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Stigma of mental illness, religious change, and explanatory models of mental illness among Jewish patients at a mental-health clinic in North Jerusalem

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Abstract
During 3 months in 2004, 38 recent referrals to a Community Mental Health Clinic in North Jerusalem, a substantially Ultra-Orthodox Jewish neighborhood, were evaluated by the Explanatory Model Interview Catalogue. This questionnaire, which includes a 13-item scale measuring stigma towards mental illness, was adapted and translated into Hebrew. Patients with a more religious upbringing expressed a greater sense of stigma towards mental illness; however, patients who now had a more religious affiliation did not. The 14 patients who had experienced a religious change toward a more religious affiliation reported a lower level of stigma than the 24 non-returnees. Even when controlling for religious upbringing, the partial correlation between stigma score and religious change was significant. Stigma was lower among younger but not older returnees. Findings from this study support the hypothesis that a stigma of mental illness may be a deterrent to the use of a public mental-health clinic for religious Jews in Israel. Ultra-Orthodox Jewish patients (especially non-Hasidic) used a nonreligious explanatory model (perception and understanding) of mental illness more often than a religious explanatory model. This last finding could reflect a shift in the Ultra-Orthodox Jewish communities from a religious to a more medical and psychological explanatory model.
Background

A stigmatized person is seen through the lens of a derogatory stereotype, as a member of a prejudiced group, instead of being seen as an individual with their own personal qualities. People with mental illness have a long history of being stigmatized and considered as “alien,” as estranged “others.” Early psychiatrists were called “alienists,” from the French *aliénè* (insane), from the Latin *alienatus* (estranged).

The implications of stigma are numerous. On a social level, stigmatized persons are blamed, rejected, and ostracized as “others” of lower social status. They may suffer from discrimination with regard to employment, housing, health benefits, and marriage. Stigma could also be attached to the relatives of a stigmatized person. Goffman (1963) referred to the stigmatization that applies to the family of a person with mental illness as “courtesy stigma.” On a personal level, stigma is internalized as a “spoiled identity,” according to Goffman, with a central feeling of shame of being inferior, different, discredited, and ostracized. This in turn could lead to withdrawal, reduced self-esteem and depression, creating a vicious circle of stigmatization and further isolation. Corrigan and Kleinlein (2005) reviewed the literature supporting the observation that many people choose not to pursue mental-health services because of stigma of mental illness. However, while reviewing the overwhelmingly negative consequences of stigma, Weiss and Ramakrishna (2001) remarked that

not all stigma is equally bad, and that some forms of stigma in proper measure may even serve a useful social function. Efforts to avoid stigma may motivate moral and ethical behavior; for some it may prevent suicide or substance abuse, and may motivate self-help and appropriate help seeking.

Different methods have been used for analyzing stigma: laboratory experiments, surveys, ethnography, first-person narratives and linguistic analysis (Link, Yang, Phelan, & Collins, 2004; Rasinski, Viechnicki, & O’Muircheartaigh, 2005). Corrigan and Calabrese (2005) reviewed several scales used in surveys to measure self-stigma: the Devaluation-Discrimination Scale includes 12 items to assess internalized stigma and rejection; the Stigma-Withdrawal Scale assesses the extent of withdrawal as a way to avoid rejection; the Measure of Self-Stigma in Mental illness (MSSMI) addresses stereotype awareness and explores whether the respondent agrees with the stereotype. Ritsher and Phelan (2004) used the Internalized Stigma of Mental Illness scale, which measures alienation, stereotype endorsement, discrimination experience, social withdrawal, and stigma resistance, to conclude that the aspect of internalized stigma most closely related to poor psychological outcome is alienation. Weiss, Jadhav, Raguram, Vounatsou and Littlewood (2001) advocated the use of a culturally specific stigma scale instead of a fixed scale in different settings.

Religion and culture influence the way a person may be labeled and stigmatized. For example, in China the cultural belief that mental illness is a result of the sins of ancestors leads to the stigmatization of the mentally ill person and his siblings. The institution of arranged marriage, in itself, perpetuates
the emphasis on the status of an entire family in evaluating the suitability of its members for marriage. An association between the institution of arranged marriages and stigma of mental illness has been reported in China (Kleinman, 1988b, p. 160), and with stigma of leprosy in India (Weiss et al., 1992).

Kleinman (1980, pp. 105–106; 1988a, p. 155) recommended that patients’ explanatory models of illness should be elicited using a “mini-ethnographic” approach by asking a few questions of the patients, in order to better understand their subjective experience of illness, promote collaboration and improve clinical outcomes and patient satisfaction (Bhui & Bhugra, 2002). In Kleinman’s footsteps, Pelto and Pelto (1997) advocated a similar “focused” ethnography, and Weiss et al. (2001) combined stigma and explanatory models queries into one semi-structured and locally adapted questionnaire, called the Explanatory Model Interview Catalogue (EMIC), which uses both qualitative and quantitative methods. Stigmatizing explanatory models of mental illness (for example, thinking that illness is related to sin), could be contributing to the stigma of mental illness, as could social and political factors.

In Jerusalem, as elsewhere in Israel, the Jewish population is composed of multiple subcultures according to their country and community of origin, and according to their level of religious observance. Three main Jewish ethnic groups are Ashkenazim (descendents of Yiddish-speaking European Jews), Sephardim (descendents of Spanish and Portuguese or North African Jews), and Oriental Jews (descendents of Jews from the Middle East and Central Asia). The level of religious observance among the Jewish patients in the catchment area of northern Jerusalem ranges from secular, Reform, and traditional, through Orthodox, to non-Hasidic and Hasidic Ultra-Orthodox. Hasidic Jews belong to a movement of Jewish mystics founded in Poland by Rabbi Israel Baal Shem Tov (1700–1760). For more details about those different ethnic and religious groups, see Greenberg and Witztum (2001, pp. 21–25 and 163).

Among Ultra-Orthodox Jews, and especially among the Hasidic Ultra-Orthodox, the lineage of a person is an important component of the social status (it even has a special term in Hebrew, yikhus, and Yiddish, yikhes). Although there have been no quantitative comparisons of stigma of mental illness in different Jewish religious affiliations, mentally ill persons have been reported to be highly stigmatized among Ultra-Orthodox Jews (Greenberg & Witztum, 2001, p. 228), resulting in a low social status. A low social status has a negative impact on arranged marriages which are the norm in Ultra-Orthodox society, as parents seek another family of the same or higher status when arranging a marriage. The opinion of the family plays a great role in the close-knit Ultra-Orthodox communities, which is known to be especially susceptible to courtesy stigma (Heilman & Witztum, 2000). In addition, it has been noted that the Ultra-Orthodox underutilize a public mental-health clinic, while newly religious Jews tend to utilize it relatively more often (Greenberg & Witztum, 2001, pp. 155–157 and 228). Greenberg and Witztum suggested that Ultra-Orthodox Jews underutilize the clinic because of its stigmatization of mental illness.
This study will ask the following questions: Is there a difference in the self report of stigma of mental illness according to the different Jewish religious affiliations, and/or according to other demographic characteristics? What is the impact of change from one religious affiliation to another on the experience of stigma of mental illness? Is there an association between different levels of reported stigma and the use of mental-health services? This study will also explore the religious and nonreligious explanatory models among the Ultra-Orthodox patients in our sample.

**Sample characteristics**

Thirty-eight recent referrals to the Herzog Hospital Community Mental Health Clinic in northern Jerusalem were interviewed. The respondents were newly assigned patients, 17.5–65 years old, evaluated or treated by one psychiatrist in the clinic during a 3-month period in 2004. Twenty-four patients were interviewed during their first visit to the clinic, and 14 patients were interviewed within the first 3 months of their first evaluation. These two groups were combined, since they did not differ significantly in stigma of mental illness. Patients were included in the sample only if they saw themselves as Jewish, by their own definition.

The patients were not assigned for this study in a random fashion, but represent a naturalistic example of a psychiatrist’s caseload in this clinic. This sample represents patients who were more likely to be in need of medications or a medical certificate than patients referred to other clinicians (psychologists and social workers). The catchment area of the clinic covers the north of Jerusalem where Ultra-Orthodox Jews constitute more than 50% of the community (Shilhav & Friedman, 1985). The patient population in the clinic is not exclusively Ultra-Orthodox but includes the full range of religious Jewish affiliations and some non-Jews.

Referrals were classified along a spectrum of religious Jewish affiliations, from secular, Reform, and traditional, through Orthodox, to non-Hasidic Ultra-Orthodox and Hasidic. The former in this continuum were labeled as less traditional and the latter as more traditional. The patients who described other religious styles were labeled as “other” in the categorical variable. Besides current religious affiliation, patients who experienced a religious change toward a more traditional religious affiliation were called “returnees” to Judaism, in Hebrew baalei teshuva (Aviad, 1983). See Tables I and II for the demographic details of the sample.

Probably reflecting the low percentage of Ultra-Orthodox women in our sample, we did not find a significant correlation between gender and the highest level of education. The older patients achieved a significantly higher level of education ($r = 0.412$, $N = 37$, $p = 0.011$).
### Table I. Gender, religious change, ethnicity, and current religious affiliation (number of patients) ($N=38$).

<table>
<thead>
<tr>
<th>Gender</th>
<th>Religious change</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Returnee</td>
</tr>
<tr>
<td>M/F</td>
<td></td>
</tr>
<tr>
<td>Total number of patients</td>
<td>24</td>
</tr>
<tr>
<td>Current religious affiliation (categorical)</td>
<td></td>
</tr>
<tr>
<td>Ultra-Orthodox</td>
<td>Hasidic</td>
</tr>
<tr>
<td>Orthodox</td>
<td>6</td>
</tr>
<tr>
<td>Orthodox</td>
<td>9</td>
</tr>
<tr>
<td>Orthodox</td>
<td>3</td>
</tr>
<tr>
<td>Orthodox</td>
<td>6</td>
</tr>
<tr>
<td>Ethnic background (one case missing)</td>
<td></td>
</tr>
<tr>
<td>Ashkenazi</td>
<td>13</td>
</tr>
<tr>
<td>Sephardic (Spain/ North Africa)</td>
<td>6</td>
</tr>
<tr>
<td>Sephardic (Spain/ North Africa)</td>
<td>4</td>
</tr>
<tr>
<td>Sephardic (Spain/ North Africa)</td>
<td>1</td>
</tr>
<tr>
<td>Religious change</td>
<td></td>
</tr>
<tr>
<td>Returnee</td>
<td>9</td>
</tr>
<tr>
<td>Non-returnee</td>
<td>15</td>
</tr>
</tbody>
</table>

*aThis category is not included in the tests of significance.
*Difference is significant: Fisher’s exact test, $p = 0.020$.
**Difference is significant: Fisher’s exact test, $p = 0.034$.

### Table II. Demographic characteristics ($N=38$).

<table>
<thead>
<tr>
<th>M/SD (age), percentage (other variables)</th>
<th>Entire sample</th>
<th>Returnee</th>
<th>Non-returnee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age* (range: 17.5–65)</td>
<td>32.8</td>
<td>33.4</td>
<td>32.5</td>
</tr>
<tr>
<td>SD</td>
<td>12.3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Marital status</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Married</td>
<td>45%</td>
<td>75%** (9/12)</td>
<td>36%** (8/22)</td>
</tr>
<tr>
<td>Never married</td>
<td>45</td>
<td>25%</td>
<td>64%</td>
</tr>
<tr>
<td>Widowed, divorced</td>
<td>11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupation</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional, or unskilled worker</td>
<td>16</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Student (full time or working part time)</td>
<td>34</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability, unemployed, retired, housewife</td>
<td>50</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Highest education religious or secular</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School, up to or through 12th grade</td>
<td>42</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Education beyond 12th grade</td>
<td>58</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Notes: The sum of the percentage for each item may not equal 100% due to rounded numbers.
*There were no significant differences between the mean age of men (32.2) and women (33.7), or between the mean age of returnees and non-returnees.
**Difference is not significant: Fisher’s exact test, $p = 0.071$ (4 patients who were widowed or divorced were excluded).
Methodology

Subjects were asked to complete a semi-structured questionnaire during the course of a first psychiatric evaluation or a follow-up visit. All 38 patients meeting the inclusion criteria (Jews 17.5–65 years old) agreed to complete the questionnaire. The questionnaire also included the following areas: personal identification, age, gender, marital status, number of children, religious affiliation, place of birth, country of origin, age of immigration to Israel, duration of mental-health problems, duration of care, type of care, diagnosis, past treatment, and medications.

Diagnosis of the 38 patients was based on the assessment of the questionnaire interview and, if available, summaries of previous treatments. The diagnosis was made by an experienced psychiatrist, applying a primary and eventually a secondary diagnosis, according to the DSM-IV (American Psychiatric Association, 1994). The distinction between primary and secondary diagnosis was made according to the severity of the diagnosis and its relevance to the main presenting problem at the time of the interview.

The semi-structured questionnaire included a Hebrew version of the “EMIC Interview for outpatient psychiatry and stigma” by Raguram and Weiss (1997) adapted for our population. The EMIC Interview is composed of queries about social and demographic information, clinical history, and perceived causes (explanatory models) of mental illness, stigma of mental illness, and past help-seeking behavior.

Stigma scale

The 13 stigma-related queries were the same as those used by Raguram and Weiss (1997) (see Table III). These 13 items were relevant in studying the stigma of mental illness according to our knowledge of the patient population of our clinic, including Ultra-Orthodox Jews. As proposed by Weiss et al. (2001), “Items for assessments of stigma were initially regarded as tentative and subsequently validated with reference to internal consistency and coverage of relevant issues.”

For this validation purpose, Cronbach’s alpha was calculated for the stigma scale. This statistic is based on the average correlation of items, a value of 1 indicating perfect inter-correlation and a value of 0 indicating as much negative as positive correlation. We used an approach previously developed for analysis of indicator of stigma (Raguram, Weiss, Channabasavanna, & Devins, 1996; Weiss et al., 2001). Items 5 and 7 of the 13 individual items of the scale were deleted from the scale, since they had an item-to-total correlation below the cutoff of 0.2 suggested by Weiss et al. (2001). We found that the stigma scale with the 13 items had good internal consistency reliability (Cronbach’s alpha = 0.725), and Cronbach’s alpha increased to 0.75 after deletion of the two items.

Each of the stigma-related queries was scored on a 4-point scale (yes = 3, possibly = 2, uncertain = 1, no = 0). For each patient, a stigma score was calculated by adding the score of each of the items from the stigma scale (excluding items 5 and 7), giving an equal weight to each item.
(Weiss et al., 2001). The individual total stigma score could range between 0 (no stigma of mental illness reported) to a theoretical maximum of 33 (maximum score for the 11 remaining questions of the scale).

**Explanatory model questionnaire**

Patients were also asked to give their opinions about the cause of their problem. They could choose as many causes as they wished. For analysis, we grouped the responses into religious and nonreligious explanatory models. The religious list included the following culturally sensitive explanatory models: “gilgul/dibbuk (spirit of dead person), Messiah figure, mazikim (evil forces), cabalists,” as well as religious explanations not specifically Jewish “bad deeds, God’s will, evil eye, demons/Satan, angels.” The nonreligious list was taken from Raguram and Weiss (1997) (see Table IV). Other culturally sensitive questions were asked: “What is the place of God in your life? Who do you turn to first at times of distress? Do you turn to your Rabbi? Your therapist? Do you have a Rabbi you trust for halakhic (legal religious) decisions or spiritual guidance?”

**Variables measuring different religious affiliations**

The variables describing religious affiliation (current or upbringing) were coded from a categorical variable into a continuous variable, in order to

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**Table III. Stigma scale: Percentage of responses and mean score for each of the 13 items of the stigma scale.**

<table>
<thead>
<tr>
<th>Items</th>
<th>Percentage of responses</th>
<th>Mean per item score</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. If possible, would you prefer to keep people from knowing about this problem?</td>
<td>2.5</td>
<td></td>
</tr>
<tr>
<td>2. Do you think less of yourself because of this problem?</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>3. Have you ever been made to feel shamed or embarrassed because of your problem?</td>
<td>1.6</td>
<td></td>
</tr>
<tr>
<td>4. If they knew about it, would your neighbors, colleagues, or others in your community think less of you because of this problem?</td>
<td>1.2</td>
<td></td>
</tr>
<tr>
<td>5. Might contact with you have any bad effects on others around you?</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>6. Do you feel others have avoided you because of your problem?</td>
<td>0.9</td>
<td></td>
</tr>
<tr>
<td>7. Would some people refuse to visit your home because of this condition?</td>
<td>0.3</td>
<td></td>
</tr>
<tr>
<td>8. If they knew about it, would your neighbors, colleagues, or others in your community think less of the family because of this problem?</td>
<td>0.8</td>
<td></td>
</tr>
<tr>
<td>9. If others were to find out about your problem, might it cause any problems for your family?</td>
<td>1.0</td>
<td></td>
</tr>
<tr>
<td>10. Would your family prefer to keep others from finding out about your condition?</td>
<td>1.7</td>
<td></td>
</tr>
<tr>
<td>11. If unmarried: If people knew about it, might this problem make it more difficult to marry? If married: Suppose you were not married. If people knew about this problem, would it be more difficult to get married?</td>
<td>2.0</td>
<td></td>
</tr>
<tr>
<td>12. If unmarried: If you were married, might this condition cause problems in your marriage? If married: Might this condition cause problems in your marriage?</td>
<td>2.2</td>
<td></td>
</tr>
<tr>
<td>13. Could this problem make it more difficult for someone in your family to marry?</td>
<td>0.7</td>
<td></td>
</tr>
</tbody>
</table>
distinguish patients belonging to a less traditional society, less close-knit, and more open to the influence of the secular world, from patients belonging to a more traditional society, more close-knit, and less open to the secular world. The variable ranged from secular, Reform, and traditional, through Orthodox, to non-Hasidic Ultra-Orthodox and Hasidic. Unless otherwise specified, “current religious affiliation” and “religious upbringing” will refer to the continuous variables only.

“Distance of return” measures the extent of religious change experienced by patients when they departed from their previous religious affiliation and reached their current religious affiliation. A returnee with the largest distance of return would be somebody who changed from secular to Hasidic. Someone with a small distance would have changed, for example, from Orthodox to non-Hasidic Ultra-Orthodox.

### Results

#### Stigma score

See Table III for the mean stigma score for each of the 13 items of the stigma scale. For the following analyses only the total stigma score will be used, and not the item scores. Association between stigma, traditional religious upbringing and current religious affiliation: Patients with a more religious upbringing reported a significantly higher level of stigma \( (r = 0.362, p = 0.042) \). However, there was no association between current religious affiliation and stigma \( (r = 0.063, p = 0.732) \).

Unless otherwise specified, the subsequent statistical analysis will include only \( N = 32 \) subjects with none of the Table V variables missing.

If we excluded the two patients who currently describe themselves as secular, we still found that patients with a more religious upbringing reported a significantly higher level of stigma \( (r = 0.394, N = 30, p = 0.031) \).
The patients who experienced a religious change toward a more religious affiliation reported a lower level of stigma than the patients who did not experience religious change (non-returnees) ($r = -0.444$, $N = 35$, $p = 0.008$).

When the extent of religious change was quantified, instead of being dichotomized, a significant negative correlation was found between the distance of return and the stigma score ($r = -0.366$, $N = 32$, $p = 0.039$), meaning that a wider religious change was associated with a lower stigma of mental illness. That this quantification does not enhance the simple dichotomy is confirmed by a weaker correlation than for religious change.

We did not find significant associations in regard to stigma when we analyzed the correlations between the stigma score, and gender, marital status, ethnic background, highest level of religious education, highest level of secular education, socio-economic status, having children, Israeli born vs. immigrant, age of immigration to Israel, or a diagnosis of psychosis.

Although stigma score and religious change were correlated, religious upbringing was significantly correlated with both (religious change: $r = -0.540$, $p = 0.001$; stigma score: $r = 0.362$, $p = 0.042$). This negative correlation between religious change and religious upbringing means that patients with a less religious upbringing were more likely to become returnees than patients with a more traditional upbringing. Intuitively, it is easy to understand that, for example, patients who were born Ultra-Orthodox were less likely to become returnees than patients who were born secular. It could have been possible that the association between religious change and stigma score was a consequence of both being related to religious upbringing. When controlling for religious upbringing, the partial correlation between stigma score and religious change was reduced.

### Table V. Correlation between stigma score, religious change, distance of return, religious upbringing, and religious affiliation.

<table>
<thead>
<tr>
<th></th>
<th>Stigma score</th>
<th>Religious change</th>
<th>Distance of return</th>
<th>Religious upbringing (continuous)</th>
<th>Current religious affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stigma score</td>
<td>$r$</td>
<td>$p$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious change</td>
<td>$r = -0.444$</td>
<td>$p = 0.011^*$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distance of return</td>
<td>$r = -0.366$</td>
<td>$p = 0.039^*$</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Religious upbringing (continuous)</td>
<td>$r = 0.362$</td>
<td>$p = 0.042^*$</td>
<td>$r = -0.540$</td>
<td>$r = -0.629$</td>
<td>$r = 0.495$</td>
</tr>
<tr>
<td>Current religious affiliation</td>
<td>$r = 0.063$</td>
<td>$p = 0.732$</td>
<td>$r = 0.116$</td>
<td>$r = 0.289$</td>
<td>$r = 0.004^{**}$</td>
</tr>
</tbody>
</table>

Notes: Includes only $N = 32$ subjects with no variable missing.  
*Correlation significant at the 0.05 level (two-tailed).  
**Correlation significant at the 0.01 level (two-tailed).
slightly but was still statistically significant (partial $r = 0.404$, $df = 29$, $p = 0.024$). Therefore, returnees reported less stigma, even after controlling for their religious upbringing.

**Stigma of mental illness according to age**

The correlation between age and stigma score was not significant ($r = 0.283$, $N = 34$, $p = 0.105$). We tested the interaction of age with religious change, in regard to stigma, to see whether there was a different age effect between returnees and non-returnees. Stepwise regression analysis indicated a significant interaction ($F = 4.642$; $df = 1, 28$; $p = 0.040$), with younger returnees having less stigma than older returnees. The older returnees were similar to non-returnees, whose stigma did not differ by age.

**Diagnosis according to religious change**

A wide range of psychopathology is represented in our sample. See Table VI for the primary diagnoses according to the DSM-IV (American Psychiatric Association, 1994). Substance abuse (3 patients), alcohol abuse (2 patients), and PTSD (1 patient) were among the secondary diagnoses at the time of the administration of the questionnaire.

In our sample of patients with severe psychopathology (since they were referred specifically to a psychiatrist), we found that returnees were diagnosed less often, although non-significantly, with psychosis (3/14 = 21%) than non-returnees (8/24 = 33%). There was a similar association for patients with affective disorder: the returnees were diagnosed less often, also non-significantly, with affective disorder (3/14 = 21%) than non-returnees (7/24 = 29%).

**Religious and nonreligious explanatory models among Ultra and non Ultra-Orthodox patients**

It is noticeable that no patient reported the following culturally sensitive religious explanatory models we included in our questionnaire: “evil eye; demons/Satan;
gilgul/dibbuk (spirit of dead person); messiah figure; mazikim (evil forces); cabalists.” The two main religious explanations given were “God’s Will” and “sins/bad deeds.”

A surprisingly small number of Ultra-Orthodox patients (4/18: 22%) used a religious explanatory model for their problem. However, there was a large disparity between the Hasidic and non-Hasidic Ultra-Orthodox patients. Among these patients, we found that Hasidic patients (3/6 = 50%) reported religious explanations for their problem, not significantly but nevertheless at trend level (i.e., 0.05 < p < 0.1), more often than non-Hasidic Ultra-Orthodox patients (1/12 = 8%) (Fisher’s exact test, p = 0.083).

We found a widespread use of nonreligious explanatory models even among the Ultra-Orthodox patients. Among the 18 Ultra-Orthodox patients, one gave both a religious and a nonreligious explanation, 11 gave only a nonreligious explanation, 3 gave only a religious explanation, and 3 gave none. McNemar’s Test was used to determine whether there was a significant difference between the 11 patients who used only a nonreligious explanation, and the 3 patients who used only a religious explanation. This was not significant but at trend level (p = 0.057) using the binomial distribution. Thus, Ultra-Orthodox patients (especially non-Hasidic) seemed to be using a nonreligious explanatory model more often than a religious explanatory model.

Discussion

Study-design limitations

The design had several limitations, in particular: sample size, selection bias, open design, and the use of a single unblinded rater. Since the sample size was small, an effort was made to transform categorical questionnaire items into continuous scales or dichotomized categories. In particular, because of the low number of currently secular subjects, it would have been impossible to compare secular and religious patients other than by using the religious affiliation “continuous variable” described earlier. We were also able to draw statistically significant conclusions despite the small subgroups of our sample (younger vs. older returnees, older returnees vs. older non-returnees). However, our study would benefit from being duplicated by using larger samples, in order to confirm those results about stigma and age.

Stigma and religious affiliation

A more religious upbringing was associated with a higher level of reported stigma of mental illness. This is consistent with previous reports of higher stigma of mental illness among Ultra-Orthodox Jews (Greenberg & Witztum, 2001). However, in our study, religious upbringing appeared to be a better predictor of the level of stigma than current religious affiliation.

There is a significant correlation between religious upbringing and current religious affiliation (r = 0.495, p = 0.004). This strong correlation is not difficult
to understand, since people are more likely to maintain the religious affiliation of their upbringing. Because of the strong correlation between those two variables, we would expect that their effect on the stigma score would be similar. Thus, the difference in correlations with the stigma score is surprising. In order to test if the difference in correlations is significant, we must take into account the stigma score variable appearing in both correlations (Hendrickson & Collins, 1970; Hendrickson, Stanley, & Hills, 1970). The difference between correlations was almost significant ($z = 1.75$, $p = 0.080$), implying that religious upbringing is somewhat more strongly associated with stigma score than current religious affiliation. It seems therefore important for the clinician to be aware of the religious upbringing when exploring the stigma of mental illness.

**Stigma and religious change**

Returnees reported less stigma. The effect of stigma of mental illness on a potential marriage may have concerned them less as they already bear the stigma of being a returnee, and would be expected to be matched only with other returnees, or somebody else in the bottom of the social scale, like a mentally ill person. There is a well-documented stigma of being a returnee among the non-returnee religious Jews (Danzger, 1989, p. 307; Greenberg & Witztum, 2001, pp. 120–121 and 145).

In addition, the returnees may belong to a self-selected group of people less sensitive to rejection and to stigma in general. They have chosen to leave their community of origin despite the rejection they may experience from family and friends. They also have chosen to join and stay in a more traditional religious group, despite the experience of the stigma of being returnees. Furthermore, the returnees who choose to become Ultra-Orthodox choose to belong to a group stigmatized in the general Israeli society.

**Stigma and underutilization of public services**

The lower level of stigma of mental illness found among returnees in this study could explain Witztum, Greenberg and Dasberg’s (1990) observation that returnees were overrepresented in our clinic. Our findings support the hypothesis that stigma of mental illness is a deterrent to the use of public services in our clinic for non-returnees when compared to returnees. This implies the importance of reducing stigma, in order to increase the use of a public mental-health clinic and allow appropriate treatment.

Two previous studies of all clients entering this clinic found rates of returnees of 13% (71/561) (Witztum et al., 1990) and 14% (91/650) (Buchbinder, Bilu, & Witztum, 1997; Greenberg & Witztum, 2001, p 155). These rates were higher than the estimate by Witztum et al. (1990) of a maximum of 6% of returnees in the clinic catchment area. In our study, the rate of returnees was even higher (37%) for a particular service in the clinic, psychiatric consultation.

In explaining the higher rate of returnees use of a public clinic, Witztum et al. (1990) proposed that returnees had a higher rate of severe psychopathology than
non-returnees. This cannot be used to explain the remarkably high rate of returnees in our sample because, despite a relatively lower percentage of severe psychopathology among the returnees, the returnees were still overrepresented in our study.

**Influence of age on stigma of mental illness**

Younger returnees reported a lower stigma of mental illness than older returnees. Older returnees may have been exposed for a longer period of time to their new current religious affiliation. They may have had more time to internalize the cultural stereotypes of their new more traditional group. In addition, their social status may have risen over the years, and they may have more to lose than their younger counterparts (as they are married and have marriageable children). It could also be that stigma is less than it used to be in the non-Ultra-Orthodox communities, so the sample of older subjects is reflecting earlier attitudes.

**Religious and nonreligious explanatory models among Ultra-Orthodox patients**

Hasidic patients attributed their problem to a religious cause more often than non-Hasidic Ultra-Orthodox patients. This is consistent with the characterization of current religious affiliation as representing traditional values. The clinician therefore needs to be sensitive to the religious explanatory models of mental illness especially for the Hasidic patients, in order to better understand and treat them, and elicit a better relationship and compliance.

The surprisingly small percentage of religious explanatory models, especially among non-Hasidic Ultra-Orthodox patients, could reflect a recruitment bias. It is possible that people with a religious explanatory model would choose to consult a rabbi for help and refuse to come to the clinic.

This small percentage of religious explanatory models could also be explained by an interview bias. The Ultra-Orthodox patients who came to our mental-health clinic may have first discussed subjects in which they thought we, as non-Ultra-Orthodox Jewish clinicians, would be interested. They may have mentioned nonreligious explanatory models in order to show that they are aware of modern scientific knowledge, and to impress us about their openness to the world. Not mentioning a religious explanation may just mean that they wanted acceptance from us. In addition, patients may have seen the Mental Health Center as basically secular, and therefore left their religion outside. They may have thought we would think they were "mad" to talk of sins or *gilgul* (spirit of dead persons). The treatments offered at the clinic may be perceived as very "irreligious," and this could explain why they avoided mentioning religious explanatory models. The clinician therefore needs to be able to go beyond the nonreligious explanatory models of mental illness first expressed by the Ultra-Orthodox patient, and also be open to listening to the religious explanatory models.

It is also possible that there has been a real change over time in the Ultra-Orthodox communities away from an explanatory model of mental illness.
heavily based on religion. The non-Hasidic Ultra-Orthodox Jews may have been even more receptive to outside influence than the Hasidim. Schachter-Shalomi (1996, pp. 257–265) and Mark (2003) describe the perception of mental illness in early Hasidism, where religious explanatory models were prevalent. The Hasidim have a worldview imbued with religious concepts. The Jewish laws in general, and even more the Hasidic doctrines, give a religious significance to all the details of the spiritual but also the material life of the Hasidic Jew. We therefore understand why the early Hasidim used religious explanatory models extensively when trying to make sense of their psychological problems or of their mental or medical illness. The probable shift in the explanatory models observed in our sample, to a reduced ratio of religious vs. nonreligious explanations (only 3:3 among Hasidim, and 1:9 among non-Hasidic Ultra-Orthodox patients), may therefore reflect the later influence of the general secular culture on the religious world.

The usage of both religious and nonreligious explanations was highlighted by this respondent, Hasidic from birth, suffering from anxiety, who, when asked about the cause of his problem, answered (in Hebrew):

One could speak from two points of view: from the point of view of a religious Jew, or from the point of view of the world knowledge. From a point of view of a religious Jew, one needs to repair transgressions. From the point of view of the world knowledge, I have heredity. My brother also is sick. Maybe I do not have enough faith; because of this, this is happening.

By choosing the neutral expression da’at ha’olam (world knowledge) to describe the scientific point of view, he made it more acceptable for him, than if he had contrasted the “religious point of view” with a “secular point of view.” In doing so, he implied that both meanings could overlap without being mutually exclusive. In one sentence, he was able to allude to the cosmic Hasidic doctrine of the tikun (reparation) of impairments caused by transgressions¹ (Lamm, 1999, p. 227; Littlewood & Dein, 1995), and in the next sentence he alluded to genetics, showing that he was conversant with both worlds. His conclusion shifted back to the religious model.

Similarly, Dein and Sembhi (2001) found that biomedical and traditional models of illness are held concurrently by Asian psychiatric patients, however: “Although, in general, western medications helped a little, the patients believe that it did not get to the root of the problem and could never cure the problem in itself.” By returning to the religious model in his conclusion, the Hasidic patient quoted above illustrated the importance of this model for him. The clinician should be attuned to the complexity of the different coexisting explanatory models of mental illness expressed by a patient. The clinician should not assume that just because a medical explanatory model was expressed, it is the one the patient will ultimately use.

There could be a tension between the religious and the nonreligious explanatory models. In fact, we found that patients who give one kind of explanation are less likely to also give the other kind of explanation, suggesting that they may be mutually exclusive for most patients ($r = -0.455$, $p = 0.009$).
Stigma and explanatory models

Link, Mirotznik and Cullen (1991) stated that labeling and stigma are a “social problem” and not “individual troubles,” and suggested directly addressing cultural beliefs by changing the negative meaning that becoming a mental patient has for most people.

It would be worthwhile applying the above suggestion to the Ultra-Orthodox population. In order to decrease stigma of mental illness, religious traditions that present a less negative view of mental illness could be emphasized not only to the patient but also to the community at large. It may be in the power of rabbis, as religious leaders of their communities, to decrease communities’ stigmatization of mental illness, using relevant religious explanatory models.

For example, Rabbi Nahum of Chernobyl (1730–1787) used a nonstigmatizing view of mental illness when comforting and guiding his Hasidim suffering from depression. He used the concept that “the falling is for the sake of the rising”: It is sometimes necessary to go down spiritually, in order to look for the fallen Divine sparks, to elevate and redeem them back to their Divine source (for more illustrations of that concept of tikun, see Lamm, 1999, pp. 371–385). By giving a religious meaning to his struggle within depression, the Hasid is connected to his fellow Jews and to his Rabbi in their common goal toward tikun and redemption, instead of being treated as a stigmatized “other.” This is therefore an example of a culturally specific teaching, used here in pastoral counseling, which could reduce stigma. See Greenberg and Witztum (2001, pp. 241–249) for this and other examples.

Rabbi Nahum of Chernobyl’s explanatory model of depression as being sometimes necessary in order to perform tikun (repair) is more elaborate but uses the same concept of tikun as the Hasidic patient, suffering from anxiety, quoted above. Further studies with larger samples could determine if there is an association between a less stigmatizing view of mental illness, like that of Rabbi Nahum, and a lower level of stigma of mental illness.

Summary

Stigma of mental illness was positively associated with religious upbringing and negatively associated with religious change, but not associated with current religious affiliation. Furthermore, stigma was associated with religious change after controlling for religious upbringing. The association between stigma and religious change was present for younger returnees, but not older returnees. This study supports the hypothesis that stigma of mental illness may be a factor in the under-representation in a public mental-health clinic of Jewish religious non-returnees when compared to returnees.

Few Ultra-Orthodox patients had religious explanatory models, but most gave non-religious explanations. Although this may be due to the context of an interview with a clinician or a reflection of the selection of those who turn for help.
to a community mental-health center not run by Ultra-Orthodox staff, it may also reflect a generational change from previous Ultra-Orthodox traditions. One of the explanations for the difference in stigma between older and younger returnees is also generational change.

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Note

[1] “Letaken averot” (to repair transgressions). Letaken (to repair) has the same root in Hebrew than tikun (reparation). The patient addressed again his faith problem, when asked about the place of God in his life, and said “tsarikh letaken et ze” (one needs to repair this), using the same concept of tikun.

References


