Community Ment Health J (2017) 53:613–625
DOI 10.1007/s10597-016-0056-9

ORIGINAL PAPER

Cultural Psychiatry: A Spotlight on the Experience of Clinical Social Workers' Encounter with Jewish Ultra-Orthodox Mental Health Clients

Anat Freund[1] · **Tova Band-Winterstein**[2]

Received: 9 November 2015 / Accepted: 28 September 2016 / Published online: 8 October 2016

Abstract Community is a complex issue, especially in two particular populations overlap: Haredi society, which embraces cultural codes common to closed communities, and the mental health population characterized by its own unique needs. The present study explores the encounter experience of social workers with the cultural perceptions of mental health clients in the Haredi community in light of Community Cultural Psychiatry. A qualitative-phenomenological approach was adopted. In-depth semi-structured interviews were conducted with 27 social workers, mental health professionals, who are in contact with ultra-Orthodox Jewish clients. Three major themes emerged from the data analysis: (1) Exclusion vs. grace and compassion. (2) Mental health: A professional or cultural arena? (3) Mental health help-seeking changing processes. This study shows that the attitude in the Haredi community toward mental health therapy undergoes a process of change. It is important to strengthen this process, together with preserving existing community informal structures of help.

Keywords Religion · Psychiatry · Qualitative research · Clinical social work · Cultural sensitivity

Introduction

Cultural Psychiatry is a branch in Psychiatry dealing with mental diseases and/or disorders existing within a certain culture. While mental pathologies are universal and exist within numerous populations, expressions of mental distress are culture-dependent, characterizing certain communities or geographic regions (Bains 2005). Cultural psychiatry advocates understanding illness in terms of the local cultures; therefore, it attempts to understand the complex and subtle ways in which culture relates to mental functions, particularly distress (Bains 2005). In the Haredi (Jewish ultra-Orthodox) community, as in other similar communities in Israel—such as Arab Muslims (Dwairy 2006)—the unique needs of the mental health population are added to the community's cultural codes (Witztum and Goodman 2003). This challenges professionals to attempt to better understand the subject's emotional world, while passing on their relevant professional knowledge (Freund and Band-Winterstein 2013).

Haredi society, as a faith-based community, is segregated, despite its interaction and complex relationship with the secular surroundings (Strean 1994). The community is generally fearful of the negative stigma frequently associated with the mentally ill, while mental disorders are often understood and labeled as basic faults of the individual (Witztum and Goodman 2003). Furthermore, seeking out mental health professionals is not an obvious alternative (Freund and Band-Winterstein 2013). The present study describes and analyzes the cultural-professional encounter of Israeli social workers treating Haredi mental health clients.

Anat Freund and Tova Band-Winterstein have contributed equally to this paper.

✉ Anat Freund
afreund@research.haifa.ac.il

Tova Band-Winterstein
twinters@research.haifa.ac.il

[1] University of Haifa, School of Social Work, Mount Carmel, Haifa 31905, Israel

[2] Department of Gerontology, University of Haifa, Mount Carmel, Haifa 31905, Israel

Multiculturalism as a Theoretical Framework

Multiculturalism refers to the existence and acceptance of ethnic cultural variety. It includes multi-traditional societies, different lifestyles, personal identities and multi-societal experience. The main concept of multiculturalism is *diversity*, meaning existing side by side among multiple ways of life. Multiculturalism is based on the assumption that in order to live a fulfilling life, people need the support of their cultural communities, whose embedded values cannot be classified on the same value scale. Thus, there is no preference for one culture over another, and each culture can be relatively adequate in regard to time, social, political and economic contexts. There is a dialectic tension between the known and the un-known that can create segregation, resistance and restraint on one hand, and acceptance, openness and interest on the other.

Characteristics of the Jewish Ultra-Orthodox Society

The Jewish ultra-Orthodox community is a differentiated group within Jewish society in Israel and worldwide, characterized by extreme views regarding faith and religious practice (Smith 2003). It is characterized by community discipline stemming from its subordination to rabbinical authority, which encourages strong loyalty to the community, while dictating strict behavioral codes. The ultra-Orthodox society is further characterized by a developed and diversified system of mutual assistance based on philanthropy (Kagitcibaci 1996). Contrary to existing stereotypes, the ultra-Orthodox society is not a homogeneous and unified group of people in black (Erhard and Erhard-Weiss 2007; Heilman and Friedman 1991). However, scholars agree that a clearly defined set of values characterizes all groups within it, such as common views, perceptions of reality, faith, adherence to religious precepts, and a persistent resistance to secularism (Hakak 2011).

This group is determined to segregate itself from external society. Their isolation is reinforced by religious norms, behavioral modes, perceptions, education and external appearances (Coleman-Brueckheimer et al. 2009; Goodman and Witztum 2002).

The Haredi sector is composed of different factions and groups with specific leadership (Heilman and Witztum 1997) and institutions whose aims are to assist people belonging to that specific group (Shelif and Wallinger 2008). Historically, social conflicts in collectivist societies were handled internally by the rabbinical authority—in other words, seeking advice from the Rabbi or a community source, while avoiding welfare involvement because exposure to state institutions might be interpreted as a form of betrayal or denouncement, especially when referring to sensitive issues such as family integrity. Today, Rabbis and community leaders understand that disclosure and cooperation contribute to improving the situation of Haredi women who experience IPV (Leshem 2003).

Haredi Community, Collectivistic Culture and Mental Health

Individualism and collectivism provides a theoretical framework for exploring the interplay between culture and mental health (Triandis 2001). Members of the Haredi community, as an extreme collectivistic culture, are obliged to subordinate their personal goals to the goals of the collective, usually a stable in-group (e.g., family, band, tribe), and much of the behavior of individuals may be related to goals that are consistent with the goals of this in-group (Caldwell-Harris and Aycicegi 2006). The individual in collectivist societies relates to a few very important in-groups, organized in concentric circles, and whose chosen goals do not threaten group harmony (e.g., the nuclear family, extended family, clan, city, state) (Triandis et al. 1988). In such a culture, there is a strong influence on the way relationships between the self and others are perceived. In the context of mental health, collectivism provides social support, and feelings of belonging, but it may also result in stress if the individual does not comply with the expected social obligations (Triandis 2001). Engaging in "deviant" behavior often results in social control and social sanctions, such as negative consequences regarding the match-making process for the individual and other family members, occupational integration within the society, social relations, and integration in educational institutes (Barth and Ben-Ari 2014). Compliance with social-cultural-collectivist codes (Haj-Yahia 2011) in the community and family is a central psycho-cultural theme in Haredi society, which reflects the nature of the relationship between the individual and society.

*Mental disorder*s refers to a wide range of behaviors classified by psychologists as abnormal (American Psychiatric Association 2013), and is a constant threat to the well-being of both the individual and the community (Gerrig and Zimbardo 2008). The stigma regarding mental health does not only affect the ill individuals; it applies to the clients' family as well (Sartorius and Schulz 2005). According to the Haredi society, this stigma is based on a collectivistic culture including myths and beliefs associated with mental diseases. When the mental illness is perceived as representing a family illness, the entire family image deteriorates, increasing the fear of "being labeled" mentally ill. While the surrounding society is relatively more receptive to mental disorders, in the Haredi community, as well as in similar communities (Arab Muslims), stigma and labeling threaten the social status of the mentally ill and their family members (Dwairy 2006; Kitai 1997).

Since we are talking about a society characterized by severe enforcement and supervision patterns (Lev-On and Neriva-Ben Shahar 2009), individuals are strictly supervised, and are expected to follow and fulfill demanding rules and procedures. It should be emphasized that stigma and labeling regarding social status is latent in the Haredi society. A negatively perceived individual is associated with a lower social status and inferiority, and should be avoided. This stigma affects various contexts, particularly matchmaking prospects (Freund and Band-Winterstein 2013). Despite the different ideologies of ultra-Orthodox and secular societies in Israel, they are both interrelated, as a result of an ever-growing population with more complex needs. In addition, recent years have witnessed more Haredi therapists working in these fields. The ultra-Orthodox "negotiate" and depend on the secular society, especially regarding general and mental health, family violence, addictions, etc. (Baum 2007; Goodman and Witztum 2002).

Seeking Help and Community Mediation in Non-Western Communities

Studies shows differences between ethnic groups and the secular society in regard to seeking help patterns, access, and service utilization (Abe-Kim et al. 2004). Haredi society, as a collectivistic culture, faces a range of obstacles, such as low awareness of services, denial of the possibility of mental illness in the community, and a negative attitude towards professional help-seeking, due to cultural constraints that have an impact on help-seeking p (Nobles and Sciarra 2000). These include the process of problem identification, receiving health and welfare services, and the choice of treatment providers (Cauce et al. 2002). In this context, Social work as a profession is a cultural mediator, aimed to advocate collaborative work with a long-standing cultural tradition. In addition, it has the potential to render more culturally appropriate interventions, bridging gaps between cultural and professional canons (Al-Krenawi and Graham 2001). In order to bridge this gap, social workers turn to other sources of help, such as family, religious leaders, traditional healers, and local professionals who promote affective help-seeking (Abe-Kim et al. 2004).

Seeking Mental Health Care in the Haredi Community

In the Haredi society, as a collectivistic culture, each therapeutic encounter has its own advantages and disadvantages related to Haredi help-seeking perceptions for the mentally ill (Kitai 1997). There is a constant conflict between coping with difficulties privately and autonomously within the community, and seeking help from external sources. Despite the fact that the Haredi population is currently more aware and eager to use external services, this basic ambivalence still prevails, and conflicts are often solved within the community, by consulting rabbis and/or additional validated authority figures recognized by the religious leadership (Ringel and Bina 2007).

Mental health is one of the few fields through which the Haredi population remains in contact with the "other [secular] world". The Haredi society has developed marginalizing concepts in regard to the individual at risk on behalf of society. This represents an extremely difficult dilemma for professionals, who must carefully maneuver between the two worlds, by explaining the nature of their work to influential rabbis in order to make them understand the importance of focusing on the individual in distress or at risk. Recently, many rabbis and ultra-Orthodox leaders have been encouraging contact with mental health professionals.

In summary, two mental health help-seeking patterns have been identified in Haredi society. Firstly, this population tends to avoid seeking mental health services, while only a handful of community members actually contact them, usually after a long period of time. Secondly, more ultra-Orthodox in extreme psychiatric categories seek help.

Culturally-Sensitive Mental Health Intervention Among the Ultra-Orthodox Population

The therapy encounter between a secular social worker and a mentally disabled ultra-Orthodox client is often characterized by distrust and a difficulty to accept cultural differences. Professionals must relate to how the client's culture affects his/her expression of distress. In order to understand the client's point of view, the social worker must speak his/her "language" (Freund and Band-Winterstein 2013). Professionals must keep in mind the notion that, besides avoiding the sharing of painful and intimate stories, the Haredi population also has difficulty developing these narratives within a socially and culturally strange environment. This is often followed by a reluctance to cope with identity, religious and *halachic* questions. Professionals who treat others must take into consideration each person's cultural identity in order to understand him and his conflicts, work with him, and improve his quality of life.

Professionals can handle this culturally-sensitive therapy by becoming more acquainted with the clients' culture, viewpoints, and explanatory model in order to successfully connect with them (Witztum and Goodman 2003). Strean (1994) relates to the available similarities between psychotherapy and the Orthodox culture. He discusses the fact that speech and dialogue are important factors in Judaism. He suggests comparing this concept to culturally-sensitive therapy in order to bridge the intercultural gap. Professionals treating the Haredi population should implement this important tool to bond with the ultra-Orthodox cultural world.

Table 1 Description of participants

	Participants	Gender	Years of experience	Work	Sector
1	Tal	F	5	Fellowship	National religious
2	Shir	F	10	Fellowship	Haredi
3	Avi	M	7	Hospital	Haredi
4	Zvia	F	27	Hospital	Secular
5	Menachem	M	7	Hospital	Haredi
6	Hanni	F	13	Welfare office	Haredi
7	Lea	F	28	Welfare office	Haredi
8	Haya	F	10	Shelter	Haredi
9	S.	F	10	Fellowship	Haredi
10	A.	F	6	Fellowship	National religious
11	M.	F	11	Hostel	National religious
12	H.	F	10	Welfare office	National religious
13	O.	M	2	Hostel	Secular
14	Z.	F	1	Hospital	Traditionalist
15	K.	F	4	Hostel	National religious
16	T.	F	7	Welfare office	National religious
17	Haya	F	2	Hostel	Secular
18	Ariel	M	2	Hospital	National religious
19	Shira	F	2	Welfare office	National religious
20	Yoel	M	2	Welfare office	Secular former religious
21	Rachel	F	2	Welfare office	National religious former Haredi
22	Miriam	F	6	Hospital	National religious
23	Avital	F	5	Hospital	Religious former Haredi
24	D.	F	5	Welfare office	Haredi
25	H.	F	4	Welfare office	Secular
26	L.	F	7	HMO	Secular
27	Z.	F	4	School for the mentally ill	Haredi

HMO Health Maintenance Organization

In summary, mental health in the Haredi community is a highly complex and sensitive issue. This society has adopted its own cultural codes, characterized by segregation and distance from the surrounding society, added to the difficulty of accepting diversity. Social workers must understand this complexity, accept it, and become deeply familiar with its characteristics in order to implement the most appropriate culturally-sensitive therapy intervention.

Vast research is available on mental disorders, in general. However, few studies deal with the mentally ill in Haredi society (Freund and Band-Winterstein 2013). Research literature mainly relates to help-seeking mechanisms of the mentally ill in the Haredi community, addressing the need for culturally-sensitive therapy. Nevertheless, very few studies, if any, have discussed the encounter experience of mental health professionals with ultra-Orthodox mentally ill clients and their families.

The present study seeks to describe the encounter experience of social workers with the cultural perceptions of mental health clients in the Haredi community. The research questions are as follows: How do social workers deal with the existing gap between their professional world and their clients' cultural world? How do social workers describe Haredi society's coping abilities with the mentally ill in their community?

Method

Sample and Population

The study was conducted using the qualitative-phenomenological method, based on a purposeful sample (Patton 2002), which focuses on the selection of participants who best represent their population and best reveal the examined phenomenon (Mason 1996). Thus, the sample included 27 social workers with different religious identities who are in daily contact with ultra-Orthodox Jewish clients across Israel. Participants included 5 males and 22 females; a total of 9 defined themselves as ultra-Orthodox,

11 were Orthodox, 1 was conservative, and 6 were secular, with 1–28 years' experience (see Table 1). It should be mentioned that despite the fact that while Orthodox and ultra-Orthodox beliefs are based on religious faith, cultural diversity exists between these two groups, including aspects such as openness, collectivism vs. individualism, and the way of corresponding and participating within the general society (Band-Winterstein and Freund 2015). All participants are mental health professionals in the public, private and third sectors, working in hospitals, welfare offices and fellowships. They treat mental health clients who have been diagnosed by psychiatrists according to the DSM, and whose mental disorders influence their normative functioning, such as working, interpersonal relationships, sleeping, eating, etc. As the participating social workers include Haredi, modern Orthodox, and secular people, each theme will be illustrated according to the similarities and differences existing among these three groups.

Research Tools

A semi-structured in-depth interview was implemented in order to shed light on the participants' experiences and their attributed meanings. The interview guide included four major content categories. Category 1: "The social worker in a multicultural society", e.g., Mention three things that come to mind regarding the 'multicultural' concept. Category 2: "The social worker in ultra-Orthodox Jewish society", e.g., How do you experience your encounter with ultra-Orthodox clients? Category 3: "Coping strategies of the ultra-Orthodox society with mental health issues", e.g., Which difficulties distinguish the ultra-Orthodox from the secular society regarding coping strategies? Category 4: "The social worker in the ultra-Orthodox society from a time perspective", e.g., How does ultra-Orthodox society relate to mental health issues today, as opposed to in the past?

Research Procedure

The interviewers were ultra-Orthodox and Orthodox social work students. They were qualified for the interviews and had gone through a reflection process (Finlay and Gough 2003) prior to the interviews, including awareness of issues related to their personal background, attitudes, and opinions of social work areas mentioned in their interviews. Bracketing was performed prior to the data analysis (Moustakas 1994) in order to gain insight into our personal opinions as secular researchers and our involvement in the research subject.

After being identified, participants expressed their agreement to participate in the interviews and determined where the interview would be held. Each participant signed a written consent form and received an explanation about the study. Interviews lasted 60–90 min, and were recorded and transcribed verbatim.

Data Analysis

Data analysis was conducted according to the interpretative phenomenological method and involved several stages (Smith et al. 2009). In the first stage—the reading and reflection of the interviews—open encoding was performed, emphasizing relevant statements. The next step was grouping the statements into units of meaning, including quotes to describe the participants' experiences and perceptions. The last step involved identifying the emerging themes by shifting from the descriptive to the interpretive level of analysis. During the content analysis, the researchers discussed disparities and sought agreement regarding theme content and interpretation of meaning. Data was organized based on agreed-upon themes identified in participants' narratives (King and Horrocks 2010). Hence, adherence to this procedure enhanced the study's credibility (Lincoln and Guba 1985).

Validity and Reliability

Trustworthiness (Lincoln and Guba 1985) was achieved as follows: Firstly, the interview was transcribed verbatim, enabling a glance at the original narrations. Secondly, each of the researchers analyzed the material separately. Finally, researchers engaged in peer debriefing by working with another qualitative researcher, serving as an external qualitative research expert who discussed and analyzed the dialogue with the researchers (Lincoln and Guba 1985; Creswell 2007).

The two researchers are senior social workers, experienced in both academic theory and social work practice. Both are liberal Jews, acquainted and rooted in Jewish tradition. Furthermore, the researchers were in constant contact with the ultra-Orthodox population within the framework of their BA and MA degree social work studies. Therefore, the researcher bias analysis and the assessment of the interviewer-participant encounter was conducted through reflection and bracketing (Liamputtong 2010). Finally, reliability was increased by the wide range of participants who narrated similar bonding experiences, as is represented by the findings.

Ethical Issues

The study was conducted within a closed society. Therefore, client confidentiality was essential (Corbin and Morse 2003), as participants pointed out that privacy in the ultra-Orthodox society is a major issue. Furthermore, some of the participants belonged to the ultra-Orthodox community

and were acquainted with the people involved in the study. This issue generated a great deal of ambivalence between confidentiality and the value of the research. This conflict was solved by withholding clients' personal details and real names from the participants.

Results

Three major themes emerged: (1) Exclusion vs. grace and compassion; (2) Mental health: A professional or cultural arena?; and (3) Mental health help-seeking changing processes.

Exclusion, Grace and Compassion as a Parallel Process

This issue relates to Haredi society's general ambivalence toward the mentally ill. Social workers describe the concealment resulting from the labeling and rejection of the mentally ill leading, as well as the expressions of benevolence and acceptance expressed toward the labeled exceptional individual.

Secrecy and concealment of the mentally ill in Haredi society derives from fear of family labeling, which often leads to matchmaking difficulties:

M. relates to the matchmaking issue as a major reason for hiding mental illness:

> Haredi society tends to hide them (the mentally ill) even more, and this affects the family; people must not know—it is a very difficult situation, a stigma, which affects the family's reputation and matchmaking prospects. In secular and religious societies, it is alright if people don't get married; it is always better if they do, but it is still alright, provided that one has a girlfriend, someone to be with. There is no such thing in Haredi society. Either you are married or you do not exist. Being single is a real problem. (M. —11 years' experience)

M. discusses the matchmaking issue. In Haredi society, couples marry through matchmakers who match men and women according to family, a common source of status. Thus, if the existence of a mentally ill individual in a family is widely known, the family's status is significantly reduced. Since this is the only way to get married, and as the option of remaining single is unacceptable, the family is compelled to hide the mentally ill family member.

Another form of labeling applies to the exclusion and rejection of the mentally ill and their families:

> I believe that this is not only related to the mentally ill, but that it has to do with all exceptional people in society. I see this according to different orientations, regarding somebody who is ill or adopted, god forbid, or someone who looks different—and some of the mentally ill look different or behave differently, which is a problem… anyone who is different in Haredi society is segregated, isolated, showing a certain behavior that isn't… this is the reason why they are not well married or else, get the odds and ends. … By the way, mental illnesses are not disclosed, they are confidential; they are strictly hidden in order to avoid harming the entire family. (T. —7 years' experience)

Social workers describe the structured difficulty to accept "abnormality" in Haredi society. Another expression of this separation is associated with the fact that the mentally ill are perceived as second-class individuals and, as such, should settle for less compared to the normative population.

> People are very reluctant; it's very frightening. This is the strongest fear related to matchmaking. I once had a client who suffered from depression and was very concerned about making a good match: "Who is going to take me? I am second-class goods"… (Z. —4 years' experience)

The family makes great efforts to avoid labeling, due to the matchmaking process, including attempts to "fix" the mentally ill:

> He (the mentally ill individual) is unable to sit and study Torah; he just isn't capable… we often hear from them (the families) that he is lazy and would benefit if he would just invest some effort… they have trouble understanding the real nature of the illness… Accordingly, this is not about not being capable, but about not trying hard enough… Then, he is compelled to study with a partner in joint cooperation and the family refuses to understand that he can't do this because he has something else in mind. (H. —10 years' experience)

Torah study is a basic and important activity in Haredi society. Those who have trouble adjusting to it are "marked" as exceptional. Therefore, families make huge efforts to integrate the mentally ill in regard to this activity. There are attempts to blur the mere existence of such an illness by using terms such as "lazy" or by saying one should "make more of an effort". This unsuitable demand not only doesn't help, but may harm the mentally ill. The family seeks therapy as the very last option:

> The family comes to us as their last option, after trying to cope by themselves, consulting the rabbi, trying alternative treatment… parents wait until they can't deal with it anymore and only then turn to therapy. They try every other possible option before therapy, such as spending a lot of money on natural foods, treatments or other bizarre alternatives. Families

> waste valuable time and money before they come to us. (L. —28 years' experience)

The family seeks all kinds of help in an attempt to avoid professional assistance for as long as possible. They turn to therapy only in extreme cases, when the relative's situation is unbearable and the parents are helpless. The family goes through a great deal of suffering and many disappointed hopes in the process of recognizing their need for professional mental health assistance. In addition, the mentally ill wastes valuable time until he finally receives treatment. This recognition and acceptance of mental illness in the family is a long and complex process. At this point, the mentally ill family member is labeled as such, while the individual and his family receive appropriate professional treatment, community assistance and support through grace and compassion:

> There are various expressions of help and mutual involvement among the mentally ill… The Haredi population is strongly aware of benevolent acts and kindness… One of my clients lives in a Haredi neighborhood and the neighbors help a lot; they really care. It's incredible. (S. —10 years' experience)

Haredi society strongly advocates values of mutual assistance and care for the disadvantaged, provided that it recognizes the existence of members in need. This attitude contradicts the rejection and stigma noted previously.

> I have seen a lot of grace in the Haredi community. If things are open, the community is very supportive. Many of my clients receive food every day, are invited over for Shabbat, and receive support… Many families host the client for a period of time… especially the young. Others are willing to constantly help and say that they "have a child in a similar situation and therefore will do such and such a thing in order to help people with these problems. I will offer my home on Shabbat because I know how hard it is". (R. —2 years' experience)

Exceptional expressions of help toward the mentally ill and their families are common when the community shares the secret, meaning when the issue is publicly disclosed and recognized. Furthermore, a family that has experienced the labeling process of one of its members and recognizes him as mentally ill, considers helping and supporting a similar family as a sort of personal mission.

Mental Health: A Professional or Cultural Arena?

Mental health professionals in Haredi society are exposed to the issue of therapy in the context of the cultural characteristics of this society. This exclusive background is expressed by three major dimensions: the client's collective perception vs. an individual approach in therapy; the question of which professional best suits the client—one who is a part of the Haredi community or one who is from outside; and an outstanding rabbi's involvement in the therapeutic process.

The Client's Collective Perception vs. an Individualized Approach in Therapy

Haredi society focuses on community, rather than individual benefits. Thus, when its members experience mental distress, they often prefer to avoid talking about themselves:

> I believe that the Haredi society, from childhood or even from infancy does not focus on the individual. People don't understand when a conversation focuses on themselves. What is this all about? How long can one talk about oneself? Each time, a greater effort is involved, as if to expand the scope… and the different language used in secular and religious society [is a problem] as well… being in therapy and talking about oneself, and what one feels, is so trivial. …According to the fundamental approach in Haredi society, one is not at the center, so therapy is very difficult. Bringing people to dialogue about themselves is extremely difficult, for some, impossible. (H. —4 years' experience)

The therapy issue raises unpleasant feelings in the mentally ill within the Haredi community. Their reluctance is explained by the prevailing notion that the individual should not place himself at the center of things. In an effective therapeutic dialogue, the client focuses on himself, his feelings and desires, while the ultra-Orthodox individual has difficulty talking about himself. In other words, referring to one's self and one's personal distress is not only illegitimate, the ability to verbalize personal distress is completely unfamiliar to the ultra-Orthodox client. This brings us to the question of who is the most appropriate social worker for a Haredi client.

Who Best Fits the Haredi Client: A Professional From Within the Ultra-Orthodox Community or One From Outside?

The question of who is the most appropriate social worker for the Haredi client is extremely important. Answers to this question are ambivalent and vary between cultural and professional compliance. Some people would rather be treated by a social worker from another culture; while M. discusses the importance of having a social worker from the same culture:

> Indeed, one does not need to be a drug addict in order to understand drug addicts, but I strongly believe that you should be assisted by someone from within your own society… There are many cultural issues that someone from the outside cannot grasp. Less resistance is met when you work from the inside and understand the culture. (M. —11 years' experience)

M. discusses the idea that the social worker need not necessarily come from a similar background or have similar experiences in order to understand the client. However, in the case of a therapeutic encounter, she believes the cultural context is extremely significant. Furthermore, identification and treatment of mental illnesses may be deceiving for the secular social worker who does not distinguish between behavior resulting from Jewish precepts or mental disorder:

> It is often hard to identify conflicts because they seem to be hidden beneath religious texts. Only people in the same sector can define whether this is normative and highly spiritual or whether it has become something obsessive, unacceptable and external. Obsessions slip into precepts, demanding accuracy and this is where obsessive individuals fall… they trick themselves. For example, a 9-year-old child I work with became very obsessive with regard to blessings. That is, he began saying all his blessings out loud, demanding that others listen and say "Amen". His parents support him. We have explained that this is not righteous behavior; it is non-normative behavior leading to obsessiveness. (H. —13 years' experience)

Mental disorders and pathologies often come "wrapped up" in the existing conventional thinking, body language, emotion and behavior of the Haredi society. This leads to delusion and the inability to distinguish between religion, faith, Jewish law or psychopathology. A religious social worker is able to identify the subtleties and the twilight zone between normative religious and exceptional behavior, which can indicate mental pathology.

Additional opinions contradict cultural suitability:

> Sometimes, people choose a social worker from another culture because they don't want to disclose situations or share intimate issues with someone from their own community, due to what is referred to as the "Communicating Religious People Law". In the end, you might realize that your social worker is indeed married to your wife's aunt's niece… Therefore, people prefer to receive assistance from someone whom nobody will ever speak to. (A. —7 years' experience)

A. claims that cultural distance leads to openness and creates appropriate conditions for less mistrust and fear of stigma. The metaphor "Communicating Religious People Law" (associated with the "Communicating Vessels Law") refers to the fact that as religious people often know each other, especially in such a closed and segregated community, this represents an obstacle for the client.

Other voices view social worker-client cultural diversity as an advantage:

> I believe that in many cases, a Haredi client should be assisted by someone from another society… Someone far from his/her own cultural world. It is often harder to share things one does not talk about when sitting with someone "similar". In this case (referring to a client), the fact that I am not someone she is familiar with and do not follow the same pattern allowed her to ask questions and relate to them without hesitating. (O. —2 years' experience)

O. believes that a Haredi client benefits most by receiving treatment from a social worker from a different cultural world. This creates a safe, therapeutic space where issues not discussed within the community may be disclosed without being concerned about the social worker's response ("It is often harder to share things one does not talk about when sitting with someone 'similar'").

The Rabbi vs. the Social Worker: Whose Authority is it Anyway?

In the Haredi community, it is a way of life to consult with one's rabbi on many issues relevant to everyday life. This is also true as regards coping with illness, in general, and mental health, in particular. How does the rabbi's involvement influence all stages of the advance of mental illness?

> People often know that the son or daughter has difficulties and makes a big effort to hide them. The mentally ill individual takes pills before the wedding and a rabbi decides when he should stop taking them. Finally, people realize that the person is no longer medicated and therefore is not ill anymore. From my experience, the person then experiences a breakdown and things get out of control. (M. —7 years' experience)

The involvement of an additional source in therapy is complex, demanding the social worker's cultural sensibility.

> The rabbi controls the situation and decides which actions should be taken; that's how things work in Haredi society. So, we must follow this line of thought and be familiar with what the rabbi says… This is an essential element when working with mental health clients in Haredi society. I sometimes refer parents of mentally ill children to the rabbi for advice, and this helps. They would never turn to a parent–child center

> in the surrounding society; it wouldn't be effective. (M. —11 years' experience)

According to M., cooperation between the social worker and the rabbi is essential in order to reduce client resistance, serving as an alternative therapeutic option as well. M. adds that, since the rabbi is a major figure in the client's life, the social worker should become acquainted with him so that they can work together as partners in the necessary culturally-sensitive therapy process.

On the other hand, O. relates to rabbinical intervention in therapy as a detrimental factor in the therapeutic process:

> When therapy is supervised by a rabbi, it is never clear or clean enough. Some rabbis believe they can help through psalms and recommend not seeking assistance outside the community. This is a conflicting approach for the mentally ill. I have heard several clients say that their rabbi tells them they are the problem: "You need to be happier; you are depressed—be happier, show your positive side". This does not help much… it does not lead to real openness in therapy. The social worker is often unable to implement a clean intervention because there is always someone else watching and supervising, so that unspeakable things don't come up. I believe that they [the rabbis] must let go, allow treatment without supervising every session. (O. —2 years' experience)

O. is aware that the role of the rabbi is an integral part of therapy, but expresses his disapproval of absolute intervention supervision on the part of the rabbinical authority, claiming that this intervention is detrimental to the quality of the therapy.

Mental Health Help-Seeking Change Processes

Change processes in the Haredi community regarding mental health are described by social workers. The negative image of social workers is slowly changing, as the Haredi community shows more of an inclination to seek out the help of mental health social workers:

> Everyone says that it used to be harder; once, no one was willing to talk to mental health social workers. Nowadays, rabbis refer people to social workers; educational counselors and school principals consult with us. (H. —4 years' experience)

Significant openness in Haredi society is expressed by the increased inclination to share difficulties and seek therapy and advice from mental health professionals. Today, rabbis refer people to professional assistance and have more trust in therapy, thus legitimizing requests from additional families to get professional help.

The differences in mental health help-seeking patterns indicate an increasing openness:

> I see that there are more requests these days, from a time perspective, and the level of requests is also changing. Today, people who are able to function turn to us, those who in the past were afraid to seek help because they could hide their illness, as it was less apparent… those who would say "people can't see that I'm ill"… I believe this reflects the process taking place within Haredi society. I don't quite know if there is more openness, but people are more willing to seek help. (T. —5 years' experience)

Change is expressed in two ways. The first relates to the amount of requests, while the second describes the variety of requests to receive help from mental health social workers. The transition from considering treatment as "taboo" to the fact that people in mental distress choose to waive their need for confidentiality and even disclose conflicts in order to get help contributes to an optimistic view of the future:

> I believe that this will improve over time… There is a great deal of openness, people talk about things more, and the higher the peoples' awareness, the easier it will be for them to request a social worker… People used to be reluctant to do so, and preferred to run away. Today, they are more active and cooperative. (L. —7 years' experience)

Mental health social workers in contact with the Haredi community experience greater openness towards the field, leading to an optimistic view of the current and future process. This optimistic approach is based on wider help-seeking awareness, increased requests for treatment, and stronger involvement of additional community sources for the benefit of the mentally ill and his/her family. This dynamic spreads within the community and influences the general climate toward professional mental health therapy.

Discussion

The article focuses on the experience of social workers' encounters with Haredi mental health clients. Three topics are discussed: (1) Exclusion vs. grace and compassion; (2) Mental health: A professional or cultural arena?; and (3) Mental health help-seeking changing processes.

Cultural psychiatry deals with the mental disorders and diseases present in a certain culture (Bains 2005). Furthermore, cultural sensibility is a major value in social workers' intervention. Results on therapy for the mentally ill in Haredi society indicate an essential linkage between cultural psychiatry and cultural sensitivity. A combination of both elements may help mental health social workers create

an appropriate and effective therapeutic relationship, while dealing with stigma, reluctance and fear in Haredi society, all of which prevent the mentally ill and their families from seeking help (Greenberg and Shefler 2002; Popovsky 2010).

One interesting research finding relates to the first topic, describing the mental health complexity in Haredi society as being comprised of a conflicting combination of exclusion, grace and compassion. This complexity is a result of the direct distress associated with the disease and the Haredi community's response, which views mental disorders as a comprehensive deficiency with far-reaching implications (Schnitzer et al. 2011). These conclusions have a direct influence on the mentally ill and his/her family, and threaten the community as a whole. The study shows that mental disorders highly affect matchmaking prospects and the ability to receive appropriate treatment on time. Mental health clients are expected to remain hidden for as long as possible, in order to preserve community integrity, thus fostering their exclusion. In Haredi society, narrow, closed attitudes and labeling reinforce the exclusion of the mentally ill, increasing their shame, guilt and alienation. These dynamics continue until the disease or the mentally ill individual can no longer be hidden or ignored by consulting rabbis. In these extreme situations, the family is willing to seek professional help in order to formally diagnose and define the mentally ill. Extreme mental health situations are those in which the family finally understands that any attempt and form of treatment might be helpful. This is a "sobering experience", leading to the family's agreement to finally perceive the true and serious reality of the situation (Yalom 2008), and engage mental health professional treatment. This pattern of conduct leads to the fact that most of the requests for mental health frameworks in Haredi society relate to extreme situations. In other words, as long as the family can hide the mental disorder, the person is kept at home at the expense of necessary and timely appropriate treatment. This phenomenon leads to the increased distress of the mentally ill and family members, as well as irreversible damage to the disturbed individual (Corrigan 2000).

Once the family and mentally ill individual have been exposed as such, they are labeled by the community as disadvantaged, leading to grace and compassion—basic values in the Haredi society. The theme "Exclusion vs. grace and compassion" describes this process, allowing us to learn more about the journey experienced by the mentally ill and their families within a cultural context, as well as the ability of mental health social workers to provide culturally-sensitive therapy.

Another issue raised by the study applies to the professional identity and authority of mental health social workers in the Haredi community. Ultra-Orthodox society is founded on collective principles, meaning that community needs and interests are fundamental, whereas individual and personal concerns are secondary issues. This perception should be taken into account in the therapeutic encounter. In other words, the person-in-environment methodology refers to a variety of approaches, which focus on the client, while all related circles—such as the nuclear and extended family, the peer group and the community (Makaros 2006). Thus, in the therapeutic encounter with a Haredi client, the social worker must understand the subject's difficulty: not only is "talking about himself" illegitimate, the individual is also often unable to verbalize his own difficulties.

Another significant finding deals with the following questions: Which social worker is the most appropriate for a Haredi client? What is the meaning of being assisted by a mental health professional from the same culture or from a different framework outside the community? There is no unanimous agreement or uniform answer to these questions. Research results indicate that Haredi clients do not always benefit from ultra-Orthodox social workers and often feel more comfortable with someone outside the Haredi community—someone neutral, unacquainted with the ultra-Orthodox establishment, holding unbiased views, and with a different level of religiosity (Al-Makhamreh and Lewando-Hundt 2008). Furthermore, a social worker who is not "one of us" meets the client's needs for anonymity, concealment and secrecy required by the closed Haredi community. On the other hand, diagnosis of the mentally ill involves a deep understanding of religious and *halachic* norms. That is to say, the Haredi social worker must be able to fully distinguish between the interpretation of texts and prayers suited to religious behavior, and to identify behavior indicating a mental disorder (Huppert et al. 2007).

The encounter between professional and religious authorities is one of the most significant research findings regarding treatment of the mentally ill (Lifshitz and Glaubman 2004). The religious authority is the highest influence in a traditional closed society. The rabbi is also involved in the treatment of the mentally ill, often in opposition to the therapist's views. The more social workers understand the need for their joint cooperation with rabbis, and the more the rabbis understand the true need to consult with mental health professionals, the more the client benefits from this mutual mediation. Internal community forces, such as rabbis and external forces like social workers together result in change. Both parties are involved in joint collaboration and mutual respect. The changing process is spiral in nature: stronger awareness leads to less concern. More consultations lead to more professionals' involvement. This contributes to diminished fear, increased legitimacy through community authority sources, more consultation, and so on.

Another aspect deriving from change is that clients look for help earlier, before reaching high distress levels. These change processes also provide the community with more legitimate therapeutic options. These courses of action are

not taken as a default, but out of the understanding that they are the best solution for the mentally ill and their family.

Despite the change processes taking place in Haredi society, based on the transition from an absolute community approach to an integration of ideological components, a strong exclusion problem is still prevalent.

Haredi community members' lives are determined by social and cultural codes leading to different coping strategies than those used by Israeli secular society. The interviews revealed the outstanding characteristics of Haredi society, which social workers should be aware of in order to meet the unique needs of this population. A Haredi family with a mentally ill member normally avoids bringing this issue to light, mainly due to concern over the matchmaking prospects of the other children in the family. Scholars relate to the tendency to hide the disorder from community members, as it is considered a severe fault affecting the status of both individual and family members alike. This hiding is followed by segregation and feelings of isolation and fear. In general, Haredi society is reluctant to seek assistance outside its own framework and would rather handle conflicts through community-based, informal sources (Witztum and Goodman 1998). Furthermore, when professional therapeutic intervention is required, members often consult with the rabbi for guidance, request advice or blessings, thus further protecting themselves from any secular influence (Ringel and Bina 2007). Mental health is one of the few areas where the ultra-Orthodox are compelled, against their will, to contact experts from the "other world". This encounter leads to a great deal of tension and constant conflict between solving issues automatically within the community and consulting external professional sources. Lately, increased trust and consultations have taken place as a result of the training of Haredi or religious community mental health professionals.

Mentally ill individuals in Haredi society experience delicate and sensitive situations within the different circles surrounding them. Routine changes considered "normal" by most of the population, are experienced by the mentally ill as sources of psychological turmoil, which threaten their delicate stability. The interviews reveal that instability and social marginality is intensified in Haredi clients by their efforts to hide the secret and the stigma. Families of the mentally ill are more concerned about social reactions and their public image than their own distress, as they belong to a sub-culture and require services from the wider culture. On the one hand, Haredi society needs the services provided by the state; on the other hand, these services are often incompatible with their religious and cultural perceptions. Thus, despite the distress expressed by Haredi clients and their currently increasing desire to overcome segregation and engage in therapy, social workers are often still unable to meet their needs. Scholars relate to a triple exclusion claiming that besides the difficulty of speaking intimately about their personal stories, clients also have a hard time sharing their stories in an unfamiliar social and cultural atmosphere, together with the difficulty of coping with questions of identity, religion and Jewish law. In sum, this study shows that the attitude in the Haredi community toward mental health therapy is undergoing a change process. It is important to strengthen and accelerate this process, whilst preserving the existing community's informal sources of help, so as not to "throw the baby out with the bathwater".

Practical Implications

The social workers' description of the Haredi society, its characteristics and attitudes toward mental disorders raised the issues of concealment, fear of stigma, and implications for the future as detrimental factors to the rehabilitation of the mentally ill. An insight into this complex issue and its direct practical implications demand the taking of appropriate measures in order to lessen the concealment and stigma. Professionals in contact with this population can operate within the community and through mediating factors such as rabbis who, as the communities' religious leaders, can bridge the gap between cultural and professional aspects. Moreover, rabbis would be able to mediate among the diverse groups in the ultra-Orthodox society. Social workers can use their professional skills to enhance the mediators' effectiveness and advance the mediation process (Al-Krenawi and Graham 2001). At the same time, social workers can learn from local leadership about how to render culturally-appropriate interventions. In addition, in their community work social workers can engage professionals from the education and health systems by promoting awareness and combating stereotypes to encourage the absorption of the mentally ill into the community. Furthermore, the creation of support groups for families of mental health clients may enhance their acceptance into their nuclear family. However, these support groups could be stigmatized by the Haredi community; therefore, mutual work between cultural mediators and professional social workers may help overcome this barrier. *Community recognition* is a platform that enables dialogue on issues regarded as taboo, thus contributing to reducing related anxieties. Long-term appropriate and effective activities within the Haredi faith–based community and among families of the mentally ill may foster the acceptance and rehabilitation of mentally ill individuals. In sum, our recommendation is that professionals will provide the local leadership with a systematic, ecological mapping of families who cope with mental illness, identifying and utilizing leverage points, as well as providing skills for the entire process. In this way, professionals may successfully achieve the integration of modern and traditional helping approaches, while remaining committed to their profession and its ethics. Moreover, emphasizing ongoing professional

reflectivity processes during the encounter with local leadership may enable professionals to address their own norms, values, opinions and beliefs and be more open to and aware of the cultural context.

References

Abe-Kim, J., Gong, F., & Takeuchi, D. (2004). Religiosity, spirituality, and help-seeking among Filipino Americans: Religious clergy or mental health professionals? *Journal of Community Psychology, 32*(6), 675–689.

Al-Krenawi, A., & Graham, J. R. (2001). The cultural mediator: Bridging the gap between a non-western community and professional social work practice. *British Journal of Social Work, 31*(5), 665–685.

Al-Makhamreh, S. S., & Lewando-Hundt, G. (2008). Researching 'at home' as an insider/outsider: Gender and culture in an ethnographic study of social work practice in an Arab society. *Qualitative Social Work, 7*, 9–23.

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-5)*. Washington, DC: Author.

Bains, J. (2005). Race, culture and psychiatry: A history of transcultural psychiatry. *History in Psychiatry, 16*, 135–154.

Band-Winterstein, T., & Freund, A. (2015). Is it enough to "speak Haredi"? Cultural sensitivity in social workers encountering Jewish ultra-Orthodox clients in Israel. *British Journal of Social Work, 45*, 968–987.

Barth, A., & Ben-Ari, A. (2014). From wallflowers to lonely trees: Divorced ultra-Orthodox women in Israel. *Journal of Divorce & Remarriage, 55*(6), 423–440.

Baum, N. (2007). It's not only cultural differences: Comparison of Jewish Israeli social work students' thoughts and feeling about treating Jewish ultra-Orthodox and Palestinian Israeli clients. *International Journal of Intercultural Relations, 31*, 575–589.

Caldwell-Harris, C. L., & Aycicegi, A. (2006). When personality and culture clash: The psychological distress of allocentrics in an individualist culture and idocentrics in a collectivist culture. *Transcultural Psychiatry, 43*(3), 331–361.

Cauce, A. M., Domenech-Rodríguez, M., Paradise, M., Cochran, B. N., Shea, J. M., Srebnik, D., & Baydar, N. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting & Clinical Psychology, 70*(1), 44–55.

Coleman-Brueckheimer, K., Spitzer, J., & Koffman, J. (2009). Involvement of Rabbinic and communal authorities in decision-making by Haredi Jews in the UK with breast cancer: An interpretative phenomenological analysis. *Social Science & Medicine, 68*, 323–333.

Corbin, J., & Morse, J. M. (2003). The unstructured interactive interview: Issues of reciprocity and risks when dealing with sensitive themes. *Qualitative Inquiry, 9*, 335–354.

Corrigan, P. W. (2000). Mental health stigma as societal attribution: Implications for research methods and attitude change. *Clinical Psychology: Science & Practice, 7*, 48–67.

Creswell, J. W. (2007). *Qualitative inquiry and research design: Choosing among five approaches* (2nd edn.). Thousand Oaks, CA: Sage.

Dwairy, M. (2006). *Counseling and psychotherapy with Arabs and Muslims: A culturally sensitive approach*. New York, NY: Teachers College Press.

Erhard, R. L., & Erhard-Weiss, D. (2007). The emergence of counseling in traditional cultures: Ultra-Orthodox Jewish and Arab communities in Israel. *International Journal for the Advancement of Counselling, 29*, 149–158.

Finlay, L., & Gough, B. (2003). *Reflexivity: A practical guide for researchers in health and social sciences*. Oxford: Blackwell Science.

Freund, A., & Band-Winterstein, T. (2013). Between tradition and modernity: Social work-related change processes in the Jewish ultra-orthodox society in Israel. *International Journal of Intercultural Relations, 37*, 422–433.

Gerrig, R. J., & Zimbardo, P. G. (2008). *Psychology and life*. Boston, MS: Pearson.

Goodman, Y., & Witztum, E. (2002). Cross-cultural encounters between care providers: Rabbis' referral letters to a psychiatric clinic in Israel. *Social Science & Medicine, 55*, 1309–1323.

Greenberg, D., & Shefler, G. (2002). Obsessive compulsive disorder in ultra-orthodox Jewish patients: A comparison of religious and non-religious symptoms. *Psychology & Psychotherapy: Theory, Research & Practice, 75*, 123–130.

Haj-Yahia, M. M. (2011). Contextualizing interventions with battered women in collectivist societies: Issues and controversies. *Aggression & Violent Behavior, 16*, 331–339.

Hakak, Y. (2011). Psychology and democracy in the name of God? The invocation of modern and secular discourses on parenting in the service of conservative religious aims. *Mental Health, Religion & Culture, 14*, 433–458.

Heilman, S. C., & Friedman, M. (1991). Religious fundamentalism and religious Jews: The case of the Haredim. In M. E. Marty & R. S. Appleby (Eds.), *Fundamentalisms observed* (pp. 197–264). Chicago, IL: The University of Chicago Press.

Heilman, S. C., & Witztum, E. (1997). Value-sensitive therapy: Learning from ultra-orthodox patients. *American Journal of Psychotherapy, 51*, 522–541.

Huppert, J. D., Siev, J., & Kushner, E. S. (2007). When religion and obsessive–compulsive disorder collide: Treating scrupulosity in ultra-Orthodox Jews. *Journal of Clinical Psychology, 63*, 925–941.

Kagitcibaci, C. (1996). *Family and human development across cultures: A view from the other side*. Mahwah, NJ: L. Erlbaum & Sons.

King, N., & Horrocks, C. (2010). *Interviews in qualitative research*. London: Sage.

Kitai, E. (1997). Health within the Haredi population—General background. *Healthy Mind: Written Platform for Reflection, Documentation and Challenging in Mental Health Issues, Topics and Encounters, 1*, 29–31.

Leshem, E. (2003). Israel as a multicultural state at the turn of the twenty-first century. In E. Leshem & D. Roer-Strier (Eds.), *Cultural diversity: A challenge to human services*. Jerusalem, IL: Magnes (in Hebrew).

Lev-On, A., & Neriya-Ben Shahar, R. (2009). "A forum of their own:" Views about the internet among Ultra-Orthodox Jewish women who browse designated closed forums. *Media Frames, 4*, 67–105.

Liamputtong, P. (2010). *Performing qualitative cross-cultural research*. New York, NY: Cambridge University Press.

Lifshitz, H., & Glaubman, R. (2004). Caring for people with disabilities in the Haredi community: Adjustment mechanism in action. *Disability & Society, 19*, 469–486.

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Beverley Hills, CA: Sage.

Makaros, A. (2006). The social worker's role in a changing society: A perspective of social workers and their clients. *Society & Welfare, 26*, 135–152. (**in Hebrew**).

Mason, J. (1996). *Qualitative researching*. London: Sage.

Moustakas, C. E. (1994). *Phenomenological research methods*. Thousand Oaks, CA: Sage.

Nobles, A. Y., & Sciarra, D. T. (2000). Cultural determinants in the treatment of Arab Americans: A primer for mainstream therapists. *American Journal of Orthopsychiatry, 70*(2), 182–191.

Patton, M. Q. (2002). *Qualitative research and evaluation methods* (3rd edn.). Thousand Oaks, CA: Sage.

Popovsky, M. A. (2010). Special issues in the care of ultra-orthodox Jewish Psychiatric in-patients. *Transcultural Psychiatry, 47*, 647–672.

Ringel, S., & Bina, R. (2007). Understanding causes of and responses to intimate partner violence in a Jewish Orthodox community: Survivors and leaders' perspective. *Research on Social Work Practice, 17*, 277–286.

Sartorius, N., & Schulz, H. (2005). *Reducing the stigma of mental illness. A report from the Global Programme of the World Psychiatric Association*. New York, NY: Cambridge University Press.

Schnitzer, G., Loots, G., Escudero, V., & Schechter, I. (2011). Negotiating the pathways into care in a globalizing world: Help-seeking behaviour of ultra-Orthodox Jewish patients. *International Journal of Social Psychiatry, 57*, 153–165.

Shelif, Y., & Walinger, M. (2008). Establishment and operation of the psycho-educational service in the Haredi sector. In G. Weil (Ed.), *Educational Psychology in a Multicultural Society*. Jerusalem, IL: Ministry of Education (**in Hebrew**).

Smith, C. (2003). Theorizing religious effects among American adolescents. *Journal for the Scientific Study of Religion, 42*, 17–30.

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Los Angeles, CA: Sage.

Strean, H.S. (1994). *Psychotherapy with the orthodox Jew*. Northvale, NJ: J. Aronson.

Triandis, H. C. (2001). Individualism and collectivism: Past, present and future. In D. Matsumoto (Ed.), *The handbook of culture and psychology* (pp. 35–50). New York, NY: Oxford University Press.

Triandis, H. C., Bontempo, R., Villareal, M. J., Asai, M., & Lucca, N. (1988). Individualism and collectivism: Cross-cultural perspectives on self-in-group relationships. *Journal of Personality & Social Psychology, 54*(2), 323–338.

Witztum, E., & Goodman, Y. (1998). Expressions of mental distress among the ultra-Orthodox: Narrative structuring and culture-sensitive narrative intervention. *Society & Welfare, 18*, 97–123. (**in Hebrew**).

Witztum, E., & Goodman, Y. (2003). Disorder, narrative, treatment: Strategic, narrative culture-sensitive intervention in the ultra-Orthodox population. In E. Leshem & D. Roer-Strier (Eds.), *Cultural diversity as a challenge to human services* (pp. 275–309). Jerusalem, IL: Magnes (in Hebrew).

Yalom, I. D. (2008). *Staring at the sun: Overcoming the terror of death*. San Francisco, CA: Jossey-Bass.