 said "*I'm not entering into a debate with him, I just am opening him to the idea that there is another way of looking at things."*

In these cases, therapists endorsed referring to a rabbi. When asked to give specific religious guidance, P4 said "*I guess there is a lot of directions to go with that, but first off I would need to check myself to make sure that I am not trying to impose my own views onto another person"* and then added that finding that in this case he would refer to a rabbi. When a religious dilemma arises within therapy P11 said he does not address it because "*I am not a posek, and it is not my role to pasken, so when necessary I would ask a ruv."* P9 would sometimes refer clients to other therapists, more closely aligned with their own R/S ideals "*And I feel this is the correct approach, because if you belong to a community and you have certain religious beliefs that I am not familiar with, then you should go to a counselor from within your own religious sect."*

Some therapists said that there have been times when they crossed a boundary in regard to discussing religious concepts and values. But even when crossing the lines, it is done with caution, and in rare cases. This internal struggle was highlighted by P6, saying that "*there is a moment when you feel like "should I, or shouldn't I" and there are a few times I have crossed that boundary, and other times that I have decided that it is better not to."* She said to her the deciding factor was"*Can I refer them to someone else for more spiritual guidance, will they listen to my recommendation to go to get that guidance, or am I the last stop."* P12 said he has taken a more active religious role with a client, but only after having established rapport and asking himself:

> *Is he going to take my words as preaching? Is he going to feel I am talking down to him? Is he going to feel like I want to give a speech, and I want to teach and not be a therapist? Is he going to feel guilt that he doesn't know this, or he hasn't heard this?"*

P5, who identifies as a rabbi in addition to being a therapist, said he has used supervision to help deal with the struggle and he has learned to ask himself "*to what extent is the rabbi part being beneficial to the relationship, to what extent is it detrimental before* crossing the boundary. Although P1 would generally refer to a rabbi, there are times he felt it appropriate to take that role as a therapist:

> *But that was not my role to pasken from them, unless they asked me for a psak halacha. And even when they asked me for a psak halacha I would give a psak, and would add that I'm not a posek, please ask your ruv.*

P7 said that she crossed that line with a client that was not responding to any other interventions saying "*my clinical skills were maxed so I figured let me try this approach, but she wasn't open to it."*

Therapists described various ways of dealing with the struggle of maintaining boundaries. One way they deal with it is recognizing their role as a therapist. P10 shared "*My job is not to teach them Torah concepts, but use what they are using to help themselves."* Several therapists endorsed that being orthodox is beneficial to them; however, it is important to remember "*The fact that I am an orthodox therapist doesn't really matter in the clinical environment, besides that we can literally speak the same language"* said P7. Recognizing that it is the client that is in therapy led P2 to recognize that "*I try not put my religion on anyone else, unless it would be viewed as helpful to them, because they would possibly be able to say, 'I'm here to work on myself, and I don't to start believing in things that are not part of my religious beliefs.'"*

This struggle became more clearly highlighted when the issues raised in therapy appeared to clash with the therapist's religious beliefs or identity. Therapists said that in these instances it is even more important to be aware of boundaries. P9 shared "*In that case I put my religious and spiritual beliefs aside and be a psychologist, as if I was working in a non-Jewish setting."* P3 said that he feels this concept applies even for clients whose beliefs do align with his own "*So even if the client is aligned with my own belief system, I still try to keep my belief system out. So, I need to recognize it, and not impress on the client, and not bring it into the session."* The importance of supervision in these issues was highlighted by P4 "*When it comes up I would really try to seek supervision about it, so I can process it."*

Therapists endorsed the concept that when they feel that they get too close to crossing the boundary, they address it. P4 said "*I might tell the client that I am uncomfortable with dealing with this, and it is a personal thing, but I don't know."* Self-awareness helps in addressing these boundaries shared P9 "*What I learned in supervision and ethics is that as long as we are aware of our biases and are upfront with them, then we can continue with therapy."* Many therapists shared that there are certain times that they end up stepping aside, rather than cross those boundaries. P7 said that she had an experience in which she felt a religious issue was too much at odds with her own beliefs "*I encountered that situation and asked a shaila, and felt like I needed to pass them on to someone else."* When clients feel as if they want the therapist to validate behaviors that counter their religious beliefs, or express a desire to give up their religious lifestyle, then "*If the client comes and tells me that I want to resolve the conflict by figuring out how to blow off my religious obligations, then I would say to them that is a limitation, and it is*

not something I can do, P12 shared. This was echoed by P5 as well *"where it totally clashes, I would have to figure out how I to discuss it with the client that I cannot help with this issue, in a way that is not damaging to the client."*

An overarching theme that emerged from the data was the challenge, and need, for therapists to maintain appropriate professional boundaries. The challenges of maintaining boundaries were due to therapists own R/S impacting therapy, recognizing the line between being a therapist and rabbi, conflicts between R/S beliefs and interventions, and not imposing R/S beliefs on the client. Therapists maintain their boundaries through self-awareness, referring to rabbinic authority when appropriate, use of supervision and referring to other professionals. Some therapists endorsed the thought that there have been times that they crossed boundaries, but usually when it was clinically indicated, and after much self-reflection.

Client-centered. Another important aspect that those interviewed said is important to consider when approaching R/S with clients is ensuring that it is done in a client-centered manner. This ideal was first expressed by some therapists in shaping their attitudes to using R/S with Orthodox clients. P7 expressed *"I think if it beneficial to the client, and the client approves of it… as long as the client approves and it aligns with the client's values then it is fine, and appropriate."* Others endorsed the idea that although they are comfortable dealing with R/S, it is the client who decides if it is important for them to address; as P8 said "*If it is important to them, which very often it is, how religion intersects with their issue, it can come into the therapy room in so many different ways, and I have no problem making it part of therapy, where indicated."* P10 shared that she uses R/S in a reflective manner, and that helps her maintain her boundaries, "*It is them*

telling me, not me telling them. We are not working with the assumption that we believe in one God and that the Torah is valid. I am working with them based on the language they are using."

Being client-centered also helps therapists recognize when they should use R/S interventions, and when to avoid it. P5 shared "*I think it is important to address for the vast majority of the clients, but it is going to be different for each client, based on the individual needs and approach."* Other therapists recognized that there are times that using R/S is inappropriate. P3 shared that his psycho-spiritual model is not appropriate for everybody "*A case where they just don't buy into it. They don't want discuss it, they don't want to bring it up, they just don't buy into the psycho-spiritual model."* This was echoed by P11 as well "*If someone comes to me with purely practical question like how do I minimize stress, or building communication skills, and doesn't see these issues through their religious or spiritual constructs then I wouldn't go there."* Sometimes the client may not be willing to address R/S aspects of themselves, P5 explained, because "*Sometimes a client will say 'I am not ready for it, I am in too much pain.' Then we have to go back to addressing the pain"* P4 added that it is because of this pain he avoids addressing religious interventions, unless the client shares that he or she is willing: "*I happen to be dealing with a client base that are coming from a background which may have been oppressive in terms of religion… I would not use it in a case where it may be triggering."* Even in a case where the client appears to be religious,"*or even if it is part of their religious beliefs they can say 'I'm not comfortable believing in it, and have doubts about it*, said P2.

Understanding the client's experience is important, as P8 said "*Exploring the client's experience, because everyone's experience, even within the same community is different, so exploring what it means to them, and understanding their perspective is important."* Understanding the client's perspective helps P12 recognize when he can confront his clients about their R/S beliefs "*If I felt that the client's relationship with religion and religious text was not riddled with guilt, or Jewish shame, and I felt he was ready for me to confront his defense mechanism, then I might challenge him on his use religion."*

Many of the therapists endorsed using a shared religious experience as a way of connecting with clients. P6, who is one of them, shared that ultimately the goal of therapy is:

> *helping clients to see their life within the context of not just what they are going through, but that there is meaning in their life and they have a framework of religion, live in a community that can support them, and they can reach out to people within their religious community to help them.*

Therefore, focusing on the client is more important than addressing perceived religious needs. P2 added that being client-centered helps the clinician because:

> *You also want to make sure that your covering your bases and making sure the person is being helped, on both a religious and non-religious basis, where the entire person is being addressed, not just their religious aspects, for the clients benefit and not just for their religious perspective.*

A theme that emerged from the data was therapists expressing the need to be client-centered when addressing their R/S needs. Recognizing the clients' needs, impacted therapists' attitudes if they used R/S interventions, and also the types of interventions they utilized. Therapists expressed using client's R/S language, framework and experiences when approaching R/S interventions. Because the therapists were also Orthodox, they shared the concept that they can utilize the shared religious experience to build rapport with their Orthodox clients, but they help them achieve wellness through the client's perspective.

Intersection of R/S with mental health. The final theme that emerged from all interviews is the intersection that R/S has with mental health. Although there was a spectrum of opinions about where the intersection happened, and what the extent of the intersection is, all therapists agreed that at some point R/S beliefs and practices of their Orthodox clients influence their mental health, their engagement in treatment, and the impact of the interventions.

R/S outlook of Orthodox clients. When addressing the meaning of R/S for Orthodox clients, some therapists interviewed felt that R/S was important to address because of the unique interplay between R/S and everyday living. P11 described the idea that this unique interplay impacts mental health because "*Being that Orthodox feel that religion is a integral part of their everyday lives, they will present with more religious and spiritual issues."* Other therapists felt that some of the R/S characteristics of the community are important to consider when entering treatment with Orthodox clients. P12 felt that his existential approach to dealing with Orthodox clients is partially influenced by his belief that "*And one can say, that without a full commitment to religion, one can*

still have a spiritual experience, but in the religion of Judaism I don't think you can have one without the other." This concept was taken further by P3, who described:

> *The [psycho-spiritual] model was that he [my supervisor] built into the therapy that whatever the situation a client was facing, wherever they were stuck, be it anxiety, depression, shalom bais, kids off the derech, helping them understand that there is reason for this, it was given to them from shomayim, and it is not out of the blue.*

Because of the importance R/S has on this community, many therapists felt that there are benefits to Orthodox Jews seeing therapists from similar backgrounds. This feeling was expressed by P9 "*The more religiously informed you are, and the more the client trusts you that you are a religious authority yourself, the more you will have credibility in saying maybe that is not what God wants you to do."* P8 felt that this advantage was present for those who were moving away from religious observance as well:

> *I think it is important to have someone who understands their culture, gets where they are coming from and understands their values. Even if they are deviating from their religious life, it is important to have someone who understands what they are deviating from, so they can understand the struggle that they are going through, and understand the meaning the struggle has to them.*

P12 expressed the thought that *"I don't think that a non-religious clinician can fully wrap their head around an Orthodox client's perspective, especially related to sex, but on other things too"* and therefore felt it best for an Orthodox clinician to treat

members of the community. There were challenges expressed for seeing clients from a similar community, with most of them related to boundary concerns, as noted previously.

Impact of R/S on mental health. There were several instances that therapists noted when R/S impacts mental health, and mental health can impact R/S. The two most notable instances were cases dealing with OCD, and cases dealing with sexual and marital issues.

OCD was identified by most therapists as a case in which mental health and religion intersect, and need to be addressed appropriately. P10 identified that "*That (misusing torah concepts) comes up a lot with OCD."* In those cases, "*you need to explore is the person acting under religious guidance, or is the person not being guided by religion, but by a more maladaptive thought process,* said P2. An example was given by P9 "*Like this kid that was struggling with shema, he is obsessive-compulsive about other things, it just happens to be that davening is a very convenient way to express his OCD behaviors."* P8 noted that in terms of treatment:

> *There is an intersection between OCD and religion (in case of client getting stuck on davening), so over there I don't know if you call it treating religious symptoms, or treating a mental health issues, but that is one case it would come in.*

One of the ways that therapists expressed in dealing with religious OCD was in eliminating the religious concern before addressing the OCD. Asking a rabbi was one way P10 said you can eliminate these concerns, stating "*Now if it is not halchik concern we can go back to spiritual values by engaging in this scrupulosity."* P9 said that he would ignore the religious aspects of the OCD and "*if it is an anxiety, it may be expressed*

through a religious fear or belief, but the treatment for anxiety, or the OCD, the behavior, or whatever we are treating, I think it is similar treatment to if we would treat someone secular." P4 said that he would take a religious approach to dealing with OCD "*So I had this OCD guy and I remember telling him that Torah is an all-encompassing lifestyle…and if you are obsessing over one particular thing… probably neglecting all other pieces of the Torah."*

R/S also impacts Orthodox clients' responses to dealing with marital or sexual issues. P12 related that he finds "*The easiest example of religious guilt in the year 2016 for most of my clients have to do with sex."* P9 identified the fact that he feels a lot of these issues come from religious mis-education saying: "*Things I have heard rebbiem… tell their students about the bedroom, and then they get married, and these concepts are psychologically in line with anything that makes sense."* Another instance used by a few therapists was anxiety, related to the abstinent lifestyle of unmarried Orthodox men. P3 said that for him one of the biggest issues he confronts is "*I will tell you what does come up a lot, motze zera l'vatala."*

When dealing with these sexual issues most therapists felt that it was best to use community resources to treat these issues. Many, like P4, endorsed either involving a rabbi, or consulting with a rabbi "*to find out how to advise him from a Torah perspective."* P10 said that in those cases she separates the religion from the presenting issue "*In the frum world you can end up with women who are engaging in intermarital affairs… so it is important for me to know what they came in. It is not my job to discuss halacha."* Another approach, taken by P1, was to process the impact of the perceived conflict:

> *So discussing those issues, and what it meant to her to go the mikvah, or not going to the mikvah, or what it does to her husband, are nuances that you need to know, and know all about what mikvah is, not just on practical level, but the preparation involved, and the reality that intimacy is forbidden for 2 weeks out of every month.*

P8 endorsed using religious text to minimize the anxiety, stating "*One case where I was dealing with a bachur who was dealing with guilt related to motzei zera l'vatala, so I brought the Alei Shur that discusses these things."*

Contradiction between mental health and religion. The concept of contradictions between R/S ideals and mental health concerns and treatment was also addressed in a general sense in the interviews. P10 stated "*You can end up having a lot of times where there seems to be a contradiction between halacha and psychology."* On the other hand, P8 shared "*I doubt you will get an answer of yes from me, because I am creative and I will always try to find a way around it."* P12 also stated added that his way of dealing with perceived contradictions is "*For the most part I find that the conflicts that arise are not contradictions, but paradoxes, and paradoxes are meant to be resolved. It's a question in helping people learn how to resolve it."* Involving a rabbi is another way of resolving potential conflicts, as stated by P9 *"I put it back on someone they trust, because they don't want to hear from me, because I am not the religious authority."*

Sometimes clients may use R/S as a way of not engaging in therapy. In such cases P9 shared that he feels that:

> *If you approach it with seichel and explain your position, then the person is not so antagonistic towards it. If you can understand them, validate them, and explain it to them in a way they can integrate it in their own worldview, then they are not so makpid.*

P7 did share that there are emerging mental health issues that can potentially create a conflict and expressed that the orthodox mental health professional is going to need to learn how to deal with these conflicts, stating:

> *I think the struggle comes along the lines with things that appear to be in conflict with our faith. For example, if someone who begins to express 'I think I'm transgender', or, 'I think I'm gay' or you're dealing with a child that is gay.*

A concern that many therapists raised was clients using R/S as a defense mechanism in dealing with a specific issue, or using R/S beliefs in a maladaptive manner, thus contributing to mental health concerns. P5 expressed that there are many clients that aspects of their religious observance "*either affects them in a negative way psychologically and their general functioning, at least the way they are interpreting their religion observance and their spirituality."* This is particularly a challenge in dealing with OCD, as expressed by P2: "*There is a possibility that one may mistakenly assume that a person is religious when they are constantly washing their hands, because they feel that they are touching things that they should not be touching."* P9 expressed the thought that these cases are difficult to deal with because "*If the person believes their irrational belief is Godly, or divine, or an absolute truth, this makes it much harder to challenge."* To deal with these issues P5 expressed the idea *"It is not different than any other maladaptive thought and belief that clients use that is detrimental, and needs to be*

challenged in a healthy way, in a way that the client feels safe and explorative." Others expressed the idea of working within the client's belief system; this idea was shared by P11 "*I would explore the issue with them, maybe refer them to some seforim, and see if they can see the concept from a different angle."* P12 discussed thus concept extensively and shared "*that many people confuse the emotional sensation of anxiety with serving God. So, if there was nothing other than anxiety, and they mistook it as serving God, that would be frustrating to me."* He said he deals with his own frustration with "*I am going to have to learn to be patient and figure out how to stick with that, and on their terms, help them resolve the conflict."*

Methods of using R/S Interventions. Therapists discussed their general approach to using what they considered R/S interventions. P12 shared "*I definitely use religion in my way of helping the person gain a better understanding of themselves."* Others, like P11, expressed processing the underlying R/S concepts of the presenting issue *"I would approach in terms of what their beliefs are about Judaism, and help them view how their framework can help them overcome their issue."*

Another way of using R/S interventions was by creating meaning, as expressed by P7 "*I do use religious practice in the context of peri-natal loss and grief work. Because for women trying to find meaning in loss, or trying to find their grief practice."* In addition to creating meaning, P6 expressed using R/S as a way of building her clients' self-image "*The message I try to impart to them is that God still loves them and that they were created with a pure and holy neshama, and no matter what they have done or experienced that will never change, and is always pure."* P7 also expressed using R/S to develop coping skills "*So integrating the language that they use, or the spiritual*

practices that they're comfortable with to help them cope, if the religious practice is something that is meaningful and valuable to them." Others expressed the thought that they use R/S interventions to help restructure, or reframe, maladaptive cognitions, and ideas; this was expressed by P8 "*At times I have shared with them different approaches that are legitimate religiously of dealing with the same concepts."* P1 shared that he uses R/S interventions to help explore the presenting problem "*Working through, first of all, the details of the preparation and the actual action of going to the mikvah, trying to understand from the client's perspective."* In addition to using R/S for exploration and intervention, P5 endorsed using it for psycho-education, to show clients that "*certain concepts that are used in psychology are connected to a religious source really helps motivate clients to be able to see things from a spiritual point of view and a psychological point of view."*

The use of spiritual interventions is particularly helpful for religious clients; P9 stated:

> *I mean there are different approaches to anxiety, but one thing that works, especially with religious clients, is just talking about their higher power. Whatever your fear is, bitachon and emuna can work, you are being taken care of, and whatever happens you're in good hands, these concepts can work. These are spiritual types of interventions.*

Clinicians did warn that the use of R/S interventions may not be appropriate for every client, P12 shared:

> *I would have to be clear that my use, or introduction of religious concepts is not going to alienate the point. Because for many clients the amount of guilt that they have around religion would be an indicator that I should not be using religious text to engage with them.*

Use of Religious Text and Concepts. Another R/S intervention that therapists discussed using was the use of religious text, concepts and sources with Orthodox clients. While some therapists, like P11 endorsed being hesitant to use religious texts, saying "*I would use it infrequently. I think that if someone has an emotional problem, quoting a source will probably not satisfy that"* most therapists expressed the thought that they use them in some manner in therapy. The reason for using them varied, but most felt that it enhances the engagement in therapy, as P2 expressed:

> *I feel that the religious books can give an added and greater dimension of internalizing a lot of the concepts. This is because a person can be more motivated to look into these seforim, and to implement them, because it is not just their therapist telling them, it is their creator and there is an added level of accountability.*

One way of using religious text was expressed by P8 "*I would use mamrie chazal to illustrate certain phenomenon, to help normalize, to engage them and even to help challenge a faulty belief, if I know that it is something they would appreciate and is part of their mindset."* Another way of using it was expressed by P4, who felt he uses it more as a way he approaches therapy, stating:

I am of the belief that Torah has all to offer, and everything we currently practice can be found in the Torah. I have seen that when I was involved in a project where we tried finding sources for things in the Torah, so I have seen that they are in the Torah.

P12 felt that using text was a matter of connecting with his clients, saying "*clients who have spent most of their lives studying religious text, I would use examples from religious text to make a point. I might use a concept allegorically, but it is just a matter of framework."* In a case in which a client uses religious beliefs as part of their maladaptive behavior, P12 expressed he would not rely on text, stating:

> *A client that comes who comes in with a lot of anxiety in his life, what am I going to do? Am I going to say to him that none of that is true? Am I going to pull out a sefer that he has never heard of, and start reading some Hebrew words and try to argue with them? No, I am not going to do that.*

Some therapists expressed using text as an adjunct to therapy; this was particularly endorsed by P6, who stated "*I may suggest to patients to daven, learn say tehillim as a way of connecting with Hashem, but I wouldn't bring into treatment."*

Use of Rabbinic guidance. Another resource endorsed by therapists is the use of rabbinic guidance. Some therapists used rabbinic authority as a way of motivating clients to engage in treatment, as stated by P5 "*On occasion, where the ruv's involvement would be beneficial to the client. Either to motivate the client, or if the client requests."*

Therapists also endorsed using a rabbi as an adjunct to therapy. One way of using a rabbi was discussed by P9, who said he uses rabbinic help to help develop alternative cognitions in how a client approaches R/S behaviors. He shared:

> *I would get them [the client] to admit that there is a spectrum and there are different, valid, ways of practicing Judaism. I would generally leave it at that, and tell them you have to consult your rebbe, or someone you trust, and see whether what you are doing is appropriate.*

P9 also expressed the thought that he felt his approach was more effective in implementing an intervention successfully. Other therapists shared that they would themselves introduce a client to a rabbi that can be a support in therapy, as P8 stated "*I approached a ruv from the community to help them realize that he was taking it to an extreme, and help them put it in the right context."* P12 shared that he would use a rabbi as an adjunct to therapy, but only in specific cases:

> *I have sent clients specifically to rabbis to discuss things that are not related to religious law, but have more to do with how the Torah conceptualized man and psychology. I have done this when I saw that the client's framework was more religious-based and not psychologically-based.*

Another way of utilizing rabbinic support of therapy was used to eliminate any religious concerns that may arise in therapy. P10 expressed the thought that this is helpful to assist he client learn to distinguish between a religious concern and a mental health concern "*That is why it is important in these types of cases to have a ruv on board. This helps clarify that things are not an halachik issue, rather it is a different type of concern."* Some therapists, like P11, shared that in these cases he would contact a rabbi in conjunction with the client,"*it came down to a basic halachik question, was it permitted or not, so we asked a ruv."* Others, like P1, expressed the idea that they would send the client to their own rabbi "*I did have a case like that, and I would ask the client*

did you ever check this concept with your rabbi, mashpia or ruv." Although expressing the fact that he preferred the client to contact a rabbi, P3 shared that "*I would ask them if they have a rabbi, and hopefully they do. I've had to get a p'sak here and there, that I involved rabbonim."* Many of the therapists shared that they themselves sometimes grapple with religious concerns, as P4 stated "*I have had to ask shailos about how to deal with specific clients."*

There was some concern expressed when using a rabbi as a resource in therapy. As P12 expressed:

> *In a case where the rabbi is playing a more communal role in their lives, and is playing the role of a leader or a guider, and providing rabbinical counseling, I would want to have some sort of contact with the rabbi, so we are not cross-pollinating the client, so to speak.*

Some therapists expressed concern when enlisting rabbinic support, P2 warned "*there are possibilities, let's say, for many people the first line of defense is the rabbi, or their priest and you have cases where the rabbi may not know what to say, or God forbid, say the wrong thing."* This fear led P7 to express the idea that:

> *It is not only a ruv, it can be working with a mikva lady who understands OCD, and is knowledgeable what is OCD, what is halacha and what is chumrah, then you can more effectively assist in finding the right compromise between halacha and your intervention.*

Recognizing the intersection between R/S and mental health was the final theme that emerged from the analysis of the data. This intersection started with recognizing the

unique R/S needs of the Orthodox population; how these beliefs can impact mental health, and approaches to mental health treatment. Study participants also identified possible conflicts between R/S and mental health needs and interventions; ways of maneuvering these potential conflicts were also explored. Therapists explored the types of R/S interventions they may use, and how they would utilize R/S concepts and R/S resources, such as involving Rabbinic guidance, to enhance therapy.

Chapter 5: Discussion

This study explored therapists' attitudes towards using spiritual and religious interventions with Orthodox Jewish clients. Because there is limited research on this population the aim of this study was to understand how therapists approach therapy with this unique population. Analysis of the interviews conducted suggested that there is a broad spectrum in the ways in which therapists' approach therapy with Orthodox clients. This spectrum ranges across the attitudes of using R/S interventions, with some therapists endorsing positive attitudes, yet others endorsing a more cautious approach. Although there was a spectrum of attitudes, all therapists endorsed using R/S interventions with their Orthodox clients, but how and when they would do so, ranged, and were based on the needs of the client. There was also a spectrum presented in the types of interventions used, ranging from unique religious interventions to using an R/S framework to deliver traditional therapeutic interventions. Finally, therapists reflected that they recognize that their own R/S influences in how they approach therapy, with many endorsing the influences in a positive manner, but they recognized the need to keep professional boundaries, and make sure they are addressing the client's needs.

Further analysis of the relevant text led to the emergence of repeated ideas, which then led to the development of themes, based on the interviews. Three major themes emerged from the analysis: the need to keep professional boundaries; the need to be client-centered, and the intersection between R/S and mental health. These three themes were discussed by all therapists during the interview process, and appear to influence their approach to addressing R/S with Orthodox Jewish clients. These three themes appear to be the overarching principles, making "Factors that Impact Therapists' Approach to Dealing with Orthodox Jewish Clients" the general theoretical construct to therapists approaching and addressing R/S with Orthodox clients.

The results of this study indicate that there are three factors that therapists need to take into consideration when doing therapy with Orthodox Jews. The first is ensuring that the therapist remains client-centered. This is consistent with previous research (Oxhandler & Pargament, 2014) that shows that when addressing R/S it is important that therapists take their clients lead when addressing R/S, so clients do not feel coerced into addressing it (Sloan and Bagiella, 2002). Most therapists interviewed also endorsed waiting for the client to bring up R/S before addressing it, an attitude expressed by therapists in other studies as well (Eck, 2002). However, previous research also indicates that clients are hesitant to bring up R/S (Ankrah, 2002); in this study it is unclear whether therapists recognize this hesitancy, or what the clients' perspectives may be.

In line with the findings of Oxhandler & Pargament (2014), therapists interviewed acknowledged the importance of exploring religious struggles, or coping mechanisms. However, they also recognized the need to maintain boundaries (Martinez et al., 2007). As discussed by Eck (2002), therapists expressed the need to be self-aware of their own

personal beliefs and how it impacts their approach to therapy. Therapists also recognized that even though they had the same religious backgrounds, the experiences of their clients' beliefs may be different from their own, and therefore they need to ensure that they are not making assumptions about R/S beliefs of their clients (Masters, 2010), and recognize the risk of getting involved in religious debate (Popovsky, 2010). Interviewees also acknowledged, as Masters (2010) stressed, that it is important to remember that addressing R/S can lead to an overemphasis on R/S and overlooking evidence-based practice; therefore it should be approached with caution.

The intersection of R/S and therapy emerged across several domains, and has been found to be consistent with suggestions in the literature. These domains included the recognition of the unique R/S needs of Orthodox population (Schnall, 2006 & Provosky, 2010) , the impact that R/S beliefs can have on mental health, both positive and negative (Rosemarin et al., 2009; Huppert & Siev, 2010), recognizing when R/S beliefs seem to be at odds with mental health concerns and interventions (Feinberg & Feinberg, 1985; Schnall et al., 2013), the different types of R/S interventions (Martinez, et al., 2007), the use of text and R/S concepts (Rawitch, 1997; Milevsky & Eisenberg, 2012) and the use of a rabbi were brought up (Schnall et al., 2014; Provosky, 2010).

There are many studies that discuss the importance of being aware of these three themes, yet none was found to combine them in a comprehensive manner. Results of this research show that these three factors, being aware of therapeutic boundaries, being client-centered, and being aware of the intersection of R/S and mental health are part of a general approach that Orthodox therapists take in addressing R/S needs of their religious clients. In addition, results indicate that therapists appear to be aware of how these three

factors impact clinical practice. Even though some therapists expressed hesitancy in their attitudes towards addressing R/S with Orthodox clients, they recognized that there are times when it is important to address. They approached doing so by recognizing 1) the needs of the client, 2) awareness of their own R/S beliefs, and how they may impact the therapeutic alliance, and 3) they need to be aware of how R/S impacts the client, in terms of what brought them into therapy, and in terms of the interventions available to them.

Although therapists did discuss their own reasons for approaching therapy with Orthodox clients using these three factors, analysis of the data gave no clear indication about the underlying reason why this is so. From the data, it can be hypothesized that the religious level of the therapist, their familiarity with the cultural needs, and inner workings of the communities that their clients are coming from, help them recognize the challenges in addressing the community's mental health needs. It may also be that therapists' need to balance their formal professional education, with their own religious identity contributes to their needing to consider how to mesh the two worlds in an effective manner. These factors may be what leads to the caution expressed by the therapists, that they need to be aware of boundaries, make sure they are meeting the client's needs, and using R/S interventions appropriately.

A comparison was made between reported attitudes to using R/S in therapy, and the results of individual scores of the BOJRM. The comparison was done to see if there may be any indication that religious levels of therapists impact their attitudes towards addressing it. Although the overall sample of interviewees identified themselves as highly religious, there were individual differences in the BOJRM scores. Results of this comparison revealed that there appears to be no connection between level of religiosity

and their attitudes. Several therapists that had high scores on the religious scale presented cautious attitudes towards using R/S, and the therapist who scored the lowest score presented with a positive attitude towards using R/S. This comparison was done by comparing raw scores and reported attitude, and further analysis may be warranted to explore how these areas may connect.

Limitations

Although qualitative studies are important in helping create an understanding of a phenomenon, the results of the study are limited in their ability to be generalized across the population. Using this study to develop a large scale quantitative study can help make these results more generalizable. The qualitative nature of the study, also, created room for interpretation, and there were times that coders struggled in understanding the responses of the therapists, and they tried to make sense of it based on the rest of the interview, but ultimately interpretation was in the eyes of the coding team.

Another limitation was that there was no working definition of what R/S is, and what R/S interventions are. This may have led to a lack of clarity about what the interview questions were, and the answers may have been influenced by how therapists understood what was meant by R/S interventions. Although therapists were asked to identify what they felt were R/S interventions, and the gist of the interview generally followed their stated definition because there was no consensus across interviews on the definition of what is considered an R/S intervention, it may have led to the spectrum of responses encountered. Future studies may benefit in creating a definition of R/S interventions and basing their exploration on that definition.

In addition, all of the therapist interviewees were self-selected, knowing that they were responding to an interview exploring their attitudes to using R/S in therapy. This may have influenced the results, because there may have been a bias in the therapists that volunteered to be interviewed.

Last, there was no scientific comparison done to explore if there is a connection between therapists' characteristics and their attitudes; therefore, the results of this study do not inform what kind of therapist would use what kind of interventions. This study was designed to start filling the gap in the literature about the use of therapy with Orthodox Jews, but there are many more characteristics that may have arisen through the study; these are characteristics that this study does not cover in depth, and further exploration is warranted.

Implications

Implications for clinical practice. Results of this study have direct implications on clinical practice. Results highlight the need for therapists to be aware of the aspects that go into addressing R/S with their religious clients. Recognizing clinical boundaries, the need to be client-centered, and how R/S beliefs are impacting the client, and their mental health needs can help a therapist address R/S in a more productive manner. This can also lead to a better therapeutic alliance, higher levels of trust, and better therapeutic outcomes.

Implications for advocacy. There are implications for advocacy that emerge from this study. Some of the factors attributed to the resistance of accessing mental health care for this community are the fear that clinicians may misjudge religious behaviors as

evidence of psychopathology; therapists will try to influence the R/S beliefs of their clients, including the belief that psychology and religion are incompatible. Findings of this study appear to indicate that at least Orthodox Jewish therapists recognize the need to be client-centered, not to impose their own beliefs on their clients, and that they can help bridge the gap between religion and psychology. Steps, such as reaching out to community leaders, providing mental health workshops and reaching out through community publications, can be taken to inform the community that therapists are aware of their fears, and that they do take the precautions to minimize these concerns; these steps can help increase the access of the population to mental health care.

The results of this study hopefully help create a picture of the complex issues that may arise when doing therapy with Orthodox Jews and how therapists approach dealing with these concerns. The results of this study help gain an understanding of how therapy can be effectively approached when dealing with a population that has many barriers to receiving appropriate mental health treatment.

Implications for furture research. There may be several other factors that were not explored in this study; these factors would benefit from further research. Although therapists interviewed did identify their theoretical orientation, and indicated the types of R/S interventions that they would use, it is not clear how their theoretical orientation impacts their approach to therapy. This may be an important factor that may contribute to the attitudes, the use of R/S interventions and also what therapists consider R/S interventions.

This study explored therapist's attitudes towards addressing R/S, and did not take into consideration the religious identity of the clients, and how they perceive the use of

R/S in therapy. Therefore, it would also be important to explore clients' feelings and views of addressing spirituality and religion in therapy, and how it impacts their treatment. Comparing results of this study with expectations and attitudes of the client base that the therapists serve can help create a more complete picture of how to address R/S with this client base.

The focus of this study was exploring attitudes of Orthodox Jewish therapists when addressing R/S with Orthodox Jewish clients. Results of the study did find unique aspects that Orthodox therapists have; these may contribute to their attitudes, and may indicate that there may be advantages for an Orthodox Jewish person to see an Orthodox therapist. However, this positive outcome may be the result of the perspective of the Orthodox therapists. Further studies comparing the responses of these therapists with a non-Orthodox therapist sample can help us understand if the outcome of this study is indeed unique to Orthodox therapists, and therefore there are indeed advantages for Orthodox people to see Orthodox therapists, or these results are generalizable to other therapists, and the advantages are just perceived advantages.

Previous research has found that a contributing factor to therapists being hesitant to address R/S with their clients is a lack of education around the subject (Plumb, 2011; Canda & Furman, 2009). This does not appear to be the case in the sample interviewed. Although only 2 of the 12 therapists endorsed having a course in R/S in therapy during their graduate training, most did endorse feeling comfortable using R/S interventions on some level. It is possible that therapists' own comfort with their R/S identity and knowledge contributed to their ability to address these areas of their clients' lives, but there may be other factors that were not explored that are contributing to this

phenomenon, and may be learned through further exploration. It may also be important to explore how having a course in R/S can help Orthodox therapists prepare to deal with the challenges of seeing Orthodox clients. All therapists interviewed expressed some struggle with dealing with seeing clients from similar R/S as they, and a course in R/S may give them the opportunity to be able cope with the conflicts Orthodox therapists may encounter.

Future research can use the results of this study to create quantitative measures to further explore the issue of using religion and spirituality in therapy with Orthodox clients. Even though a comparison between therapists' religious beliefs and their attitudes to addressing R/S with Orthodox clients was done in the study, and findings did not indicate any trend, further exploration in this area is warranted. To build on the findings of the study it would be beneficial to explore further how therapists' own religious identities affect their attitudes and use of religious and spiritual interventions in therapy.

Findings of this study can also serve as a basis for a new model to approaching R/S with Orthodox clients. Using the emerging themes as a basis, this model can help therapists recognize how they can effectively approach therapy with this population. Therapists will learn to recognize the need to keep appropriate boundaries, what some challenges may be in keeping them, and recognizing how they can take the steps to cope effectively with issues that may arise. The model can also build on recognizing what the client's R/S needs are in therapy, come up with a manner of assessing how R/S is affecting the clients functioning, and how therapists can recognize the client's R/S needs and wants, in therapy. Finally, the model can develop a comprehensive manner of delivering interventions in a religiously and spiritually sensitive manner.

This model can also help to recognize what types of interventions to use and when, and what types of resources, such as rabbinic support, religious text, are available to help the client engage and effectively create change in the Orthodox client. This model can also be generalized across different religious and spiritual communities, and help inform therapists dealing with these communities what is the most effective manner to deliver treatment for the populations they serve.

Conclusion

In conclusion, this current study explored how Orthodox Jewish therapists go about addressing R/S with their Orthodox Jewish Clients. Results of the research showed that therapists recognize the importance of three factors that impact their approach: the need to maintain professional boundaries, the need to be client-centered and the recognition of the intersection of R/S and mental health, which includes resources and interventions to use for this population. These findings can help expand the knowledge of the mental health field, and has practical applications in clinical practice. When dealing with a religious, or spiritual, client, a therapist should be aware of these three factors, and approach therapy through this lens. This is especially true in really conservative religious populations, and/or culturally diverse populations, where there is hesitancy for clients to obtain mental health treatment for fear of being judged, of being misunderstood, or of being coerced to change their beliefs. Therapists that filter their interactions with these clients through the lens of the three factors explored can help meet their clients where they are , help them recognize that they will maintain their boundaries, and utilize the appropriate interventions for that particular client. This would require therapists to immerse themselves in the client's culture to learn the appropriate boundaries, recognize

the needs of the client and educate themselves on how they can effectively provide interventions. Therapists making the effort to approach therapy in this manner can help minimize the gap that these minority populations encounter in addressing their mental health needs**.**

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Appendix A

Demographic Questionnaire

Initials_____

Gender _____ Age_____

Religious Affiliation (check one)

__ Chasidish

__ Yeshivish

__ Ultra-Orthodox

__ Orthodox

__ Modern Orthodox

__ Open Orthodox

__ Non- Orthodox

__ Unaffiliated

__ Other _____

Degree (check all that apply):

__ MA/MS General Psychology

__ Counseling/MHC

__ MSW

__ PsyD

__ PhD

__ MD

__ Other_____

Did you have a course in religion and spirituality in your graduate training? Y N

Are you licensed? Y N (if yes: License type: _____)

What is you theoretical Orientation? _____

Clinical populations served _____

Years of overall experience: _____

Practice setting: (check all that apply)

__ Psychiatric hospital

__ Medical hospital

__ Chemical dependency treatment

__ Private practice

__ School (if yes: is it a Jewish school? Y N)

__ Home based practice

__ Community Agency (if yes: is it a Jewish agency? Y N)

__ College counseling center

__ Other _____

Percentage of clients that are Orthodox _____

Years of clinical experience serving Orthodox patients_____

Appendix B

Brief Orthodox Jewish Religiosity Scale

This questionnaire has about 11 questions about your religious beliefs and practices. Please try to answer all the questions as best and honestly as possible. Circle the number that best describes your answer. The numbers can reflect either strength of agreement from strongly disagree to strongly agree.

1 = Strongly Disagree
2 = Disagree
3 = Slightly Disagree
4 = Neither Agree or Disagree
5 = Slightly Agree
6 = Agree
7 = Strongly Agree

1. My religion influences everything I do.
2. I believe that the Torah was given to Moshe by G-d at Sinai.
3. I try to observe halacha [religious law] as carefully as possible.
4. I believe G-d directs and controls the world.
5. My religious observance is primarily out of social expectation. [reversed scored]
6. I believe G-d loves all His creations.
7. I feel that G-d is always accessible to me.
8. I feel G-d listens to my prayers.
9. I feel Divine intervention (hashgacha) within my life.
10. I believe in G-d.
11. I say Brochos [blessings] with Kavaana [devotion].

Source: Pirutinsky, S. (2009). The terror management function of Orthodox Jewish religiosity: A religious culture approach. *Mental Health, Religion and Culture*, 12, 247 - 256.

Note: This is a self-report instrument. No special skills are required to administer this measure; however
interpretation should only be carried out by individuals with appropriate training in psychological
assessment. Provided that the scales are not modified or sold for profit, and complete and accurate
references to relevant published works are provided in all print copies and cited in academic work, no
permission is required to use or distribute these instruments when used for research or healthcare purposes.

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Appendix C

Interview Questions

What do you think I am referring to when speaking about R/S interventions with Orthodox Jewish clients?

What do you feel the difference between religion and spirituality are?

What are your feelings about using R/S interventions with Orthodox Jewish clients?

How do you use R/S interventions with Orthodox Clients?

Have you encountered a case where you involved a rabbi in the therapeutic process?

Describe a case that you felt that using R/S interventions were either appropriate or inappropriate to use?

How do you deal with a case where you feel the client is using R/S concepts in maladaptive manner?

How do you deal with cases where there appears to be a conflict between religious beliefs and psychology?

How do you feel that your own R/S beliefs influence how you approach therapy with Orthodox clients?

What are some of the advantages or disadvantages to seeing clients from the same religious background?

Do you have anything else to add to the topic?