

Portfolio Volume 1: Major Research Project

**The Experience of Orthodox Jewish Therapists  
Offering Therapy to Chareidi Female Adolescents**

Claire E Franklin  
12240125

Submitted to the University of Hertfordshire in partial fulfilment of  
the requirements of the degree of Doctor of Clinical Psychology

Word Count: 29,950

June 2023

The candidate confirms that the work submitted is her own and that appropriate credit has been given where reference has been made to the work of others.

This copy has been supplied on the understanding that it is copyright material and that no quotation from the thesis may be published without proper acknowledgement.

The right of Claire E Franklin to be identified as Author of this work has been asserted in accordance with the Copyright, Designs and Patents Act 1988

© 2023 The University of Hertfordshire and Claire E Franklin

All work throughout this research has been appropriately anonymised and all identifiable information removed, so that no participant can be identified.

## Table of Contents

---

<b>i Acknowledgments</b> .....	8
<b>ii Glossary</b> .....	9
<b>iii List of figures and tables</b> .....	11
<b>iv List of abbreviations</b> .....	12
<b>v Abstract</b> .....	13
<b>1. Introduction</b> .....	14
1.1. Overview.....	14
1.2. Positioning the researcher.....	14
1.2.1. Personal position in relation to the research topic, and a disclaimer .....	14
1.2.2. Position on the intersection of Judaism and psychology .....	16
1.2.3. Epistemological and theoretical position.....	17
1.3. Mental health in the post-pandemic era.....	19
1.4. The UK Orthodox Jewish community .....	20
1.4.1. Mental health and the Orthodox Jewish community .....	22
1.4.2. Adolescent mental health within the Orthodox Jewish community .....	26
1.5. Systematic Review .....	29
1.5.1. Introduction .....	29
1.5.2. Methods .....	29
1.5.2.1. Types of studies .....	29
1.5.2.2. Topic of interest .....	30
1.5.2.3. Types of participants .....	30
1.5.2.4. Types of interventions .....	31
1.5.2.5. Search methods for the identification of studies .....	32
Electronic searches.....	32
Grey literature .....	33
Searching other sources .....	33
1.5.2.6. Selection of studies.....	33

1.5.2.7. Characteristics of the included studies.....	35
1.5.2.8. Quality assessment of the included studies.....	40
1.5.2.9. Data management, analysis, and synthesis.....	40
1.5.3. Results.....	41
1.5.3.1. Overview.....	41
1.5.3.2. Challenges of the therapy experience.....	42
Emotions.....	42
Beliefs.....	44
Culture.....	45
Language and communication.....	48
1.5.3.3. Strategies that help the therapy experience.....	48
Emotions.....	48
Beliefs.....	49
Culture.....	50
Language and communication.....	51
‘Being’.....	54
1.5.4. Assessment of confidence of the review findings.....	55
1.5.5. Discussion.....	56
1.6. Rationale and aims of this study.....	57
1.7. A note about language.....	59
<b>2. Methodology.....</b>	<b>60</b>
2.1. Overview.....	60
2.2. Design.....	60
2.2.1. Rationale for using Interpretative Phenomenological Analysis (IPA).....	60
2.2.1.1. Phenomenology.....	62
2.2.1.2. Hermeneutics.....	63
2.2.1.3. Idiography.....	64
2.2.2. Stakeholder consultation and participatory research design.....	64
2.3. Ethics.....	67

2.4. Procedure .....	69
2.4.1. Recruitment .....	69
2.4.2. Data collection .....	69
2.4.3. Interview schedule .....	69
2.4.4. Pilot interview .....	70
2.4.5. Data transcription .....	70
2.5. Participants .....	71
2.5.1. Inclusion and exclusion criteria .....	71
2.5.2. Participant demographics .....	71
2.6. Data analysis .....	72
2.7. Quality assurance .....	73
2.8. Reflective processes .....	77
2.8.1. A note on bracketing and self-reflexivity .....	77
2.8.2. Researcher experience of the participants .....	78
<b>3. Results</b> .....	<b>80</b>
3.1. Overview .....	80
3.2. GET 1: Personal & professional overlap when working in one's own community .	81
3.2.1. How therapists feel when boundaries are blurred .....	81
3.2.2. Managing confidentiality within a community context .....	86
3.3. GET 2: Working with Chareidi clients: Being culturally sensitive .....	89
3.4. GET 3: Helping Chareidi Gen Z on their journey to adulthood.....	96
3.5. GET 4: Experiencing connection and disconnection .....	102
3.5.1. Feeling connected .....	102
3.5.2. When values are at odds with each other: feeling disconnected.....	109
<b>4. Discussion</b> .....	<b>118</b>
4.1. How the findings relate to existing research .....	118
4.2. Strengths and limitations.....	125
4.3. Implications .....	129
4.3.1. Clinical implications.....	129

4.3.2. Service implications .....	131
4.4. Recommendations for future research .....	133
4.5. Dissemination plans.....	135
4.6. A final reflection .....	135
<b>5. References.....</b>	<b>137</b>
<b>6. Appendices.....</b>	<b>156</b>
6.1. Appendix A: Quality assessment using Critical Appraisal Skills Programme (CASP).....	156
6.2. Appendix B: Systematic review search strategy.....	158
6.3. Appendix C: Papers published before 2012 .....	159
6.4. Appendix D: GRADE-CERQual evaluation.....	161
6.5. Appendix E: Recruitment poster .....	165
6.6. Appendix F: Interview schedule.....	167
6.7. Appendix G: Consultants agreement .....	170
6.8. Appendix H: Consultants' reflections.....	172
6.9. Appendix I: Ethical approval notification .....	173
6.10. Appendix J: Participant information sheet.....	174
6.11. Appendix K: Participant consent form .....	178
6.12. Appendix L: Non-disclosure agreement.....	180
6.13. Appendix M: Signposting information (Support services) .....	181
6.14. Appendix N: Transcript extract .....	182
6.15. Appendix O: Example of PETs in NVivo .....	184
6.16. Appendix P: Example of PETs in paper form .....	185
6.17. Appendix Q: Example of a participant's finalised PETs .....	186
6.18. Appendix R: Extracts from the primary researcher's reflective diary.....	189

---

## i. Acknowledgements

I am indebted to my supervisors, Dr Emma Karwatzki and Dr Lauren Topper, who advised and encouraged me throughout and went above and beyond their roles by attending several late-night research consultant meetings.

Sincere thanks to my precious research participants; I feel honoured to have explored your experiences with you. You have taught me so much about how to be an excellent therapist.

I am grateful to my two research consultants who offered their time, reflections, and expertise. Thank you, my friends, for taking part in my research journey.

I consulted with several important people during this project: thank you Kate MacFarlane, master-transcriber; Dr Rachel Starr, IPA expert; and Gina, analysis-buddy. Your support was invaluable.

Thank you to my parents and parents-in-law for their love and care.

None of this thesis would have come to fruition without the love and patience of my three very dearest men in this world: Yochanan, Yossi, and Yedidya. Your unwavering support means so much to me and this research is dedicated to you. Thank you for bearing with me.

Finally,

מִה־אֲשִׁיב לֵה' כָּל־תַּגְּמוּלוֹתַי עֵלַי:

*How can I repay G-d for all His kindness to me? (Psalms, 116:12)*

With humility and awe, I thank G-d, The Holy One Blessed Be He, for giving me the endurance, discipline, and ability to serve Him and His people with love and dedication.

## ii. Glossary of selected Jewish terms

---

Bar and Bat Mitzvah	Jewish adolescents reach this milestone at ages 13 and 12, respectively, and are henceforth required to fulfil the Torah commandments like adults.
Chareidi	<i>Adj., lit. Heb.</i> trembling; <i>pl.</i> Chareidim. Implies strict religious Jewish practice. Whilst 'Ultra-Orthodox' is often used in the literature to describe Chareidi groups, it can be deemed offensive due to its negative connotations of the group's practice.
Chillul Hashem	<i>Lit.</i> desecrating G-d's Name (Leviticus, 22:32), i.e., bringing harsh criticism upon G-d and His teachings. When committing a Chillul Hashem, there is a risk of non-Jews losing respect for the Jewish community, Judaism, or even G-d, which is deemed a serious matter in Judaism and is therefore forbidden.
G-d	G-d is the infinite, both immanent and transcendent power that created the world and continues to rule over it and its inhabitants. G-d's name is not printed in its complete form, unless when used for Jewish ritual, since the Torah forbids to erase, destroy, or desecrate the name of G-d (Deuteronomy, 12:4).
Halacha	<i>Noun; adj. halachic.</i> An overall term used for the legal Code of Jewish Law
Hashem	<i>Lit. Heb.</i> The Name. Since G-d's Divine name is considered too holy to pronounce outside of formal prayer, the term Hashem is used.
Judaism	A monotheistic religion believed to have been initiated by the patriarch Abraham, and which comprises the collective religious, cultural, and legal tradition and the civilization of the Jewish people.
Orthodox Jewish	Umbrella term for several Jewish religious denominations. A common denominator is the strict observance of the Torah commandments, for example keeping fully kosher and adhering to the laws of the Sabbath (Shabbat).
Secular	Not religious.
Shidduch	<i>Noun; pl.</i> Shidduchim. The Jewish matchmaking process where two potential candidates meet to consider whether they are compatible for marriage. When a match is made, this is also called a shidduch.
Talmud	A written recording of the rabbinical debates in the 2 <sup>nd</sup> - 6 <sup>th</sup> centuries. It is the legal commentary on the Old Testament and

---

prescribes how Torah commandments should be followed. It also includes biblical interpretation, ethics, and customs.

#### Torah

The totality of Jewish teaching, including the five books of Moses, often referred to as the 'Old Testament' (which Orthodox Jews believe was received from G-d on Mount Sinai in 1312 BCE), later biblical texts, and the 'Oral Law' (Talmud) that many believe was Sinaitic too but was written down in subsequent centuries.

---

**iii. List of figures and tables**

---

Figure 1	PRISMA flow diagram.....	34
Figure 2	Five steps of thematic synthesis .....	40
Figure 3	Thematic map .....	42
Table 1	A community psychology framework.....	18
Table 2	SPIDER criteria .....	31
Table 3	Religious affiliation of participants .....	35
Table 4	Participants' roles or professions .....	36
Table 5	Types of clients seen .....	36
Table 6	Data extraction table .....	38
Table 7	Examples of Professional Standards Authority accredited registers .....	71
Table 8	Frequency of themes across participants .....	74
Table 9	Four indicators of high-quality IPA .....	76
Table 10	Mental health presentations discussed by therapists.....	80
Table 11	Group experiential themes and subthemes .....	81

---

#### **iv. List of abbreviations**

---

CAMHS	Children and Adolescent MH Services
CASP	Critical Appraisal Skills Programme
CBT	Cognitive-behavioural therapy
CERQual	Confidence in Evidence from Reviews of Qualitative research
CYP	Children and young people
EDI	Equality, diversity, and inclusion
EPOC	Effective Practice and Organisation of Care
GET	Group experiential theme
GRADE	Grading of Recommendations Assessment, Development and Evaluation
IPA	Interpretative Phenomenological Analysis
MH	Mental health
OJ	Orthodox Jewish
PET	Personal experiential theme
SPIDER	Sample, Phenomenon of Interest, Design, Evaluation, Research Type

---

## **v. Abstract**

No published research to date has investigated the mental health experiences of Orthodox Jewish adolescents in the UK, although anecdotally, the Jewish mental health community is aware of the prevalence of mental health difficulties amongst young people. This lack of research highlights a serious gap in how to best support this population in the community and in mainstream services. As a first step into this field of study, this research explored the experiences of seven London-based Orthodox Jewish female therapists offering talking therapy to strictly Orthodox Jewish (Chareidi) female adolescents in the private sector, using semi-structured interviews. An interpretative phenomenological analysis of the interview data identified several themes: The therapists navigated personal and professional overlap when working within their own community, dealt with blurred boundaries, and managed the complexities of confidentiality within a close-knit community context. Furthermore, their therapeutic practice was culturally informed, and they applied cultural sensitivity with their clients. The therapists talked about how they helped Chareidi Gen Z on their journey to adulthood and how they experienced both feeling connected to their clients, and feeling disconnected when values were at odds with each other. The implications from this study included the need to engage Orthodox Jewish adolescents in future research so that their voices can be captured, the importance of continuing to increase culturally sensitive mental health promotion, education, and provision within the Chareidi community, and for mainstream services to facilitate access for the Chareidi community by prioritising culturally informed practices and community partnership work.

## 1. Introduction

### 1.1. Overview

The purpose of this study was to explore the experience of offering mental health (MH) support within the Orthodox Jewish (OJ) community. The aim was to embed this study within the existing body of research about the Jewish community. A distinction is made between the Jewish population as a *minority* group (statistically making up less than half a percent of the general population; Graham & Boyd, 2022), compared to *minoritised* groups, who are marginalised not due to their numbers but due to lack of social power, equity and/or racial oppression (Wingrove-Haugland & McLeod, 2021). Research on marginalised communities *per se*, for example to serve as a comparison, are thus not included in this study.

This chapter describes the researcher's personal relationship with the research topic, their position on how contemporary knowledge about MH and psychology originates from ancient wisdoms such as Judaism, and their epistemological and theoretical position. It addresses MH within the context of the OJ community, broader society, and adolescence, and explains the religious and sociocultural background of the OJ community. A systematic review is presented, to embed the present study within the existing body of literature, and finally, the rationale, aims, and research question of this study will be outlined.

## 1.2. Positioning the researcher

### 1.2.1. Personal position in relation to the research topic, and a disclaimer

I self-identify as an OJ woman. I view the world with a Torah<sup>1</sup> lens and navigate the modern, secular world from that position. As a member of a minority group, I believe my existence is based on my ancestors' survival through the ages as a persecuted and discriminated people, and because G-d<sup>2</sup> believes that I have a purpose to fulfil in this world (e.g., Dessler, 1963).

Whilst Jews have lived relatively peacefully in Western countries since the Holocaust, antisemitism remains rife (Community Security Trust, 2023). Alongside the intergenerational trauma that antisemitism has perpetuated over the ages, it influences how Jewish people think, behave, and function in society (Krauskopf et al., 2023).

As a female OJ trainee clinical psychologist, I consider myself an insider researcher. My identity as a religious Jew affected how I carried out this research, and I tried to be careful about bracketing my assumptions and biases throughout, with reflective journaling and supervision, seeking non-Jewish perspectives, and consulting with other Jewish therapists (Dörfler & Stierand, 2021).

It is considered an important Jewish value to protect the reputation of G-d, the Torah, and the Jewish people (Talmud<sup>3</sup> Yevamot, 79a). Judaism prohibits a 'Chillul Hashem' (literally, desecrating G-d's Name; based on Leviticus, 22:32), i.e., bringing harsh criticism upon G-d

---

<sup>1</sup> *Torah* in this study is defined as the totality of Jewish teaching, including the written text often referred to as the 'Old Testament' (which Orthodox Jews believe was received from G-d on Mount Sinai in 1312 BCE), later biblical texts, and the 'Oral Law' (or Talmud) that many believe was Sinaitic too but was written down in subsequent centuries.

<sup>2</sup> G-d's name is not printed in its complete form, unless when used for Jewish ritual, since the Torah forbids to erase, destroy, or desecrate the name of G-d (Deuteronomy, 12:4).

<sup>3</sup> The Torah is comprised of the Old Testament (the five books of Moses) and the *Talmud* (Oral Law). The Talmud is a written recording of the rabbinical debates in the 2<sup>nd</sup>- 6<sup>th</sup> centuries and is the legal commentary on the Old Testament and prescribes how Torah commandments should be followed. It also includes biblical interpretation, ethics, and customs.

and His teachings. It could be argued that by presenting in this study the views of individual Jewish therapists, by extension there is a risk of non-Jews losing respect for the Jewish community, Judaism, or even G-d, which is deemed a serious matter in Judaism (Ethics of the Fathers, 4:4). In this research, I was motivated not only to avoid a Chillul Hashem but also to shine a light on the Jewish community, and to offer beneficial and useful insights into the MH realm of the OJ community. I therefore wish to emphasise that whilst seven female OJ therapists' views and my personal interpretations of their voices are presented in this study, they do not represent the community as a whole or claim to speak for all Jews or all London-based, female, OJ therapists. I believe this disclaimer is crucial, as any generalisation could invalidate other OJ therapists' experiences, beliefs, and attitudes.

### **1.2.2. Position on the intersection of Judaism and psychology**

Philosophically, there is some ambivalence between Jewish thought and psychology. Whilst Judaism teaches that G-d is the omnipotent curer of all illness and encourages religious obedience, conformity, and deferring to rabbinic authority; psychology emphasises liberal values of independence and autonomy (Hess, 2018). Nevertheless, Judaism is not primarily focused on theological and philosophical discourse, and permeates all matters of practical, real-life, everyday issues. As such, Jewish writings comprise a large body of Torah law on health and social concerns, education and teaching, relationships, and community matters (Ives, 2016).

Judaism does indeed encourage people to seek support from medical and psychological professionals for issues pertaining to the body and mind (Haimovich & Leiser, 2017). The Torah teaches that it is helpful to consult with a therapist or mentor to talk through difficulties (*Acquire for yourself a teacher/Rabbi'*, Ethics of the Fathers, 1:16; and *'When*

*there is worry in a man's heart, talking it through can make him feel better'*, Proverbs, 12:25). Furthermore, psychological concepts are pervasive in Jewish thought and are rooted in the ancient traditions of the Torah. Judaism views a person's cognitive, emotional, and spiritual development (and the struggles therein) as a life-long journey of self-improvement, and psychological therapy is considered a method that can help with this process (Fish, 2011; Shabtai et al., 2016). Key Jewish ideas have developed into psychological theory, for example:

- A *'person's heart and thoughts follow his actions'* (Sefer HaChinuch 16, Aharon Halevi of Barcelona, 13<sup>th</sup> century) highlighted the interconnectedness of thought, emotion, and behaviour. This became a foundational principle of cognitive-behavioural therapy (CBT) as developed by Aaron T. Beck (1963).
- *'Anger can be treated by setting aside a time to practice calm'* (Hilchot De'ot 1:12, Maimonides, 12<sup>th</sup> century). It could be argued that this idea developed eventually into the Dialectical Behavioural Therapy principle Opposite Action.
- *'One who does one good deed will find it easier to do another'* (Bartenura, 15<sup>th</sup> century) illustrates the concept of behavioural activation.

The positivist principles of CBT appear to be largely compatible with Torah values and Jewish beliefs around thought, emotions, and behaviours (Shabtai et al., 2016). Beyond individual self-improvement, the Torah also instructs Jews to offer social, emotional, and economic support to those in need (Loewenthal, 2006a; *'The people of Israel are responsible for one another'*, Shavuot, 39a). This demonstrates how the Jewish value of social justice is regarded as a basic tenet of community wellbeing.

The Jewish psychological concepts described in this section shed light on the context of the OJ therapists who were interviewed in this study, and how their views on MH and psychology might be formed not only by their secular professional education but also by their religion and culture.

### **1.2.3. Epistemological and theoretical position**

A critical realist lens was adopted, acknowledging that social processes and contexts mediate reality (Willig, 2012), and that whilst there might be a real world, our understanding and knowledge of it is limited by our humanity (Sayer, 1992). Individuals' experiences are thus understood as being based on their subjective experiences of the world.

Jews are often excluded from conversations about diversity and inclusion (Baddiel, 2021; Golker & Cioffi, 2021). This can make them feel alienated and marginalised from discussions around culturally adapted MH provision (Gehl, 2014). As part of implementing social justice in research and clinical practice, Lyons et al. (2013) proposed that lived experiences of marginalised groups should be explored so that they can be improved according to their own values, rather than those dominant in society. Through applying cultural humility, such work should include intentional and continuous reflection on positionality; curiosity, listening, respect, and openness; a commitment to building mutual partnerships; and a critical consideration of the principles and rules that underlie the researcher's judgment and interpretation (Mosher et al., 2017). One method is to apply community psychology principles (Moritsugu et al., 2019) and acknowledge the sociocultural, religious, and historical contexts of its participants, and their beliefs and lifestyles that at times lay in contrast to the dominant Western worldview.

Bernal and Sáez-Santiago (2006) put forward a culturally centred framework that could aid community psychology work (see Table 1).

**Table 1**

***A community psychology framework (Bernal & Sáez-Santiago, 2006)***

---

Guidelines

---

Use native language

Consider relationships within the community

Acquire cultural knowledge

Joint understanding of metaphors

Tailor concepts, goals, and methods to the culture

Consider context

---

They argued that language included grasping the cultural norms and nuances of emotional expressions and mannerisms. The relationship dimension referred to the cultural understandings of relationships within a community, and how people relate to others outside of their community. Furthermore, they suggested that cultural knowledge, including an understanding of a community's history, customs, values, and metaphors could enhance cultural sensitivity. They argued that in community psychology practice, concepts, goals, and methods should be culturally informed, and that understanding a community's broader context was important.

As a OJ female trainee clinical psychologist, I brought this framework to this research and aimed to position my findings within the religious and cultural context that both I and my participants live in. As such, an epistemological position was adopted that aligned authentically with the values of the researched community.

### **1.3. Mental health in the post-pandemic era**

The coronavirus pandemic revealed how significant world events can result in people experiencing increasing levels of adverse MH (Office for Health Improvement & Disparities, 2022). Professional therapy bodies have published guidelines on how to reduce inequality in MH provision, and how to support people across demographic intersections such as race, gender, religion, class, etc. (e.g., British Psychological Society [BPS], 2022a; British Association for Counsellors and Psychotherapists, 2023). Prevalence rates of poor MH have risen particularly in the younger population, with children and young people (CYP) experiencing increased social problems such as bullying and loneliness, and higher levels of economic stress (BPS, 2022b; Newlove-Delgado et al., 2022).

Such patterns are similar in the Jewish community, with rates of poor MH in CYP having increased since the coronavirus pandemic (Graham et al., 2020). To date, whilst the existence of MH difficulties within the community has been increasingly recognised, and charitable community MH organisations have emerged to support Jewish CYP (Glaser, 2022; Jewish Chronicle, 2021; Jewish Weekly, 2021), little academic research about Jewish adolescents' MH has been published. Evidence of MH difficulties amongst Jewish adolescents, in particular in the UK, remains largely anecdotal. JTeen (2023), a London-based charity that supports Jewish adolescents via text message and helpline, reported that from 2021-2022, over 70% of the 766 adolescents who reached out to them sought support for relationship difficulties, anxiety, and depression. Noa Girls (2023), a MH charity for OJ adolescent girls, stated that in 2022 they supported 250 individuals in the UK, of which over 70% presented with anxiety and/or depression, and over 40% were dealing with difficulties in school, eating disorders or disordered eating, poor parental MH, safeguarding issues, self-

harm, and suicidal ideation. These organisations' reports demonstrate how the prevalence of an under-researched community and resulting publicly under-funded MH provision can increase the potential of overlooking serious wellbeing risks for young people, for example, self-harm, safeguarding issues, and suicide. Furthermore, it can perpetuate public services' disregard and marginalisation of this population's needs and create further disconnection between what is offered, what is accessed, and what is indeed effective in reducing MH difficulties in the community (e.g. Alvarez et al., 2022).

#### **1.4. The UK Orthodox Jewish community**

The 2021 UK Census estimated that approximately 288,646 people (0.46% of the population) who participated in the national survey identified as Jewish, with around 69% of the UK Jewish population based in Greater London and Hertfordshire (Graham & Boyd, 2022), and other OJ communities of significant size in Manchester and Newcastle (Kada, 2019). Within the Jewish population, the Orthodox community encompasses a wide spectrum of Jewish beliefs and practices. The focus of this study is the Chareidi<sup>4</sup> subgroup. The Chareidi (*adj.*, *plural* Chareidim) community is the fastest growing subgroup (Staetsky, 2022), with over 50% of Jewish births attributed to them (Mashiah, 2018). UK Chareidi communities are primarily located in the London Boroughs of Barnet and Hackney, Manchester, and Newcastle (Kada, 2019). Chareidim universally live a traditional form of Judaism and strictly comply with the Torah laws that govern their relationship with G-d and with fellow humans

---

<sup>4</sup> *Chareidi* (*lit. Heb.* trembling, pronounced *cha-ray-dee* with the German guttural *ch*) implies meticulous care in Jewish practice. This term will be used to describe the population researched, rather than 'Orthodox', or 'Ultra-Orthodox', because 'Orthodox' is the umbrella term for several denominations (for example, Modern Orthodox, *Chareidi*, and Chassidic). Whilst 'Ultra-Orthodox' is often used in the literature to describe *Chareidi* groups, it can be deemed offensive due to its negative connotations of the group's practice (Shafraan, 2014).

(Margolese, 1998). An insular, collectivist, and heterogenous community, Chareidim live close to each other in order to access social infrastructures such as synagogues, schools, and kosher food (Loewenthal & Rogers, 2004). Torah law delineates their ritual and everyday practices, values, and behaviour within the family, in business, and all other parts of life, including parenting, education, sexual behaviour, dress code, and speech (Schnall, 2006).

The Chareidi community prioritises keeping the outside world out, partly due to antisemitism, but also to strictly maintain a purity of culture and values (Holliman & Wagner, 2015). The community is greatly influenced by historical persecution and the intergenerational trauma that has persisted over the centuries (Gabbay et al., 2017). As such, Chareidim meet most of their health, educational, social, and economic needs within their own, self-contained community (Tkatch et al., 2014). However, due to limited numbers of qualified Chareidi doctors and therapists (Schleider, 2021), members at times do turn to the outside for physical and mental help (Freund & Band-Winterstein, 2017).

Rabbis play an important role, as they are considered the link in an unbroken chain that historically connects the Jewish people back to receiving the Torah on Mount Sinai (Gabbay et al., 2017). The strong sense of collective identity paired with rabbinical figures who interpret the Torah's teachings offers resilience and maintains the survival of Chareidim in what is perceived as a hostile world with opposing values (Freund & Band-Winterstein, 2017). Rabbis are consulted on Jewish legal and spiritual matters and guidance on family and relationship issues, health, and finances. Since religious communities largely view MH practitioners as irreligious (Rosmarin & Pirutinsky, 2020), they are more likely to access psychological support from clergy or OJ MH professionals, rather than mainstream MH professionals, even for serious conditions and despite the risk of moving in the same social circles (Hess, 2018; Wang et al., 2003). Rabbis can act as gatekeepers to support outside of

the Chareidi community by either endorsing or disapproving of external services and thus preventing access to activities that might conflict with religious views (Huppert et al., 2007; Kada, 2019; Leavey et al., 2007).

#### **1.4.1. Mental health and the Orthodox Jewish community**

Over two decades ago, Greenberg and Witztum's (2001) book 'Sanity & Sanctity' brought the intersection of MH and the Chareidi community to the fore, and in subsequent years, the existence of MH difficulties within the community became increasingly recognised (Golker & Cioffi, 2021). Stigma around MH is significant, with Chareidim describing feeling ashamed about accessing psychological therapy and expressing fear of losing their social status in the community and impacting their wider family network regarding marriage and job prospects, and entry to educational institutions (Greenberg & Witztum, 2013; Sharman & Jinks, 2019). Contrasting this, OJ therapists are also confronted with ethical dilemmas when clients grapple with leaving the OJ community and their system wants them to stay (Baruch, 2014). Nevertheless, a 25-year review highlighted that Orthodox Jews were increasingly open to receiving MH support (Schnall et al., 2014), and accessing psychological therapy has been endorsed by increasing numbers of Chareidi rabbis, particularly as they become overwhelmed with significantly complex issues brought to their pastoral and counselling care (Loewenthal, 2006b). Since the coronavirus pandemic, several community MH awareness initiatives endorsed by Chareidi rabbis, such as psychoeducational events for OJ parents about adolescent MH have begun to emerge, indicating that OJ MH organisations are keen to promote MH literacy and reduce stigma in the community.

Judaism prioritises the preservation of health (Deuteronomy, 4:15), and this religious precept may encourage OJ people to seek help despite their concerns regarding stigma

(Pirutinsky & Rosmarin, 2022). Since Chareidi individuals appear more open now to receiving MH support but are concerned about meeting professionals of different world views, their ambivalence toward mainstream MH services may be less related to MH support per se and more related to the perceived threat of being treated by a culturally insensitive practitioner (Haimovich & Leiser, 2017; Sharman & Jinks, 2019). Chareidim may also resist accessing statutory MH services due to concern about antisemitism (Schleider, 2021), and a fear that religious laws might be broken in therapy, for example regarding speech (not speaking badly about one's parents; Loewenthal, 2006b) and social or sexual behaviours (endorsing homosexual intercourse; Heilman & Witztum, 1997; Loewenthal, 2006a).

Greenberg and Witztum (2001) found that Chareidi clients with severe and enduring MH difficulties were over-represented in MH services, and under-represented with more minor difficulties, and they argued that this was due to OJ people accessing rabbinical and social support for minor psychological challenges, and only accessing professional help when difficulties were too serious to ignore or were no longer manageable within the community. Schnall (2006) suggested that at crisis level, Chareidim were indeed more likely to accept therapy from an OJ practitioner, despite an increased fear of breaches in confidentiality and likelihood of meeting them at communal events (McEvoy et al., 2017).

However, seeing a coreligionist for therapy does not only increase anxiety in clients about confidentiality. Rabinowitz (2014) found that when both client and therapist are OJ, conflict can arise in their relationship, if their religious observance differs. If the therapist is more strictly observant, the client might feel judged, and if the client is more observant, the therapist may question whether they or their practice is depreciated by the client.

Recent research in the US found that Orthodox Jews with anxiety or depression accessed MH support just as much as a non-Jewish control group (Pirutinsky & Rosmarin, 2022), putting the culturally specific stigma-narrative into question. They considered whether therapeutic provision within the community possibly *reinforced* exclusionary norms and stigmatic attitudes, and if culturally informed practice within mainstream services should be prioritised instead (Pirutinsky & Rosmarin, 2022). Ignorance about cultural and religious needs can create avoidable conflict (Gabbay et al., 2017), and mainstream therapists largely lack education on how to address religious and spiritual matters in therapy (Rosmarin & Pirutinsky, 2020). Rosmarin and Pirutinsky (2020) found that in a New York-based MH clinic, where non-religious and non-Jewish staff were familiar with the OJ population, OJ and non-OJ clients benefitted equally from seeing OJ and non-OJ clinicians for CBT (Rosmarin & Pirutinsky, 2020). Non-religious therapists' knowledge and respect about Chareidi beliefs, customs, and religious lifestyle (e.g., modest dress, same-sex clinician, avoiding appointments on Jewish holidays) appears to contribute to the success (Popovsky, 2010; Rosmarin & Pirutinsky, 2020).

Greenberg and Witztum (2013) suggested services use cultural brokers to help deliver culturally sensitive care. They also highlighted the risk of having community volunteers offer culturally specific support that was subpar to professional standards. They therefore argued that when developing services within communities, it was important to ensure quality control of culturally adapted therapy, and to increase opportunities for OJ people to train and qualify as professionally accredited practitioners, so that OJ clients were not only supported by culturally aware therapists, but also received effective, evidence-based care.

In the UK, the community psychology literature has explored the benefits of partnership work between NHS services and community organisations. Perry et al. (2018) explored the effectiveness of collaborating on and delivering a culturally informed psychoeducational course within the Chareidi community. Kada (2019) published guidance for MH practitioners on how to adapt CBT for the Chareidi community. He argued that access to healthcare for under-represented groups such as the Chareidi community could be improved by developing an extensive dialogue between mainstream services, Rabbinical and communal leaders, and OJ individuals with lived experience. This would help form a pathway for the Chareidi community to access already existing services. He also suggested for public services to be run from neutral, communal, satellite locations, to increase accessibility. Additionally, he advocated for creating rabbinically approved psychoeducational materials for the community, rather than signposting OJ clients to mainstream materials.

Golker and Cioffi (2021) explored the experience of Jewish therapists offering CBT to Chareidi adults. They found that therapists emphasised the importance of understanding Chareidi culture and being able to identify when their clients' culture-specific practice would be considered normative and when it might be pathological. Additionally, they suggested that growing numbers of MH community campaigns and MH conversations in synagogues have helped somewhat to confront the shame experienced by many Chareidim in relation to help-seeking. Whilst they highlighted increased suspicion and concern about confidentiality amongst Chareidim, they argued that building trust helped therapeutic alliance, and that trust could be increased through a shared understanding of religious beliefs and how explaining the compatibility of CBT with Torah values, using religious teachings to corroborate therapeutic practice, and seeking rabbinic guidance when needed helped clients to engage with therapy.

#### **1.4.2. Adolescent mental health within the Orthodox Jewish community**

Adolescence is the period of life between 10 and 24 years, characterised by significant physiological, psychological, and social change (Andrews et al., 2021). A meta-analysis of 192 epidemiological studies suggested that most diagnosable MH conditions begin during adolescence (Solmi et al., 2022). Within the OJ community, adolescence coincides with a significant increase in societal expectations. At ages 12 and 13, respectively, girls and boys reach bat/bar mitzvah and are henceforth required to fulfil the Torah commandments like adults. Students pursue both the national curriculum and Torah study during their daily schedule, and many move away from home for religious study by mid-adolescence. By early twenties, many adolescents are dating and preparing for marriage (Latzer et al., 2019). Overall, adolescence is a particularly demanding period in a OJ person's life (Gabbay et al., 2017).

To date, no research has explored the experience of OJ therapists offering support to Chareidi adolescents in the UK. In some areas, over half of the Chareidi community is under 16, with families having an average of seven children (Interlink, 2016; Pirutinsky et al., 2015), although there are currently no statistics about the number of Chareidi adolescents in the UK (Sharman & Jinks, 2019), nor how many have required or received community-based or mainstream MH support.

Chareidi CYP access mainstream services significantly less compared to their non-Jewish counterparts (Rowland, 2016). Sharman and Jinks (2019) found that school staff in OJ primary schools in Barnet believed that parents' low uptake of private or mainstream support for their children was due to stigma around mental MH, not wanting to pay for support, fear of social services, and an impression that statutory services had long waiting

lists and would not adapt their practice to the family's cultural and religious needs. Staff argued that MH terminology put parents off and that they were more likely to accept support if therapists were also Orthodox, rabbinic approval was sought, and the support was advertised as 'art' or 'play' therapy, rather than talking therapy or counselling.

In summary, the intersection of MH and the OJ community is embedded in Torah values around self-improvement and personal growth, a belief that G-d is the ultimate healer, and a collective religious responsibility to support those in need. Evidence to date about MH amongst Chareidi adolescents is largely based on community organisations' knowledge, rather than published research, and this gap highlights a risk of public services potentially overlooking serious mental ill health within the OJ community. The Chareidi community has increasingly opened its doors to MH support, but stigma and fear of practitioners who are culturally and religiously unaware remains prevalent. Whilst culturally adapted support within the community is advocated by some researchers, others highlight the risk of this reinforcing stigma and perpetuating unprofessional practice and have published evidence of OJ and non-OJ practitioners being equally effective at supporting OJ clients in a culturally sensitive mainstream therapy service.

To situate this study within the existing body of literature, a systematic review was undertaken. The following chapter illustrates the published evidence to date about the experience of offering MH support to the OJ community.

## **1.5. Systematic Review**

### **1.5.1. Introduction**

The purpose of this systemic review was to synthesise the existing literature's findings about therapists and community members' impressions and experiences of therapy for OJ individuals. In this review, the term stakeholder, which in the consultation literature is employed to describe different roles and positions within a wider system (see Madill & Sullivan, 2018), was used to group therapists and other community members who supported or were otherwise associated with OJ individuals who were accessing therapy. The objective was to situate the focus of the present thesis, therapists offering therapy to female Chareidi adolescents, within the existing body of knowledge. Cochrane's Effective Practice and Organisation of Care (EPOC) guidance for qualitative evidence syntheses (Glenton et al., 2020) was used as a review template. The present thematic synthesis sought to answer the following question:

*What does existing literature tell us about stakeholders' experiences of therapy for Orthodox Jewish individuals?*

### **1.5.2. Methods**

#### **1.5.2.1. Types of studies**

Initial scoping searches revealed scarce research focused on therapeutic work with OJ adolescents. Rather than reviewing literature about support for adolescents in general, it was decided, in consultation with the research team, to focus on OJ individuals across the lifespan accessing therapeutic support, as this seemed most relevant to situate the current research project within a context of understanding the interplay between MH and the OJ community. Since the present research project explored the experience of *offering* therapy,

rather than *receiving* therapy, this review also centred the perspective of therapists and other people involved in supporting OJ individuals.

Published and unpublished primary studies, in the English language, that used qualitative study designs such as interpretative phenomenological analysis, thematic analysis, and grounded theory were included. Unpublished studies were included due to the scarcity of published studies and were subject to the same quality appraisal. Mixed methods studies were included where it was possible to extract the data that were collected and analysed using qualitative methods. Purely quantitative research was excluded as it would not describe the depth and richness of people's experiences.

Studies graded as low using the Critical Appraisal Skills Programme (CASP; 2022; see Appendix A) for assessing the methodological limitations of qualitative studies were excluded, for example if they had no ethical approval from an established research ethics committee or were opinion and clinical papers. Careful consideration was taken to balance the inclusion of relevant literature, whilst simultaneously not compromising the credibility or trustworthiness of the review findings. As a result, some more innovative publications (and the insights therein) were omitted.

#### ***1.5.2.2. Topic of interest***

Studies were included that described stakeholders' experiences of therapy for OJ individuals.

#### ***1.5.2.3. Types of participants***

The participant pool was intentionally left broad in order to capture a variety of experiences. Existing literature suggested that a broad range of roles offer formal and informal MH support within the OJ community. This includes Rabbis, teachers, MH practitioners, or simply community members supporting others, with a variety of professional roles both within and

outside the MH field being represented (e.g., Galloway & Byrne, 2016; Perry et al., 2018).

Studies investigating the experience of familial caregivers (e.g., parents) or clients themselves were excluded, as the objective was to focus on the experiences of offering external sources of support.

#### **1.5.2.4. Types of interventions**

Interventions were required to include psychological/MH support, e.g., psychological therapy, or consultation on MH issues within the OJ community. Research settings that were entirely outside of the OJ context were excluded i.e., where neither participants nor clients (receiving support from participants) were OJ, and studies restricted exclusively to specialist, highly focused interventions around couple work, marital sexual practice, pre-/post-natal support, infertility, and marriage.

The SPIDER tool, developed to synthesise qualitative research (Cooke et al., 2012), was used to summarise the inclusion criteria (see Table 2).

**Table 2**  
**SPIDER criteria (Cooke et al., 2012)**

Spider Term	Review definition
Sample	Mental health practitioners and community members
Phenomenon of Interest	Offering therapeutic support to orthodox Jewish individuals
Design	Had a research methodology, participants, and ethical approval
Evaluation	Experience
Research type	Any qualitative or mixed methods research methods design

### ***1.5.2.5. Search methods for the identification of studies***

#### *Electronic searches*

The following electronic databases were searched<sup>5</sup>, as per recommendation of the School's Information Officer and existing literature on systematic reviews (e.g., Davies, 2019): CINAHL Plus, Scopus, EBSCOhost, Education Research Complete, MEDLINE, OpenDissertations, ProQuest Dissertations and Theses, PsycArticles, and the University of Hertfordshire electronic library database. Search strategies were developed for each database (see Appendix B).

Searches were limited to English. Databases were searched from 2012 until 27/10/2022. A ten-year frame was selected because it was believed that the target population of this research, contemporary adolescents, who have grown up in the digital age (e.g., with social media), are likely to experience communal life differently to generations before. The Jewish community and their approach to MH and stigma has shifted (Schnall et al., 2014), as has the support provision for CYP's MH, through the transformation programme that initiated CYP IAPT around a decade ago (Burn et al., 2020). Within this context, this review restricted publications to a time frame of ten years, with older publications being summarised earlier in the introduction<sup>6</sup>.

---

<sup>5</sup> Preliminary investigations indicated that systematic reviews conducted in Israel, where there is a significant population of Orthodox Jewish communities, used the same electronic databases as research conducted in Western countries such as the UK.

<sup>6</sup> Reference lists of the included studies were examined. Literature published before 2012 that was cited by four or more of the included studies and was relevant to the thesis was mentioned in the introduction. A list of these studies can be found in Appendix C.

### *Grey literature*

A grey literature search was conducted in the following sources to identify studies not indexed in the databases listed above: Cochrane Library, ResearchGate, and the Trip, Gale OneFile and Base databases<sup>7</sup>. Finally, Google Scholar<sup>8</sup> revealed around 13.2k results. The first 100 titles were eyeballed after sorting by relevance. Grey literature search strategies are in Appendix B.

### *Searching other resources*

Reference lists of all the included studies were reviewed. A cited reference search for all included studies was conducted in Google Scholar. Authors of included studies and researchers with expertise relevant to the review topic were contacted to request studies that might meet the inclusion criteria.

#### **1.5.2.6. Selection of studies**

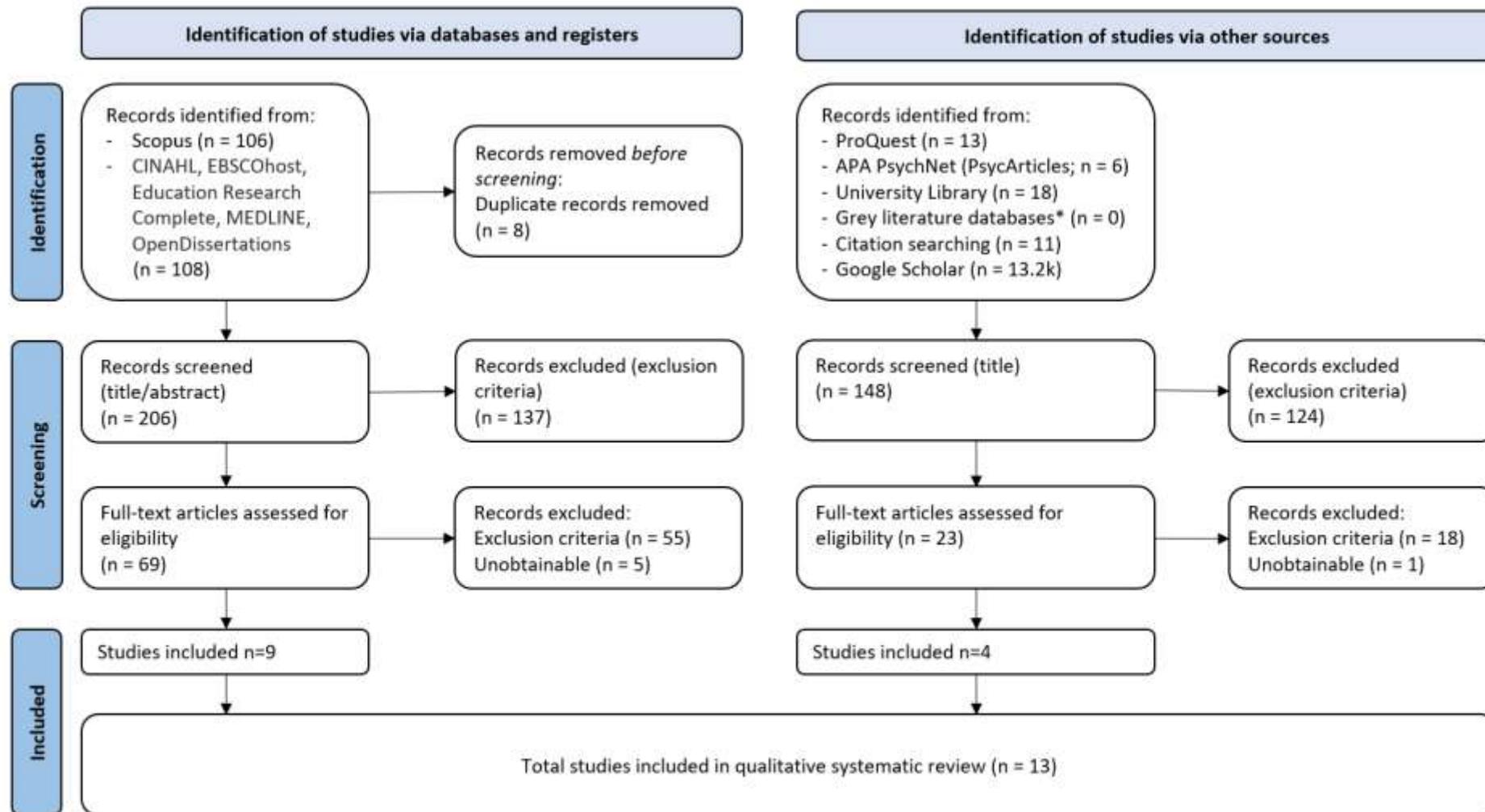
The initial search yielded 262 results which were filtered down to thirteen full-text articles. The PRISMA flow diagram (Page et al., 2021) in Figure 1 shows the process of screening and selecting studies for inclusion.

---

<sup>7</sup> [www.cochranelibrary.com](http://www.cochranelibrary.com); [www.researchgate.net](http://www.researchgate.net); [tripdatabase.com](http://tripdatabase.com); [www.gale.com/intl](http://www.gale.com/intl); and [www.base-search.net](http://www.base-search.net)

<sup>8</sup> [www.scholar.google.com](http://www.scholar.google.com)

Figure 1  
PRISMA flow diagram (Page et al., 2020)



\* Cochrane library, Trip, Gale Onefile, Open Access Thesis and Dissertations (OATD), Bielefeld Academic Search Engine (BASE), and ResearchGate

### 1.5.2.7. Characteristics of the included studies

Of the studies investigated in this review, all samples included Jewish participants only, except for Bloch et al. (2022), where religious affiliation was not defined for all participants, but included three secular Jewish, three non-Jewish, and twelve Jewish but religiously unspecified participants. Across all the samples, over two thirds of the participants were either OJ or Chareidi (see Table 3).

**Table 3**  
**Religious affiliation of participants**

Religious Affiliation [%]	Study
Chareidi [42.4%]	Band-Winterstein & Freund (2015), Box Bayes & Loewenthal (2013), Freund & Band-Winterstein (2017), Galloway & Byrne (2016), Golker & Cioffi (2021), Horwitz et al. (2019), Podolsky-Krupper & Goldner (2021), Wang & Perlman (2021), Whiteley (2016)
Orthodox Jewish, but not Chareidi [28.8%]	Band-Winterstein & Freund (2015), Baruch (2014), Freund & Band-Winterstein (2017), Galloway & Byrne (2016), Golker & Cioffi (2021), Keidar et al. (2021), Sharman & Jinks (2019), Whiteley (2016)
Secular Jewish [20.7%]	Band-Winterstein & Freund (2015), Bloch et al. (2022), Freund & Band-Winterstein (2017), Galloway & Byrne (2016), Golker & Cioffi (2021), Keidar et al. (2021), Whiteley (2016)
Jewish, but otherwise Unspecified [6.5%]	Bloch et al. (2022)
Non-Jewish [1.6%]	Bloch et al. (2022)

Participants held a variety of professional and community positions (see Table 4). One study (Galloway & Byrne, 2016) defined participants as community figures, partly involved in MH provision, but gave no further details.

**Table 4**  
***Participants' roles or professions***

Role [%]*	Study
Social workers [43.5%]	Band-Winterstein & Freund (2015), Freund & Band-Winterstein (2017), Wang & Perlman (2021)
Art therapists [13.6%]	Keidar et al. (2021), Podolsky-Krupper & Goldner (2021)
Rabbis [11.4%]	Baruch (2014), Box Bayes & Loewenthal, (2013), Horwitz (2019)
Other community figures [11.4%]	Baruch (2014), Box Bayes & Loewenthal, (2013), Galloway & Byrne (2016), Horwitz (2019), Sharman & Jinks (2019), Whiteley (2016)
Psychiatrists [9.8%]	Bloch et al. (2022)
Talking therapists [8.2%]	Golker & Cioffi (2021), Wang & Perlman (2021)
Other MH practitioners [2.2%]	Galloway & Byrne (2016), Whiteley (2016)

***\*As percentiles are rounded up, sub-totals may amount to more than 100%.***

Therapeutic experiences involved work with all ages (see Table 5).

**Table 5**  
***Types of clients seen***

Client type [%]	
Adults & families [36.4%]	Band-Winterstein & Freund (2015), Freund & Band-Winterstein (2017), Sharman & Jinks (2019)
Adults* [34.8%]	Bloch et al. (2022), Box Bayes & Loewenthal (2013), Galloway & Byrne (2016), Golker & Cioffi (2021), Wang & Perlman (2021), Whiteley (2016)
Working-age adults only [12.5%]	Horwitz et al. (2019), Podolsky-Krupper & Goldner (2021)
Children only [9.2%]	Keidar et al. (2021)
Adolescents only [7.1%]	Baruch (2014)

***\*Adult clients; but unclear if children/adolescents too***

Purposive and/or convenience sampling was employed by all studies except two. Snowball sampling was employed by four studies. Five studies were conducted in Israel, three in the United States, and five in the UK (London). Data collection for all studies involved semi-structured individual interviews, except Wang & Perlman (2021) who collected data through semi-structured focus groups. Research designs were all purely qualitative and included Consensual Qualitative Research, IPA, Grounded Theory, and Thematic Analysis. Details of the data extraction can be seen in Table 6.

**Table 6**  
**Data extraction table**

Authors (Year)	Country	Study aims	Sampling & Methodology	Sample Description	Findings (broad themes)	Strengths and limitations
Band-Winterstein & Freund (2015)	Israel	Explore how social workers express their cultural sensitivity in encounters with Chareidi clients	Purposive Semi-structured interviews. IPA	Jewish social workers (n=33; 40% modern orthodox, 33% secular, 27% Chareidi)	Themes: Social workers' preparation for the therapy encounter; Use of conventional Chareidi language and content of the therapy session; Therapeutic intervention: between rabbinical and professional authorities	Showed perspectives of insider and outsider therapists (Chareidi and non-Chareidi)
Baruch (2014)	USA	Explore lived experience of orthodox Jewish professionals trying to connect with at-risk youth, and how they approach religion in their work	Purposive/snowball Semi-structured interviews. IPA	Orthodox Jewish professionals (n=13; Rabbis, MH workers, mentors)	Themes: Being authentic & non-judgmental; Not taking it personally & bracketing own values; Being real & connecting to humanness; Focusing on well-being, not religion	Insider researcher, excluded some sections of Chareidi community due to language barriers (females/ Yiddish-only speakers)
Bloch et al. (2022)	USA	Identify psychiatrists' challenges and successful strategies in the care of Chareidi patients	Convenience/purposive & snowball Semi-structured interviews. Thematic analysis	Psychiatrists (n=18; 72% secular Jewish, 27% non-Jewish)	Challenges: Fear of the outside world; Limited disclosure and concerns about confidentiality; Diagnostic/prognostic complexity; Conflict between Jewish law/community norms and treatment protocol. Strategies: Proactively involve patient's system, set boundaries when necessary; Proactively assess/address patient's fear of stigmatization; Assess patient's symptoms in context; Enlist help of trusted/experienced third party; Appeal to Chareidi Jewish values/beliefs	Insider researcher, primarily inpatient settings
Box Bayes & Loewenthal (2013)	UK	Investigate views and understandings of depression in the Chareidi community, and beliefs around how it should be treated	Purposive Semi-structured interviews. IPA	Chareidi community members (n=10; mental health workers, Rabbis, and other community figures)	What helps: using religiously approved psychotherapy, culturally aware therapists, alternative healing practices, prayer, distraction, exercise and relaxation, support from Rabbi, reading Jewish self-help books, orthodox Jewish support services, medication as a last resort. Recommended use of culture-brokers. Found that stigma was disincentive for seeking and receiving support and treatment	Insider researcher, limited direct experience of actual therapy, focus on lay support, fairly superficial data
Freund & Band-Winterstein (2017)	Israel	Explore how social workers deal with cultural differences between them and their clients, and how they describe Chareidi society's coping abilities with the mentally ill in their community	Purposive Semi-structured interviews. IPA	Jewish social workers (n=27; 40% modern orthodox, 36% secular, 33% Chareidi)	Themes: Secrecy and concealment; Compassion within community; Clash of professional and cultural values; improvements in attitudes to MH help-seeking	Secular researchers, appeared quite biased and critical of Chareidi community

Galloway & Byrne (2016)	UK	Investigate attitudes towards talking therapies of members of the North London Chareidi community	Purposive Semi-structured interviews. Thematic analysis	Jewish community members working in statutory and voluntary organisations (n=6; 83% orthodox)	Themes: Changes within statutory services: have greater knowledge of orthodox clients' needs/values; Changes within orthodox Jewish communities: reduced stigma, increased knowledge about MH issues; Importance of orthodox Jewish community services and resources: culture-specific provision is pivotal; More still to do: stigma still has impact on help-seeking	Illustration of how sustained partnership between statutory services and BME communities can reduce stigma and improve accessibility, but: outsider researchers, no reflection on relationship with participants
Golker & Cioffi (2021)	UK	Explore the experience of orthodox Jewish CBT therapists working with orthodox Jewish clients	Convenience/purposive Semi-structured interviews. Thematic analysis	Jewish CBT therapists (n=5; 80% orthodox)	Themes: Cultural understanding; Confronting shame; Building Trust; Religious beliefs	Insider researcher, restricted to CBT therapy only
Horwitz et al. (2019)	Israel	Investigate perspectives on scrupulosity amongst Chareidi Rabbis	Purposive Semi-structured interviews. Grounded theory	Chareidi Rabbis in leadership positions (n=15)	Rabbis used their expertise in Jewish law to support individuals with symptoms of scrupulosity, preferred liaising with orthodox Jewish therapists although most were also open to working with culturally aware and respectful non-religious therapists	Insider researcher, restricted to Rabbis supporting men
Keidar et al. (2021)	Israel	Explore how non-Chareidi art therapists experience art therapies with Chareidi children	Snowball Semi-structured interviews. Consensual Qualitative Research	Jewish art therapists (n=17; 82.4% secular, 17.6% modern orthodox)	Themes: Perceptions of the significance and objectives in arts therapy with Chareidi children; Influence of the cultural difference between therapist and clients on emotional experience and therapeutic relationship; Use of arts in therapy; Systemic aspects	Outsider perspectives, females only
Podolsky-Krupper & Goldner (2021)	Israel	Examine how Chareidi therapists perceive art therapy	Snowball Semi-structured interviews. IPA	Chareidi art therapists (n=8)	Themes: Perception of MH; Challenges arising in therapy; Encounter between therapy and religion; Encounter between art and religion	Balance of client/therapist voices (though client-reported data not relevant for the review); females-only, restricted to art therapy
Sharman & Jinks (2019)	UK	Explore views of staff in orthodox Jewish schools in Northwest London about therapeutic services	Purposive Semi-structured interviews. Thematic analysis	Orthodox Jewish school staff (n=7)	Themes: Schools recognise their role in supporting pupils' needs; Parents' attitude to MH provision is diverse; Reasons for poor uptake of therapeutic services; Attitudes to external agencies; Importance of therapists' religious beliefs; Lack of signposting awareness within community for culture-specific MH provision	Participants not MH support providers or receivers, females only
Wang & Perlman (2021)	USA	Understand the challenges and successful integration of social work practice and Judaism	Purposive Semi-structured focus groups. Thematic analysis	Orthodox Jewish social workers and psychologists/counsellors (n=18; 77.8% and 22.2%, respectively)	Themes: Reasons for choosing social work as a profession; Integration of religion and social work; Tensions in practice; Resolving religious and professional tensions	Range of mental health practitioner voices
Whiteley (2016)	UK	Explore the representations of and responses to mental health conditions within the Chareidi Jewish community in North London	Convenience/purposive Semi-structured interviews. Thematic analysis	Chareidi mental health practitioners (n=7)	Themes: Chareidism and the place of emotional difficulties within the community; Community awareness and understanding of mental health conditions; stigmatisation of mental health conditions and its implications; Limitations of accessing support and services; Progression and what is needed	Outsider researcher

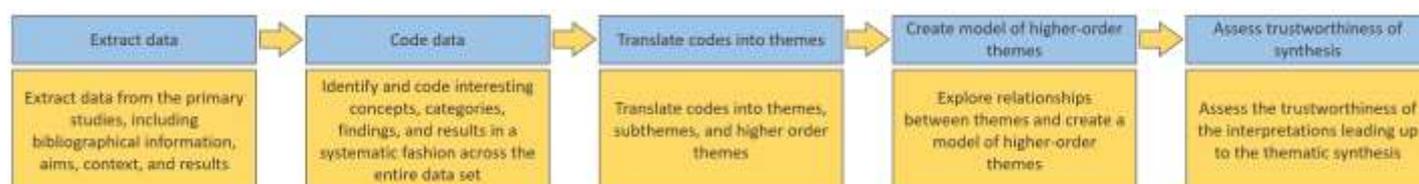
### **1.5.2.8. Quality assessment of the included studies**

A quality assessment of the included studies was conducted using CASP (2022; Appendix A). Seven studies did not discuss the relationship between researcher and participant (Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Galloway & Byrne, 2016; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021; Wang & Perlman, 2021). Holding both insider or outsider positions in relation to participants and the topic of study can result in significant personal biases and preconceptions. In order to minimise this, it is suggested that self-reflection about one's assumptions is essential throughout the research process (Aburn et al., 2021). It is acknowledged that whilst this process was not described in over half the included studies, quality was otherwise rated overall as high.

### **1.5.2.9. Data management, analysis, and synthesis**

A thematic synthesis (Flemming & Noyes, 2021; Thomas & Harden, 2008) was conducted to analyse the data. This was conducted in line with Cruzes and Dybå's (2011) process (see Figure 2) to elicit key themes, subthemes, and concepts across the qualitative studies and presenting them in a thematic map that answered the review question.

**Figure 2**  
**Five steps of thematic synthesis (Cruzes and Dybå, 2011)**



First, data extraction involved reading all selected papers and getting immersed with the data. Second, data was coded using an integrated approach as described by Cruzes and Dybå (2011), i.e., both inductive (ground-up) coding, and deductive coding, whereby codes

developed in any one of the studies were then applied to the other studies. Extraction included any findings relevant to the review question, such as beliefs, emotions, and behaviours and how they might relate to working within OJ culture and religion. Third, the list of codes was organised into higher order and sub-themes. Fourth, the themes were synthesised into a thematic map which depicted how the themes answered the review question, whilst keeping in mind that this was one possible version of a thematic map at the exclusion of other possibilities. Lastly, the trustworthiness of the synthesis was assessed using CERQual (Confidence in Evidence from Reviews of Qualitative research), a tool developed by the GRADE (Grading of Recommendations Assessment, Development and Evaluation) working group (Lewin, 2018). The four components of CERQual are; methodological limitations, coherence, adequacy of data, and relevance (see Appendix D). Throughout, bracketing was employed to minimise bias or subjective influence over the review (Smith et al., 2022). Journaling was used throughout the data collection and analysis process, and the research consultants were engaged in reviewing the codes, themes, and thematic map, to facilitate ongoing reflection.

### **1.5.3. Results**

#### ***1.5.3.1. Overview***

The aim of this review was to investigate what the existing literature tells us about stakeholders' experiences of therapy for OJ individuals. Findings are presented under two higher-order themes as depicted in the thematic map in Figure 3, namely; Challenges of the therapy experience, and Strategies that help the therapy experience. Themes were divided into subthemes, namely; Emotions, Beliefs, Culture, and Language and Communication.

**Figure 3**  
***Thematic map***

Challenges of the therapy experience	Strategies that help the therapy experience
<ul style="list-style-type: none"> <li>• Emotions</li> <li>• Beliefs</li> <li>• Culture</li> <li>• Language &amp; Communication</li> </ul>	<ul style="list-style-type: none"> <li>• Emotions</li> <li>• Beliefs</li> <li>• Culture</li> <li>• Language &amp; Communication</li> <li>• 'Being'</li> </ul>

It became apparent that many study findings discussed therapy for OJ individuals as an experience of developing rapport with clients, with a view to increasing engagement and trust. Beyond the more pragmatic therapeutic strategies of 'doing', e.g., discussing confidentiality, or normalising difficulty, 'being' with clients was also considered, e.g., being empathic, or authentic (Baker, 2016). 'Being' was included as an additional subtheme for the Strategies theme. Although all included studies specifically investigated therapy experiences with OJ clients, many findings were found to be relevant for all clients. Therefore, for each subtheme, generalisable findings are presented first, and findings that specifically address engagement with OJ clients are presented after.

### ***1.5.3.2. Challenges of the therapy experience***

#### *Emotions*

Several studies reported that stigma, fear, and distrust can affect engagement and rapport-building and that clients can feel suspicious, ashamed, and terrified (Baruch, 2014; Bloch et al., 2022; Box-Bayes; Golker & Cioffi, 2021; Freund & Band-Winterstein, 2017; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Whiteley, 2016). The social stigma can affect help-

seeking, lead to denial of illness, and can become a barrier to treatment adherence (Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019). Keidar et al. (2021) found that once parents knew they could trust the therapist, they would let the child be seen without them. There were fears that their culture-specific beliefs and lifestyle would not be approved of or would be misinterpreted as symptoms of mental ill health (Galloway & Byrne, 2016; Golker & Cioffi, 2021; Podolsky-Krupper & Goldner, 2021), to the extent that statutory services and social services were avoided because of the worry that they might encourage people to leave the community or discard their practices and beliefs (Box Bayes & Loewenthal, 2013; Galloway & Byrne, 2016; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019). Several studies found that trust-building was particularly difficult if the therapist was not from the same culture (e.g., Galloway & Byrne, 2016; Keidar et al. (2021).

*“They think, well... how can anybody else understand what I’m talking about when I talk about emunah and bitachon<sup>9</sup>... they feel uncomfortable to expose that to someone who has no understanding of what it means.”* (Community member; Galloway & Byrne, 2016; p. 40)

Podolsky-Krupper & Goldner (2021) found that OJ clients displayed lower emotional expression due to the need to maintain secrecy and because of the Jewish value of not expressing anger or jealousy<sup>10</sup>. Keidar et al. (2021) found that OJ children displayed a pronounced lack of emotional literacy. Intergenerational trauma from the Holocaust was

---

<sup>9</sup> *Emuna* and *Bitachon* (Hebrew) both loosely mean ‘belief’. According to 13<sup>th</sup> century Torah scholar Moshe ben Nachman, known as Nachmanides, *Emunah* is the knowledge that G-d created and continues to run all of creation. *Bitachon* means faith, or trust in G-d (Sefer HaEmunah *U’Bitachon*, ch.1)

<sup>10</sup> “Be not easily provoked to anger”, and “Rabbi Elazar HaKapar said, ‘Envy, lust and [the desire for] honour put a man out of the world’.” (Ethics of the Fathers, 2:10 & 4:21, respectively)

also perceived to affect how Jewish clients might manage their emotions, for example using learned behaviours such as disconnecting from emotions as a strategy to survive (Whiteley, 2016).

A worry about the threat of the 'outside world' appeared to be particularly pertinent for OJ clients and stakeholders (Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Horwitz et al., 2019; Whiteley, 2016), where difficulties were shrouded in secrecy and concealment due to the real consequences on marriage prospects, employment, and education. Support might therefore be avoided until difficulties are very severe and receiving help is unavoidable (Freund & Band-Winterstein, 2017; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Whiteley, 2016).

### *Beliefs*

The review findings revealed clients' and stakeholders' multi-faceted beliefs: Clients might be unclear about what therapy is or does (Golker & Cioffi, 2021). Both might want a culturally compatible or even identically religious therapist (Horwitz et al., 2019; Sharman & Jinks, 2019), others might prefer a therapist outside of the community so that they feel more able to 'reveal their secrets' (Podolsky-Krupper & Goldner, 2021).

Clients might overvalue the therapist and thus abdicate themselves of their responsibility to self-educate (Bloch et al., 2022), or view therapy solely as a pragmatic approach to helping them fulfil their roles effectively (Keidar et al., 2021). Furthermore, they might prefer private therapy if they believe that statutory services offer a poor service (Sharman & Jinks, 2019).

Clients can have significant concerns about confidentiality, stigmatisation, and a need to uphold an image within their community (Bloch et al., 2022; Box-Bayes; Golker & Cioffi, 2021; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Whiteley, 2016).

*“In our service, we [have] a, very, very private entrance and a different exit, so that nobody bumps into each other. Also, [we manage] the appointments so that there are no two people going to be coming in at the same time.”* (CBT therapist; Golker & Cioffi, 2021; p. 10)

Several studies described how therapists navigate having different personal beliefs and values to their clients (Band-Winterstein & Freund, 2015). Non-OJ therapists can feel discomfort, inauthentic, and silenced when adjusting to the clients’ cultural needs, can feel judged and scrutinised and develop increased alertness and caution towards their clients (Keidar et al., 2021; Wang & Perlman, 2021), and can experience internal frustration and anger about their clients’ lifestyle and beliefs (Baruch, 2014; Keidar et al., 2021). They may need to manage their own antagonism, bias, and prejudice towards the community (Baruch, 2014; Bloch et al., 2022), and can have difficulty accepting their clients’ ‘abnormality’ narrative when presentations would be deemed ‘normal’ in secular contemporary society (Freund & Band-Winterstein, 2017). In contrast, OJ therapists described how their religion informs their clinical practice and how they viewed their work as a religious calling (Baruch, 2014; Wang & Perlman, 2021).

### *Culture*

Therapeutic experience can be influenced heavily by the cultural clashes and conflicts between therapist and client, in terms of values, beliefs, and contexts (Band-Winterstein & Freund, 2015; Baruch, 2014; Box Bayes & Loewenthal, 2013; Golker & Cioffi, 2021; Horwitz et al., 2019; Keidar et al., 2021; Sharman & Jinks, 2019). Clients might be unfamiliar with self-expression and seeking support for an individual, if they live in a collective society (Freund & Band-Winterstein, 2017; Wang & Perlman, 2021).

To deliver culturally sensitive support, therapists must assess symptoms within an OJ context and resolve whether a behaviour or belief is considered 'normal' or 'pathological' in that community (Bloch et al., 2022).

*"I [...] had to learn a lot more about her specific [sect] because part of her symptoms could have been seen as culturally normative[...] [R]eading certain texts from a rabbi and finding messages in it could be normative amongst her family and friends. However, the degree to wh[ich] she was doing it was no longer normative." (Psychiatrist; Bloch et al., 2022; p. 6)*

For OJ clients, cultural beliefs and practices can reinforce non-engagement with support, when psychological difficulty makes it harder for them to meet the demands of orthodox practice, for example praying<sup>11</sup>, or observing *Shabbat*<sup>12</sup> (Bloch et al., 2022; Horwitz et al., 2019; Wang & Perlman, 2021). In the OJ community, the rabbinical authority is prioritised over the therapeutic one (Band-Winterstein & Freund, 2015; Freund & Band-Winterstein, 2017; Horwitz et al., 2019). Therefore, liaising with rabbis, who are viewed in the OJ community as arbiters between individuals and *halacha*, Jewish law (Horwitz et al., 2019), allows for a holistic understanding of how an individual should observe the religion according to their personal circumstances, whilst accounting for their treatment plan (Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Horwitz et al., 2019).

*"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*

---

<sup>11</sup> According to Jewish law (*Talmud Brachot*, p. 8a), males aged thirteen and older are obligated to pray in a quorum of at least ten males, three times daily.

<sup>12</sup> According to the fourth of the ten commandments given at Sinai, Jews are required to 'Remember the *Shabbat* day, and keep it holy' (Exodus, 20:8). Orthodox Jews do not travel, turn on electricity and technology, cook, work, or use money every *Shabbat*, and observe several rituals including prayer, festive meals, and lighting candles (Bix, 2020).

*thought and be familiar with what the rabbi says... This is an essential element when working with mental health clients in Haredi society.”* (Social worker; Freund & Band-Winterstein, 2017; p. 620)

Therapists can be challenged when contending with the wider system that might include not only a client’s family and wider community, but also ‘cultural brokers’ who live in the community and are also knowledgeable in the MH field (Bloch et al., 2022; Box Bayes & Loewenthal, 2013). For example, in the OJ community, rabbis are not only viewed as a superior authority compared to a clinical expert but are also sometimes the gatekeepers to uptake of services (Band-Winterstein & Freund, 2015; Freund & Band-Winterstein, 2017; Horwitz et al., 2019; Whiteley, 2016). Educating rabbis about MH can therefore help whole communities (Horwitz et al., 2019; Whiteley, 2016). Therapists working with OJ clients need to learn about how their treatment protocol might be affected by Jewish law and community norms in relation to *Shabbat*, dietary laws, religious holidays, treating the opposite sex, safety risks of clients using *tefillin* and *tallis*<sup>13</sup>, *yichud*<sup>14</sup>, marital laws, and laws of speech<sup>15</sup> (Bloch et al., 2022; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021). For example,

*“If the client is a man, I may leave the door open. I avoid locking the door because of yichud [prohibition against seclusion of a man and a woman who are not married or close blood relations].”* (Social worker; Band-Winterstein & Freund, 2015; p. 976)

---

<sup>13</sup> *Tefillin* (phylacteries) and *Tallis* (prayer shawl with strings) are used in prayer and can pose a safety risk to psychiatric patients, due to their strings and leather bands (Bloch et al., 2022)

<sup>14</sup> See ensuing quote

<sup>15</sup> Jewish laws of speech include avoiding speaking badly about others, or oneself (Glinert et al., 2003)

### *Language and communication*

Each culture will have their own conceptualisations of MH (Bloch et al., 2022) and attitudes to accessing services (Whiteley, 2016). For OJ clients, not only language can be a significant barrier to communication, e.g., if clients speak Yiddish only, but also reading between the lines, and understanding body language (Keidar et al., 2021).

*“We just don’t speak the same language. A lot of it is in the subtext, in the ability to decipher both the hidden messages and the body language.”* (Art therapist; Keidar et al., 2021; p. 6)

### **1.5.3.3. Strategies that help the therapy experience**

#### *Emotions*

Trust, engagement, and therapeutic alliance can be augmented when therapists address their clients’ concerns and expectations, normalise, and validate difficulties, proactively discuss the fear of stigmatisation, demonstrate their knowledge of the client’s culture, and encourage work on culture-specific goals (Band-Winterstein & Freund, 2015; Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017). In Horwitz et al. (2019), rabbis used their authority to calm clients’ anxieties and fears about G-dly punishment, for example, they took charge of client’s fears by placing religious responsibility on themselves:

*“Where a woman was still anxious and unwilling to accept a rabbi’s ruling, the rabbi said, It’s ok, and if not, your gehinom<sup>16</sup> is on me.”* (Horwitz et al., 2019; p. 90)

---

<sup>16</sup> Hebrew term for ‘hell’

With OJ clients who live in small close-knit communities, confidentiality is a significant factor that can affect engagement. Particularly when therapists are part of the same community as their client, discussing how they will manage situations where they might encounter each other socially can help create safety and trust (Golker & Cioffi, 2021).

### *Beliefs*

Several studies highlighted the importance for therapists to bracket their stereotypes about a client's culture, and personal values that might be different to their client's (Band-Winterstein & Freund, 2015; Baruch, 2014; Galloway & Byrne, 2016; Golker & Cioffi, 2021), and to reflect on their cultural biases and tendencies to stereotype or feel heightened emotions about other cultural groups (Golker & Cioffi, 2021; Keidar et al., 2021). A further recommendation was to learn about the philosophical world outlook of clients, especially about their beliefs and values around therapy and the development of MH difficulties (Freund & Band-Winterstein, 2017; Golker & Cioffi, 2021). Different opinions were found about OJ clients preferring a therapist from their own community, or from the outside. Keidar et al. (2021) argued that some clients might reveal more to non-Jewish therapists as clients believe they will not be judged badly and feel more assured that information about them will not be passed on to others in the community. Conversely, OJ clients might be more willing to work with someone who understands and lives according to Jewish law and culture too (Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019), or at least demonstrates knowledge of the culture (Bloch et al., 2022; Freund & Band-Winterstein, 2017).

*“Well, a counsellor for that school would have to be someone from the community because others they would not understand, they [would] start*

*asking the children questions which are not appropriate.”* (School staff member; Sharman & Jinks, 2019; p. 339)

In Horwitz et al.'s (2019) study, even the participant with the strongest opposing view to seeking outside support (a Chareidi rabbi) acceded that psychological symptoms of a non-religious or cultural nature could be treated with secular techniques.

Specific to OJ clients, some studies argued that the therapeutic experience could be enhanced if therapists aligned themselves with the client's religious values and beliefs, by using religious teachings to explain concepts and principles (Golker & Cioffi, 2021; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021), utilising therapeutic models that were compatible with Torah values, e.g., CBT (Golker & Cioffi, 2021; Horwitz et al., 2019), and by considering how the Torah offers guidance on how to deal with emotional difficulties (Box Bayes & Loewenthal, 2013; Whiteley, 2016). Importantly, it was argued that therapeutic alliance could be damaged if therapists challenged religious teachings (Golker & Cioffi, 2021; Horwitz et al., 2019).

### *Culture*

Keidar et al. (2021) found that helping clients to develop self-expression, an emotional vocabulary, and practice decision making increased clients' ability to engage with therapy. Additionally, it was argued that flexibility and creativity was needed when accommodating a client's needs and making cultural adaptations to therapy, e.g., discussing culturally appropriate topics only, and adjusting to the needs of the OJ lifestyle (Bloch et al., 2022; Keidar et al., 2021). Particular features within more strictly observant sections of the OJ community are that firstly, clients might have large nuclear families and therefore feel

unfamiliar with receiving individual attention such as a personal therapeutic space (Keidar et al., 2021).

*“To give them a warm place where the child can feel themselves again, which is hard when there are so many children at home.”* (Art therapist; Keidar et al., 2021; p. 4)

Secondly, some topics are taboo and never discussed with children and unmarried young adults, for example sex. Keidar et al. (2021) argued that a therapist’s self-education by consulting with client, family, community figures, and other therapists was important because knowledge of cultural values aided therapists to not only understand the culture of their client, but also helped them detect when a behaviour might be considered a red flag, e.g., if a child talked about anything sexual.

Religious meditation and meditative prayer were suggested as a culturally sensitive intervention to relieve anxiety (Box Bayes & Loewenthal, 2013; Golker & Cioffi, 2021). It was found that rabbis applied their expertise in Jewish law to support their students with symptoms of scrupulosity, i.e., compulsive moral or religious observance. They also used religious concepts to counteract compulsions by appealing to their clients’ emotions, for example telling them to stop repeated handwashing as it could be viewed as stealing from the water supply owner (Horwitz et al., 2019).

#### *Language and communication*

The therapy experience can be enhanced if therapists avoid using jargon. Additionally, it helps to use culture-specific conventional language, which for OJ clients might include religious metaphors, teachings, and stories, and being aware of euphemisms (Band-Winterstein & Freund, 2015; Keidar et al., 2021).

*“One day, I called a client and she said: ‘I’m in a situation’... I said: ‘What situation?’ Then I understood that she was pregnant.”* (Social worker; Band-Winterstein & Freund, 2015, p. 979)

Art therapy approaches were highlighted as a useful approach to bridge language barriers and promote culture-specific artistic expression (Keidar et al., 2021). Further recommendations included proactively using a whole system approach, to communicate and deliver interventions across the whole system, including not only the professionals and the wider family but also the rabbinic authority, community volunteer, translator, and school (Band-Winterstein & Freund, 2015; Bloch et al., 2022; Golker & Cioffi, 2021; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019). This can not only help with shifting understanding, beliefs, and attitudes across the system (Band-Winterstein & Freund, 2015), but also with establishing therapeutic goals, setting boundaries, psychoeducation, and earning trust across the system (Bloch et al., 2022; Golker & Cioffi, 2021; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019; Whiteley, 2016). It also means that the therapist can enquire what might be culturally appropriate or forbidden when working with a child (Keidar et al., 2021).

*“It’s very important to have guidance about cultural sensitivity... to have someone who knows the population instruct you.”* (Art therapist; Keidar et al., 2021, p. 11)

Sometimes, self-disclosure about one’s own religious or cultural background can help with building trust (Bloch et al., 2022; Podolsky-Krupper & Goldner, 2021).

*“[U]sually, [if] people [...] would ask questions about your faith [or] level of observanc[e] [...], you would not capitulate. But in this particular case, I think*

*[disclosure] really help[s] to [...] forge some sort of alliance [...] [O]therwise, it becomes a barrier.” (Psychiatrist; Bloch et al., 2022; p. 8)*

It can help to be explicit about not wanting to impose ones' own values onto the client, and an exchange of rules can help build rapport (Baruch, 2014; Bloch et al., 2022).

Psychoeducation can help too, for example educating about the need for gathering a detailed history. However, trust is sometimes built when therapists accept and anticipate limited disclosure, because secrecy can be deeply ingrained in communities who fear the outside world (Bloch et al., 2022).

Band-Winterstein & Freund (2015) argued that a therapist can act as an interpreter and advocate between the OJ client and the outside world. Working directly with communities can be helpful in building trust both within the therapy room and beyond. Studies recommended collaborating on community MH campaigns, increasing MH awareness via synagogues, offering training for culture-specific community services (Golker & Cioffi, 2021; Sharman & Jinks, 2019), liaising with cultural brokers (Box Bayes & Loewenthal, 2013) and developing joint publications with community partners (Galloway & Byrne, 2016). Working with closed and more marginalised communities might also require planning around who in the community is best approached for referrals (Box Bayes & Loewenthal, 2013; Keidar et al., 2021). Further recommendations included working with schools to identify problems (Sharman & Jinks, 2019), and increasing accessibility to statutory services by employing OJ practitioners (Galloway & Byrne, 2016). A sustained partnership between statutory services and local communities can reduce stigma and improve accessibility (Galloway & Byrne, 2016; Golker & Cioffi, 2021).

*'Being'*

The quality of 'being' with a client refers to the mindful stance one takes as a therapist and the motivation of wanting to develop connectedness and presence in clinical practice (Baker, 2016). The included studies described several ways of 'being' that appeared to help the therapeutic experience. Several studies described having cultural humility and sensitivity, and how accepting one's limits of knowledge can help forge a trusting therapeutic alliance (Bloch et al., 2022; Horwitz et al., 2019; Keidar et al., 2021). They argued that it was important for therapists to respect the client and their world, and to recognise which red lines not to cross. Qualities they found to help were, for example, being authentic, open to learn, non-judgmental, owning one's clinical, but not cultural expertise, and remembering that communities are heterogenous (Baruch, 2014; Keidar et al., 2021; Rowland, 2016; Sharman & Jinks, 2019). Further 'being' qualities described were, transcending cultural difference and connecting to humanness, speaking to shared values, and creating a genuine connection (Baruch, 2014; Bloch et al., 2022; Golker & Cioffi, 2021). Several studies maintained that it was important for practitioners to practice ongoing reflectivity and to own their personal values, norms, and beliefs, and to contrast them with their clients' (Band-Winterstein & Freund, 2015; Baruch, 2014; Freund & Band-Winterstein, 2017; Golker & Cioffi, 2021; Keidar et al., 2021). A particular state of 'being' was described in Podolsky-Krupper & Goldner (2021), where OJ therapists spoke of pursuing their career because offering therapy was viewed as a religious value. They described how their relationship with G-d was influenced by the work and added value to their personal religious life.

*“Everything is connected. The Torah enriches therapy, and the therapy wonderfully enriches the Torah.”* (Art therapist; Podolsky-Krupper & Goldner, 2021, p. 738)

#### **1.5.4. Assessment of confidence of the review findings**

CERQual (Lewin et al., 2018) was used to assess the trustworthiness of the review findings (Appendix D). Methodological limitations included limited reflexivity around the researcher-participant relationship or not acknowledging a study’s particularly biased and critical narrative around the OJ community. Freund and Band-Winterstein (2017) described Chareidi society as,

*“...characterized by severe enforcement and supervision patterns, [where] individuals are strictly supervised, and are expected to follow and fulfil demanding rules and procedures* (p. 615)

They added that,

*“... narrow, closed attitudes and labelling reinforce the exclusion of the mentally ill, increasing their shame, guilt and alienation.”* (p.622)

Additionally, six study samples included over 80% females, and 2 study samples included over 80% males, with 64% of the combined sample being female. This resulted in seven out of nine subthemes drawing data from five or more (predominantly) single-sex studies.

Otherwise, there were no concerns about how well-supported the themes were across the included studies (coherence). Adequacy determined the degree of richness and quantity of data, and it was found that at least half of all the included studies contributed thick data to each theme, except the Language and Communication Challenges and the Culture Strategies

themes, to which only three and two studies contributed data, respectively. Relevance assessed study context in relation to the review question and was rated high.

In summary, overall trustworthiness in the review findings was rated as high.

#### **1.5.5. Discussion**

This thematic review outlined two main themes, Challenges of the therapy experience, and Strategies that help the therapy experience, which were subdivided into Emotions, Beliefs, Culture, and Being. Most findings, although explored within an OJ context, were relevant to all communities and cultures. Many findings appeared to centre around the rapport-building stage at the beginning of therapy when trust and engagement are in infancy. Findings specific to OJ close-knit and insular communities focused on how to manage confidentiality within a 'village mentality', where everyone knows each other and there are real fears about social consequences to mental ill health, how to involve rabbis in therapy, considering the effect of religious lifestyles on therapeutic practice (e.g., working with the opposite sex), and the benefits of using Jewish sources therapeutically.

Findings across the studies portrayed rich data on the experience of working with OJ clients, and how collectivist culture and religious lifestyle affects clients' beliefs, behaviours, and ways of engaging with therapy. Most studies were conducted by insider researchers, some of which were presenting their own OJ communities, and others who reflected as secular, non-orthodox Jews on the experiences of their OJ brethren. Sensitivity, humility, and curiosity was present across studies and revealed valuable insights into working with a minority religious community.

The studies were conducted in the UK, in the United States, and in Israel. Israeli and American studies researched experiences of social workers, art therapists, and Rabbis; and

psychiatrists, youth mentors, and MH practitioners; respectively, and studies in the UK focused on CBT therapists in one study, and community engagement in four. The prevalence of studying not only the experience of professionals, but also of community stakeholders, perhaps highlights the community psychology values that contemporary research is pursuing at this time.

This finding perhaps mitigates a possible limitation of this review, that talking therapy, the focus of the present thesis, was under-represented, with talking therapists being participants in only two included studies.

Global MH has recently been significantly impacted by the coronavirus pandemic (Nochaiwong et al., 2021). Since most of the included papers in this review collected data before the pandemic, some of the findings may be outdated. It is therefore suggested that research into MH in the Jewish community at the present time is essential as it can offer direction for MH provision in the post-pandemic era.

To date, the literature has not sufficiently explored the experience of offering therapy to OJ female adolescents specifically. None of the studies included in this review focused on adolescent MH within the UK OJ community. The present thesis therefore sets out to explore how the therapy experience with adolescent females aligns with the findings of this review.

### **1.6. Rationale and aims of this study**

As part of the diversity and inclusion agenda to explore different cultures' attitudes and values around therapy, further studies are needed to identify how people with MH difficulties can be supported across demographics such as ethnicity, race, and religion (NHS England, 2020). Rather than superimposing dominant, Western, secular models of therapy

on all communities, culturally sensitive research-based evidence should inform how to best support the diverse communities in the UK (Samier & ElKaleh, 2023).

The dearth of research investigating MH in adolescent Chareidi populations highlighted a gap between literature and anecdotal evidence. The challenge of engaging Chareidi adolescents as research advisers, not to mention as research participants, as described later in the methodology section, highlighted a barrier to involving them in MH research. Perhaps developing trusting conversations within the Chareidi MH community could be a first step to exploring MH in Chareidi youth? This study therefore explored the experiences of OJ therapists offering support to Chareidi adolescents.

This study investigated a specific religious minority community in the UK. Additionally, the focus of this research was restricted to females because in Chareidi society, sociocultural and religious gender-segregation begins in infancy (Rowland, 2016). Whilst this study considered how findings could be generalised to other communities, in particular those who identify as being different to the dominant host culture, it is acknowledged that the specific cultural and religious themes found in the present study might not be universal.

This study aimed to answer the following research question:

*What is the experience of Orthodox Jewish therapists offering therapy to  
Chareidi female adolescents?*

With MH difficulties in adolescents increasing since the coronavirus pandemic (BPS, 2022b), and MH care for CYP being woefully underfunded (Davies, 2021), the present felt like an opportune time to find out how therapists experienced their work with this population.

### **1.7. A note about language**

As illustrated, the OJ community encompasses a wide spectrum of Jewish beliefs and practices. Since the focus of this study is the exploration of MH within a specific subgroup of the OJ community, the term Chareidi is used to describe therapists' clients, since participants were asked to speak about their Chareidi clients specifically. The therapists themselves, however, self-identified across several OJ subgroups and are therefore described as Orthodox Jewish.

## **2. Methodology**

### **2.1. Overview**

An overview of the research design employed in this study is outlined in this section. First, the selected research methodology is described, including a rationale behind this choice. Then, details of the participatory research design are provided. Subsequently, ethical considerations, and processes for recruitment, data collection, data analysis and quality assurance are discussed.

### **2.2. Design**

A qualitative design was selected because it was deemed the most suitable method for exploring the depth and richness of each individual's lived experience (Barker et al., 2015). Seven participants engaged in online semi-structured individual interviews. Using a critical realist lens, the aim was to answer the research question by exploring the subjective nature of individuals' experiences of reality as mediated by their religious and cultural understandings and their other intersecting identities.

#### **2.2.1. Rationale for using Interpretative Phenomenological Analysis (IPA)**

Interpretative Phenomenological Analysis (IPA) was selected as the most suitable qualitative method for this study, as it allowed an in-depth and rich analysis of the meanings that participants attached to their experiences (Smith & Nizza, 2022).

IPA views individuals to be in direct relationship with their environment, culture, and language, and argues that these interactions shape how people make sense of their experiences. IPA recognises that in order to understand experience, we are dependent upon participants' descriptions. IPA's phenomenological, idiographic, and interpretative approach

sheds light on individuals' experiences from their frame of reference. There were several reasons for selecting IPA as the research method. Firstly, IPA's focus on in-depth analysis of rich, idiographic data, was regarded as best suited to the research question of exploring individual therapists' experiences. With little research to date having investigated the experience of offering therapy to chareidi adolescents specifically, an in-depth analysis of idiographic data was deemed a suitable first step to exploring this area of interest. Secondly, IPA is appropriate for small sample sizes, with purpose-fully selected participants, which was an inevitable outcome for this project, since the pool of eligible research participants was relatively small. Thirdly, rather than relying solely on participants' own descriptions, their experiences are understood by *interpreting* their accounts and situating the researcher *within* the dialogue rather than separate from it (Smith et al., 2022). This particular characteristic of IPA was significant as the primary researcher engaged with the data from a perspective of having lived experience of the area under investigation. This meant that whilst their personal views were bracketed, their interpretations were embedded in background knowledge about the community and culture. Whilst other qualitative methods also consider participants' meaning making and experience (Busetto et al., 2020), they require larger sample sizes than IPA, and focus primarily on the themes found across participants (Smith et al., 2022).

IPA is theoretically rooted in phenomenology, hermeneutics, and idiography (Smith et al., 2022). A brief overview of these concepts follows, in order to further demonstrate the suitability of IPA for this study.

### **2.2.1.1. Phenomenology**

Philosopher Edmund Husserl described phenomenology in the early 20<sup>th</sup> century as the enquiry into subjective human experience. Later phenomenologists included Martin Heidegger, Maurice Merleau-Ponty and Jean Paul Sartre (Smith et al., 2022). Husserl's original ideas about phenomenology are briefly presented here, and Heidegger's ideas are presented further down in the discussion about hermeneutics.

Husserl argued that rather than examining experience purely through lenses of realism (*there is objective knowledge*) or idealism (*knowledge is entirely subjective, or in the mind*), phenomenological enquiry helps us understand how the world appears to our awareness through our own experience of it (Smith et al., 2022). Through phenomenological enquiry, we reflect upon our immediate or lived experiences. In Husserl's exploration of epistemology, i.e., how we come to *know* things, he took a descriptive approach and distinguished between external or 'outer' perception (*äussere Wahrnehmung*) and internal, or 'inner' perception (*innere Wahrnehmung*). He highlighted how when we experience things in the world, this can involve an interpretation of how we experience things that are 'out there', externally to us, for example our sensory perception alongside any taken-for-granted preconceptions we might have previously developed about such an experience. He argued that by bracketing our 'outer perceptions', we can pay attention to what is happening inside us, i.e. our inner thoughts, emotions, or embodied representations of the experience itself (Moran, 2013). In IPA, this descriptive, phenomenological approach allows a researcher to investigate their participants' experiences (Smith et al., 2022). Through the process of bracketing, the researcher centres participants' experiences and suspends judgments emerging from their own lived experience (Dörfler & Stierand, 2021).

Heidegger moved beyond Husserl's epistemological focus, and considered ontology, the science of being, i.e., how we come to understand the world through our *being* in the world (*Dasein*). Heidegger argued that it was impossible to experience a phenomenon without referring to our lifeworld (*Lebenswelt*), i.e., our understanding of the world and our life experience (Neubauer et al., 2019).

### **2.2.1.2. Hermeneutics**

Hermeneutic phenomenology, the philosophical basis of IPA, argues that we subjectively understand the world by interpretation, or hermeneutics. Based on Heidegger's views on ontology, the present study assumes that participants interpreted their lived experience based on their individual lifeworlds.

Hermeneutics has a strong tradition in Judaism and was traditionally the process of talmudical interpretation of biblical texts (Cushman, 2011). Schleiermacher (1998) argued that modern hermeneutic theory not only involved a textual interpretation based on linguistic conventions, but also an interpretation of the cultural understanding, intentions, and context of the author. He suggested that by interpreting not only text, but also author, hermeneutics formed the basis of a holistic analysis.

Smith et al. (2022) defined the dynamic and iterative relationship between text and author, utterance and speaker, part and whole as the hermeneutic circle. For example, it means that to understand a whole person, we consider parts of them, for example, their thoughts, feelings, actions, and context, and to understand the parts of a person, we also consider them as a whole. IPA applies the hermeneutic circle by taking an iterative approach to initially interpreting an individual participant's experiences in isolation, then within their larger context of multiple experiences, and finally alongside other participants' experiences,

whilst dynamically moving up and down these levels to expand the interpretation. IPA applies a double hermeneutic; whilst the participants' interpretation of their experiences is defined as a first-order interpretation, the researcher's interpretation of their interpretation is defined as second order (Smith et al., 2022).

### ***2.2.1.3. Idiography***

Idiography involves understanding the specific details and particularities of individual experience. In contrast, the nomothetic approach explores experience across multiple individuals. This results in experiences being grouped together and turned into a 'universal' experience, or statistical average, where differences between individuals are subsumed and the average arguably describes nobody directly (Barlow & Eustis, 2022). In IPA, the idiographic nature of the analysis means that the particular experiences are spotlighted so that the specific group of people and their unique contexts are better understood. In the present study, the idiographic nature of IPA allowed participants to speak in detail from their personal perspectives and to draw upon their subjective, rich experiences both as therapists, Orthodox Jews, and as being members of the same community as their clients.

### **2.2.2. Stakeholder Consultation and Participatory Research Design**

Key principles of participatory research include direct involvement of stakeholders in the research. Stakeholders are actively sought out to provide consultation on recruitment, and data collection, analysis and interpretation. This not only empowers stakeholders to have a voice in research and reduces the power hierarchy between researcher and researched, but also allows research to be directly informed by community-driven aims and objectives (Caretta & Pérez, 2019; Conrad & Scannapieco, 2021).

Stakeholder consultation was central to the present study and included two stages. First, stakeholders were consulted during the development of the research project. Second, once the research protocol was established, a stakeholder consultation group was formed to guide the research process.

For the initial stage, stakeholders were consulted to explore their views on research priorities, narrow down the particular focus of this research, and formulate the research question itself. This preliminary collaboration included consultations with a senior local Chareidi Rabbi, several local Chareidi therapists, and charitable organisations (Noa Girls and JTeen), all involved in supporting local Chareidi female adolescents and their families. These consultations highlighted the need for explorative research that would start bridging the gap between local, anecdotal knowledge, and published research.

Attempts to involve Chareidi adolescents at this stage proved challenging. Two young women were initially consulted on the design of the recruitment poster (Appendix E) and interview schedule (Appendix F) but declined to offer further consultation due to health reasons and anxieties about privacy and confidentiality. This highlighted the challenge of involving Chareidi adolescents, particularly adolescents with lived experience of psychological distress, in research. It was therefore decided that developing trusting conversations within the Chareidi MH community was perhaps a first step to exploring MH in Chareidi youth.

In the subsequent stage, following approval by the university research ethics committee, two OJ female stakeholders were engaged to offer consultation throughout the research process. They were selected because of their experience of both offering and receiving therapy within the local Chareidi community. Their role, as well as my responsibilities towards them,

was explained to them with the help of a consultant's agreement, which they both signed in advance of offering any consultation (Appendix G). We met every three months, on five occasions, together with the supervisory team. Additionally, several in-depth consultations were held individually with the stakeholders. Of note, the principal and external supervisors held dual roles, and both supervised the research project and participated in the stakeholder consultation. The principal supervisor, external to the Jewish community, reported that their attendance at stakeholder meetings provided them with valuable context to make sense of participants' experiences. The external supervisor supported the project with their academic and clinical expertise, but also with their inside knowledge as a member of the OJ therapy community.

Consultants suggested changes to the interview schedule, for example, asking participants about their personal experience of therapy and supervision. They also recommended introducing interview questions with some background information about the researcher's aims and expectations, to guide participants in their responses, help forge rapport between researcher and participant, and help them develop relational safety with the researcher. For example, introducing questions about identity with some background information about having multiple identities, helped participants decide how to reflect about their identities as female OJ therapists.

Consultant meetings also served as a space to reflect on issues pertaining to the research topic, such as how to define terms such as 'Chareidi' or 'Orthodox Jewish', the stigma of poor MH across cultures and communities, and how consultants and participants felt about the OJ therapy community being portrayed in research. Issues around confidentiality within a small community were discussed, for example, how it related to recruitment, data

collection, and dissemination of findings. Finally, evolving thematic maps were shared, and findings were discussed, in order to increase overall research-validity through triangulation (Caretta & Pérez, 2019). Consultants' reflections about their project involvement are in Appendix H.

### **2.3. Ethics**

Ethical approval was obtained from the University of Hertfordshire Ethics Committee (Protocol number LMS/PGT/UH/04938; Appendix I). Guidelines for ethical research practice were adhered to, including how to conduct data collection online (BPS, 2021a, 2021c).

Prior to seeking consent for participation, participants and research consultants were given digital copies of the information sheet, and a preview of the interview schedule (Appendices J and F, respectively). Time was taken to answer any participant and consultant queries.

Consent to participation was obtained online (Appendix K), and a formal agreement clarified the consultants' and primary researcher's roles (Appendix G). The confidentiality policy, details of how data would be securely stored, and withdrawal policies were described in those forms.

Participants were informed in detail about the confidentiality policy and the limits to it, i.e., that appropriate services would be contacted if there were concerns about their or anyone else's immediate safety. Due to the sensitive nature of confidentiality within a small, close-knit community, and the scarcity of eligible participants, anonymisation of participants' names and identifying details, and those of their clients, was critical. The process of anonymisation of their data was reiterated during interviews as needed, and all participants were sent their quotes and pseudonyms in advance of finalising this paper, in order to allow

them to consent to publication or request deletion, further anonymisation of their quotes, or a pseudonym change. All participants consented to the selected quotes being published.

The Data Protection Act (2018) was followed to protect participants' and consultants' identities. All identifying material, i.e., interview recordings and demographic data were stored electronically on cloud storage (OneDrive). Full transcripts were only viewed by the primary researcher and an external professional transcriber, who signed a non-disclosure confidentiality agreement (Appendix N). All anonymised transcripts were saved as password protected documents on an external hard drive and will remain securely stored for a maximum of 5 years, in line with the University of Hertfordshire Data Management Policy (2023).

Participants' and consultants' wellbeing was prioritised throughout all research stages. They were informed that whilst no psychological distress during interview (or consultant meetings) was anticipated, they would be offered space to discuss and reflect, and were sent details of local support services upon interview completion/initial consultant meeting (Appendix M). Continuous self-reflexivity helped establish research validity and accountability. Methods used included bracketing, introspection, discursive deconstruction, and ensuring emotional safety for researcher and participants/consultants (see below; Ahern, 1999; Bowtell et al., 2013; Ikävalko & Brunila, 2019). No participants or consultants disclosed any distress. Upon completion of all the interviews, participants were entered into a raffle for a £50 high-street shopping voucher, which the winning participant received. Consultants were financially reimbursed for their time, as approved by the research ethics committee.

## **2.4. Procedure**

### **2.4.1. Recruitment**

A purposive sample was reached by contacting therapists through social media and local contacts. Following receipt of ethical approval, the recruitment poster was advertised in a Whatsapp group for local Jewish MH practitioners, and eligible candidates were contacted directly.

### **2.4.2. Data collection**

Once participants had read the information sheet, signed the consent form, and discussed any queries about the research process, they were invited by email to attend a 90-minute Zoom semi-structured interview at a time of their convenience. Whilst the interview was driven by pre-determined open questions, an inquisitive, non-judgmental, and Socratic style of questioning was employed to draw out rich descriptions of thoughts, emotions, and concepts. Four participants attended 90-minute interviews, and three participants attended two 45-minute interviews across two days. Following an interview debrief, participants received an email including information about local support services.

### **2.4.3. Interview schedule**

The interview schedule was developed in consultation with stakeholders, supervisors, and researchers who had conducted interviews in a similar area of research (Golker & Cioffi, 2021). It set out to gather background information about participants' training and supervision experiences and explore their experiences of working with Chareidi female adolescents. Interviews explored therapists' therapeutic experiences and the meanings that they made in their work with Chareidi female adolescents and was guided by the participants on what they decided to disclose. It examined if and how their religious identity

played a part in the therapy process, how the therapeutic space was negotiated between therapists and clients that are members of the same close-knit minority community, and how stigma, high levels of fear and suspicion, and confidentiality were navigated within this context. It explored what therapists believed their clients' reasons were for accessing support privately from them as coreligionists, and their impressions of possible barriers to their clients accessing statutory services. The interview schedule was sent by email in advance, to allow participants to familiarise themselves with the questions.

#### **2.4.4. Pilot interview**

The interview schedule was piloted with an OJ female therapist who works with Chareidi working-age adults, rather than adolescents, to test out procedures and receive feedback on the interview. Whilst the interview schedule was well-received, and the therapist felt put at ease and comfortable to engage with sensitive questions, they also encouraged more curiosity and bracketing of assumptions about fellow OJ therapists' experiences, since preconceptions could influence how questions were asked, and how participant responses were managed.

#### **2.4.5. Data Transcription**

All recorded Zoom interviews were stored on the university cloud storage and shared with the professional transcriber, who sent anonymised transcriptions via encrypted email to the primary researcher. Accuracy was verified by cross-checking audio and text files.

## 2.5. Participants

### 2.5.1. Inclusion and exclusion criteria

In line with Chareidi preferences for same-sex therapists (Rosmarin & Pirutinsky, 2020), female talking therapists, accredited by a professional body with a Professional Standards Authority accredited register (examples in Table 7) were recruited. Therapists near-accreditation, i.e., who had completed over 300 hours of supervised practice, were also eligible for participation, if they met all other criteria.

**Table 7**

***Examples of Professional Standards Authority accredited registers***

Register
British Association for Counselling and Psychotherapy (BACP)
British Association for Behavioural and Cognitive Psychotherapies (BABCP)
Health and Care Professions Council (HCPC)
UK Council for Psychotherapy (UKCP)



Therapists were eligible for participation if they self-identified as having an OJ lifestyle and Torah observance. Eligibility also included having seen at least two Chareidi female adolescents for direct therapeutic intervention. Therapists were restricted to northwest London, due to geographical differences in Jewish lifestyle, although their clients could be located in any area of London.

### 2.5.2. Participant demographics

The pool of eligible participants was small; demographics are therefore described very broadly, to protect participants' identities. Seven female OJ talking therapists, based in northwest London, aged 30-70, participated in this study. The sample size was determined

by Smith and colleagues' (2022) recommendation for IPA professional theses. Therapists had trained in several therapeutic modalities, were accredited or near accredited by at least one of the bodies in Table 7, received regular supervision, and most worked with both Jewish and non-Jewish clients.

## **2.6. Data analysis**

Data analysis followed guidance from Smith et al. (2022) and consultation with an IPA researcher from the Birkbeck University IPA Research Group<sup>17</sup>. Interview transcripts were analysed one by one, to protect the idiographic process. Analysis followed six stages, namely, reading and re-reading, line-by-line exploratory noting, developing experiential statements, searching for connections across themes and developing personal experiential themes (PETs), moving to the next case, and finally, looking for patterns across cases and developing group experiential themes (GETs; Smith et al., 2022).

During the first stage, each interview was read and re-read, whilst cross-checking the interview recording. Bracketing at this stage involved annotating transcripts with initial thoughts and ideas and noting a brief overall reflective summary of each interview.

Exploratory notes were developed and written on the right side of the transcript page and included a line-by-line analysis that included highlighting descriptive, linguistic, and conceptual features, including key words, metaphors, repetitions, and personal reflections and interpretations. Simultaneously, experiential statements, i.e., concise summaries of the exploratory notes, were developed and written on the left side of the transcript page (see Appendix N for an extract).

---

<sup>17</sup> [www.ipa.bbk.ac.uk](http://www.ipa.bbk.ac.uk)

At this stage, NVivo Pro 12 (QSR International, 2018) was used to facilitate the grouping of transcript sections into experiential statements and PETs. Each transcript uploaded into a separate NVivo file and clustered into superordinate and subordinate PETs (example in Appendix O), using process of abstraction, polarisation, and subsumption. Patterns between themes were thus grouped together; oppositional, or convergent and divergent ideas were grouped together; and subordinate themes were incorporated under more general superordinate themes (Smith & Nizza, 2022). A self-reflective process throughout the analysis, including discussion with the supervisory team and the consultants, ensured that themes remained grounded within the participants' accounts. For each participant, PETs were printed and mapped out on paper (example in Appendix P) and then consolidated into a document listing superordinate and subthemes (example in Appendix Q). Whilst the above process was completed for each participant, separately and independently from the other participants, the final stage included a cross-case examination of PETs, to help draw out GETs. This was again conducted through finding commonalities, and the process of abstraction, polarisation, and subsumption. Finally, a process of triangulation completed by reviewing the findings with consultant team, who felt that the themes broadly matched their experiences of being OJ female therapists in the local community.

## **2.7. Quality assurance**

The CASP (2022) quality indicators, as described in the systematic review, were consulted to achieve high research quality. Additionally, an IPA-specific assessment of quality and validity, using criteria recommended by Smith and colleagues (Smith & Nizza, 2022; Smith, 2011a, Smith 2011b), found that this study was phenomenological, hermeneutic, and idiographic; delineated a clear description of all study procedures; offered a credible, coherent, and

sufficiently in-depth analysis; included extracts of at least four out of seven participants for each subtheme (see Table 8); and was interesting and engaging not only for readers connected to the specific topic (i.e., therapy within the OJ community), but also for readers unfamiliar with the OJ community.

**Table 8**  
***Frequency of themes across participants***

Participants	GETs and subthemes					
	1.1.	1.2.	2.	3.	4.1.	4.2.
Rivka		x	x		x	x
Devora			x	x	x	
Rachel		x	x	x	x	x
Esther	x	x	x	x		x
Malka	x			x	x	x
Miriam	x	x	x	x	x	x
Leah	x		x	x		x

A breakdown of Smith's (2011a) criteria highlighted the following:

*Have a clear focus.* This study included an exploration of the experience of therapists as an embodied, cognitive, affective, and behavioural manifestation. The interview questions asked about experience from different angles, i.e., in relation to the multiple identities that therapists held, the interaction between their professional and personal lives, their views on Chareidi adolescence, and the cultural and therapeutic values that informed their beliefs, opinions, and experiences. As such, the study had a clear focus on therapists' experiences.

*Have strong data.* The transcripts covered detailed descriptions for all the interview questions for each participant. Whilst some participants gave richer responses than others, and Socratic questioning could have evoked more detailed responses from more guarded

participants, given the restricted length of the interview a balance was sought between obtaining richness and covering the questions that were deemed important. Overall, study was rated as having strong data.

*The paper should be rigorous.* Smith (2011a) asserted that for a study of this size, at least half of the participants should contribute to each theme. Rigour was achieved with every participant contributing useful data to at least four out of six subthemes.

*Sufficient space must be given to the elaboration of each theme.* Whilst this study presented 4 GETs and 6 subthemes in total, several further themes could have been described, e.g., how therapists managed risk and safeguarding in independent practice, experiences of working with the system around their clients, and how they navigated and combined their multiple identities not only as therapists but also as mothers, wives, and community leaders. Due to the size of this doctoral thesis however, a balance was sought between presenting meaningful themes that were particularly prevalent across all participants and elaborating enough in each theme. Sufficient space was given to discuss each subtheme, but deeper interpretation might have offered a richer analysis.

*The analysis should be interpretative, not just descriptive.* Interpretations for each extract were not only descriptive, but also conceptual. However, whilst they conveyed the researcher's engagement with the double hermeneutic, a more detailed interpretation of the linguistic patterns, pauses, repetitions, and temporality may have offered further insights into the participants' experiences.

*The analysis should be pointing to both convergence and divergence.* Similarities featured very strongly in this study, and efforts were made to capture differing views and experiences, in order to highlight not only convergence, but also divergence, primarily to uphold the IPA

value that each person will experience phenomena differently (Smith et al., 2022).

Divergence was described in most GETs, and one GET ('Experiencing connection and disconnection'), divergent ideas were its core theme.

*The paper needs to be carefully written.* Feedback from the consultant team was that the results section was a clear and easy-to-read narrative of the findings. As a research project that incorporated the voices of stakeholders and valued their opinion, their feedback denoted a desirable outcome.

Smith's (2011a) criteria above were expanded to four quality indicators of excellence (Nizza et al., 2021; see Table 9).

**Table 9**  
***Four indicators of high-quality IPA (Nizza et al., 2021)***

---

Quality indicator

---

Constructing a compelling, unfolding narrative

Developing a vigorous experiential and/or existential account

Close analytic reading of participants' words

Attending to convergence and divergence

---

Whilst the present study is not judged as having achieved the quality indicators to perfection, validity and quality was rated as good, because:

- It conveyed a coherent narrative, which was unfolded from one extract to another, with each extract portraying an additional element or perspective of the story.
- The narrative illustrated existential and experiential perspectives of participants' accounts, including their visceral, value-driven, and emotion-laden reactions to their experiences.

- Applying a double hermeneutic included presenting an interpretation of each extract, whilst oscillating between part and whole, i.e., accounting for the idiographic detail, and incorporating it into the broader narrative.
- Lastly, convergence and divergence were illustrated across themes and the narrative sufficiently conveyed participants' individuality, and their commonalities.

## **2.8. Reflective processes**

### **2.8.1. A note on bracketing and self-reflexivity**

I admit feeling a considerable weight of responsibility to not misinterpret my participants' quotes, but also accept that the hermeneutic circle is a significant feature of my selected research methodology.

A rigorous reflective process to bracket researcher assumptions and judgments, acknowledge biases, and actively seek out blind spots, was undertaken throughout all the research stages. Reflective writing, sampled in Appendix R, helped me consider how my lived experiences as a female member of the London OJ community and student of Jewish religious thought, and as a clinician and academic researcher all influenced my beliefs, ideas, and emotions about the research topic, how I approached the different research stages, and how I interpreted the interview data. The process of self-reflexivity, bracketing, and collaboration with the stakeholder consultants helped me engage in self-awareness, intentionality, and to approach the data with purpose. Nevertheless, my status as an insider researcher affected the development of the research question, recruitment, interviewing, engagement with stakeholder consultants, data analysis and interpretation, and steered the direction and emphasis of each research decision (Levitt et al. 2022).

### 2.8.2. Researcher experience of the participants

Due to the need to protect participants' identity, rather than presenting details about each participant individually, some reflections on my experience of interviewing the participants is provided.

During recruitment, there was a familiarity between me and the participants due to inevitable shared social connections. To quote a participant, Jewish people tend to 'place' one another, and this can help build rapport. Nevertheless, familiarity did not preclude the need to build relational safety, and for one participant, this was particularly relevant: I interviewed her across two sessions, and I felt that during the first session, she was more guarded in her responses, more serious-looking, and delved less deeply into her emotions. In the second session, she smiled more, seemed more relaxed, and perhaps felt more comfortable speaking with me. She explored her emotions more with me and described a greater depth of experience. This highlighted the moral significance of thoughtfully addressing how to put participants at ease during research interviews.

How participants responded to questions during the interviews also appeared to differ depending on their therapeutic approach, level of professional experience, and knowledge of IPA. Varying levels of reflective thinking were apparent across participants, and some spoke more about what they *did* in therapy, rather than how the experience *felt*. The difference between participants speaking more about tasks and goals, versus taking a contemplative meta-position perhaps also seemed to reflect the therapeutic models they practiced, and it propelled me to devote more effort in drawing out their experiences.

Participants were at different stages of their career, and this became apparent in the interviews. My impression was that the more experienced therapists appeared more

confident and described very nuanced ways of understanding their work, and less experienced therapists appeared to feel more challenged by and unsure about clinical dilemmas they faced.

One participant was knowledgeable about IPA; this resulted in a particularly meaningful interview for me, and included rich data because she was aware of what type of information would be useful to me.

Overall, I found the interviews engaging, emotionally meaningful, and filled with rich insight and feeling. I felt pride to be speaking to these therapists and very touched that they opened up to me.

### 3. Results

#### 3.1. Overview

The results of the analysis are presented in this section. Therapists talked about working with a variety of MH issues, as listed in Table 10.

**Table 10**  
***MH presentations discussed by the therapists***

Presentations
Anxiety presentations (e.g., Generalised Anxiety Disorder, Obsessive Compulsive Disorder, exam anxiety, anxiety about social status in community)
Depression and low mood
Neurodevelopmental conditions (e.g., Autism Spectrum Disorder, Attention Deficit Hyperactivity Disorder)
Trauma presentations (e.g., intergenerational trauma since Holocaust, Post-Traumatic Stress Disorder)
Relationship issues (family, dating)
Behaviours that are antithetical to Orthodox Judaism (porn, homosexuality, abuse, leaving the community)
Social media use

The idiographic method of IPA (Smith et al., 2022) resulted individual PET maps for each of the seven participants, from which four GETs and subthemes were developed to show the overarching themes present across all the therapists' accounts (see Table 11). The GETs are illustrated with participant quotes, offering first-order interpretations of their experiences. Punctuation in the quotes, including quotation marks, were used to facilitate readability, and are considered a subtle part of the researcher's process of interpreting the therapists' accounts. Using double hermeneutics (Smith et al., 2022), the researcher's second-order

interpretations are presented, with an expectation that the reader will engage with the narrative and create their own meaning and third-order interpretation of the data.

**Table 11**  
***Group Experiential Themes (GETs) and subthemes***

---

GETs and subthemes

---

1. Personal and professional overlap when working in one's own community
    - 1.1. How therapists feel when boundaries are blurred
    - 1.2. Managing confidentiality within a community context
  2. Working with Chareidi clients: being culturally sensitive
  3. Helping Chareidi Gen Z on their journey to adulthood
  4. Experiencing connection and disconnection
    - 4.1. Feeling connected
    - 4.2. When values are at odds with each other: feeling disconnected
- 

### **3.2. GET 1: Personal and professional overlap when working in one's own community**

Participants all worked and lived within the OJ Jewish community. Whilst some therapists intentionally supported clients in neighbouring OJ communities rather than their own, participants spoke about the significant interconnectedness within the London-based OJ Jewish community, and how they experienced this.

#### **3.2.1. How therapists feel when boundaries are blurred**

When therapists and clients are members of the same, close-knit community, it can be more challenging to keep one's professional and private lives separate. Therapists described how they navigated boundaries and overlaps, and they talked about not only wanting to maintain professionalism, but also wanting to protect the privacy of both themselves, and their clients.

Esther described how her clients handled their joint community membership in contrasting ways. She found that she was challenged by some clients who wanted to work out who they had in common, because it might disturb the therapeutic relationship:

*Sometimes it actually will happen that they'll start asking me questions, trying to figure out if we're related or something, or if we know people in common, and it's like I have to sort of veer the conversation away... but they almost want to find out that we've got a distant cousin in common... so they feel sort of more comfortable. And I would say I find it a little bit difficult... almost like you worry about confidentiality or something... you know... [...] I just feel like maybe what if they're going to sort of try to find out who we know in common, and who can they ask questions about me to... I don't know... like just something that would... that could be an interference in a way with the therapy, so I try to sort of shut down that kind of conversation a little bit in the nicest way, so that we're not focusing on that – we're focusing on our relationship, and that, you know, does that actually matter, if we know people in common...?*

Esther spoke about clients feeling more comfortable if they had a person in common, and how this increased her own discomfort because it risked their relationship not being private and confidential. She appeared anxious about being 'found out' if someone told her client personal things about her (*who can they ask questions about me to*). Additionally, she referred to her concern that a triangulation with an external person might interfere with their therapeutic relationship (*that could be an interference [...] with the therapy*). This blurring of boundaries highlighted how therapy does not happen in isolation but is situated

in a social context. Client and therapist navigate overlapping personal spaces outside the therapy room. The therapist's role as a professional, separated from the personal sphere, is not fully detached from the therapist's position as a member of the same community. Being known to the client as a therapist only, without any personal background story, appears more difficult to attain when client and therapist share a social context. Conversely, the client is also not 'only' a client, but a person who the therapist might also encounter in other contexts. Esther highlighted divergence too: some clients appeared to *avoid* wanting to find common acquaintances, as it put their anonymity at risk:

*With some people it's literally the complete opposite. If they see any kind of connection anywhere, they won't want to see you in therapy, because they're so worried about confidentiality or meeting me at an event.*

This raised the question whether she preferred working with clients who avoid making a personal connection, or whether having a shared cross-cultural understanding trumped this and resulted in her making allowances for the overlap into her personal life.

Therapists acknowledged their discomfort when seeing clients outside the therapy room:

*Malka: There was a really awkward situation when my client walked in at an event, and she saw me there with my kids, stressed, frazzled, everyone running everywhere... And I kind of gave her a secretive smile that no one else would see, so she at least recognised that I wasn't ignoring her, but I was really... I wouldn't say embarrassed, but I was definitely like... this is a very different version of me compared to the one she sees in the therapy room... so I guess I was more self-conscious about how I was behaving.*

Interviewer: *What were you wondering about when they saw you?*

*Malka: I guess... judgement...? They see a very narrow me. They see me, but only in relation to them, because I don't really self-disclose at all, meaning, they wouldn't know if I have kids, they don't know anything about me.*

Malka described the awkwardness and fear of judgement she felt when encountering a client in her personal life, and how her therapeutic approach of not disclosing anything about herself was threatened. It affected how she behaved (*I was more self-conscious about how I was behaving*) because she concluded that her client was exposed to parts of her that would be unexpected, and perhaps parts they would not have chosen to see (*this is a very different version of me*). Whilst feeling awkward and self-conscious, Malka was able to simultaneously mentalise how her client might feel and *gave her a secretive smile* that tried to communicate that they had a private connection.

Miriam described her awareness of how encounters in the public context can make both her and her clients feel vulnerable:

*I work in a community where I live, so I've got to be a bit more careful. I've been in many places and my clients are there... and equally for them, it's much harder than it is for me, but it's hard... but it's not terribly hard because I've got used to it. [...] At the beginning it was just awful because I felt so bad for them, and now, I'm OK with it. Sometimes, it's humiliating for me because clients will say to me "Oh I saw you walking with your kids", and I'm thinking "Oh my gosh, was I telling the kids off? Did you get an insight into just how crazy my life is?" So, there's a bit of vulnerability there, but I guess the reason perhaps that's OK is because then I go back to "I'm OK. I'm just good enough, filled with mistakes and shortcomings." I don't struggle with those things any*

*more... earlier on in my training these things were very difficult for me, but at this point less so, and there's a little bit more awareness of being out and being a bit more careful when I'm out.*

She hinted at how she reminds herself about being 'good enough' when being observed by her clients, but that she is *more careful* when she's out, indicating that over time, she has perhaps increasingly reflected on the effect of such encounters on her clients, and on her.

Malka and Miriam demonstrated how disquieting it can feel when clients are exposed to their tumultuous lives of motherhood and childrearing and how this contrasts the controlled environment that they are usually offered in the therapy room.

Leah went one step further and suggested that when her clients see her in the public sphere, they can observe how she role-models being 'good enough', for example by practicing her religion in ways that might be viewed by her Chareidi clients as more relaxed, and less strict. She described a scene where she encountered a client in a local kosher shop:

*Sometimes I am there, and I'll see them, and either they'll be shocked or I'll just smile or just walk by and then just try to discuss it later on, but they'll see that in my cart there might be the non-Cholov Yisroel<sup>18</sup> chocolate, so, it's like they're getting a feel for me, and I present who I am. And that makes them relax.*

Leah suggested that perhaps their witnessing her behaviours outside the therapy room was a learning opportunity for clients to understand her better (*they're getting a feel for me*). Her choice to purchase the chocolate, an action understood by the Chareidi community as a

---

<sup>18</sup> Many OJ people follow a halachic stringency to consume dairy products that only contain milk that was supervised by a Rabbi when being extracted from the cow, due to fears of consuming milk from prohibited animals, e.g., pigs milk. The Rabbinically supervised milk is called *Cholov Yisroel*.

more lenient approach to Orthodox Judaism, perhaps served as a signal to clients that she was open to jointly making sense in therapy their idiosyncrasies and any non-conforming behaviours.

The therapists highlighted how managing the overlap between their professional and personal lives was multi-faceted. At times, the overlap was addressed in the therapy room, either in preparation for the eventuality, or after having encountered a client in the public arena. For some, it served as an opportunity to make known their values. Differing emotions were experienced, and whilst therapists acknowledged the discomfort for clients who encountered their therapists in their personal lives, therapists also admitted that the overlap could be challenging for them.

### **3.2.2. Managing confidentiality within a community context**

The overlap between work and private life as experienced by the therapists highlighted the complexity of confidentiality within a small community. Rachel described how she managed navigating local spaces outside the therapy room by naming it with her clients and ensuring that the principles of confidentiality applied to her, but not them:

*I always say "If I see you anywhere, like I'm not going to come over to you, because this is your space – right – and I'm the adult... and I keep things that go on in here, I keep it private, but you... you can do whatever you want, you can tell people, right?"*

Discussing confidentiality with clients played a part in developing trust and relational safety in therapy:

*I had to spend quite a bit of time speaking about the parameters of confidentiality within the context of the Jewish community... you know, 'if I see*

*you at the kosher grocery store, [...] I'm going to ignore you – not because I don't like you or [...] don't remember our work, just because I keep it very confidential.' And I spent a long time on that and revisited it as the work went on because it... I just feel it is massive in such a small community, and I probably will bump into them at some sort of simcha<sup>19</sup>... [...]. I could end up being related to them for all I know (chuckles). And parents... I mean, one of the mothers, I actually do bump into quite regularly and... and... um... so, I also tend to speak a lot about confidentiality to parents as well. (Rivka)*

Rivka considered the inter-relatedness of families in a small community, and therefore explained how she not only offered the clients but also their families an explanation of the parameters of confidentiality.

Esther elaborated on the importance of addressing confidentiality with parents:

*Sometimes they are very involved, and they'll... they'll be contacting me for... wanting to speak on the phone for updates, and what do I do about this, and... and I have to [...] tell them... you know... it is confidential... there is only so much I can say and... that I have to ask permission as well... if I can even say anything to the parent... and then they do normally... um... kind of back down a bit and... sort of try and leave it to you to get on with it.*

Esther's account of the boundaries she required to communicate to parents highlighted how supporting an adolescent meant that she held in mind the parents' needs too. Therapists were aware of the anxiety and stigma around receiving MH support and how it could affect social status and marriage prospects. In a context where therapist and clients are members

---

<sup>19</sup> A *simcha* is a celebratory gathering, e.g., a wedding or bar mitzvah.

of the same community, the timelessness of confidentiality seemed particularly apparent:

*I say, "Confidentially has no time limits, even if in 20 years' time somebody calls me for a shidduch<sup>20</sup>..." (Rivka)*

Not only clients, but therapists also wanted to protect their own privacy. Whilst therapists followed therapeutic practices such as maintaining client confidentiality, the need for therapists to have privacy over their own lives was acknowledged too. Miriam described not having found a personal therapist for herself, perhaps because of her challenge to find an entirely neutral person who was not connected to her through others:

*Seeing as I know everyone, and I work with everyone, and I refer to everyone, and finding it very difficult to even think of a space that would actually be private and could be sacred for me, and could be something that I would truly feel... it's very rare that I come across people that would be like safe territory for me... I just mean completely external to the community... and, I think I'm just still in search for...that perfect person who's external to all of the connections that I have. (Miriam)*

The impression Miriam gave was that there was such a strong community interconnectedness that it was difficult for her to carve out an entirely separate and private space for herself. It brought to mind a comment made by a research consultant who argued that once a therapist signposts other community members to another practitioner, this practitioner no longer provides a neutral space for the therapist because the practitioner is challenged to bracket their experiences with other community members. This means that

---

<sup>20</sup> A *shidduch* is the process where two potential candidates meet to consider whether they are compatible for marriage. When a match is made, this is also called a *shidduch*.

for the signposting therapist, the only way they might feel they can find a neutral practitioner to work with themselves, is to restrict other community members' access to them and 'keep them to themselves'. This might explain Miriam's dilemma of searching for a private space for herself, whilst admitting, *I refer to everyone*, meaning, there is no one where she truly felt that they were unbiased by their work with other members of the community.

The therapists described how they explained confidentiality to clients and their parents, particularly due to the real possibility of them meeting each other outside the therapy room. They highlighted how they felt the limits of confidentiality were stretched when they themselves wanted an unbiased, private space for their own therapy, but struggled to find a practitioner who they felt could sufficiently bracket any encounters they might have had with other OJ clients.

### **3.3. GET 2: Working with Chareidi clients: being culturally sensitive**

Working within their own OJ community, therapists not only grappled with the overlap between their professional and personal lives, but also how to best support clients within their culture-specific context. They spoke about the practices they adopted that were sensitive to the cultural and religious needs of their clients, and how having a religious and cultural commonality helped foster mutual understanding.

The therapists believed that Chareidi adolescents' parents selected an OJ therapist because they wanted their children to work with someone who understood their religious and cultural background. Rivka explained:

*A lot of them are quite protective in terms of their girls' exposure to people from other faith backgrounds, or people from a secular background. So, I*

*think they feel a bit safer with somebody who has similar values and a similar background. I think they felt that the young person wouldn't be comfortable with speaking to somebody who wasn't Jewish. And I think rightly so that their kids would just be more comfortable, they'd be able to use language that I would understand and refer to concepts that I would understand.*

Making clients comfortable appeared important to Rivka, and she implied that when clients go to therapy, they are vulnerable and therefore require a foundation of safety and comfort before they are able to engage. By seeing an OJ therapist, there is mutual cultural understanding, which means that certain things (*language that I would understand, concepts that I would understand*) would not need explaining, allowing perhaps for a faster development of trust and rapport. This was also a reason why some therapists believed clients avoided seeing a CAMHS practitioner:

*I think there's a fear that if they go to CAMHS there is going to be some, you know, wacko person who doesn't understand them, and tells them to do things that are completely not within their value system. (Miriam)*

Contrary to the safety and comfort that Rivka described between an OJ therapist-client interaction, Miriam argued that CAMHS services could ignite distrust and misunderstanding, due to a fear of being exposed to values that were antithetical to their religious values.

Esther described the clients' relief when they meet a therapist who understood their way of life:

*There is something about them feeling that I really understand where they're coming from, you know, and some of the issues that come up, like we have a real understanding, coming from the same cultural background, and the same*

*sort of schooling and... they just kind of smile because they think "Oh, she gets it! She really gets it."*

Therapists conceded that having a common language helped:

*The language puts them at ease... dropping in the Yiddish-isms and the colloquialisms. (Devora)*

*It's like they don't have to... err... translate things. They don't have to explain things in different ways. You know, it's just... straight away I'm getting it. I think that really works nicely. (Esther)*

*We use Jewish phrases and we can make generalisations or humour or assumptions around when they're talking about... "Oh... err... you know... Yom Tov<sup>21</sup> was difficult..."... me understanding what that actually means, because I understand what they've been through, but I've also had a hard Yom Tov. (Miriam)*

Beyond using culture-specific language, phrases, and making conversation about cultural commonalities, such as religious festivals, Devora also collaborated with clients to understand how religious concepts might help them make sense of things:

*One client came with a whole load of Torahdig<sup>22</sup> beliefs that were feeding into her beating herself up and not living how she should be living... um... and I was able to start helping her question whether there was anything else she'd heard within a Torah framework that might actually be the opposite to that...*

---

<sup>21</sup> A Yom Tov is a Jewish festival.

<sup>22</sup> The Yiddish method of ending a noun with '-dig' turns the word into an adjective.

Devora alluded to her understanding of Jewish concepts that her client was referring to, and how as an OJ therapist she was not only knowledgeable about the concepts, but also able to challenge any unhelpful thinking around them. In reference to using religious texts in therapy, she elaborated:

*I might say, "Well, you know I've found a couple of these things, shall we have a look at them together, and you can kind of see what you think, and pull it out yourself and see what... what comes up for you..."*

Devora's approach indicated how cultural and religious knowledge that could be shared between client and therapist allowed for personalised, culturally sensitive therapeutic work. Differing views were voiced about seeking guidance from Rabbis. It appeared that for some therapists, it helped to involve a halachic authority figure:

*I've worked with some amazing Rabbonim<sup>23</sup>, and I think OCD is one that comes up a lot. Rabbonim have come into the treatment, have come into a phone call, and have given permission for the girl to essentially do Exposure Response Prevention and not have to worry about halacha<sup>24</sup>, so, will say to clients, "You do not need to worry about... chametz<sup>25</sup>, it does not apply to you on Pesach<sup>26</sup>, full stop." So, that would be one of the main things that I brought them in on. (Miriam)*

Miriam highlighted how engaging with a halachic authority, i.e., a Rabbi knowledgeable in Jewish law who could pronounce a ruling based on an individual's personal circumstances,

---

<sup>23</sup> Rabbis (Hebrew)

<sup>24</sup> *Noun; adj. halachic*. An overall term used for the legal Code of Jewish Law

<sup>25</sup> On Passover, Jews refrain from eating leavened bread, *chametz*, and make efforts to rid their homes of it in advance of the festival.

<sup>26</sup> *Pesach* is the biblical term for Passover

helped treating scrupulosity and obsessive-compulsive disorder. However, whilst many therapists encouraged clients to seek Rabbinic advice, some did not involve Rabbis directly in their work. A divergence within this theme was voiced by Rachel, for example, who explained:

*Not too much, I'm going to be honest. If there's a halachic question, then they answer the question, not me. So, I tell them to discuss it. There are some Rabbonim that I would tell people to go to, but I don't necessarily call a Rav<sup>27</sup>.*

It appeared that Rachel distinguished between offering therapy, and asking halachic questions, as she did not feel qualified to make a ruling (*They, i.e., the Rabbis, answer the question, not me*). Instead of engaging directly with a Rabbi, she encouraged clients to consult with Rabbis themselves.

Important to cultural sensitivity was the awareness of cultural nuance and subtext, for example, being culturally knowledgeable about what behaviours might be acceptable in modern, Western society, but perhaps were taboo within the Chareidi community:

*I know what the meaning of behaviour is from a cultural and communal perspective, so if somebody tells me, you know, I go out and see boys, I have an understanding of what that means culturally, although I check in... in terms of what that means to them personally and to them as a family, but from a cultural perspective, I know that that's risqué, and that wouldn't be expected from a Chareidi teenage girl. (Rivka)*

---

<sup>27</sup> Rabbi (Hebrew)

Therapists described how they felt conscientious to not expose their adolescent clients to ideas that the parents would oppose. They suggested that they gauged their clients' religious values and level of observance, and adjusted themselves to this context by avoiding taboo topics and inappropriate language and ideas:

*When I'm in the room with a Chareidi young person... I immediately click (clicks her tongue)... narrow, myopic upbringing until they show me 'not so'... and vocabulary will be dialled down... um... and my freedom to say anything I need to say will be dialled down. I will put it in a different way. I do not want to ever introduce Instagram, Tik Tok, Snapchat to a Chareidi kid! Unless, in our conversation they bring it up. So, I will take my cue from the way they are in the session... which we all do, we should do, but even more so with a Chareidi person. (Leah)*

The description of Chareidi upbringing being 'myopic' alluded to Leah's impression that sheltered young people would have limited exposure to Western ideas, values, and lifestyles. She talked about not exposing her clients to ideas that might be antithetical to their cultural beliefs and values, and that she was guided by her clients about what was acceptable, and what was taboo. It also revealed how therapists consider the expectations of client, family, and wider system and how this influenced their positioning and practice.

Leah also used a Torah source to explain how she supported Chareidi adolescents:

*You start, you know... 'pis'chu li pesach shel machat'... just give me that little opening... just that little thing...*

Here she referred to an interpretation of Song of Songs, where it is said that G-d declares, 'Open for Me one opening of repentance like the eye of the needle, and I will open for you

*openings that wagons and carriages enter through it.'* (Shir HaShirim Raba 5:2:2). This Talmudic interpretation refers to the idea that if you give G-d a small amount, then He will offer you lots in return. Leah used this analogy to explain how when her clients offer her a small, hesitant exposure of their difficulties, she uses this as an opening to allow for space and safety to talk about things that they might not feel safe to discuss in any other context.

Rachel described a different analogy of how she adjusted her therapeutic approach with her Chareidi clients:

*I've been doing this for a while, so, the line that I'm treading is... it is almost, like visually, I feel like I don't want to trample on a scene, right, I want to tread lightly within the scene but I may adjust a few sort of things so that the scene itself stays pretty much intact, but there's, even just those minor adjustments make it much more liveable in... So, it's delicate and there's really a skill to it.*

Rachel acknowledged that being not only aware of cultural sensitivities, but also applying this practically in the therapy room required skill and experience and was delicate work (*I want to tread lightly*). She advocated for wanting to put the person's religious and cultural beliefs and practices at the forefront of her work, whilst sensitively considering which elements were open to flexibility and change and would not compromise the client's values.

She argued:

*I don't necessarily challenge. I am super-careful not to challenge the things that keep them healthy within their society, because I'm only there for a very short period of time, I'm not going to carry them throughout, and I'm very aware of that. I want them to be healthy within their society, you know, functioning individuals within their society, not outside of their society. So, it's*

*a real delicate balance between understanding, and helping them thrive within that.*

Rachel conceded that the therapy work was a brief opportunity to make a positive difference in a person's life. She alluded to her values of supporting, but not creating dependency (*I'm not going to carry them throughout*). Rachel said she avoided taking great strides and upsetting a system, because she wanted them to be *functioning individuals within their society, not outside of their society*.

The therapists voiced their views on how they applied cultural sensitivity with clients, adjusted their language, and scaffolded discussions about concepts and values to fit with the clients' cultural and religious background. They allowed clients to take a lead on what they were comfortable to talk about and explained how Rabbis influenced their work.

#### **3.4. GET 3: Helping Chareidi Gen Z on their journey to adulthood**

Therapists considered the stage in life that adolescent clients were in, and how this played a part in their work with them. Therapists talked about the influence of family on the therapy, how they worked with the broader societal and culture-specific pressures on adolescents, and the responsibility they felt around supporting them.

The term Gen Z was intentionally applied, to highlight how the present post-pandemic generation of adolescents might differ considerably with regards to their experience of MH and attitudes to help-seeking, compared to previous and future adolescent cohorts (Mahapatra et al., 2022).

Therapists talked about the challenge of engaging adolescents in therapy, whether they benefited from the experience, and what they took from their first experience of therapy. Malka for example described how sometimes, adolescents seemed to address superficial

issues in therapy. She considered this a stepping-stone to doing deeper therapeutic work in the future:

*I could tell, as a therapist, that there was a lot more that was not maybe conscious and everything like that, but I knew that my work had been done... because she was ready... and I felt that it was a good experience of therapy... if she ever wants to bring... do this again with anyone else, then she'll be able to... um... if she ever does want to reach out... she'll be able to.*

Therapists mentioned the pressure they felt from parents and adolescents to improve their wellbeing:

*I think there's definitely something coming from the parents [...] because, I find often, they'll come to me after having months of nothing, because I think the parents were reluctant to go in for it, hoping they would get pushed forward on the NHS, and then they sort of got to rock bottom, and then they were like "Right – we have no choice now, we have to put them in therapy." And then it's like the child probably feels that, you know, "Oh OK. So, now I'm going to get better because my parents are paying privately for me to get therapy", yeah, so I think there must be something that feeds in... (Esther)*

Esther's impression that adolescents were expecting to get better undoubtedly raised expectations of her being able to fulfil this goal. Whilst parents might have been reluctant initially to seek support, signifying perhaps that going into the therapy was stigmatising to them, the expectations towards the therapist seemed compounded by them seeking support as a last resort, when things *got rock bottom*. Seeking therapy from an independent,

private practitioner, where clients are customers, may add an extra layer of pressure to perform and 'deliver the goods'.

Therapists highlighted the general pressures that adolescents were under, which perhaps was mirrored in the therapy room where they were expected to 'get better'. High expectations abounded, particularly to achieve academically and socially:

*I'm seeing quite a bit of the push of high standards... that the stress that a lot of them are under, achieving academically... (Devora)*

*It's almost like I know what they're going to say before they say it, when they sit down for the first time, you know, I've heard that before (chuckles). I think also it could be to do with pressure in the community as well when they come to me with anxiety, and it's around exams, and doing well at school, and then I do think about the fact that culturally I think students – Jewish students – do feel quite pressured to do well and to, you know, almost excel in their careers and get into good universities or whatever it is. A lot of them do seem to, it's not exclusive, obviously, to our religion, but it's just something that I've noticed [...] They have a lot of pressure on... I don't know if they put the pressure on themselves or if they feel the pressure... some of it is from school as well, or from parents, or peers, but I do feel that comes up quite a lot...*

*(Esther)*

*It's fascinating, that collectivist... that feeling of like, "I have so much responsibility to live up to my family name, or to not bring shame to my family name, I must not be seen as a 'let down', right, as a disappointment to the family" (Rachel)*

Rachel pointed to the collectivist mentality in the OJ community for individuals to do well because they represented a family or system. This challenge, of navigating individualistic approaches within a collectivist culture was perhaps particularly challenging when offering 1:1 support, where both person-centred needs and the wider system's expectations required attention.

Leah described how she feels responsible to educate her adolescents:

*Working with this girl, she said, "I was home feeling sorry for myself, and I put out my story", and all of a sudden, like "Oh my gosh, she's got a smart phone, this is going to be hell on earth!" That made... my job is, a person who cares about her welfare because I'm a therapist, err, now I have to suss out... "Oh, you know, on Snapchat or Instagram..." "Oh, yeah, so what'd you write?" [...] And then that... a year later has led us into safe, working on, err, safeguarding yourself on the internet, to help her not to be pulled down the grooming hole. But because she comes from a myopic area, she's not got any education, so, that's an example for you.*

Applying her knowledge about the Chareidi community, Leah assumed that Chareidi adolescents had less exposure to social media compared to non-Chareidi peers and would receive less support on how to keep safe online. Leah's caring for her clients (*a person who cares about her welfare*) was permeated by sadness, highlighted below, where she suggested that adolescents today lacked guidance and positive role models:

*I mean, [...] there's a higher power over me, so no matter what hard slog I have to go through, I get through it...and it gives me an insight into things, but it also gives me a compassion to other people who are not fortunate*

*enough to have a North. You have to know there's always a North." And when I start, like within a few sessions, I'll say to them, "I need to know what your... err, who do you look up to? Who is above you? What do you believe in? The stars? The water? The sun? Buddha? Just... give me something you truly believe in." When it comes to my young girls in the Chareidi world, they're so battle-worn... they're battle-beaten and they're so confused, and they're so harassed... So, they don't have their North... again, the sadness, that hurts. I'm a mother, I love my kids...so, that's the moral, ethical part, you know, it is my faith, but I will not push it on anyone. It's not my job... except I do believe we need to have something that grounds us.*

Leah appeared to acknowledge her position as being an authority that they turned to (*I'm a mother*) and was nevertheless pained by the lack of such a figure in the adolescents' lives. Her narrative of adolescence being a confusing battle that wears them out emphasised her impression that they needed support and guidance.

The challenge of dealing with MH difficulties as a young person can be compounded by how it coincides with education, seeking employment, and sociocultural pressures, such as getting married. Miriam talked about the awareness required when supporting Chareidi adolescents, and how their current life circumstances might explain how they engage with therapy:

*If someone is coming and... part of the problem is that they are constantly pretending and faking, and they're actually struggling deeply, but their whole pretence and façade is all happy-clappy and strong, I understand that this is not only because of their defences and what they want to portray to the*

*outside community, but also because socially and stigma-wise that is the face you need to present if you are at a dating age. They can't afford to now disclose to the world that they are depressed or that they are extremely anxious because that would change their shidduch prospects.[...] So, say someone's under pressure... because I know that they are going to be dating in six months or a year, there's a consideration that if you're under a time pressure, this issue does need to be resolved a little bit quicker, because... but understanding that shidduch is going to happen either way, that's the reality of it, so my goal is to help you and be as ready as you can for that. If I really feel they're not ready, I will happily say that and encourage them to take their time...but it's just having an understanding of what processes are in place, and what their trajectory is without necessarily (sighs deeply)... formulating that as the problem...*

Miriam expressed how her awareness of the time scale of the Chareidi dating process helped her work within the constraints and boundaries of the community's value system. She implied that for the Chareidi community, improving an adolescent's MH was part of a greater goal to eventually get them married, and that her role was to work the therapeutic treatment around that timescale. The goals of the community or family might, or might not, align with the client's aspirations.

Working with Chareidi adolescents revealed several factors that played a part in the therapists' experiences of offering therapy. Therapists talked about how their support could be viewed as being a stepping-stone for future help and the pressure they felt to make clients feel better. They observed the significant expectations put on adolescents, felt

sadness at adolescents' lack of positive adult role models, and considered the realistic time frame within which they were able to have an impact.

### **3.5. GET 4: Experiencing connection and disconnection**

Divergent feelings were expressed about how the therapists related to their clients. On the one hand, experiences and feelings of connection were articulated, particularly due to their shared identities as OJ individuals. On the other hand, when values clashed, a sense of disconnection was experienced both viscerally and emotionally.

#### **3.5.1. Feeling connected**

Therapists connected to their Chareidi clients due to their shared religion, culture, and community:

*I think there's a kinship and there's something... I see myself in them. (Rachel)*

This was suggestive of a connection through a shared identity, and of self-recognition: perhaps they mirrored something she had experienced as a Chareidi adolescent herself, in the past.

Cultural familiarity and mutual understanding appeared to help therapists connect and build trust:

*I think familiarity with their lives... I think the lifestyle of a Chareidi Jew is very different in so many ways. So, just being really familiar with the lifestyle, familiar with the values, the day-to-day activity, just appreciating that the week before Pesach there's going to be a lot upheaval in the home, and there's going to be a lot of change and busy-ness... maybe not too much time for deep discussions... I think being familiar with having a large family and*

*what that involves... a large family with lots of commitments. I think I use a lot of my personal experience to understand families from that perspective... so, I suppose with every similarity that you have with a client, you can use it. You know, there's always a danger that your experience of a large family is very different to their experience of a large family, so it's trying to be aware of that but I think it actually, usually in my cases that I've experienced it, being quite a significant advantage and of benefit to the family that I think their level of trust with me is... their starting level is quite high. I think they have a certain level of trust and familiarity that they know... they can place me (gives a bit of a laugh). They, you know, as Jews we're very good at placing people pretty early on in our discussions...and I think they can place me, [...] they can orientate themselves a little better from you know being able to know who I am and what my background is. (Rivka)*

This idea of orientating oneself and placing someone perhaps allowed clients to feel that even though they were navigating the unfamiliarity of therapy, it was taking place within their cultural comfort zone. This in turn appeared to help the therapist to build rapport with them.

*It definitely helps the fact that I get them. That I get their lifestyle and also can be compassionate with the challenges of that. [...] So, a lot validation of sometimes the struggles of being a Jewish teen [...] I definitely think having that understanding, normalising it constantly, and being able to develop that compassionate, validating voice for themselves, [...] and also just bringing in*

*like, that camaraderie, “We both in this together... we both know that it can be sometimes really hard, can’t it?” (Devora)*

This shared culture and identity also promoted feelings of loyalty:

*Loyalty... there’s a feeling of loyalty and responsibility that comes up for me... not everyone can do it because they wouldn’t access things what everyone else would access... so, there’s not that many people that can do this, so that’s where the responsibility... [...] And I guess because I believe in supporting people from within my community, I guess I’m passionately committed and devoted to doing that. [...] I feel... I identify a lot with my religious patients... it’s that my... my work makes me feel religious. I think my work feels like a spiritual experience for me. It’s like my spiritual cup of... when I think like... I don’t... and maybe this is because of the stage of life I’m at... that it’s just so intense and busy and full in every way... in a blessed way... that I (slight pause)... but I often feel like I’ve done all that Jewish stuff, like I’ve done my Jewish stuff but then I’m like “Well, you didn’t! You didn’t do any learning<sup>28</sup>, you didn’t do any davening<sup>29</sup> today, you didn’t do any... though my whole day’s been so Jewish!” So, it feels all very connected spiritually... spiritual and holy... not that I am holy, but what I’m trying to do is holy work, and therefore I feel very connected, so I think my work makes me feel more connected.*

*(Miriam)*

---

<sup>28</sup> In Jewish religious communities, the term ‘learning’ is used to mean studying the Torah.

<sup>29</sup> Jewish colloquial term for praying

Miriam voiced being not only committed and devoted because she identified with her clients, but also because she felt responsible to support them, because she believed that they would not access public services, that there was a lack of OJ professionals who offered Chareidi adolescents the type of support that she gave. By comparing spiritual experiences such as prayer and Torah study (*learning*) to her work, she also emphasised how offering therapy to Chareidi adolescents was a spiritual endeavour that connected her to her clients, the Chareidi community, and her religion.

Malka considered whether she was on a personal mission to support her coreligionists:

*I think if they weren't Jewish, I don't think I would think about them that much [...]. You care more. I think it's really more like family, there's like definitely a deeper connection there.[...] It's definitely a deep sense of caring. I think definitely with frum<sup>30</sup> clients... you do go the extra mile, no question, and I, I wouldn't do this work not in the frum community, meaning, I'm not going to put so much time and energy and effort and mental space... I wouldn't do this for anyone else. I wouldn't put myself out there, so, I don't think... I wouldn't do this for anyone else. So, really, my whole therapy is for the frum clients in a way.*

Malka's motivation to support people in her own community revealed her observance of the Torah principle (Babylonian *Talmud*, tractate *Shavuot* 39a) *kol Yisrael arevim zeh bazeh*, meaning, all of Israel are responsible for one another. By supporting Chareidi adolescents therapeutically, perhaps she felt she was fulfilling this command.

---

<sup>30</sup> A Yiddish, colloquial term for Orthodox Jewish

Rachel talked about therapy rectifying something inside her:

*Obviously I've chosen, right [...], I could have worked with anybody, and I have chosen to work with Chareidi young women. So, I guess what is it that draws me is probably a sense of wanting to rectify what I did not learn for myself when I was a teenager. You know, the idea that I would have loved to have somebody wiser, older, totally mine, right, in that confidential space where... and a stranger, so somebody that I could share something with, that would not have judged me, and would have been totally on my side. You know the funny thing is that... I may not have actually wanted it when I was a teenager, but I think that I would have wanted it, right? (laughs) So, it's kind of, [...] like when you remember your childhood memories, so like you analyse them through an adult lens, and you think, "So, I was thinking about the fact...and at that point, I was thinking...", and you, like, "No I wasn't..." - it wasn't that neat, right... but, that's something, it kind of feels like a little bit of healing for myself, you know.*

Rachel described how on the one hand, supporting adolescent girls was healing and rectifying for her, and on the other hand, she admitted that this was perhaps a motivation of her adult self, looking back at her younger self, rather than what her younger self would have actually wanted. As an adult, with the benefit of hindsight, perhaps because the work felt personally healing, she wondered whether adolescents might benefit from therapy more than they think.

The nature of her work being retroactively healing was further amplified when she talked about the 'kick' she gets when working with Chareidi clients, almost as though she were pursuing a life mission that benefited not only her, but also her clients:

*How do I relate to my clients, as a Chareidi therapist? I think I get a kick out of it [...]. Because, again, I can definitely use Yiddish terms and terminology and people can definitely express things to me in Yiddish, and that's totally fine, but then I will also quote whoever, or whatever I've just been reading, and bring it into... and what I enjoy is the look on their face, maybe possibly expanding their own... I like expanding their world, which may sound hysterical in a certain way, but I feel like it can be expanded, and it's good for them, and people appreciate it, and again, I don't want to be like 'them and me' but people do appreciate... the kick that I get out of it is kind of like when people sort of notice and realise for themselves that they can let other things in their life, and it will not damage their ability to be, you know, the best Jew that they can be, but it might even enhance it. Again, I wouldn't introduce [...] Tik Tok, but I would introduce them to concepts that, [...] you know, different people's ideas about things that might be useful in terms of them understanding themselves, and that's why I think I get a kick out of it, because I think they feel like they can trust me because I'm not... because I am as dedicated... and again, so... when you do that and then you talk about Hashem<sup>31</sup>, and you talk about... and I feel I have a very well thought-through understanding of my relationship with Hashem, and when I can kind of talk in*

---

<sup>31</sup> Literally 'The Name', a term used for G-d

*that way, and explain it, and understand it, I get a kick out of it being, you know, like “Wow... you don’t have to look a certain way, you don’t have to fit into a certain box...” and I get a kick out of bursting open that box for them, which is... you can learn from other people, people who don’t look exactly like you are, people who can still teach you things...*

Rachel highlighted her drive to broaden the horizon for young people (*I like expanding their world*), how she offered them alternative ways to view themselves and the world (*burst open that box for them*), and how she navigated this sensitively within the cultural context, by bringing G-d into the conversation (*when you do that and then you talk about Hashem*), which implied to her clients that her although ideas might be novel to them, they were aligned with their joint religious, OJ values.

Part of the therapists’ desire to be culturally sensitive also involved them talking about their identity as OJ women and how this influenced and motivated their work with Chareidi adolescents. For example, Devora talked about being a ‘Baalas Teshuva’ (someone who did not grow up in an OJ family but became OJ later in life):

*I mean, these kids are all from very frum homes... and they’re listening to me and are taking on board what I’m saying. I think it is validating of who I am, certainly as a Baalas Teshuva, like, yeah, I’ve made it, I’m integrated, I’m accepted as... “You’re one of us, and I can talk so openly to you about these things...” That certainly re-affirms my identity as a frum Jew.*

She went on to explain how their acceptance of her not only re-affirmed her identity as a member of the OJ community, but also how as a Baalas Teshuva, she was motivated to encourage her clients to think about their own developing religious identity:

*It does work to the benefit because the journey you take of questioning, and recording Hashgacha Pratis<sup>32</sup> moments, and things like that to develop your Ahavas Hashem<sup>33</sup>, and all these things, and they haven't gone through that. No frum kid or frum adult has actually gone through that experience, so, I get them to, you know, I bring in my... I mean I'm very authentic, and I won't hide it. I will bring in Ahavas Hashem... I'll drop it in, I won't make it heavy, and it will be a way of testing the waters, if this kid actually has a relationship with their Yiddishkeit<sup>34</sup>, and if that can possibly be helpful as something that they value.)*

Devora described how she was aware that many people unquestioningly pursued a life aligned with the values of their community and had not critically examined the beliefs underlying their lifestyle choices. She suggested that the novelty of her tentatively, and never forcefully (*it will be a way of testing the waters*), exposing clients to ideas such as having a relationship with G-d (*develop your Ahavas Hashem*) and deliberating how G-d influenced a person's life (*recording Hashgacha Pratis moments*) could help clients find more meaning in their lives and make better sense of their values.

A shared kinship and loyalty, even a sense of being related to each other, influenced how therapists viewed their work with OJ clients and helped them build trust and rapport in the therapeutic relationship. For some therapists, the work appeared to be grounded in their religious commitment of caring for their fellow Jewish counterparts and shaped their

---

<sup>32</sup> Hebrew, literally, personal Divine intervention, the idea that G-d directly causes things to happen to an individual.

<sup>33</sup> Hebrew, literally, love of G-d

<sup>34</sup> Yiddish for Jewishness, i.e. Jewish identity/practice

motivation to broaden clients' perspectives. For others, the work just felt spiritually meaningful and connected them to existential ideas around their life purpose and meaning.

### **3.5.2. When values are at odds with each other: feeling disconnected**

Therapists also navigated situations where their values did not align with the client's values. Such clashes required them to manage difficult feelings whilst considering their moral integrity and how to work with ideas that were antithetical to their own views.

Rachel said:

*I have to work harder at not judging Chareidim than I do at not judging the non-Jew. I feel like sometimes I feel more judgemental with people who are... it's harder to kind of 'bracket' that a little bit from myself because I just feel my blood pressure starting to rise...it's visceral... because with non-Jews it's something that is just different... I just listen to it and I accept it for what it is. [...] But in the Chareidi community, sometimes I'm like "Ohh... you're not serious!" [...] You know, in the Chareidi community sometimes I will just... because it's so close to what I'm... I feel like I have the choice between one or the other... then when they are choosing something that I haven't chosen, you know...*

She admitted that due to her self-identification with the Chareidi community, she felt particularly challenged when presented with values in the community that did not align with hers. She gave an example to illustrate this, where she differed in her view as to whether a mother should alert her child to her pregnancy:

*So, for example, let's say if an adolescent is living in a home where she knows her mother is about to have a baby, ok, she knows her mother is about to*

*have a baby , but she doesn't know when, right. She just doesn't know when her mother's about to have a baby - it could be two months... it could be tomorrow. And she knows that as soon as her mother has a baby, she then has to take care of all the kids, right, and [...] she maybe has some exams that need studying for, and she doesn't know when this is happening now or not, and there's a lot of anxiety around it, right, and I'm like "For goodness' sake!" (chuckles) You know, it's really hard in my own mind, to me, like... "Tell your child! Like tell the child that is the 15-year-old... that is going to be dealing with all of this... please tell them when to anticipate that this might happen..." And nobody's ever mentioned that the mother was expecting in the first place because we don't talk about such things, right, but the child knows, and the child thinks she knows... well, maybe something's wrong with the mother, but she's pretty sure that it's probably this, right – there's a lot of anxiety. And that somehow creates more stress within me, or more of a conflict within me about doing my role as a non-judgemental, congruent presence... and, you know, just being like "OK. There's such an easy way to solve this" (laughs)... "Just tell them!"*

Rachel described a visceral response to fellow Chareidi counterparts when they decided differently to her. The emotional closeness she felt towards them appeared to make it more difficult for her to reserve judgment, perhaps because she feels that she is personally invested in their decision-making. If a stranger makes a poor decision, perhaps it affects you less than if it is your relative, or a member of your own community. She said:

*It feels like it's because I'm so close to that... it's not as if it's a totally different cultural scenario, you know, it's very close... and I feel that it's just misguided because it's not what I would do [...], so, it feels like it's almost like attacking my personal sensitivities or my sensibilities.*

Esther talked about wanting to reserve judgment but also owned up to finding that *very hard* and finding it *quite challenging* to feel that she was the only adult who the client was sharing their rebellious behaviour with. She mentioned feeling responsible and how she struggled to manage this therapeutically, perhaps because of how much the rebellious behaviour did not align with the values of both her and her client's religious community. She spoke about being unsure about how to manage such situations:

*I think sometimes it can be difficult when things come up and I'm not... I'm feeling a bit uneasy, like do I, I don't know, am I doing anything wrong? You know, if they're talking to me about something that they're doing that is wrong or something and I almost, like "Do I have to say something? Do I...?" You know, and that really comes into it.*

Esther continued:

*I think coming from an Orthodox background, you know, a religious background, and, so, when a client comes to me, I know that they also come from this religious background, but they are sort of pushing the boundaries and they're doing things that they know are wrong and sometimes they talk about doing things that are very wrong [...], and I do find it very hard to, I mean, obviously, I do hold back, and I do try hard not to judge, because that's my job but it is... sometimes I have to stop myself from slipping in a way, and*

*kind of making a comment "Oh, do you really want to be doing that?" Or, you know, just something... it's like it's very... I find that quite challenging because I almost feel like I have a responsibility in a way because they're coming to me with, you know, innermost thoughts and feelings that they wouldn't necessarily be telling anyone else, especially not their parents... and, at times, you feel like "Oh my goodness!" You know, you don't want them to be doing these things, and you don't like the fact that no one knows about it but I'm not talking about dangerous, because that's different - I'm talking about things that are not permissible.*

Malka acknowledged that she pursued values that at times required 'cording off' from the outside world, so that she could continue adhering to her moral compass. Outside of her private and personal life, she described needing to 'just deal with it' when confronted with behaviours, ideas, or language that were at odds with her personal values:

*It was basically like I... in my private life, I've created a boundary that I feel I need and I want, but in my work, those boundaries can be breached at any point, and that's something that I just have to deal with.*

However, she also accepted that difficult feelings could arise for her in such situations, and embraced self-compassion when things felt particularly challenging:

*There probably was a...yeah, there probably was a thought that was like "My work is really hard", because... well yeah it's like I don't want that in my brain... I don't want... I felt a bit contaminated.*

Malka admitted that her work exposed her to things she disliked (*I don't want that in my brain*), and perhaps even made her feel disgusted (*contaminated*), because it breached her

values and might influence her thinking. The concept that another person's words or ideas could contaminate you, reveals the metaphoric concept of a virus taking over one's thinking and spreading across one's thoughts. Perhaps for Malka, being strong in her religious convictions and values served as a 'barrier' to the contamination. Malka's experience appeared to contrast other therapists' assertions documented earlier who were particularly keen to widen their clients' ideas and views about things.

Miriam talked about how she dealt with situations where she disagreed with a client's behaviour, for example where a client engaged in what she felt was an unhealthy relationship. She described engaging in self-reflection and supervision to decide how to manage this therapeutically:

*My alarm bells were... it doesn't feel like a safe and healthy relationship... so, not to the degree that actually, you know... I did spend a lot of time thinking about it, supervision time... trying to, distance what's my religious view, what's my therapeutic view, and what's my parental view and, you know, because everything was coming up for me... but, yeah, she didn't... ultimately, I was challenging her in some way or she was feeling that challenge, and she didn't stay... I think that probably did... impact the work because she knew that I couldn't... I didn't agree and didn't support...*

Miriam relayed how she *distanced*, or perhaps bracketed, her religious, therapeutic, and parental personal values in order to ensure that she could support the client in the best way possible, but how the disagreement between client and therapist eventually resulted in a termination of the therapeutic relationship. This suggested that whilst clashes in values

should be reflected on and worked through therapeutically, at times the clash was too strong and could no longer uphold the relationship.

Rivka described how she learned to deal with a misalignment of values during her professional training:

*That training session in particular, I think there was always a bit of a visceral tussle between my personal values and the conversations that I'm having in my work with somebody who I didn't agree with. But, that training just helped me work with my different beliefs, and... kind of shelve them, notice them, acknowledge them, and shelve them, and use them helpfully in the work with the client in mind. So, I think prior to that training it was always a bit of a tussle and that training helped me position myself, I think.*

She related how the clash of values resulted in an embodied response for her (*a visceral tussle*), but that she used a reflective process - notice, acknowledge, shelve - to manage such conflicts. She described how this played out in the therapy room:

*So, in the room, with that client, I did feel, I noticed, and I heard my little voice with my own personal beliefs, and I did have to take a moment to just think about them and acknowledge them. And I think once my contradictory beliefs or values pop up, as long as I attend to them emotionally I think that I can then have the distance to then use them... try and think how I can use them helpfully in the work – whether that's just leaving them to one side – and working, just providing space, quote unquote despite them, or whether using them to inform me about what that father must feel and think, and to*

*encourage the young person to mentalise and see beyond their own experience which I think will be helpful for them going forward in life.*

The process of having an inner dialogue and acknowledging her emotions appeared to allow her to use her insights therapeutically, for example to support a client to mentalise another person's opposing viewpoint.

Leah interpreted why clients might present with rebellious behaviours in the therapy room. She said that she interpreted such behaviours as a method for clients to establish whether they were offered non-judgment and could consider trusting the therapist and opening up about more difficult parts of themselves:

*I think they're looking for something different that... I've had some Chareidi clients who have come to me, literally with a cheeseburger in their hands, in the session, and they need to know that I won't react, they need to know that... that there is this space... they need to kind of explore it. So, it's non-judgemental and yet I'm frum. I'm not the mother, I'm not the aunt, I'm not going to, like, who cares? There's a reason why she's doing this. A lot of times they're coming to me because they... I've had a few girls who want to choose a life for themselves, or they are searching in... within themselves. They don't necessarily want to give up their religiosity but do not like where they're coming from... and it's a step out of their world, into something different. But there'll be Shabbos<sup>35</sup> talk, and there'll be Yomtov... and there'll be the feeling I'll get from something, and it will come through in the therapy [...]. So, it's an experimental space but with someone religious.*

---

<sup>35</sup> Sabbath (Yiddish/Ashkenazic pronunciation)

Leah talked about clients seeking *something different* to what they were used to, perhaps a place where they could experiment with things that were usually prohibited in their lives. Whilst these behaviours, such as eating a cheeseburger<sup>36</sup>, might not be picked up by a non-Jewish therapist, for Leah, an OJ therapist who knows what is acceptable in their community, and what prohibited, she argued that clients were testing the waters to see how she would react. Leah alluded to what she assumed were the underlying reasons a client might present this way (*there'll be the feeling I'll get from something*), and then went on to say:

*There's usually a reason why they're specifically bringing in that cheeseburger... that was a cheeseburger experience because she needed me to see her eating it. She's done it before outside the room, before she came, she had plenty of time in which to go to McDonald's. Um, that particular experience led to two weeks later, when she told me that a man had exposed himself to her.*

Leah highlighted that her attitude of reserving judgment and promoting openness in her therapeutic relationships, allowed clients to test out how safe they felt with Leah to open up about more intimate struggles they were dealing with.

Clashing values and feelings of disconnection triggered visceral responses, perhaps specifically *because* of the feelings of connection described in the other subthemes.

Therapists described how they interpreted and managed such clashes and admitted how the similarities between their and their clients' cultural identities made reserving judgment harder and made them feel a fiercer responsibility towards their clients.

---

<sup>36</sup> Cheeseburgers are not kosher as Jewish law prohibits eating meat and dairy simultaneously.

## 4. Discussion

This study explored seven OJ female therapists' experiences of supporting female Chareidi adolescents, as an initial step to deepening our understanding of MH difficulties in Chareidi adolescents.

### 4.1. How the findings relate to existing research

The experiences of the therapists were analysed using IPA (Smith et al., 2022), and four GETs and subthemes illustrated the observed overarching themes:

In the first GET, *'Personal and professional overlap when working in one's own community'*, the therapists highlighted the interconnectedness of their private and professional lives, and how they managed a blurring of boundaries and confidentiality. The first subtheme, *'How therapists feel when boundaries are blurred'*, explored the multi-faceted challenge of managing the intersection of private and public, or personal and professional life. They described how at times, this overlap was addressed in the therapy room, either in preparation for the eventuality of encountering each other, or after having come across each other in public. For some therapists, the overlap appeared to serve as an opportunity to make known their values; for others, it appeared to feel anxiety-provoking and awkward. Differing emotions were experienced, and whilst therapists acknowledged the discomfort for clients who encountered their therapists in their personal lives, therapists also admitted that the overlap could be challenging for them. This theme was present in the existing literature, including how practitioners protected their clients' and their own privacy, and how they managed social encounters outside the clinic room (Golker & Cioffi, 2021; McEvoy et al., 2017; Podolsky-Krupper & Goldner, 2021; Keidar et al., 2021; Whiteley, 2016).

Clark's (2000) work/family border theory may help to make sense of some of the challenges expressed by participants. In this theory, Clark described how individuals negotiate their work life balance and manage their roles in both domains. Clark argued that the degree to which individuals integrated their personal and work domains, or kept them separate, was variable. Borders between personal and work domains could be physical, temporal, or psychological borders, i.e., borders might demarcate where and when work and home life took place, and which thinking, behavioural and emotional patterns were appropriate in one domain but not the other. Clark's theory suggested that some people were more flexible, and others more rigid about how much the different domains permeated each other, and that violation of a person's preferred approach could result in dissatisfaction or conflict.

During the coronavirus pandemic, when government lockdown measures caused heightened boundary permeability and border violation, increased stress and burnout was prevalent in the workforce, highlighting the importance of effective organisational staff wellbeing policies during the post-pandemic time of adjustment (Adisa et al., 2022; Rapp et al., 2021). For independent workers such as the participating therapists in this study, efforts to maintain a healthy work-life balance were perhaps not only influenced by the overlap between the therapists' different life domains, but also by the post-Covid19 changes to home and work environments.

In the second subtheme, '*Managing confidentiality within a community context*', the therapists described how they explained confidentiality to clients and their parents, particularly due to the risk of them meeting each other outside the therapy room. They highlighted how confidentiality and having a private, unbiased, and safe space was not only relevant to their clients, but also for them as therapists, and how they struggled to find a

practitioner for their own therapy who could sufficiently bracket any encounters they might have had with other OJ clients. This finding corresponded with the existing literature about confidentiality in OJ communities (e.g., Golker & Cioffi, 2021; McEvoy et al., 2017; Podolsky-Krupper & Goldner, 2021). Whilst the therapists in the present study discussed their experiences of supporting clients in their own community, it has been argued previously that some OJ clients perceived a risk when seeing a Jewish therapist, because they believed they were more likely to pass on information about them in the community compared to non-Jewish therapists who were external to their social group (Keidar et al., 2021).

The challenge of navigating client confidentiality within small communities, and the complexity of clinicians' multiple relationships, professional and personal roles, and community expectations, has also been addressed in other societies, for example in relation to rural and isolated communities in Alaska. O'Neill et al. (2016) discussed how practitioners experienced stress when balancing the professional requirements of their roles with their community membership, and that their communities were worried that practitioners might unintentionally share information about clients to others. They found that there was a fear that people who had lived in the community their whole life and now worked as MH practitioners would be too challenged to bracket their knowledge about intergenerational family histories and assumptions associated with them, in order to provide a neutral therapeutic space for clients. Contrastingly, like the findings in the present study, O'Neill et al. (2016) also found that whilst outsider practitioners were believed to maintain stronger confidentiality, they were also viewed as lacking an insider view that would help them understand the community's culture and history.

It appears that across societies, many practitioners try to balance supporting clients within their community, whilst adhering to professional codes of ethical practice (e.g., BPS, 2021b). They deal with increased complexity with regards to maintaining confidentiality, offering a neutral and non-judgmental space, and applying therapeutic boundaries in their work. The present study demonstrated that many practitioners might consider this balance and determine whether they are willing to engage in it, or whether they are more inclined to take an outsider position and only support clients external to their own community. The therapists portrayed in this study showed that this decision-making process can include therapists evaluating their priorities and preferences, and selecting their clients based on personal preference, beliefs, and values.

In the second GET, *'Working with Chareidi clients: Being culturally sensitive'*, the therapists voiced their views on how they applied cultural sensitivity with clients, adjusted their language, and scaffolded discussions about concepts and values to fit with the clients' cultural and religious background. They seemed to argue that their clients sought support from them specifically because they matched culturally or religiously, as found in previous research that indicated that clients seek support from therapists with whom they share similar cultural or religious values (Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017; Golker & Cioffi, 2021; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021; Rosmarin & Pirutinsky, 2020; Sharman & Jinks, 2019). The cultural sensitivity was described as 'treading carefully'; the therapists expressed wanting to help adolescents function well in their own society, and to allow clients to take a lead on what they were comfortable to talk about. This was in line with the idea that therapists avoid topics that might be considered taboo for their client or community (Bloch et al., 2022; Freund & Band-

Winterstein, 2017; Gabbay et al., 2017; Greenberg & Witztum, 2013; Keidar et al., 2021; Rosmarin & Pirutinsky, 2020).

The therapists addressed if and how Rabbis influenced their work, and like in previous research, whilst some highlighted that they collaborated with Rabbis, others encouraged their clients to speak with their Rabbi, but avoided facilitating a therapeutic consultation themselves (Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Horwitz et al., 2019; Rabinowitz, 2014). Finally, several therapists described how they used religious concepts and principles to aid the work, as detailed by other researchers (Box Bayes & Loewenthal, 2013; Golker & Cioffi, 2021; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021; Whiteley, 2016).

The therapists' experiences of supporting OJ adolescents involved grappling with cultural sensitivity. The therapists seemed to show cultural humility (Mosher et al., 2017), by acknowledging cultural values, allowing the client to take a lead on what was permissible to discuss, considering the usefulness of Rabbinic involvement, and at times, utilising religious ideas in the work in order to offer culturally informed practice.

The third GET, *'Helping Chareidi Gen Z on their journey to adulthood'*, revealed several factors that played a part in the therapists' experiences of offering therapy to Chareidi adolescents. Therapists talked about how their support could be viewed as being a stepping-stone for future help and the pressure they felt to make clients feel better. They observed the significant expectations put on adolescents, felt sadness at adolescents' lack of positive adult role models and a responsibility to educate adolescents about keeping themselves safe. They also considered the realistic time frame within which they were able to have an impact.

Whilst to date insufficient literature exists on MH in UK OJ adolescents, anecdotally it is believed that significant levels of psychological distress is present in some Chareidi adolescent clients, as reported by the local OJ MH organisations such as Noa Girls and JTeen. The findings in this study also evidenced this, for example in the therapists' sadness about their clients' difficulties. One therapist described today's adolescents as '*battle-worn, [...] confused, and [...] harassed*'; another spoke about the small window of opportunity to support older adolescents therapeutically before they got married. Some therapists talked about how they felt saddened when they perceived clients having a lack of direction. They talked about the high expectations placed upon adolescents to achieve academically, socially, and religiously, similarly described by Latzer et al. (2019), and how they experienced adolescent behaviour that was culturally viewed as rebellious and antithetical to religious obedience (Hess, 2018) as an opportunity to forge therapeutic trust and relational safety.

The fourth GET, '*Experiencing connection and disconnection*', illustrated a divergent theme of how the therapists related to their clients. In the subtheme, '*Feeling connected*', a shared kinship and loyalty was portrayed, even a sense of being related to each other. This sense of familiarity influenced how therapists viewed their work with OJ clients and helped them build trust and rapport in the therapeutic relationship. For some therapists, the work felt spiritually meaningful, for others it appeared to be grounded in their religious commitment of caring for fellow Jews (Loewenthal, 2006a) and shaped their motivation to broaden clients' perspectives. Like in the existing research, some therapists viewed their work as a religious calling (Baruch, 2014; Podolsky-Krupper & Goldner, 2021; Wang & Perlman, 2021) and they cared for and connected deeply to the OJ adolescents they supported (Baruch, 2014; Bloch et al., 2022; Golker & Cioffi, 2021).

The second subtheme, *'When values are at odds with each other: feeling disconnected'*, highlighted how clashing values and feelings of disconnection triggered visceral responses in some therapists, perhaps specifically *because* of the feelings of connection and familiarity described above. Making sense of physical embodiments of experience is central to IPA (Smith, 2011a). The IPA literature suggests that a consideration of the interaction between a participant's visceral, embodied response and their cognitive interpretation of and emotional reaction to it, offers rich information about their experience. In this study, the therapists described their embodied responses when values clashed. They discussed how they interpreted these feelings and managed them, and they admitted how the similarities between their intertwined cultural identities made reserving judgment harder and had them feel more fiercely responsible towards their clients.

To summarise, the evidence from the research about supporting OJ adults appears to be reflected in the experiences of therapists supporting OJ adolescents too. Overall, the experiences of the seven therapists in this study highlighted how a shared culture and religion can foster understanding within a therapeutic relationship and build connection, trust, and rapport, and how understandably, many clients seek therapeutic support from therapists who they believe have a similar understanding of the world (Band-Winterstein & Freund, 2015; Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017; Golker & Cioffi, 2021; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021; Rosmarin & Pirutinsky, 2020; Sharman & Jinks, 2019). ). It also demonstrated the challenges of this commonality, for example how managing confidentiality and the protection of privacy, and bracketing assumptions of shared understanding is particularly central to the work (Bloch et al., 2022; Box-Bayes; Golker & Cioffi, 2021; McEvoy et al., 2017; Podolsky-Krupper & Goldner, 2021; Keidar et al., 2021; Whiteley, 2016). Furthermore, the

findings indicated how clashes in values can feel very personal due to the social, cultural, and religious interconnectedness between therapist and client (Band-Winterstein & Freund, 2015; Rabinowitz, 2014). This relates to the concept of moral injury. Standard moral injury involves a person experiencing negative emotional and cognitive consequences after witnessing a situation where a culpable and immoral transgression was perpetrated (Griffin et al., 2019). Complex moral injury can occur in non-culpable situations, where existential and spiritual conflict, and a betrayal or disruption of core values affects one's world view or interpersonal relationships (Fleming, 2022). The discomfort felt by the therapists in this study when confronted with clashing values, highlighted how they each uniquely appeared to manage complex moral injury in their work.

The experience of supporting young people during adolescence highlighted how this life stage can be fraught with change, but also how adolescence in Gen Z might differ to how the therapists' might have experienced it themselves one or two generations earlier.

Therapists appear to be exposed to issues and presentations that are different to working with adults, and face dealing with unique aspects of Gen Z's developmental trajectory (Mahapatra et al., 2022), alongside broader considerations regarding the tasks, life cycle transitions, and rate of developmental progression inherent during the period of adolescence (Branje, 2022; Linford, 2022).

#### **4.2. Strengths and limitations**

The purpose of this study was to involve OJ therapists in research, so that their experiences were centred as practitioners involved in MH support for Chareidi adolescents. The aim was to build relationships between the research community and the OJ MH community, so that

in the future, MH experiences amongst OJ youth might be explored directly with the adolescents themselves.

An important principle in the present study was to engage in stakeholder participation, so that the research could be directly informed by community-driven aims and objectives (Conrad & Scannapieco, 2021). Consultation with various stakeholders throughout the research process informed how the study was conducted, helped me engage in self-awareness, reflexivity, intentionality, and to approach the data with purpose, and assisted in my interpretations of the collected data. As an insider researcher committed to bracketing my own agenda, I acknowledge that my ideas will have affected my line of questioning during the interview process and influenced the hermeneutic circle during data analysis. Nevertheless, using IPA allowed for an inductive approach that centred the therapists' experiences.

The proliferation of online research data collection enabled participants with limited time outside of their work and family commitments to take part in virtual interviews. This allowed for voices that might have otherwise been marginalised in research to be included (BPS, 2021c; Jackson, 2022).

IPA methodology was rigorously followed, and the study was deemed a sufficiently good quality piece of research based on Nizza et al.'s (2021) quality indicators of excellence. The study was aligned with Smith's (2011a) quality criteria and offered an in-depth data analysis, included themes that were each distributed across most participants, and engaged the reader in the intricacies of offering therapy to OJ female adolescents.

Overall, the findings highlighted how much can be learnt from this group of therapists about the respect that they give their clients, their desire to be culturally sensitive and open to

their clients' perspectives, how they let clients take a lead on what they feel comfortable to talk about in therapy, how they manage clashing values and acknowledge them introspectively, and finally, how they work with clients without pushing their own agenda.

Nevertheless, several factors could have improved the present study. Firstly, working harder to engage adolescents in the stakeholder consultation could have helped focus the research more directly on adolescent MH. Whilst the general research topic of this study was adolescent MH, it was captured and interpreted through a third-party lens. By interpreting adolescent MH through therapist experiences, the absence of adolescents themselves was felt. For example, research consultant meetings were frequently and inadvertently punctuated with speculative hypotheses about adolescent experience, rather than focusing solely on the experiences of the therapists in the study. This highlighted the curiosity of the research group to understand Chareidi adolescents' understanding of their MH, brought to light the importance of the research community to continue to break down barriers and to develop trusting relationships with the community, so that adolescents can be encouraged to participate in research, and so that adolescent positions can be represented and honoured in the academic literature. Whilst engaging adolescents in research consultation appeared difficult on this occasion, alternative research methodologies might have been more effective, for example using photovoice or other community psychology principles that might have encouraged adolescents to participate (Macias et al., 2023).

A further limitation was that due to time constraints, the participating therapists were not consulted on their views about the themes extracted from the data. This could have added a further triangulation of the findings.

The participatory research design (Conrad & Scannapieco, 2021) demanded from the principal researcher critical self-reflection, ethical practice, and clear communication to all the consultants. At times, communication about my expectations of the consultants appeared not clear enough and resulted in some consultants feeling confused and unsure. Supervision helped mitigate these challenges, but offering consultants further information about the research methodology, clarity about the purpose of their roles, and a less ambiguous explanation of my intentions within meetings might have helped reduce confusion.

When discussing the findings with the stakeholder group, overall, consensus of my interpretations appeared high. However, whilst participatory research includes stakeholder perspectives, it also runs the risk of being perceived as fully reflective of *all* community members' experiences. This assumption can result in a concealment of alternative community perspectives and marginalise voices that are already excluded (Caretta & Pérez, 2019). The inclusion of stakeholders in this study therefore not only increased the risk of misunderstanding within the consultation group, but also stressed the challenge of how to manage conflicting opinions and reach adequate consensus.

On one occasion, a consultant experienced a negative visceral response to a therapist's quote, and a discussion ensued as to whether it was to be included in the findings, or not. In this particular quote, participant Malka asserted that she would only work with Jewish clients because she felt it (at least partly) fulfilled her religious purpose in life. The consultant felt that they adhered more strongly to the concept of caring for all people regardless of their religious or cultural denomination (*'Beloved is man for he was created in the image of G-d'*, Ethics of the Fathers, 3:14). The consultant expressed anxiety that Malka's quote could

be interpreted by readers as portraying the experience of *all* Jewish, or OJ therapists. As a group, we agreed that religiously, views within the Jewish community were varied, and whilst some OJ practitioners might hold views such as Malka's, others might feel that it was antithetical to their pluralistic position of supporting anyone, regardless of their faith background.

This incident appeared to reflect a broader experience of both the participants and stakeholders involved in this study. Malka felt close and connected to her clients through their religious status, but 'contaminated' when they brought ideas into the room that were antithetical to her beliefs. Rachel felt her blood boil when her values clashed with her clients'. Much like these therapists, it appeared that when the consultant was confronted with an idea that felt disagreeable, it engendered intense feelings. This mirroring of the participants' experience in consultants resulted in a discussion on how the research findings would be interpreted by the readership, and how they would judge and make sense of the research findings based on their own relationship with the researched phenomenon.

The scenario highlighted the importance of leading a research stakeholder group sensitively, considering all the varying perspectives respectfully, and being transparent about the boundaries of stakeholders' involvement. Whilst I acknowledged the consultants' views and perspectives and predominantly followed their recommendations, as the primary researcher engaged in the double hermeneutic process of IPA, I was also the final arbiter on which findings to include, how to interpret and present them, and which reflections about this decision to incorporate.

### **4.3. Implications**

The findings of this study offered several clinical and service implications.

#### **4.3.1. Clinical implications**

The findings highlighted how working within one's own community can create dilemmas relating to how one manages the boundaries between one's personal and professional life. It necessitates practitioners to find a balance between supporting their own community with cultural sensitivity and understanding, whilst simultaneously maintaining professionalism, confidentiality, and discretion, and seeking adequate supervision and reflective spaces to help bracket assumptions and biases. Having cultural and religious knowledge of the OJ community appeared to result in heightened levels of trust and rapport between therapists and clients.

A model that draws attention to culturally informed and sensitive practice, as provided by the seven therapists in this study, is Bernal and Sáez-Santiago's (2006) community psychology framework that was presented earlier in the introduction. The findings clearly indicated that a shared language and culture, and knowledge of the community, aided the therapists' work. The principles of this framework could be utilised clinically in public services, for example to help train teams to support groups that traditionally avoid seeking mainstream support.

The finding that the OJ therapists believed that being culturally matched with their clients generated trust and rapport within the therapeutic relationship is not a universal phenomenon. In a study exploring young black men's experiences of accessing mainstream therapy (Dera, 2021), it was found that an overreliance on cultural matching presumed interpersonal similarity and overlooked other intersecting identities such as gender and religion. Cultural matching presupposed that client and therapist would have congruous life experiences and values, despite the vast diversity of experiences amongst black men. Dera

argued that when black men were matched with black therapists in public services, it also prevented non-black therapists to educate themselves, be exposed to black men's experiences, and develop skills to support black men therapeutically. This finding aligned with Pirutinsky and Rosmarin's (2022) assertion that cultural matching could reinforce exclusion and stigma.

Dera's (2021) findings imply that having a shared culture and religion, like the participants and their clients in this study, can give rise to the assumption that culturally matched clients and therapists might think alike and have congruent beliefs and values. This study highlighted how the therapists, and the primary researcher, had to manage their assumptions carefully. It suggested that clinicians consider their responsibilities and commitments to both their professional practice and to their religious and community practices. It is also proposed that non-Orthodox and non-Jewish practitioners consider their preconceived views about the OJ community and engage in acknowledging and reflecting on their implicit and explicit biases.

#### **4.3.2. Service implications**

Whilst the focus of this study was to explore therapists' experiences of supporting adolescents, inevitably, all the therapists engaged in interpreting their clients' choices, values, and behaviours. Across the different themes, the therapists alluded to the reasons why OJ adolescents might have decided to seek private therapy from them, rather than from mainstream public services.

The therapists unanimously stated that they believed clients were indeed worried about a clash of values in services such as CAMHS, and that many preferred to seek out private therapy for that reason (Galloway & Byrne, 2016; Golker & Cioffi, 2021; Haimovich & Leiser,

2017; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019). They talked about how OJ clients could feel misunderstood when their OJ attitudes and behaviours lay opposed to those in secular Western society. For example, whilst eating a cheeseburger would be considered normative within secular society, it would be a marker of a strong rebellion within Chareidi society. Conversely, some religiously acceptable behaviours could be mislabelled as aberrant within public services (Bloch et al., 2022).

This research clearly highlighted that people like to feel understood. In contrast to Dera's (2021) research, the therapists in this study argued that in the Chareidi community, adolescent clients believe that they will receive stronger understanding from an OJ therapist compared to a non-OJ mainstream therapist. The findings highlighted effects of having a shared minority culture and religion within a therapy context, positioned in a predominantly secular world that is perceived as significantly different in values, beliefs, and lifestyle. Whilst recognising that this study did not hear from the young people directly, this insight should encourage services to increase their collaboration with the communities they serve.

These findings emphasise the importance of policy makers in the NHS to prioritise clinicians' education and training about the different cultural groups in the UK, so that they can exert cultural sensitivity and humility in their work (NHS England, 2020; Pirutinsky & Rosmarin, 2022), and address disparities in access to MH services (e.g., Sewell Report, 2021). In order to serve the population researched in the present study, it would therefore be important to hire suitably qualified OJ practitioners within public services that operate in areas where there are higher concentrations of Jewish populations (Galloway & Byrne, 2016; Greenberg & Witztum, 2013), and to partner with local community organisations (Galloway & Byrne, 2016; Golker & Cioffi, 2021; Kada, 2019), as this can ensure that services are culturally

informed, prevents people from being overlooked within healthcare, and increases the necessary support required for serious mental ill health, for example, self-harm, safeguarding issues, and suicide (Alvarez et al., 2022). It is argued that culturally informed services should publicise their openness, curiosity, and understanding of OJ life, as this could improve engagement and increase access for the OJ population. OJ practitioners working with adolescents are uniquely placed to understand the level of MH stigma that exists for this group and how OJ adolescence is influenced by the demands of familial, communal, cultural, and religious expectation. Culturally aware practitioners can advocate for OJ adolescents' needs and ensure that services are sensitive to their values. Some of this work has already commenced. For example, two OJ charitable organisations in London are commissioned to provide IAPT (Improving Access to Psychological Therapies) services to the Chareidi community (e.g., Bikur Cholim, 2019). It would be useful for these opportunities to expand, and for the impact of these collaborations between public services and OJ charities to be researched and published.

The UK government has repeatedly advocated for an increase in equality, diversity, and inclusion (EDI) within health and social care (e.g., NHS England, 2020; The Sewell report, 2021). Unfortunately, there is evidence that antisemitic and anti-religious prejudice is often side-lined in EDI training (Baddiel, 2021; Kuper, 2023).

Thoughtful planning of multi-cultural competency training (Dera, 2021) should therefore include consultation with Jewish as well as other marginalised groups.

#### **4.4. Recommendations for future research**

This study shed light on an under-researched topic. Whilst it was an attempt at developing trusting conversations within the OJ MH community, it also highlighted that there remain

significant gaps in the literature about service user and service-level MH experience and provision for Chareidi adolescents.

Conducting further MH research projects within the Chareidi community should address several structural levels; e.g., capture Chareidi adolescents' experiences more directly, evaluate Chareidi adolescents' access to services, and research further how partnership work between the different MH organisations within and external to the Chareidi community could be expanded and improved.

On a service user level, research should explore how to involve Chareidi adolescents in conversations about MH, and how to utilise data collection methods that encourage research participation, for example using digital platforms and social media more creatively, or employing photovoice (Macias et al., 2023). Additionally, service evaluations of the community MH initiatives run by organisations such as JTeen and Noa could offer insights on outcomes, benefits, and disadvantages of supporting Chareidi adolescents in the third sector.

In this study, Bernal and Sáez-Santiago's (2006) guidelines also helped during the earlier research stages and could be tested further. For example, during the interview and data collection process, having a shared language and culture, a joint understanding of religious meaning and metaphors, and sensitivity to comprehend the cultural subtext and context of clients' presentations, appeared to aid the development of rapport and trust during the research interviews. This framework could be utilised at the research level, like in the present study, to test out whether having cultural sensitivity in research increases participation of cultural groups who are underrepresented in academia.

Priorities for service-level research are manifold and ideally should be informed by the stakeholders of the OJ community (Caretta & Pérez, 2019; Conrad & Scannapieco, 2021). For example, research could assess the efficacy of MH community projects and evaluate whether they increase MH literacy and understanding within the community, reduce fear and stigma, and increase engagement of the Chareidi community in mainstream services. Research could also investigate the prevalence of Chareidi adolescents in mainstream services, their presentations and outcomes, and evaluate the effectiveness of delivering multi-cultural competency trainings.

Whilst this study centred OJ therapists' experiences, further research might also capture non-Jewish practitioners' and NHS employees' experiences of supporting Chareidi clients. Exploring outsider perspectives could add useful perspectives on how to best support the community and could further inform public policy.

#### **4.5. Dissemination plans**

The exploration of MH within the OJ community is only of value if the findings are shared with relevant stakeholders. Initially, the research findings of this study will be shared with study participants and local community MH organisations supporting Jewish teenagers (e.g., Noa Girls, JTeen, and local CAMHS) as a poster or leaflet. The local Jewish press and special interest groups such as the Jewish MH practitioners Whatsapp group will be contacted to offer more detailed information via interview, webinar, blog, or newspaper article. The findings will also be submitted to a peer-reviewed journal (e.g., *Mental Health, Religion & Culture*; Routledge) that has published research in this field.

Due to my motivation to avoid a 'Chillul Hashem' (as discussed in the Introduction chapter), and an acknowledgment that the Jewish community faces significant antisemitism and

discrimination (Community Security Trust, 2023), the dissemination of findings will be conducted sensitively, in consultation with stakeholders. Dissemination is hoped to serve as a tool to continue developing trusting relationships in the community.

#### **4.6. A final reflection**

In this study, the voices of seven therapists were centred. At times, it was difficult to steer away from interpreting the therapists' *clients*, rather than restricting interpretation to the therapists themselves. I suppose that is because really, I wanted to know how adolescents feel about and manage their wellbeing. So, this project is dedicated to those adolescents of today, who are trying to manage life whilst experiencing MH difficulties, and whose voices were not heard in this project. I want to tell them: "We're here, and we want to listen, and we want your voice heard too." If an adolescent reads this study and thinks, "My voice has not been heard", then I would welcome you with open arms to be courageous and speak up. We want to know what life is like for you, so that we can support you.

## 5. References

- Aburn, G.E., Gott, M., & Hoare, K. (2021). Experiences of an insider researcher – interviewing your own colleagues. *Nurse Researcher*. doi: 10.7748/nr.2021.e1794
- Adisa, T.A., Antonacopoulou, E., Beauregard, T.A., Dickmann, M., & Adekoya, O.D. (2022). Exploring the impact of COVID-19 on employees' boundary management and work-life balance. *British Journal of Management*, 33(4), 1694-1709. doi: 10.1111/1467-8551.12643
- Ahern, K.J. (1999). Ten tips for reflexive bracketing, *Qualitative Health Research*, 9(3), 407-411.
- Alvarez, K., Polanco-Roman, L., Samuel Breslow, A., & Molock, S. (2022). Structural racism and suicide prevention for ethno-racially minoritized youth: A conceptual framework and illustration across systems. *American journal of psychiatry*, 179(6), 422-433.
- Andrews, J.L., Ahmed, S.P., & Blakemore, S.J. (2021). Navigating the social environment in adolescence: The role of social brain development. *Biological Psychiatry*, 89(2), 109-118. doi: 10.1016/j.biopsych.2020.09.012
- Baddiel, D. (2021). *Jews don't count*. UK: TLS Books.
- Baker, S. (2016). Working in the present moment: The impact of mindfulness on trainee psychotherapists' experience of relational depth. *Counselling and Psychotherapy Research*, 16, 5-14. doi: 10.1002/capr.12038
- Band-Winterstein, T., & Freund, A. (2014). Is It Enough to 'Speak Haredi'? Cultural Sensitivity in Social Workers Encountering Jewish Ultra-Orthodox Clients in Israel. *The British Journal of Social Work*, 45(3), 968-987. doi: 10.1093/bjsw/bct167

Barker, C., Pistrang, N., & Elliott, R. (2015). *Research methods in clinical psychology: An introduction for students and practitioners*. John Wiley & Sons.

Barlow, D.H., & Eustis, E.H. (2022). The importance of idiographic and functionally analytic strategies in the unified protocol for transdiagnostic treatment of emotional disorders. *Journal of Contextual Behavioral Science, 24*, 179-184.

Baruch, D. (2014). *Lived Experiences of Orthodox Jewish Professionals Working with At-Risk Youth in the Orthodox Community* [Unpublished Doctoral Thesis]. USA: University of Wisconsin-Milwaukee. <https://dc.uwm.edu/etd/662>

Beck, A.T. (1963). Thinking and depression: I. Idiosyncratic content and cognitive distortions. *Archives of General Psychiatry, 9*(4), 324-333. doi: 10.1001/archpsyc.1963.01720160014002

Bernal, G., & Sáez-Santiago, E. (2006). Culturally centred psychosocial interventions. *Journal of Community Psychology, 34*, 121-132.

Bikur Cholim (2019). *Annual Review 2019*. <https://bikurcholim.co.uk/about-us/>

Bix, A.S. (2020). 'Remember the Sabbath': a history of technological decisions and innovation in Orthodox Jewish communities. *History and Technology, 36*(2), 205-239, doi: 10.1080/07341512.2020.1816339

Bloch, A.M., Gabbay, E., Gerber, L.M., Dickerman, A.L., Knowlton, S., & Fins, J.J. (2022). Challenges and strategies in the psychiatric care of the ultra-Orthodox Jewish population: A thematic analysis of 18 psychiatrist interviews. *Transcultural psychiatry*. Advance online publication. doi: 10.1177/13634615221126052

- Bowtell, E.C., Sawyer, S.M., Aroni, R.A., Green, J.B., & Duncan, R.E. (2013). "Should I Send a Condolence Card?" Promoting Emotional Safety in Qualitative Health Research Through Reflexivity and Ethical Mindfulness. *Qualitative Inquiry, 19*(9), 652-663. doi: 10.1177/1077800413500927
- Box Bayes, J.E., & Loewenthal, K.M. (2013). How do Jewish teachings relate to beliefs about depression in the strictly orthodox Jewish community? *Mental Health, Religion & Culture, 16*(8), 852-862. doi: 10.1080/13674676.2012.726215
- Branje, S. (2022). Adolescent identity development in context. *Current Opinion in Psychology, 45*, 101286. doi: 10.1016/j.copsyc.2021.11.006
- British Association for Counsellors and Psychotherapists (2023, February). *BACP equality, diversity and inclusion strategy*. <https://www.bacp.co.uk/about-us/edi/edi-strategy/>
- British Psychological Society (2021a). *BPS Code of Human Research Ethics*. British Psychological Society. <https://explore.bps.org.uk/content/report-guideline/bpsrep.2021.inf180>
- British Psychological Society (2021b, December 8). *Code of Ethics and Conduct* [Guidance]. Leicester: British Psychological Society. doi: 10.53841/bpsrep.2021.inf94
- British Psychological Society (2021c). *Ethics guidelines for internet-mediated research*. British Psychological Society. <https://explore.bps.org.uk/content/report-guideline/bpsrep.2021.rep155>
- British Psychological Society (2022a, May 16). *Using Community Psychology approaches to reduce the impact of inequality through the Community Mental Health Framework*

[Guidance BRE52a]. <https://www.bps.org.uk/guideline/using-community-psychology-approaches-reduce-impact-inequality-through-community-mental>

British Psychological Society (2022b, March 8). *Children and Young People's Mental Health and Psychological Wellbeing* [Briefing]. <https://www.bps.org.uk/news/bps-responds-analysis-and-reports-decline-children-and-young-peoples-mental-health>

Burn, A.M., Vainre, M., Humphrey, A., & Howarth, E. (2020). Evaluating the CYP-IAPT transformation of child and adolescent mental health services in Cambridgeshire, UK: a qualitative implementation study. *Implementation Science Communications*, 1(89). doi: 10.1186/s43058-020-00078-6

Busetto, L., Wick, W., & Gumbinger, C. (2020). How to use and assess qualitative research methods. *Neurological Research and Practice*, 2(14). doi: 10.1186/s42466-020-00059-z

Caretta, M.A., & Pérez, M.A. (2019). When Participants Do Not Agree: Member Checking and Challenges to Epistemic Authority in Participatory Research. *Field Methods*, 31(4), 359-374. doi: 10.1177/1525822X19866578

Clark, S.C. (2000). *Work/Family Border Theory: A New Theory of Work/Family Balance*. *Human Relations*, 53(6), 747-770. doi: 10.1177/0018726700536001

Community Security Trust (2023, February 9). *Antisemitic Incidents Report 2022*. <https://cst.org.uk/news/blog/2023/02/09/antisemitic-incidents-report-2022>

Conrad, P., & Scannapieco, M. (2021). Assessing the needs of urban American Indians in north Texas: a community-based participatory research project. *American Indian & Alaska Native Mental Health Research: The Journal of the National Center*, 28(2).

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: The SPIDER tool for qualitative evidence synthesis. *Qualitative Health Research, 22*(10), 1435-1443.

*Critical Appraisal Skills Programme (2022). CASP Qualitative Studies Checklist.* Retrieved November 30, 2022, from <https://casp-uk.net>

Cruzes, D.S., & Dybå, T. (2011). Recommended Steps for Thematic Synthesis in Software Engineering. *International Symposium on Empirical Software Engineering and Measurement, 275-284.* doi: 10.1109/ESEM.2011.36

Cushman, P. (2011). The danger of cure, the value of healing: Toward a Midrashic way of being. In R. W. Cutter (Ed.), *Midrash and medicine* (pp. 211-233). Woodstock, VT: Jewish Lights.

Davies, A. (2019). Carrying out systematic literature reviews: an introduction. *British Journal of Nursing, 28*(15), 1008-1014.

Davies, V. (2021). No wrong door: Addressing injustices and achieving better mental healthcare provision for under-18s in acute physical healthcare settings. *BJPsych Bulletin, 1-7.* doi: 10.1192/bjb.2021.1

Dera, N. (2021). *A Thematic Analysis Exploring Young Black Men's Experiences of Accessing and Engaging in Psychological Therapy within Primary Care* [Unpublished Doctoral Thesis]. UK: University of Hertfordshire. doi: 10.18745/th.25177

Dessler, E.L. (1963). *Mikhtav me-Eliyahu*. Israel: The Committee for the publication of the writings of Rabbi E.L. Dessler.

- Dörfler, V., & Stierand, M. (2021). Bracketing: a phenomenological theory applied through transpersonal reflexivity, *Journal of Organizational Change Management*, 34(4), 778-793. doi: 10.1108/JOCM-12-2019-0393
- Fish, N. (2011). *Nachas Ruach: Torah-based psychotherapy and tools for growth and healing*. US: Targum Press.
- Fleming, W.H. (2022). Complex Moral Injury: Shattered Moral Assumptions. *Journal of Religion and Health*, 61, 1022-1050. doi: 10.1007/s10943-022-01542-4
- Flemming, K., & Noyes, J. (2021). Qualitative Evidence Synthesis: Where Are We at? *International Journal of Qualitative Methods*, 20. doi: 10.1177/1609406921993276
- Freund, A., & Band-Winterstein, T. (2017). Cultural Psychiatry: A Spotlight on the Experience of Clinical Social Workers' Encounter with Jewish Ultra-Orthodox Mental Health Clients. *Community mental health journal*, 53(5), 613-625. doi: 10.1007/s10597-016-0056-9
- Gabbay, E., McCarthy, M.W., & Fins, J.J. (2017). The Care of the Ultra-Orthodox Jewish Patient. *Journal of Religion & Health*, 56, 545-560. doi: 10.1007/s10943-017-0356-6
- Galloway, A., & Byrne, A. (2016). 'There is something about working together': Improving talking therapies provision to the Orthodox Jewish communities of North London. *PBS Clinical Psychology Forum*, 284, 38-42.
- Gehl, N. (2014). Jewish care and counseling. In D.A. Leeming (Ed.), *Encyclopedia of Psychology and Religion* (pp. 913-916). Springer. doi: 10.1007/978-1-4614-6086-2\_9239

Glaser, K. (2022, October 10). *Are the kids OK? The mental health crisis among Jewish teens.*

Jewish Chronicle. <https://www.thejc.com/life-and-culture/all/are-the-kids-ok-the-mental-health-crisis-among-jewish-teens-2zyGZZ7ITfUjOvdw7tOIMW>

Glenton, C., Bohren, M.A., Downe, S., Paulsen, E.J., Lewin. S., on behalf of Effective Practice

and Organisation of Care (EPOC). (2020). *EPOC Qualitative Evidence Synthesis:*

*Protocol and review template (Version 1.1).* Oslo: Norwegian Institute of Public

Health. <http://epoc.cochrane.org/epoc-specific-resources-review-authors>

Glinert, L., Loewenthal, K.M., & Goldblatt, V. (2003). Guarding the tongue: A thematic

analysis of gossip control strategies among orthodox Jewish women in

London. *Journal of multilingual and multicultural development*, 24(6), 513-524. doi:

10.1080/01434630308666514

Golker, C., & Cioffi, M.C. (2021). Cultural adaptations of cognitive behaviour therapy for the

Orthodox Jewish community: a qualitative study of therapists' perspectives. *The*

*Cognitive Behaviour Therapist*, 14(e3), 1-20. doi: 10.1017/S1754470X20000616

Graham, D., & Boyd, J. (2022, November 29). *Jews in Britain in 2021: First results from the*

*Census of England and Wales.* Institute for Jewish Policy Research.

<https://www.jpr.org.uk/reports/jews-britain-2021-first-results-census-england-and-wales>

Graham, D., Lessof, C., & Boyd, J. (2020, October 5). *Hidden effects: The mental health of the*

*UK's Jewish population during the COVID-19 pandemic.* Institute for Jewish Policy

Research. <https://www.jpr.org.uk/reports/hidden-effects-mental-health-uks-jewish-population-during-covid-19-pandemic>

Greenberg, D., & Witztum, E. (2001). *Sanity and sanctity – mental health work among the ultra-orthodox in Jerusalem*. New Haven, CT: Yale University Press.

Greenberg, D., & Witztum, E. (2013). Challenges and conflicts in the delivery of mental health services to Ultra-Orthodox Jews. *Asian Journal of Psychiatry*, 6(1), 71-73. doi: 10.1016/j.ajp.2012.10.008

Griffin, B., Purcell, N., Burkman, K., Litz, B., Bryan, C., Schmitz, M., Villierme, C., Walsh, J., & Maguen, S. (2019). Moral injury: An integrative review. *Journal of Traumatic Stress*, 32(3), 350-362. doi: 10.1002/jts.22362

Haimovich, M., & Leiser, D. (2017). Ultra-Orthodox Jewish perceptions of psychotherapy and psychopathology. *Bar-Ilan University Press*, 32.

Heilman, S.C., & Witztum, E. (1997). Value-sensitive therapy: Learning from ultra-orthodox patients. *American Journal of Psychotherapy*, 51(4), 522-541. doi: 10.1176/appi.psychotherapy.1997.51.4.522

Hess, E. (2018). Authority, psychotherapy and the authority of the therapist in the religious Haredi community. *The American Journal of Psychoanalysis*, 78(2), 137-158. doi: 10.1057/s11231-018-9137-6

Holliman, R., & Wagner, A. (2015). Responsive counseling in Jewish Orthodox communities. *Journal of Counselor Practice*, 6, 56-75. doi: 10.22229/joc038712

Horwitz, B., Littman, R., Greenberg, D., & Huppert, J.D. (2019). A qualitative analysis of contemporary ultra-orthodox rabbinical perspectives on scrupulosity. *Mental Health, Religion & Culture*, 22(1), 82-98. doi: 10.1080/13674676.2019.1585778

- 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*(10), 925-941. doi: 10.1002/jclp.20404
- Ikävalko, E., & Brunila, K. (2019). Coming to discursive-deconstructive reading of gender equality. *International Journal of Research & Method in Education, 42*(1), 33-45. doi: 10.1080/1743727X.2017.1413085
- Interlink, Orthodox Jewish Voluntary Action (2016). *Proposal to City & Hackney CCG: Meeting gaps in mental health services for Charedi children and young people* [Unpublished manuscript].
- Ives, Y. (2016). Making a Jewish Contribution to the Social Sciences: What Are Jewish Social Values and Why Do They Matter? In M. Ben-Avie, Y. Ives, & K. Loewenthal (Eds.), *Applied Jewish Values in Social Sciences and Psychology* (pp. 1-19). Springer. doi: 10.1007/978-3-319-21933-2\_7
- Jackson, J. (2022). Expanding opportunities to maximise research recruitment and data collection using digital tools. *International Journal of Social Research Methodology*. doi: 10.1080/13645579.2022.2091258.
- Jewish Chronicle (2021, September 2). *Camp Simcha expands to support children with serious mental health issues*. <https://www.thejc.com/community/community-news/camp-simcha-expands-to-support-children-with-serious-mental-health-issues-1.520041>
- Jewish Weekly (2021, May 4). *Highly successful evening on “Navigating Teen Challenges”*. <https://thejewishweekly.com/highly-successful-evening-on-navigating-teen-challenges/>

JTeen (2023). *JTeen Summary Report January 2021 – January 2023* [Unpublished Data].

Kada, R. (2019). Cultural adaptations of CBT for the British Jewish Orthodox community. *The Cognitive Behaviour Therapist*, 12, 1-9. doi: 10.1017/S1754470X18000120

Keidar, L., Regev, D., & Snir, S. (2021). Non-Haredi Arts Therapists' Perceptions of Therapy With Ultra-Orthodox Children. *Frontiers in Psychology*, 12, 599872. doi: 10.3389/fpsyg.2021.599872

Krauskopf, I.E., Bates, G.W., & Cook, R. (2023). Children of Holocaust Survivors: The Experience of Engaging with a Traumatic Family History. *Genealogy*, 7(1), 20. doi: 10.3390/genealogy7010020

Kuper, A. (2023). Reflections on addressing antisemitism in a Canadian faculty of medicine. *Canadian Medical Education Journal*, 14(2), 158-170. doi: 10.36834/cmej.76086

Latzer, Y., Stein, D., & Witztum, E. (2019). Treating ultra-orthodox adolescents with eating disorders in Israel: Culturally sensitive interventions, difficulties, and dilemmas. *Journal of Clinical Psychology*, 75(8), 1455-1468. doi: 10.1002/jclp.22790

Leavey, G., Loewenthal, K.M., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. *Social Science & Medicine*, 65(3), 548-559. doi: 10.1016/j.socscimed.2007.03.050

Levitt, H.M., Surace, F.I., Wu, M.B., Chapin, B., Hargrove, J.G., Herbitter, C., Lu, E.C., Maroney, M.R., & Hochman, A.L. (2022). The meaning of scientific objectivity and subjectivity: From the perspective of methodologists. *Psychological Methods*, 27(4), 589-605. doi: 10.1037/met0000363

- Lewin, S., Bohren, M., Rashidian, A., Munthe-Kaas, H., Glenton, C., Colvin, C.J., Garside, R., Noyes, J., Booth, A., Tunçalp, Ö., Wainwright, M., Flottorp, S., Tucker, J.D., & Carlsen, B. (2018). Applying GRADE-CERQual to qualitative evidence synthesis findings - paper 2: how to make an overall CERQual assessment of confidence and create a Summary of Qualitative Findings table. *Implementation Science*, *13* (Suppl. 1), 10. doi: 10.1186/s13012-017-0689-2
- Linford, H. (2022). *Safeguarding young people: risks, rights, resilience and relationships*. London: Jessica Kingsley Publishers.
- Loewenthal, K.M. (2006a). Orthodox Judaism: Issues and features for psychotherapy. In E.T. Dowd & S.L. Nielsen (Eds.), *The psychologies in religion: Working with the religious client* (pp. 203-217). New York: Springer.
- Loewenthal, K.M. (2006b). Strictly orthodox Jews and their relations with psychotherapy and psychiatry. *World Association of Cultural Psychiatry*, 128-132.
- Loewenthal, K.M., & Rogers, M.B. (2004). Culture-Sensitive counselling, psychotherapy, and support groups in the orthodox-Jewish community: How they work and how they are experienced. *International Journal of Social Psychiatry*, *50*(3), 227-240. doi: 10.1177/0020764004043137.
- Lyons, H.Z., Bike, D.H., Ojeda, L. Johnson, A., Rosales, R., & Flores, L.Y. (2013). Qualitative research as social justice practice with culturally diverse populations. *Journal for social action in counselling and psychology*, *5*(2), 10-25.
- Macias, R.L., Nava, N., Delgadillo, D., Beschel, J., & Kuperminc, G. (2023). Finding voice in a year of collective trauma: case study of an online photovoice project with youth. *American journal of community psychology*, *71*, 114-122. doi: 10.1002/ajcp.12630

Madill, A., & Sullivan, P. (2018). Mirrors, portraits, and member checking: Managing difficult moments of knowledge exchange in the social sciences. *Qualitative Psychology*, 5(3), 321-339. doi: 10.1037/qup0000089

Mahapatra, G.P., Bhullar, N., & Gupta, P. (2022). Gen Z: an emerging phenomenon. *NHRD Network Journal*, 15(2), 246-256. doi: 10.1177/26314541221077137

Margolese, H.C. (1998). Engaging in Psychotherapy with the Orthodox Jew. *American Journal of Psychotherapy*, 52(1), 37-53. doi: 10.1176/appi.psychotherapy.1998.52.1.37

Mashiah, D.C. (2018). *Vital statistics of the UK Jewish population: births and deaths*. UK: Institute for Jewish Policy Research.

McEvoy, P., Williamson, T., Kada, R., Frazer, D., Dhliwayo, C., & 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, 557-572. doi: 10.1186/s12913-017-2509-4

Moran, D. (2013). Edmund Husserl and phenomenology. In A. Bailey (Ed.), *Philosophy of Mind: The Key Thinkers* (pp. 37-58). London: Bloomsbury.

Moritsugu, J., Vera, E., Wong, F.Y., & Duffy, K.G. (2019). *Community Psychology* (1st Edition). Routledge. doi: 10.4324/9780429021558

Mosher, D.K., Hook, J.N., Captari, L.E., Davis, D.E., DeBlaere, C., & Owen, J. (2017). Cultural humility: A therapeutic framework for engaging diverse clients. *Practice Innovations*, 2(4), 221-233. doi: 10.1037/pri0000055

- Neubauer, B.E., Witkop, C.T., & Varpio, L. (2019). How phenomenology can help us learn from the experiences of others. *Perspectives on medical education, 8*, 90-97. doi: 10.1007/s40037-019-0509-2
- Newlove-Delgado, T., Marcheselli, F., Williams, T., Mandalia, D., Davis, J., McManus, S., Savic, M., Treloar, W., & Ford, T. (2022). *Mental Health of Children and Young People in England*. Leeds: NHS Digital.
- NHS England (2020, October 16). *Advancing mental health equalities strategy* [Guidance]. <https://www.england.nhs.uk/publication/advancing-mental-health-equalities-strategy/>
- Nizza, I.E., Farr, J., & Smith, J.A. (2021). Achieving excellence in interpretative phenomenological analysis (IPA): Four markers of high quality. *Qualitative Research in Psychology, 18*(3), 369-386. doi: 10.1080/14780887.2020.1854404
- Noa Girls (2023). *Noa Girls Impact Report 2022* [Unpublished Data].
- Nochaiwong, S., Ruengorn, C., Thavorn, K., Hutton, B., Awiphan, R., Phosuya, C., Ruanta, Y., Wongpakaran, N., & Wongpakaran, T. (2021). Global prevalence of mental health issues among the general population during the coronavirus disease-2019 pandemic: a systematic review and meta-analysis. *Scientific Reports, 11*, 10173. doi: 10.1038/s41598-021-89700-8
- O'Neill, L., Koehn, C., George, S., & Shepard, B. (2016). Mental health provision in northern Canada: practitioners' views on negotiations and opportunities in remote practice. *International Journal for the Advancement of Counselling, 38*, 123-143. doi: 10.1007/s10447-016-9261-z

Office for Health Improvement & Disparities (2022, February 28). *Wellbeing and mental health: Applying All Our Health* [Guidance].

<https://www.gov.uk/government/publications/wellbeing-in-mental-health-applying-all-our-health>

Page, M.J., McKenzie, J.E., Bossuyt, P.M., Boutron, I., Hoffmann, T.C., Mulrow C.D., Shamseer, L., Tetzlaff, J.M., Akl, E.A., Brennan, S.E., Chou, R., Glanville, J., Grimshaw, J.M., Hróbjartsson, A., Lalu, M.M., Li, T., Loder, E.W., Mayo-Wilson, E., McDonald, S. . . . Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. *British Medical Journal*, 372, n71. doi: 10.1136/bmj.n71

Perry, A., Gardener, C., Dove, J., Eiger, Y., & Loewenthal, K.M. (2018). Improving mental health knowledge of the Charedi Orthodox Jewish Community in North London: A partnership project. *International Journal of Social Psychiatry*, 64(3), 235-247. doi: 10.1177/0020764018756935

Pirutinsky, S., & Rosmarin, D.H. (2022). A comparative study of mental health diagnoses, symptoms, treatment, and medication use among Orthodox Jews. *Transcultural Psychiatry*, 59(6), 756-766. doi: 10.1177/13634615211068607

Pirutinsky, S., Schechter, I., Kor, A., & Rosmarin, D.H. (2015). Family size and psychological functioning in the Orthodox Jewish community. *Mental Health, Religion & Culture*, 18(3), 218-230.

Podolsky-Krupper, C., & Goldner, L. (2021). "God is a painter": How Jewish Ultra-Orthodox art therapists and clients perceive mental health treatment. *Transcultural psychiatry*, 58(6), 731-744. doi: 10.1177/1363461520944742

- Popovsky, M.A. (2010). Special issues in the care of ultra-orthodox Jewish psychiatric in-patients. *Transcultural Psychiatry*, 47(4), 647-672. doi: 10.1177/1363461510383747
- QSR International Pty Ltd. (2018). *NVivo qualitative data analysis*. Version 12 Pro [Software]. <https://support.qsrinternational.com/nvivo/s/>
- Rabinowitz, A. (2014). Psychotherapy with Orthodox Jews. In P.S. Richards & A.E. Bergin (Eds.), *Handbook of psychotherapy and religious diversity* (pp. 233-256). American Psychological Association. doi: 10.1037/14371-010
- Rapp, D.J., Hughey, J.M., & Kreiner, G.E. (2021). Boundary work as a buffer against burnout: Evidence from healthcare workers during the COVID-19 pandemic. *Journal of Applied Psychology*, 106(8), 1169-1187. doi: 10.1037/apl0000951
- Rosmarin, D.H., & Pirutinsky, S. (2020). Do religious patients need religious psychotherapists? A naturalistic treatment matching study among Orthodox Jews. *Journal of Anxiety Disorders*, 69, 102-170. doi: 10.1016/j.janxdis.2019.102170
- Rowland, G. (2016). *How do parents within the Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?* [Unpublished Doctoral Thesis]. UK: University of East London.
- Samier, E.A., & ElKaleh, E.S. (2023). Introduction: Exploring culturally sensitive and Indigenous research methods. In *Culturally Sensitive Research Methods for Educational Administration and Leadership* (pp. 1-22). London: Routledge.
- Sayer, A. (1992). *Method in social science: a realist approach* (2nd Edition). London: Routledge.

- Schleider, Z.S. (2021). *Therapeutic Thinking on the Parameters of Engagement for Working with Orthodox Jewish Children and Adolescents* [Unpublished Master's Thesis]. UK: Middlesex University.
- Schleiermacher, F. (1998). *Hermeneutics and Criticism and other Writings* (A. Bowie, Trans and Ed.). Cambridge: Cambridge University Press. doi: 10.1017/CBO9780511814945.001
- Schnall, E. (2006). Multicultural counseling and the Orthodox Jew. *Journal of Counseling & Development, 84*, 276-282. doi: 10.1002/j.1556-6678.2006.tb00406.x
- Schnall, E., Kalkstein, S., Gottesman, A., Feinberg, K., Schaeffer, C. B., & 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), 161-173. doi: 10.1002/j.2161-1912.2014.00052.x
- Shabtai, D.G., Pirutinsky, S., Rosmarin, D.H., & Ives, Y. (2016). Integrating Judaism into cognitive behavioral therapy. In M. Ben-Avie, Y. Ives, & K. Loewenthal (Eds.), *Applied Jewish Values in Social Sciences and Psychology* (pp. 133-149). Springer. doi: 10.1007/978-3-319-21933-2\_7
- Shafran, A. (2014, February 24). *Don't Call Us 'Ultra-Orthodox'*. Forward. <https://forward.com/opinion/193209/dont-call-us-ultra-orthodox/>
- Sharman, S., & Jinks, G.H. (2019). How are counselling and therapeutic services experienced by orthodox Jewish primary schools in North-West London? What are the cultural sensitivities, attitudes, and beliefs of senior staff members in these schools? *Mental Health, Religion and Culture, 22*(4), 331-343, doi: 10.1080/13674676.2019.1571027

Smith, J.A. (2011a). Evaluating the contribution of interpretative phenomenological analysis.

*Health Psychology Review*, 5(1), 9-27. doi: 10.1080/17437199.2010.510659

Smith, J.A. (2011b). Evaluating the contribution of interpretative phenomenological analysis:

a reply to the commentaries and further development of criteria. *Health Psychology*

*Review*, 5(1), 55-61. doi: 10.1080/17437199.2010.541743

Smith, J.A., & Nizza, I.E. (2022). *Essentials of interpretative phenomenological analysis*.

American Psychological Association.

Smith, J.A., Flowers, P., & Larkin, M. (2022). *Interpretative Phenomenological Analysis:*

*Theory, Method and Research*. (2<sup>nd</sup> Edition). London: Sage.

Solmi, M., Radua, J., Olivola, M., Croce, E., Soardo, L., Salazar de Pablo, G., Il Shin, J.,

Kirkbride, J.B., Jones, P., Kim, J.H., Kim, J.Y., Carvalho, A.F., Seeman, M.V., Correll, C.U.,

& Fusar-Poli, P. (2022). Age at onset of mental disorders worldwide: large-scale meta-analysis of 192 epidemiological studies. *Molecular Psychiatry*, 27, 281-295 (2022).

doi: 10.1038/s41380-021-01161-7

Staetsky, D. (2022, May 3). *Haredi Jews around the world: Population trends and estimates*.

Institute for Jewish Policy Research. <https://www.jpr.org.uk/reports/haredi-jews-around-world-population-trends-and-estimates>

The Sewell Report (2021, March 31). *The report of the commission on race and ethnic*

*disparities*. <https://www.gov.uk/government/publications/the-report-of-the-commission-on-race-and-ethnic-disparities>

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology*, 8, 45. doi:

10.1186/1471-2288-8-45

Tkatch, R., Hudson, J., Katz, A., Berry-Bobovski, L., Vichich, J., Eggly, S., Penner, L.A., & Albrecht, T.L. (2014). Barriers to Cancer Screening Among Orthodox Jewish Women. *Journal of Community Health*, 39(6), 1200-1208. doi: 10.1007/s10900-014-9879-x

UK Legislation (2018). *Data Protection Act 2018*.

<https://www.legislation.gov.uk/ukpga/2018/12/contents>

University of Hertfordshire (2023). *Data Management Policy*. University of Hertfordshire.

[https://www.herts.ac.uk/\\_\\_data/assets/pdf\\_file/0003/233085/IM16-Data-Management-Policy.pdf](https://www.herts.ac.uk/__data/assets/pdf_file/0003/233085/IM16-Data-Management-Policy.pdf)

Wang, D., & Perlman, A. (2021). In their own words: Orthodox Jewish social workers integration of religion and values into practice. *Journal of Religion & Spirituality in Social Work: Social Thought*, 40(2), 126-145. doi: 10.1080/15426432.2020.1826385

Wang, P.S., Berglund, P.A., & Kessler, R.C. (2003). Patterns and correlates of contacting clergy for mental disorders in the United States. *Health Services Research*, 38(2), 647-673. doi: 10.1111/1475-6773.00138.

Whiteley, C. (2016). *"To wear a badge of mental health issues or concerns is almost a badge of shame... of Otherness": Representations of and responses to mental health conditions within the Ultra-Orthodox Haredi Jewish community in North London* [Unpublished Doctoral Thesis]. UK: University of Surrey.

Willig, C. (2012). Perspectives on the Epistemological Bases for Qualitative Research. In H.

Cooper (Ed). *APA Handbook of Research Methods in Psychology: Volume 1.*

*Foundations, Planning, Measures and Psychometrics* (pp. 1-42). Washington DC: APA

Books.

Wingrove-Haugland, E., & McLeod, J. (2021). Not “Minority” but “Minoritized”. *Teaching*

*Ethics*, 21(1).



Was there a clear statement of findings?	Green												
Is the research rated as valuable?	Green												

*Green=yes, red=no*

**6.2. Appendix B: Systematic review search strategy**

Databases	Search strategy
CINAHL Plus, Scopus, EBSCOhost, Education Research Complete, MEDLINE, OpenDissertations, ProQuest Dissertations and Theses, PsycArticles, Cochrane library	<p>("cognitive therap*" OR psychotherap* OR "behav* therap*" OR "behav* intervention" OR relaxation OR mindfulness OR meditation OR hypnosis OR hypnotherap* OR "psych* intervention" OR "psych* therap*" OR "psych* treatment" OR "psych* support*" OR therap* OR cbt OR "cognitive behav*" OR psychoeducation* OR psycho-education* OR "mental health support" OR counsel*)</p> <p>AND</p> <p>(Hasidic OR Chasidic OR Hassidic OR Chassidic OR Haredi OR Charedi OR Hareidi OR Chareidi OR "Ultraorthodox Jew*" OR "Ultra-orthodox Jew*" OR "Orthodox Jew*")</p>
University of Hertfordshire electronic library	<p>(Haredi OR chareidi OR charedi OR orthodox jewish)</p> <p>AND</p> <p>therap*</p>
Google Scholar	"orthodox Jewish", therapy
Trip database	Orthodox, Ultra-orthodox, Haredi, Charedi, Chareidi; each term searched separately
Gale Onefile	Jewish, Orthodox; each term searched separately
Open Access Thesis and Dissertations (OATD)	Jewish, Orthodox; each term searched separately
Bielefeld Academic Search Engine (BASE)	Jewish, Orthodox, Chareidi, Charedi; Haredi, each term searched separately
ResearchGate	Haredi, Jewish Orthodox, therapy

**6.3. Appendix C: Papers published before 2012 that were cited by four or more of the systematic review's included studies**

Reference	Citation frequency	Cited by
Huppert, J.D., Siev, J., & Kushner, E.S. (2007). When religion and obsessive-compulsive disorder collide: Treating scrupulosity in ultra-orthodox Jews. <i>Journal of Clinical Psychology, 63</i> (10), 925–941. doi: 10.1002/jclp.20404	6	Bloch et al., 2022; Freund & Band-Winterstein, 2017; Golker & Cioffi, 2021; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021; Whiteley, 2016
Popovsky, M.A. (2010). Special issues in the care of ultra-orthodox Jewish psychiatric in-patients. <i>Transcultural Psychiatry, 47</i> (4), 647–672. doi: 10.1177/1363461510383747	6	Band-Winterstein & Freund, 2014; Baruch, 2014; Bloch et al., 2022; Freund & Band-Winterstein, 2017; Keidar et al. 2021; Podolsky-Krupper & Goldner, 2021
Greenberg, D., & Witztum, E. (2001). <i>Sanity and sanctity – mental health work among the ultraorthodox in Jerusalem</i> . New Haven, CT: Yale University Press.	4	Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Podolsky-Krupper & Goldner, 2021; Whiteley, 2016
Greenberg, D., & Witztum, E. (2013). Challenges and conflicts in the delivery of mental health services to Ultra-Orthodox Jews. <i>Asian Journal of Psychiatry, 6</i> (1), 71–73. doi: 10.1016/j.ajp.2012.10.008	4	Golker & Cioffi, 2021; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Whiteley, 2016
Heilman, S. C., & Witztum, E. (1997). Value-sensitive therapy: Learning from ultra-orthodox patients. <i>American Journal of Psychotherapy, 51</i> (4), 522-541. doi: 10.1176/appi.psychotherapy.1997.51.4.522	4	Band-Winterstein & Freund, 2014; Whiteley, 2016; Freund & Band-Winterstein, 2017; Baruch, 2014
Leavey, G., Loewenthal, K., & King, M. (2007). Challenges to sanctuary: The clergy as a resource for mental health care in the community. <i>Social Science &amp; Medicine, 65</i> (3), 548–559. doi: 10.1016/j.socscimed.2007.03.050	4	Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Horwitz et al., 2019; Whiteley, 2016
Loewenthal, K.M., & Rogers, M.B. (2004). Culture-sensitive counselling, psychotherapy and support groups in the orthodox-Jewish community: How they work and how they are experienced. <i>International Journal of Social Psychiatry, 50</i> (3), 227–240. doi: 10.1177/0020764004043137	4	Box Bayes & Loewenthal, 2013; Galloway & Byrne, 2016; Sharman & Jinks, 2019; Whiteley, 2016

Schnall, E. (2006). Multicultural counselling and the orthodox Jew. *Journal of Counselling and Development*, 84(3), 276. doi: 10.1002/j.1556-6678.2006.tb00406.x

4

Baruch, 2014; Galloway & Byrne, 2016; Golker & Cioffi, 2021; Sharman & Jinks, 2019

---

**6.4. Appendix D: GRADE-CERQual evaluation (Lewin et al., 2018)**

Review theme	Contributing studies [n]	Methodological limitations	Coherence	Adequacy	Relevance	Overall CERQual assessment	Explanation of overall assessment
<b>1 Challenges of the therapy experience</b>							
1.1 Emotions	Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017; Galloway & Byrne, 2016; Golker & Cioffi, 2021; Horwitz et al., 2019; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019; Whiteley, 2016	Moderate concerns: Limited reflexivity* (5 studies), minor recruitment gender bias (7 predominantly single-sex studies)**	No concerns	No concerns: 11 out of 13 studies contributed thick data to review finding	Very minor concerns: 2 studies only indirectly relevant to review question.  Perspectives came from MH practitioners, community figures, school staff	High confidence	Due to no or very minor concerns regarding coherence, adequacy, and relevance, and moderate concerns regarding methodological limitations
1.2 Beliefs	Band-Winterstein & Freund, 2015; Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017; Horwitz et	Moderate concerns: Limited reflexivity (5 studies), minor recruitment gender bias (7 predominantly single-sex studies)	No concerns	No concerns: 10 out of 13 studies contributed thick data to review finding	Very minor concerns: 2 studies only indirectly relevant to review question.  Perspectives came from MH practitioners,	High confidence	Due to no or very minor concerns regarding coherence, adequacy, and relevance, and moderate concerns regarding methodological limitations

	al., 2019; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019; Wang & Perlman, 2021				community figures, school staff		
1.3 Culture	Band-Winterstein & Freund, 2015; Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017; Golker & Cioffi, 2021; Horwitz et al., 2019; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019; Wang & Perlman, 2021; Whiteley, 2016	Moderate concerns: Limited reflexivity (5 studies), minor recruitment gender bias (8 predominantly single-sex studies)	No concerns	No concerns: 12 out of 13 studies contributed thick data to review finding	Very minor concerns: 2 studies only indirectly relevant to review question.  Perspectives came from MH practitioners, community figures, school staff	High confidence	Due to no or very minor concerns regarding coherence, adequacy, and relevance, and moderate concerns regarding methodological limitations
1.4 Language & Communication	Bloch et al., 2022; Keidar et al., 2021; Whiteley, 2016	Minor concerns: Limited reflexivity (1 study), minor recruitment gender bias (2 studies)	Very minor concerns– limited findings	Moderate concerns: 3 out of 13 studies contributed thick data to review finding	No concerns.  Perspectives came from MH practitioners	Moderate confidence	Due to variable but overall minor concerns regarding coherence, adequacy, relevance,

		predominantly female)					and methodological limitations
<b>2 Strategies that help the therapy experience</b>							
2.1 Emotions	Band-Winterstein & Freund, 2015; Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017; Golker & Cioffi, 2021; Horwitz et al., 2019; Podolsky-Krupper & Goldner, 2021	Minor concerns: Limited reflexivity (1 study), minor recruitment gender bias (5 predominantly single-sex studies)	No concerns	Minor concerns: 8 out of 13 studies contributed thick data to review finding	No concerns. Perspectives came from MH practitioners, community figures	High confidence	Due to no or minor concerns regarding coherence, adequacy, coherence, relevance, and methodological limitations
2.2 Beliefs	Band-Winterstein & Freund, 2015; Baruch, 2014; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Freund & Band-Winterstein, 2017; Galloway & Byrne, 2016; Golker & Cioffi, 2021; Horwitz et al., 2019; Keidar et al., 2021;	Moderate concerns: Limited reflexivity (6 studies), minor recruitment gender bias (7 predominantly single-sex studies)	No concerns	No concerns: 11 out of 13 studies contributed thick data to review finding	No concerns. Perspectives came from MH practitioners, community figures	High confidence	Due to no concerns regarding coherence, adequacy, and relevance, and moderate concerns regarding methodological limitations

	Podolsky-Krupper & Goldner, 2021; Whiteley 2016						
2.3 Culture	Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Golker & Cioffi, 2021; Keidar et al., 2021	Minor concerns: Limited reflexivity (2 studies), minor recruitment gender bias (1 study female-only)	Very minor concerns – limited findings	Moderate concerns: 4 out of 13 studies contributed thick data to review finding	No concerns. Perspectives came from MH practitioners, community figures	High confidence	Due to variable but overall minor concerns regarding coherence, adequacy, relevance, and methodological limitations
2.4 Language & Communication	Band-Winterstein & Freund, 2015; Bloch et al., 2022; Box Bayes & Loewenthal, 2013; Galloway & Byrne, 2016; Golker & Cioffi, 2021; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019; Whiteley, 2016	Minor concerns: Limited reflexivity (4 studies), minor recruitment gender bias (5 studies predominantly female)	No concerns	Very minor concerns: 9 out of 13 studies contributed thick data to review finding	Very minor concerns: 2 studies only indirectly relevant to review question.  Perspectives came from MH practitioners, community figures, school staff	High confidence	Due to overall very minor concerns regarding coherence, adequacy, coherence, relevance, and methodological limitations
2.5 'Being'	Band-Winterstein & Freund, 2015; Baruch, 2014; Bloch et al., 2022; Freund & Band-Winterstein, 2017; Golker &	Moderate concerns: Limited reflexivity (5 studies), minor recruitment gender bias (7	No concerns	No concerns: 10 out of 13 studies contributed thick data to review finding	Very minor concerns: 2 studies only indirectly relevant to review question.  Perspectives came from MH	High confidence	Due to no or very minor concerns regarding coherence, adequacy, relevance, and moderate concerns regarding

---

Cioffi, 2021; Horwitz et al., 2019; Keidar et al., 2021; Podolsky-Krupper & Goldner, 2021; Sharman & Jinks, 2019; Wang & Perlman, 2021	predominantly single-sex studies)	practitioners, community figures, school staff	methodological limitations
--	--------------------------------------	--	-------------------------------

---

*\*Limited reflexivity includes not reflecting on researcher-participant relationship, and/or researchers showing a particularly biased and critical approach to orthodox Jewish practice, and not reflecting on this*

*\*\* Predominantly single-sex signifies studies with  $\geq 80\%$  of one gender*

6.5. Appendix E: Recruitment poster

**University of Hertfordshire UH** RESEARCH PARTICIPANTS NEEDED

בס"ד

**ARE YOU A QUALIFIED ORTHODOX JEWISH FEMALE THERAPIST?**

**DO YOU SUPPORT CHAREIDI FEMALE TEENAGERS?**

ARE YOU WILLING TO TAKE PART IN A RESEARCH INTERVIEW ABOUT YOUR EXPERIENCES SUPPORTING YOUR CLIENTS?

100% CONFIDENTIAL, ALL ANONYMITY ASSURED  
ENTER £50 AMAZON VOUCHER RAFFLE

APPROVED BY UNIVERSITY RESEARCH ETHICS COMMITTEE  
(HEALTH, SCIENCE, ENGINEERING & TECHNOLOGY; PROTOCOL NO. LMS/PGT/UH/04938)

CONTACT  
CLAIRE FRANKLIN  
TRAINEE CLINICAL PSYCHOLOGIST  
C.E.FRANKLIN@HERTS.AC.UK

90 MINS OF YOUR TIME

MORE INFO:  
BIT.LY/INFOFRUMTHERAPIST

## 6.6. Appendix F: Interview schedule

*Explain confidentiality and review information sheet and consent form, remind about length of interview and focus of the conversation.*

Do you have anything planned straight after?

I expect this to take 90mins but I want to make sure I provide enough space to discuss your experiences in detail. 90mins might seem like a long time but the time actually passes really quickly. Are you ok if it takes longer?

So.... What made you say yes to joining?

### *Instructions*

In this interview, we are going to think about your work with Chareidi, female teenagers. You can talk about examples if you like, but please anonymise your clients to protect their confidentiality. You can also talk about key experiences that you've had as a therapist. Please keep in mind that I am particularly interested in your work with female Chareidi teenagers, rather than all the different clients that you see. If you also work in the NHS, please let me know if you are speaking about those experiences too, although the main focus should be on your independent work.'

### Interview questions

#### Religious background

So, let's think about identity. this is a big question, we have multiple identities, we are women, Jewish, frum but living in a country that is largely secular, we are therapists. Have you ever considered this question, or where your identity sits in all of this? Do you have any ideas about how we can make talking about identity meaningful for you in this conversation?

- If you could tell me a bit about your religious identity, where you would put yourself on the spectrum of orthodox Judaism, and why? This is about how you self-identify, rather than how you believe others see you.
- Separately, what does Chareidi mean to you?

#### Therapy process

Now I am going to ask you a few questions that don't need a lot of elaboration.

- Please could you tell me what forms of therapy you are trained in, where you learnt your skills, and if you are happy to, whether you have personally benefited from any types of therapy?

- Who supervises you, and how did you choose your supervisor?
- Please could you tell me what you do in your role as a therapist, specifically how it relates to offering therapy to Chareidi teenage girls?
- Can you tell me about your process of receiving new therapy enquiries and accepting clients?
- Why and how do you believe Chareidi adolescent clients pick you?

Now I am going to ask you questions that I'd like you to consider in more depth. Now I'd love you to give me a real flavour of your experiences. You can talk about your feelings, what you were thinking at the time, and really immerse yourself in the experiences you are talking about.

A note on confidentiality - I will do my best to anonymise things and I can check with you after how it is written – so don't worry too much about identities, locations etc – you don't need to censor it all because I will make sure to do that later.

#### Experience of offering therapy to female Chareidi teenagers

- I'd you to tell me a bit what the experience is like to offer therapy to female, chareidi teenagers.
- How do you relate to them as an orthodox Jewish therapist?
- What is the focus of your work, or what type of goals does your work focus on?
- What challenges do you face in your work?
- What barriers are there, for example in terms of the therapy itself, the context in which your work, and any halachic or hashkafic ones?
- I want to ask you about ethical dilemmas. So, when you dealing with a dilemma in your work, for example something that doesn't sit right with you on a moral or ethical level, who is 'with you in the room', so to speak, when you are working these things out? In other words, which of your identities or people do you hold in mind influence your decisions? So for example, if your client brings something which is a halachic or hashkafic, or ethical dilemma for you, or for them, how do you work things out? Do you talk solely from your role and perspective of being a therapist, or do you also wear the hat of being a religious Jew?
- Can you think of any dilemmas that you've faced?
- What works well?
- Do Rabbis or other authoritative figures play a part in your work? How?

- What is your opinion on why your clients are accessing therapy within the Chareidi community rather than via Children and Adolescent Mental Health Services (CAMHS)?
- How has your therapeutic experience from a psychological perspective been affected by Covid-19?

#### Identity as Orthodox Jewish clinician

- How much does your religious identity affect your work with frum female teenagers?
- How does your work inform how you see yourself (*prompt*, your identity, as a woman, chareidi Jew, mother, therapist, etc)?
- How does your work affect you in your personal life? And how does your personal life affect you in your work?

#### *Debrief*

Is there anything else you would like to say? Any questions for me?'

*Check re: consent form addendum question about keeping anonymised transcript for secondary analysis.*

## 6.7. Appendix G: Consultants agreement

### Consultants Agreement

This agreement is intended to support conversations between the lead researcher with the supervisory team and consultants to ensure clarity from the outset for this project.

#### Title of research project

**Experiences of Orthodox Jewish therapists offering therapy to Chareidi female adolescents**

(Ethics approval from Health, Science, Engineering and Technology Ethics Committee with Delegated Authority; UH protocol number LMS/PGT/UH/04938)

#### Research Team

Main researcher: Claire Franklin

Supervisory Team: Dr Emma Karwatzki, Clinical Lead, DClinPsy, University of Hertfordshire

Dr Lauren Topper, Clinical Psychologist

Consultant Name:

*confidential*

#### Agreement

**As the main researcher on this project, I agree to and take responsibility for:**

- |   |   |
|---|---|
| Taking a lead to organise any meetings with the consultants   | Tick ✓<br><input checked="" type="checkbox"/> |
| Sending draft designs for research to consultants for feedback with clear notice of deadlines   | <input checked="" type="checkbox"/>           |
| Offering feedback about how involvement from consultants has added value to the research  | <input checked="" type="checkbox"/>           |
| Provide final electronic copies of the research to all consultants  | <input checked="" type="checkbox"/>           |
| Providing feedback of research findings and take lead and offer opportunities to collaborate on writing presentations and publications. | <input checked="" type="checkbox"/>           |
| Acknowledge consultants in thesis write up and subsequent publications  | <input checked="" type="checkbox"/>           |

**As a consultant to this project, I understand that:**

- Involvement as a consultant is purely on a voluntary basis and I can notify main researcher should commitments change
- Consultants may dip in and out at different stages of research depending on their area of expertise
- I agree to:
- Provide feedback and expertise to different aspects of research design, recruitment, data collection and write-up
- Express interest should I wish to collaborate on writing presentations or publications
- Offer guidance and expertise on any ethical concerns or considerations at the earliest convenience
- Maintain anonymity of participants and abide by the ethical principles as outlined in the information sheet given to participants.

Signatures

Signature of main researcher: C. Franklin

Date: 23/05/2022

Signature of consultant: *confidential*

Date: 23/05/2022

## 6.8. Appendix H: Consultants' reflections

"The consultation spaces:

- Enabled an opportunity to tune in to the experience of the consultants and to listen carefully, enabling a more reflective space that can sometimes be squeezed whilst in the "doing" mode of research supervision.
- Enabled me to contextualise my advice and feedback as a research supervisor.
- Enabled me to understand the ways in which interview schedules and structure can be flexed and carefully constructed in response to consultant feedback.
- Enabled me to consider the varied experiences within the OJ community and the potential emotional responses to the findings ahead of dissemination."

### **Dr Emma Karwatzki, principal supervisor and participant in consultant meetings**

It has been an honour as well as an extremely interesting journey supporting Claire in her research . The reflection groups which were held throughout this process allowed insight into how varied the response to the research question is. Importantly, the individuals within this group demonstrated how conversation which is filled with a mutual respect and desire to understand, can be held amongst those who are linked with their love of thought, yet who may differ with regards to the basis of those thoughts. This element was important in aiding the current research project, yet can be extended to all and any research question.

### **Dr Lauren Topper, external supervisor and participant in consultant meetings**

"I was honoured to be involved in your project, Claire. I enjoyed the energy of the meetings and the fact that we were all coming from somewhat different backgrounds and perspectives. I felt that you were very open to and grateful for any feedback you were given and that helped make it feel that we were useful to you and that you were benefitting from the time - which felt positive and rewarding. On a personal level, as a therapist within the community that you were describing, the research touched on many areas that felt relevant to me. I found it an interesting experience to be on one level considering your material through a lens of objective, academic research, while on the other, the close nature of the material to my subjective life experience rendered it somewhat challenging to view and to respond with objectivity. I felt that you grappled with this yourself and that we all worked together to consider how best to manage the conundrum. I think that in general, my participation in the group made me think more deeply about the way in which the shared religious or cultural experience of therapist and client can play out in the therapy room particularly in those areas that are assumed but not discussed. This feels an important and fruitful consideration for my practice. Many thanks for inviting me to participate."

### **Research consultant, anonymous**

"I found it incredible meeting 'like-minded' people (with shared interests about healing) and having deep, intriguing conversations. It was confusing at some points as to what the point of all of this was, as I am a very practical person and felt we could go on and on talking and making our interpretations, but all in all I learnt a lot and feel grateful to see so many people passionate about helping others. Most interesting of all for me was that I noticed that lived experience of true love and empathy on a very deep level can't be taught or studied."

### **Research consultant, anonymous**

## 6.9. Appendix I: Ethical approval notification



### HEALTH, SCIENCE, ENGINEERING AND TECHNOLOGY ECDA ETHICS APPROVAL NOTIFICATION

TO Claire Franklin  
CC Dr Emma Karwatzki  
FROM Dr Simon Trainis, Health, Science, Engineering & Technology ECDA Chair  
DATE 30/03/2022

---

Protocol number: LMS/PGT/UH/04938  
Title of study: Experiences of Orthodox Jewish therapists offering therapy to Chareidi female adolescents

Your application for ethics approval has been accepted and approved with the following conditions by the ECDA for your School and includes work undertaken for this study by the named additional workers below:

no additional workers named

#### General conditions of approval:

Ethics approval has been granted subject to the standard conditions below:

**Permissions:** Any necessary permissions for the use of premises/location and accessing participants for your study must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

**External communications:** Ensure you quote the UH protocol number and the name of the approving Committee on all paperwork, including recruitment advertisements/online requests, for this study.

**Invasive procedures:** If your research involves invasive procedures you are required to complete and submit an EC7 Protocol Monitoring Form, and copies of your completed consent paperwork to this ECDA once your study is complete.

**Submission:** Students must include this Approval Notification with their submission.

#### Validity:

This approval is valid:

From: 01/05/2022

To: 01/05/2023

## 6.10. Appendix J: Participant information sheet



UNIVERSITY OF HERTFORDSHIRE

### ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS (‘ETHICS COMMITTEE’)

#### FORM EC6: PARTICIPANT INFORMATION SHEET

##### **Title of study**

*Experiences of Orthodox Jewish therapists offering therapy to Chareidi female adolescents*

##### **Consent to participate in a research study**

The purpose of this information sheet is to provide you with the information that you need to help you decide whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at Hertfordshire University. Before you decide whether to do so, it is important that you understand the study that is being undertaken and what your involvement will include. Please take the time to read the following information carefully and discuss it with others if you wish. Do not hesitate to ask me anything that is not clear or for any further information you would like to help you make your decision. Please do take your time to decide whether or not you wish to take part.

The University’s regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

<https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs>

(after accessing this website, scroll down to Letter S where you will find the regulation)

##### **What is the purpose of this study?**

This research aims to explore the experiences of Orthodox Jewish therapists who have recently or are currently offering therapy to Chareidi female adolescents.

##### **Do I have to take part?**

It is completely up to you whether or not you decide to take part in this study. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. Agreeing to join the study does not mean that you have to complete it. You are free to withdraw at any stage without giving a reason, until such point as your contributions have

become anonymised. If you choose to take part, I will ask you to meet me for an interview that would last for a maximum of 90 minutes. During the interview, I will be interested in hearing about your own personal experiences of offering therapy to Chareidi female adolescents. I will also ask your opinion about why some Chareidi families prefer private therapeutic support, rather than accessing CAMHS, and I will be interested to hear from you how the pandemic might have affected your clients' mental health and what they bring to therapy.

### **Are there any restrictions that may prevent me from participating?**

You are eligible to take part in this study if you:

- Self-identify as a female Orthodox Jewish therapist (for example, but not restricted to, identities such as Chareidi, Chasidish, Yeshivish, Heimish, or Modern Orthodox Machmir)
- Have seen at least two London-based Chareidi female adolescents for direct therapeutic treatment in the past two years
- Are accredited by the BACP, BABCP, HCPC, or UKCP, or are near-accreditation (i.e. have completed over 300 hours of supervised practice)

### **Where will interviews take place?**

The interview will take place at a time and location of your convenience and choice. This could be at your home or workplace, or at a local community centre that offers discreet, confidential spaces. You can choose to meet me face to face, or virtually.

### **What are the benefits of participating?**

Some people might find that reflecting about their experiences is helpful. Whilst there might be no direct benefit to you participating, the findings will be very novel for our community, because to date, no one has explored the experiences of frum therapists offering therapy to female, frum adolescents. It is hoped that the research will highlight the strengths of offering culturally adapted therapy within the Chareidi community and will also highlight the barriers in parts of our community to accessing NHS services such as CAMHS. This may result in changes to services to make them more accessible and improve liaison between statutory services and Jewish mental health charities.

### **What are the risks of participating?**

It is not expected that taking part in the research will contain any risk. Whilst I do not predict this interview will upset you, it is possible that you could find talking about your experiences difficult and you could become distressed. If this does occur, you will be offered a break in the interview, or should you not wish to continue, the interview may be terminated. If you remain upset and want further support, then I will be able to signpost you to support networks (see page below).

**What about the confidentiality of my clients?**

I will request that you anonymise your clients throughout the interview and that you change any identifying characteristics. It will be your choice how many clients you want to speak about, and it might be helpful to focus on a maximum of three, to help you speak more deeply about your experiences of offering therapy to them. It is recommended to refrain from telling your clients that you will be taking part in the research in case this information caused them undue distress. If you have a reason to tell them, then it would be important to let them know that the focus of the research is not about their personal difficulties, but about your personal experiences as a therapist.

**Will my personal details and interview be kept confidential?**

Your privacy is of utmost importance. Your name and any identifying details will be changed and anonymised via the interview transcription. A certified transcription service that is strictly bound by confidentiality will be used. I will not discuss your individual interview with anyone except the research supervisors and will maintain your anonymity during my discussions with them. Interviews will be audio-recorded (and video-recorded if we meet virtually). These recordings will be kept securely and will be destroyed at the end of the study the very latest by December 2023. Password protected electronic copies of anonymised transcripts will be kept for five years, to allow enough time to write the study up for publication. Short and fully anonymised transcript extracts will be published in the thesis appendix.

The only exception to this confidentiality would be if you were to disclose any information that would suggest that you or another individual was at risk of harm. This may mean that information about you or the individual would be shared with a third-party agency in order to ensure your and everyone else's safety. If you disclose any information that would suggest that your client was at risk of harm, then we will discuss together whether a safeguarding procedure would need to be followed, and I will encourage you to disclose their identifying details with relevant agencies in order to prevent further harm to them and others.

**Will the data be required for use in further studies?**

Anonymised data collected may be re-used or subjected to further analysis as part of a future ethically-approved study, but you do not have to agree to this. I will be asking for your consent to this separately.

**Will you contact me again?**

If you agree to it, I may ask to meet with you again, or to speak on the phone. This would be to gather your opinion on the themes I identified in your answers. You would be under no obligation to speak to me a second time. I will not contact you about the study again without your explicit consent.

**Who has reviewed this study?**

This study has been reviewed by The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. The UH protocol number is LMS/PGT/UH/04938.

**Who can I contact if I have any questions?**

If you would like further information or would like to discuss any details personally, please get in touch with me by email ([c.e.franklin@herts.ac.uk](mailto:c.e.franklin@herts.ac.uk)). Please feel free to ask me any questions. If you are happy to continue, you will be asked to sign a consent form prior to your participation. Please retain this information sheet for reference.

If you have any questions or concerns about how the study has been conducted, you may also contact the study's principal supervisor (Dr Emma Karwatzki, email: [e.karwatzki@herts.ac.uk](mailto:e.karwatzki@herts.ac.uk), Tel. No.: 01707 286322).

**Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study, please write to the University's Secretary and Registrar at the following address:**

Secretary and Registrar  
University of Hertfordshire  
College Lane  
Hatfield  
Herts  
AL10 9AB

**Thank you very much for reading this information and giving consideration to taking part in this study.**

**6.11. Appendix K: Participant consent form**



UNIVERSITY OF HERTFORDSHIRE

**ETHICS COMMITTEE FOR STUDIES INVOLVING THE USE OF HUMAN PARTICIPANTS  
(‘ETHICS COMMITTEE’)**

**FORM EC3: CONSENT FORM FOR STUDIES INVOLVING HUMAN PARTICIPANTS**

I, the undersigned *[please give your name here, in BLOCK CAPITALS]*

.....

of *[please give contact details here, such as email address or phone number]*

.....

hereby freely agree to take part in the study entitled

**“Experiences of Orthodox Jewish therapists offering therapy to Chareidi female adolescents”**

(Ethics approval from Health, Science, Engineering and Technology Ethics Committee with Delegated Authority; UH protocol number LMS/PGT/UH/04938)

- |   |                                    |
|---|------------------------------------|
| I confirm that I have read the information sheet relating to the above research study and have been given a copy to keep.   | Tick ✓<br><input type="checkbox"/> |
| I have been offered an advance read the interview schedule, which I have done if I wanted to.   | <input type="checkbox"/>           |
| The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information.  | <input type="checkbox"/>           |
| I understand what is being proposed and the procedures in which I will be involved have been explained to me.   | <input type="checkbox"/>           |
| I understand that my involvement in this study, and particular data from this research, will remain strictly confidential, unless there are concerns about the immediate safety of myself, my clients, or any other individual. | <input type="checkbox"/>           |
| I have been told that only Claire Franklin, the researcher involved in the study will have access to identifying data.  | <input type="checkbox"/>           |

I understand that a certified transcription service that is strictly bound by confidentiality will be used to transcribe my interview.

I understand that short and fully anonymised transcript extracts will be published in the thesis appendix.

It has been explained to me what will happen once the research study has been completed.

I understand that all identifiable data, including the audio and/or video recording of my interview and this consent form, will be deleted by the end of December 2023, and an anonymised transcript will be kept in a password protected document for 5 years.

I have been told that in the event of any significant change to the aims or design of the study I will be informed, and asked to renew my consent to participate in it.

I hereby freely and truly consent to participate in the study, which has been fully explained to me as per the information sheet.

I understand that I have the right to withdraw from the study at any time without any consequence and without being obliged to give any reason, until such point as my data is anonymised.

*Addendum:*

I consent to the principal researcher re-analysing my fully anonymised transcript within the next 5 years, should they want to research a different, related research question.

Yes

No

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Date: .....

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date: .....

## 6.12. Appendix L: Non-disclosure agreement

### Non-Disclosure Agreement with Transcription Company

This non-disclosure agreement is in reference to the following parties:

Claire Franklin (discloser)  
and  
Kate MacFarlane (transcriber)

- The recipient agrees to not divulge any information to a third party with regards to the transcription of audio/video recordings, as recorded by the discloser. The information shared will therefore remain confidential.
- If the recipient is able to identify and knows the participant in the recording, the recipient agrees to cease transcription, inform the discloser and destroy any copies of the recording.
- The recipient also agrees to destroy the transcripts as soon as they have been provided to the discloser.
- The recipient agrees to return and/or destroy any copies of the recordings they were able to access provided by the discloser.

**TRANSCRIBER TO COMPLETE:**

SIGNED: *Kate MacFarlane*

NAME: KATE MACFARLANE

DATE: 22/9/2022

**University of Hertfordshire UH** Ethics Committee

This is an official notification by student of the University of Hertfordshire in respect of a study involving human participants.

**Title of study:** Experiences of Orthodox Jewish therapists offering therapy to Chareidi female adolescents  
**Protocol Number:** LMS/PGT/UH/04938

**Approving Committee:** The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

If you have any queries concerning this document, please contact me Claire Franklin, Trainee Clinical Psychologist, [c.e.franklin@herts.ac.uk](mailto:c.e.franklin@herts.ac.uk) or my supervisor Dr Emma Karwatzki, Academic Manager & Lead, [e.karwatzki@herts.ac.uk](mailto:e.karwatzki@herts.ac.uk)

### **6.13. Appendix M: Signposting information (Local and national support services)**

#### **Barnet Wellbeing Service (IAPT)**

[www.lets-talk-iapt.nhs.uk](http://www.lets-talk-iapt.nhs.uk), Tel. No.: 020 8702 5309

Free psychological therapy via the NHS

#### **Mind in Barnet**

[www.mindeb.org.uk](http://www.mindeb.org.uk), Tel. No.: 020 8343 5703

Free counselling via the NHS

#### **Samaritans**

Tel. No.: 116 123

24 hours a day, confidential and non-judgemental emotional support whenever you need someone to talk to.

#### **Saneline**

Tel. No.: 0300 304 7000

Daily 4.30pm – 10.30pm, Saneline is an out-of-hours telephone helpline offering practical information, crisis care and emotional support to anybody affected by mental health problems.

#### **SHOUT**

Text 'SHOUT' to 85258

24 hours a day, start a text conversation on this free, confidential and anonymous service. Trained volunteers can offer support and get you to a calmer and safe space.

#### **The Helpline**

<https://thehelpline.org.uk>, Tel. No.: 0330 127 3333

24/7 mental health helpline for the Jewish Community

#### **Relief**

[www.reliefhelp.org](http://www.reliefhelp.org), Tel. No.: 0333 344 5595

Mental Health referral service for the Jewish community

## 6.14. Appendix N: Transcript extract

Experiential statements	Raw Transcript	Exploratory notes <sup>37</sup>
Feeling anxiety/uncertainty around professional and personal overlap	<p>P: ... I'm <b>familiar</b> ... I send my kids to <b>similar</b> schools as they send their kids ...</p> <p>I: ... <i>mmm</i> ...</p> <p>P: ... so, there's more of that overlap, so I feel that there's ... there's more chance that I'd be asked to <b>use my personal resources</b> therapeutically and I think, <b>initially</b>, when that ... that kind of revelation comes up, I ... I get a bit of an 'arghhhhh' (chuckles) ... an anxious reaction like 'Help! Yikes! <b>I've been discovered!</b>' or 'This personal side now has ... I now have to think about this personal side being shared therapeutically' ... um ... so yeah ...</p> <p>I: <i>[...] So do you literally work out a policy on how to manage that overlap ... like in those situations where you might not even necessarily know the client, and therefore decide to work with them, but what if they then bring people into the sessions to discuss that you <u>do</u><sup>38</sup> know ...</i></p> <p>P: ... um ... I don't think there is a policy ... I really, really don't think there should be a policy because I think that anyone should have ... I think in wanting to even have a personal policy that ... that feels to me like there should be a one-size-fits-all response ...</p>	<p><b>Familiarity/similarity</b> – link to common ground (having school age children) - conflict of sharing personal side in professional context only with Jewish clients</p> <p><b>Using personal resources</b> therapeutically – she thinks about how to engage with her client therapeutically about her personal information that has been revealed. <b>This overlap happens more with Chareidi clients and is anxiety provoking 'I've been discovered'</b> - can be a vulnerable place to be in (consider power dynamics between client and therapist!). <b>Initially</b> – is this is an anxiety-inducing dilemma initially, but over time gets easier once they have established more rapport?</p> <p>No policy on how to manage overlap, as this would feel too rigid.</p>
Importance of reflecting in supervision	<p>I: ... <i>right</i> ...</p> <p>P: ... because I'm scared that I'll meet uncertain territory ...</p> <p>I: ... <i>mmm ... hmm</i> ...</p> <p>P: ... so, I do feel rather than a policy, or rather than ... I need to think it through with my supervisor a bit more, but I'm not hoping to find some sort</p>	<p>Having a policy = having trouble with managing <b>uncertainty</b></p> <p><b>Rather than a fixed one-size-fits-all policy, she wants to be flexible and embrace uncertainty as part of her role as a therapist</b></p>

<sup>37</sup> Colour code: **Conceptual**, **Descriptive**, **Linguistic**

<sup>38</sup> *Underlined to show emphasis of interviewer's question*

A personalised introspective approach for dealing with one's own anxieties as a therapist

of magic solution for it, or some one-size-fits-all response because I do feel that ... that's almost ... it's almost in response to a certain anxiety which is – as a therapist – I deal with uncertainty, and I don't know what the client's going to say and how it's going to affect me ... um ... and I suppose my confidence to work with my ... to notice and attend to my emotional responses and to work with them, and try and have the ... the kind of presence or to ... to be able to think about how I can use my ... personal side of me therapeutically. So, I want to maybe discuss it and explore it a bit more with my supervisor, so I'm a bit thought through about the different options that ...

*I: ... mmm ...*

P: ... I could take next time, and a bit more ... err ... confident about how I can use my quite private personal information in a way comfortably in a therapeutic context ...

*I: ... mmm ...*

P: ... but I don't think that I'll end up with a ... some sort of rule, and I don't think that I ... I'm aiming for that really because it is about me and managing uncertainty.

*I: Mmm ... mmm ... mmm ... yeah ... but I mean it might not necessarily be a policy because, as you say, that does feel kind of very ... um ... you know, pushing people into a little box, but it might be kind of loose principles of ... of you know, intuitively – if it feels such-and-such – this is the kind of thing that has worked in the past ... I might use this time, and I might consider doing on this occasion.*

P: And maybe ... and I think that my own ... exploring my own worries about why I'm anxious about disclosing personal information ... getting that clear to myself I think ... would just make me able to (slight pause) ... to see when it fits ... and calmer about being able to use my personal information beneficially ... so, I think it's work I have to do really.

She feels confidence – to notice and attend to her emotional response and to work with it

Have the presence to think about how to use her personal side therapeutically

She talks about her personal approach to managing the 'overlap' situation – noticing, attending to emotion, working with it, discuss and explore it in supervision, consider options for next time – Moving from emotional to cognitive.

The more experienced the therapist, the more confidence in having developed and being able to use such an approach, when confronted with a dilemma?

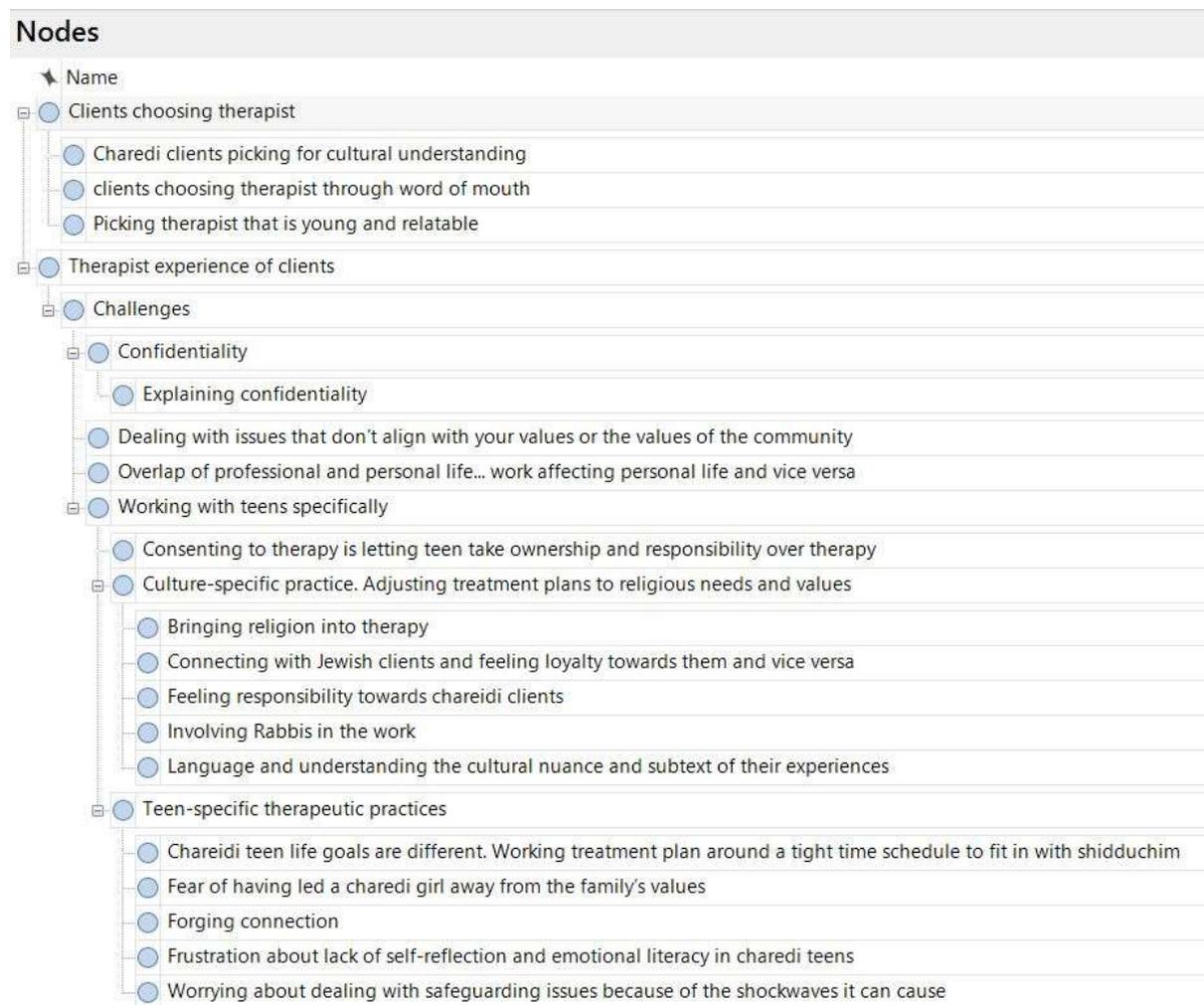
It's about me and managing uncertainty – taking ownership over the uncertainty and therefore not applying a fixed, rigid rule for each client or situation, because she is committed to learning about herself each time something comes up – a fixed rule would prevent that.

Moving from uncertainty to clarity:

Tussle between wanting to be flexible and accept uncertainty, but also getting that clear to myself, i.e. wanting clarity about her anxieties

It's work I have to do really – this is ongoing work

### 6.15. Appendix O: Example of drafting PETs in NVivo





## 6.17. Appendix Q: Example of a participant's finalised PETs

---

### 1. Being shaped by multiple identities

---

#### 1.1. Identifying as an Orthodox Woman

Being an Orthodox Woman: Clash between feeling and identifying with being deeply religious, and disagreeing with some Orthodox practices in contemporary society

Jewish family background

#### 1.2. Intersection of religious and therapist identity

Religious identity permeating her work and feeling sadness when clients don't see the beauty of it or consider developmental religious journey that they are going through

Religious values affecting work by giving her roots in values and a direction to follow

Work helping her find meaning in the world

#### 1.3. Journey as a therapist

Becoming more relaxed and confident as practitioner helped grow practice

Work affecting self-esteem and confidence, parenting and satisfaction, feeling respected and sought-after

#### 1.4. Identity as a mother

Mother instinct - Challenge of witnessing teens make bad decisions that you cannot control

#### 1.5. Having been an adolescent

Identifying with her teen clients because she was also once a young person

---

### 2. The nuts and bolts of being a therapist

---

#### 2.1. Training background and professional competencies

Personal therapy

Referral process

Supervision

Training background

#### 2.2. Having model-specific practices

Finding strategies to gently encourage positive behaviours in clients/ feeling responsibility to educate 'myopic chareidi teens'

Focusing on relationship between therapist and client, rather than psychoeducation

Techniques she does to help her manage her own difficult feelings

---

---

**3. Clients choosing a private OJ therapist, rather than CAMHS**

---

**3.1. Clients and therapist choosing each other**

Selecting someone experienced

Being someone who markets themselves as collaborative

Deciding when a client is not suitable for her way of working

**3.2. Jewish therapy world within a changing global context**

Jewish therapists have become much better

OJ therapists are more trusted: You can't trust NHS workers

---

**4. Working in the OJ community specifically**

---

**4.1. Overlap between personal and professional life**

Being on show in personal life when you see clients, and wanting to be authentic, so that you can role-model confidence and normality

Bringing her Self into therapy so help normalise and build rapport

Carrying burdens of work into personal life

Navigating discomfort when boundaries are pushed in the overlap between personal and professional

**4.2. Working with chareidi clients**

Adjusting language for cultural appropriateness

Feeling challenged by the chareidi community's attitude to educating their children

Using Rabbis in work as a sounding board

Analogies and Metaphors: myopia in chareidi society

Cultural understanding, i.e. Chareidi clients choose her because she understands what being Jewish means

---

**5. Working with adolescents specifically**

---

**5.1. Creating relational safety with teens**

Dealing with engagement and wanting to make a positive difference in their lives

Bringing in religion to therapy to think about personal responsibility and empowerment

Offering a safe and sacred space for a client to explore and experiment with things that might not be socially acceptable in their community or culture

**5.2. The effects of the internet as a window to the outside world**

Effect of internet on teen wellbeing

Lots of chareidi teens going off the derech

Sadness when there's an expectation to help a teen stay 'on the derech' when they have not been given a positive religious experience and childhood by the family

Validating negative experiences with clients, opening them up to alternative narratives within Judaism

**5.3. Expectations toward the therapist**

When the therapist is expected to sort out intergenerational or parental issues in the teenager because the parents haven't done the work themselves

Sadness and dread due to feeling high expectations to have a positive effect on teen

---

## **6.18. Appendix R: Extracts from the primary researcher's reflective diary**

### **Thoughts on terminology such as Chareidi versus Orthodox Jewish**

How do you define Chareidi? It's subjective; and Orthodox Jewish (OJ) feels very broad for me because some people call themselves OJ due to their synagogue membership, but not because they continuously adhere to Orthodox Jewish thought, lifestyle, and practice. Being Chareidi on the other hand means for me that the Torah is at the forefront of everything, and influences how a person thinks, believes, and acts. Many people won't regard me as Chareidi because of how I dress, speak, my baalas teshuva background, my career, the schools my kids go to, the social circles I am in. What is the yardstick that individuals use, and is it that we compare ourselves to others to define whether we are Chareidi, or OJ?

### **My motivation behind the research, as an OJ community member**

There is anxiety within Chareidi society about what a publication about mental health in the community might reveal. I want to step gently and carefully into this field and maintain openness, curiosity, and keep differing agendas, perspectives, and needs in mind. Mental health within the OJ community is bound up with stigma and taboo. Whilst I want to highlight the beauty of having access to a culturally sensitive, OJ therapist, I also want to make sure that the realities of what people are going through will be told – even if it's messy, uncomfortable, and painful. Sometimes being brave and vulnerable can reveal opportunities for learning and growth.

### **Experience of doing IPA for the first time**

I am fluctuating between feeling confident that I know that I am doing, and feeling utterly helpless, confused, fearful, having an embodied sensation of 'pulling teeth', needing to physically force my eyes and mind into the transcript data to pull out exploratory notes, and formulate experiential statements. It feels unfamiliar, and cognitively painful. Simultaneously, I am curious about my participant's experiences and how they make sense of them... my brain hurts!

### **Research ethics: anonymising participants**

When thinking about my participant's concern about their and their clients' anonymity, I wonder about who holds the power in deciding the level of anonymity required. Assumptions are made about what 'anonymous' means, depending on one's professional or personal experience. For some people perhaps, changing names and locations is enough. In this community, where the population is so dramatically smaller, *any* contextual, situational, personal, or professional details could identify people. Noticing my assumptions and allowing my participants to have full authority to decide which details are made public and which aren't, allows them to engage with the interview process. For example, if you talk about a girl with dyslexia, ginger hair, and of Irish origin, these details could be attributed to hundreds, if not thousands of people in the UK. Within the London Orthodox Jewish community, there might only be one such person.