How do parents within the Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?

Gemma Rowland

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Abstract

Previous research suggests that children of minority groups may be underserved by mainstream services (Elster, Jarosik, VanGeest & Fleming, 2003). There has been an identified need for research that focuses on barriers to accessing services faced by minority groups, such as the Orthodox Jewish community (Dogra, Singh, Svirdzenka & Vostansis, 2012). Given that parents are often the gate-keepers to care (Stiffman, Pescosolido & Cabassa, 2004), understanding their help-seeking behaviour is crucial to ensure that Orthodox children and families are given the same opportunities to access services as their majority group peers. To date there is extremely limited research on the help-seeking behaviours of Orthodox Jewish parents. The current study sought to consider the experiences of Orthodox Jewish parents who have accessed Child and Adolescent Mental Health Services (CAMHS) in order to seek help for their families.

Semi-structured interviews were completed with nine Orthodox Jewish parents with regards to their experiences of accessing tier 2 CAMHS for their child. A thematic analysis was conducted. Four themes were found: 'The Orthodox community as unique', 'Pathways to help', 'Attitudes towards mental health' and 'The parental journey'.

Participants described a number of significant cultural barriers to seeking help. Stigma was identified as occurring in relation to mental health and also in relation to the process of help-seeking, as suggested by previous research within adult Orthodox populations (Feinberg & Feinberg, 1985). These stigmas relate to concerns regarding labelling and future matchmaking for the child and their siblings. Parents experience emotional and practical strains in parenting a child with mental health difficulties and in accessing psychological support for their children. The implications for service level change and clinical practice are considered.

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I would like to dedicate this thesis to my parents, who have believed in me when I could not believe in myself and who helped me to find help when I needed it.

Contents

CHAPTER 1: INTRODUCTION

This chapter outlines the background and context for the research. It begins by outlining key information about the Orthodox Jewish community and defines to whom is referred to when using by the term Orthodox Jewish. Within the chapter there is a discussion relating to the attitudes and experiences of parents in the general population who have accessed CAMHS (Child and Adolescent Mental Health Services). Barriers to help-seeking for families in the general population and minority groups are summarised. In addition, the wider context is explored via a discussion of the relationship between mental health and stigma in other minority groups, considering whether these issues may also relate to the Orthodox community. An account of the relevant literature is provided within this chapter, with details of the literature search strategy. The way in which mental health is understood within the Orthodox community is explored, alongside the relationship between mental health and stigma in the community. Following from this, literature relating to mental health and young people within the Orthodox community is summarised, in addition to an exploration of help-seeking behaviour by Orthodox parents. Information about the research site is provided and the context of the service through which recruitment took place is considered. A discussion about the obligation of the NHS to ensure equal access to services is included. Finally, the research rationale, aims and questions are summarised.

1.1 Background and context

For the purpose of clarity, it is necessary to begin with a definition of to whom is referred to when using the term ‘Orthodox Jewish’ within this thesis. The UK Jewish community can be understood as having many levels of practice, including Liberal, Reform, United and Orthodox. The term Orthodox is open to interpretation and can be seen as a spectrum rather than referring to a homogenous group. Though some Orthodox groups are often referred to as ‘ultra-Orthodox’ within literature, the term has been viewed as offensive and divisive due to its negative implications for other levels of practice. For this reason, the simpler term ‘Orthodox’ is used. When referring to the ‘Orthodox community’ within this thesis, this primarily refers to individuals who may identify as being part of Charedi, Hasidic and/or Modern

Orthodox communities, as opposed to Secular, Liberal, United or Reform. A brief outline of the differences between these groups is provided below.

1.1.1 The Orthodox Jewish community

The UK Jewish populace is estimated to make up 0.5% of the total UK population (Connett, 2015). Of this, the Orthodox community are thought to make up approximately 16%, a number that appears to be rapidly increasing due to high birth rates within the Orthodox community (Staetsky & Boyd, 2015). Research suggests that the Orthodox community is growing at a rate of approximately 4% per annum (Vulkan & Graham, 2008). Based on these figures, estimates project that by 2031, 50% of Jewish children will be Orthodox. However, the accuracy of estimates of the Orthodox population may be debatable, given that Orthodox Jews may be reluctant to name their religion/ethnicity on official documents in the wake of the Holocaust.[1]

The Orthodox population are differentiated from 'mainstream' Jewish populations given their strict observance of Jewish teachings and traditions. They can be seen as unified by their strict adherence to the divine word of the Torah, Talmud and other holy texts, remaining strictly observant of religious rules and Jewish laws (known as Halacha), defined within the Torah (Huppert, Shiev & Kushner, 2007). There are a variety of common features within Orthodox groups, including modest dress and strict dietary requirements, as well as strict rules in relation to the Sabbath, including abstaining from any type of work. Technology cannot be used from dusk on Friday until sundown on Saturday. It is therefore important for families to live within walking distance of Synagogues and as a result Orthodox communities rise up around places of worship.

1.1.2 The Orthodox community and acculturation

Within literature, the term acculturation has often referred to a linear process of minority group members (usually migrants) assimilating to a new, majority group culture (Gordon, 1964). Alternate models of acculturation have emphasised that

[1] This is because some people fear that this information could be used to persecute Jews, replicating Nazi Germany.

adopting the cultural practices of the host community does not necessarily mean that minority groups reject their own cultural beliefs and practices. Berry (1980) suggests that there are various categories relating to acculturation, including: assimilation (adopting the majority culture and discarding the heritage culture), separation (rejecting the majority culture and retaining cultural traditions) and integration (adopting majority culture whilst also retaining one's cultural heritage).

Schwartz, Unger, Zamboanga & Szapocznik (2010) emphasise that much of the literature on the topic of acculturation adopts a 'one size fits all' approach, failing to attend to contextual factors and individual differences. In order to fully understand acculturation, having a thorough understanding of the context in which it occurs is of critical importance. When considering context, Schwartz et al (2010) emphasise the value of attending to language, culture and recognising the differences in 'type' of migrant. Many families within the Stamford Hill community, which this study focuses on, are of migrant and/or refugee origin[2]. Regardless of whether members of the community have individually experienced discrimination or persecution, the spectre of the persecution of the Jewish community during the Holocaust looms. In addition to this, the community faces the reality that anti-Semitic crime in the UK has risen by 53% from 2014-2015 [3] (Community Security Trust, 2015). It has been acknowledged that when individuals from a minority/migrant background experience discrimination or persecution that they may be more likely to reject the majority culture (Rumbaut, 2008). The interplay between persecutory historical and current contexts may contribute to the Orthodox community remaining separate from the majority UK culture. In addition, experiences of both direct, and inter-generational trauma, may impact on the ability or willingness to adapt to a majority culture (Akhtar, 1999). As such, there may be a number of factors that impact on the low level of acculturation within the Orthodox community. In addition to the above, the strict cultural and religious beliefs upheld by community leaders and community members, are at a stark contrast to the majority UK culture. There is an implicit idea that Western

[2] Many Jews fled to the UK as a result of the Holocaust.
[3] In the Stamford Hill area, which this study focuses on, anti-semitic crime has risen by 87% between November 2014-November 2015 (Seabrook, 2015).

culture is at odds (or incompatible) with Orthodox Jewish culture. The way in which these ideas impact on help-seeking behaviour is discussed further below.

As such the Orthodox community can be seen as an enclave culture, a community that chooses to separate itself from mainstream society (Hakak, 2011). Enclave cultures may lose access to mainstream governmental resources; whilst this may be deliberate in some cases, in other cases it may be due to the cultural distance between the enclave culture and mainstream society. As part of this enclave culture, it is common for most Orthodox children to attend private religious schools where the state has minimal input to educational provision (Pirutinsky, Schecter, Kor & Rosmarin, 2015). From the age of 16, most Orthodox girls attend Jewish teaching colleges, whilst young men attend institutions such as Yeshivas, to further study the Torah and other Jewish texts (Loewenthal, Glinert & Goldblatt, 2010). Gender segregation is typical from the age of two, and men and women do not mix socially outside of the family or work contexts. It is considered improper for men and women to interact; touching is frowned upon and many Orthodox men will refrain from making eye contact with women outside of the family. This may create difficulty if it becomes necessary to interact with secular women in the wider secular community, as it may be interpreted as socially unacceptable or antagonistic. For men, the study of the Torah is highly valued and full-time religious study is a celebrated occupation (Loewenthal, 2009). In addition men have a Halachic requirement to pray at least three times a day, if not more. There tend to be fixed gender roles within the community, with women as responsible for raising the children (often with the help of older daughters) and maintaining the home. Though in majority Western cultures such a role may be seen as subjugated, women in Judaism are highly valued and their role is seen as critical to the functioning of the family.

1.1.3 Key groups within the Orthodox community

It is important to differentiate between Orthodox groups to demonstrate the many differences within the Orthodox community and to highlight the lack of homogeneity that may be otherwise perceived. Rather than being one group, the Orthodox are made up of a multitude of sub-groups, each with their own theological beliefs and maintaining different levels of contact with the secular world (Popovsky, 2010). Given

the requirements of this piece of work, it is not possible to explore all of the many groups and sects within the wider Orthodox Jewish community, though it is important to note that there are many differences between different branches of Orthodoxy. Similarly, a discussion about non-Orthodox Jewish identities (e.g. Reform, Liberal, United) is not provided. For the purposes of providing relevant background information, a brief overview of the majority Orthodox groups living in Stamford Hill is provided.

1.1.3.1 Charedi. The term Charedi is derived from the Hebrew for ‘fear’ and can be interpreted as "one who trembles in awe of God" (Isaiah 66:2,5). Within literature, these individuals are often referred to as ‘Strictly Orthodox’ or ‘Ultra-Orthodox’. As such, the term Charedi has come to denote those who are ‘religious, pious and observant’ (Holman & Holman, 2002). The Charedi reject modern life, viewing many aspects of technology as harmful and threatening to ones spirituality and relationship with God. Charedi Jews are likely to avoid interaction with those outside of the Charedi community.

1.1.3.2 Hasidic. The Hasidim are a movement within Charedi Judaism. Within the Hasidic population there are a number of different groups that operate as according to the rulings of different Rabbinic authorities (e.g. Lubavitch, Satmar, Belz). Each of these groups has individual characteristics, but all can be seen as prescribing to the strict observance of Judaic law and teachings. Hasidic Jews are understood to be unlikely to make major decisions without consulting with their local Rabbi (Margolese, 1998). The Hasidim reject secular values and are likely to limit contact with the secular world wherever possible and following from this, are therefore likely to avoid technology (Weiselberg, 1992).

1.1.3.3 Modern Orthodox. Modern Orthodoxy can be differentiated from other types of Jewish Orthodoxy, in that engagement with the modern world is not necessarily seen as a threat to ones spirituality, but rather as an opportunity to expand it. However, despite embracing the modern world, Modern Orthodox Jews continue to follow and practice Jewish law to a high level (Berman, 2014), including keeping Kosher, abstaining from using technology over Shabbat and dressing modestly.

1.1.4 The role of community leaders

The Rabbi can be seen as maintaining a significant authority within the Orthodox community, guiding members of the community in all aspects of their lives. The Rabbi may be seen as an interpreter of secular life (Slanger, 1996) and can use his authority to influence congregants to take up his favourable/unfavourable attitude towards things that are approved or disapproved of. The Rabbi may therefore be approached to help with decision making, in order to ensure that life choices are in accordance with Jewish law. Whilst many of these decisions may relate to practical matters, congregants may approach the Rabbi for help making decisions relating to physical health (Coleman-Bueckheimer, Spitzer & Koffman, 2009), or mental health (Goodman & Witzum, 2002). In addition the Rebbetsen (Rabbi's wife or other senior female figure) may be approached by female members of the community for advice and support in relation to a range of issues (Bayes & Loewenthal, 2013). The Rebbetsen is likely to offer counselling to engaged young women in regards to their role and obligations as a married woman. As such, strong relationships based on advice and support may rise up between the Rebbetsen and female members of the community.

1.1.5 The Orthodox community in Hackney

Hackney is a diverse and densely populated borough in East London. The Orthodox community in Hackney are settled in the north of the borough, with pockets of the community in the south of Haringey, the neighbouring borough. The hub of the community is in Stamford Hill. A large proportion of the Stamford Hill community are understood to be Charedi Jews and as a result the community is often referred to as the Charedi community, to the exclusion of the other Orthodox groups residing in the area. When considering the context of the Stamford Hill Orthodox community, it is apparent that much of the community appear to have rejected the majority Western culture, minimising contact with the secular world. The Orthodox community can be seen as a unique enclave culture in regards to its self organised infrastructure, including the provision of Orthodox police, fire services and kosher shops. The community provides education through gender segregated private religious schools, from nursery to beyond the age of 18 (Holman & Holman, 2002). There are approximately 29 Orthodox Jewish schools in Hackney. They provide a traditional

Charedi environment, with an emphasis on Jewish studies, particularly for boys (Interlink, 2014). There are a number of Jewish charitable organisations within the area that serve to meet the needs of the Orthodox population. This includes access to social work and family support, children's centres, care homes and in more recent years, therapeutic support.

According to census data, it is estimated that the Jewish Orthodox community make up 7.4% of Hackney's population (Mayhew, Gillian & Waples, 2011), a much higher average than the UK's Jewish population in general. In addition, Hackney is home to the highest concentration of Orthodox families in the UK, containing over 13500 individuals (Staetsky and Boyd, 2015). As such, Orthodox households are much larger than the average household size for Hackney (Mayhew, et al, 2011). However, as previously mentioned, it is difficult to accurately assess the number of Orthodox families in the community given the caution with which written details of ethnicity/religion are provided. There are therefore conflicting reports on the size of the community, with other reports suggesting the population is likely to be over 22000 (Interlink, 2014). The community is exceptionally young and it is believed that over half of the Charedi Orthodox population is made up of children and young people below the age of 16 (Interlink, 2016). It is suggested that the Orthodox community is more likely to experience poverty and deprivation than other Jewish families. This may be in part due to the large number of children in each family, but also because of the emphasis on the study of Jewish texts. In Hackney only 43.5% of Jews under the age of 25 have qualifications and thus are likely to struggle in gaining the types of positions that would help them to support a large family (Abramsom, Graham and Boyd, 2011). Martin et al (2007) highlight that the Stamford Hill Orthodox community is unique in their insularity[4] and in their need to deny problems or difficulties occurring within their private/family lives. This has obvious implications for accessing mental health services, as discussed further below.

[4] The Stamford Hill community is seen as unique in comparison to other Orthodox communities e.g in Manchester, Antwerp and New York.

1.1.5.1 The value of family. Family can be seen as the epicentre of Orthodox Jewish life. Children are regarded as blessings (Loewenthal, 2006) and procreation is strongly encouraged as a way of fulfilling God's will and continuing Jewish life (Callister, Semenic, & Foster, 1999). As a result, many Orthodox couples begin trying for a baby immediately after marriage and often have high numbers of offspring in comparison to the average population. It is estimated that Orthodox families typically have approximately seven children on average (Pirutinsky et al, 2015) and contraception is typically prohibited. Arguably, in the Orthodox community marriage is the key to family life and this means that marriage occurs at a much younger age than in the general population, often in the late teens or very early twenties.

A key role for a parent is to help their children find a suitable marriage partner in order to support the continuance of both the community and religion (Rockman, 1994). There are a number of qualities that are seen as desirable within a partner and family background may be an important consideration within the process. Factors such as poor physical or mental health may have a significant impact on the likelihood of finding a suitable marriage partner, not only for the individual, but for their siblings, as the reputation of the family may be called into dispute. Those who are unmarried are regarded as spiritually incomplete. Valuing family does not simply place emphasis on marriage and procreation, but also places importance on respecting one's parents. In Orthodox families, respect for one's parents can be seen as in line with respecting God (Weiselberg, 1992). As such, adult children are likely to take on caring responsibilities for their parents as they enter old age, alongside caring for their growing families.

1.2 Children and young people; help-seeking for mental health difficulties

Before considering the specifics of mental health within the Orthodox community, it is likely to be helpful to consider the impact of mental health difficulties on young people in the general population, and the factors influencing families to seek help. As many as 10% of young people are estimated to experience mental health difficulties at any one time (Green, McGinnity, Meltzer, Ford & Goodman, 2005). Mental health

difficulties can be understood as emotional, behavioural or social difficulties that have a significant impact on the day to day functioning of a child and their family. Mental health difficulties in childhood are associated with a number of long term consequences, such as poor educational attainment, increased risk of substance misuse and an impact on social relationships (Goodman, Joyce & Smith, 2011). In the UK, children and young people experiencing mental health difficulties are likely to be seen in CAMHS, where a variety of interventions may be on offer. Whilst adolescents over the age of 16 may be able to access these services without parental consent, the majority of children and young people must have the support and consent from their parents to access services.

1.2.1 Parents as gatekeepers to care

Children and young people experiencing mental health difficulties are most likely to turn to family or friends for support, rather than directly seeking professional help (Rickwood, Deane, Wilson, & Ciarrochi, 2005). Some young people may be able to access psychological support through school, but parental consent is usually required as these systems tend to operate via a referral process. As such, parents and carers have an important role in facilitating access to professional psychological help (Boulter & Rickwood, 2013) and children are largely reliant on this parental support (Sayal, et al 2010). Arguably, parents can therefore be seen as the primary "gatekeepers to care" (Stiffman, Pescosolido & Cabassa, 2004). Given the valuable role of parents/carers in seeking psychological support, it is important to consider the process of help-seeking and how this is experienced by parents.

1.2.2 Parents' experiences of accessing CAMHS

There is limited available research on the individual experiences of parents accessing CAMHS and similar psychological services. Of the limited research, a key paper by Boulter and Rickwood (2013) highlighted that many parents seek support from informal sources whilst engaged in the process of accessing professional services. They identified a number of concerns that may impact parents in seeking help, including worries about the impact of the child's mental health on the rest of the family. In addition, parents discussed a wish to alleviate negative emotions evoked within themselves by their child's difficulty. All parents interviewed by Boulter and

Rickwood (2013) highlighted the difficulties they faced in coping with their child's problems, with the majority stating that being unable to manage these problems on their own was a factor that pushed them towards seeking support. The paper also highlighted the impact of other peoples concerns on seeking help, with concerns by teachers, family or friends helping to facilitate service utilisation. Parents described struggling with inflexible and inaccessible services, fitting with further research in this area (Holmboe, Iversen & Hanssen-Bauer, 2011). Barriers for those attempting to access CAMHS may include lengthy waiting times, inconvenient appointment times and physically inconvenient locations.

1.2.3 Factors affecting help-seeking

Much of the literature focusing on the topic of seeking help from CAMHS refers to parents bringing their child(ren) to professional services. This language often positions the child as either being the problem, or as having a problem that is internal to them. Arguably this perspective ignores both the family context and wider contextual factors. In order to avoid further problematizing language, the process of help seeking will be referred to as families accessing services, rather than referring to parents seeking help for their children (as constructed within the literature). There have been various suggestions about factors that may invoke families to seek help from professional agencies, including the idea that low parental self efficacy and increased levels of stress can predict service use (Janicke & Finney, 2003). In addition, families from urban, White, higher socio-economic backgrounds have been found to be more likely to seek professional help (Logan & King, 2001). A three-phase approach to help-seeking by families has been suggested, consisting of problem recognition, the decision to seek help and service utilisation (Power, Eiraldi, Clarke & Mazzuca, 2005). However, it is unclear whether all families necessarily proceed through these stages (Broadhurst, 2003) and if they do, it may not be a linear process. Alternatively, Logan & King (2001) also propose a help-seeking model in relation to adolescent psychological difficulties. They highlight the multitude of contextual factors that impact on both the contemplative and action stages when considering how and where to seek help. This includes, but is not limited to, the intensity and number of symptoms experienced by the young person, the parent's attitude towards mental health services, their own history of service use, as well as

various barriers to services. This model benefits from considering the multiple levels of context that influence such a decision, as well as considering the parent's own relationship to help (Reder & Fredman, 1996). However, the model postulates that the adolescent's difficulty is an internal, individual problem, rather than something that can be understood as a reaction to multiple contexts, including that of the family environment.

1.2.3.1 Problem identification and recognition of severity.

A barrier to mental healthcare for young people may be the initial identification of a problem. It has been suggested that many parents of children who would meet the diagnostic criteria for a mental health problem, do not view their child as having a problem (Sayal, Taylor & Beechman, 2003). Whether or not a mental health difficulty is identified is likely to be influenced by the perceived severity of the problem as viewed by parents, teachers and primary care clinicians such as GPs (Bennett, Power, Rostain, & Carr, 1996). Parents with children who have problems that cause a significant impact on both child and family, creating an increased carer burden, are more likely to recognise that there is a problem and thus seek help (Power et al, 2005). This means that mental health problems that are internalised, such as depression, may not be easily identified within children and thus help may be less likely to be sought.

Parental beliefs and understanding about the causes of their child's behaviour may also impact on whether a problem is recognised; this may result in differences between cultures as to whether problems are recognised and/or identified. Parents who feel their child is displaying 'normal' child behaviour are unlikely to seek support, as are parents who have an alternate explanation for behaviour. In addition, if a parent believes their child's difficulties are related to external factors that are likely to change (e.g. peer group difficulties), they may believe such problems will improve by themselves and may be less likely to seek psychological help (Pavuluri, Luk & Mgee, 1996). Less than half of parents who have children with a mental health difficulty perceive there to be a significant problem; this suggests that problem perception is a major barrier to help-seeking (Teagle, 2002).

1.2.3.2 Intention and attempts to seek help.

Parents have described the decision to seek help as being complicated by a variety of factors. This may include difficulties in locating sources of support; some parents may believe it is inappropriate, or not possible to access support for behavioural or psychological difficulties through their GP (Sayal et al, 2010). This may be in part because psychological or behavioural problems are often perceived as separate from physical health, and GPs may be more likely to be associated with physical healthcare. Finding out about sources of support has become easier with increased awareness of mental health and many resources are available online. However, information provided online regarding seeking support may be contradictory or unclear, leaving parents at a loss for where to go. This may be particularly so for those who have literacy difficulties or where there is a language barrier. Some parents may not actively choose to seek help, but may feel pressured into seeking support or accepting a referral put forth by school, health visitors or other professionals. Feeling as though one does not have a choice over such a referral may therefore impact on later engagement with CAMHS. It may be that a parent's individual relationship to help (Reder & Fredman, 1996) impacts on the decision of seeking help. Those who have had a past positive experience of psychological services may be more likely to decide to seek support based on this experience (Wu et al, 2001) and vice versa. Along these lines, research suggests that the help-seeking behaviour of mothers, strongly impacts on their children's service use (Cardol et al, 2005).

1.2.3.3 Cultural factors.

Cultural factors may relate to help-seeking in a number of ways. Our understandings of what is 'normal' or a sign of mental illness are based on social constructions rooted in socio-political and cultural contexts. Therefore, different cultures will have different constructions relating to their expectations and understanding of children's behaviour. These constructions may influence whether a parent views behaviour as problematic and will therefore influence whether or not they seek help. In western cultures such as the UK, we draw on a multitude of ideas to understand children's behaviour and what falls within the realm of normality, versus what is conceptualised as a mental health problem. We may draw upon theories such as attachment theory

(Ainsworth & Bowlby, 1991), models of child development (e.g. Piaget, 1970; Vygotsky, 1978) or epigenetics. In addition, we have an abundance of wider cultural narratives about children relating to gender, age and stage. In other cultures, these ideas may not be widely acknowledged and therefore there may be significant differentiations in what behaviour is understood as normal and/or acceptable.

Research suggests that children of minority ethnic backgrounds are less likely to be engaged in mental health services than majority group (white) children (Zimmerman, 2005; Freedenthal, 2007) and that they are likely to face more barriers to accessing mental health services (Lavis, 2014), which is arguably related to cultural factors. However, there is limited available research on the factors that affect help-seeking in minority groups accessing CAMHS. Within the limited research available, Messent and Murrell (2003), found that London based Bangladeshi parents faced particular difficulties when seeking help for their families. This was in part due to a lack of awareness of available services and their purpose. It was suggested that CAMHS would need to explicitly advertise and raise awareness in order to support families to access the service. Given the limited research on parental help-seeking within minority cultures, it may therefore be helpful to also consider the literature on help-seeking patterns in minority adult populations, as parents who seek help for their own psychological difficulties are more likely to seek help for mental health difficulties identified within their children (Curry, 1998).

Explanations of mental illness have been shown to be related to cultural health beliefs (Helman, 1990). Hall and Tucker (1985) explored the relationship between beliefs about the causes of mental distress, and attitudes towards seeking help from professionals. They found that the way in which mental illness was conceptualised was significantly related to attitudes towards seeking professional help. These results are demonstrated by Sheikh and Furnham (2000) within British Asian groups and by Chen and Mak (2008) for Chinese groups. Traditional Chinese cultures may discourage emotional expression, based on the belief that the expression of emotional distress will have an impact on the way in which one is perceived by others. As a result, help-seeking for psychological or emotional problems is less likely than within Western cultures (Mak & Chen, 2006). Hatfield, Mohamad, Rahim

& Tanweer (1996) found that within the British Asian community, mental illness may be viewed as an act of God. Therefore, prayer was seen as an appropriate response to such distress and seeking support from professionals would be less likely. Given the research within this area, it is likely that cultural beliefs within the Orthodox Jewish community will have some level of influence on help-seeking behaviour. This is explored further below.

1.2.3.4 Stigma.

Goffman (1963) describes stigma in terms of "spoiled identities". Individuals who do not meet expected social norms become the subject of negative judgements by others and as such are rejected and/or marginalised by dominant groups. Stigma can be seen across four levels: individual stigma, public stigma, internalised stigma, and stigma by association. Public stigma can be understood as the widespread prejudice and discrimination that occurs as a result of particular stereotypes e.g. people with mental health problems are dangerous and unpredictable (Corrigan et al, 2010). Individuals with mental health problems may hold ideas about themselves that are perpetuated by society e.g. mental health problems are due to personal weakness (Watson, Corrigan, Larson & Sells, 2007). This is associated with self-shaming, feeling judged and feelings of self-disgust. In addition, family or friends may experience stigma by association of knowing an individual with a stigmatised problem such as mental illness. This means that they may encourage the individual to hide their stigmatised problem, in order to protect themselves from experiencing negative judgements. There are numerous research studies suggesting that stigma relating to mental illness and stigma towards individuals with mental health difficulties is widespread (e.g. Crisp, Gelder, Rix, Meltzer & Rowlands, 2000). In addition, internalised and perceived public stigma has been found to impede help-seeking for psychological problems (Lally, Conghaile, Quigley, Bainbridge & McDonald, 2013).

Though stigma relating to mental health is widespread, studies relating to minority communities have found high levels of stigma towards those with mental health problems. This is influenced by beliefs about the aetiology of mental health difficulties as well as factors relating to family and community structures (Knifton et

al, 2010). In cultures where family reputation is highly valued, there is an implicit implication that mental illness will affect ones' ability to meet family obligations and take up expected roles; this in turn inhibits disclosure of mental health difficulties and thus maintains stigma (Wynaden et al, 2005). Shame and guilt have also been identified as factors associated with stigma in minority Chinese communities (Lee, Lee, Chiu & Kleinman, 2005). Again, shame is highlighted as a problem within certain South Asian cultures, due to beliefs about mental illness being inflicted as punishment for wrong doings (Karim, Saeed, Rana, Mubbashar & Jenkins, 2004). As such, stigma by association can be seen as a particular issue within minority groups where there is an emphasis on family and community. Given that the Orthodox Jewish community is both extremely family and community focused, stigma relating to mental health may be a particular issue. This is discussed further below.

1.3 Literature review

An initial literature search was conducted using the search terms 'Orthodox Jewish', 'Parent' and 'Mental Health', and 'Orthodox Jewish', 'Mental Health' and 'Help-seeking'. These were later combined to refine the search. These terms were selected as they appeared to bring up the most relevant sources of data. Other combinations were attempted but the specificity of search terms meant only a minute pool of research was returned. Using the final choice of search terms, and excluding repetition in search results, searches across EBSCO databases PsychInfo and Academic Search Complete returned a total of 30 papers, 8 of which were relevant. Searches across Science Direct databases returned 49 papers, of which 4 were relevant. Date ranges were not used as the body of literature on this area is extremely small. For this reason, non-peer reviewed doctoral theses were included in the search results. In addition, Google Scholar and the British Library e-theses online service were used to identify 'grey literature' that may have otherwise been missed. Through these means, an additional 3 papers were identified as relevant. Following from this, reference lists in articles of interest were hand searched to gather relevant literature. This strategy yielded the majority of relevant literature on the topic. Articles were understood to be relevant if they focused on issues of mental health in the Orthodox Jewish population, and contained information regarding help-seeking that

was likely to be applicable for parents seeking support for their families. Articles were excluded if they were not related to the Orthodox Jewish population, mental health and/or help-seeking.

Whilst there is research that investigates attitudes towards specific mental health problems such as depression in Orthodox Jewish adults (Bayes & Loewenthal, 2013), there appears to be a scarcity of literature that examines the particular issues that may arise for Orthodox Jewish parents whose children may be experiencing emotional or behavioural difficulties. In the limited literature on the topic, one paper was identified (Schnitzer, Loots, Escudero & Schecter, 2011) that specifically discusses Orthodox Jewish parents' experiences of accessing children's mental health services. Schnitzer et al (2011) focused on the way in which Orthodox Jewish parents in Antwerp make the decision to consult 'regular' mental health services for their families. Using Grounded Theory analysis, they found that Orthodox parents make the decision to seek support based on a number of cultural dynamics, such as gender, parenting discourses and socio-religious frameworks. They also identified three key help-seeking pathways; school initiated, parent initiated without schools knowledge, and an 'interfering pathway', where both school and parents are involved. Schnitzer et al (2011) found that an extremely limited number of families accessed mainstream mental health services.

Tepfer (2009) explored attitudes towards help-seeking amongst Orthodox Jewish parents in New York State. Those who were self-affiliated with more insular Orthodox subgroups, and who appeared less open to Western values, utilised lower levels of mental health services. Levels of stigma towards psychological help-seeking were found to be predictive of intentions to seek support. Additionally, women were found to have more positive attitudes towards help-seeking than men; the attitude that they had towards seeking help for themselves positively correlated with their attitude towards seeking psychological help for their children. This fits with the research outlined above, suggesting that mothers are more likely to seek help for their children if they have accessed services themselves (Cardol et al, 2005).

As described, parental attitudes towards their families seeking professional psychological support have been found to be a predictor of the likelihood of whether

their families would access psychological services (Curry, 1998). Research has shown that there are a multitude of common factors across cultures that may impact on attitudes towards help-seeking, such as gender and social stigma (Tepfer, 2009). It is apparent that stigma relating to mental health is common across many cultures, including Orthodox Judaism, and that this will extend to mental health difficulties experienced by children and young people. If a child displays unusual behaviour then doubt may be cast on the suitability of any members of the family for future marriages. Greenberg, Buchbinder, and Witzum (2012), discuss the impact of mental illness on marriage prospects at length. They highlight the social complexity of having an identifiable mental health problem within the Orthodox community and the many difficulties that may arise from it. They highlight the impact of stigma on mental health within the community; as such it is possible to see why it may be more likely that Orthodox parents may be more cautious than other groups when seeking psychological help for their children. This is discussed in more detail below.

Zoltan-Rockoff (2009) investigated the factors involved in choosing a therapist for ones child. This study found that parents preferred to access a professional who was competent in a variety of areas, rather than accessing a professional who was also Orthodox. However, attitudes towards what are perceived as favourable qualities within a therapist is likely to vary according to religious affiliation, with variability between sects. Significant differences have been found between Orthodox groups attitudes to seeking psychological treatment (Bronstein, 2007), including the likelihood of preference for working with an Orthodox professional. In addition, there are likely to be differing attitudes towards consulting with the Rabbi about psychological treatment, and about the impact of accessing support on one's marital prospects.

When considering the weaknesses within the literature search and its relevance to the present study, one thing to consider is that the vast majority of papers that were reviewed are from outside of the UK. Though the Orthodox community across the globe is likely to share many common features, there may be particular cultural factors that are specifically relevant to the British Orthodox population. This may be particularly so for the Stamford Hill community, given that the community has been

identified as unique (Martin et al, 2007). Further to this, it is notable that several of the papers reviewed are doctoral theses, rather than published peer-reviewed journal articles. Whilst doctoral theses are likely to be of a high standard and will have been reviewed by experienced professionals, they may lack the same rigorous assessment given to an academic article. However, given the dearth of research in the area it seems pertinent to peruse all sources of information, rather than only those that are published. There may be many reasons that important research fails to be published and 'grey literature' may hold significant value (Pappas & Williams, 2011), particularly in areas of novel research.

1.4 Mental health and the Orthodox community

Mental illness can be understood in a number of ways within Orthodox culture. When considering the nature of depression, Bayes and Loewenthal (2013), reviewed key rabbinic literature and identified two key causal factors. Firstly, there is an idea that experiences of depression may relate to individual sin and failure to live a life in accordance with Jewish law. In addition to this, external stressors (such as difficult life experiences) were also seen as influencing depression and similar melancholic episodes. As such depression can be seen as a natural response to external events, or as a result of a lack of faith and/or observance. Loewenthal (1995) highlights that the Hebrew term for madness roughly translates to 'sickness of the soul'. This suggests that poor mental health is linked in some way to spirituality or religiosity. It is therefore understandable that prayer and religious study have sometimes been recommended as ways of combatting such problems, in conjunction with a range of behavioural, cognitive and emotional approaches as put forth by rabbinic authorities (Bayes & Loewenthal, 2013). In a similar vein, mental health problems can be thought of as a test from God, or as part of a divine plan (Martin et al, 2007). It has been suggested that Orthodox Jews share an equally positive attitude towards seeking psychological help as their non-Orthodox peers (Kaminetsky & Stricker, 2000), though this is in contrast to the majority of literature on the subject. In recent years there have been increasing numbers of Orthodox community organisations that serve to meet the emotional needs of the population (Loewenthal & Rogers, 2004). The increased visibility of these organisations may have contributed to

changing attitudes towards mental health have slowly improved within the Orthodox community, perhaps in line with changing attitudes within the general population (Schnall et al, 2014).

1.4.1 Stigma and cultural barriers to psychological help in the Orthodox community

Research focusing on stigma within the Orthodox community has found two key issues; stigma relating to mental health problems, and stigma related to seeking help from a mental health professional (Feinberg & Feinberg, 1985). Whilst stigma in relation to mental health appears to have decreased, stigma relating to seeing a mental health professional continues to be a barrier to help-seeking (Schnall et al, 2014). This may be because problems requiring professional help are seen as more severe than problems that can be dealt with within the family or community. In addition, there may be concerns about seeing therapists who are not Orthodox, fearing that they may not understand the Jewish way of life, or that they may disrespect important values (Sublette & Trappler, 2000). Loewenthal and Rogers (2004) highlight the importance of Rabbinic approval when advising and/or supporting clients. Whilst there are differing views within the Orthodox community, generally Orthodox Rabbis hold a positive attitude towards professional help-seeking and there is evidence that suggests that Rabbis are willing to liaise with members of the psy-professions (Bayes & Loewenthal, 2013). However, anti-psychotherapy views have also been advocated by some Rabbinic authorities, with fears that psy-professionals are heretics and will offer advice that contravenes Jewish laws (Bayes & Loewenthal, 2013). Though these views may not be widespread within the Orthodox community, they may serve to strengthen worry and stigma in relation to seeking support for mental health difficulties. Orthodox clients are more likely to choose to have an Orthodox therapist (Rube and Kibet, 2004), based on rabbinic teaching as well as concerns about the level of understanding a non-Orthodox therapist may have.

Attitudes towards mental health in the Orthodox community are complicated by the inherent importance of being able to ‘marry off’ ones children to fulfil the first commandment of the Bible, “Go forth and multiply” (Martin et al 2007*).* In many Orthodox communities, marriages are arranged via a matchmaker. As discussed,

matches rely on a variety of factors and undesirable factors may impact on having a choice in matches. Those who are known to have mental health difficulties may thus have their marriage opportunities significantly limited. In addition, the marital choices of other family members may also be affected (Popovsky, 2010). This creates heightened anxiety about marriage and leads to a cycle of silence around mental health issues. Those who remain unmarried face further stigma as they may be viewed as spiritually deficient by some (Weiselberg, 1992). Biological/medical models of mental health may create greater stigma within the Orthodox community as they are perceived as implying an inherent genetic difficulty, thus casting doubt over the nature of the whole family (Pirutinsky, Rosen, Shapiro-Safran & Rosmarin, 2010). As a result, problems relating to mental health can be ignored or denied; consequently having an impact on the need/desire for services. Loewenthal and Rogers (2004) highlight issues of confidentiality as key within the small and close-knit Orthodox community. The effects of a breach of confidentiality in these cases can have significant and long-lasting effects for the whole family (Popovsky, 2010).

1.4.2 Mental health, and Orthodox children and young people.

There might be a number of reasons that young people within the community require psychological support, as there would be in any population. Research has shown that pre-school children in the Orthodox community show significant levels of behavioural difficulties, though lower than expected given the levels of deprivation in the community (Lindsey, Frosh, Loewenthal & Spitzer, 2003). This is supported by follow up research by Frosh, Loewenthal, Lindsey and Spitzer (2005), who argue that comparatively low-levels of behavioural disturbance in school age Orthodox Jews may be related to compensatory factors such as family cohesion and social support. An increase in eating disorders has also been noted, due to high levels of pressure on young women to be thin (Rube & Kibel, 2004), as this is deemed to make a marriage match more likely. It is notable that there is a dearth of literature regarding the mental health of Orthodox Jewish children and young people. This has implications for the way in which Orthodox young people may experience CAMHS, and may mean that services are unaware of the particular needs that these young people may face.

Orthodox young people are likely to face significant difficulties accessing mental health services for a number of reasons. Firstly, there is a widespread lack of awareness of, and confidence in NHS mental health services within the Orthodox community. Parents may not feel NHS services are relevant to them, or may be doubtful about professionals' ability to work with their families because of significant cultural differences (Interlink, 2016). As a result, families are less likely to access CAMHS and if help is sought, it is likely to be at a later stage when problems have escalated in severity. Parents may also prefer to see Orthodox practitioners working privately in the community. These practitioners are likely to charge fees that many families will struggle to afford and some may offer services with no evidence-base (Interlink, 2016). Parents and schools may be reluctant to engage with statutory services, as they are concerned about the ability of non-Orthodox professionals to understand and engage with Orthodox children and young people. This is not simply due to cultural differences, but also in regards to differences in education and social systems (Interlink, 2014). There is likely to be a suspicion towards psychological services and as such services such as CAMHS may not be taken up unless there is a significant need (Interlink, 2014).

There is limited research on the impact of religiosity on parenting (Hakak, 2011). Frosh (2004) has suggested that this is related to the tensions between conservative religions and the typically liberal values held by many members of the therapeutic professions. Respect for one's parents is key in Jewish law and as a result, parents may take up a more authoritative stance. There are likely to be particular expectations in relation to the behaviour of children and young people and the paths they will follow; indeed, Charedi education maintains a focus on acting in a way in accordance with divine will, rather than focusing on ones own wishes (Hakak, 2011). Behaviour that deviates from the expected cultural norms may thus be a significant concern for parents.

1.4.3 Culturally sensitive practice

As outlined above, cultural differences are often a significant barrier to help for families. The delivery of culturally sensitive practice is therefore critical to engagement and work with the Orthodox community. In order to be culturally

sensitive one must have knowledge and understanding of other cultural practices, and must show consideration and respect for these beliefs/practices (Foronda, 2008). In addition, considering how one's own cultural background may impact on the beliefs and assumptions that are made as a therapist, is key to working in a culturally sensitive manner (Kubokawa & Ottaway, 2009). Cultural sensitivity is important not only on an individual clinician level, but also within a service level context. Frameworks for delivering culturally sensitive practice when working with the Orthodox community in Israel have been developed (e.g. Bilu & Witzum, 1993; Witzum & Buchbinder, 2001; Stolovy, Levy, Doron & Melamed, 2013). They highlight the conflict that can occur when a client's cultural or religious beliefs substantially differ from the therapist, and emphasise that the suspension of any disbelief or scepticism on the part of the therapist is critical in order to successfully work across cultural differences. A genuine respect for, and curiosity about the beliefs and practices of the client is necessary in order to facilitate a therapeutic relationship. Their frameworks highlights the importance of a collaborative working relationship, based upon the cultural symbols and metaphors of the client. Bilu & Witzum (1993) discuss the way they have been able to do this in detailed vignettes.

There are practical and service level issues that may cause difficulties for Orthodox clients. These may include being offered a therapist of the opposite sex, appointments on Jewish holidays, or may relate to more concrete factors such as the location and appearance of the community bases. For example, Bilu and Witzum (1993) discuss the positive effect of positioning mezuzoth[5] on doorframes within their clinics in order to provide a familiar point of reference for clients who may find it difficult to be in multicultural settings. It is important to recognise the different context of Jerusalem and Stamford Hill when drawing upon this literature, but equally it is helpful to have an understanding of factors that may impact on engagement and attendance.

It is important to note that simply having knowledge of the Orthodox (or any other)

[5] A piece of parchment inscribed with Hebrew verses from the Torah, usually contained in a decorative case. Mezuzoth are usually positioned on door frames in Orthodox Jewish homes, as commanded by Halachic Law.

culture, is not enough to ensure that one is practicing in a culturally sensitive manner (Sue & Zane, 1987). Rather, it is drawing upon this knowledge to tailor interventions that is likely to be helpful. On an individual level this may include sensitivity to language, as well as demonstrating an awareness of culture (e.g. upcoming religious holidays) to develop a trusting relationship with a client. Developing culturally sensitive practices on a broader level can be more complicated, as outlined above. However, there are steps that can be taken, such as a commitment to working and consulting with community organisations. Indeed, Schnall (2006) emphasises the importance of liaising with Rabbi's and other community leaders to develop successful working relationships that may give clients more confidence in non-Orthodox therapists.

1.5 Equal access to services

Though the need to provide equal access to services for minority groups has been on the NHS agenda for some time (DoH, 2004; 2005; 2009; 2014), more recently there has been an awareness of the need for research into the service utilisation and barriers to accessing CAMHS for minority groups (Dogra, Singh, Svirdzenka & Vostansis, 2012). Despite this awareness, there is evidence that Orthodox Jewish individuals have been (perhaps inadvertently) excluded from mental health initiatives aimed at minority groups. This may be for a number of reasons. Firstly, they may be excluded from such initiatives as Judaism is typically regarded as a religion, rather than an ethnicity or culture and is thus overlooked. Inclusive practice within the NHS has tended to focus more on issues of ethnicity, rather than spirituality and religious identity (Levitt & Balkin, 2009). Given the value of religion and spirituality to so many of the population, this is a significant deficit in mental health provision. There is evidence to suggest that the wider Jewish population is generally well represented in psychological services (Mishne, 2006) and this may serve to obscure the fact that services may be inaccessible for those who are Orthodox. Finally, the fact that the Orthodox population is relatively small in the UK as a whole, with large pockets of community in North London and Greater Manchester, means that the population may be overlooked. Inclusivity for the Orthodox population therefore seems to be a

borough or service level issue, rather than becoming the subject of nationwide policy.

Despite the lack of nationwide policy, localities where there are large Orthodox Jewish communities (such as Hackney) have made efforts to develop accessible services. The BME access service in Hackney has co-developed guidance for professionals and conducted small-scale research into making NHS services more accessible for the Orthodox population (McFarlane, 2008; Galloway, 2015). Recent research within the BME access service (Galloway, 2015), found that services operating within a culturally sensitive framework are highly valued, though levels of stigma regarding mental health remain high. It was suggested that community psychology approaches may be beneficial in delivering psychological services to the Orthodox community. Further to this, charitable organisations such as Interlink have begun to investigate the way in which Orthodox children and young people access services in Hackney. As a result, there is an emerging body of small-scale research projects that are contributing to the development of culturally competent services within the locality.

1.6 Research rationale

Previous research suggests that children of minority groups may be underserved by mainstream services (Elster, Jarosik, VanGeest & Fleming, 2003). As discussed, this is likely to be particularly so for Orthodox Jewish children given that the Orthodox population has largely been excluded from equal access initiatives. There has been an identified need for research that focuses on the barriers to accessing services faced by minority ethnic groups, such as the Orthodox Jewish community (Dogra et al, 2012). Given that parents are often the gate-keepers to care (Stiffman et al 2004), understanding their help-seeking behaviour is crucial to ensure that Orthodox children are given the same opportunities to access services as their majority group peers. To date there is extremely limited research on the help-seeking behaviours of Orthodox Jewish parents. Research by Shnitzer et al (2011) discussed the ways in which Orthodox Jewish parents in Antwerp decide to access mainstream services. As a result they suggested a number of strategies to enhance the accessibility of

services. There is currently no other peer-reviewed research examining the experiences of Orthodox Jewish parents seeking help from CAMHS, and thus we have little understanding of the best ways to ensure that members of this group are able to access services. Clinical Psychologists within the NHS have an obligation to ensure that there is equal access to services for all minority and majority groups.

1.7 Research aims

The principal objective of the proposed study is to establish how parents/carers within the Orthodox Jewish community experience the process of accessing CAMHS. The research aims to consider whether there are barriers that have to be overcome in order to access services outside of the Orthodox community, and how these are experienced. Of interest is whether there may be particular concerns about accessing a mental health service for children.

Secondary research aims include establishing:

- Who do parents within Orthodox Jewish community turn to for support and advice?
- How is having a non Orthodox therapist experienced?

CHAPTER 2: METHODOLOGY

This chapter outlines the ethical and epistemological positions in which the study is based, explaining how these impacted on the choice of approach and analysis. A summary of how the study was completed is outlined. The process of thematic analysis is briefly described. Reflections on the researcher's position and relationship with Judaism are included.

2.1 Ethical and epistemological positions

2.1.1 Ethical considerations – why ask the research questions?

There is a distinct lack of literature within this area. Healthcare professionals such as psychologists have an obligation to ensure that NHS services are accessible to individuals regardless of their race, religion or cultural background (NHS, 1999; DoH, 2011). However, some NHS services may be less likely to be accessed by minority ethnic groups, such as the Orthodox Jewish community. This may be especially relevant for CAMHS given potential concerns about stigma. As such, seeking further information about how accessing CAMHS has been experienced may provide valuable insights. It has been highlighted that psychological research ought not simply offer insight and increased knowledge, but to aim to impact on professional practice (Barker, Pistrang and Elliott, 2001) and it is hoped that this research may lead to adjustments to services to make them more accessible, providing psychological help to those who may otherwise not receive it.

The primary research questions for this study were:

- How do parents/carers within the Orthodox Jewish community experience the process of accessing CAMHS?
- Are there barriers that have to be overcome in order to access statutory services such as CAMHS? If so, what are the barriers and how have participants experienced them?
- Are there particular concerns about accessing a mental health service for children?

2.1.2 Epistemological positions

A critical realist approach to this research has been adopted, acknowledging that reality is mediated by social processes and contexts (Willig, 2012). As such, this research comes from a position that argues that there is a real world, but that our understanding and knowledge of the world is fallible (Sayer, 1992) and based within a wider historical, cultural and social context (Harper, 2011). Participants' experiences are therefore understood as being constructed on the basis of their individual perspectives and positions in the world.

2.2 The recruitment site and service context

The recruitment site is a well established Tier 2 CAMHS in Hackney that has been in operation for a number of years. It is made up of clinicians who are primarily Clinical Psychologists. Stamford Hill and its surrounding areas are covered within the service area, meaning that the core of the Orthodox community is within the catchment area of the service. Despite anecdotal and academic information highlighting that the Orthodox community are reluctant to engage with services from outside of the community, many Orthodox families have been seen within the service over the years, though exact numbers are not known due to the way in which demographic data is recorded. As discussed, many Jewish people may be wary of recording their religion on official records, meaning that proving up to date information about referral patterns will continue to be difficult. There may be a number of factors associated with this. Staff are based within GP practices and children's centres across the borough, which may remove the stigma that could otherwise occur from being seen accessing a service which is obviously identifiable as related to mental health.

The service has made good working relationships with Orthodox Jewish services in the area and consequently has a good reputation and may be recommended by Orthodox professionals, or those who feel confident to disclose they have accessed the service. The service has recently been able to co-facilitate a parenting group specifically for Orthodox Jewish parents, for which it received good feedback. It also has a history of working jointly with Orthodox organisations. The fact that the service

has gained a good reputation within the Orthodox community may facilitate both referrals and the likelihood of engagement with the therapeutic process.

2.3 Research design and rationale

A qualitative approach was selected. Qualitative approaches focus on how participants see, experience and understand the world around them (Braun & Clarke, 2013), and focus on the meanings made from experiences, using language as a tool to do this. Qualitative approaches are able to attend to the complexity of individual experiences, whilst also searching for patterns within these experiences. As such, qualitative research gives rise to rich, meaningful data.

2.3.1 Rationale for methodology

Qualitative methodologies allow for a variety of different approaches to research and analysis. Thematic analysis (TA) was chosen as a desirable methodology through which to consider the research questions. A number of other methodologies were considered prior to the decision to use TA.

2.3.1.1 Interpretive Phenomenological Analysis (IPA). IPA was considered as a viable method for the current study. IPA focuses on the lived experiences of participants, and considers the way in which participants make sense of their experiences (Smith & Osborn, 2008). IPA is particularly suited to providing an in depth analysis of individual/personal experiences and perspectives, and its epistemological stance meant that this was a suitable methodological approach to the study. However, IPA has been understood to lack the substance of alternate methodologies such as TA (Braun & Clarke, 2013). In addition, due to IPA's specific focus on individual experiences, there was a concern that using it on an under-researched topic may result in too narrow of a focus. This was particularly so given that the premise of the study was to provide a broad exploration of the topic.

2.3.1.4 Discourse Analysis (DA). Discourse analysis pays particular attention to the role of language in the construction of reality. It has been suggested that DA is most suitable to be applied to the study of naturally occurring text and conversation (Potter & Hepburn, 2005). In addition, DA takes a constructionist epistemological stance, at

odds with the researchers' critical realist stance. As such, DA was excluded as a potential approach to data analysis.

2.3.1.1 Grounded theory (GT). GT approaches attempt to understand and explain human behaviour and social processes. GT has a number of advantages, including its epistemological flexibility. GT encourages researchers to take an assumptive and open-minded stance, and is posited to provide a rich data sample. Milliken (2010) suggests that GT is well-suited for areas where there is limited prior research, and as such GT was considered as a methodology. However, GT aims to develop theories of social phenomenon, and to do so relies on having a large and diverse sample (McLeod, 2011). As a result, GT was deemed not to be suitable as this research focuses on a small, homogenous group (Orthodox Jewish parents, who have accessed CAMHS). Rather than developing a theoretical account, the current study is interested in developing an understanding of how Orthodox Jewish parents have made sense of their experiences.

2.3.1.5 Advantages of TA. Though the above methodologies were considered, it was concluded that TA would be a better fit. As with any approach, TA has some weaknesses, including the fact that participants' individual stories have the potential to become lost within large datasets (Braun & Clarke, 2013). However, given the relatively modest sample size within this study, it may be that this occurs to a lesser degree. The decision to use TA was made for a number of reasons. Firstly, TA fits well within a critical realist approach (Braun & Clarke, 2012) and as such supports the researchers' epistemological stance. In addition, TA allows a significant degree of flexibility in comparison to other methodologies (Braun & Clarke, 2006). This flexibility is not just in relation to epistemological positions, but also in regards to the way in which the researcher engages with the data, allowing for a variety of approaches to TA. Given that this is a subject where there is little available research, it seems pertinent to take an open, flexible approach in order to 'map the terrain' (Beakwell, Smith & Wright, 2012) of a novel area. Further to this, whilst TA allows the researcher a significant amount of flexibility, it benefits from having a clear protocol outlining how to undertake a meaningful analysis (Braun & Clarke, 2013).

2.3.2 Approach to TA

Themes identified through TA can be found via an inductive, or deductive approach (Braun & Clarke, 2006). An inductive TA attempts to code data by focusing purely on the content of transcripts, ignoring the researchers assumptions (Braun & Clake, 2006) and avoiding identifying themes based on existing frameworks. Joffe & Yardley (2004) suggest that the use of inductive TA may be particularly relevant for new and emerging areas of research. This can therefore be seen as a suitable approach for this area of research. In contrast, a deductive TA attempts to map data onto pre-identified areas of interest, usually influenced by literature within the area (Willig, 2013). Braun & Clarke (2006) highlight that adopting a purely deductive TA may result in a poorer description of data, as themes that do not fit into the pre-determined area of interest may be ignored. Whilst an inductive approach may be preferable, it is difficult for a researcher to take a purely inductive approach, as one's knowledge and preconceptions will invariably influence the themes that are identified within data (Joffe & Yardley, 2004). In addition, when conducting research, it is necessary to consider current literature in order to ensure that research is novel (Joffe, 2012) rather than repetitive. Arguably, this means that research cannot be conducted without some knowledge of relevant research in the area. Consequently, whilst a primarily inductive approach was adopted, both inductive and deductive approaches to TA were implemented.

During analysis, transcripts were examined at the latent level, looking beyond the surface level meaning to focus on the assumptions and ideas that inform the semantic content of the data (Braun and Clarke, 2006). As such, it is assumed that the content of data is influenced by wider social contexts.

2.4 Procedure

2.4.1 Ethical considerations

There were a number of ethical considerations when planning and conducting the research. There was a possibility that children who knew their parents were participating in interviews may have been worried about the content of any discussions. To prevent potential distress to children of participants, a discussion took place with each participant. It was highlighted that the focus of the interview was

not on the child or the child's particular difficulties, but rather on the experiences as parents accessing CAMHS. All participants were given the opportunity to think about ways to explain the interviews to their children.

Whilst it was not expected that interviews would cause any distress to participants or their children, information about sources of support was made available (Appendix C). It was also made clear to participants that they were able to pause, terminate or withdraw from the interview if it were to cause any distress or discomfort.

2.4.2 Confidentiality and anonymity

As in any research of this nature, confidentiality is of critical importance. Issues relating to mental health can be a sensitive area, and this may be more so within the Orthodox community. It was therefore important to be aware of the value of privacy and confidentiality, which influenced the locations that were suggested for interviews. It was important to offer a range of locations for interviews to be conducted, as each potential location had both benefits and flaws. For example, offering to meet at a participant's home may have been more convenient for participants, but there may also be a concern that neighbours would notice an unfamiliar person entering the family home, which could raise unwelcome questions. In contrast, attending an interview at a GP surgery may be less convenient, but offer more privacy.

The CAMHS team held participant details. The researcher did not access any clinical files. When clinicians had gained initial consent to be contacted, names and telephone numbers were passed to the researcher using secure NHS mail. All participants received an explanation of confidentiality and what this would cover. Participant names were anonymised by use of a pseudonym. Any identifying details were also anonymised. Transcripts and consent forms were kept in a locked environment. Full transcripts were only viewed by the researcher, though short extracts were shared with supervisors. Participants were made aware of this prior to giving consent.

2.4.3 Ethical approval

Ethical approval was sought from the University of East London. In addition, approval was sought from the NHS Research and Ethics Committee (REC). The REC requested minor amendments to the participant information sheet (Appendix A) and consent form (Appendix B). They also requested clarification on how participants' children would be protected from experiencing any distress should they be worried about their parents' participation in the study. The response to the REC is available in Appendix F. Ethical approval was granted in August 2015.

2.4.4 Protection from harm

Participating in psychological research should not cause harm (Willig, 2013). In this context, harm can be understood as on-going emotional distress. Whilst it was not anticipated that participating in the study would cause participants any lasting distress, there was a possibility that some participants could find taking part in an interview upsetting. As a result, particular attention was given to body language and non-verbal cues of distress within interviews. At the start of the interview participants were reminded they were able to pause or terminate the interview at any point. All participants were provided with details of local support agencies. Participants were alerted to my obligation to maintain safeguarding standards within the Patient Information Sheet. This information was verbally reiterated at the start of each interview. Participants signed a consent form to confirm their recognition of this.

It was also important to consider the researcher's well-being and safety during the interview process. The field supervisor was informed of all dates and times of interviews, as well as where they would take place. Local NHS trust Lone Working procedures were followed.

2.4.5 Informed consent

Prior to the interview, participants had the opportunity to speak on the phone with the researcher, and were sent a copy of the information sheet. The information sheet was presented again at the start of the interview, in addition to the consent form requiring a signature. The consent form highlighted key issues such as confidentiality

and safeguarding, and these messages were read orally to participants to ensure that any literacy concerns did not prevent informed consent.

2.4.6 Supervision

Academic supervision was provided by the Director of Studies at UEL. In addition, supervision was provided by the field supervisor in the CAMHS in which recruitment took place.

2.4.7 Recruitment of participants

Permission was given by Homerton University Hospital NHS Foundation Trust to recruit from the Tier 2 CAMHS service. The thesis was set up in conjunction with this service, with the knowledge that many Orthodox Jewish families accessed the service. In addition, clinicians reported having strong links with the Orthodox Jewish communities through their relationships with Orthodox Jewish charities and children's centres. After being given information about the study, clinicians were asked to consider whether there were Orthodox families that may be amenable to participating in the research. Clinicians who felt they had potential participants then discussed this with a senior clinician within the team and if appropriate, discussed it with the potential participant. If a potential participant agreed to be contacted by the researcher, they were called and given an explanation of what the research involved. If they were interested an interview date was scheduled.

2.4.8 Inclusion and exclusion criteria

There were a number of criteria for participation. Participants were required to be over the age of 18, having accessed the service via a referral for their child. Participants were required to be fluent in English, though English did not need to be their first language. Participants were also required to be Orthodox Jewish. Whilst religion is gathered as part of the core data set in CAMHS, this does not specify whether the family is Orthodox. As such, clinicians were asked to identify participants based on their individual knowledge of the families they had worked with.

2.4.9 Participants

It is not known how many participants declined for their details to be passed to the researcher, as clinicians did not record this data. Contact details for twenty-four potential participants were provided. These participants were contacted by phone by the researcher. It was not possible to reach seven of these individuals by phone, despite repeated attempts. Of the remaining seventeen potential participants, six people declined to participate. Most of those who declined did not offer a reason and were not pressed to provide one[6]. Two participants initially agreed to take part, but cancelled on the day of the interview. One of these individuals explained that this was because they felt there would be no direct benefit in participating. In total, nine individuals took part in interviews (see Table 1) and this was believed to be an appropriate sample size to be able to conduct a meaningful qualitative analysis (Clarke & Braun, 2013; Guest, Bunce & Johnson, 2006). Of the nine participants, two were men. Two participants identified as Modern Orthodox, one as Breslover Orthodox, one as Hassidic and four as Charedi Orthodox. Of the four participants who identified as Charedi, two specified that they are aligned to the Lubavitch sect, and two participants specified an alignment to the Belz sect. One participant found it difficult to identify with any one particular area of Orthodoxy, suggesting they were between Modern and Charedi.

Table 1: Summary of demographic information

Name of participant	Age	Marital status	Number of children	Age range of children (years)
Rebecca	24	Separated	1	3
Sarah	34	Divorced	4	4-12
Elizabeth	27	Married	4	3-9
Rachel	27	Married	5	1-9
Karin	37	Married	4	12-17
Miriam	29	Married	5	1-11
Gideon	40	Married	4	12-17
Solomon	65	Married	4	2-22
Hannah	30	Married	4	3-8

[6] Reasons that were given primarily related to a lack of time to commit to an interview.

2.5 Data collection

2.5.1 Resources

Interviews were recorded using a digital audio recorder. Interview rooms were made available at a local GP practice for two interviews. Seven interviews were conducted within the family home.

2.5.2 Interview process

Initially the use of focus groups was considered but it was felt that given the potentially sensitive nature of discussions and the close nature of the Orthodox community, group discussions may not feel safe for participants. It was felt that using semi-structured interviews would allow there to be a focus in questioning, whilst still allowing participants flexibility and freedom to discuss their experiences. Two pilot interviews were completed. One interview was completed with a colleague as a preparatory exercise. A further pilot interview was completed with a consenting participant. The pilot interview highlighted the value of creating rapport and putting the participant at ease. Following from this, eight further interviews were completed. Wherever possible, interviews were completed on different days to ensure that focus was maintained and that content of interviews did not become mixed (Rubin & Rubin, 1995).

2.5.3 Interview schedules & design

Once a draft interview schedule had been designed, members of the community provided consultation on the phrasing and content of the schedule[7]. This was partly to ensure that questions were culturally appropriate, but also in order to ensure that the areas of questioning seemed likely to be relevant in the eyes of community members. The field supervisor was able to provide contact details for two members of the Stamford Hill community who agreed to provide feedback on the schedule and other documents. These individuals were parents and/or grandparents who were familiar with First Steps. In addition, informal consultation took place with an Orthodox acquaintance. Draft documents were sent by email if possible, or

[7] Consultation regarding the PIS and consent form also took place.

discussed over the phone. The consultation process did not result in any major changes to the schedule, PIS, or information sheet. Phrasing was found to be appropriate and was not viewed as likely to cause any offence. However, as a result of this process, additional questions were added to the start of the interview schedule. These questions focused on the experience and nature of the Stamford Hill Orthodox Jewish community. It was felt that these additional questions would provide valuable contextual information, as well as ensuring that any personal assumptions about the community could be avoided.

Considering the research questions, the interview schedule can be seen as focusing on two broad areas. Firstly, questions regarding the experience of accessing CAMHS and any associated concerns. Secondly, questions about the perceived impact of religion on these experiences. Given the epistemological approach taken to research, it was important that the approach to questioning was not constructed on prior reading. As such, open, non-assumptive questions were incorporated within the interview schedule (Appendix D). It was important to allow for flexibility to pursue further exploration of potentially important topics raised by participants. The interview schedule was therefore used as a guide to facilitate a conversation, rather than as something that needed to be adhered to at all costs.

2.5.3 Transcription

Orthographic transcription methods were used, as this is the suggested approach to be used alongside TA (Gibson & Hugh-Jones, 2012). This is in contrast to other forms of transcription such as Jeffersonian transcription, which focuses on para-linguistic features of speech (Gibson & Hugh-Jones, 2012). Each interview was transcribed as soon as possible after the interview had been completed. As part of the process of transcription, audio-recordings were played repeatedly to ensure that a verbatim account had been provided. In most cases, transcription occurred within the days following the interview, allowing for time to be spent on reflection on the interview, and adjustment of questions if needed (Rubin & Rubin, 1995).

2.6 Data analysis

Data analysis was guided by Braun and Clarke's (2006) six-phase approach. However, this was not a linear process; rather stages of analysis were continually revisited. Chamberlain (2000) emphasises that good qualitative analysis does not arise from simply following steps, but rather is a result from meaningful engagement with data. The format of data analysis is outlined below.

The first phase of data analysis involved becoming familiar with the data. This involved listening to audio-recordings, transcribing, and re-reading transcripts numerous times. Throughout the reading of data, thoughts and ideas were noted (Appendix K). Once familiarised with the data, aspects that appeared relevant to the broad research questions were labelled. These codes captured both semantic and latent level readings of the data (Appendix, L; Appendix M).

Following from the creation of initial codes, codes were revised and the third phase of identifying themes began (Appendix N). A theme should represent a pattern of meaning within the data set. This was an active process involving reviewing codes to identify similar ideas and/or overlap. Once themes had been identified, they were reviewed via a number of stages. Firstly, coded data was examined to ensure that themes appeared to fit with the codes, as well as with data that seemed important and relevant to the research questions. Some themes were therefore modified as a result of disparity between codes and themes. Following from the examination of codes and themes, the entire data set was reviewed to ensure that identified themes fully captured the meaning within the data, and that this was meaningful in relation to the research questions. At this stage themes were revised, with some themes being dropped completely. Mind maps were used to facilitate the process of revising themes (see Appendix O, P, Q and R).

The fifth phase involved naming and defining themes, ensuring that each theme and subtheme was clearly identifiable. Extracts of data were identified to illustrate these definitions. Narratives around themes were developed, and an analytic approach was taken to highlight the ways in which extracts of data and themes were related. Even at this stage of analysis, themes continued to be adjusted to ensure they

accurately showed a meaningful relationship between data and themes, in relation to the research questions. The final stage of writing can be seen as a creative and analytic process of engaging with the data, rather than a static approach where findings are thoughtlessly recorded (Braun & Clarke, 2013).

2.7 Reflexivity

Maintaining a reflective approach was an important part of research. To support this, a reflective diary was used throughout the thesis process, primarily through the interview and analysis stages.

2.7.1 The researchers' position

Willig (2013) highlights the importance of reflexivity and transparency when a researcher has a pre-existing relationship with the area in which they complete research. There are therefore a number of contexts that influence my interest in this area. Firstly, I have a background working in CAMHS[8] and have an interest in my clients "relationship to help" (Reder & Fredman, 1996). As a result, I have spent time considering the factors that contribute to engagement with mental health services, and the additional complexity that arises when a parent seeks help for their child. Perhaps more significantly, I was raised in an area of North London close to many Orthodox communities and consider myself to be 'culturally' Jewish. In addition to this, I have lived experience of mental health difficulties that began in my early teens. As such, my parents experienced parenting a young person with mental health difficulties on the periphery of the North London Jewish community, and this is something that we have discussed over the years.

2.7.2 Relationship to Judaism

I have thought about my own position as a 'cultural' Jew (Rocker, 2015). Whilst I was raised in a secular household, my mother was brought up within the Jewish faith. Judaism is understood as being passed on through the mother and I was therefore recognised by others as a part of the Jewish community. There were long periods of my life where I felt frustrated about the assumptive stance of members of the

[8] I also previously worked within the tier 2 Hackney CAMHS service in which participants were recruited.

community, and felt irritated about being labelled as Jewish when I did not always identify with this label.

There were many Jewish traditions that were upheld within my family, such as Shabbat[9] dinners and celebrating Jewish holidays. In my teens, I attended Jewish youth groups and took a GCSE in Jewish studies, typical of many of my Jewish peers. Despite growing up on the periphery of the Jewish community, I was aware of an inner conflict between 'belonging' and 'not-belonging'. Whilst many aspects of Jewish life are familiar to me, other aspects feel alien. Religion has also been a source of contention within my family; as such I have felt both rejected from and rejecting of Judaism.

Given the complex feelings I have towards Judaism, it would be impossible for these experiences not to colour my assumptions in some way. It was therefore important for me to consider and openly reflect on how my experiences and positioning would impact on the research process. As I have grown older, I have spent less time around the Jewish community and upon reflection, wonder whether I have been guilty of 'othering', as the differences between my life and that of my Orthodox peers become more apparent. Some of these reflections are painful on a personal level, making it all the more important to consider and openly reflect on how these experiences may impact on the questions I asked and the assumptions I have made.

[9] The Friday night meal held to mark the start of the Jewish Sabbath.

CHAPTER 3: ANALYSIS

This chapter outlines the themes constructed from the data gathered within nine participant interviews. Using TA, codes were gathered into four key themes, each with sub-themes (see Table 2.) The analysis below is presented as according to these key themes, titled: 'The Orthodox Jewish community as unique', 'Pathways to help', 'Attitudes towards mental health' and 'The Parental Journey'.

3.1 Summary of key themes.

The first theme considers the way in which the Orthodox community is experienced by participants. The second focuses on factors related to help-seeking. The third theme focuses on the attitudes towards mental health within the community, considering the impact of stigma on help-seeking. The fourth theme focuses on the emotional/internal processes related to the problem and intervention.

Table 2. Themes and subthemes

Key themes	Sub-themes
The Orthodox Jewish community as unique	• An insular, traditional community • Not a homogenous group
Pathways to help	• Finding out where to go • Cultural differences as a barrier • Perceived benefits of working with a non-Orthodox therapist
Attitudes towards mental health	• Presence of stigma in the community • The impact of labelling and finding a match • Being open-minded and prioritising the child • Attitudes are changing
The parental journey	• The emotional impact of the problem • The emotional impact of seeking help • A shift in understanding

To improve the readability of interview quotes, minor changes have been made. If words have been excluded to shorten the length of a quote, a dotted line within brackets is presented (…). If additional information is provided to provide clarity to the reader, it is presented within square brackets, like so [text]. Utterances of 'um', 'uh' and 'er' have been removed for ease of reading. Pauses are represented by a dotted line with no brackets. As outlined above, identifying information is changed or removed to protect the anonymity of participants. In longer extracts of data the interviewers speech is represented by **I:** and a participant's speech is represented by their pseudonyms initial e.g. Rebecca's speech would be represented by **R:**.

3.1.1 Development of themes

As outlined above, a process of refining themes was undertaken. Initial themes (Appendix K) were examined, and either combined or divided to create novel, specific themes. As themes were divided into themes and subthemes, this process of revision continued. For example, the major theme 'The parental journey' initially included the following subthemes; 'Being open-minded' and 'Personal experiences impact' (Appendix O). Upon further examination and revision, these subthemes were dropped (Appendix P) as they were felt to reflect a detail of the data, rather than being significant enough to represent a sub-theme. Similarly, within the major theme 'The Orthodox Jewish community as unique', three subthemes were initially developed (Appendix O). However, upon revision it was felt that the initial subtheme 'Orthodox Judaism as a traditional culture' was not fully distinct from the subtheme 'An insular, religious life'. As a result, it was felt to be appropriate to combine these two sub-themes to create the sub-theme 'An insular, traditional culture' (Appendix R). The process of developing and revising themes also involved the re-naming of major themes. For example, the theme 'Finding help' (Appendix O) was renamed 'Pathways to Help' to reflect that help-seeking is an on-going process. Sub-themes were revised to encapsulate the relevant data; at times this meant sub-themes initially connected to another theme, were considered in a new light. For example, the subtheme 'Benefits of working with a non-Orthodox therapist' was initially positioned under the main theme 'The Parental Journey'. Upon revision, it was felt

that working with a non-Orthodox therapist was more related to the theme 'Pathways to help' and as such, the sub-themes were modified (Appendix R).

3.2 The Orthodox Jewish Community as unique

The first theme considers the nature of the community, and the way in which being a part of the community is experienced by participants. In addition, it provides a context in which one can situate further themes. This theme is considered as according to two sub themes; 'An insular, traditional community' and 'Not a homogenous group'. The sub-themes are distinct and separate in that they address different aspects of belonging to the community, whilst being connected via the broader theme regarding the distinctiveness of the community.

3.2.1 An insular, traditional community

The Orthodox Jewish community was described as insular by all participants.

> *'It's a closeted, self contained community'* (Gideon, 178-179)

> *'It's a religious life and in certain ways we're closed in'* (Rebecca, 5-6)

This was recognised in regards to the relationships that are engaged in, as well as in relation to the physical proximity of local resources.

> *'It's quite a close knit community (…) I find it very important to belong like, belonging to a community where people know you, people care, you know if you need any help there's always someone there to guide you with anything you need.'* (Miriam, 11-25)

There seemed to be an implicit idea that staying within the community provides a level of safety and routine. Being within a small community where you are known can be beneficial and supportive, on both practical and emotional levels. There is both a comfort in belonging, or being a part of a community made up of like-minded

individuals who understand one another, and are able to provide support should it be needed for any reason.

One participant reflects that in many ways the insularity of the community is no different from that of other small communities.

> *'It's quite insular the whole community. In general it's like any other community I should imagine more like of a smaller village type (…) so it tends to be that people growing up in a small village they tend to know everybody in the village and if they don't know them personally they know about them.'* (Solomon, 10-18)

Solomon's use of the term 'village' brings up different ideas in relation to safety, quality of life and insularity. He highlights that not only is the community insular in regards to physical logistics and religious need, but that there is a particular closeness within the community that results in the majority of members of the community knowing one another, or failing this, knowing about other individuals and events occurring within their lives. Similarly, Karin highlights that the insularity of the community results in the type of gossiping that Solomon alludes to.

> '*Whereas in this community, and we live so close to each other, people know, it's the same building, same, people see other things, and it gets repeated and you sort of see it and you sort of know it'* (Karin, 520-522)

In some ways the insularity of the community can be experienced as oppressive because of its close-knit nature. Some participants felt that their private lives were open to scrutiny and judgement as a result of this. Several participants noted that it could be difficult to keep things private and that this had its own difficulties. For some, the insularity and judgement of the community can be isolating.

> *'Yeah, it is closed community. They look at you different. Lets say if your skirt is not long enough, like they believe it should be, so. You not including, you not together with them, and they look at you different'* (Sarah, 64-66)

Expressing different views, or being seen as going against the grain can result in rejection, isolation and detachment from the community. Three participants go on to describe situations that have not only left them without support, but have also resulted in them experiencing hostility from members of the community. This is in stark contrast to the experiences of support and belonging expressed by the remaining participants.

Participants described the Orthodox community as having its own unique religious and cultural traditions. These traditions can vary and encompass a wide range of daily activities within the Orthodox Jewish world.

> *'It's the way of… of bringing up children, it's the way a woman will dress in the street, it's the way, it's, it's all different, it's all different these kind of way.*'
> (Sarah, 32-34)

Traditions not only apply in relation to Halachic law, but also in day to day aspects of life such as attire and ideas about raising ones children. Cultural and/or religious traditions apply to all aspects of life to some extent. To some, ensuring observance of both Jewish holidays as well as day-to-day practicalities can feel overwhelming at times.

> **'***Being Jewish is, it's a lot, it's a big toll, there's all these holidays and the mother has to prepare all these… um meals and it's, it's quite (…) an on-take. You know, and one of the holidays you have to clean your whole house and prepare it for Passover. And the kitchen you have to do the changeover and it's quite stressful and… all these holidays take a big part of your life.'*
> (Elizabeth, 173-179).

There is an acknowledgement that following Jewish traditions requires a great deal of effort. This is particularly so for women whose traditional gender role includes responsibility for child-rearing, the organisation of the household, and ensuring that families are suitably prepared and organised for the Jewish holidays. Not only is

there a tremendous amount to be done, but also this is complicated by large family sizes and the frequency of Jewish holidays throughout the years. However, though following traditions may be burdensome at times, they are important in bringing the family together and celebrating tradition.

Tradition does not only apply to the following of Jewish holidays, but also in terms of the wider cultural norms. Participants described the cultural expectation of couples to marry and start a family at a young age.

> '*There's a lot, a lot of people that find it very hard when they finish when they get to the age of twenty or twenty four, they have two or three kids because they're married at eighteen, twenty around that age.'* (Karin, 33-36)

To some extent, maintaining tradition can be an arduous task. Young couples may struggle with the reality of a culture that values having large families at a relatively young age, whilst maintaining a Jewish home to the expected level of observance.

3.2.2 Not a homogenous group

It was clear from participants that there was a significant amount of variation within the Orthodox Jewish community, and that in many ways the term 'Orthodox Jewish' obscures the specific traditions and teachings within sects.

> '*I'm like, the Chasidic whatever, and so yeah we're Lubavitch'* (Elizabeth, 14-15)

> '*We belong to Belz, you might have heard about it.'* (Rachel, 18)

Participants highlighted that there were a variety of groups within the Orthodox community, and sects within these groups operating as according to the teachings given by different Rabbis.

> *'But within Charedi as well there's different sects, different Rabbis'* (Karin, 80-81)

'*There's all different Jewish, we all believe in in, the bible and what it says but some people take it to extreme way um. It's also depend where you come from yeah.*' (Sarah, 4-6)

'We come from different countries… certain traditions develop differently' (Hannah, 38-39)

Although there are common beliefs within Judaism as a whole, the level of observance or interpretation of the Bible (and Torah) will depend on a number of factors, one of which may be the individuals' particular cultural heritage[10], in addition to the physical location in which they grew up. In part, this can be seen as expected within the wider cultural context, however, participants described feeling that the specific cultures of different groups would not be known by non-Orthodox individuals. It therefore seems likely that individuals from outside of the Orthodox community may expect far more similarities within the community than there actually are. In addition, there may be a certain level of discord between particular groups or sects.

'I guess there are people that are so extreme such fanatic followers and I'm not in that sect at all I can't I can't relate to that at all (…) we're not like you know cutting off people, there are some here you know you get some terrible criteria that you have to fit into if you join a particular group you know' (Solomon, 77-85)

Some particular sects may be seen as 'extreme' or fanatical, whereas others may be understood as more relaxed in regards to attire, and lifestyle choices. There may be a level of implicit judgement towards the traditions and lifestyles held within other sects. Despite their common features, it may be hard for members of different sects to relate to one another.

[10] The majority of the UK Jewish population is made up of Ashkenazic Jews with European heritage, and Sephardi Jews with Spanish/Middle-Eastern heritage.

3.3 Pathways to help

This theme describes the way in which participants found help, including examining particular barriers to help and the impact of working across cultural differences. There are three subthemes; 'Finding out where to go', 'Cultural differences as a barrier' and 'Perceived benefits of working with a non-Orthodox therapist'. These subthemes are clearly differentiated, though are connected through the exploration of the factors that affect families in their help seeking processes.

3.3.1 Finding out where to go

Participants expressed different stories about how they had found help[11]. Many participants described feeling at a loss as to where to look for help and that this was anxiety provoking.

> *'The truth is I didn't know where to look'* (Rebecca, 32)

Participants were asked about whether they felt able to speak to friends, family or their Rabbi for advice. Of those who had Rabbis[12], none of the participants had spoken to their Rabbi or the Rebbetsen and felt this was not the type of problem that they would contact them about. Most participants had spoken to their immediate family and/or close friends about having some concerns, but reported that their friends and family were unable to suggest where they could go for help. Four participants were unaware that their GP was able to help with the types of difficulties experienced by their children.

> *'I didn't know that you can go to a GP for emotional health as well I didn't know that, I didn't know on the NHS you can just go through the GP and access the services*.' (Hannah, 82-84)

One participant described that although she was aware that her GP would be able to help with a referral for her child's behavioural difficulties, her wider family and friends

[11] A summary of experiences that influenced participants' pathways to help is provided in Appendix J.
[12] 6 participants had a relationship with a Rabbi.

are largely unaware that their GP is able to help with referrals, even in relation to physical health needs.

> *'I don't know if people would think of going (…) I know somebody, a friend, their child is having a problem with this that and the other. I said, did you get referred? She said, my GP can do that? It wasn't even for mental health, it was actually for something else'*. (Karin, 863-866)

This lack of knowledge meant that for some participants, their help-seeking process was impeded to a certain extent in the early stages. For those participants who were unsure about where to seek help, many turned to their child's school or to local Jewish charities for advice

> *'Someone suggested I call up [a local charity] I don't know if you've heard of them, it's an organisation in the Jewish community. And they suggested that I should go to my GP and ask for help.'* (Rebecca, 32-35)

> *'I was thinking I'd find out from the school and I thought I would go that way.'* (Miriam, 180-181)

Several individuals felt that their experiences of working with different professionals, or personal experiences of help-seeking had made finding support for their child less of a stressful and daunting process. One participant described that this process had also subdued any initial concerns about seeking help outside of the community.

> '*Sadly I'm used to it I was in an abusive marriage so at the beginning I also didn't know where to look for help until I learnt. So, at that point I was like, okay, it's starting again 'where do I go for help' but I found it quite quickly it wasn't too difficult (…) Like I've seen many different people I've been for help for myself so it wasn't so strange for me to go to kind of an outsider.'* (Rebecca, 37-40/57)

Previous experience of working with individuals outside of the community in some capacity makes it easier to seek help from organisations outside of the community. For participants who were more familiar with the NHS, there was no doubt that their GP would be able to support them in accessing a referral regarding their child's difficulties. For those who had looked within the community for support, it was felt that there was a dearth of support that was specifically focused on the emotional well-being of children and young people.

> *'There is nothing, nothing. There is nothing. (…) there isn't anything [in the community].* (Sarah, 352)

3.3.2 Cultural differences as a barrier

Participants described specific cultural barriers that may apply to Orthodox Jewish parents seeking help for their children. Firstly, as outlined above, there is a recognition that the community tends to be insular, and participants reflected that many parents are likely to prefer to seek help from within the community.

> *'People like to stick to themselves to their own community to their own help.'* (Rebecca, 64-65)

Participants described that many people may perceive a risk in seeking help outside of the community. There may be a number of reasons for this. Firstly, as outlined by Hannah, there was an idea that professionals outside of the community may not understand the complexity of Jewish life, and the profound impact that following traditions has.

> *'They might feel that they're not understood or you know they might think people from outside wouldn't be attuned to our culture and our sensitivities'.* (Hannah, 168-170)

This in turn may lead parents to feel that they have not been understood and that important information becomes lost through miscommunication. Participants highlighted that it is not simply being misunderstood that is a concern, but rather that

there is a worry that a non-Jewish professional may inadvertently offer advice or solutions that directly convene Jewish teachings.

> *'[We would worry about people from outside the community] giving ideas that might not be in line with our way or of education.'* (Miriam, 183)

Most participants expressed ideas that being given ideas that do not fit with Jewish teachings would be difficult but that they would primarily be concerned about the impact of this on their children.

> *'If you come in, with a trousers, to a Jewish frum[13] Charedi house, it's not acceptable for a woman to wear trousers, so it's, you're going to give bad influence to my kids, wearing that in my house (…) you can't come not in long sleeved t-shirt into they house because they bringing they kids with this and this belief and it's not right.* (Sarah, 607-615)

There was a sense that parents are keen to protect their children from harm that may be associated with exposure to the outside world. Some participants also expressed worry about leaving their child alone with a non-Jewish therapist. For some, this may relate to worries about their child's physical safety being with a stranger, but others expressed worries that a non-Jewish therapist may expose their child to other cultural or religious ideas, which in itself could be damaging.

> '*If it's not Jewish I don't know what she's saying to them, she might be saying to them other religion'*. (Elizabeth, 390-391).

In addition to these worries, participants described a worry about being judged or criticised on the basis of their religious beliefs and practices.

> *'Yeah, you coming to look in the pockets of what's going on, what they doing, and not everybody likes it'* (Sarah, 585-586)

[13] 'Frum' is a Yiddish word meaning 'pious', used to describe those who are highly observant.

There was an idea that a professional from outside the community could be intrusive, looking for faults or wrongdoing on behalf of the parent. As many families are unfamiliar with NHS and statutory service processes, it is possible that there could be particular concerns about the power of the state and potential repercussions.

> *'You know we don't want anyone interfering because we feel that we're doing right and we go and suddenly there should be a problem… you hear all different stories of social services taking away kids and stuff and you feel you're doing the right thing and you can't know what others think.'* (Rachel, 189-199)

Rachel describes narratives about children being taken away as a result of interference from statutory agencies. She recognises that although parents feel they are doing the best they can for their child, others may not agree with their choices. Rachel can be seen as implicitly referring to cultural parenting practices within the community and how professionals from 'outside' may interpret them.

One participant highlighted that the incidents of corporal punishment within the community (committed by parents and teachers) would be a significant barrier to help for many individuals, as they would be aware that this is not acceptable within the secular community.

> *'You know they stand from diametrically opposing kind of viewpoints, vantage points into the world and onto the child's place in the world'*. (Gideon, 297-298)

Gideon suggests that this is symptomatic of the extreme cultural differences between the Orthodox Charedi and secular world, and the way in which the role of the child is conceptualised.

3.3.3 Perceived benefits of working with a non-Orthodox therapist

Although participants identified a number of issues that could arise when considering seeking support from a non-Orthodox professional, they also highlighted that these

were not necessarily issues that they personally felt affected by. Most participants felt the religion and/or culture of their therapist would make no difference.

> *'No, I mean in the community, out the community. I know all these professional people are with, what's the word? They're confidential.'* (Miriam, 278-279)

> *'It doesn't matter, a professional, who's a professional, from inside the community or from outside the community, I don't look it at that way. I look at that professional people, professional person who it is. It doesn't matter for me.*' (Sarah, 375-378)

The idea that therapists have professional training was seen as important to all participants. The label of 'professional' seems to come with an understanding of extensive training and knowledge, and an automatic assumption that a confidential service will be on offer. Some participants felt that working with a non-Orthodox therapist could be preferable in some ways.

> *'[Seeing a non-Orthodox therapist] might have been beneficial because I could trust that person more than I would trust an Orthodox therapist you know (…) I think people would have a certain shyness to a health professional who was from within the community (…) if everyone knows everyone and you bring a therapist from within the community there's a potential for, for some awkwardness there and potential for a breach, breaches of confidentiality*.' (Gideon, 389-398)

Gideon highlights that the insularity of the community would raise confidentiality concerns should he turn to an Orthodox therapist and that this meant that speaking to a non-Orthodox therapist would feel safer. This idea was expressed by a number of participants. Some participants expressed the idea that it would be easier as a parent to open up to a non-Orthodox therapist. In addition, some participants also felt it would be easier for their child to work with someone from outside of the community.

'He was happier to have someone not in the community than out, cos he couldn't say his, anger (…) He wouldn't be able to say to somebody who's Orthodox.' (Karin, 738-741)

Karin felt that it would be harder for her son to express culturally unacceptable feelings and/or thoughts to an Orthodox therapist. There may be more of a felt sense of judgement from an Orthodox therapist, which could prevent someone being fully open and thus would impact on the potential benefit of the therapy.

*'**K:** Yeah we didn't want anyone Orthodox, didn't want anyone Jewish. We wanted a different view, a blank view if you know what I mean. Not a pre-set, not, not pre-existent, pre-set with ideas.*
***I:** So you felt if you'd seen somebody Orthodox they would have alre- kind of had a sense...*
***K:** Yeah they see him and this is what should be, and tick all the boxes and you don't tick the boxes, you're different thing, I wanted somebody who didn't know him, who was, that's what I was looking for*.' (Karin, 749-758)

Karin highlights a feeling that an Orthodox therapist would not see beyond her child's difficulties and how these may set him apart from other young people within the community. Other participants also felt that seeing a non-Orthodox therapist would be beneficial as they would provide an alternative point of view.

'Sometimes if you belong to one community you just think like the community and you don't you know, think a bit out of the box I would say (…) so it was quite good because she sees children from all different schools, so not just Jewish children, so that's what I liked it, because you know she had a bigger wider base to compare'. (Rachel, 149-158)

Rachel describes that her therapist had a breadth of knowledge regarding the way in which other children behave and are parented. Consequently, the therapist was able to see the problem through a different lens.

Although having a non-Orthodox therapist could be facilitative of the help-seeking process in some ways, all participants expressed the inherent value of working with professionals who were attuned to the Orthodox culture and as such were mindful of cultural differences.

> *'[The therapist] really sort of had a good feel for what our lifestyles are all about and she didn't… and she didn't like impose on us anything that was you know, not in line with our ways.'* (Hannah, 175-177)

> *'I found that they do respect your belief they're not going to tell me to do something (…) they do respect other people's belief and I believe everybody should do so'*. (Sarah, 406-409)

Participants expressed an underlying idea that if the therapist had imposed ideas that were at-odds with Jewish teachings, or undermined them in some way, it may have had implications for the therapeutic relationship and the likelihood of the intervention being continued. As the therapists were culturally sensitive and respectful, this ensured that the participants felt comfortable to continue with the intervention.

3.4 Attitudes towards mental health

This theme describes views about mental health within the Orthodox Jewish community, with a focus on mental health difficulties experienced by children and young people. Three sub-themes were identified, and their titles reflect the content within them; 'Presence of stigma in the community', 'The impact of labelling and finding a match', and 'Being open-minded and prioritising the child'.

3.4.1 Presence of stigma in the community.

All participants acknowledged that there is some level of stigma towards mental health and seeking support for associated difficulties, regardless of whether they have had personal experience of this.

> *'It's got stigma around it and people gonna know (…) you wouldn't go round saying when I spoke to a therapist and they told me this* (Karin, 535-537)

If people are comfortable with seeking help, it is unlikely that this would be openly spoken about because of the level of stigma within the community. Some participants acknowledged that being part of a social circle where stigma was not present provided a level of support.

> '*There could be a stigma here but, I felt, amongst my friends, it didn't really bother me. I mean, my friends were really supportive, so it didn't really matter.'* (Rebecca, 138-138)

Rebecca highlights that having some form of social/emotional support from peers goes some way to alleviate any effects that could occur from stigma within the community. However, not all participants experienced this level of support. Hannah describes choosing not to tell the majority of her friends or family that she is seeking psychological support for her child.

> *'[I told people] based on the people who I thought would be accepting of it and not critical and not blaming you know, I, you know I didn't want to expose myself to any negativity so I told, yeah I didn't tell many people… to protect my child from being treated or viewed as a problem (…) it's uncomfortable. It's so much easier to be open just you know, normal. It's hard to have a worry about hiding things from people that you're close with'*. (Hannah, 427-435)

Hannah's concerns about being criticised may relate to judgements about her parenting and/or about her decision to seek support. The impact of either of these would be understandably stressful. In addition, Hannah describes trying to protect her child from experiencing stigma; she goes on to talk about choosing not to tell her parents about seeking help. In a culture where family is so important and a great deal of time is likely to be spent with the child's grandparents this throws up a number of complexities. Hannah acknowledges that it's difficult not to be open; in part this may be because she loses a certain amount of support for herself as she

struggles to parent a child who has difficulties. However, there are also a number of practical difficulties that would need to be overcome, and Hannah goes on to highlight that attending appointments often means lying about her whereabouts. In such a close-knit community, this may be particularly difficult and may add a further layer of stress to her situation. One participant experienced an extremely negative reaction from her ex-partner when she disclosed that she and their child had attended therapy.

> *'**S:** He doesn't believe in children's psychologists. He tells me (…) okay you go to psychologist, you are mental, you need a mental help.*
> ***I:** That's what he said to you?*
> ***S:** Yeah, that's what he said to me. You need a mental help, not the child, everything's fine with the child. You go to mental help."* (Sarah, 424-429)

Sarah describes her ex-partner as representative of people within the community who don't believe in accessing psychological support for children. She describes being blamed and criticised for seeking support for her child, and having her decision undermined. Levels of stigma in the community, as described by participants, are likely to make openly seeking help very difficult for the majority of parents.

> '*But yes, there is there is a stigma here and it worries me to a degree it does yeah, you know we don't want to you know block things for your own children you know, you want to leave things open for them whatever's possible.*'
> (Solomon, 346-349)

Seeking help for your child could have repercussions for the child and their options in life and was described as a concern for several participants. In addition, participants spoke about particular concerns about being seen within a service specifically labelled as treating 'mental health' problems.

> *'It's in the name I suppose. Mental health is... is, it sounds like he's, there's something seriously wrong with him and I feel like no, there's not something seriously wrong with him he just needs a little help'*. (Elizabeth, 531-534)

Elizabeth describes a sense of apprehension about what it would mean to access support from a mental health service. The term mental health was seen by some to indicate something severe and as such was viewed as frightening. Three participants described feeling they would be more reluctant to get support from a service that had the term 'mental health' in its name, which may be indicative of wider cultural understandings about mental health within the Orthodox community. Elizabeth also described her personal experience of having a family member with mental health problems.

> *'[The situation] is really depressing for me, for my family. We can't talk about it, it's really sad. And we felt like, he didn't, he himself, didn't at one point say, no, and stood up and stopped himself.'* (Elizabeth, 592-594)

Elizabeth puts forward an idea that her family member had some level of control over his mental health problems and suggests she feels that he should have been able to stop himself from becoming so unwell. There is a level of blame directed towards the individual, as well as an idea that he had a level of personal responsibility in taking control of his situation. This may relate to wider cultural narratives and stigma about mental health. Not being able to talk about it within the wider family seems to not only link to feelings of sadness, but also frustration and disappointment.

3.4.2 The impact of labelling

Participants highlighted that stigma in the community is heavily contributed to by worries about labelling their child and the impact that this could have on future marriage prospects; not only for the child but also their siblings. Being identified as having a mental health problem and/or seeking help for this is likely to have significant repercussions. All participants expressed worry about their children as being labelled as having a mental health difficulty.

> *'I wouldn't want him to be labelled, oh he's got some mental issue and… don't go anywhere near him because he's got, there's something wrong with him, when there's not anything wrong with him'* (Elizabeth, 473-475)

There is an implicit idea that being labelled as having a mental health problem will mark you as different and as someone to be avoided. Elizabeth's description brings to mind ideas about mental health problems being contagious and that those who do have identified difficulties are at risk of becoming social pariahs. Participants expressed that being labelled has a long-lasting effect and that it is almost impossible to get rid of a label once it has been given to you. One participant described her own experience of being labelled (for reasons other than mental health) and the overwhelmingly isolating impact that this had.

> '*You have a label, a sticker on you. Like you're not good… they don't even think about the circumstance about what happened (…) they're looking at you, looking at you a hundred percent in a different way. It's not what I'm feeling it's literally what I saw (…) So everything that will happen with the children, with the house or anything, it will be connected to that [label]'*. (Sarah, 136-143)

Not only does being labelled result in social isolation, but the label changes the way in which people see you; you are no longer seen as just an individual, but rather you are seen only through the lens of the problem. In addition, any future difficulties are related back to the problem rather than seen within their own context. In this way, Sarah highlights why parents will desperately avoid their children being given a label of having mental health difficulties.

> *'So once somebody goes for help here or there, they get labelled, when he was young he went this and this and this. It sort of makes a black mark (…) A mark on their credit check, you know what I mean?* (Karin, 506-510)

Openly seeking help for ones child is very likely to result in the child being labelled. Participants suggested that fear of labelling means that many parents may turn to psychological help as a last resort, instead preferring to pursue alternative methods such as homeopathy. Karin refers to a 'credit check' relating to the process of finding

a marital match[14]. One of the most significant impacts of labelling was seen as the potential damage it may cause to future marriage prospects for the child.

> '*Because marriage is arranged, marriages are arranged I think that's probably a huge, a huge factor (…) you know you wouldn't choose a family where there's a history of psychotic episodes you know you'd steer away from that family so people, people don't want their family to be associated with mental illness*.' (Gideon, 346-352)

Psychological difficulties in children can therefore be seen as a problem that affect the wider family rather than just the individual and/or their parents. Given that marriage is central to Jewish life, this is a significant and life-changing problem.

> *'A lot of it is genetic, so, if my parents would look for somebody for me they'd look at the other side and check is there any nerve problem, is there any mental health problem (…) you eliminate certain things (…) I mean that's the aim of Jewish life, is to marry and have kids.'* (Karin, 498-504)

Understanding mental health as genetic/hereditary has significant repercussions for matchmaking. In addition, the fear of failing to find a match will have significant repercussions on stigma about mental health within the community and in turn, help-seeking for psychological difficulties. If marriage and children is the aim of Jewish life, then mental health difficulties can be seen as a barrier that prevents life from taking its desired course.

Given that people within the Orthodox community tend to get married in their late teens, finding a match preoccupies parents from when their children are at a young age.

> '*At a very young age people are already thinking about you know [marriage], I have young kids like all under nine(…) I'd say I have friends the same sort of*

[14] When parents look for a suitable partner for their child, they review family histories to identify suitability e.g. undertake a credit check.

age group and at sometimes they say things about you know like worrying about their children's future marriage prospects.' (Hannah, 331-336)

'*Perhaps at this age of eight one thinks well you know we've got plenty of time but the whole main thing is to do with the marriage you know, in time and as I said before this town is a small village and everybody knows everything.*' (Solomon, 341-344)

Both Solomon and Hannah are aware of the cultural pressure to focus on finding a match for their children, despite recognising their children are relatively young. The insular nature of the community means that others may well be aware of any 'labels' attached to a child and that this will be held in mind when making decisions about potential partners for their children in the future. Labelling therefore has serious life-long consequences for children and their families.

'*They're more worried that when it comes to getting them married people won't want to marry them because of access to mental health services in the past.'* (Rebecca, 143-145)

In addition, the very act of seeking support for a mental health problem can have repercussions and as such, being open about seeking help is likely to be extremely difficult, if not impossible.

3.4.3 Being open-minded and prioritising the child

Despite the significant stigma within the community, participants all displayed an open-minded attitude about mental health and seeking help for their child's mental health difficulty.

'I personally try to keep an open mind and be honest with myself and not let myself get carried away with, yeah, stigmas cos I think it's a shame to stop ourselves from getting the help we need just because of those type of things.' (Hannah, 384-387)

> ‘*Stigma is important for me, but not as important as healing the child.’* (Solomon, 352-353)

Although stigma is present, all participants were able to mentally put this to one side and seek help despite of it. Some participants saw seeking help as taking a logical solution to their child’s difficulty.

> *‘ I believe somebody has a headache they should go take painkillers, somebody got anxiety problems take something for anxiety (…) I believe everyone should deal with what they've got to deal with, not let it load up you know’.* (Miriam, 223-228)

> ‘*I believe very much when there's a problem deal with it straight away, don't just let it accumulate.*’ (Karin, 427-428)

Participants largely felt that seeking therapeutic support was likely to have a significant impact on the problem and this trust in the process appeared to help them to access services.

> *‘I think of both of our parents, if they would have had the option back in the day, some of our siblings would have been significantly helped by professional help and I think, I think yeah people should use it more readily, I think it's a shame that people don't. You know if, you know my feeling is if you're struggling get help that's my feeling’*. (Gideon, 270-274)

Many participants reflected on their own histories and in doing so implicitly considered how these have impacted on their attitudes towards mental health. Gideon considers the way in which his family members could have been supported and in doing so seems to reflect on the way in which things could have been different if help had been available.

‘I know my children, I know their needs and I don’t care about Jewish people looking at me in a different way, and I don’t care if my ex will fight with me, I will just carry on.’ (Sarah, 458-460)

‘*I don’t care about these things, I’m going to do what’s best for my child, and I didn’t really care what anyone was going to think.* (Rebecca, 138-140)

All parents reflected that their child’s well-being was the most important thing to them and that ensuring they were well took priority over any worries about stigma, labelling or finding a match. In some ways it was seen as a parent’s duty to explore all possible areas of help, regardless of their individual feelings or the possible consequences. In some ways this could lead to an internal conflict between their perceived duty as a parent to ensure both the well being of their child, and the quality of their future match.

There was an understanding that not seeking help would not only affect the child but would have an impact on the wider family relationships. Participants described feeling that if a problem is not addressed during childhood, it could have an impact on their whole adult life.

‘If it's a sad childhood it affects the whole of the life you know and others around them.’ (Solomon, 188-189)

‘I believe it's much more important for a person to remodel themselves when they're young, whatever their problem is, than to go through adulthood with this stupid problem and cause everyone else damage or, you know what I mean? Ruin their own life plus other people's.’ (Karin, 566-569)

‘*I think it's better to help a child when they're young, it's easier than when they're older and they're already set on their path*.’ (Rachel, 219-220)

Participants expressed that the determination to seek help for their child’s difficulties was related to their beliefs about the value of early intervention for children, and the

profound and life-long impact that this may have on the child and those around them. The majority of participants felt that an early intervention approach would not only address the current problem, but would also provide children/young people with an internal sense of stability and the tools that they need to manage difficulties as they grow older.

> *'And whatever you get, whatever you can, help them when they're younger, I think that's the root of what a proper person they're going to be, it's when they're, from when they're born I think, I feel. The roots, when you see a tree, the stronger the roots are down in the ground, the stronger the tree, will be able to stand any wind any push any thing*.' (Elizabeth, 661-667)

Elizabeth summarises this view by emphasising that what happens to a person in their childhood is at the heart of how they function in adulthood. Though in some ways Elizabeth sees a child's nature as somewhat innate from birth, she also suggests that by providing a child with early 'help', you strengthen their ability to grow up healthily and work through difficulties that they may face later in life.

3.4.4 Attitudes are changing

There was a sense that although stigma is still a significant issue within the community, attitudes towards mental health are changing. However, this was understood by participants to be occurring at a slower rate than in the secular community.

> '*I think it is changing together with the wider population I think it is changing as well but maybe at a slower rate or maybe not all across the board maybe only in some areas.*' (Hannah, 532-534)

> *'I think the rate of change elsewhere has an impact on the Charedi community but it just takes longer to see it through'* (Gideon, 175-176)

Participants suggested that there were a number of things that may impact on changing attitudes. There was an idea that as attitudes in the secular community

shift, this filters down to the Orthodox community, albeit at a slower rate, given the restrictions on media[15] within the community. There was also an idea expressed by some participants that the widespread use of personal therapy within the American Orthodox community[16] may impact on views about therapy in the Stamford Hill community.

> *'The American mentality of seeking professional help probably impacts the community as well.*' (Gideon, 195-196)

One participant spoke about the increased provision for children with special educational needs, describing that in the past this would never have occurred. They viewed this as representative of a shift in wider cultural attitudes about children being different.

> '*People perhaps (…) never in the past would have done anything but if they see a facility like that available and it would help them then they are trying to access it now'*. (Solomon, 422-424)

Participants described feeling that mental health is spoken about more openly now than in the past. For example, several participants described reading about psychological difficulties in the weekly Jewish publications.

> *'If you look at the Jewish magazines, there are more therapists which are Jewish as well, which are around, and they advertise there and there's, people write stories about this. There's more awareness about it in a way*.' (Karin, 792-795)

[15] In addition to the limited use of electronics and the internet, secular newspapers and magazines are avoided due to the content being at odds with Orthodox values. As such, weekly Jewish publications are favoured within the community.

[16] A high proportion of Orthodox individuals have relatives or close friends within the American Orthodox population; there is a large community in New York.

'I think it's more available now (…) I think of like, what used to go on in the world, how mental health was always covered up and hidden. And people couldn't get help that way.' (Miriam, 367-369)

The increased awareness leads to increased understanding, which in turn has an impact on seeking help. There is an idea that in the past there were no services or therapists providing mental health support for children and young people, in contrast to now where there are more options available to those in the community. Several participants felt that those wanting to raise awareness of CAMHS or similar services within the community would be best placed to advertise these in the weekly publications.

3.5 The parental journey

This theme outlines the experiences of participants whose children have faced emotional, behavioural or social difficulties understood as occurring within the arena of mental health. The theme is comprised of three subthemes; 'The emotional impact of the problem', 'The emotional impact of seeking help' and 'A shift in understanding'. The impact of the problem, and the impact of seeking help are seen as two distinct processes that relate to a shift in problem perception.

3.5.1 The emotional impact of the problem

Participants spoke at length about the emotional impact of coping with a child's difficulties. Most participants described their child as having behavioural issues, or problems relating to managing anger. The impact of coping with their child's difficulties was described as having an intense emotional toll.

'I just felt so lost, I didn't know how to get through to him' (Hannah, 80)

'I believe that if I wasn't strong enough I wouldn't survive it' (Sarah, 449)

Hannah's difficulty with 'getting through' to her child suggests that the problem has created a level of distance between them that cannot be breached; finding a way

around the problem leaves Hannah adrift from her expected path. Similarly, Sarah's description of her experience highlights the intense emotional weight of trying to find a way to manage the problem. Some participants described a sense of feeling out of control and powerless as a result of not knowing how they could help their children, wishing for a map to guide the way. Others felt that the difficulty made them feel frustrated and as though they were engaged in unrelenting conflict that was tiring and a drain on their internal resources.

> '*Everything is a constant sort of struggle'* (Gideon, 229)

> *Yeah it was a continuous, yeah a continuous battle with him, a continuous work with him*. (Elizabeth, 79-80)

The language used by participants suggests that the problem creates a rift between parent and child, each taking an opposing position where they vie for the upper hand. Not only is there an emotional impact in managing this conflict but there was also an acknowledgement from several participants that this impacted on the day-to-day management of the household. The experience was seen as having an effect on the whole family, which in turn added to the feelings of stress and worry outlined by participants.

> '*We literally step on eggshells going round him, everyone's scared to anger him cos he can do anything he can get violent (…) I don't know what it's gonna be. And the whole atmosphere in the house is very very tense when he's in a bad mood'* (Karin, 312-316)

Karin describes her sense of the overwhelming power held by her son's anger, with family members facing a precarious path to avoid an outburst. The tension experienced by participants was often compounded by worried about the future, whether the problem will be life-long, and if so, what this would mean for their child.

3.5.2 The emotional impact of seeking help

Participants described worries about their personal responsibility as parents and whether there was something that they had done that resulted in their situation. This fear was something that was acknowledged by some participants as something that concerned them as they considered seeking help.

> *'I guess as a parent I think sort of your biggest concern (…) [about seeking help] is coming face to face with your failings as a parent you know, none of us are perfect parents you know sometimes we get angry you know, and I think that's probably my biggest that would have been my biggest sort of hesitancy about going to somewhere.'* (Gideon, 444-448)

Gideon described an implicit idea that parents are responsible for their children's behaviour and well-being. When children have a problem, participants may not only worry about acknowledging that their parenting has been less than perfect, but also that their parenting will be judged or criticised by the individual providing help. The majority of participants expressed some level of worry that seeking help may involve a degree of criticism from professionals, that they will be exposed as not following the correct parenting path. Despite these fears, upon accessing a therapeutic intervention, participants described feeling supported and empowered.

> *'Letting it all out to someone who knows and someone who understands already, it's already has a calming effect (…) gave me a feeling of empowerment that it's in my hands and you know I can do the right thing.'* (Hannah, 221-225)

In contrast to the expectation that there may be a level of criticism, Hannah describes feeling reassured that she is on the right path and has the skills and expertise to be able to manage future obstacles. There is an idea that 'letting it all out' in itself has a positive 'calming' effect. In addition, the majority of participants spoke about experiencing the therapeutic relationship as something uniquely powerful.

> *'I'll never forget. She helped me (…) in my most crisis lifetime event, with my son. And imagine me as a mother, I was extremely worried and frustrated (…) And the fact that I knew that they, somebody there, helped me and understand me and listen to me and guide me, it helped me so much. And I wasn't, I felt not alone. I really felt not alone then.* (Sarah, 631-636)

Sarah describes her experience of the therapeutic relationship as being something that helped her in a number of ways. Her experience of being supported in such a unique way helped her to feel as though she was being guided through a situation that had seemed impassable. Several other participants also described the profound emotional impact of the intervention; something appeared to be valued almost as highly as the changes seen within the children. However, not all participants experienced the intervention as positive.

> '*It was just you know, just talk about it. And almost like talk about it enough and it'll go away but it doesn't of course.*' (Solomon, 141-142)

Two participants experienced the therapeutic intervention as ineffective and expressed feelings of frustration and disappointment. However, they reflected on their changes in understanding their child's needs. Despite this, there seemed to be a need for a concrete solution to be put in place, and when this perceived solution could not be found the therapy appeared to reach an impasse.

3.5.3 A shift in understanding

There seemed to be a process through which the child's problem was initially recognised and constructed by their parents, and how a therapeutic intervention leads to changes in the understanding of the difficulty. Participants outlined a number of initial possible explanations for their child's difficulties, many of which were initially centred on understanding the difficulty as something related to age or stage of development.

> '*I thought she'd outgrow it as she became older and changed her setting (…) But she just started all over again, she was really miserable and it like*

affected her home life as well. That's when I thought it's not a normal thing for a child to behave like that.' (Rebecca, 10-14)

Initially the child's problems were understood as being likely to resolve in time. When problem resolution did not occur, or became worse, parents felt that rather than it being something that would go away on its own, it was something that would require some form of action on their part. Recognition of a problem can be hampered by uncertainty about what constitutes 'normal' childhood behaviour and this can delay the identification of a problem.

'She's my oldest, and I didn't really realise anything was wrong. You know when (…) when you don't see others who you can compare to you don't [know]'. (Rachel, 41-43)

'*He's not different to other children here so in a way, we thought well maybe this is how kids are I don't know, we, it was our first child'*. (Solomon, 224-225)

Comparing your child to others is one way that some participants tried to identify whether a difficulty was something out of the ordinary. However, this did not always provide any clarification. When it became clear that there was a problem, participants came up with various explanations.

'*My husband's family have one or two like this that are a bit aggressive and had tantrums as boys. And I said he's growing up like them (…) my family are much more placid'*. (Karin, 612-614)

For some, making sense of the problem can be related to ideas about the child inheriting particular personality traits. This may lead a parent to feel more or less responsible for the problem. Other ideas about the nature of the problem included the problem being a biological or medical problem, behaviour performed for attention, or as a communication about the child's internal world. Different understandings about the nature of the problem may impact on what parents expect to help.

‘I guess he's got that gene and that's why he is the way he is, but that doesn't necessarily mean that we can write him off, we can work on him and he can be normal person with nothing wrong.’ (Elizabeth, 614-617)

Even though the idea of a genetic or inherent medical problem could be understood as something that would be difficult to change, there is still hope that things can return to ‘normal’. Regardless of the understanding of the problem, participants felt that there was something that could be done to help, whether this was therapeutic, relational or medical. The majority of participants hoped that they would be given advice and support about how to manage the problem. Participants acknowledged that the problem was unlikely to change overnight and were aware that there was likely to be an on-going process towards change. There was also an idea that the child having space to ‘open up’ in would in some way help.

‘I was hoping he was gonna speak to them and then... open up and eventually it'll help him. (…) it's not gonna be a miracle, I knew it wasn't gonna, it's gonna be a process. (…) the fact that he gets to speak to somebody and express himself, that alone's probably gonna be a help.’ (Karin, 690-695)

‘Give me the guidance and on how to deal with him, like, give me the tools on how, yeah, on how to deal with him. Cus I knew that this was gonna be, it’s not short term problem’. (Elizabeth, 405-407)

As the therapeutic intervention progressed, most participants experienced a shift in their understanding of the nature of the problem. Even those who felt certain the issue was genetic/biological described a change in their way of thinking to some extent. For some, there was an increased ability to recognise the good within their child, rather than the problem obscuring this. For others, there was an increased understanding of their child’s individual experiences and the reasons for their behaviour.

> *'I think I started to understand more what he was going through more (…) I think that I learnt to understand him more and get less frustrated with him which, which that probably had, probably had some impact on our interaction.*' (Gideon, 253-255)

Gideon describes that increased understanding led to a decrease in frustration, which in turn changed the pattern of interaction between father and son. Many other participants described this pattern. In turn, the understanding of what would benefit the child shifted for many parents. The majority of participants described an initial expectation that the intervention would focus on changing the child. As their understanding of the problem developed, a shift in thinking occurred and many parents recognised that there were things that they could do that may have an impact.

> *'I thought (…) they were gonna take my child and give me back a new child you know let them do all the hard work! But you know at the end of the day I realised as parents it's our job (…) there's no point in giving over the job to someone else for short while, it's better that I get the tips on how to deal with it in the long term*.' (Hannah, 267-273)

Hannah describes her realisation that it is better for her to understand her child and manage their difficulties independently, moving away from her initial expectation that the therapist would fix the problem.

CHAPTER 4: DISCUSSION

This chapter considers how the findings of this research relate to the original research aims and questions, as well as considering how this fits with existing literature. In addition, a critical appraisal and reflective account of the research process is provided. Finally, the implications of the research will be discussed.

4.1 Research aims

The aim of the research was to increase the understanding of the ways in which Orthodox Jewish parents experience seeking help for their children, when their child has a difficulty that can be conceptualised as a mental health problem.

The primary research questions were:

- How do parents/carers within the Orthodox Jewish community experience the process of accessing CAMHS?
- Are there barriers that have to be overcome in order to access statutory services such as CAMHS? If so, what are the barriers and how have participants experienced them?
- Are there particular concerns about accessing a mental health service for children?

Secondary research questions included:

- What is it like to work with a non-Orthodox therapist?
- Who do Orthodox Jewish parents turn to for help?

The research questions will be addressed through a discussion of the identified themes. These in turn will be considered in relation to the relevant literature.

4.2 Discussion of themes

4.2.1 The Orthodox Community as unique.

Though this theme does not directly relate to the research questions, it facilitates understanding of the community and therefore provides a greater insight to the way

in which community membership may help or hinder help-seeking. Participants highlighted the unique close-knit and insular nature of the Stamford Hill Orthodox community, in keeping with the literature (e.g. Martin et al, 2007). McMillan and Chavis (1986) highlight that having a sense of community relates to four key elements; membership, integration, fulfilment of needs and a shared emotional connection. Many participants within this study describe experiencing all of these elements and as such felt comfortable in their community membership. They found security in the implicit support found by belonging to a cohesive community.

However, there were also a number of perceived difficulties associated with living within the community. Participants highlighted that the insularity of the community can result in it being difficult to maintain privacy. To paraphrase one of the participants quoted above, everybody knows everybody, and if they do not know them directly then they know of them. This means that news travels fast, having particular implications for those experiencing stigmatised problems such as mental health difficulties. In addition to this, those who find themselves on the periphery of the community due to their particular beliefs, level of practice, or life circumstances, report not only feeling isolated from the community, but actively criticised and judged. Several participants described these experiences.

There is extremely limited literature available regarding the way in which Orthodox Jewish individuals experience belonging to the Orthodox community (e.g Kissil & Itzhaky, 2015), and none pertaining to the North London Orthodox community. As a result, there is a risk that those working with the community neglect to see the diversity within different sects. The experiences portrayed by participants emphasises the lack of homogeneity and the discord that may arise between those with different levels of observance.

4.2.2 Pathways to help

This theme described the factors that impacted on participants' experiences of accessing therapeutic help for their children. It addresses the process of finding out where help can be accessed, and the particular cultural barriers that may arise for Orthodox Jewish parents. In addition, it outlines why some parents may have a

preference for working with a non-Orthodox therapist.

Whilst some participants felt they were confident in approaching school or their GP for help in finding support regarding their child's difficulties, many participants were unsure of where to look for help, and whether there were necessarily services that could support their child's difficulties. This fits with prior research that highlights many parents are unsure of where to turn to when difficulties arise (Sayal et al, 2010). This problem may be particularly acute for Orthodox individuals who typically are unable to rely on the use of the internet to find out information about mental health difficulties and/or services. In addition, Orthodox parents may be less aware of services and less confident in the NHS than their secular peers (Interlink, 2016). None of the participants felt that they would turn to a Rabbi for advice or support regarding their child's difficulties. Martin et al (2007) found that views about consulting with the Rabbi about emotional difficulties vary. It seems that parents within this study felt a Rabbi's advice was best suited to practical questions, rather than for emotional support, or for child-rearing advice.

As discussed within the introduction, Schnitzer et al (2011) found three pathways to help for Orthodox Jewish parents in Antwerp; 'the hidden pathway' initiated by parents, 'the school-initiated pathway' and the 'interfering pathway' where both school and parents are involved. In the current study, only the 'hidden' pathway was identified. Parents were the ones who identified the problem and initiated help-seeking, often choosing to refrain from telling school due to concerns about their child being labelled. Two participants highlighted that school raised their child's behaviour as problematic but did not put forth a referral for any talking therapy. One school suggested art therapy as a possible solution. The differences in help-seeking pathways between Orthodox parents in Antwerp and Stamford Hill may be related to the particular insularity of the Stamford Hill community, as highlighted by Martin et al (2007).

Whilst there are several Orthodox Jewish organisations that work with mental health difficulties in North London (e.g. Chizuk, Jami), these largely focus on adult mental health and as such, participants were correct when they stated that there were

limited services within the community that are able to work with the mental health needs of Orthodox young people. The Orthodox services that are able to work with children and young people require a fee, and given the financial situation for many families (Boyd, 2011) the fee is likely to act as a further barrier to help. Indeed, the cost of accessing private therapy was highlighted as a potential barrier to accessing help within the community.

Participants identified a number of cultural barriers to accessing CAMHS and suggested that many parents are likely to have a preference for accessing help from within the community. Some participants had particular concerns about whether a non-Orthodox therapist might offer advice that contravenes Jewish teachings and that this may have a damaging effect on their child's spiritual well being. Some participants commented on the general levels of suspicion and caution with which the secular world is regarded. There was an identified level of mistrust towards secular mental health services, something previously acknowledged as a potential barrier to mental health care (Schnall et al, 2014). One participant highlighted the significant disparity between secular and Orthodox views regarding the role of the child and the ways in which behaviour may be managed. It was suggested that widespread use of corporal punishment relates to the mistrust of the secular state, as parents and schools are fearful of the consequences should secular authorities become aware of the situation. This participant's experience corresponds with recent media reports highlighting the use of corporal punishment in Charedi schools (e.g. Fenton, 2016; Cuminsky, Ungoed-Thomas & Griffith, 2014; Mortimer, 2014). However, it is not possible to say whether this is the primary reason for suspicion towards the state, and the historical context of the abuse of state powers during the Holocaust should not be ignored.

Many of the narratives portrayed by participants seeking support within CAMHS fit alongside those belonging to Orthodox adults seeking mental health support (Martin et al, 2007; Schnall et al, 2014; Sublette & Trappler, 2000). Some participants expressed a preference in working with an Orthodox therapist who would understand Jewish life, and others acknowledged concerns about feeling judged and levels of confidentiality when seeking help from an Orthodox therapist. Bronstein (2007)

highlights that preference for working with an Orthodox therapist is likely to relate to the sect to which one belongs. Although the participants within the current study felt generally accepting of working with a non-Orthodox therapist, this cannot be seen as routine within all Orthodox sects. One of the things that was particularly valued about working with a non-Orthodox therapist was the perception that they would offer a new way of understanding and/or coping with the problem. In addition to this, working with someone from outside of the community was seen to reduce the risk that confidentiality may be breached.

As outlined within the introduction, there is limited literature on factors affecting minority groups from seeking help in CAMHS. The results of this study suggest that there are similarities between the concerns of Orthodox Jewish parents and other minority group parents (e.g. Messent & Murrell, 2003; Bradby et al, 2008).

4.2.3 Attitudes towards mental health

This theme described the different views about mental health difficulties experienced by Orthodox children and young people. It outlined the difficulties associated with one's child being 'labelled' and the relationship between stigma and finding a match. In addition, it considered whether attitudes are changing within the community and to what extent this may be occurring.

All participants made reference to the presence of stigmatised attitudes towards mental health within the community, in keeping with the limited literature focused on the Orthodox Stamford Hill community (Martin et al, 2007; Interlink, 2014; Interlink, 2016) and literature regarding the wider Orthodox community (Feinberg & Feinberg, 1985; Schnall et al, 2014). Participants made reference to the range of stigmas as portrayed by Goffman (1963). Of particular note was the significant impact of stigma by association, particularly in relation to marital prospects for the wider family, as discussed by Greenberg et al (2012).

Though participants sought help in spite of these concerns, the pressure to keep help-seeking private was an issue for many, as reported by Greenberg et al (2012). All participants reported being cautious to whom they disclosed that their child was

experiencing difficulties for which they were seeking professional help. This was in part due to a fear of being criticised or judged, but also seemed to be related to a fear that they and their child would be gossiped about. Bradby et al (2007) found that British Asian families had similar concerns about the stigma of mental health and a fear of their child being gossiped about. These were identified as major disincentives to seek help via CAMHS, and in many ways mirror the concerns of Orthodox parents. Though many participants felt able to tell immediate family and/or close friends about the problem to some extent, telling them that they were seeking professional help was harder. This meant that several participants lost a level of social support as they progressed through their help-seeking journeys. This was difficult on both practical and emotional levels. Given that social support is an important factor in the help-seeking process (Rickwood & Braithwaite, 1994), being unable to rely on ones family and/or friends may have a negative impact and may therefore make seeking help harder.

The responses of participants seem to reflect the findings by Feinberg & Feinberg (1985), who found that there is not only stigma regarding mental health, but there is also an additional stigma related to help-seeking from professionals. The experience of mental health stigma is not unique to the Orthodox Jewish population and it has been highlighted that this is a particular concern for minority groups (Wynaden et al, 2005). When considering the different layers of concern regarding both mental health stigma and help-seeking stigma, there were a number of similarities. When considering stigma related to mental health, participants expressed worries about the child being labelled, gossiped about and being treated differently, leading to exclusion from social events and thus the ability to live a ‘normal’ life. This in turn leads to explicit concerns about the child (and their siblings) likelihood of finding a match (see Diagram 1 below).

Diagram 1. Perceived impact of mental health stigma

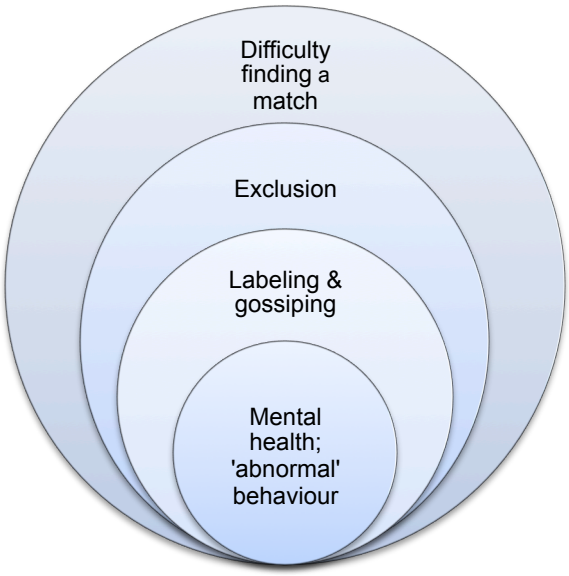
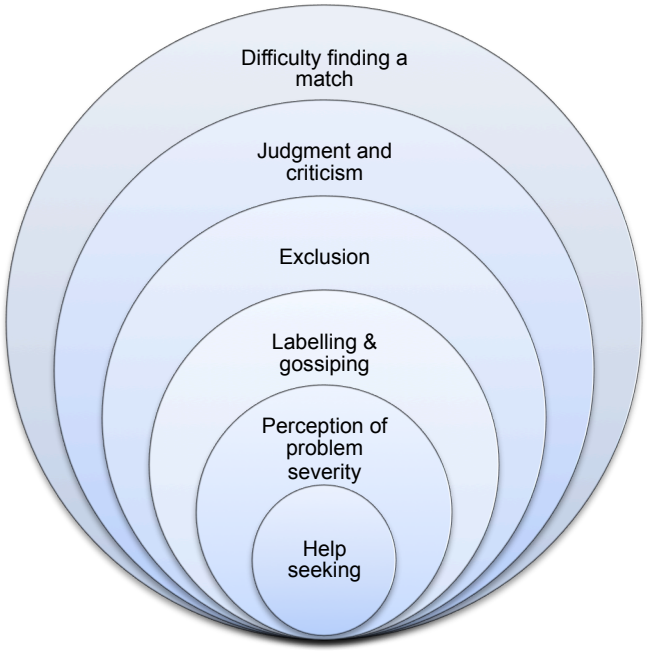


Diagram 2. Perceived impact of help-seeking



When considering the impact of stigma related to seeking help (Diagram 2), the core concern seems to be that if one seeks help for a problem, it indicates that the problem is severe in nature. This may be particularly so if one seeks help from professional agencies from outside of the Orthodox community. As such, the child

risks being labelled as having a severe ‘mental health’ problem. This again leads to exclusion. In addition to this, there is likely to be a level of judgement and criticism towards the parent, relating to their parenting practices but also to their decision to seek mental health support for their child. Again, there are repercussions for the child’s marriage prospects in later life.

Labelling was described by participants as having potentially life-long repercussions. As outlined above, participants suggest that having a label changes the way in which you are viewed by others and as a result, your actions will always be viewed through a label-focused lens. The label of mental health carries particular connotations. Some participants referred to implicit ideas about mental health being contagious, and consequently those known to suffer from mental health difficulties may be avoided. Given that parents may be concerned about finding a match from when their children are relatively young in age, receiving a label at any stage in childhood may have an array of consequences. As such, there is the potential that many parents will avoid help-seeking where possible. Participants relayed that fear of labelling leads to a preference for homeopathy and other ‘natural’ remedies, as problems helped through these means are seen as less severe.

Despite the significant impact of stigma and other recognised barriers, parents prioritised their child’s wellbeing. Some participants felt that it was their duty as a parent to explore all options, regardless of the potential consequences. Seeking professional help was seen as a practical solution, and there was an idea that ‘opening up’ and talking about a problem, would go some way in relieving it. Some participants drew upon personal or familial experiences to highlight their reasons for seeking help, recognising the profound and life-long effect that psychological difficulties can have on an individual and their families, a similar finding to Boulter and Rickwood (2013). As such, participants valued an early intervention approach. Tackling a problem during childhood was understood not only to be more effective, but was also seen to provide the child with skills to use throughout their lives.

There was also an acknowledgement that attitudes towards mental health are changing, fitting with prior research in the Stamford Hill community by Martin et al

(2007), and with research conducted in the New York community (Schnall et al, 2014). Participants generally felt that attitudes were likely to be changing more slowly than in the secular world, though some participants expressed curiosity about whether stigmatized attitudes would really differ so greatly. Participants attributed a number of factors to the gradual shift in attitudes, including more articles regarding mental health within Jewish publications. In addition, there was an idea that close family links to the New York Orthodox community (where there is reportedly a higher incidence of personal therapy) may also have an impact. The increased availability of therapeutic support within the community had also gone some way to increase the awareness of mental health and in turn attitudes were seen to be changing.

4.2.4 The parental journey

This theme considered parents' emotional experiences and responses to the problem and the intervention. Participants highlighted that they faced a significant emotional response to their child's difficulties. Several participants spoke about feeling lost, alone and powerless. There was an idea that coping with the problem required a level of inner strength. The idea that parents experience emotional turmoil as they cope with their child's difficulties has been found in other qualitative research addressing the experiences of parenting a child understood as experiencing mental health difficulties (e.g. Stapley, Midgley & Target, 2016; Byrne et al 2008). Indeed, many of the themes found by Stapley et al (2016) correspond with reports from the participants. Of particular similarity were ideas relating to parents having to 'walk on eggshells' in order to avoid causing further upset, and an awareness that the problem affects not only the child and their parent, but the whole family. In turn, this impacts on running of the household and the care offered to other children. Given the significant time taken up by running a Jewish household, this placed additional stress on parents. The emotional distress experienced by parents was compounded by a worry about the future and how this would impact on the child later in life. This relates back to worries about children meeting cultural expectations of getting married and starting a family, as well as to the idea that it is not possible to be happy or spiritually fulfilled without these things.

There are not only emotional implications in coping with the problem; several participants also highlighted feeling worried and anxious about attending their initial CAMHS appointments. Parents described experiencing guilt and feeling worried that they were responsible for the problem and that they would be judged and criticised by professionals. Again, this is in keeping with the small body of literature regarding parents accessing CAMHS (e.g. Boulter & Rickwood, 2013; Stapley et al, 2016). However, these worries about accessing CAMHS are likely to be compounded for parents from the Orthodox community, as they have particular concerns that the impact of their cultural traditions on their lifestyles and parenting may be subject to critical appraisal by secular professionals. Several participants described that the intervention had a significant impact on their emotional state. Clinicians were reported to have given parents a level of emotional support and reassurance about their parenting skills that was experienced as empowering by the majority of participants. This emotional support was valued almost as highly as the changes seen within the children.

Similarly to the findings by Bone, O'Reilly, Karim and Vostanis (2015), though parents described a positive relationship with their therapist, systemic issues such as waiting times and appointment regularity were highlighted as an area for improvement. Many participants appreciated this was due to the wider context of the NHS, rather than failings on the clinicians part. Two participants found the intervention to be ineffective and felt that a diagnostic approach and the possible use of medication may have been more helpful for their child's particular difficulty. However, despite finding the interventions to be ineffective, the participants reflected that the way in which they made sense of their child's difficulties had changed in some way. There may be a split between the culture of a therapist working within an NHS context, and the parent's knowledge of what treatments and interventions are offered elsewhere e.g. in the USA or Israel.

The majority of participants described a shift in their understanding of the problem and the intervention that needed to take place in order to make an impact. Participants described initially struggling to make sense of the difficulty, comparing their child to others of the same age, or assuming the difficulty may be related to

their age or stage of development. Participants also viewed the problem as potentially genetic, or as an inherited personality trait. As the intervention progressed, participants felt that they had an increased understanding of their child's experiences and actions. This shift in understanding created space for most participants to be able to react differently to the behaviour, and to a realisation that there were changes they could make in their parenting.

4.3 Summary of new contributions to the literature

This study creates novel contributions to the limited literature relating to child mental health within the Orthodox Jewish community. The study is somewhat reflective of information gathered within the literature review, suggesting that Orthodox Jewish parents of children with mild-moderate mental health difficulties experience similar barriers to help as parents from other minority groups. In addition, they experience many of the same barriers to help as Orthodox Jewish individuals accessing adult mental health services. What is particularly apparent from this study is how little research has been completed within the UK Orthodox Jewish population. As such, there are a number of novel contributions from this study, the key findings of which are briefly summarised below.

- Orthodox Jewish parents experience the emotional impact of having a child with mental health difficulties similarly to the results of research with parents from the general population.
- Participants described generally having a positive experience of CAMHS, and found that clinicians were culturally sensitive and knowledgeable about Orthodox Jewish culture.
- Orthodox Jewish parents may be at risk of experiencing a level of social isolation as a result of help-seeking for their children.
- Working with a non-Jewish therapist has the potential to raise concerns about the spiritual/religious well being of the child. However, it can also be seen as advantageous in providing a new perspective.
- There is a significant level of stigma in the community relating to the mental health of Orthodox Jewish children, and relating to seeking help for such

difficulties. Consequently, many Orthodox Jewish families may be cautious about accessing CAMHS.

- There is a significant concern that accessing CAMHS may impact on a child's future marriage prospects.

In addition to these findings related to the Orthodox Jewish community, the study contributes to the literature on the experiences of parents accessing CAMHS and may provide further insights that relate to the experiences of other minority groups.

4.4 Methodological considerations

4.4.1 Design and analysis

Qualitative research is often criticised for its small sample size when compared to sample sizes in quantitative research. In addition to this, the interpretive nature of qualitative analysis has led to concerns relating to the validity of such methodologies (Willig, 2013). Despite these concerns, qualitative research is posited to produce rich, contextualised data that opens up possibilities for understanding human experiences (Braun & Clarke, 2013). TA takes a particularly flexible approach and facilitated the reporting of a large body of data, whilst still allowing for the richness of individual experiences to be explored. Given the extremely limited body of research in this area, a flexible and open-ended methodology was important in order to ensure that all aspects of data could be explored.

4.4.2. Interview schedule

Though consultation with members of the community about the content of the interview schedule took place, co-constructing the schedule may have identified additional areas of interest and may have opened up different areas of questioning.

4.5 Limitations

4.5.1 Recruitment and sample

The present study is limited by the fact that participants were all recruited from the same Tier 2 CAMHS. Those who were suggested as suitable participants and subsequently decided to take part may be more likely to be those who have had a

positive experience of the service. Many participants explained that their reason for participation was because of their positive experience and a desire to ensure that other families were able to access the same level of support. During the recruitment stages of this study twenty-six families were contacted, however of this number only nine individuals chose to participate. Finding participants was a difficult process, and many of those who declined to participate appeared apprehensive about the prospect of being interviewed.

Those who participated in interviews tended to describe themselves as open-minded, and several participants made reference to use of electronics within the home[17]. As such, it may be that the sample is made up of those who would find accessing a service outside of the community the easiest. It is notable that several of the participants expressed negative feelings about the Orthodox community and may therefore have been keen to share an alternate view from that put forth by community leaders. Families who are more heavily observant and/or involved in the community may face additional issues in accessing CAMHS and this needs further exploration.

In addition, by excluding potential participants who have accessed Tier 3 CAMHS, the sample is made up of individuals whose children will have experienced mild-moderate problems; parents of children with more significant difficulties may have different experiences. It is acknowledged that recruiting from both Tier 2 and Tier 3 may have resulted in a more comprehensive data sample.

The sample was relatively small. However, Guest, Bunce and Johnson (2006) suggest that the sample size is adequate for data saturation. In addition to this, the themes identified within interviews seemed to be applicable to the majority of participants and in keeping with views expressed via other qualitative research in the area. As such it can be seen as representationally generalizable (Lewis & Ritchie, 2003) to others within the Stamford Hill community. Given the similarities between experiences of mental health in the Stamford Hill community and other global

[17] Electronics such as television, the internet and computers tend to be frowned upon by Orthodox Rabbinic authorities.

Orthodox communities, it seems likely that the results of the current study are also inferentially generalizable to other Orthodox Jewish communities (Lewis & Ritchie, 2003). However, given that the Stamford Hill Orthodox community is thought to be unique (Martin et al, 2007), further research in this area is necessary.

Despite these identified difficulties, it has still been possible to access a 'hard to reach' group and to recruit a reasonable number of participants. The information gathered within this study clarifies the unique position of Orthodox parents accessing CAMHS, thus providing an insight into an under-researched and under-resourced community.

4.5.2 Interview schedule

The interview schedule contained specific items relating to participants experiences of stigma, and may therefore have promoted greater attention to the topic of stigma. However, there was an awareness that this could be an issue and therefore this question was left until the latter part of interviews to see whether this was something that was raised spontaneously. In addition to this, the interview was carefully constructed in a way that promoted open-ended questions to facilitate participants to be able to openly share their experiences. In doing so, many participants began to discuss stigma prior to reaching the point in the interview where it was planned to specifically ask about the topic.

4.6 Reflective account

4.6.1 Process

During this research I experienced a number of difficulties in recruiting participants. This was partly to be expected, as I was conscious of the sensitive area of the topic and the close-knit nature of the community. Within my extended Jewish family, my choice of topic was met with concern, and I was advised it would be difficult to find members of the community who would be willing to speak to me. Others expressed shock and surprise that issues of mental health in any form affected the Orthodox community. I wondered whether these attitudes might have been reflective of narratives about mental health, child rearing and help-seeking within the wider

Jewish community. As such, recruitment was in some ways more successful than I had predicted, though the process remained difficult.

Throughout recruitment I was careful to ensure participants were aware there was no obligation to take part in the study. During the initial phone calls with potential participants it was clear that many participants were unsure about whether to participate. I had some instances of receiving cancellations in the hours before interviews were due to commence, or participants not attending the interview at all. In one instance, an individual who didn't attend their initial interview said that she had forgotten about the appointment but was happy to reschedule; however, in our meeting the participant's nervousness made me wonder whether she had felt obligated to participate. Though I made it clear there was no obligation to take part and the research was unrelated to any current or future treatment, the fact remained that I was identified as a 'trainee psychologist' and had a professional link to the service by virtue of contacting the participants. It may be that I was positioned as a 'powerful' professional and as a result, some participants may have felt that it was difficult to turn down the request to be interviewed. Whilst this may have been due partly to individual life-circumstances, I wondered whether my difficulties with recruitment were somewhat indicative of the 'hard-to-reach' nature of the community.

4.6.2 Positions

In keeping with my critical-realist stance, I understood what was reported by participants to be an accurate reflection of their individual experiences. However, I was also aware of social-constructionist ideas regarding the way that our positions can impact on what is and is not possible to be said. As such, some participants may have felt less able to express particular ideas. For example, if participants positioned me as a non-Jewish person in the interviews, it may then have been difficult for them to discuss why they would not like to see a non-Jewish therapist. It may have also meant that if I was seen as being related to the service, participants may have been cautious about relaying negative views about the service or the intervention. In this way, the collection of data may have been limited in some way.

In my reflective diary (Appendix S), I considered how my status as an 'outsider' may influence data collection. At the end of an interview, one participant indirectly asked me whether or not I was Jewish. When I acknowledged my position as a non-practicing Jew, I was verbally embraced as being 'one of us'. I wondered how the interviews may have been affected had I disclosed my position at the start of interviews. I noted that many participants explained things to me that were already familiar to me such as the process regarding Shabbat dinners. However, at other times I had to be cautious about my own assumptions, such as checking out whether a participant's use of the word 'frum' was being used in the same way that I have grown to understand it.

> ***I**: So if you're Charedi you're seen as more frum? Or, could you…you mentioned about frum before, could you clarify what that is?*
> ***S**: Wearing a very short wig and very… it's not modern clothes (…) The men, they walk around with payos, yeah and with a hat, with a black clothes. The woman will be the same sort (…) They have a special dress code you need to follow even certain tights colour or…*
> ***I**: And do you see frum and Charedi as the same thing, or can frum be other Jewish people also?*
> ***S:** No, they're all Jewish, all Jewish but, it's kind of divided to section*
>
> Sarah, 73-85

Though Sarah's explanation was largely in keeping with my own understanding of the word, I felt it was of benefit to check that I was understanding and interpreting her accounts in the way in which she meant. At other times, checking my understanding opened up conversations and facilitated the interview process.

Maintaining an awareness of my position was important throughout both the interview and analysis processes. I was aware that as an outsider I was at risk of misunderstanding the nuances of Orthodox life and was also cautious of the way in which my position may impact on the way in which I interpreted the data. When reading my analysis I therefore continually questioned how my position and

relationship to the community might have impacted on which features of data were focused on.

4.6.3 Ethical concerns

During my interview with Gideon, he described the widespread issues of corporal punishment within Charedi homes and schools[18]. Though I was aware that there can be issues related to the quality of broader teaching in some Orthodox schools, I was not aware of the issues that Gideon described. After this interview, I spent some time considering the ethical and safeguarding issues that arose as a result from this interview and discussed this with the field supervisor on several occasions. It became clear from this conversation that these are widespread and deeply entrenched issues, which require a great deal of thought and systemic input. Gideon discussed the way in which statutory bodies and Jewish authorities hide the level of this abuse, and it was this that I found most shocking. This does not just seem to be an individual account, based on recent media attention (e.g. Fenton, 2016; Gamp, 2016)[19] and anecdotal information from the field supervisor. It felt important that I did not hide this disclosure or disregard it from my reflections. I did not want to be part of any implicit process of hiding something that could be understood as systematic abuse. In my discussion with the field supervisor, we discussed the wider issues relating to this disclosure and acknowledged that this something that is beyond a service-level issue and is highly politically charged. As such, it requires careful consideration as there is a risk that quick reactions could drive these incidences further underground. Though respecting Orthodox values is important and cultural colonialism must be avoided, the safety of children within the community is paramount.

4.7 Evaluation

The research has been evaluated in line with Spencer and Richie's (2012) framework for qualitative research.

[18] There was no explicit disclosure; rather Gideon described a general awareness of these practices within the Orthodox community. It was therefore not possible to make a safeguarding referral.
[19] In addition, OFSTED closed a Charedi school recently based on similar allegations.

4.7.1 Credibility

Spencer and Ritchie (2012) argue that credibility relates not only to the plausibility of research findings, but relates to the clarity of the research process and the ability to see how conclusions have been made. As such, a thorough overview of the methodology has been provided, and examples of data extracts, coding processes and thematic maps are shown within the appendices. The findings of the study have been compared with the research literature, and similarities and differences have been highlighted. Practical constraints meant that the analysis was completed solely by the researcher, though the Director of Studies and Field Supervisor were involved in discussion regarding the analysis and a draft of the method, analysis and discussion was shared.

4.7.2 Contribution

As outlined above, the study has provided a number of novel contributions to the emerging literature. This has been considered in relation to existing literature relating to the Orthodox Jewish community, stigma, and minority group access to CAMHS. In addition to this, the limitations of the study have been considered and recommendations for future research have been made.

4.7.3 Rigour

The concept of rigour considers the transparency of the research process, arguments for the decisions regarding methodology and design and the thoroughness with which the research was completed. Spencer and Richie (2012) suggest that when considering the rigorousness of qualitative research, they are primarily concerned with ideas relating to reflexivity, auditability and defensibility.

4.7.3.1 Reflexivity. The assumptions and values contributing to the researcher position have been considered, both prior to conducting the study, during data collection and post-analysis, as outlined within the method, discussion and appendices.

4.7.3.2 Auditability. Documents outlining the steps taken in analysis and examples of data are included in the appendices. A clear account of the methodology and underlying epistemology has been provided.

4.7.3.3. Defensibility. A rationale for undertaking the study, the methodology and the sample have been provided. This has been related to the broader evidence base.

4.8 Implications and recommendations

4.8.1 Research

This study opens up a number of possible pathways for future research. Broader research could be conducted across the use of CAMHS across Orthodox communities in North London (e.g. including communities in Barnet and Haringey) and across the UK (e.g. including the Orthodox community in Salford). Of course, there is scope for similar studies across the global Orthodox populations. The study has shown that it remains difficult to access families who may be more strictly observant and/or more wary of the secular world. Further research could be co-constructed and conducted alongside members of the community to ensure a range of perspectives are considered.

On a local level, the current study could be replicated within the Tier 3 service in Hackney to see whether parents describe similar themes when a young person faces more significant mental health needs. Following from this, to ensure that families who have had a less positive experience of CAMHS are accessed, recruitment from the BME access service and third sector services may provide alternate viewpoints. In addition to this, given the broad nature of the study, research could focus on gathering further in depth information on particular aspects of the results; for example, a phenomenological approach could be taken to examining the experience of belonging to the Orthodox Jewish community, or the emotional impact of parenting a child in distress.

Further topics of research could include considering the experiences of clinicians working with the Orthodox community. This could focus on the way in which

clinicians may or may not adapt their practice to meet the cultural needs of the client group. This would add to the limited literature that addresses cultural sensitivity when working with Orthodox populations (e.g. Witzum & Buchbinder, 2001), particularly given the lack of research specifically relevant to the UK populace.

Should further community psychology approaches be implemented (see below), evaluation of outcomes, as well as an exploration of the experiences of those facilitating and attending interventions would be of interest.

4.8.2 Service level

The study has several implications at service level. At the broadest level, the study highlights the significant impact that mental health stigma continues to have within the Orthodox community. Although CAMHS within Hackney appear to be aware of cultural barriers and share information regarding the Orthodox culture with new employees, this study explicitly states the particular concerns for parents attending the service. As such service level implications include ensuring that all staff working within the service are made aware of the Orthodox Jewish cultural context and the particular issues that may arise for families as a result of a referral.

Services should be developed in response to the needs of the local community and as such, should be developed in consultation and collaboration with members of the community to ensure congruence with cultural beliefs (Schnall, 2006; Webster & Robertson, 2007). This is currently occurring within the service through working jointly with Koach[20] to provide parenting support. Using community psychology ideas, services can continue to share psychological knowledge with members of the Orthodox community (Friere, 1972). This could include further training for Orthodox Jewish community leaders and/or members to allow the delivery of culturally sensitive, evidence based interventions to the community. Given that many members of the community may be particularly wary about accessing NHS psychological services, community psychology approaches would facilitate access to support to those who may be otherwise unlikely to receive it. The current study provides an

[20] An Orthodox community organisation; a Rabbi and his wife have been trained to co-deliver parenting interventions.

evidence base that can be shared with commissioners to highlight the particular needs of the Orthodox community in order to further develop collaboration between services and community organisations.

To ensure that good practice is not developed in isolation, services working with the Orthodox community would benefit from liaison and the sharing of ideas. This should not just be limited to liaison between the various CAMHS operating within Hackney, and should include working together with the BME service and local Orthodox organisations wherever possible. Quarterly meetings attended by representatives of these services would ensure the development of good practice across the borough. In addition, this would ensure the development of culturally sensitive service structures, rather than only relying on the culturally sensitive practices of individual clinicians.

4.8.3 Clinical Practice

Given that participants highlighted the inherent value of working with culturally sensitive practitioners, it is critical that therapists working with Orthodox families ensure they are aware of the issues that are likely to impact on initial engagement and rapour building e.g. dressing appropriately, not shaking hands with the opposite sex. Clinicians must be aware of issues of safeguarding within the community and have support to consider how to address such endemic issues. Clinicians should recognise that the Stamford Hill community is not homogenous and consequently, Orthodox clients will have different traditions, different experiences of belonging to the community, and different understandings about the causes of mental health difficulties. It is important that clinicians retain a position of curiosity and are wary of making assumptions, as well as ensuring that the client's beliefs and cultural practices are incorporated into the work, rather than set aside (Witzum & Buchbinder, 2001).

It has been suggested that community psychology approaches are effective tools to use when working with issues of stigma (Parker & Aggleton, 2003). It may therefore be beneficial to turn to community psychology approaches (e.g. Holmes, 2010) when working with the Orthodox Jewish community as suggested by Galloway (2015).

Though anecdotal evidence suggests that some clinicians are using these tools in order to unite Orthodox Jewish parents with similar experiences[21], this is not happening across the board. When considering how community psychology approaches could be further integrated into clinical practice there are a number of ways in which this could be developed. Given that the results of this study indicate that families affected by mental health are likely to lose some level of social support, it may be of benefit to routinely offer (consenting) families the opportunity to be put in contact with other families experiencing similar difficulties. The simplest way of beginning to develop this could be by encouraging parents who have attended adapted parenting groups to remain in contact with one another[22] via a peer support style model. This level of social support and thus prevent parents from feeling isolated. In addition, it may have a wider systemic impact on stigma relating to mental health within the community. Stigma flourishes when those affected by stigmatised problems feel the need to hide the problem, as discussed by Goffman (1963). By creating a network of those who are affected by a stigmatized problem, there may be an increased awareness that these difficulties occur for many families. Over time, this may have a gradual impact on the level of awareness about mental health within the community that could lead to a gradual shift in the way mental health is viewed when finding a marital match. This could be supported through the training of peer workers as discussed above.

The approach of bringing people together may be particularly helpful for parents who are concerned about their children's experiences of physical chastisement at school. Further anecdotal evidence from the Field Supervisor suggests that in some cases parents have been able to join together to address these difficulties with school leaders. If these families were to be routinely offered the opportunity to make links with families who are also dissatisfied with their children's experiences at school, it may lead to some level of systemic change. In this way families could be supported to think together about ways in to address their concerns via social action. However, it is important for clinicians to be aware of the significant repercussions that such an

[21] For example, starting to create a network of Orthodox parents who have shared experiences so that they can provide support to one another.
[22] The service has recently adapted an evidence based parenting group and delivered it in a culturally sensitive format to a group of Orthodox Jewish parents.

approach could have for families. This type of work with the community could draw upon the work of Holland (1992) with a move from the problem being viewed as an individual one, to a social one.

Given the value of working alongside community leaders (Schnall, 2006), it is critical to ensure that this takes place wherever possible. Developing good working relationships with children's centres and local schools may also lead to increased confidence in clinicians. Through developing good working relationships with community services, consultation, education and collaboration is more likely to occur. Through the sharing of ideas, it may be possible to challenge preconceptions about mental health, and as such stigma may be further addressed.

4.9 Conclusion

This study aimed to provide an insight into the experiences of Orthodox Jewish parents who have accessed CAMHS. The use of TA allowed for a flexible approach to identify and understand the particular issues that may arise for Orthodox parents. The findings have been placed in context to the current literature. As there is extremely limited literature available on the topic, the current findings offer a unique insight into the Orthodox Jewish community, the way that the mental health of children and young people is understood, and how help-seeking has been experienced by Orthodox parents. Orthodox Jewish parents face significant cultural barriers when seeking help from CAMHS, and Clinical Psychologists have a role in ensuring that services are accessible for families from all cultural backgrounds. It is important that access to services is continuously considered and steps are taken to ensure that not only do services become more culturally aware, but also that steps are taken towards producing community level changes.

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APPENDICES

Appendix A: Participant Information Sheet

Homerton University Hospital NHS
NHS Foundation Trust

UEL University of East London

UNIVERSITY OF EAST LONDON
School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

The Principal Investigator
Gemma Rowland, Trainee Clinical Psychologist
U1331812@uel.ac.uk

Consent to Participate in a Research Study

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in a research study. The study is being conducted as part of my Professional Doctorate in Clinical Psychology degree at the University of East London. Joining the study is entirely up to you, before you decide I would like you to understand why the research is being done and what it would involve for you. If you are interested in participating, I will go through this information sheet with you, to help you confirm whether or not you would like to take part and answer any questions you may have. I'd suggest this should take about 10 minutes.

Project Title

How do parents within the Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?

What will happen if I participate?

The project aims to explore the experiences of Orthodox Jewish parents who have accessed support at First Steps. If you choose to take part, I would ask you to meet me for an interview. This would last for approximately one hour. If you would like to complete the interview with your husband/wife the interview may take slightly longer. You will be asked about your experience of accessing a service outside of the Orthodox Jewish community, and asked about factors that may have led you to seek help. You will also be asked about the specific experience of seeking help for your child/children, though

would not be expected to talk in detail about your child's specific experiences or difficulties.

This research is not part of your child's treatment at First Steps and you are not obliged to participate. Participation in the project is voluntary and you may withdraw at any time should you change your mind about participating. Whether you choose to take part in the research will have no impact on your child's treatment within the service.

Where will interviews take place?

The interview will take place at a location that is convenient to you. This could be at Stamford Hill GP practice, or local community centers.

What are the benefits of participating?

Some people may find that talking about their experiences is helpful, though there is unlikely to be any direct benefit to participating in the research. It is hoped that the research will highlight barriers to accessing NHS and other statutory services in the Orthodox Jewish community. It is hoped the research will identify specific barriers to accessing children's mental health services. This may result in changes to services to make them more accessible.

What are the risks of participating?

It is not expected that taking part in the research will contain any risk; though it is possible you could find talking about your experiences distressing. Whilst I do not predict this interview to upset you, it is possible that you could find talking about your experiences difficult and 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 feel you would like support with this I will be able to signpost you to support networks.

What about my child's views?

You are under no obligation to discuss your role in this research with your child. It is entirely your decision. This research is about your experience, as a parent, of accessing First Steps. However, should your child be aware of the research it is possible they could be worried about being talked about. We will not discuss your child's difficulties in any detail. If you feel you would like to tell your child you will be taking part in the research it would be important to let them know the focus of the research is not about their personal difficulties, rather it is on your personal experiences as a parent.

Will my personal details and interview be kept confidential?

Your privacy is of the upmost importance. Your name and any identifying details will be changed/anonymised via the transcriptions of interviews. The researcher will not discuss your individual interview with anyone except the research supervisors. Interviews will be audio-recorded; these recordings will be kept securely and will be destroyed at the end of the study in the summer of 2016. Password protected electronic copies of anonymised transcripts will be kept for two years, as it may be that the study will be written up for publication. If the study were published all identifying details would be removed. The researcher supervisor and examiners will be able to read extracts from the anonymised transcriptions of interviews.

The only exception to this confidentiality would be if you were to disclose information that suggests that your child or another individual is at risk of harm. In this case safeguarding procedures would be followed. This may mean that information would be shared with other agencies in order to ensure the safety of the child or individual.

Will you contact me again?

If you agree to it, I may ask to meet with you again, or to speak on the phone. The purpose of a second meeting would be to gather your opinion on the themes I identified in your answers. You would be under no obligation to meet me a second time. I would

Homerton University Hospital NHS
NHS Foundation Trust

UEL University of East London

not contact you again without your explicit consent.

Disclaimer

You are not obliged to take part in this study and should not feel that you have to. If you choose to participate you are free to withdraw at any time. Should you choose to withdraw from the study you may do so without disadvantage to yourself and without any obligation to give a reason.

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 invitation letter for reference.

If you have any questions or concerns about how the study has been conducted, please contact the study's supervisor: Dr Paula Magee, School of Psychology, University of East London, Water Lane, London E15 4LZ. Telephone. Email p.l.magee@uel.ac.uk]

or

Chair of the School of Psychology Research Ethics Sub-committee: Dr. Mark Finn, School of Psychology, University of East London, Water Lane, London E15 4LZ. (Tel: 020 8223 4493. Email: m.finn@uel.ac.uk)

Thank you in anticipation.

Yours sincerely,

Gemma Rowland
Trainee Clinical Psychologist

Appendix B: Participant Consent Form

Homerton University Hospital NHS
NHS Foundation Trust

UEL University of East London

UNIVERSITY OF EAST LONDON

Consent to participate in a research study

How do parents within the Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?

I have the read the information sheet relating to the above research study and have been given a copy to keep. 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. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

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 a child or any other individual. Only the researcher involved in the study will have access to identifying data. It has been explained to me what will happen once the research study has been completed. I understand that the audio recording of my interview will be deleted by the end of summer 2016, and an anonymised transcript will be kept in a password protected document for 2 years.

I understand that participating in this research will have no impact on any current or future service at First Steps. Details shared within the interview will not be shared with First Steps staff.

I hereby freely and fully 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.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Homerton University Hospital NHS
NHS Foundation Trust

UEL University of East London

Researcher's Name (BLOCK CAPITALS)

.....

Researcher's Signature

.....

Date: .....

Appendix C: Resources for local support

Where to go for help

Local support

- Ezer Leyoldos – support to children and families in the Orthodox community: 020 8 880 2488

- Bikur Cholim – provides psychological help and support to young people, adults, carers and families who are experiencing emotional difficulties in their everyday wellbeing: 02088025032

- Jami - Mental health support for the Jewish community: 020 8201 8074/ 020 8458 2223

- Talking matters, tots 2 teens - counselling for children aged 5-15: 020 8802 9222

- Norwood – support for children, families and people with learning disabilities: 020 8809 8809

- Jewish care – support for a variety of problems: 020 8922 2000, or 020 8922 2222

- Jewish Women's Aid – help for women in abusive relationships: 020 8445 8060 or 0800 591 203

- Talking matters wellbeing centre – support for adults experiencing stress: 020 8802 9222

- Yad Voetzer – family support service, provides emotional and moral support 020 8809 2828

Other sources of support:

- First Steps – early intervention children's service accepting self referrals: 0207 683 4611

- Hackney Learning Trust –parent advice service in regards to children's education: 020 8820 7519

- The Samaritans – confidential telephone support for those experiencing low mood or suicidal thoughts: 116 123.

- Domestic Violence helpline - 0808 2000 247

- Hackney & City mind – mental health support: 020 8525 2301

Appendix D: Interview Schedule

Verbal explanation of confidentiality, review information sheet. Reminder of length of interview and focus of interview.

The Stamford Hill community and faith

- To start off, could you tell me a little bit about the local community?
- How would you describe your faith? Do you feel as though you are a part of the Orthodox Jewish community? What about the term Charedi, does that fit with how you would describe yourself? What does it mean to you?

Help-seeking

- Parents who attend services like First Steps often have a worry about their child. When did you first become worried about your child?
- Who did you first turn to for advice?
  (Follow up questions; Did you speak to family members about the problem; what did they suggest? Did you seek advice from trusted community members; what did they suggest? Do you have a rabbi – was this someone you spoke to?)
- What was it like trying to find help for the problem? Did you look for help within the Jewish community? What (if any) support did you seek prior to your referral to CAMHS?
  (Follow up questions; How was your experience of this support? What was helpful/unhelpful?)
- What led you to consider seeking help from a statutory/NHS service rather than from within the Jewish community?
  (Follow up questions; Was there any concern about seeking help within the community for this particular difficulty?)
- Where did you first hear about CAMHS/First Steps?

Worries and expectations

- What were your expectations about coming to CAMHS – if any?
  Did you have initial concerns or worries about seeking help from CAMHS?
  (Follow up question; To what extent did these worries delay you seeking help?)

- Were you worried about having a non Orthodox-Jewish therapist? If so, what was most concerning?
  (Follow up questions: What was it like to work with a non-Orthodox therapist? Were there any advantages of seeing a non-Orthodox therapist? Were there any disadvantages of seeing a non-Orthodox therapist?)
- How did you find the experience of seeking help from CAMHS?
  (Follow up questions: What was helpful/unhelpful? What did your child make of the help? What did other family members make of the help?)
- Was your experience of seeking help from CAMHS different from experiences of seeking help from other statutory/NHS services? If so, how?

Other questions:

Are you aware friends/family/acquaintances having similar problems? What did they do? Is this something that you have discussed? How did you hear about this?

Debriefing:
Anything else you would like to say? Any questions for me? Anything you would like to ask?

Details of support agencies.

Appendix E: University of East London Ethical Approval

NOTICE OF ETHICS REVIEW DECISION

For research involving human participants
BSc/MSc/MA/Professional Doctorates in Clinical, Counselling and Educational Psychology

SUPERVISOR: Paula Magee **REVIEWER:** Joy Coogan

STUDENT: Gemma Rowland

Title of proposed study: How do parents within the Charedei Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?

Course: Professional Doctorate in Clinical Psychology

DECISION *(Delete as necessary)***:**

***APPROVED, BUT MINOR CONDITIONS ARE REQUIRED BEFORE THE RESEARCH COMMENCES**

APPROVED: Ethics approval for the above named research study has been granted from the date of approval (see end of this notice) to the date it is submitted for assessment/examination.

APPROVED, BUT MINOR AMENDMENTS ARE REQUIRED BEFORE THE RESEARCH COMMENCES (see Minor Amendments box below)**:** In this circumstance, re-submission of an ethics application is not required but the student must confirm with their supervisor that all minor amendments have been made before the research commences. Students are to do this by filling in the confirmation box below when all amendments have been attended to and emailing a copy of this decision notice to her/his supervisor for their records. The supervisor will then forward the student's confirmation to the School for its records.

NOT APPROVED, MAJOR AMENDMENTS AND RE-SUBMISSION REQUIRED (see Major Amendments box below)**:** In this circumstance, a revised ethics application must be submitted and approved before any research takes place. The revised application will be reviewed by the same reviewer. If in doubt, students should ask their supervisor for support in revising their ethics application.

Minor amendments required *(for reviewer)*:

The submission date has passed, so they cannot complete their work by then, please amend. The researcher should only go to the participants home as a last resort, and must

ensure they carry out the said procedure of letting someone know where they are and when they leave. Please note the typo in the consent form, it should read 'I have read the information' not I have the read the information'

Major amendments required *(for reviewer):*

Confirmation of making the above minor amendments *(for students)*:

I have noted and made all the required minor amendments, as stated above, before starting my research and collecting data.

Student's name *(Typed name to act as signature): Gemma Rowland*
Student number: u1331812

Date: 5.5.15

ASSESSMENT OF RISK TO RESEACHER *(for reviewer)*

If the proposed research could expose the researcher to any of kind of emotional, physical or health and safety hazard? Please rate the degree of risk:

- [ ] HIGH
- [ ] MEDIUM
- [x] LOW

Reviewer comments in relation to researcher risk (if any):

Reviewer *(Typed name to act as signature)*:

Date:

This reviewer has assessed the ethics application for the named research study on behalf of the School of Psychology Research Ethics Committee (moderator of School ethics approvals)

Appendix F: Letter to NHS ethics outlining amendments

UNIVERSITY OF EAST LONDON
School of Psychology
Stratford Campus
Water Lane
London E15 4LZ

John Richardson
NRES Committee London - Camberwell St Giles
Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

08.08.15

Dear Mr Richardson,

Study Title: **How do parents within the Charedei Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?**

REC reference: **15/LO/1171**

IRAS project ID: **174080**

I am writing in response to your provisional outcome letter in regards to the above project. You requested that I consider the below points.

Input and consultation from community members and/or community leaders.

You suggested that the project would benefit from the input of community members or leaders, but agreed this could take place at my discretion. I have now discussed the PIS, consent form and interview schedule with three members of the Stamford Hill Orthodox Jewish community. The documents have been amended accordingly. The members of the community are parents and/or grandparents, and are familiar with First Steps (CAMHS recruitment site). I plan to discuss these further with other members of the Orthodox community prior to interviews commencing. I also plan to conduct a pilot interview and will review the questions again with this participant.

Amendments to the Patient Information Sheet (PIS) and consent form.

You requested that I clarify issues of safeguarding/confidentiality within the PIS. You also requested that the length of time the audio recordings will be kept should be

highlighted on both the PIS and consent form. The PIS and consent forms have now been amended accordingly.

As suggested, I have reviewed the HRA style and content guide and amended the structure, style and content of the PIS. The PIS now clearly states the potential benefits and risks of participating in the study.

I will verbally discuss the PIS with each participant to ensure they understand all possible risks related to participating. They will be given opportunity to ask any questions they wish. I have highlighted in the PIS that participation is voluntary and regardless of whether they decide to participate or not, there will be no repercussions.

Risk to relationship between parents and children

The committee was concerned about the potential risk of discussing children in their absence. As I highlighted to the committee, and as is clear on the interview schedule, the focus of the discussion is on the parental experience of accessing the service. This is because in CAMHS, parents are typically the 'gateway to care' (Schnitzer et al, 2011). However, I agree that it is possible that should children be aware of their parents participation in the research, they may still be worried or anxious about the outcome of discussions. This could impact on their relationship with their parent, particularly should they strongly feel they do not wish their parent to participate.

I have amended the PIS to highlight that it is possible children could be concerned about this. In my initial conversations with parents where we discuss the PIS I will highlight that this could be an issue. I will ask parents whether they are planning to discuss their participation with their child/whether their child is aware of the project. If parents plan to disclose their participation to their child, or if their child is aware, I will discuss with the parent ways to talk about it with their child that may minimise any potential anxiety. I am in the process of creating a document that highlights suggested ways of talking about the study and reassuring their children about the content of the discussion should they have any concerns.

As we agreed, it would not be appropriate for me to meet with the children or young people due to the nature of the research project.

I hope this letter and the accompanying amended documents resolve your queries.

Kind regards,

Gemma Rowland
Trainee Clinical Psychologist/Chief Investigator

Appendix G: NHS ethical approval

NHS
Health Research Authority
NRES Committee London - Camberwell St Giles
Level 3, Block B
Whitefriars
Lewins Mead
Bristol
BS1 2NT

Telephone: 0117 342 1391

21 August 2015

Ms Gemma Rowland
103 High Street
Northwood
HA6 1ED

Dear Ms Rowland

Study title:	**How do parents within the Charedei Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?**
REC reference:	**15/LO/1171**
Protocol number:	**N/A**
IRAS project ID:	**174080**

Thank you for your letter of 17th August 2015, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details. Publication will be no earlier than three months from the date of this favourable opinion letter. The expectation is that this information will be published for all studies that receive an ethical opinion but should you wish to provide a substitute contact point, wish to make a request to defer, or require further information, please contact the REC Manager, Tina Cavaliere, nrescommittee.london-camberwellstgiles@nhs.net. Under very limited circumstances (e.g. for student research which has received an unfavourable opinion), it may be possible to grant an exemption to the publication of the study.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database. This should be before the first participant is recruited but no later than 6 weeks after recruitment of the first participant.

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g. when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non-clinical trials this is not currently mandatory.

If a sponsor wishes to request a deferral for study registration within the required timeframe, they should contact hra.studyregistration@nhs.net. The expectation is that all clinical trials will be registered, however, in exceptional circumstances non registration may be permissible with prior agreement from NRES. Guidance on where to register is provided on the HRA website.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see

"Conditions of the favourable opinion" below).

Non-NHS sites

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	*Version*	*Date*
Interview schedules or topic guides for participants [Example interview schedule]	1	06 April 2015
IRAS Checklist XML [Checklist_18062015]		18 June 2015
IRAS Checklist XML [Checklist_13082015]		13 August 2015
IRAS Checklist XML [Checklist_17082015]		17 August 2015
Other [Response to REC provisional opinion]	1	13 August 2015
Participant consent form [Consent form]	3	20 July 2015
Participant consent form [Tracked changes consent form]	3	20 July 2015
Participant information sheet (PIS) [Participant Information Sheet]	3	20 July 2015
Participant information sheet (PIS) [Tracked changed PIS]	3	20 July 2015
REC Application Form [REC_Form_15062015]		15 June 2015
Referee's report or other scientific critique report [Assessment feedback RE research proposal]	1	26 February 2015
Research protocol or project proposal [Research proposal]	1	18 November 2014
Summary CV for Chief Investigator (CI) [CV for CI]	1	06 April 2015
Summary CV for supervisor (student research) [Supervisor CV]	1	20 April 2015

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The HRA website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

User Feedback

The Health Research Authority is continually striving to provide a high quality service to all applicants and sponsors. You are invited to give your view of the service you have received and the application procedure. If you wish to make your views known please use the feedback form available on the HRA website:
http://www.hra.nhs.uk/about-the-hra/governance/quality-assurance/

HRA Training

We are pleased to welcome researchers and R&D staff at our training days – see details at http://www.hra.nhs.uk/hra-training/

15/LO/1171	Please quote this number on all correspondence

With the Committee's best wishes for the success of this project.

Yours sincerely

Pp

Mr John Richardson
Chair

Email:nrescommittee.london-camberwellstgiles@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: *Professor Neville Punchard*
Roger Griffith, Homerton University Hospital NHS Foundation Trust

Appendix H: Research & Development approval

Homerton University Hospital NHS
NHS Foundation Trust

Research & Development
Chair: Dr Claire Gorman

Christine Mitchell-Inwang
Research & Development Manager
Christine.Inwang@homerton.nhs.uk

Homerton University Hospital
Research and Development
Yellow Roof Top Office
Homerton Row
London
E9 6SR

Tel: 020 8510 5134
Fax: 020 8510 7850
www.homerton.nhs.uk

Dr Beth Hill
Clinical Psychologist
Homerton University Hospital NHS Foundation Trust
Homerton Row
London E9 6SR

15th October 2015

Dear Dr Hill,

Re: How do parents within the Charedei Orthodox Jewish community experience accessing a community Child and Adolescent mental health service?

R&D No: 1542

Thank you for sending all the relevant documents for Homerton University Hospital Trust Research and Development Approval of the above research study. As part of the Research and Development approval process we have conducted a site specific assessment for this study. I am happy to inform you that the Trust has approved the conduct of the study and that the Trust will indemnify against negligent harm that might occur during the course of this project.

The following main document/s has been received by R&D department as part of the approval process;

Protocol Version 1.0	Dated: 03/09/2015
Participant Information Sheet Version 3	Dated: 20/07/2015
Consent Form Version 2	Dated: 15/06/2015

All other document/s you have sent in as part of the process has also been received.

I would like to draw your attention to the following conditions of the approval of this research project with which you must comply. **Failure to do so may result in the Trust withdrawing R&D approval which allows you to conduct this research project at Homerton University Hospital NHS Foundation Trust.**

Untoward events - Should any untoward event occur it is **essential** that you complete a clinical incident form and write on the form '**R&D**'. Contact the R&D Office immediately and if patients or staff are involved in an incident you must also contact the Risk Manager on 020 8510 7649.

Status of Research - Inform us if your project is amended or if your project terminates early/requires an extension as well as informing the Research Ethics Committee. This is necessary to ensure that your indemnity cover is valid and also helps the office to maintain

up-to-date records. A copy of any publications arising from the research should be sent to the R&D Office for use in the R&D Annual Report. Please be reminded that this hospital should be acknowledged in any publication.

Research Information - You will be required to complete a project update as required by the R&D Office to ensure that we have up to date information so that we can send accurate reports to the DoH and research networks. The project update form will be emailed or sent to you by the R&D Office.

Research Governance - As part of research governance, all investigators accessing identifiable personal information are required to comply with current data protection requirements.

Intellectual Property - If you believe that protectable intellectual property may arise from your research, please contact the Christine Mitchell-Inwang, R&D Manager on ext 5134 who will advise you on the proper course of action.

Monitoring of Studies – You must comply with the Trust's legal responsibility as host of this research project to monitor and audit the research to ensure that the Research Governance Framework and Good Clinical Practice (GCP) if applicable is being adhered too. Monitoring questionnaires will be sent to you and random audit visits will also take place across the trust and will be conducted following at least a seven day notice period. **Failure to respond to any of these monitoring or auditing requests may result in the Trust withdrawing your R&D approval to conduct this research at Homerton University Hospital NHS Foundation Trust.**

Please note that all NHS and social care research is subject to the DoH *Research Governance Framework.* If you are unfamiliar with the standards contained in this document, you may obtain details from the Trust R&D Office or from the DoH website (www.dh.gov.uk).

Please do not hesitate to contact Christine Mitchell-Inwang, Research and Development Manager or me if you have any further questions.

Yours sincerely,

Dr Claire Gorman
Director Research & Development

Appendix I: UEL confirmation of change of title

SCHOOL OF PSYCHOLOGY
uel.ac.uk/psychology
Acting Dean: Professor Rachel Mulvey, BA MA DCG PhD FICG FHEA

UEL
University of East London

Date: 05/02/2016

Student number: u1331812

Dear Gemma,

Notification of a Change of Thesis Title:

I am pleased to inform you that the School Research Degree Sub-Committee has approved the change of thesis title. Both the old and new thesis titles are set out below:

Old thesis title: How do parents within the Chareidi Orthodox Jewish Community experience accessing a community Child and Adolescent mental health service?

New thesis title: How do parents within the Orthodox Jewish Community experience accessing a community Child and Adolescent mental health service?

Your registration period remains unchanged. Please contact me if you have any further queries with regards to this matter.

Yours sincerely,

Dr Kenneth Gannon
School Research Degrees Leader
Direct line: 020 8223 4576
Email: k.n.gannon@uel.ac.uk

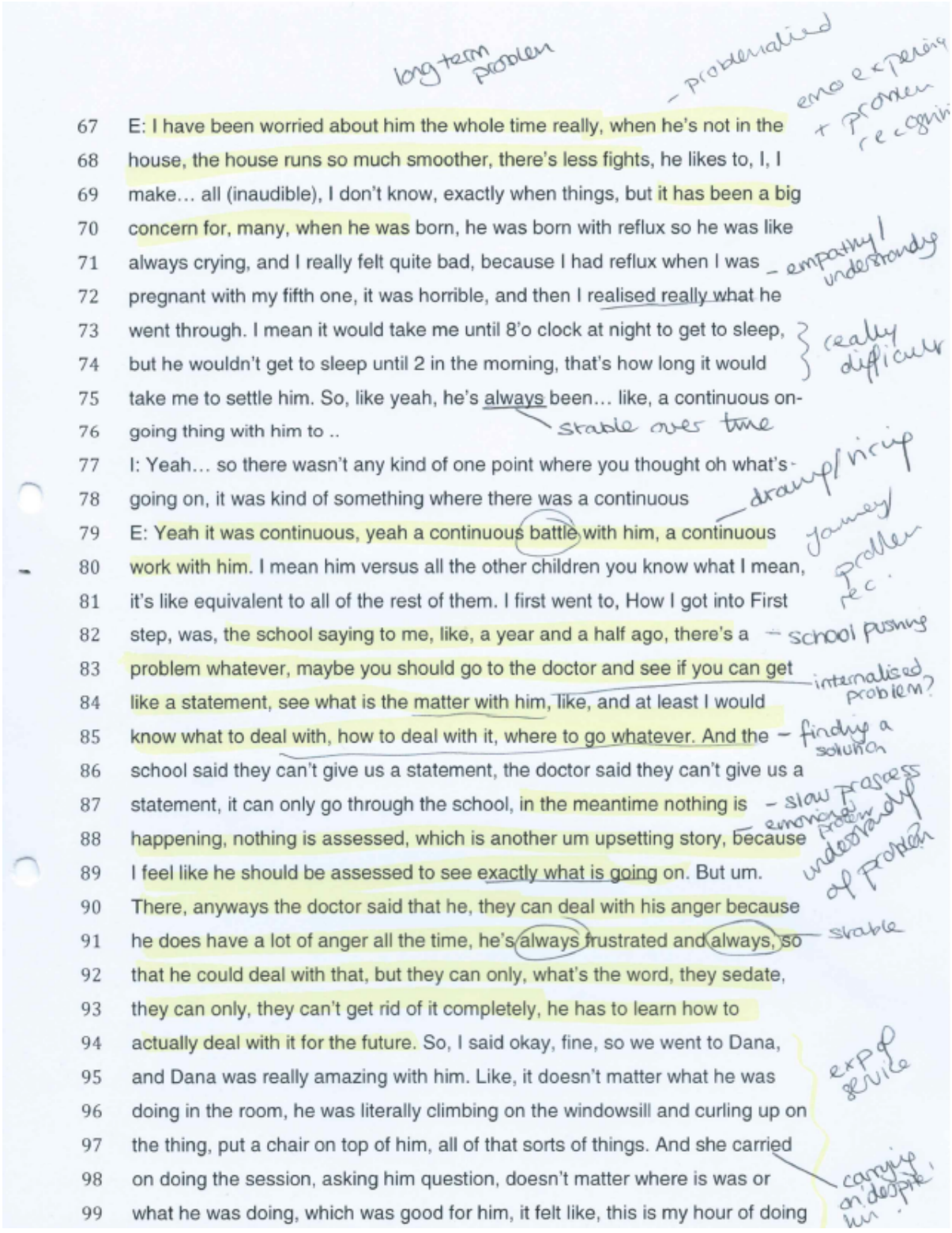
Stratford Campus, Water Lane, Stratford, London E15 4LZ
Tel: +44 (0)20 8223 4561
Email: m.r.mulvey@uel.ac.uk

Appendix J: Experiences influencing pathways to help

Name	Personal experiences	How they heard about First Steps
Rebecca	Sought help for herself regarding abusive relationship	Community organisation recommended a referral
Sarah	Worked in a school	Colleague recommended a referral
Elizabeth	Sought help for herself regarding bereavement	GP referred
Rachel	Not disclosed	GP referred
Karin	Family friend is a child therapist. Knowledge of the NHS.	GP referred
Miriam	Not disclosed	Sister accessed First Steps and recommended it
Gideon	Family friend is a child therapist. Knowledge of the NHS.	GP referred
Solomon	*Information excluded as potentially identifiable*	GP referred
Hannah	Worked in a school	Colleague recommended a self-referral to First Steps.

Note: Information that could identify participants has been excluded.

Appendix K: Worked extract example



67 E: I have been worried about him the whole time really, when he's not in the
68 house, the house runs so much smoother, there's less fights, he likes to, I, I
69 make… all (inaudible), I don't know, exactly when things, but it has been a big
70 concern for, many, when he was born, he was born with reflux so he was like
71 always crying, and I really felt quite bad, because I had reflux when I was
72 pregnant with my fifth one, it was horrible, and then I realised really what he
73 went through. I mean it would take me until 8'o clock at night to get to sleep,
74 but he wouldn't get to sleep until 2 in the morning, that's how long it would
75 take me to settle him. So, like yeah, he's always been… like, a continuous on-
76 going thing with him to ..
77 I: Yeah… so there wasn't any kind of one point where you thought oh what's-
78 going on, it was kind of something where there was a continuous
79 E: Yeah it was continuous, yeah a continuous battle with him, a continuous
80 work with him. I mean him versus all the other children you know what I mean,
81 it's like equivalent to all of the rest of them. I first went to, How I got into First
82 step, was, the school saying to me, like, a year and a half ago, there's a
83 problem whatever, maybe you should go to the doctor and see if you can get
84 like a statement, see what is the matter with him, like, and at least I would
85 know what to deal with, how to deal with it, where to go whatever. And the
86 school said they can't give us a statement, the doctor said they can't give us a
87 statement, it can only go through the school, in the meantime nothing is
88 happening, nothing is assessed, which is another um upsetting story, because
89 I feel like he should be assessed to see exactly what is going on. But um.
90 There, anyways the doctor said that he, they can deal with his anger because
91 he does have a lot of anger all the time, he's always frustrated and always, so
92 that he could deal with that, but they can only, what's the word, they sedate,
93 they can only, they can't get rid of it completely, he has to learn how to
94 actually deal with it for the future. So, I said okay, fine, so we went to Dana,
95 and Dana was really amazing with him. Like, it doesn't matter what he was
96 doing in the room, he was literally climbing on the windowsill and curling up on
97 the thing, put a chair on top of him, all of that sorts of things. And she carried
98 on doing the session, asking him question, doesn't matter where is was or
99 what he was doing, which was good for him, it felt like, this is my hour of doing

Appendix L: Coding manual

1. The Orthodox Jewish community is not a homogenous group
2. The Stamford Hill community is close minded
3. The Orthodox Jewish community wary of outsiders/professionals
4. The Orthodox Jewish community is insular
5. The Orthodox Jewish community is religious
6. The Orthodox Jewish community are judgemental
7. It's a close knit community
8. The Orthodox Jewish community is supportive
9. The Orthodox Jewish community is unique
10. The Orthodox Jewish community is like a small village
11. Everybody knows about everybody
12. It's hard to hide things in the community
13. Doing something the community disagree with has serious consequences
14. It's a religious life
15. It is hard to be accepted in the community
16. Jewish rules impact on day to day life
17. The Jewish life is an on-take
18. Mothers are under a lot of stress because of family size
19. Judaism takes a toll on you
20. Large families make it hard to focus on one child
21. Rabbi's offer spiritual guidance rather than practical/emotional
22. There is a culture clash
23. People are apprehensive about secular ideas
24. Outsiders seen as critical
25. Being an outsider in the community is very hard
26. There is a difference in the way insiders and outsiders see things
27. Not knowing where to get help
28. There are no mental health services for children in the community
29. You can go to the GP for support
30. School would know where to direct for help
31. People prefer 'natural' remedies as these are less likely to result in labelling as seems less severe
32. Not knowing that the GP can help with emotional health
33. Not knowing that there are services
34. Seeing the GP as for physical needs
35. There needs to be more awareness about services
36. There is help available in the community
37. If you are a professional it doesn't matter what religion you are
38. As long as the information is confidential it doesn't matter who you speak to

39. Better to have a non-Orthodox Jewish therapist
40. If you have an Orthodox Jewish therapist you might hold things back
41. Non Jewish therapists have different ideas
42. Non Jewish therapist may take a wider perspective
43. Non Jewish Therapist may not fully understand the culture
44. You don't need to be Jewish to understand the way of life
45. A Jewish therapist would have a pre-set idea
46. It's better to have a Jewish therapist
47. A Jewish therapist would understand the culture
48. Orthodox Jewish therapists in the community are not properly trained
49. Orthodox Jewish therapists in the community are not confidential
50. Easier to trust a non Orthodox Jewish therapist
51. Seeing a Orthodox Jewish therapist may mean you would be less open
52. Easier to talk to non Orthodox Jewish therapist
53. Some parents would feel safer with a Orthodox Jewish therapist
54. People may worry they won't be understood by non Orthodox Jewish therapist
55. People may worry that a non Jewish therapist won't understand the culture
56. A non-Jewish therapist might impose incompatible ideas
57. A non-Jewish therapist might try to convert the child
58. There is a conflict between secular and Charedi views on child-rearing
59. There may be a conflict between the secular therapy and Charedi culture: this makes it harder to get help
60. Worry about therapist criticising Jewish practice
61. Therapist may be a bad influence on the child
62. Having a qualification means you are trustworthy
63. Parents may worry about being judged or criticised by outsiders
64. Therapist seen as potentially invasive
65. Parents personal experiences made it easier to find help
66. Parents personal network as a source of support
67. Family can only offer so much advice
68. Parent having support helps them to find help/negates stigma
69. Parents own experience impacts on their understanding of the problem
70. Not knowing how to communicate with the child
71. Not knowing how to help
72. Feeling lost
73. Feeling stressed/worried
74. Feeling responsible to help the child
75. Need inner strength to get through the experience
76. Not having a network to talk to is isolating
77. The problem affects the whole family
78. Hiding help-seeking is stressful
79. Trying to protect the child from being labelled/problematised
80. Worry about the child's future

81. Therapist as culturally competent
82. Therapist can help to make sense of a problem
83. Therapist can help identify what the problem is
84. Therapist means you are not alone/have someone on your side
85. Experience of being listened to and understood by therapist was powerful
86. Having support had a profound emotional effect
87. The intervention transformative
88. Therapy opens up communication
89. Therapy is a journey
90. Seeing a therapist was calming
91. Seeing a therapist helps to ‘let it out’
92. Seeing a therapist was empowering
93. Could see a change as a result of therapy
94. Getting help changed the understanding of the problem
95. Getting help gave more insight into my child’s needs
96. Increased understanding changed the interactions between parent and child
97. Space to think about your children is helpful
98. Talking helps people
99. Idea that ‘opening up’ will help
100. Getting help as a process
101. Therapy helps you learn to manage
102. Therapy will mean future life is easier
103. You need to treat the underlying problem
104. You need to change the way you think to get better
105. Talking is better than taking medicine
106. Therapy gives you the tools that you need to move forward
107. Talking therapy is not enough
108. Needed a concrete solution
109. Thought the work would be more with the child
110. Talking therapy is not for everyone
111. Worry about having to face up to the impact of your parenting
112. Seeking help as possibly exposing your failings as a parent
113. Worrying about own ability as a parent to know how to help your child
114. If people know they might judge you/criticise you/ blame you
115. Help-seeking may result in labelling
116. Therapist may be invasive/critical
117. Long term problem
118. The child’s problem is stressful
119. The child’s problem has repercussions for the parent
120. The child’s problems have a significant effect on the family
121. Coping with child’s problem is a struggle
122. The child behaves that way for the sake of it
123. The child behaves that way because they want attention

124. There is a right and a wrong way of raising children
125. Children need specific things to help them
126. The child has an inherent genetic/characteristic trait
127. The problem as being separate to the personality
128. Problem as internal to the child
129. The problem might be speech or behaviour
130. View that children will ‘grow out of it’ and this stops help-seeking
131. Comparing your child with others to understand
132. Categorising children to know how to manage them
133. It’s hard to identify a problem
134. Mental health difficulties are not something that needs to be hidden
135. Mental health difficulties are not a choice
136. Seeking help as logical/practical
137. It’s better to seek help early
138. The child’s needs are more important than stigma/views of others
139. Childhood affects the whole of someone’s life
140. Help for children must be prioritised
141. Emotional health is as important as physical health
142. It’s important to nip problems in the bud so they don’t grow/ Addressing problems early stops them from growing
143. Needing help is not the same as having a mental health problem
144. Everyone has issues
145. There shouldn’t be stigma
146. Mental health difficulty is seen as something that doesn’t go away
147. Mental health difficulty seen as stable, on-going and internal
148. There is a life long impact of untreated mental health difficulty
149. Mental health difficulty impacts on the whole family not just the individual
150. Stigma is silencing
151. Mental health would not be discussed
152. There is stigma in every culture but perhaps more so in the Jewish community
153. People would keep quiet about seeking help
154. People wouldn’t seek help due to stigma
155. Some people will go to extreme lengths to hide their child’s difficulties
156. Mental health is seen as different from physical health
157. Mental health sounds severe
158. CAMHS sounds scary and more severe
159. Mental health problem suggests something is intrinsically wrong with you
160. Mental health difficulty as something that can be overcome
161. Needing psychological/emotional support as shameful (suggests a weakness)
162. A problem would have to be very serious for people to get help
163. Rabbi’s have some influence on how therapy is viewed

164. Mental health problems can be a vicious cycle in families
165. It's harder to acknowledge an emotional/behavioural problem than a physical problem
166. People would prefer to try natural remedies rather than meds/therapy as seen less labelling
167. People don't think about context they just see the label
168. Labels are permanent and effect everything
169. Being labelled has serious consequences
170. Being labelled can stop you finding a match
171. Fear of labelling prevents help-seeking
172. Seeing a therapist would mean you were labelled
173. Not talking openly as a way of protecting oneself and ones child from stigma, shame and judgement
174. There is a danger people will give up on trying to change if they are labelled
People would worry about seeking help because of the impact on future marriage prospects
175. Marriage is very important
176. Marriage & having children is the aim of Jewish life
177. Marriage and match-making is thought about from when children are young
178. Lack of marriage is tragic
179. Lack of marriage is symptomatic of something being wrong
180. It is a parent's goal to find their child a match
181. People would avoid a match with someone with mental health difficulties
182. Seeking psychological help may impact on finding a match
183. People marry young
184. People know about each other's past
185. May be harder to seek help for older children where finding a match is closer
186. There is more awareness about mental health issues
187. There is more awareness about SEN
188. There are more SEN services
189. People are more likely to get SEN services than in the past
190. Attitudes and practices are changing in the Orthodox Jewish community
191. There needs to be more awareness in the community
192. Attitudes change at a slower rate in the Orthodox Jewish community
193. Support for CYP is more available than in the past
194. In the past people couldn't get help because mental health wasn't talked about
195. The US culture of seeking therapy may impact on attitudes

Appendix M: Coded extract example

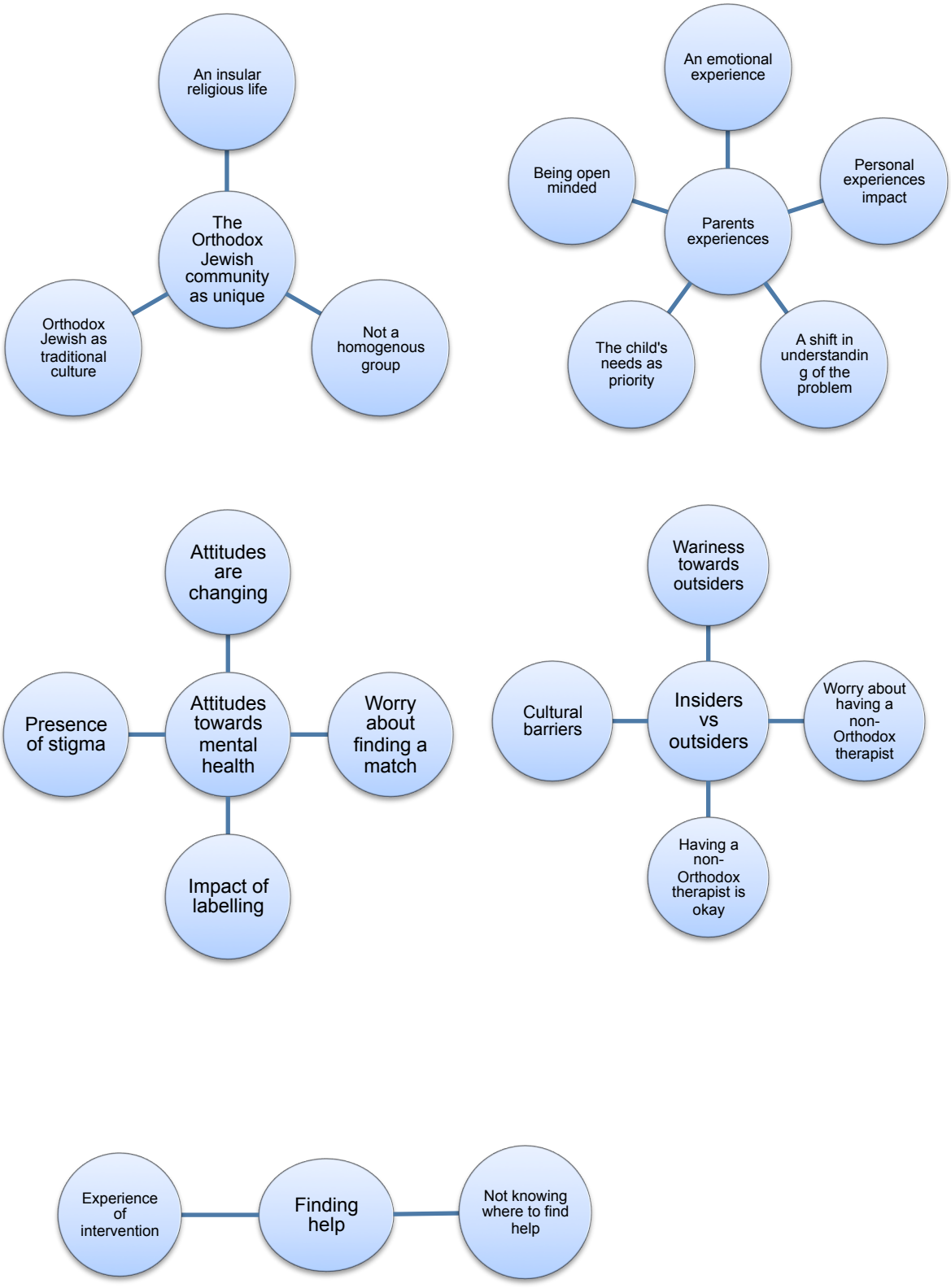
Code number	Initial code	Participant number & line number	Quote
3	The Orthodox Jewish community wary of outsiders	2, 203	They don't like anyone from outside coming in to them…
		2, 607	Maybe they're afraid of you telling them something wrong about the way that they are living their life, the way they believe or… because if you come in, with a trousers, to a Jewish frum Charedi house, it's not acceptable for a woman to wear trousers, so it's, you're going to give bad influence to my kids, wearing that in my house.
		6, 294	You know there's such a clash between what the therapist would tell you and what you would find in Charedi schools. You know it's all very top down it's, it's, you know... there would, the two sort of standpoints, you know they stand from diametrically opposing kind of viewpoints, vantage points unto the world and onto the child's place in the world that, you know, lots of people believe actually quite vehemently that it's wrong to seek out sort of er therapists…
		6, 402	There is a civilisation sort of clash of of cultures thing, but for me that wasn't an issue. But for other people it might be …
		8, 167	Some people might be a bit wary of like taking such services from outside. They might feel that they're not understood or um you know they might think people from outside wouldn't be attuned to our culture and our sensitivities.

4	The Orthodox Jewish community is insular	1, 64-65	I don't know, that's just kind of the aetiology here, I'm not sure why. People like to stick to themselves to their own community to their own help.
		2, 11-12	And they're very close minded community. And they're not necessarily will go to professional people from outside unless they have to.
		2, 64-66	Yeah, it is closed community. They look at you different. Lets say if your skirt is not long enough, like they believe it should be, so. You not including, you not together with them, and they look at you different…
		4, 11-12	It's quite a close knit community…
		5	Whereas in this community, and we live so close to each other, people know, it's the same building, same, people see other things, and it gets repeated and you sort of see it and you sort of know it...
		6, 6-8	It's um an area that is quite I would say quite insular to be honest erm. Most of the services erm that are happening in town are done within the community…
		6, 11-14	So it's, it's quite insular the whole community. In general it's like any other community I should imagine more like of a smaller village type if you like because er it's a small village within a village within a town…

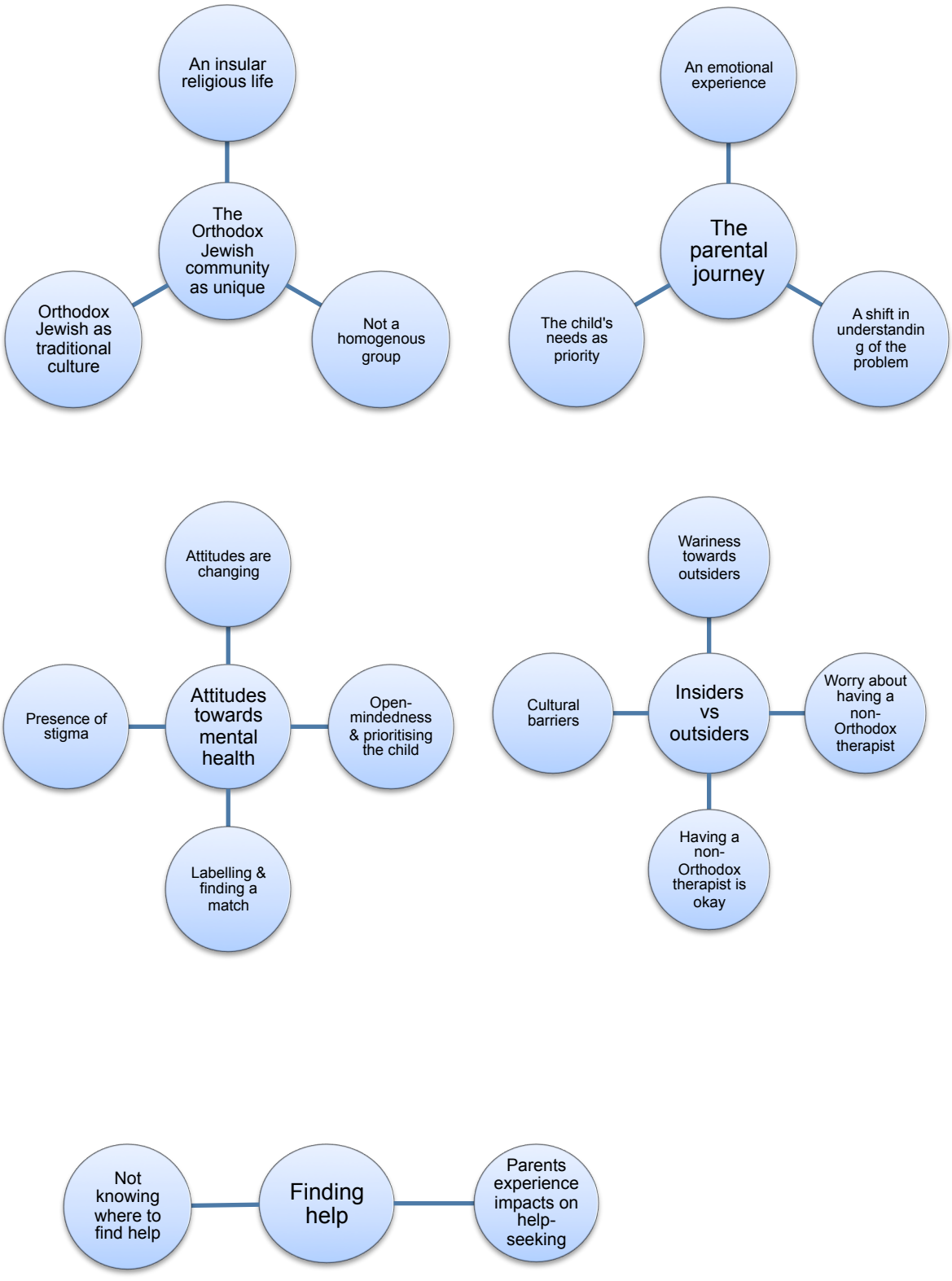
Appendix N: Initial themes

1. The community – Theme describes the community being religious, insular and made up of different groups.
2. Jewish life – Theme describes the impact of tradition/ observance on day to day life
3. Inside vs outside – Theme describes the juncture between being within the community and wariness towards outsiders
4. Finding services – Theme describes differences in knowledge about accessing services and preferences for particular treatments.
5. Parent's personal experiences – The emotional experience of parents and how this impacts on their help-seeking.
6. Experience of intervention – Theme describes the parents experience of the therapist and the internal impact of the intervention
7. Worries about help-seeking
8. The problem – The understanding of the problem
9. Parent's views on help-seeking/mental health – Parents feel that help for children and young people should be prioritised and that seeking help is necessary.
10. Mental health and stigma in the Orthodox Jewish community – Theme outlines the different ideas about mental health held within the wider community
11. Labelling – Theme outlines worries about labelling and its link to stigma and help-seeking
12. Finding a match – Theme describes the importance of marriage and how worries about finding a match may impact on help-seeking/disclosure
13. Jewish vs non-Jewish therapist- Theme outlines different ideas about the religion/belief of therapist
14. Changes in attitudes towards mental health – Theme outlines the way in which attitudes towards mental health have changed.

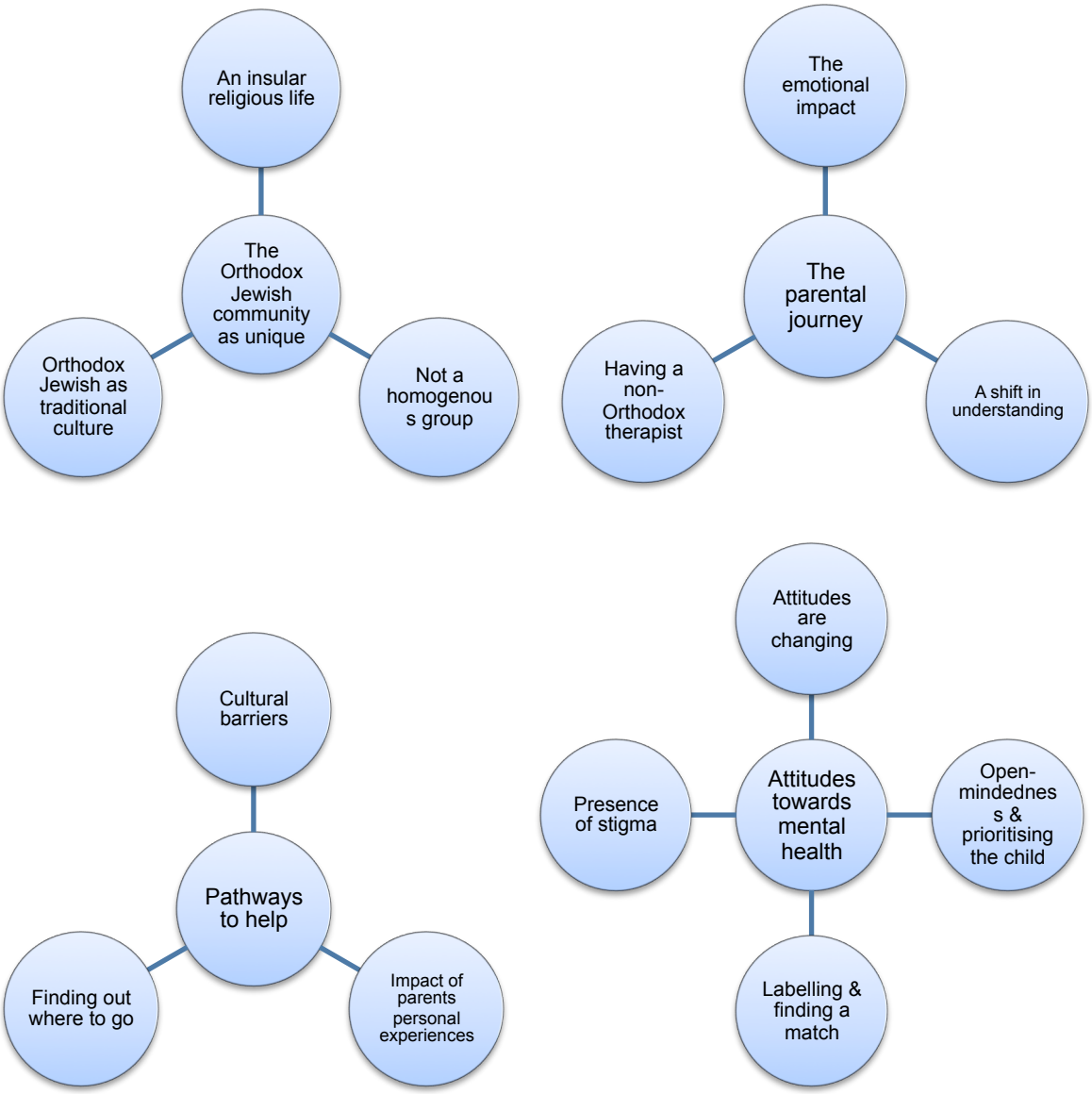
Appendix O: Initial mind-map exploring themes



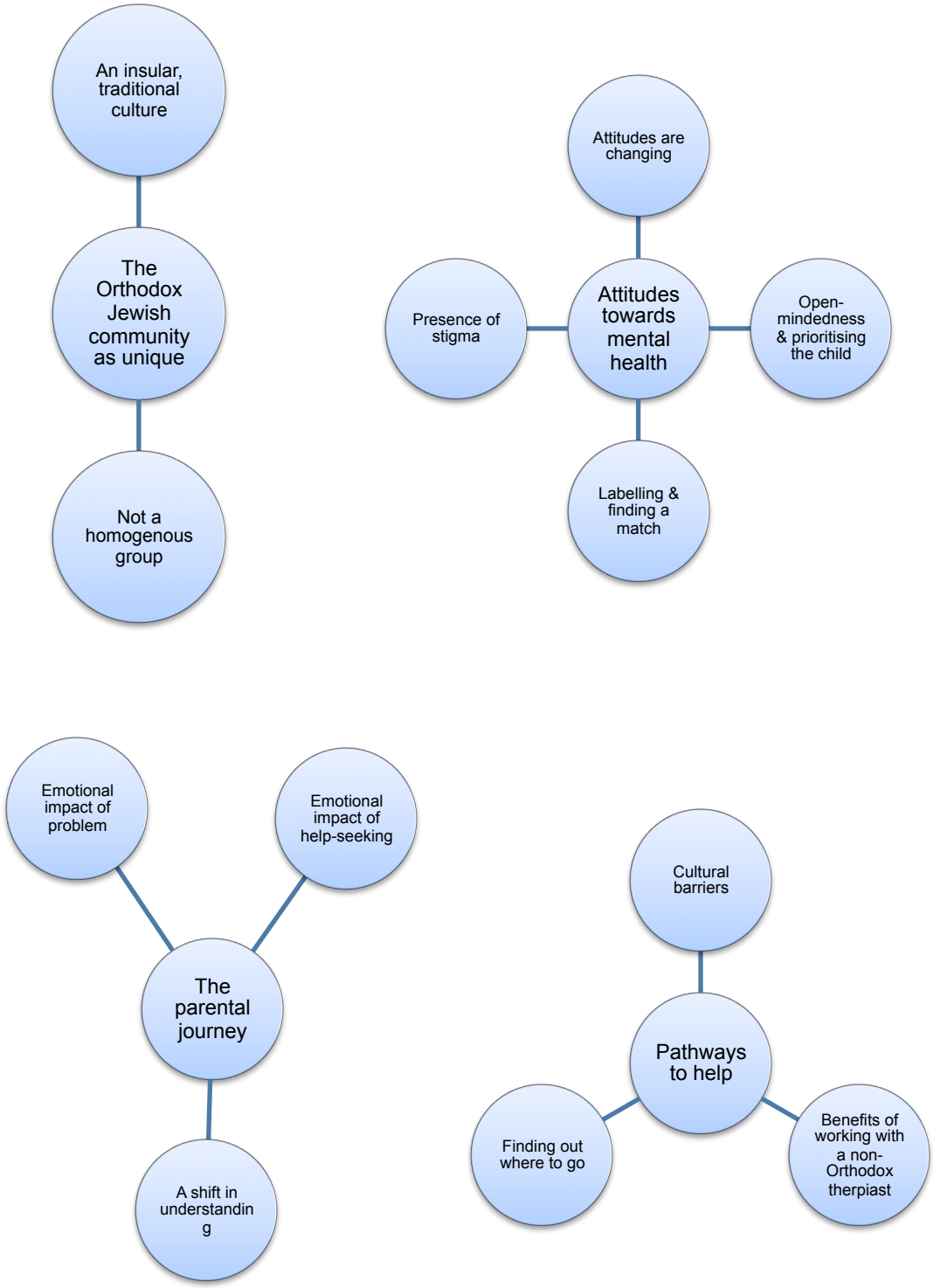
Appendix P: Mind-map of revised themes 1



Appendix Q: Mind map of revised themes 2



Appendix R: Final thematic mind map



Appendix S: Reflective diary extracts

17th November 2015: Extract of reflective diary entry after interview with Rebecca.

I wonder how much my initial reading has affected my ideas and positioning, and know I will need to make some changes to the interview schedule – it feels like I have made some basic assumptions. Though maybe this is less to do with reading, but more to do with my own context/ my history with the Jewish community. My knowledge of what it means to be Orthodox is almost certainly coloured by the friendships and social relationships I have had with people who would probably identify as Modern Orthodox. I wonder whether I could have done more to make her feel more at ease; I felt she was anxious and maybe this is why she didn't talk as much as I would have expected. I wondered whether she felt pressured into taking part? I think I need to do more checking out in my next interview.

30th January 2016: Extract of reflective diary entry

I've been thinking about how hard it has been to access parents who are willing to take part, and then if they do take part how hard it is to invite engagement and encourage conversation to flow. Do they feel an obligation to take part; they may see this as helping the service that helped them? Is it a lack of engagement/making comfortable on my part? I wonder if this research is reaching the families who need to be reached. I feel that those who experience the most stigma and the most barriers are the ones that would benefit most from this research, but it's a vicious cycle as I imagine cultural barriers would prevent them from accessing the service. I wonder if I had recruited differently whether I would have been able to access a wider variety of individuals? Also I have been thinking that of the parents I've spoken to, those who have had help themselves seem to be thinking slightly differently about the topic, maybe a bit more reflective? I was thinking about own relationship with Judaism/identity as Jewish. In some ways it's disconcerting that I am so very obviously an 'outsider'- I had wondered whether I would be asked about my own religion/background but I think my perceived lack of knowledge/lack of knowledge is almost self-explanatory for the people I've spoken to so far.

16th February 2016: Extract of reflections after interview with Solomon

I wonder how much of what Solomon spoke about regarding the widespread selective mutism in boys is his interpretation of the situation. If this is a widespread issue I wonder if it relates to the corporal punishment that Gideon spoke about? It would make sense that boys would be very quiet at school if they are worried about being punished for speaking out of turn. It would be interesting to find out from clinicians whether this is something they have recognized, or whether it really is just the way in which Solomon is making sense of the situation. Solomon spoke a lot about special needs and the way in which attitudes have changed regarding this. I wonder whether this is because children with the needs he described might be more likely to have appeared different in terms of their behaviour or appearance, and maybe there is less to lose when seeking help for a child who is already visibly different? I also wonder whether the increased provision for children with additional needs has in turn influenced the way in which they are viewed – if there are services for their difficulties perhaps this goes some way to normalise their difficulties? This sort of fits with what other parents have said about increased awareness of mental health and how that may be partly related to the increased provision for these difficulties.