An Orthodox Jewish
Perspective: A Qualitative Approach: Exploring the
Impact of Religion and Spirituality within Counselling and
Psychotherapy.

Eli Kasmir

Supervised by: Julia Robinson   April 2019

ABSTRACT

Previous research exploring the role of religion/spirituality within counselling/psychotherapy has largely taken a quantitative approach, whilst also being limited in terms of its investigated religions. In response to these limitations, this study qualitatively explored the role of religion/spirituality within counselling/psychotherapy from an Orthodox Jews perspective. Six UK people who identified as Orthodox Jews, participated in semi-structured interviews. A thematic analysis was conducted on the interview transcripts, which led to the identification of the following superordinate themes:

1. Therapist selection process
2. Religion/Spirituality and their Intersection with Therapy
3. Conceptualisations of Community Attitudes

Each superordinate theme provided insight into the complexity of the relationship of religion/spirituality within therapy, from the perspective of an Orthodox Jewish client. The research supported previous literature concerning the influence ones' religion/spirituality on their engagement with therapeutic services. Moreover, the findings indicated toward the prolific effects therapy can have over ones religious and spiritual beliefs and practices, of which ought to be researched further.

KEY WORDS:	RELIGION	SPIRITUALITY	COUNSELLING	PSYCHOTHERAPY	ORTHODOX JUDAISM

Introduction

Definitions

Whilst the terms 'religion' and 'spirituality' are often assumed to be interchangeable, they are in fact distinct (Hage et al., 2006). Religion is described as adherence to common beliefs, behaviours and practices, underpinning a specific faith (Hill et al., 2000). Spirituality refers to the subjective, embodied, and emotional experience of closeness or connection to the sacred or transcendent (Davis et al., 2015).

Addressing Religion/Spirituality in Counselling/Psychotherapy

Religion/spirituality are key factors in shaping one's self-perceptions, worldviews and behaviours (Cornish et al., 2014). Research concerning the relationship between religion/spirituality, physical and mental health has increased vastly in recent years (Koenig et al., 2012). With a significant proportion of findings alluding to the positive benefits of incorporating religion/spirituality within the therapeutic process (Smith et al., 2007).

A pioneer study investigating the desire for the integration of religious/spiritual beliefs within psychotherapy, found 55% of clients expressed the desire to explore these constructs within the therapy session (Rose et al., 2001), thus demonstrating the pertinence of incorporating such demises into therapy. These findings have been replicated multiple times (Dillao, 2012; Martinez et al., 2007; Wade et al., 2007). However, with the exception of the Rose et al. (2001) study, most participants recruited were Caucasians and/or Christians, limiting the generalisability of the findings due to differing cultural backgrounds.

The purpose of therapy is to attend to ones' psychological well-being (Carroll and Nuro, 2002). This process encompasses confronting ones' self-perceptions, interpersonal relationships, behaviours and values. Religious/spiritual beliefs are entwined and coexist within such dimensions, highlighting the salience of addressing these ideologies within therapy (Smith and Richards, 2005), as well as the importance of the therapist encouraging spiritual expression (Plumb, 2011). Arguably, religion/spirituality carry many of core values that are integral to the therapeutic process, and can increase the effectiveness of therapy when integrated appropriately (Masters, 2010). For example, discussing concepts of forgiveness, mindfulness, hope and meaning can bestow positive effects within the therapeutic relationship (Martinez et al., 2007; deMamani et al., 2010). They can also be used to address positive and negative coping mechanisms, which can play a key role in shaping ones' mental health (Oxhandler and Pargament, 2014).

Gockel (2011) found that clients regarded spirituality as an essential component to the therapeutic relationship. When the therapist ignored this construct, individuals terminated treatment prematurely, due to feeling misunderstood or devalued. A meta-analysis of 31 studies reported an overall effect size, *d = .56,* when religion/spirituality were integrated across a multitude of clinical mental health interventions (Smith et al., 2007). These findings suggest the effectiveness of addressing religion/spirituality in treating depression, anxiety, and eating disorders. However, when a therapist is ignorant to, and disregards such values, there is a negative impact on the therapeutic outcome, decreasing the efficacy of treatment.

Notwithstanding, the quantitative nature of the data can often overlook the depth of experience that a qualitative design can reveal.

Religion/spirituality have been perceived as healing forces in therapy (Goedde, 2001). Clients' also expressed the view that religious/spiritual interventions whether implicit or explicit were effective. Nevertheless, participants also related apprehensions regarding discussing religion/spirituality in therapy, including fear of the therapist imposing their worldview and values on the client and having a therapist that synthesised an appropriate balance of religion/spirituality during therapy. Mayers et al. (2007) found that whilst clients were reluctant to divulge religious/spiritual beliefs within a secular model of therapy, after sharing them they felt alleviated and felt their faith and spiritual growth was strengthened throughout therapy. Participants were undergoing or had completed therapy at the time, overlooking the experiences of those who may have refused or terminated treatment.

Addressing religion/spirituality within therapy may not always serve as beneficial, and should therefore be circumvented in therapy (Sloan and Bagiella, 2002). Reasons for avoiding these forces within counselling/psychotherapy include minimisation of evidence-based practices, infringements of privacy, and potential discrimination or offence toward individuals whom are not religiously inclined or affiliated (Saenz and Waldo, 2013; Ripley et al., 2001). Alternatively, discussing religion/spirituality within therapy can lead to the hypercritical engagement of philosophical or theological discussions that are unimportant to therapy (Sloan et al., 2001), and can lead to the overemphasis of the gravity of religion/spirituality (Masters, 2010).

Rizzuto (1996) suggests that the therapist should abstain from making any pronouncements concerning God or religion, since it distorts the client's capacity to work through their personal religious/spiritual beliefs. This coincides with the prevalent belief that religious/spiritual interventions lie within the realms of spiritual mentors or leaders as opposed to counsellors or psychotherapists (Tillman, 1998; Fallot, 2001), thus suggesting that amalgamating religion/spirituality within counselling/psychotherapy is the crossing of a social boundary (Passmore, 2003). Subsequently, since religion/spirituality are considerably highly subjective experiences, when the client and therapist share religious backgrounds, individual differences underpinning their faith tend to be overlooked by generalising religious beliefs (Masters, 2010).

Judaism

The Jewish population in the United Kingdom is comprised of approximately 250,000 people (Office for National Statistics, 2011). Orthodox Judaism is the name given to the traditionalist branch of Judaism. There is significant diversity between Orthodox Judaism subgroups, differing in the degree in which they integrate with mainstream society, as well as their cultural and family traditions (Cooperman et al., 2013). Orthodox Jews are united in their theological belief that the Torah (*Old Testament*) was revealed to Moses, by God on Mount Sinai, and was passed down and expanded upon by generations of rabbinical scholars (Schnall, 2006). It is for this reason that Orthodox Jews believe Jewish Law is unchangeable and advocate strict adherence to its jurisprudence.

The laws dictated by the Torah form a religious, cultural and social framework underpinning Orthodox Jewish life (Schlesinger, 2014). By acting in accordance with Jewish Law, Orthodox Jews believe they are placing God at the epicentre of their world (Rabinowitz, 2000), whilst simultaneously elevating the mundane acts in their lives, transforming them into spiritual deeds, providing understanding into the meaning of life (Milevsky and Eisenberg, 2012).

Orthodox Judaism and Mental Health

"Jews have been largely attributed an invisible status in the fields of counselling and psychology in general and within the multicultural counselling movement in particular," (Arredondo and D'Andrea, 1999:14). For the Orthodox Jew, pursuing mental health treatment can serve as problematic from both a personal and social perspective. Strean (1994) suggests that when Orthodox Jews seek counselling it can be viewed as a personal weakness since they are professing that their religion *"does not have all the answers"* and acting heretically. Many consider themselves to be high achievers who do not need to undergo counselling or psychotherapy, deterring them from the service (Zedek, 1998).

Internal struggles are viewed as turmoil within the soul, such as conflicts with evil inclination, and therefore many are perplexed as to how therapy could help them address this metaphysical activity (Schnall, 2006). Many conceptualise psychological illness as a divine test from God, believing it is within their own capacity to overcome such challenges, thereby refraining from therapy (Margolese, 1998).

The insular nature of Orthodox communities can create stigma concerning the pursuance of psychological treatment (Schnall, 2006), there is also a general mistrust of the services, and individuals assert the belief that psychology and religion are incompatible (Schnall et al., 2014). Wickler (1986) proposed that individuals are fearful of being cast as "crazy" by their communities, having detrimental effects on their family's reputation and diminishing potential marriage prospects (Bayes and Loewenthal, 2013; Loewenthal, 2006).

Divine commandments such as honouring parents and prohibitions of gossiping can influence an Orthodox Jew's decision to undergo therapy or the way in which they behave (Popovsky, 2010). Engaging with non-Orthodox therapeutic services is condemned as the crossing of a social boundary (Tilly, 2004), a parameter often not broken without the permission of ones' Rabbi, *spiritual leader* (Schnitzer et al., 2009). Rabbis can possess strong apprehensions concerning their congregants receiving help from outside the Orthodox community (Band-Winterstein and Freund, 2013), or from the opposite gender (McEvoy et al., 2017), thus suggesting that Orthodox Jews should receive help from professional they share a cultural background with (Spitzer, 2003).

To date, the perspectives of Orthodox Jewish clients' in relation to the impact of religion/spirituality within counselling/psychotherapy has not been thoroughly researched namely, across the UK. It is therefore uncertain what the most appropriate and efficient ways are of amalgamating religion/spirituality within therapeutic treatment for this ethnic minority. Exploring clienteles' views is pertinent

in determining how the sustainability of incorporating religion/spirituality within counselling/psychotherapy can be maximised.

The present study

The aim of this research was to explore Orthodox Jews experiences of religion/spirituality within counselling/psychotherapy. To achieve this, individual semi-structured interviews were conducted, and analysed using thematic analysis.

The research aimed to answer the following questions using thematic analysis:

1) What is the impact of religion within counselling/psychotherapy?
2) What is the impact of spirituality within counselling/psychotherapy?

Methodology

Research design

Since this research aimed to gain a detailed awareness into Orthodox Jews' perceptions towards religion/spirituality within therapy, a qualitative approach was deemed suitable. Qualitative research is a data collection method capturing an individual's feelings, thoughts and emotions (Quinlan, 2011). This type of research aims to understand the participant's perspective and worldview, by engaging with the individual's experiences (Strauss and Corbin, 2014) thus making it an appropriate design for this study. Some of the key objectives of qualitative research are to explore topics that have not been extensively researched, to identify potential variables that can be studied using a quantitative approach and to engage in an extensive and holistic approach to examine the phenomena (Creswell, 2012).

Due to the lack of research and understanding, concerning Orthodox Jews and mental health issues (Brachfeld, 2017) specifically, from the clients' perspective, this approach was used to generate a sufficient understanding of the topic. The interviews took place in a room at Manchester Metropolitan University (MMU). This location served as a safe and neutral environment for participants, thus allowing subjects to engage deeply about their experiences of religion/spirituality within counselling/psychotherapy.

Participants and recruitment

A small sample size (*N = 6: see Table 1*) was used in order to obtain rich, in-depth data, from the population under investigation (Braun and Clarke, 2006). The sample size also allowed for a minimum of three hours of interview material necessary for thematic analysis (Gough et al., 2003). A mix gendered selection provided the opportunity to seek whether any differences found were influenced by gender (Lincoln and Guba, 1985).

Recruitment occurred via purposive sampling. This sampling method serves as a widely adopted technique in qualitative research (Robinson, 2014), and allowed for the identification. Posters advertising the study including the researchers contact details (see Appendix 1) were distributed throughout Orthodox Synagogues and local Jewish enterprises across a predominantly Orthodox community in Manchester, England, with the majority of them coming from highly religious backgrounds.

Table 1. Description of Participants

Pseudonym	Age (years)	Occupation
Hannah	18	Student
Rachel	21	Student
Joshua	27	Personal Trainer
Sophie	45	Nursery Owner
Alex	49	Retail Manager
Andrew	51	High School Teacher

Data collection

Ethical approval was obtained (see Appendix 2) prior to any data collection, thus ensuring that any research conducted was in accordance with the British Psychological Society (2018) Code of Ethics and Conduct and the British Psychological Society (2014) Code of Human Research Ethics. If individuals were considering participation in the study they contacted the researcher via e-mail. Subjects were then sent a participant information sheet (see Appendix 3) informing them of the research, and stipulated that an interview would take place at a room at MMU, lasting approximately thirty minutes. The information sheet gave a thorough explanation of the research process including what was required from the participants, as well as potential risks and benefits of partaking in the study. It further stated that any data collected would remain anonymous and, of the participants' rights to withdraw from the study without explanation.

Once participants agreed to partake in the study, a time was scheduled to conduct the interview. After arrival, subjects were provided with consent forms (see Appendix 4), in which they agreed to partake in the study. Participants were then asked to give a pseudonym which they would be referred to throughout interview and transcript, thus ensuring their anonymity. Since subjects may have perceived the interview topic to be sensitive and embarrassing (Adams, 2010), participants were made aware of this prior to the start, and they were notified of their right not to answer any questions they deemed to be distressing.

The semi-structured interview (Smith, 1995) was then conducted. Due to the fluid nature of this type of interview the questions asked were relatively general. However, the researcher used an interview schedule (see Appendix 5) consisting of 12-items, including prompts. Both probes and paraphrasing were used by the researcher throughout the interviews as a way of building rapport (Bell et al., 2014), and encourages participants to elaborate on initial responses (Rossetto, 2014). The questions designed addressed two specific areas: (a) ones' religion/spirituality beliefs and, (b) how ones' religious and/or spiritual beliefs impacted on their experiences of counselling/psychotherapy.

This type of data collection was used since it gives rise to open answers (Potter and Hepburn, 2005), and allows the researcher to be systematic and consistent, whilst also enabling the interviewer to simultaneously explore responses beyond specific questions asked (Berg, 2001). Furthermore, semi-structured interviews are believed to be highly similar to naturalistic conversation whereby interviewers and interviewees incorporate material from their everyday interactions into the interview

(Smith et al., 2008), thus making them an appropriate methodology for the present study. However, a limitation of this type of interview is the propensity it has to veer off track (Partington, 2001), although any key topics forming the basis of the interview should be answered (Potter and Hepburn, 2005).

The interviews were recorded and stored on an audio device (Dictaphone), and were destroyed once the interviews had been transcribed, thus ensuring that no data was missed during transcription (King and Horrocks, 2010). Upon completion, a debrief sheet (see Appendix 6) was presented to subjects where they were thanked for their voluntary contribution to the research. It also displayed the contact details of the University as well as the contact details of respective mental health organisations in case any distress was caused to the participant during the interview. The participants kept a copy of the debrief sheet containing their unique identification code in the event of withdrawal, no participants withdrew.

Data analysis

The recorded interviews were transcribed verbatim in English (see Appendix 7), with the transcription notation system informed by Braun and Clarke's (2013) guidelines, data was then analysed using a thematic analysis. This method was applied since 'through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex amount of data,' (Braun and Clarke, 2006: 78) and since it is the most effective method in identifying hidden meanings within a transcript (Guest et al., 2012).

Since the research aimed to gather data from a specific group of people, Orthodox Jews, and their experiences of religion/spirituality within counselling/psychotherapy, a deductive thematic analysis was used to analyse the data. This method was used since it is '… suited to a wide range of research interests and theoretical perspectives,' (Braun and Clarke, 2013. p. 120). Furthermore, it enables large bodies of data to be summarised using key features, as well as highlighting differences and similarities within a data set (Braun and Clarke, 2006).

The first stage of thematic analysis is data familiarisation. This stage involved the researcher re-reading the data multiple times, and allowed the researcher to gain a deep and familiar sense of the data set. The next stage involved generating initial codes and made note of these on the Microsoft Word document the transcript was transcribed to. The codes were then synthesised together to generate themes, of which were reviewed and refined. A theme encapsulates significant elements regarding the research question and is constant across the data set (Braun and Clarke, 2006). Themes were then defined and named by the researcher and a report was produced. During the process, the researcher created an audit trail by writing notes and memorandums (Pope et al., 2007). Three main themes were identified in this study; they were reviewed in two levels and checked to ensure they were relevant. Level one involved looking at the extracts of the coded data and level two considered the entire data set. Once the themes were reviewed they received labels.

Analysis and Discussion

The analysis sought to understand the role of religion/spirituality within counselling/psychotherapy. A thematic analysis of the interview transcripts yielded

the following three superordinate themes; (1) Therapist Selection Process, (2)

Religion, Spirituality and their Intersection with Therapy, and (3) Conceptualisations

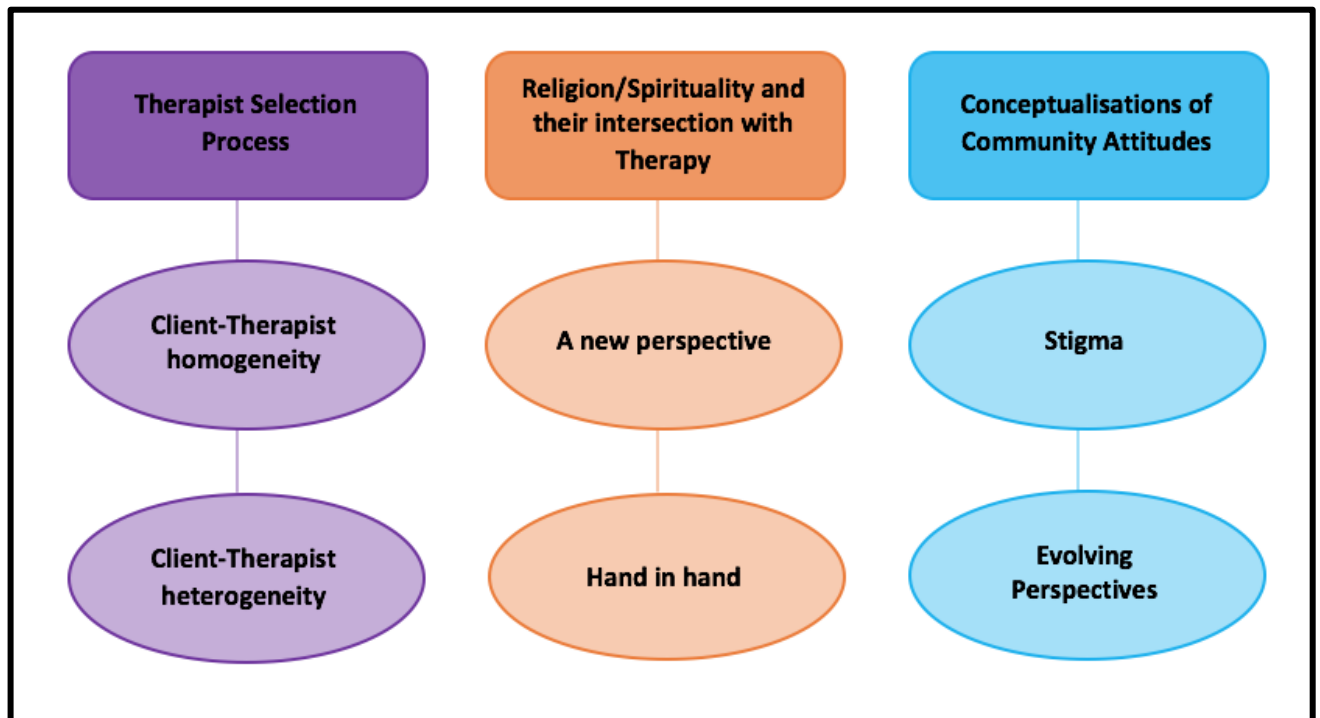of Community Attitudes, each with two subordinate themes (see **Figure 1**).

Figure 1. A Summary of Superordinate (top row) and corresponding Subordinate

themes.

Theme one: Therapist Selection Process

This theme captures participants' perceptions of the therapeutic encounter prior to

undergoing counselling or psychotherapy. Placing much emphasis on motivations

and thought processes involved in the selection of a therapist.

Subtheme A: Client-Therapist homogeneity

Two-thirds of participants mentioned a preference of seeking a therapist of the same

faith as themselves, or at the very least, sharing a similar religious background. The

discourses implied that there are a multitude of factors effecting ones' preference in therapist. The examples within this subtheme demonstrate the participants' recognition of the complexity of religion, social boundaries and theological beliefs.

(Rachel, 204 – 207): *'It's like walking into a room and already being understood, for me personally, all I wanted was someone who would understand the idiosyncratic parts of my faith and religion, and an Orthodox Jew seemed like the right path."*

Rachel's use of the word 'idiosyncratic' could indicate her belief, that parts of religion/spirituality are somewhat complex to comprehend. The multifaceted infrastructure of her religion, combined with the convoluted aspects of her faith, may have caused her to seek the psychological services of someone whom she shared a common background with. Rachel assumed that by doing so, she would feel appreciably understood and at ease. In support of this, Schnall et al. (2014) claim that due to the multidimensional nature and complexity of Judaism, Jews should seek the professional mental health expertise of those of the same faith. Conversely, Wickler (1989) found that 45% of Orthodox respondents favoured a non-Orthodox therapist, due to wavering concerns about the protection of confidentiality. Thus, suggesting a change in attitudes over the past 30 years.

(Hannah, 250 - 254): *"You wouldn't holiday in the North pole wearing a bikini and sandals, it's just not appropriate, nor would you go to a French speaking hospital as first port of call."*

In a similar vein, this extract demonstrates how ones' religious background can influence their choice of who they should engage in the therapeutic services of. The above quote could indicate the importance of the client feeling comfortable within their social and religious 'norms' and boundaries. This displays similarities with the Landes et al. (2013) study, whereby female students reported higher levels of anticipated comfort when engaging with a female therapist, in comparison to males. One of the main reasons clients will opt for a therapist similar to themselves stems from the patients' assumption that a therapist will display a greater level of empathy when they are most similar to the client (Pikus and Heavey, 1996).

(Andrew, 229 – 231): *'I felt that a lot of frustration towards G-d, and I imagined this was something I would work through in therapy. The Catholic goes to the Priest, like the Muslim goes to the Imam, and the Buddhist goes to the Monk.'*

In line with the other participants, Andrew's religious and spiritual beliefs were an integral part of the therapist-selection process. However, as opposed to just focussing on the barrier of the social boundary, he further develops their ideas, introducing his relationship with a deity. Prior to embarking on the therapeutic journey, in an attempt to localise his distress, Andrew recognised the salience of his theological beliefs in connection to his mental well-being. His insight encapsulating help-seeking behaviours of various religions, and their 'spiritual leaders' coincide with the works of Henderson (2018) whereby, having a therapist who is more attuned to the religious needs of the client, leads to a better therapeutic alliance and outcome.

Spitzer (2003) suggests that Orthodox Jews should seek help from professionals whom they share a cultural background with. He explains that the beliefs, behaviours and emotions of Orthodox Jews cannot be ascertained by those of a different faith. Due to potential limitations in the understanding of the relatively complex Jewish rituals and belief system, suitable treatment should preferentially be administered by those with an extensive awareness of the religious and cultural values of the Orthodox Jewish community. Alternatively, Orthodox Jewish communities by nature, exist as highly insular entities (Schnall, 2006). Certain aspects of Jewish Law promote the segregation of communities, from mainstream secular society. As a result, engaging with non-Orthodox psychotherapists can be viewed as a violation of a religious and social boundary (Passmore, 2003), thus pressurising individuals to get help from someone within their community.

Subtheme B: Client-Therapist heterogeneity

In paradox to the above subtheme, this subtheme encapsulates participants' experiences and attitudes towards a therapist of a different religious affiliation. The extracts suggest that having a therapist of a different faith can pose as a passive or enthralling motive to receive mental health treatment.

> **(Joshua, 298 – 301):** *"to be honest, I didn't think it the identity or affiliation of my therapist would make a difference. When you have a medical illness, it's not a question of religion. It's about getting the best help for you."*

From this extract, it becomes apparent that the identity of the therapist is unimportant, and asserts minimal influence on the clients' therapist-selection

process. Whilst the literature denotes an inextricable link between religion/spirituality and mental health (Smith et al., 2007). Joshua is challenging the framework suggesting that they are unrelated components. Additionally, the use of the word 'you', indicates the highly subjective nature of psychological distress, whilst acknowledging that for others having an Orthodox therapist might serve as a more appropriate strategy.

(Sophie, 206 – 207): *'There was something quite compelling about seeking help from someone who knew nothing about you."*

(Sophie, 215): *'I would finally be free of the boundaries and constraints of religion.'*

In contrast, Sophie suggests that client-therapist heterogeneity was a salient factor in choosing which therapist to engage in counselling with. From her perspective religion/spirituality was a mental straight jacket. Growing up within the realms of an Orthodox Jewish community caused her to experience religion/spirituality as an oppressive force. The interaction between her faith and pre-conceptions about therapy, propelled her to seek mental health services from a non-Jewish individual. This challenges the previous subtheme (Landes et al., 2013) and suggests that individuals prefer client-therapist heterogeneity.

When considering the client-therapist selection process, it is useful to examine theories surrounding how people make choices in general. Payne (1976) proposed that making a choice consists of multiple stages, with the plausible choices emerging

through a process of elimination. Thus, suggesting that clients examine and disregard a multitude of options prior to engaging the services of a specific therapist. This theme builds upon this theory suggesting that ones' life experiences and relationship with their religion/spirituality pose as one of the multiple stages that make up ones' decision making process of who to engage in the therapeutic services of (Spalter, 2013).

Theme two: Religion/Spirituality and their Intersection with Therapy

Participants' affinity with therapy was a predominant discussion throughout the interviews. All participants indicated that therapy had impacted their religious/spiritual practices or beliefs, with some expressing the idea of an inextricable link between the domains.

Subtheme A: A New Perspective

This subtheme captures the influence that therapy had on the religion/spirituality levels. For some participants' this manifested as a mental thought process, thus reflecting a change in their attitudes. For others' it materialised as a behavioural change.

(**Alex, 203 – 205**): *"...religion is pre-dated… better to focus on the now"*

Alex is inferring that therapy gave him a new psychological perspective. As opposed to focusing on the nuances and meticulousness of his religion, he gained a contemporary perspective. Placing emphasis on adapting to live within modern day society. Other participants aligned with this process of change.

(Hannah, 601): *"…I'm not as strict with the laws anymore"*

For Hannah, therapy changed the way she practiced religion, going from a place of strict adherence to the laws, to a relaxed approach. Some of the laws dictated by Judaism are believed to foster mental illness e.g. obsessive compulsive disorder, (Lack, 2012). Thus, suggesting a direct relationship between ones religious practices and their mental state.

Alternatively, the active modification of participants' behaviours and belief systems affirms the apprehensions and scepticisms of Rabbinic authorities (Band-Winterstein and Freund, 2013). The current data suggests that, even in the presence of receiving help from a therapist of the same faith, individuals are still subject to having their beliefs and practices contested.

The extracts here infer a therapy-religion interaction, in that therapy has the propensity to alter ones' religious/spiritual mechanisms. Previous literature suggests that religion/spirituality play key roles within the therapeutic encounter and that they are related to one another (Mayers et al., 2007). However, the subtheme here denotes that therapy can change the relationship individuals have with their religion/spirituality. Due to the fragility of the counselling session, therapists ought to be mindful of this relationship throughout the therapeutic encounter. Clinicians are predisposed to their own beliefs and values (Collins et al., 2010). In the counselling session, the therapist should dwell upon the multicultural counselling core component of self-awareness (Collins and Arthur, 2007). This could minimise any

potential effects of ethnocentrism, prejudice and stereotypes, and instil a more collaborative working alliance between the therapist and client, thus facilitating the long-term outcome of therapeutic treatment.

Subtheme B: Hand in hand

This subtheme extracts parts of the participants interviews that reflect their views regarding the relationship between religion/spirituality and therapy. Both Rachel and Sophie state their view how the systems are all interlinked.

(Rachel, 540 - 541): *"…you can never have one without the other"*

(Sophie, 400): *"it's impossible for them to be compartmentalised"*

These quotes demonstrate how Rachel and Sophie perceive religion/spirituality and therapy to interact with one another and influence a person's mental health, therapy being the dominating force within the relationship. Thus, it can be inferred that religion/spirituality and therapy are all potent entities that co-exist and converge with one another. Interestingly, both participants conceptualise this paradigm by using terminology pertaining an 'infinite' time bound. This may indicate toward the magnitude of their experiences.

Literature suggests a longstanding relationship between religion/spirituality and therapy (Rose et al., 2001). Therapy is a journey of reflecting on ones' thoughts, beliefs, behaviours and emotions. It promotes the ideals of kindness, positive thinking and broadening of perceptions. Jurisprudence within Orthodox Judaism

advocates multiple ideas in conjunction with the values of therapy e.g. respect, honesty and kindness (Milevsky and Eisenberg, 2012). Furthermore, the extracts here contradict claims that religion/spirituality should be left outside the therapy session, since they bare no bearings in accordance with ones' mental wellbeing (Rizzuto, 1996). However, it is important to note that psychological illness, religion/spirituality and therapy are highly subjective experiences (Masters, 2010) and therefore, it could be suggested that the therapist should consider the context of the therapy prior to administering treatment.

Theme three: Conceptualisations of Community Attitudes

Participants' awareness and attitudes concerning the influence of their social environment was a prevalent discussion throughout the interviews. Participants' spoke about the stigma pervasive across the community, and how it caused them to be reluctant to undergo therapy.

Subtheme A: Stigma

Participants who recounted going through therapy at some point in their childhood, placed significant emphasis on the influence of stigma and their community. Thus, it can be inferred that participants' decision to undergo counselling or psychotherapy as well as their experiences, can be remarkably attributed to their social network. The extracts below demonstrate the conspicuous stigma attached to counselling or psychotherapy within the Orthodox Jewish community.

(Sophie, 230 - 233): *'If people know you're in therapy you get a black mark against your name.'*

The use of the idiom 'black mark' suggests the radical stance the community take when viewing counselling or psychotherapy. Owen et al. (2012) suggest that there several perpetuating stigmas attached to seeking therapy. However, Sophie is suggesting that such stigmas are amplified within the Orthodox Jewish community. This aligns with existing literature whereby Orthodox individuals seeking mental health services are branded as "crazy" and can bring shame upon their family's reputation (Wickler, 1986; Bayes and Loewenthal, 2013). Other extracts appear to adhere to this line of thought;

(Rachel, 434 – 438): *'The first time I discovered therapy was because the school sent me there because of an incident that occurred. The first question she asked me was "are you worried this will affect your marriage prospects?" I never saw her again.'*

Rachel underwent therapy with an Orthodox therapist. Here she is shedding light on the poignant issue relating to the stigma encircling the pursuant of mental health services. Whilst she is suggesting that her community, in this case her school, provided her access to counselling sessions, overriding the stigma attached. She is conveying the impression, that Orthodox therapists can become immersed and blinded by their community stigmas and norms, placing too much emphasis on these within the therapeutic encounter (Ripley et al., 2001). Whilst addressing religion/spirituality within therapy can help facilitate the therapeutic outcome (Masters, 2010) it is important to note that there is a complex interplay between these two systems (Smith and Richards, 2005). Rizzuto (1996) notes that when the

therapist projects his or her religion/spirituality beliefs even in a relatively passive manner, it can cause the client offence, turmoil and frustration (Saenz and Waldo, 2013), which can lead to the premature termination of treatment, as reflected by the above excerpt.

Participants' experiences remained in congruence with Satorius's (2007) perspective of the different types of stigma that surround engagement with mental health treatment. The close-knit, insular nature of Orthodox Jewish communities has the propensity to magnify the taint of attending therapy (Schnall, 2006). Members of the community are receptive to these occurrences and can create apprehensions toward undergoing therapy, as well as the way in which they conduct themselves.

Subtheme B: Evolving Perspectives

Within this subtheme, participants reflected and elaborated upon the role of the community and the impact it had upon therapy. Although participants generally viewed the 'community' as a negative force, others regarded it as a positive entity.

(Hannah, 378 – 379): *"the ignorance of mental health is an infectious disease across the whole community"*

It seems that through Hannah's experiences with in dealing with her mental health and her social environment, she felt as if the community had failed her. The way in which Hannah stresses the community's 'ignorance' may imply that she believes the community turns a blind eye to the prevalence of mental illness. Subsequently, the terminology 'infectious disease' connotes to a widespread phenomenon persistent

throughout the entire community. The use of the physical health metaphor could indicate her view that mental illness is conceptualised in the same way as physical conditions, further implying that there is a cure for this epidemic. This could require the community taking an active stance on mental health and engaging with the present issues. Whilst other participants raised the same concerns as Hannah, they identified a cataclysmic shift that transpired across the community.

(Alex, 555 – 559): *"… we are living in the age of the mental health revolution…it's time to speak up, speak out."*

(Andrew 460 – 467): *"there are now mental health awareness talks organised by local schools and Synagogues,"*

Both Joshua and Andrew acknowledge the birth of the mental health era. They are inferring that in the past the Orthodox Jewish community nurtured an environment where mental health issues where disregarded and 'swept under the carpet'. However, in light of the global recognition of the awareness of mental health issues (World Health Organisation, 2005), such communities have mirrored this position and began to address these concerns (Weinstein, 2015). In other words, these extracts conceptualise the dominant role that the community plays with regard to the encouragement or disparagement of engaging with mental health services.

The spiritual leadership within the Orthodox community can display strong apprehensions and misgivings in relation to congregants pursuant of mental health services (Schnitzer et al., 2009), thus barricading members of the community to

acquire mental health services. Additionally, one of the theological underpinnings of Judaism states, that suffering can serve as a divine test or retribution from G-d (Margolese, 1998). Whilst research suggests that such religious teachings can increase ones' psychological resilience (Martinez et al., 2007), it can also have a negative impact on the individual – causing them to suffer in silence. When the community advocate that adversities in a persons' life are divine, and that the individual has the potential to overcome them. It can prevent a person from seeking the services they need, as to avoid acting heretically (Strean, 1994).

This subtheme reasons, that the aetiology of psychological illness involves a series of interactions between ones' interpersonal relationships, education, religious institutions and society, all of which can alleviate mental health issues. Bronfenbrenner's (1979) theory of ecological systems suggests that connections between individuals and systems present within communities, play a significant role in providing support to an individual. This can take place at a micro or macro level. According to this model, when there is a lack of continuous support between each of the different systems, it jeopardizes the mental health of an individual. Alas, communities ought to recognise the pivotal role they play in the psychological well-being of their members.

Conclusion

The findings were in conjunction with previous literature, demonstrating the importance of the identity of the therapist, the role of stigma, the influence of the community and the complexity of the mental wellbeing, religion/spirituality relationship. However, it appears that due to the insular nature of Orthodox Jewish

communities, such factors and effects were magnified. Mental health services of any affiliation should be cautious of such effects and amalgamate them into the course of therapy.

Alternatively, participants placed particular emphasis on the role of educational institutions. This may reflect the pivotal role they play in individuals' psychological wellbeing. Essentially, mental health services could work alongside schools and colleges to meet the psychological needs of children and adolescents.

Whilst the original research sought to understand the impact religion/spirituality has within therapy, unexpectedly, the findings emphasised the prolific effects therapy can have on ones' religious/spiritual beliefs, values and practices, thus alluding to an active relationship of interaction between religion/spirituality and mental health. When executing mental health services, practitioners ought to be mindful of the fragility of the dynamics of the encounter and conduct themselves with the utmost integrity.

Limitations of study and future research

Despite its strengths, this study was not without its' limitations. Firstly, no working definition of religion/spirituality were provided. Due to the multidimensional nature of these constructs, this may have led to a lack of clarity about what the interview questions were asking, thus giving rise to a broad spectrum of answers. Given the idiosyncratic nature of the current accounts, it could be suggested that the thematic approach lacked a depth of experience that alternative analyses could provide.

Future designs could utilise an interpretive phenomenological approach (IPA) to investigate further.

The small sample size may have served as a limitation. Whilst six participants is an acceptable number, the results should be interpreted cautiously in terms of generalisability. Future research could explore which specific aspects of therapy have the greatest influence on ones' religion/spirituality as well as the positive and negative effects associated with them. Alternatively, most of the participants recruited in this study came from relatively religious backgrounds. Future research could explore the views of 'Modern' Orthodox Jews in order to establish any differences or similarities between these sects. Gender differences may have influenced the outcome of the interviews. Due to the restrictions prohibiting male and female interactions within Orthodox Judaism (McEvoy et al., 2017) male participants may have been less comfortable, thus being less talkative throughout the interview. Future research could incorporate a gender matched design to explore this further.

Reflexive Analysis

According to Willig (2013) there are two aspects of reflexivity: personal and epistemological.

Being a British Orthodox Jewish woman, who lives in a predominantly Orthodox Jewish community, I feel as if I possess a sufficient understanding of Orthodox Judaism, its' beliefs, values and practices. Nevertheless, I was apprehensive not to assume that participants held the same perspectives as myself. My choice of topic

was derived at from my interests in this area combined with my past experiences of the impact of religion/spirituality within counselling/psychotherapy.

Since I shared a similar ethnic background to the participants, this meant that I was able to understand the responses given by participants on a personal level. This mutual socio-cultural background could have made participants feel more comfortable throughout the interview. However, I recognised that this may have led to biases when conducting the interviews and analysing the data. Therefore, I worked hard to detach myself from my own experiences during the analysis.

I took an impartial approach when conducting the thematic analysis and writing the report. In view of existing literature concerning the impact of religion/spirituality on counselling/psychotherapy, I was receptive to potential findings. No methodological problems were encountered when conducting the study however, I was challenged by the emergence of the unexpected direction of the relationship between therapy and religion. Whilst I set out to use a deductive approach, the development of this unforeseen theme made me reassess my ways, causing me to integrate an inductive element to the analytic approach. The selection of thematic analysis was heavily influenced by my greater previous experience of this form data analysis. However, given the gravity of this piece of academic research to my BSc, this created a sense of vulnerability as I contemplated the appropriateness of my analytic approach. Given the nature of the extracted themes, I recognise that my age may have influenced responses if participants conceptualised me as representing an evolving understanding of mental health help-seeking behaviour within the Jewish community.

References:

Adams, J. (2010) 'Motivational narratives and assessments of the body after cosmetic surgery.' *Qualitative Health Research,* 20(6) pp. 755 – 767.

Arredondo, P. and D'Andrea, M. (1999) 'How do Jews fit into the multicultural counseling movement?' *Counseling Today,* 42(6) pp. 14.

Band-Winterstein, T. and Freund, A. (2013) 'Between tradition and modernity: social work-related change processes in the Jewish ultra-orthodox society in Israel.' *International Journal of Intercultural Relations,* 37(4) pp. 422 – 433.

Bayes, J. E. B. and Loewenthal, K. M. (2013) 'How do Jewish teachings relate to beliefs about depression in the strictly orthodox Jewish community?'. *Mental Health, Religion and Culture,* 16(8) pp. 852 – 862.

Bell, K., Fahmy, E. and Gordon, D. (2014) 'Quantitative conversations: the importance of developing rapport in standardised interviewing.' *Quality and Quantity,* 50(1) pp. 193 – 212.

Berg, B. (2001) *Qualitative research methods for the social sciences.* 4th ed., Needham Heights, MA: Allyn and Bacon.

Brachfeld, S. (2017) *Therapists' attitudes to using spiritual and religious interventions with Orthodox Jewish clients.* Ph. D. Philadelphia College of Osteopathic Medicine.

Braun, V. and Clarke, V. (2006) 'Using thematic analysis in psychology.' *Qualitative Research in Psychology,* 3(2) pp. 77 – 101.

Braun, V. and Clarke, V. (2013) *Successful qualitative research: a practical guide for beginners.* London: SAGE.

British Psychological Society (2014) *Code of Human Research Ethics.* Leicester: British Psychological Society.

British Psychological Society (2018) *Code of Ethics and Conduct.* Leicester: British Psychological Society.

Bronfenbrenner, U. (1979) *The Ecology of Human Development: Experiments by Nature and Design.* Cambridge, MA: Harvard University Press.

Carroll, K. M. and Nuro, K, F. (2002) 'One size cannot fit all: A stage model for psychotherapy and manual development.' *Clinical Psychology Science and Practice,* 9(4) pp. 396 – 406.

Collins, S. and Arthur, N. (2007) 'Culture-infused counselling: a fresh look at a classic framework of multicultural counselling competencies.' *Counselling Psychology Quarterly,* 23(2) pp. 203 – 216.

Collins, S., Arthur, N. and Wong-Wylie, G. (2010) 'Enhancing reflective practice in multicultural counseling through cultural auditing.' *Journal of Counseling and Development,* 88(3) pp. 340 – 347.

Cooperman, A., Smith, G. A., Hackett, C. and Kuriakose, N. (2013) *A portrait of Jewish Americans: Findings from a Pew Research Centre survey of US Jews.* Washington, DC: Pew Research Centre.

Cornish, M. A., Wade, N. G., Tucker, J. R. and Post, B. C. (2014) 'When religion enters the counseling group: multiculturalism, group processes, and social justice.' *The Counseling Psychologist,* 42(5) pp. 578 – 600.

Creswell, J. W. (2012) *Educational research: Planning, conducting, and evaluating quantitative and qualitative research.* 4th ed., Boston, MA: Pearson.

Davis, D. E., Rice, K., Hook, J. N., Van Tongeren, D. R., DeBlaere, C., Choe, E. and Worthington, E. L,. Jr. (2015) 'Development of the sources of the spirituality scale.' *Journal of Counseling Psychology,* 62(3) pp. 503 – 513.

deMamani, A. G. W., Tuchman, N. and Duarte, E. A. (2010) 'Incorporating religion/spirituality into treatment for serious mental illness.' *Cognitive and Behavioural Practice,* 17(4) pp. 348 – 357.

Diallo, A. (2012) 'Clients' willingness to incorporate religion or spirituality in counseling: a brief report.' *Rehabilitation Counseling Bulletin,* 56(2) pp. 120 – 122.

Fallot, R. D. (2001) 'Spirituality and religion in psychiatric rehabilitation and recovery from mental illness.' *International Review of Psychiatry,* 13(2) pp. 110 – 116.

Gockel, A. (2011) 'Client perspectives of spirituality in the therapeutic relationship.' *The Humanistic Psychologist,* 39(2) pp. 154 – 168.

Goedde, C. (2001) 'A qualitative study of the client's perspectives of discussing spiritual and religious issues in therapy.' *Dissertation Abstracts International: Section B: The Sciences and Engineering,* 61(9-B) pp. 4983.

Gough, B., Lawton, R., Madill, A. and Stratton, P. (2003) *Guidelines for the supervision of undergraduate research in psychology.* York: LTSN Psychology.

Guest, G., Namey, E. E. and Mitchell, M. L. (2012) *Collecting qualitative data: a field manual for applied research.* Thousand Oaks, CA: SAGE Publications.

Hage, S., Hopson, A., Siegel, M., Payton, G. and DeFanti, E. (2006) 'Multicultural training in spirituality: An interdisciplinary review.' *Counseling and Values,* 50(3) pp. 217 – 234.

Henderson, T. E. (2018) *The influence of the therapist-patient religious/spiritual congruence on satisfaction with therapy: A review of research.* M. A. Rowan University.

Hill, P. C., Pargament, K. I., Hood, R. W., McCullough, J. M. E., Swyers, J. P., Larson, D. B. and Zinnbauer, B. J. (2000) 'Conceptualizing religion and spirituality: Points of commonality, points of departure.' *Journal for the Theory of Social Behaviour,* 30(1) pp. 51 – 77.

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

Koenig, H. G., King, D. and Carson, V. B. (2012) *Handbook of religion and health.* New York: Oxford University Press.

Lack, C. W. (2012) 'Obsessive-compulsive disorder: Evidence-based treatments and future research.' *World Journal of Psychiatry,* 2(6) pp. 86 – 90.

Landes, S. J., Burton, J. R., King, K. M. and Sullivan, B. F. (2013) 'Women's preference of therapist based on sex of therapist and presenting problem: an analog study.' *Counselling Psychology Quarterly,* 26(3-4) pp. 330 – 342.

Lincoln, Y. S. and Guba, E. G. (1985) *Naturalistic Enquiry.* Newbury Park, CA: Sage Publications.

Loewenthal, K. M. (2006) *Orthodox Judaism: Features and Issues for Psychotherapy. The psychologies in religion.* London: Springer.

Margolese, H. C. (1998) 'Engaging in psychotherapy with the Orthodox Jew.' *American Journal of Psychotherapy,* 52(1) pp. 37 – 53.

Martinez, J. S., Smith, T. B. and Barlow, S. H. (2007) 'Spiritual interventions in psychotherapy: evaluations by highly religious clients.' *Journal of Clinical Psychology,* 63(10) pp. 943 – 960.

Masters, K. S. (2010) 'The role of religion in therapy: time for psychologists to have a little faith?' *Cognitive and Behavioural Practice,* 17(4) pp. 393 – 400.

Mayers, C., Leavey, G., Valliantaou, C. and Barker, C. (2007) 'How clients with religious or spiritual beliefs experience psychological help-seeking and therapy: A qualitative study.' *Clinical Psychology & Psychotherapy,* 14(4) pp. 317 - 327.

McEvoy, P., Williamson, T., Kada, R., Frazer, D., Dhliwayo, C. and Gask, L. (2017) 'Improving access to mental health care in an Orthodox Jewish community: a critical reflection upon the accommodation of otherness.' *BMC Health Services Research,* 17(1) pp. 557.

Milevsky, A. and Eisenberg, M. (2012) 'Spiritually oriented treatment with Jewish clients: Meditative prayer and religious texts.' *Professional Psychology: Research and Practice,* 43(4) pp. 336 – 340.

Office National Statistics. (2011) *Ethnicity and religion in England and Wales.* London: Office National Statistics.

Owen, J., Thomas, L. and Rodolfa, E. (2012) 'Stigma for seeking therapy: Self-stigma, social stigma and therapeutic processes.' *The Counseling Psychologist,* 41(6) pp. 857 – 880.

Oxhandler, H. K. and Pargament, K. I. (2014) 'Social work practitioners' integration of clients' religion and spirituality in practice: a literature review.' *Social Work,* 59(3) pp. 271 – 279.

Partington, G. (2001) 'Qualitative research interviews: identifying problems in technique.' *Issues in Educational Research,* 11(2) pp. 32 – 44.

Passmore, N. L. (2003) 'Religious issues in counselling: are Australian psychologists "dragging the chain"?' *Australian Psychologist,* 38(3) pp. 183 – 192.

Payne, J. W. (1976) 'Heuristic search processes in decision making.' *Advances in Consumer Research,* 3(1) pp. 321 – 327.

Pikus, C. F. and Heavey, C. L. (1996) 'Client preferences for therapist gender.' *Journal of College Student Psychotherapy,* 10(4) pp. 35 – 43.

Plumb, A. M. (2011) 'Spirituality and counselling: Are counsellors prepared to integrate religion and spirituality into therapeutic work with clients?' *Canadian Journal of Counselling and Psychotherapy,* 45(1) pp. 1 – 16.

Pope, C., Mays, N. and Popay, J. (2007) *Synthesising qualitative and quantitative health evidence: a guide to open methods.* Maidenhead: Open University Press.

Popovsky, R. M. A. (2010) 'Special issues in the care of Ultra-Orthodox Jewish psychiatric inpatients.' *Transcultural Psychiatry,* 47(4) pp. 647 – 672.

Potter, J. and Hepburn, A. (2005) 'Qualitative interviews in psychology: problems and possibilities.' *Qualitative Research in Psychology,* 2(4) pp. 281 – 307.

Quinlan, C. (2011) *Business Research Methods*. Ireland: Ireland Academic Press.

Rabinowitz, A. (2000) 'Psychotherapy with Orthodox Jews.' *In* Richards, P. S. and Bergin, A. E. (eds.), *Handbook of psychotherapy and religious diversity.* Washington, DX: American Psychological Association, pp. 237 – 258.

Ripley, J. S., Worthington, E. L., Jr. and Berry, J. W. (2001) 'The effects of religiosity in preferences and expectations for marital therapy among married Christians.' *American Journal of Family Therapy*, 29(1) pp. 39 – 58.

Rizzuto, A. M. (1996) 'Psychoanalytic treatment and the religious person.' *In* E. P. Shafranske (ed.) *Religion and the clinical practice of psychology*. Washington, DC: American Psychological Association, pp. 409 - 431.

Robinson, O. C. (2014) 'Sampling in interview-based qualitative research: A theoretical and practical guide.' *Qualitative Research in Psychology,* 11(1) pp. 25 – 41.

Rossetto, K. R. (2014) 'Qualitative research interviews: Assessing the therapeutic value and challenges.' *Journal of Social and Personal Relationships,* 31(4) pp. 482 – 489.

Rose, E. M., Westfield, J. S. and Ansley, T. N. (2001) 'Spiritual issues in counseling: clients' beliefs and preferences.' *Journal of Counseling Psychology,* 48(1) pp. 61 – 71.

Saenz, R. and Waldo, M. (2013) 'Clients' preferences regarding prayer during counseling.' *Psychology of Religion and Spirituality*, 5(4) pp. 325–334.

Satorius, N. (2007) 'Stigma and mental health.' *The Lancet,* 370(9590) pp. 810 – 811.

Schlesinger, R. (2014) 'Clinical Social Work with Orthodox Jews: A Relational Approach.' *In* Relational Social Work Practice with Diverse Populations*.* Springer: New York, pp. 179 – 194.

Schnall, E. (2006) 'Multicultural counseling and the Orthodox Jew. *Journal of Counseling and Development,* 84(3) pp. 276 – 282.

Schnall, E., Kalkstein, S., Gottesman, A., Feinberg, K., Schaeffer, C. B. and Feinberg, S. S. (2014) 'Barriers to mental health care: a 25-year follow-up study of the Orthodox Jewish community.' *Journal of Multicultural Counseling and Development,* 42(3) pp. 161 – 173.

Schnitzer, G., Loots. G., Escudero, V. and Schechter, I. (2009) 'Negotiating the pathways into care in a globalizing world: help-seeking behaviour of ultra-orthodox Jewish parents.' *International Journal of Social Psychiatry,* 57(2) pp. 153 – 165.

Sloan, R. P. and Bagiella, E. (2002) 'Claims about religious involvement and health outcomes.' *Annals of Behaviour Medicine,* 24(1) pp. 14 – 21.

Sloan, R. P., Bagiella, E. and Powell, T. (2001) 'Without a prayer: methodological problems, ethical challenges, and misrepresentations in the study of religion, spirituality, and medicine.' *In* T. G. Plante and A. C. Sherman (eds.), *Faith and Health: Psychological Perspectives.* New York: Guildford Press, pp. 339 – 354.

Smith, J. A. (1995) 'Semi structured interviewing and qualitative analysis.' *In* Smith, J. A., Harre, R. and Van Langenhove, L. (eds.). *Rethinking Methods in Psychology.* London: Sage, pp. 9 - 26.

Smith, J. A., Hollway, W. and Mishler, E. G. (2008) 'Commentaries on Potter and Hepburn, 'Qualitative interviews in psychology: problems and possibilities.' *Qualitative Research in Psychology,* 2(4) pp. 309 – 325.

Smith, T. and Richards, P. S. (2005) 'The integration of spiritual and religious issues in racial-cultural psychology and counseling.' *In* R. T. Carter (ed.). *Handbook of racial-cultural psychology and counseling: Volume 4. Theory and research.* New York: Wiley, pp. 132 – 159.

Smith, T. B., Bartz, J. and Scott, R. P. (2007) 'Outcomes of religious and spiritual adaptation to psychotherapy: A meta-analytic review.' *Psychotherapy Research,* 17(6) pp. 643 – 655.

Spalter, D. (2013) *How clients choose their psychotherapist: Influences on selecting and staying with a therapist.* Ph.D. Middlesex University.

Spitzer, J. (2003) *Caring for Jewish patients.* Oxford: Radcliffe Publishing.

Strauss A. and Corbin, J. (1998) *Basics of Qualitative Research: Techniques for Developing Grounded Theory.* Thousand Oaks, CA: Sage Publications.

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

Tillman, J. G. (1998) 'Psychodynamic psychotherapy, religious beliefs, and self-disclosure.' *American Journal of Psychotherapy,* 52(3) pp. 273 – 286.

Tilly, C. (2004) 'Social boundary mechanisms.' *Philosophy of the Social Sciences,* 34(2) pp. 211 – 236.

Wade, N G., Worthington Jr, E. L. and Vogel, D. L. (2007) 'Effectiveness of religiously tailored interventions in Christian therapy.' *Psychotherapy Research,* 17(1) pp, 91 – 105.

Weinstein, J. (2015) *Mental health in the Jewish community.* 27th November. The Jewish Chronicle. [Online] [Accessed on 12th February 2019] https://www.thejc.com/mental-health-in-the-jewish-community-1.147712

Wickler, M. (1986) 'Pathways to treatment: how Orthodox Jews enter therapy.' *Social Casework: The Journal of Contemporary Social Work,* 67(3) pp. 113 – 118.

Willig, C. (2013) *Introducing qualitative research in psychology.* 3rd ed., Maidenhead: Open University Press.

World Health Organisation. (2005) *Promoting Mental Health: Concepts – Emerging Evidence – Practice.* [Online] [Accessed on 12th February 2019] https://www.who.int/mental_health/evidence/MH_Promotion_Book.pdf

Zedek, M. R. (1998) 'Religion and mental health from the Jewish perspective.' *In* H. G. Koenig (ed.), *Handbook of religion and mental health.* San Diego: Academic Press, pp. 255 – 261.