Thesis

Beliefs about mental illness and attitudes towards seeking help: A study of British Jewry

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1. Abstract

Existing research and anecdotal accounts have consistently reported that Jewish people are positively inclined to seek treatment for mental health problems, including making use of psychiatric services and psychotherapy. However, much of this data has been based on samples of American Jewry and there appear to be no existing studies in the UK which have quantitatively investigated whether there are similar help seeking preferences for mental health problems amongst British Jewry. The present study investigated Jewish people's attitudes and intentions to seek professional help for mental health problems and their experiences of seeking professional help in the UK. Using the theoretical framework of the Theory of Reasoned Action (Fishbein and Ajzen, 1975; Ajzen & Fishbein, 1980) the study also aimed to determine the strongest predictors of intentions and attempts to seek professional help, according to people's attitudes, perceived social pressure, beliefs about the causes of mental illness and level of religiosity. The study included 126 Jewish people who were predominantly recruited from synagogues and community centres across the UK.

Results indicated that a high percentage of this sample would be willing to see a mental health professional if they experienced a mental health problem. According to multiple regression analysis, attitudes towards seeking professional help and stress-related causal beliefs most strongly predicted intention to seek professional help. Despite the sample being non-clinically recruited, 63% of participants reported that they had experienced a mental health problem and the majority of these individuals had sought professional help in the past. Path analysis revealed that actual attempts to seek professional help were directly influenced by intention to seek professional help, perceived social pressure and supernatural causal beliefs. Given the high prevalence of mental health problems and use of professional mental health services amongst this sample, clinical considerations highlighted the need for preventative mental health strategies and culturally sensitive mental health services for Jewish people. Limitations of the study include the use of an opportunity sample which was unable to recruit members of the Ultra-Orthodox Jewish community.

2. Introduction

Jewish people have been strongly associated in the literature concerning the history of psychiatry and psychotherapy, which has often suggested that they are over-represented both as practitioners and clients (Ball & Clare, 1990; Mishne, 2006). The relationship between Jewish people and the disciplines of psychiatry and psychotherapy is most evidently reflected in the early days of the psychoanalytic movement which was dominated by Jewish thinkers including Freud and Klein (Rube & Kibel, 2004). However, the relationship between Jewish people and mental illness has been an issue of debate for centuries, which has frequently argued that Jews are more prone to developing mental illness (Gilman, 1984; Kohn, Levav, Zolondek, & Richter, 1999; Sanua, 1992). Since the mid 19th century up until the early 20th century, numerous statistical studies appeared to report higher incidence of mental illness among European Jews compared with the populations around them (Bilu & Witzum, 1997; Gilman, 1984). Consequently, by the end of the 19th century the notion of the inherent tendency of Jewish people to develop mental illness had become a widely accepted medical assumption, specifically within Europe, and was often deliberately stated in order to maintain the inferior status of Jews, by characterising them as mad (Kohn, et al., 1999). Consequently, anti-Semitic propaganda stereotyped Jews as being mentally unstable and these prejudices were promoted by writers of the day who claimed that Jewish people had a greater susceptibility to develop mental illness due to their inclination towards interbreeding and marriages between blood relatives (Bilu & Witzum, 1997; Gilman, 1984).

During the early 20th century, more compassionate explanations of Jewish psychopathology emerged. These accounts suggested that Jewish people are susceptible to developing mental illness as a result of their constant desire and drive for success and happiness causing over exertion and exhaustion of the brain and nervous system, which ultimately results in mental ill health (Gilman, 1984). It was also thought that the aetiology of mental illness in Jewish people may also reflect their membership of a persecuted minority. Moreover, it was suggested that the enduring impact of discrimination and persecution for being Jewish causes internalisation of

anti-Semitism, generating feelings of self-hatred and inferiority which ultimately manifests as mental ill health (Gilman, 1984; Kohn, et al., 1999; Schlosser, 2006).

Over the past two decades research on the mental health of Jews in the diaspora[1], has lent some support to these ideas. From their meta-analysis of affective disorders in Jews which included published data and literature from 1900 up until the late 1990s, Kohn et al. (1999) identified higher rates of affective disorders amongst Jews compared to non-Jews, yet only a small effect size was found. Since that time, studies which have been predominantly based on samples of Jews living in the USA have also identified a possible increased vulnerability to affective disorders (Wang, Lederman, Andrade, & Gorenstein, 2008). For example, in their study of a large Jewish community in Chicago, Benjamins et al. (2006) found that lifetime prevalence rates and self-reported measures of depression were slightly higher than national estimates. Based on data from the National Institute of Mental Health (NIMH) Epidemiologic Catchment area study in the 1990s, Levav et al. (1997) found that Jewish men had significantly higher rates of major depression than Catholics, Protestants and all non-Jews combined. From their analysis of the same data, Yeung and Greenwald (1992) reported that lifetime rates of psychiatric disorders among Jews did not differ when compared with Catholics and Protestants. However, when comparing the distribution of specific psychiatric disorders, Jews had significantly higher rates of major depression and dysthymia but lower rates of alcoholism.

Whilst it is possible that Jewish people are vulnerable to mental ill health it has been alternatively suggested that they appear to have higher rates of mental illness because they are more likely to report their emotional difficulties and seek professional help. Before outlining further relevant research regarding mental health issues amongst Jewish people it is appropriate to clarify the meaning of the terms which will be used throughout this study to refer to these topics.

[1] 'Diaspora' refers to the populations of Jews who live outside of Israel, e.g. in the UK, USA and Europe etc.

2.1 Definition of terms

Jewish people/Jews

These terms will be used interchangeably throughout this study to refer to any individuals whose mother was a Jew or any person who has gone through the formal process of conversion to Judaism (Rich, 2008).

Mental illness and mental health problems

The terms *"mental illness"* and *"mental health problems"* will be used interchangeably to refer to emotional problems which cause disturbance to one's daily routine and activities such as learning, communicating, working and relationships. Moreover, these terms may include distressing reactions to life events and circumstances, e.g. stress, bereavement and trauma and they will also be used to describe psychiatric conditions such as depression and schizophrenia.

Help seeking

The term *"help seeking"* will be used broadly to refer to an individual's attempts to seek help in the event of experiencing a mental health problem. It refers to attempts to access and take up a range of different sources of help including professional mental health services, community/religiously based resources and/or informal support provided by friends and family.

Mental health professional/ Professional/ Professional help

The term *"mental health professional"* will be used to describe individuals who have been trained to deal with mental health problems including psychologists, psychiatrists, social workers, and family physicians (Mackenzie, Knox, Gekoksi, & Macaulay, 2004). The term will be shortened to *"Professional"* or *"Professional help"* at times throughout this study.

Mental health services/mental health care

These terms will be used interchangeably to refer to formal mental health services, including psychotherapy which are statutory (i.e. NHS) or privately run, usually staffed with mental health professionals including psychologists, psychiatrists, social workers, family physicians, counsellors and psychotherapists.

Community based help

This term refers to Jewish community centres and Jewish voluntary and charitable organisations providing support for Jewish people with mental health problems.

Religious based help

This term refers to religious activities such as prayer and Rabbinical counselling/advice which may be sought in response to a mental health problem.

2.2 Jewish help-seeking for mental health problems

Various studies both from the UK and the USA have demonstrated that Jewish people are more likely than the general population to seek formal systems of care (i.e. from GPs and mental health professionals) for the treatment of mental health problems. In an early study of this type, Srole and Langer (1962) examined the religious backgrounds of attendees of a psychiatric outpatient clinic in New York City. Their findings indicated that Jews had twice as much treatment as Protestants and ten times that of Catholics, yet their mental morbidity rates were the lowest. Given that Jewish people had the greatest tendency to seek psychiatric help despite their healthier mental health status, Srole and Langer (1962) concluded that it is the high socio-economic status of the Jews which assists their access to psychiatric treatment together with their enlightened attitudes towards mental health issues which contributes towards Jewish people's tendency to seek professional mental health care. It has also been argued that Jews are inclined to use professional mental health care because they hold particular attitudes emphasising that physical and mental illness should be cared for in the same way, i.e. by accessing the most advanced treatment available (Kohn et al.,

1999; Srole & Langer, 1962). However, it is worth noting that Srole and Langer's (1962) conclusions were based on data obtained nearly 50 years ago and therefore their findings are unlikely to be accurately representative of modern day Jewish communities. Moreover, their data was based on a clinical sample of attendees of local outpatient mental health services and thus one should be cautious about generalising their conclusions to wider Jewish populations with and without mental health problems who are not involved with mental health services.

Also drawing from data collected from NIMH Epidemiology study which was previously cited, Yeung and Greenwald (1992) reported that Jews were more likely than other religious groups (e.g. Catholics and Protestants) to seek treatment from mental health practitioners and medical staff. These findings were significant even when adjusting for sex, age, race and socioeconomic status (the latter being a composite score derived from occupational level, educational level and income). In their study of elderly Jewish people living in the UK, Bowling and Farquhar (1993) indicated that this group was more likely than other elderly people of White British origin and other ethnic minority groups to report dissatisfaction with their emotional well-being and concerns regarding their physical and mental health. Although Bowling and Farqhuar (1993) reported that they controlled for age and gender, it is not clear whether they controlled for other demographic information such as level of education and socio-economic status which could confound these findings.

In another UK study, Loewenthal et al. (2002) specifically examined Jewish people's willingness to admit to and seek help for depression compared to Protestants. Results indicated that Jewish people were more likely to self-report depression and seek help for the condition than Protestants. Loewenthal et al. (2002) concluded that these findings lent further support to existing research indicating that Jewish people have more positive attitudes towards mental ill health and help seeking. However, again it is unclear as to whether these findings controlled for potential confounders including socioeconomic status and level of education. There is also a body of research indicating that Jews hold favourable attitudes towards psychotherapy and they are also over-represented in terms of their actual use of psychotherapy (Kaminetzky & Stricker, 2000; Yeung & Greenwald, 1992). Nevertheless, the majority of studies indicating these trends were conducted over a decade ago and have largely been based

on samples of secular Jewry and therefore may not represent the lifestyle choices of all contemporary Jewish communities in the diaspora (Bilu & Witzum, 1997).

Although there has been little direct and quantitative measurement of Jewish people's attitudes towards help seeking for mental health problems, and/or their actual help seeking behaviour in the UK, recent data routinely collected from statutory mental health services demonstrates that Jewish people continue to be significantly involved with mental health practitioners. According to the 2001 census, the Jewish population in the UK is estimated to be approximately 270,500 which forms 0.4% of the total population (Graham, Schmool, & Waterman, 2007; Office for National Statistics, 2009). Data from the 'Count me In'[2] census in 2008 indicated that 1.8% of inpatients admitted to mental health and learning disability services in the UK were Jewish. Taken together, these percentages reveal that Jewish people are significantly over-represented as service users in statutory inpatient mental health services in the UK. Moreover, their use of inpatient services is four times higher than would be expected for a population of their size. Whilst this observation supports earlier literature emphasising the association between Jewish people and mental illness, it remains unclear as to whether this is because Jewish people are more likely to suffer mental health problems and/or because they are more inclined to use professional mental health services. Furthermore, this data does not shed any light on their use of outpatient mental health services including psychotherapy.

Whilst it appears that Jewish people are over-represented in professional mental health services, these observations are not entirely generalisable to the Jewish population as a whole. For example, it has been reported that Ultra-Orthodox Jews (i.e. very religiously observant Jews) would use professional mental health services as a last resort and they tend to be under-represented as statutory mental health service users (Talking Matters, 2007). In the London Borough of Hackney, which is home to an estimated 20,000 Ultra-Orthodox Jews, figures from 2000 revealed that there were only 24 recorded Orthodox Jewish service users (data from East London and City Mental Health NHS Trust, cited in Talking Matters, 2007). The apparent low service

[2] The 'Count Me In' census records information pertaining to all in-patients of mental health and learning disability services in the UK. It specifically records information pertaining to the ethnicity of all in-patients in order to highlight inequalities in access and outcomes that may affect in-patients from Black and minority ethnic communities, or their carers.

uptake in the Ultra-Orthodox Jewish Community may be due to community members following the recommendations of religious leaders who view psychotherapy and psychiatry as undermining of Jewish teachings, and alternatively advocate that Jews must seek guidance from Rabbis and the Torah (i.e. the Jewish bible) (Greenberg & Witzum, 2001). The reluctance of Ultra-Orthodox Jews to use professional mental health services significantly contrasts with previous reports of Jewish people being favourably inclined to make use of this support. Given that the latter findings were largely based on secular populations of Jews, it appears that there are major discrepancies in help seeking attitudes and behaviours between different denominations of Jewish people according to their level of religious observance and affiliation.

2.3 Religion and mental health

Within the domain of health research there has been an increasing trend over recent years to investigate the influence of religion on dimensions of physical and mental health (Masters, et al., 2009). More specifically, there has been an extensive amount of research which has focused on the impact of religious beliefs and practice on mental health. Much of this literature has investigated whether these forms of religious involvement contribute to psychopathology or psychological well-being (e.g. Harris, Edlund, & Larson, 2006; Hill & Pargament, 2003; Loewenthal & Cinnirella, 1999; Rosmarin, Paragament, & Mahoney, 2009b; Vilchinsky & Kravetz, 2005). Equally, there have also been a large number of studies which have examined the role of religious beliefs and practice in coping with psychological problems. However, Trice and Bjorck (2006) have identified that religiously based beliefs about psychological disorders also impact on help-seeking behaviours, beliefs concerning aetiology and mental health service utilisation rates. Although often overlooked in the research literature, it appears that religious variables are significant in helping to understand and predict help-seeking pathways for mental ill health (Abe-Kim, Gong, & Takeuchi, 2004).

2.4 Beliefs about the causes of mental illness

Several studies have investigated the relationship between beliefs about the causes of mental health problems and help-seeking preferences within specific religious and ethnic groups (e.g. Bhui, Rudell, & Priebe, 2006; Hartog & Gow, 2005; Sheikh & Furnham, 2000; Trice & Bjorck, 2006). Whilst these studies have indicated varied results, overall they suggest that religiously based beliefs about the causes of mental ill health predict help-seeking preferences. Generally speaking, individuals who are religiously orientated may be more likely to seek out religious leaders than mental health professionals because they attribute the aetiology of their problems to religious issues rather than psychological causes (Abe-Kim et al., 2004). In a general sense it follows that if an individual attributes a religiously based cause to their psychological difficulty then it is likely that they will seek to remedy the situation through a religiously based intervention (Hartog & Gow, 2005). For example, if one believes that their emotional distress is a form of punishment for behaving in a manner which goes against religious teachings, they may subsequently pray or seek guidance from clergy in an attempt to rectify their situation. Given this apparent relationship between causal beliefs about mental illness and help seeking preferences, attention to these beliefs in Jewish people will contribute to a greater understanding of the factors affecting their treatment choices.

Whilst ancient descriptions of mental illness amongst Jews can be traced back to Biblical texts, little reference is made to its causes yet there appears to be some delineation between spirit possession and insanity (Loewenthal, 1995). However, according to Kottek (1992), the Bible refers to madness and confusion of the mind in terms of consequences of disobeying religious teachings. Loewenthal (1995) also explains that the Hebrew term for madness 'Choleh Nefesh' means 'sickness of the soul', resulting from spiritual and moral failings. This suffering is thought to be a warning to the individual to improve their spiritual and moral strength. Given these interpretations of mental ill health, it is not surprising that members of the Ultra-Orthodox Jewish community are more likely to rely on religious teachings and leaders who emphasise the use of religious resources such as prayer and Rabbinical advice when suffering mental distress. However, less religious Jewish people who have assimilated into the dominant Western culture are more likely to alternatively or

additionally consider stress-related and Western physiological explanations of emotional problems which indicate psychiatric and psychological intervention (Rose, unpublished data). Whilst it is unclear as to which causal beliefs Jewish people in the UK attribute to mental ill health, the extent of the relationship between causal beliefs and Jewish people's help seeking attitudes and behaviours also has yet to be directly measured.

2.5 Religiosity and help seeking

In an attempt to understand how religious beliefs influence help seeking preferences, a handful of studies have investigated the influence of one's level of 'religiosity' on people's inclinations to seek professional mental health care and psychotherapy. The term 'religiosity' is typically used to define an individual's level of devotion to religious beliefs and adherence to religious practices (Abe-Kim, et al., 2004). In their study of Filipino Americans, Abe-Kim et al. (2004) considered the influence of religious affiliation, religiosity and spirituality on help-seeking from religious clergy and mental health professionals. Findings demonstrated that high religiosity was associated with more help-seeking from religious clergy but not less help-seeking from mental health professionals.

Before considering whether religiosity influences help seeking preferences in Jewish people it is worth providing a general description of their religious background with regard to Judaism. In a very basic sense, Judaism is a religion which provides a set of ideas about the world (e.g. the world was created by one G-d[3]) and rules for living (e.g. based on teachings of the 'Torah' which refers to the Old Testament) (Rich, 2008). It is also worth explaining that there are several denominations of Judaism which are often referred to as 'branches', 'movements', and/or 'affiliations' of Judaism. These terms will be used interchangeably throughout the current study to describe different denominations. Jewish denominations differ from each other in terms of their understanding and practice of Jewish law and their interpretation of Biblical texts. In the UK, the main denominations are Ultra-Orthodox (e.g. including Chassidic and Haredi movements), Orthodox (e.g. including Lubavtich), Modern

[3] In accordance with the Jewish customs of the researcher, the hyphen in the word 'G-d' has been used to denote the letter 'o' as it is considered blasphemous to write this word in full when it is being used in a non-sacramental context (i.e. in a thesis as opposed to a prayer book).

Orthodox (e.g. United Synagogue movement and also refers to Jews who define themselves as 'traditional') and Non-Orthodox (e.g. Reform, Liberal and Masorti streams).

Ultra-Orthodox Jews strictly observe Jewish law and are largely unassimilated in modern society, preferring instead to live in very close knit communities in which they have access to kosher butchers and grocers, prayer and study houses, schools, ritual baths and many other services essential to the maintenance of Ultra-Orthodox Judaism (Loewenthal & Rogers, 2004). Modern Orthodox Jews also adhere to Jewish Law but have integrated into modern society whilst maintaining religious traditions. Reform Judaism differs from more religiously stringent movements by emphasising personal interpretation of Jewish law and integration into modern society. However, many people who call themselves Jews do not strictly practice Judaism or may not practice it at all yet they are still considered to be Jewish if they were born to a mother who was Jewish. This also extends to how people describe their denomination; Jewish people may have been born into a particular denomination e.g. Modern Orthodox and describe their background as such, yet their religiosity (e.g. level of observance and devotion) may not reflect the level of religious adherence historically followed by this denomination. In other words, Jewish denomination does not necessarily indicate level of devotion or adherence to Jewish teachings and practices. Furthermore, many Jewish people in Britain do not assign themselves to a particular Jewish affiliation and alternatively refer to themselves as 'secular' which generally means that although they were born Jewish they do not follow the practices and beliefs of Judaism and are largely unobservant of relevant religious practices.

In an attempt to measure whether religiosity influences help seeking preferences amongst Jewish people, Kaminetzky and Stricker (2000) examined the relationship between help seeking attitudes and religious affiliation amongst Jewish people in the USA. More specifically, they investigated whether there were differences in attitudes towards seeking psychological help between Orthodox, Reform and Conservative denominations. According to their findings, there were no differences among the different affiliations in terms of their attitudes, with all three groups expressing positive attitudes towards seeking psychological help. According to Kaminetzky and Stricker (2000), this suggests that an individual's degree of religiosity does not

influence their attitudes towards seeking help for emotional problems. On the other hand, for those participants who indicated they had sought professional help in the past, it appeared that one's level of religious observance may influence the pathway taken to seek professional mental health care. This being most evident for Orthodox Jewish participants who indicated that whilst they were equally likely to have seen a mental health professional as those in other groups, they also viewed a Rabbi as being capable of solving psychological problems. Furthermore, approximately half of the Orthodox respondents had sought the help of a Rabbi in the past for an emotional problem. However, the findings of this study should be interpreted cautiously. Although Kaminetzky and Stricker (2000) used a 'religiosity' scale to measure the extent of people's religious practice and devotion, they largely used Jewish denomination to investigate the relationship between religiosity and attitudes towards help seeking. Going back to an earlier point, it is worth reiterating that some Jewish people may assign themselves to a particular Jewish denomination (based on birth/family background) but may not follow the level of religious adherence historically stipulated by that denomination. Therefore, one could argue that Kaminetzky and Stricker's (2000) findings do not accurately address the relationship between the level of religious commitment and practice and help seeking preferences.

Whilst Kaminetzky and Stricker (2000) reported positive attitudes towards seeking psychological help amongst Orthodox Jews, research investigating help seeking preferences in Orthodox Jewish people in the UK suggests that they fear they may be misunderstood by statutory mental health practitioners, including the possibility that their religious rituals and strong beliefs will be pathologised or challenged (Cinnirella & Loewenthal, 1999; Loewenthal & Cinnirella, 1999; Minshe, 2006, Talking Matters, 2007). It is also reported that mental health problems attract a significant social stigma in the Ultra-Orthodox community, particularly as people fear they will be shunned within the community (as it limits opportunities e.g. for marriage) which often means that when mental illness surfaces it is often denied or covered up. Taken together these findings highlight that an understanding of Jewish people's inclinations towards seeking help for mental health must consider their religious beliefs, levels of practice and observance and the extent to which these factors complement or conflict with dominant medical and psychiatric approaches to mental health (Cinnirella & Loewenthal, 1999; Loewenthal & Cinnirella, 1999).

2.6 Beyond religion: A question of Jewish culture and ethnicity

Despite their reported vulnerability to affective disorders and predominantly positive inclinations to seek mental health services and make use of psychotherapy, several researchers have argued that Jewish specific mental health issues have been overlooked within the field of clinical psychology and psychiatry (e.g. Langman, 1995; Mishne, 2006; Schlosser, 2006; Weinrach, 2002). For example, Schlosser (2006) identified that whilst Jews appear to be over-represented as psychotherapy clients, there has been limited research into which psychotherapeutic approaches are most effective with Jewish people. Furthermore, within mainstream clinical psychology and psychiatry literature and training courses, there is little, if any mention of Jewish mental health issues despite their prominent role in these disciplines both as clients and practitioners (Mishne, 2006; Schlosser, 2006). According to Schlosser (2006) it is vital for mental health practitioners to be aware of Jewish issues not only because they are likely to use services but also because of the persistence of negative Jewish stereotypes and anti-Semitism. Despite appearances of unproblematic assimilation and secularity amongst many Jewish people in the UK, Schlosser (2006) and Langman (1995) emphasise that anti-Semitism is ever-present and its persistence can contribute to potential biases in therapy, particularly when there is a lack of information and reliance on Jewish stereotypes. Mishne (2006) goes on to highlight that the denial and trivialisation of Jewish distress is in itself a form of anti-Semitism which neglects the reality of poor Jews, Jews of colour and the inter-generational transmission of emotional trauma from the Holocaust.

Relevant literature has also suggested that Jewish mental health has received minimal attention within statutory mental health services, precisely because of their over-representation as clients (Mishne, 2006). This has contributed to the flawed assumption that Jewish people are not a minority in need of any special focus by mental health services. In addition to this, Schlosser (2006) suggests that Jewish issues have been neglected because being Jewish is an invisible minority status. Friedman et al. (2005) point out that Jews within the UK and the USA are predominantly White and often represent a successful community with high socioeconomic status and therefore they are not viewed in the same way as other

minority groups. Moreover, Mishne (2006) and Langman (1995) both explain that this is because Jews appear to have successfully assimilated and thrived in the dominant White culture and thus they have been assumed to be exempt from oppression and the stressors associated with membership of other minority groups. Consequently Jewish people have been typically excluded from discussions of discrimination, diversity and inclusiveness which are considered to be key principles within modern statutory mental care (Friedman, et al., 2005; Langman, 1995; Mishne, 2006; Weinrach, 2002).

Based on a brief review of relevant mental health policy in the UK, this observation appears to be evident given that Jewish people are not included in documents outlining mental health initiatives aimed at Black and Minority Ethnic (BME) groups. For example, there are no references to Jews or Jewish people across three recent key documents[4] published by the Department of Health (DoH), which describe plans to improve inclusivity and access to mental health services, including improving access to psychological therapies, amongst BME groups. Langman (1995) also asserts that despite Jews being more materially advantaged and socially powerful than other minorities, this does not prevent them from being victims of anti-Semitism. Nevertheless, Mishne (2006) suggests that Jews continue to be left out of directives aimed at promoting opportunities for other minority groups because services are either unaware of the history of Jewish oppression and the extent of current anti-Semitism or some are simply reluctant to acknowledge it.

In attempt to explain the suspected neglect of Jewish mental health issues within mental health care, relevant literature has also considered the debate about Jewish people's status as a minority ethnic group. It has been proposed that Jews are often left out of initiatives aimed at promoting access to mental health services within Black and ethnic minority groups because they are considered solely to be members of a religious group not an ethnicity or culture (Langman, 1995). On the contrary, Jewish people have also been defined as a distinct culture and ethnicity because their way of life is often underpinned by Jewish expectations, belief systems and family dynamics

[4] These documents are *'Improving Access to Psychological Therapies (IAPT) Black and Minority Ethnic positive practice guide'* (DoH, 2009), *'Inside Outside: Improving Mental Health Service for Black and Minority Ethnic communities in England'* (DoH, 2003) and *'Delivering race equality in mental health care' (*DoH, 2005).

many of which are not based on biblical or religious teachings (Langman, 1995; Mishne, 2006; Schlosser, 2006). More specifically, whilst some Jews primarily adopt a religious lifestyle based on the laws of Judaism, more secular Jews may largely follow a cultural routine whereby they maintain traditional foods, customs and social activities largely without adherence to traditional religious practice. In spite of these differences, Schlosser (2006) argues that most Jews are likely to consider being Jewish as an important aspect of their identity that sets them apart from the majority White population as being a member of a specific ethnic/cultural group.

Acknowledging that Jewish people represent a distinct ethnic and cultural group suggests that Jewish people may be exposed to similar cultural factors which have been found to influence help seeking in other cultural and ethnic minority groups. Moreover, just as research on other cultural and ethnic groups indicates that culturally unique explanatory models, beliefs and attitudes concerning mental ill health determine motivations, barriers and pathways to different forms of help, these factors are also likely to play a role in the help seeking preferences of Jewish people (Pirutinsky, Rosmarin, & Pargament, 2009). In the same way that research investigating cultural factors is fundamental to culturally appropriate service development and interventions, this process should also apply to Jewish communities in the UK.

While it appears that a variety of factors (e.g. pre-existing positive orientations towards psychotherapy, causal explanations of mental illness, religiosity, etc) appear to contribute to help seeking behaviour in Jewish people, research on other religious and ethnic groups indicate other factors which may be relevant if one is to develop an in-depth understanding of Jewish help-seeking preferences. As previously discussed, beliefs about the causes of mental illness appear to be a significant factor influencing attitudes towards seeking help from professional mental health services. Much research has also suggested that knowledge of and familiarity with mental health services and use of social support systems also need to be taken into account. For example, in their study, Sheikh and Furnham (2000) examined the relationship between cultural beliefs about the causes of mental illness and attitudes associated with seeking professional help for mental illness amongst British Asians, Westerners (i.e. English and European participants) and Pakistanis. They found that causal beliefs

about mental distress were significant predictors of attitudes towards seeking professional help for the British Asian and Pakistani groups. They also reported that significant predictors of positive attitudes towards help seeking were sex, level of education and religion. Fung and Wong (2007) also considered the influence of causal beliefs about mental illness, together with beliefs about perceived accessibility to services and their relationship with attitudes towards seeking professional help in five ethnic minority groups of South Asian Women. They found that when other variables were controlled for, the most significant predictor of attitudes towards seeking professional help was perceived accessibility to services (e.g. the extent to which they felt they would be allocated a mental health worker of their own culture).

In a study of an Arab-Muslim population in the USA, Aloud (2004) identified that their attitudes towards seeking formal mental health and psychological services were influenced by cultural beliefs about mental illness, knowledge and familiarity with formal services, perceived societal stigma and use of religious and social support. Diala et al. (2000) also indicated that attitudes towards seeking professional help can also be affected by using services. More specifically, Diala et al. (2000) found that prior to seeking professional help, African American's had positive attitudes towards formal services which were comparable to, and in some cases more favourable than those of whites. However, following contact with services, they held more negative attitudes about professional services and were less likely to use them in the future, possibly suggesting exposure to discrimination on the part of service providers. This brief review of studies indicates the complexity of the factors which influence attitudes towards seeking professional help, some of which may also be relevant to Jewish people.

2.7 Models of help seeking for mental health problems

Whilst a vast number of studies have investigated cultural factors influencing help seeking for mental health problems, only a handful of these have used theory-based models of help seeking to inform their understanding (Mo & Mak, 2009). The application of theory-based models to aid understanding of help seeking may highlight the processes by which access to and provision of appropriate mental health care can be improved. In terms of psychologically based models, the Theory of

Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975, 2009) has been an extremely influential theoretical framework which has been successfully used to predict a wide range of health-related behaviours ranging from condom use (e.g. Albarracin, Johnson, Fishbein, & Muellerleile, 2001) to undertaking physical activity (e.g. Hagger, Chatzisarantis, & Biddle, 2002). The TRA has also been applied to understanding mental health related behaviours, including predicting intention to seek professional help for mental health problems (e.g. Bayer & Peay, 1997).

In its original and simplest form, the TRA is based on the fundamental assumption that an individual's behaviour is determined by their intention to perform the behaviour (referred to as *behavioural intention),* and that behavioural intention is ultimately a function of their *attitude towards the behaviour* and their *subjective norm* (Ajzen & Fishbein, 1980). Figure 1 shows a simple diagram of the TRA.

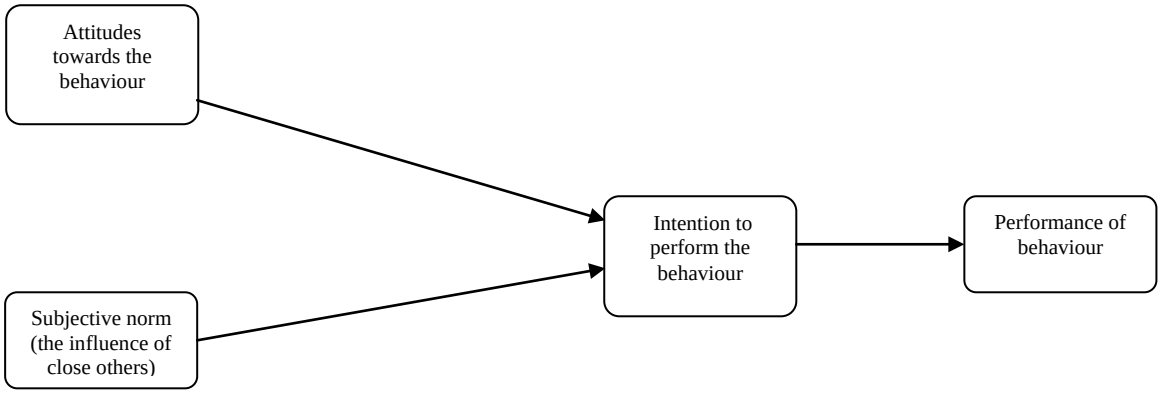

Figure 1: A diagram of the initial Theory of Reasoned Action (as proposed by Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975).

According to the TRA, '*attitudes towards the behaviour'* refer to the individual's beliefs which reflect their positive or negative evaluation of the consequences of performing the behaviour, which suggests that the more positive the evaluation of the consequences, the more favourable the attitude. At its inception (between 1975-1980) the TRA used the term '*subjective norm'* to refer to the individual's perception of social pressure from important others to engage or not engage in the behaviour (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975, 2009). The more that important others are believed to approve rather than disapprove of the behaviour in question, the greater

the subjective norm, i.e. perceived social pressure (Fishbein & Ajzen, 2009). According to the TRA, once attitudes and perceived norms have been formed they lead to the formation of '*behavioural intention'* (which is a process that the individual may be unconsciously aware of), in other words, their readiness to perform that behaviour. Fishbein and Ajzen (2009) also explained that intention essentially provides an estimate of the likelihood that a individual will perform a specific behaviour. Generally speaking, the more favourable an individual's attitude and subjective norm toward a certain behaviour, the greater the individual's intention to perform that behaviour. Nevertheless, Fishbein and Ajzen (2009) explained that the relative importance or weight of these determinants of intention is likely to vary according to the behaviour in question and also from one population to another.

In a recent review of the TRA, Fishbein and Ajzen (2009) describe how the TRA was revised since the original 1975 and 1980 model to include an additional determinant of intention called *perceived behavioural control*. This additional component refers to an individual's beliefs about their personal control over the behaviour in question and whether the believe they will be able to perform the behaviour, according to environmental resources and opportunities (Ajzen, 1991; Reyna & Farley, 2006). Whilst Ajzen (1991, 2002) incorporated this component into his 'Theory of Planned Behaviour', Fishbein and Ajzen (2009) subsequently reported that numerous studies including meta-analyses have shown that the contribution of perceived behavioural control to intention is often limited, and on average explains less than 5% of the additional variance in behaviour. Fishbein and Ajzen (2009) subsequently acknowledged that *perceived behavioural control* may not be a predictor of every type of behaviour. Moreover, if the individual is in an environment which provides them with the means to perform the behaviour, an additional measure of perceived behavioural control will account for little, if any additional variance, suggesting that when making predictions about some behaviours measuring this component is unnecessary.

Despite the breadth of empirical evidence supporting the TRA's effective application to understanding a range of health-related behaviours, it has not been entirely without criticism. Fishbein and Ajzen (2009) acknowledge that various criticisms have been levelled at the TRA, including those which have highlighted that it places too much

emphasis on behaviour being rational and deliberate (rather than spontaneous and impulsive) and that it does not sufficiently address the role of emotion and affect in contributing to behaviour. It has also been argued that the components within the TRA do not entirely explain people's intentions and actions. For example, the TRA does not account for the contribution of other factors (e.g. including age, gender, ethnicity, religious affiliation, socio-economic status, past experiences, etc) which are likely to underpin attitudes, social influence, intentions and behaviour. However in response to the latter criticism, Fishbein and Ajzen (2009) have welcomed the vast amount of research studies on the model which have attempted to increase the amount of explained variance in intentions and behaviour by adding one or more predictors.

2.8 Conclusions and future research

According to both anecdotal reports and research data, Jews have a historical relationship with clinical psychology both as practitioners and clients yet despite this association, Jewish mental health appears to receive little attention in professional mental health services. Despite data being available on the admission of Jewish inpatients to statutory mental health services in the UK, there appears to be a lack of comprehensive data about Jewish people's use of outpatient services, psychotherapy and community/religiously based resources in the event of experiencing a mental health problem. Without this it is difficult to assess the extent of Jewish people's mental health needs and given that they are often solely identified as a religious group, their unique cultural issues (e.g. exposure to discrimination through antisemitism, favourable attitudes to psychotherapy) which may be pertinent to developing more appropriate mental health care remain overlooked (Heller Levitt & Balkin, 2003). There appear to be few, if any existing studies in the UK which have quantitatively explored whether Jewish people's apparent positive inclinations to seek professional help for mental health problems are a myth or genuine characteristic of British Jewry.

Given the reported reluctance of the Ultra-Orthodox Jewish community to seek professional help (see Talking Matters, 2007 for a review), which is at odds with research suggesting that Jewish people are generally favourably inclined to seek professional help, it suggests that religiosity may be a significant factor in

determining their help seeking preferences. Research on other religious/culturally diverse groups also suggests that there are a number of other factors which are worth investigating in order to understand help seeking preferences in the Jewish community, for example, beliefs about the causes of mental illness. Psychologically theory-based models, such as the TRA, also emphasise the role of an individual's attitudes and the influence of their social environment which may also help to explain intention and attempts to seek professional help seeking amongst Jewish people. Moreover, the TRA offers a specific model on which to specifically measure the extent to which these factors, e.g. attitudes, the influence of close others, causal beliefs about mental illness, predict their intentions to seek professional help and related behaviour. Thus, it is possible that a study measuring these factors and examining their relationship to intentions to seek help and actual help seeking behaviour could contribute to a more definitive understanding of Jewish help seeking behaviour than that which currently exists.

2.9 The present study

To the best of the researcher's knowledge, there are no existing quantitative studies in the UK which have specifically examined the factors (e.g. beliefs about the causes of mental illness, religiosity, and attitudes) which contribute to Jewish people's reported preferences to seek professional help for mental health problems. Moreover there appears to be little, if any research which has examined the relationship between their apparent favourable inclinations to seek professional help and their actual attempts to do so. Therefore, the present study aims to use an adapted model of the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975, 2009) to identify which factors predict intention to seek professional help within the Jewish community. Provided that Jewish people are willing to share their experiences of seeking professional help it will also be possible to identify the factors which predict this behaviour. Understanding the relative importance of these factors could be useful for mental health service providers in helping them to formulate the most appropriate care for British Jewry.

2.9.1 Research aims

This study aims to:

- Explore Jewish people's inclinations towards seeking professional help for mental health problems, including psychological therapy.
- Explore Jewish people's experiences of seeking help for mental health problems if they are willing to share this information.
- To examine the extent to which one's level of religious observance and beliefs are associated with intention and attempts to seek professional help.
- To also examine how various other factors (e.g. attitudes towards seeking help professional help, the influence of close others, beliefs about the causes of mental illness) relate to their intentions and attempts to seek professional help.
- To establish, through a modified version of the Theory of Reasoned Action which of these factors, are the strongest predictors of intention and attempts to seek professional help.

2.9.2 Research hypotheses

Based on the research questions, the study specifically makes predictions according to the Theory of Reasoned Action (TRA):

- Whilst the TRA predicts that attitudes and subjective norms (the influence of close others) will predict intention to seek professional help, this study also predicts that intention to seek professional help will vary according to these variables and a number of additional factors:

> Attitudes towards seeking professional help will be positively associated with greater intention to seek professional help.

> Subjective norm will be related to intention to seek professional help, specifically that the more one's personal/social influences are positively oriented towards professional mental health care, the more favourable the person's intention to seek professional help.

> Beliefs about the causes of mental illness will be related to intention to seek professional help (e.g. Western-physiological and stress-related causal explanations will be positively associated with intention to seek professional

help, yet non-Western physiological and supernatural causal beliefs will be negatively associated with intention to seek professional help).

> Level of religiosity will be negatively associated with intention to seek professional help; the greater one's level of religiosity, the less inclined a person would be to seek professional help, yet the more inclined they would be to seek religious help.

- In terms of actual help seeking for mental health problems, it is expected that for those who are willing to report having had a mental health problem, a large proportion of these people will have sought professional help.
- According to the TRA, it is expected that actual professional help seeking will be strongly predicted by intention to seek professional help, which will be largely mediated by attitudes towards seeking professional help and subjective norm.

3. Method

3.1 Design

The present study used a non-experimental research design which involved a survey of the Jewish community using a questionnaire. A questionnaire survey was considered to be an appropriate method of investigation as it provided the opportunity to use attitudinal scales, enabling the measurement of beliefs and attitudes by requiring participants' responses to a set of belief and attitudinal statements relating to the research questions (Robson, 1999; Talking Matters, 2007). Furthermore, the questionnaire approach has been extensively employed in a large proportion of studies concerning the relationship between beliefs about mental illness and attitudes towards seeking professional help (e.g. Al-Krenawi, Graham, Dean, & Eltaiba, 2004; Aloud, 2004; Fung & Wong, 2007; Hall & Tucker, 1985; Mo & Mak, 2009; Sheikh & Furnham, 2000). However, as yet, there appear to be no existing studies in the UK which have utilised a questionnaire survey design to investigate these issues in the Jewish community.

Questionnaire surveys and face-to-face interviews appear to have been the predominant methodologies of choice amongst previous studies investigating beliefs and attitudes towards mental ill health. Therefore the choice of research design was based on consideration of the relative merits of both of these approaches. For example, it was acknowledged that interviews would allow more in-depth exploration of the research topic, whereas questionnaires would limit the discovery of alternative/additional factors which have not been previously considered by the researcher to contribute to the area of investigation. Nevertheless, these limitations were offset by the advantages of using a questionnaire survey as it was felt that this design would enable a greater number of participant responses to be collected during the limited time frame of the study and participant responses were less likely to be influenced by investigator bias (Sibbald, Addington-Hall, Brenneman, & Freeling, 1994).

Given the persistent nature of stigma related to the questionnaire subject matter (i.e. mental illness and seeking professional help), it was also felt that participants may be

more likely to disclose their own experiences of mental ill health and help seeking using a questionnaire rather than through face-to-face interviews (Cartwright, 1988). Using a questionnaire survey would also enable distribution of the questionnaire to a wider geographical area, particularly as the questionnaire was going to be posted to potential participants. However, it was acknowledged that response rates to postal surveys are notoriously low and are often subject to response bias (i.e. it is predominantly individuals who have a particular affinity/relationship with the research topic who respond) thereby jeopardising the representativeness of the sample (Sibbald, et al., 1994; Williams, 2003). According to Dillman (2009), the use of two or more survey modes is likely to boost response rates, therefore distribution of the questionnaire was extended to email (containing an internet link to the questionnaire) and it was also featured as an internet link on various Jewish websites to alert people to take part in the study. The researcher also attended community centres/events to directly ask people if they would be willing to take part in the study.

3.1.2 Piloting the questionnaire

The questionnaire was piloted on five Jewish people who were well known to the researcher who represented a range of religious observance and were from Orthodox and Modern Orthodox backgrounds. Feedback from the pilot questionnaire mainly included suggestions about changing some of the wording of items. Where possible, amendments were made to questions/measures which the researcher had developed, whereas pre-existing measures were not changed as it was possible that this may jeopardise their reliability. References to other changes made following the pilot of the questionnaire will be documented later in the description of measures.

3.2 Procedure

3.2.1 Participants and Recruitment

Participants were a non-clinical population and inclusion criteria stipulated that they must be over the age of 18 years-old, define themselves as Jewish and currently live in the UK (including Great Britain and Northern Ireland) in order to take part in the study. Participants were recruited through a number of ways:

a) The researcher approached synagogues and Jewish organisations in London and Leeds through an initial phone call explaining the study and asking if they would be willing to help recruit participants on the researcher's behalf. The researcher asked each organisation/synagogue whether it would be possible for her to provide questionnaire packs in prepaid envelopes to the organisation/synagogue which they could then send out to a proportion of their members (thereby their members contact details would remain anonymous). This was followed up with a letter/email and an 'Information Sheet' (see Appendix 1) outlining the purpose of the study. Accordingly 150 questionnaire packs were distributed across the organisations/synagogues who agreed to distribute them to their members on the researcher's behalf. Some organisations alternatively agreed to email their members containing an internet link to the online version of the questionnaire pack or they agreed to display the internet link to the questionnaire on their website. However, it is not known how many members of organisations/synagogues were emailed about the study or how many people viewed the internet link on the organisation's/synagogue's website.

b) The researcher also contacted various community centres, (again through an initial phone call, followed up with a letter/email and the information sheet about the study) asking if she could visit and ask attendees if they would like to take part in the study. At a small number of community centres who agreed to this, the researcher distributed the information sheet to attendees at Jewish education classes and mother and baby groups. Approximately 20 attendees said that they would be willing to take part in the study and therefore they were given a questionnaire pack including a stamped addressed envelope so that they could return the questionnaire through the post in their own time.

c) The researcher also recruited participants by posting the questionnaire pack (including a stamped addressed envelope) to Jewish personal contacts and acquaintances, or by emailing them the internet link to the online version of the questionnaire. Approximately 50 paper questionnaire packs were sent out to personal contacts and 120 people were emailed about the study containing the internet link to the online questionnaire.

The questionnaire pack contained the information sheet (Appendix 1), a consent form (Appendix 2), the questionnaires (Appendices 3-9) and a debrief sheet (Appendix 10), together with a stamped addressed envelope enabling participants to return the questionnaire in their own time. On receiving the questionnaire pack or viewing it online, participants were first presented with the information sheet explaining the purpose of the study and what it would involve. If potential participants were willing to take part in the study they were instructed to complete the consent form, followed by the questionnaire. At the end of the questionnaire participants were then provided with a debrief sheet explaining the study in more detail. For participants who had completed the paper version of the questionnaire they were advised to send the questionnaire and consent form back to the researcher in the stamped addressed envelope provided.

3.3 Measures

The questionnaire pack was made up of seven questionnaires (Appendices 3-9), including pre-existing measures which had been used in previous research studies investigating beliefs and attitudes towards mental health and help seeking, whereas other sections were developed by the researcher for the purposes of the present study. The first section (Appendix 3) included a personal background questionnaire requiring participants to give demographic information including sex, age, current location, country of birth, marital status, number of children, level of education and occupation, all of which are variables that may interact with an individual's attitude towards seeking help for mental health problems (Kaminetzky & Stricker, 2000). The subsequent sections aimed to measure/operationalise the main areas of investigation, whilst the final section provided participants with an opportunity to give more in-depth information about their actual experiences of help seeking if they wished to do so. Therefore the survey was subsequently divided into these sections:

- Religious background including Jewish denomination and level of religiosity
- Beliefs about the causes of mental illness
- Attitudes towards seeking professional help
- Attitudes towards seeking psychological therapy

- Beliefs about what important close others would think about seeking professional and religious help (i.e. items measuring 'subjective norm' according to the Theory of Reasoned Action)
- Intentions to seek different forms of help (e.g. religious, social, professional help)
- Experiences of mental health problems and attempts to seek help

The following questionnaires corresponded with each of these sections:

Religious background questionnaire

This is a 9-item self-report questionnaire (see Appendix 4) which was developed by the researcher to obtain information about the participant's Jewish background and affiliation (e.g. Orthodox, Reform, Secular). Although there were existing measures of religious background available, e.g. Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Fetzer Institute, 1999), they appeared to be inadequate in their specificity to Jewish religious observance and practices. Attempts to contact researchers who had developed measures specifically for Jewish people (e.g. Kaminetzky and Stricker) were unsuccessful. Other religious background measures which were referred to in previous literature on Jewish people were largely based on Israeli populations and although they were obtained they required a significant amount of translation from Hebrew to English which was not possible within the time constraints of the present study.

The religious background questionnaire particularly aimed to measure a participant's *'religiosity'* which refers to an individual's level of devotion to religious beliefs and the extent of their adherence to religious practices (Abe-Kim, Gong, & Takeuchi, 2004). Measures of religiosity typically include self-report items pertaining to the individual's frequency of attendance at religious services, participation in religious group activities (e.g. bible studies classes), participation in private religious activities, including private prayer, studying of holy texts and the extent of an individual's religious beliefs and their level of commitment (Abe-Kim, et al., 2004; Loewenthal, MacLeod, Lee, Cook, & Goldblatt, 2002; Masters, et al., 2009). Thus, current questionnaire items pertaining to religiosity were based on two dimensions: *religious*

observance (i.e. participation in religious activities and maintaining religious laws/customs) and *religious commitment beliefs*, with higher scores indicating greater religiousness. It appeared that there was a strong relationship between these two dimensions, as religious observance was significantly correlated with commitment beliefs ($r = 0.85$, $p<0.01$). Due to the high correlation between *religious observance* and *religious commitment beliefs*, it was considered appropriate to add these dimensions together to provide an overall 'religiosity' summary score which was used in the subsequent analysis of survey data. In order to confirm the discriminatory validity of this Jewish religiosity scale, a one-way ANOVA indicated that there were significant differences across Jewish denominations in terms of their overall religiosity score, with greater religiosity reported amongst more strictly practicing Jewish denominations. According to Levene's Test of Equality of Means, homogeneity of variance was violated; therefore the Welch *F*-ratio is reported, $F(3, 44.64) = 24.59$, $p<0.001$. This finding supports the expectation that more strictly practicing denominations are generally more religious, which in turn supports the validity of the measure in being able to discriminate between Jewish denominations.

Five items from the Brief Multidimensional Measure of Religiousness/Spirituality (BMMRS; Fetzner Institute, 1999) were included to measure participation in religious group activities, private religious activities and commitment. Moreover, these items were adapted to be more consistent with typical Jewish dialect (for example, where the BMMRS refers to the word 'synagogue' this was replaced with the Yiddish word 'shul[5]'). The BMMRS is a measure that was developed specifically to assess key dimensions of religiousness and spirituality which are considered to relate to physical and mental health outcomes. However, for the purposes of the present study, items of the BMMRS assessing spirituality were not considered for inclusion as this was not a variable under current investigation and it was considered more relevant to include items specifically addressing Jewish religiousness.

[5] 'Shul' is the Yiddish word for synagogue. 'Yiddish' refers to Jewish dialect which is based on Hebrew, German, Polish, Hungarian, Russian and Romanian languages which emerged in Jewish communities after the beginning of the diaspora to Eastern Europe in the 15th century (Rosten, 1974). Although British Jewry today use little Yiddish in common parlance, the word 'Shul' is still commonly used to refer to the synagogue.

Three of the remaining items were based on an amalgamation of measures which have been previously developed to measure Jewish religiousness in relation to mental health issues (e.g. Kaminetzky & Stricker, 2000; Rosmarin, Pargament, & Krumrei, 2009a; Vilchinsky & Kravetz, 2005). Items which appeared to most prominently feature amongst the three measures used in these studies were included in the present measure of religiousness, which included an item requiring participants to specify their Jewish affiliation (i.e. secular, Orthodox, Reform) and frequency and observance of Jewish practices, including observing the Sabbath and eating kosher food. The remaining item asked participants to specify their Jewish background in terms of their international heritage, namely whether they are 'Ashkenazi' (i.e. from Eastern European descent) or 'Sephardi' (i.e. descending from Spain and Portugal or Asian and African origin).

Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990)

'The Mental Distress Explanatory Model Questionnaire' (MDEMQ) is a 45-item questionnaire (Appendix 5) intended to measure explanatory beliefs about the causes of mental distress (Eisenbruch, 1990). As Eisenbruch (1990) used the term 'mental distress' to refer to occasions when people experience sadness, anxiety, strange beliefs and disorganised behaviour, it was considered that this measure was consistent with the concept of mental ill health referred to in the present study. According to Eisenbruch (1990), the MDEMQ was designed to be used in predominantly Western populations and therefore it includes items relating to natural causes or external causes of mental distress, yet also includes items suitable for a variety of other cultures including folk and supernatural explanations of mental distress. The participant is asked to rate how likely each of the listed causes could contribute to mental distress on 5-point Likert scale ranging from 'Not at all likely' to 'Highly likely'.

For the purpose of analysis Eisenbruch (1990) suggested that each of the listed causes can be tabulated into four categories including 'Western physiological' (e.g. chemical imbalance in the brain), 'non-Western physiological' (e.g. movements of wind, drafts, gas, milk or air flowing through a person's body), 'stress' (e.g. general life stress or trauma, grief) and 'supernatural' (e.g. dangerous unprovoked spirit) causes. Whilst the

MDEMQ has not been validated in a Jewish population, it has been used in previously documented studies (e.g. Fung & Wong, 2007; Sheikh & Furnham, 2000) which have investigated factors influencing attitudes towards seeking professional help amongst ethnically diverse groups. These studies have reported satisfactory internal reliability, for example, Sheikh and Furnham (2000) reported Cronbach's alpha analyses on each of the causal categories which demonstrated acceptable reliability (between 0.71 to 0.95) in each of their three ethnic groups (including British Asians, Westerners i.e. English and European participants, and Pakistani participants).

Unsuccessful attempts were made to contact the author of the MDMEQ to obtain a copy of the original measure. This request was considered particularly necessary as the original research paper describing the questionnaire (Eisenbruch, 1990) simply provides a list of potential causes of mental distress rather than presenting them as questionnaire items which a participant could endorse. Despite email correspondence with researchers who had reported using the measure in their study (e.g. Fung & Wong, 2007), they were also unable to locate the original questionnaire and they alternatively sent their own adapted version of the MDMEQ. However, it was noted that Fung and Wong's (2007) version of the MDMEQ presented one category of potential causes consecutively rather than presenting them in a random order, i.e. 'Western physiological' causes were all listed together, followed by all the non-Western physiological, followed by all the 'Stress-related' causes and so on. It was considered that this may lead to response set, whereby participants may simply respond similarly to all items in the same causal category without paying attention to the specific content of each item (Barker, Pistrang, & Elliott, 2005). Therefore, in the present study the order of the 45-items was randomised with items from different causal categories now following a random order. Furthermore, following feedback from the pilot stage of the questionnaire, the presentation of the response scale was changed from asking participants to simply circle a number from 1 to 5 corresponding to their chosen response (e.g. 1 indicating 'Not at all likely', whereas 5 indicated 'Highly likely'), to alternatively labelling the scale with words (e.g. ranging from 'not at all likely' to 'Highly likely') at the top of the list of questionnaire items and providing tick boxes for the participant to indicate their chosen response. Moreover, it was commented that simply using numbers was confusing as participants would have

to keep referring to the explanatory paragraph at the beginning of the questionnaire to remind them which number denoted their response.

Inventory of Attitudes Toward Seeking Mental Health Services (Mackenzie, Knox, Gekoksi, & Macaulay, 2004)

The 'Inventory of Attitudes Toward Seeking Mental Health Services' (IASMHS) is a 24-item questionnaire (Appendix 6) which assesses attitudes associated with seeking professional help for mental health problems**.** Moreover, participants are asked to rate on a 5-point Likert scale how much they agree with attitudinal statements relating to seeking help from mental health professionals (including psychologists, psychiatrists, social workers and family physicians), the stigma of mental illness and its treatment. Higher scores indicate a greater willingness to seek professional help in the event of experiencing a mental health problem. The IASMHS is largely based on Fischer and Turner's (1970) 'Orientations to Seeking Professional Help' (OSPH) questionnaire which was a 29-item scale, made up of four subscales reflecting distinct facets of attitudes including 'recognition of the need for psychotherapeutic help', 'stigma tolerance', 'interpersonal openness' and 'confidence in a mental health practitioner'. Despite the extensive use of the OSPH in many previous studies examining of attitudes towards help seeking for mental health problems (e.g. Al-Krenawi, et al., 2004; Aloud, 2004; Fung & Wong, 2007; Hall & Tucker, 1985; Jang, Giyeon, Hansen, & Chiriboga, 2007; Sheikh & Furnham, 2000), the IASMHS was developed by Mackenzie et al. (2004) in order to address several conceptual and methodological criticisms levelled at the OSPH.

In addition to concerns about the outdated language of the OSPH, Mackenzie et al. (2004) also highlighted that it refers almost exclusively to psychiatrists and psychologists as mental health professionals which does not acknowledge that many other professionals provide mental health care including community nurses and social workers. The OSPH is also conceptually limited as it was developed prior to the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and the Theory of Planned Behaviour (TpB; Ajzen, 1991) and thus does not contain items which sufficiently reflect measurement of constructs relevant to these models, namely an individual's subjective norm and perceived behavioural control. Mackenzie

et al.'s (2004) methodological concerns about the OSPH refer to its use of a 4-point rating scale and its four factor subscale. Moreover, they argued that rating scales with fewer than 5 points are less reliable and valid than scales with 5 to 7 points and they are more likely to produce Type II errors. Furthermore, Mackenzie et al. (2004) criticise the use of a four factor subscale by highlighting Fischer and Turner's (1970) admission that they only obtained poor to moderate subscale reliabilities, suggesting that independent interpretation of subscale scores should be avoided.

Given that the OSPH has been widely used in research studies, Mackenzie et al. (2004) wanted to avoid developing a brand new measure. Alternatively they decided to develop an adapted and extended version of the OSPH to produce the IASMHS. In order to counter the conceptual limitations of the OPSH, the adapted IASMHS included items pertaining to the TpB (Ajzen, 1991). For example, 'perceived behavioural control' which is an element of the TpB model referring to an individual's perception of how easy or difficult it will be to perform a behaviour, is represented in item 13 (e.g. 'It would be relatively easy for me to find the time to see a professional for psychological problems')[6]. The IASMHS also included amendments to the language used in the OSPH by substituting the more generic word of 'professional' each time the terms 'psychiatrist' and 'psychologist' was used in the original measure, with a short paragraph explaining that 'professional' refers to psychologists, psychiatrists, social workers and doctors (Mackenzie, et al., 2004). Methodological adaptations included replacing the 4-point rating scale with a 5-point scale. Unlike the four subscales of the OSPH, factor analysis revealed that the IASMHS has three factors which, according to Mackenzie et al. (2004), represent key elements of the TpB, including 'Psychological openness' and 'Help-seeking propensity' reflecting perceived behavioural control, and the third factor, 'Indifference to stigma', reflecting an individual's subjective norm. Cronbach's alpha analyses demonstrated good internal consistency across the overall scale and amongst the three subscales (between 0.76 and 0.87).

[6] Despite its prominence in revisions of the TRA, *'perceived behavioural control'* was not specifically measured as a variable in its own right in the present study given that many studies have reported that it has a very limited contribution to the additional variance of a wide variety of behaviours (Fishbein & Ajzen, 2009).

Attitudes Toward Seeking Professional Psychological Help: A Shortened Form (Fischer & Farina, 1995)

'The Attitudes Toward Seeking Professional Psychological help: Shortened Form' (ATSPPH:SF) questionnaire is a 10-item questionnaire (Appendix 7) which is also an adaptation of Fischer and Turner's (1970) OPSH. In addition to its brevity, the ATSPPH:SF also differs from the OPSH by putting more emphasis on assessing attitudes towards seeking psychological therapy rather than help from a range of mental health professionals. Participants are asked to rate on a 4-point Likert scale how much they agree with each of these statements, with a higher score indicating more positive attitudes toward seeking psychological treatment. Similarly to its predecessor, the ATSPPH:SF has been used in various studies investigating attitudes towards help seeking for mental health problems (e.g. Jang, et al., 2007; Vogel, Wester, Wei, & Boysen, 2005), and of further relevance, Kaminetzky and Stricker (2000) used it in their study of Jewish people's attitudes towards seeking psychotherapy in the USA.

In terms of the psychometric properties of the ATSPPH:SF, Fisher and Farina (1995) reported Cronbach's alpha analysis as 0.84, indicating reasonable internal consistency of the 10-item scale. Given that their data was based on a sample of college students, Elhai et al. (2008) have since investigated the internal consistency, construct and criterion validity of the scale using what they considered to be a more representative community sample by including primary care medical patients in addition to college students. Statistical analysis supported these psychometric elements of the ATSPPH:SF, including reliability of the overall scale which was reported to be 0.77 and 0.78 across both groups (Elhai, et al., 2008). It was noted during the pilot stage of the present study that participants commented on the perceived repetition of questions when they reached the ATSPPH:SF after having previously completed the IASMHS. In fact their perception was somewhat justified as there are four items on the ATSPPH:SF which strongly resemble four of the items on the IASMHS and one item is identical to an item on the ISAMHS. Despite these comments it was decided that the measure should still be included as it provided additional data investigating attitudes specifically towards psychological therapy.

Intentions to Seek Help scale

The Intentions to Seek Help (ISH) scale is a 12-item questionnaire (Appendix 8) designed by the researcher to specifically measure the remaining key concepts of the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), namely *subjective norm* and *intention* to seek different forms of help (including both professional and non-professional forms of help such as friends and family and religious based support)**.** Although the TRA underwent theoretical revisions to include an additional component called *'perceived behavioural control'*, which was subsequently included in Ajzen's (1991, 2002) Theory of Planned Behaviour (TpB), it was decided that this would not be specifically measured in the present study owing to evidence cited by Fishbein and Ajzen (2009) who have reported that the contribution of perceived behavioural control to intention is often limited, and on average explains less than 5% of the additional variance in behaviour.

A review of the relevant literature indicated that there was one existing questionnaire which had been developed by Bayer and Peay (1997) to measure intentions to seek professional help according to components of the TRA. However, whilst this provided a guide to wording items, the structure of items were largely based on suggestions made by Ajzen's (2006) and Fishbein and Ajzen (2009) who provide examples on how to construct a TRA and/or TpB questionnaire.

Subjective norm

Given that this concept reflects the influence of close others (e.g. friends and family), participants were asked to rate on a 5-point Likert scale how much they agree with each statement reflecting beliefs about whether people close to them would endorse professional and/or religious help if the participant was suffering a mental health problem. Higher scores indicate that the participant believes that close others would more highly approve of professional/religious help.

Intention

According to Fishbein and Ajzen (2009), intention to perform a behaviour can be gauged quite simply by asking a participant whether they would be willing to perform the behaviour in question. Therefore participants were asked to rate on a 5-

point Likert scale how much they agree with each statement reflecting the extent to which they would intend to seek professional and religious help if they had a mental health problem.

Experiences of different forms of help and support

This questionnaire (Appendix 9) was designed by the researcher to give participants the opportunity to provide information about their actual experiences of help seeking for mental health problems**.** Furthermore, since only a handful of studies have investigated Jewish people's experiences of help seeking for mental health problems in the UK, which have predominantly focused on Orthodox Jewish people (e.g. Loewenthal & Rogers, 2004; Talking Matters, 2007), it was considered that this information may complement attitudinal data aiming to determine whether Jewish people are positively inclined to use professional mental health services as previous research has suggested. Moreover, by obtaining this information, it would be possible to identify predictors of actual help seeking behaviour according to an adapted model of the TRA. However, for participants who did not wish to answer these questions they were given the option of omitting this section of the questionnaire or they could answer questions about a person who is known well to them if they preferred.

The majority of questions in this section are based on a questionnaire developed by 'Talking Matters' which is counselling service for the Orthodox Jewish community. In 2007, staff within the service carried out a needs assessment of mental health services in the Ultra Orthodox community of Stamford Hill in London. Their methods of investigation included the use of semi-structured interviews of community members and a questionnaire asking about their own or a close other's experiences of using mental health services. In order to maintain brevity, only 12 questions were taken from the Talking Matters 30-item questionnaire which mainly asked participants to specify which services they had originally sought, been recommended, eventually used and their evaluation of them. Furthermore, most of the questions were adapted from their original format to include a wider range of potential mental health services (e.g. private psychotherapy, support group within the NHS, etc.), some of which were suggested during the pilot stage of the questionnaire. Potential responses

were also presented in tick boxes which made it clearer for participants to indicate their responses.

3.4 Planned analyses

Given that the study aimed to measure elements of the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), it was expected that preliminary bivariate analyses, such as Pearson's r correlations, would be used to examine relationships between the components of the model, e.g. attitudes and their association with intention to seek help. According to a breadth of research studies applying the Theory of Reasoned Action to predict health-related behaviours, multiple regression analysis appears to be the statistical test of choice (Rashidian, Miles, Russell, & Russell, 2006). For the purposes of conducting multiple regression analysis, a priori test of sample size was conducted in order to provide the minimum sample size required to perform relevant calculations. This calculation was based on alpha level (0.05), number of predictors (nine), anticipated effect size (0.25) and desired statistical power (0.8) which calculated a minimum sample size of 74.

Provided that sufficient participants reported that they had experienced mental health problems and were willing to report help seeking experiences, it would be possible to subsequently conduct a path analysis to investigate whether the adapted model of the TRA could predict actual help seeking behaviour.

3.5 Ethical considerations

The main ethical considerations of this study focused on informed consent, confidentiality and storage of data. In terms of informed consent, it was highlighted in the participant information sheet (Appendix 1) what taking part in the study would involve. Both the information sheet and consent form (Appendix 2) also stated that taking part in the study was entirely voluntary and that one could withdraw from the study at any time without having to give a reason. With regard to confidentiality, participants were informed that all information gathered through the study would remain confidential to the researcher and their information was anonymous to the researcher as participants were not required to give specific identifiable information

such as their name or contact details. However, participants were asked to provide a unique code only identifiable to themselves which would enable the researcher to remove their data from the study should they wish to withdraw at any time. Participants were informed that only the researcher would have access to their completed questionnaires and these would be locked in a secure location. All computerised data files pertaining to the questionnaire responses were password protected and had no identifying information.

The researcher was aware that through the process of completing the questionnaire participants may become aware of their own mental health needs and/or it may raise issues relating to their current/previous mental health concerns and treatment. In order to account for this possibility the researcher included on the debrief sheet a list of potential sources of support that participants could access should they feel that they would like some assistance with their mental health concerns. The debrief sheet (Appendix 10) prompted the participants to use the listed resources if the questionnaire left them feeling distressed.

Ethical approval was obtained from the School of Psychology Ethics Committee at the University of Hertfordshire. Once ethical approval this had been obtained (see Appendix 11 for the ethics application form and approval certificate), only then were potential participants asked if they would be willing to take part in the study and questionnaire packs were distributed. Further ethical approval was considered unnecessary as the sample recruited were a non-clinical population.

4. Results

The results of the data analysis will initially begin with the following sections: (1) Demographic information and religious profile of the sample; (2) Descriptive analysis of the variables which may be associated with intention to seek professional help; (3) The prevalence of mental health problems amongst the sample and help seeking.

More in-depth statistical analyses will subsequently be reported in order to address the main hypotheses of the study concerning the adapted model of the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and intention to seek professional help. These analyses will be presented in the following order: (4) Bivariate analyses of variables which may be associated with intention to seek professional help; (5) Multiple regression analysis identifying reliable predictors of intention to seek help.

Finally the results chapter will report the subgroup analysis focusing on actual help seeking behaviour: (6) Point-biserial correlations of variables considered to be associated with actual help seeking; (7) Path analysis of help seeking behaviour; (8) Exploratory analyses investigating why people did not seek professional help.

4.1 Demographic information and religious profile of the sample

4.1.1 Age and gender

As shown in Table 1, the sample included a larger number of female participants (56%) than male participants (44%). The age of participants ranged from 19 to 95 years-old, with the mean age of the sample being 46 years old.

Table 1: Frequency counts and percentages of the gender and age of the sample.

Gender	**Frequency**	**Percentage**
Male	55	44%
Female	71	56%
Total	126	100%
Age (in years)	**Frequency (N = 126)**	
Mean	46 years	
Range	19 - 95 years	
Age groups	**Frequency (N=126)**	**Percentage**
19 – 30 years	48	38%
31 – 50 years	17	13%
51 – 70 years	49	39%
Over 71 years	12	10%
Total	126	100%

4.1.2 Educational achievement and socio-economic status

Data pertaining to level of education and socio-economic status are presented in Table 2. Over three-quarters of the sample (77%) had obtained A-Levels and higher educational qualifications, with 31% having obtained postgraduate qualifications. Based on data regarding participants' occupations, the socio-economic status of the sample was high, with 74% of the sample assigned to the highest socio-economic classifications, namely 'Managerial & professional occupations' and 'Intermediate occupations'[7]which are respectively the first and second highest socio-economic classes in the UK.

[7] These classifications are based on the National Statistics Socio-Economic Classification (NS-SEC) system which has been the official measurement of socio-economic status used by the UK government since 2001 (Office for National Statistics, 2008). The socio-economic classification is based on coding information regarding an individual's occupation and their employments status (e.g. whether they are self-employed, in a large organisation etc). However, it was not possible to obtain information about employment status from participants in this sample and therefore the classifications reported here are based on occupation alone and may not be an entirely accurate reflection of participants' socio-economic status.

Table 2: Frequency counts and percentages of educational qualifications and socio-economic class

Highest educational qualification	**Frequency (N = 126)**	**Percentage**
None	7	6%
Diploma	8	6%
O-Levels/GCSEs	14	11%
A-Levels	10	8%
Undergraduate degree	48	38%
Postgraduate degree	39	31%
Total	126	100%
Social class	**Frequency (N = 126)**	**Percentage**
Managerial & professional occupations	78	62%
Intermediate occupations	15	12%
Small & own account workers	6	5%
Lower supervisory & technical occupations	1	<1%
Semi-routine & routine occupations	14	11%
Not classified (e.g. students or inadequately described occupations)	12	9%
Total	126	100%

4.1.3 Geographical location and countries of origin

In terms of geographical location, Table 3 indicates that most participants live in London/South East England (43%), Leeds (43%) and Manchester (12%) which broadly reflects the Jewish communities in which the researcher is currently/has been linked to or located. Whilst the majority of participants were born in the UK, 12% of participants originated from Israel, USA, Russia, mainland Europe and Australia.

Table 3: Frequency counts and percentages of the geographical location of participants and their country of origin

City/location in the UK	**Frequency (N=126)**	**Percentage**
Birmingham	2	1%
Leeds	54	43%
Manchester	14	12%
London/South East England	54	43%
Other	2	1%
Total	126	100%
Country of origin	**Frequency (N = 126)**	**Percentage**
United Kingdom	106	85%
USA	4	3%
Israel/Middle East	4	3%
South Africa	3	2%
Mainland Europe	4	3%
Netherlands	1	<1%
Russia/Eastern Europe	3	2%
Australia	1	<1%
Total	126	100%

4.1.4 Religious profile of the sample

For the purposes of analysis, Table 4 provides data pertaining to the Jewish denominations of participants which were collapsed into four main groups. Nearly half of participants (48%) described themselves as affiliated to the 'Modern Orthodox' denominations which also includes those who describe themselves as 'Traditional'. 22% of participants described themselves as 'Secular/Culturally Jewish but not practising' and 17% of participants belong to 'Orthodox' streams including Lubavitch and Chassidic denominations. According to one of the most recent data of synagogue membership across the UK, 55% of synagogue members are affiliated to Modern Orthodox denominations, whilst 11% are affiliated to Orthodox

denominations (Hart & Kafka, 2006). These figures indicate that the proportion of Jews affiliated to each denomination are broadly representative of national estimates[8].

Table 4: Frequency counts and percentages of Jewish denominations and Jewish background.

Denomination	**Frequency (N=126)**	**Percentage**
Modern Orthodox	60	48%
Orthodox	21	17%
Other e.g. Reform or unspecified	17	13%
Secular/Culturally Jewish but not practising	28	22%
Total	126	100%
Jewish background	**Frequency (N=126)**	**Percentage**
Ashkenazi	105	83%
Sephardi	12	10%
Unknown/unspecified	9	7%
Total	126	100%

Table 4 also indicates that the majority of the sample were Ashkenazi, whilst just under 10% were of Sephardi descent.

4.2 Descriptive analysis of variables associated with intention to seek professional help

Religiosity

Religiosity was a measure of religious observance (i.e. participation in religious activities and maintaining religious laws/customs) and religious commitment beliefs. For a more detailed explanation of how religiosity was measured please refer to the Methods section. A one-way ANOVA indicated that there were significant

[8] It is worth emphasising that these estimates are based on individuals who are formal members of a synagogue. However, many Jewish people define their denomination without formal synagogue membership and therefore these estimates may not provide an exhaustive representation of the proportion of Jewish denominations.

differences across Jewish denominations in terms of their overall religiosity score, with greater religiosity reported amongst more strictly practicing Jewish denominations. According to Levene's Test of Equality of Means, homogeneity of variance was violated; therefore the Welch *F*-ratio is reported, $F(3, 44.64) = 24.59$, $p<0.001$. As shown in Table 5, the mean religiosity score for the sample as a whole (10.17) falls between 'Other' and 'Secular/culturally Jewish but not practising' groups.

Table 5: Means and standard deviations of religiosity scores according to Jewish denomination (N Total = 126)

Jewish denomination (descending according to level of religious adherence)	**N**	**Mean (SD)**
Orthodox	21	16.81 (8.96)
Modern Orthodox	60	11.05 (6.48)
Other e.g. Reform or unspecified	17	10.47 (6.91)
Secular/culturally Jewish but not practising	28	3.14 (4.04)
Total sample	126	10.17 (7.82)

Beliefs about the causes of mental illness

Beliefs about the causes of mental illness were split into four categories: Stress, Western Physiological, Non-western Physiological and Supernatural causes (please refer to the Methods section for a more detailed explanation of how causal beliefs were measured). It is worth noting that correlational analysis revealed that all four categories of causal beliefs were inter-correlated which is surprising given that some of the categories are supposed to represent very different causal explanations of mental illness (e.g. Western Physiological beliefs were moderately positively correlated with Supernatural beliefs, $r = 0.51$, $p<0.001$), suggesting the need for further investigation of these categories.

Table 6 shows the extent to which this sample of Jewish people endorsed the four categories of causal beliefs compared to other religious groups in Britain reported by Sheikh and Furnham (2000). Based on this data, it appears that this sample of Jewish people more strongly believed in stress-related causes of mental illness than other

religious groups, and indicated less belief in western physiological, supernatural and non-western physiological causes than other religious groups.

Table 6: Mean and standard deviations of scores on each causal belief category amongst the current sample and data based on other religious groups in Britain

Category of causal belief	Jewish Mean (SD)	Muslim Mean (SD)	Hindu Mean (SD)	Sikh Mean (SD)	Christian Mean (SD)	No religious affiliation Mean (SD)
Stress causes	**53.0 (8.8)**	50.2 (12.3)	47.4 (12.0)	48.1 (10.2)	51.3 (11.4)	53.7 (11.1)
Western physiological causes	**29.2 (5.2)**	33.2 (8.6)	32.1 (7.7)	34.9 (10.1)	33.8 (6.6)	34.6 (7.0)
Supernatural causes	**39.5 (15.0)**	51.9 (20.9)	48.0 (16.5)	46.7 (15.9)	47.4 (17.9)	46.1 (17.6)
Non-western physiological causes	**11.2 (4.2)**	16.5 (5.5)	16.3 (5.4)	14.0 (4.5)	15.8 (5.4)	15.1 (5.3)

Attitudes towards seeking help

Two measures of attitudes were used; one of which measured attitudes towards seeking professional help and the other was a more specific measure of attitudes towards seeking psychological help (please refer to the Methods section for more in-depth descriptions of these attitudinal measures). Pearson's r indicated that there was a significant correlation between these two scales ($r = 0.69$, $p<0.001$). On the measure of attitudes towards seeking professional help the mean total score was 65.58 (SD = 12.92). Compared to a normative sample on which this measure was originally based (a community sample of Canadian adults with and without mental health problems, mean = 69.2, SD = 14.4), the current sample appeared to hold slightly less positive attitudes towards seeking professional help than this group. According to scores on the scale specifically measuring attitudes towards seeking psychological help, the mean total score was 20.72 (SD = 5.71), which is similar to mean scores based on an American Jewish sample (Orthodox Jewish group mean = 18.3, Conservative Jewish group mean = 20.3, Reform group mean = 19.3, reported by Kaminetzky & Stricker, 2000).

An independent samples t-test indicated there were no significant differences in attitudes towards seeking professional help (t=-1.51, df = 124, p = 0.13) nor attitudes towards seeking psychological help (t = -1.01, df = 124, p = 0.31) between men and women. A one-way ANOVA indicated that there were no significant differences in attitudes towards seeking professional help (F = 0.35, df = 3, 122, p = 0.79) and psychological help (F = 0.68, df = 3, 122, p = 0.57) according to age group. There were also no significant differences in attitudes towards seeking professional help (F = 0.43, df = 6, 119, p = 0.86) and psychological help (F = 0.69, df = 6, 119, p = 0.66) in relation to socio-economic status. Furthermore, there did not appear to be any significant differences in attitudes towards seeking professional help (F= 0.34, df = 6, 118, p = 0.91) and psychological help (F = 0.98, df = 6, 118, p = 0.44) according to level of educational qualification.

Subjective norm

In terms of participants' subjective norm (please refer to the Methods section for a more detailed explanation of how subjective norm was measured) in relation to seeking professional and religious help, Table 7 shows that nearly two-thirds of the sample agreed that close others would think they should seek professional help. Much fewer participants agreed that people close to them would think they should turn to prayer and the help of G-d and even fewer still agreed that close others would think they should seek the help of a Rabbi.

Table 7: Frequency and percentages of the sample (N total = 126) endorsing statements reflecting subjective norms about different forms of help

Subjective norm about different forms of help	**Frequency (N=126)**	**Percentage**
Most people who are important to me would think I should seek a professional if I were experiencing emotional distress	91	72.2%
Many people like me would turn to G-d and prayer to help with their mental health concerns	33	26.2%
The people in my life whose opinions I value would think I should see a Rabbi if I had emotional problems	14	11.1%

Although an independent samples t-test suggested that there were no differences in subjective norm relating to seeking professional help between men and women (t = -

1.86, df = 124, p = 0.07), these differences were approaching significance. One-way analysis of variance revealed that there were no significant differences in subjective norm associated with seeking professional help according to age group (F = 1.39, df = 4, 121, p = 0.24), socioeconomic status (F = 1.12, df = 4, 121, p = 0.35) and level of educational qualification (F = 0.53, df = 4, 120, p = 0.71).

Intention to seek help

Intention to seek different forms of help was indicated by participants endorsing statements reflecting intentions to seek different forms of help, including professional, religious, community based help and support of friends and family (please refer to the Methods section for a more detailed explanation of how intention to seek help was measured). According to Table 8, the majority of the sample (77%) indicated that they would seek professional help in the event of experiencing a mental health problem. Many participants also indicated that they would seek help from family and friends if they were experiencing a mental health problem, whereas much fewer participants would seek the religious based help including seeking the help of a Rabbi and turning to G-d. Table 8 also suggests that less than a quarter of participants would prefer to use Jewish community based services over NHS provision.

Table 8: Frequency and percentages of the sample (N total = 126) endorsing statements reflecting intentions to seek different forms of help

Intentions to seek different types of help	**Frequency (N=126)**	**Percentage**
I would see a professional if I was experiencing emotional distress	97	77.0%
I would prefer to use Jewish community based mental health services than those provided by statutory services (e.g. the NHS)	26	20.6%
I would seek the help of a Rabbi if I thought I had a mental health problem	15	11.9%
I would turn to G-d to help me deal with emotional problems	34	29.4%
I would ask for help from my friends and family if I had emotional problems	88	69.8%

An independent samples t-test indicated that there were no significant differences in intention to seek professional help between men and women ($t = -0.74$, $df = 124$, $p = 0.46$). One-way analysis of variance revealed that there were no significant differences in intention to seek professional help according to age group ($F = 1.39$, $df = 3, 122$, $p = 0.25$), socioeconomic status ($F = 0.65$, $df = 6, 119$, $p = 0.69$) and level of educational qualification ($F = 0.56$, $df = 6, 118$, $p = 0.76$).

4.3 The prevalence of mental health problems amongst the sample and help seeking

Although this survey was aimed at the general Jewish community, a substantial proportion of individuals reported that they had experienced a mental health problem. More specifically, 63% (N=79) of participants indicated that they have/have had a mental health problem. However only 68 participants who had reported a mental health problem were willing to share information about their mental problem and the types of help/support they sought.

Which mental health problems were reported?

Participants were asked to write down a brief description of the problem and/or a formal diagnosis if they knew this information. According to Table 9, the most common mental health problems were anxiety and depression which were reported by nearly half of participants (47%) who had indicated that they have/have had a mental health problem. In contrast, much fewer individuals reported eating disorders (4%) and drug/alcohol problems (2%). However, 19 % of individuals did not specify the nature of their mental health problem. A Chi-squared test was used to confirm whether there were any gender differences in the types of problems being reported. This indicated that there were no significant differences amongst men and women in the types of problems they reported (Chi-squared = 8.90, (df = 7), p = 0.26).

Table 9: Frequencies and percentages of mental health problems of participants who were willing to provide information about their experiences of seeking help

Type of mental health problem	Frequency(N=68)	Percentage
Depression	18	26%
Anxiety problems (including phobia, panic, stress, etc)	14	21%
Sleeping difficulties	8	12%
Bipolar disorder	4	6%
Eating disorder	3	4%
Drug/alcohol problems	1	2%
Other e.g. bereavement, psychosis, Obsessive Compulsive Disorder, marital difficulties	7	10%
Unspecified	13	19%
Total	68	100%

Help seeking for mental health problems

What help was sought?

Based on the responses of individuals who were willing to report their experiences of help seeking (N=68), the majority of this group (N=58; 85%) indicated that they had sought professional help (including a GP, counsellor, psychiatrist, etc). Table 10 indicates all types of help which were sought by participants when they experienced a mental health problem (including professional, non-professional and religious help). For example, over half of participants sought help from their GP (57%) and over half sought help from informal means including their friends (51%) and family (54%).

Table 10: Frequencies and percentages of participants who sought different forms of help

Type of help sought	**Frequency[9](N=68)**	**Percentage[10]**
Rabbinical advice	12	18%
Mekubal advice[11]	2	3%
Prayer	17	25%
Support from friends	35	51%
Support from family	37	54%
GP	39	57%
Psychiatrist	25	37%
Psychologist	24	35%
Counsellor/therapist	32	47%
Social worker	6	9%
Jewish mental health organisation	10	15%
Other e.g. hypnotherapy	5	7%

[9] These frequencies represent the number of individuals (from the group of participants who were willing to share information about their help seeking experiences, N=68) who sought a particular form of help.
[10] Therefore these percentages are calculated from the total number of participants (N=68) who shared information about their help seeking rather than being calculated from the total number of responses indicating that multiple sources of help were sought.
[11] A 'Mekubal' is a religious leader from the Kabbalist movement

What help was eventually used?

According to Table 11, approximately half of participants eventually used support from their friends (51%) and family (50%) and just under took up advice from their GP (43%). Use of professional mental health services also appeared to be relatively high; 41% used psychiatric medication and up to a third (34%) of participants received counselling/psychotherapy through the NHS.

Table 11: Frequencies and percentages of the types of help participants eventually used

Type of help eventually used	Frequency[12]	Percentage[13]
Support from friends	35	51%
Support from family	34	50%
Advice from GP	29	43%
Medication	28	41%
Counselling/psychotherapy in NHS	23	34%
Prayer	13	19%
Private psychotherapy	11	16%
Admission to hospital	8	12%
Rabbinical advice	8	12%
Support group in NHS	8	12%
Counselling/psychotherapy in Jewish mental health organisation	6	9%
Support group in Jewish mental health organisation	5	7%
Involvement of social worker	5	7%
Mekubal advice	3	4%
Other e.g. 12 Step programme, physical exercise	13	19%

[12] Again these frequencies represent the number of individuals (from the group of participants who were willing to share information about their help seeking experiences, N=68) who sought a particular form of help.

[13] Therefore these percentages are calculated from the total number of participants (N=68) who shared information about their help seeking rather than being calculated from the total number of responses indicating that multiple sources of help were sought.

How did people rate the help received?

When asked to rate their experiences of seeking help for mental health problems, Table 12 indicates that the majority of participants (68%) felt positive or very positive about the help they had received/used.

Table 12: Frequencies and percentages of the ratings of services/help received

Rating	Frequency (N=68)	Percentage
Very positive	14	21%
Positive	32	47%
Neither positive or negative	14	21%
Negative	2	3%
Very negative	1	1%
Unspecified	5	7%
Total	68	100%

4.4 Testing the research hypotheses: Bivariate analyses of variables associated with intention to seek help

Given that this study aimed to measure elements of the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980) this section will be structured accordingly; preliminary bivariate analyses examining existing components of the theoretical model will be reported first (i.e. attitudes and subjective norm) followed by other possible contributory variables (i.e. religiosity, beliefs about the causes of mental illness, level of education) and the extent to which they are associated with intention to seek professional help. Following these preparatory analyses, a multiple regression analysis with a backward selection algorithm will be reported. This was used to identify those predictors of intention to seek professional help that make a unique contribution to the prediction model overall when controlled for the other predictors in the model.

For the purposes of conducting multiple regression analysis, variables were checked for their linearity and as this condition was met Pearson's r was used to perform the preliminary bivariate analyses reported here. Similarly, important predictors regarding the actual behaviour of help seeking (i.e. yes versus no) were identified on the basis of a bivariate correlational analysis involving point-biserial correlations between the predictors and help seeking behaviour. Whilst the multiple regression analysis regarding intention to seek professional help involved the whole sample (N=126), the analysis regarding the behaviour of seeking professional help could only be applied to a subgroup of the sample comprising those who had reported a mental health problem (N = 68) and thereby suggesting a need to act in response to their problems.

Attitudes towards seeking help and intention to seek professional help

Two measures of attitudes were used; one of which measured attitudes towards seeking professional help and the other was a more specific measure of attitudes towards seeking psychological help (please refer to the Methods section for more in-depth descriptions of these attitudinal measures). In accordance with the Theory of Reasoned Action, Table 13 indicates that there were strong positive correlations between attitudes towards seeking professional help and intention to seek professional help (Pearson's $r = 0.58$, $p<0.001$) and attitudes towards seeking psychological help and intention to seek professional help ($r = 0.61$, $p<0.001$). Moreover, these findings indicate that more favourable attitudes towards seeking professional and psychological help were related to greater intention to seek professional help.

Subjective norm and intention to seek professional help

Again, in accordance with the Theory of Reasoned Action, Pearson's r indicated that there was a moderate positive correlation between subjective norm to seek professional help and intention to seek professional help ($r = 0.39$, $p<0.001$). This finding which is shown in Table 13 suggests that the greater one's subjective norm towards seeking professional help, the greater one's intention to seek this help.

Religiosity and intention to seek professional help

'Religiosity' was measured according to a self-report questionnaire developed by the researcher to assess a participants' level of religious participation/observance and religious commitment beliefs (a more detailed explanation of the religiosity measure can be found in the Methods section). As shown in Table 13, Pearson's r indicated that there was not a significant relationship between religiosity and intention to seek professional help ($r = 0.09$, $p = 0.16$), suggesting that there is no association between one's level of religiosity and intention to seek professional help. Interestingly however, there was a moderate correlation between religiosity and intention to seek religious based help ($r = 0.59$, $p<0.01$ one-tailed). It would therefore appear that whilst religiosity is not related to intention to seek professional help, greater religiosity is related to greater intention to seek religious based help.

Beliefs about the causes of mental illness and intention to seek professional help

Beliefs about the causes of mental illness were split into four categories: Stress, Western Physiological, Non-western Physiological and Supernatural causes (please refer to the Methods section for a more detailed explanation of how causal beliefs were measured). Before bivariate analysis were performed, it is worth noting that correlational analysis revealed that all four categories of causal beliefs were inter-correlated which is surprising given that some of the categories are supposed to represent very different causal explanations of mental illness (e.g. Western Physiological beliefs were moderately positively correlated with Supernatural beliefs, $r = 0.51$, $p<0.001$), suggesting the need for further investigation of these categories.

As can be seen in Table 13, Pearson's r revealed that there was only a weak positive correlation between stress-related causal beliefs and intention to seek professional help ($r = 0.19$, $p = 0.02$). This finding suggests that greater endorsement of beliefs about stress-related causes of mental illness were associated with greater intention to seek professional help.

Table 13: Correlation coefficients of variables which may be associated with intention to seek professional help

Variables potentially associated with intention to seek professional help	**Strength of correlation Pearson's *r* coefficient (N=126) 'Intention'**	**Level of Significance**
Attitudes towards seeking professional help	0.58	P<0.001
Attitudes toward seeking psychological help	0.61	P<0.001
Subjective norm	0.39	P<0.001
Religiosity	0.09	P = 0.16
Beliefs about the causes of mental illness:		
a) Stress	0.19	P = 0.02
b) Western physiological	0.14	P = 0.07
c) Non-western physiological	0.05	P = 0.28
d) Supernatural	0.09	P = 0.16
Level of education	-0.08	P = 0.19

Education level and intention to seek professional help

Although the original hypotheses did not include predictions about the relationship between educational achievement and intention to seek professional help, it was subsequently considered appropriate to test this variable given the high level of educational achievement across this sample. However, as can be seen in Table 13, Pearson's r revealed that there was no significant association between level of education and intention to seek professional help ($r = -0.08$, $p=0.19$).

4.5 Testing the research hypotheses: Identifying reliable predictors of intention to seek professional help using multiple regression analysis

Initial model of intention to seek professional help

The initial model which aimed to predict intention to seek professional help, based on Ajzen and Fishbein's (1980) 'Theory of Reasoned Action', was assessed using multiple regression analysis. This model is presented in Fig 2. Initially nine potential predictor variables (including attitudes towards seeking psychological help, attitudes towards seeking professional help, subjective norm, level of religiosity, the four

categories of causal beliefs and level of education) were entered into the multiple regression in order to identify which of these variables best predicted intention to seek professional help. The multiple regression analysis employed a backwards selection procedure to identify only reliable predictors and remove those variables from the model which made no substantial contribution to its predictive power.

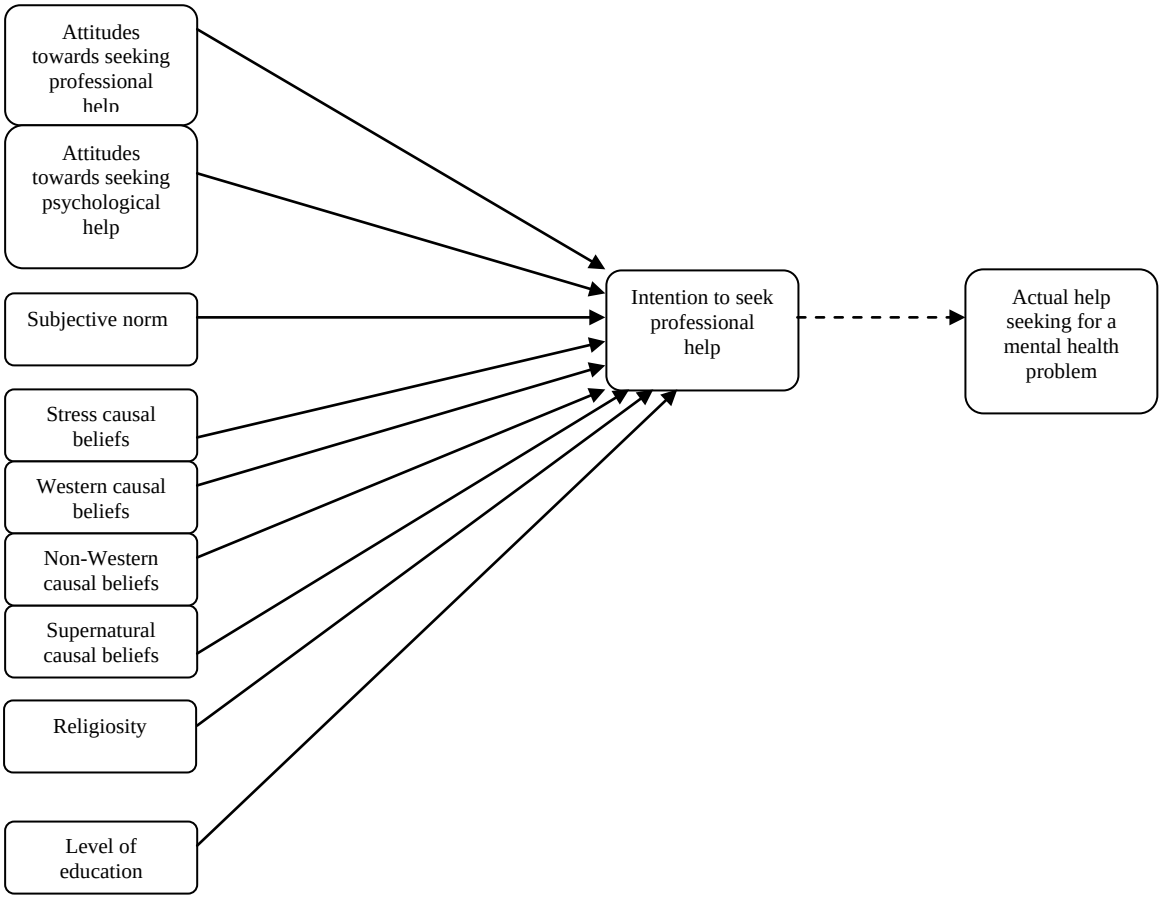

Figure 2: Initial model of potential predictors of intention to seek professional help.

The Beta values and significance of each potential predictor are shown in Table 14, which indicate the strength of each variable in predicting intention to seek professional help. The full model including all nine predictors was statistically significant, $F(9,115) = 10.7$, $p<0.001$ and explained 46% of the variance, but the adjusted R^2 was smaller (R^2 adjust = 0.41) indicating that the model contained non significant predictors.

Table 14: Beta values and levels of significance of all nine predictor variables initially entered into the multiple regression analysis (N=126)

Predictor variable	Beta	T	Significance
Attitudes towards seeking professional help	0.26	2.63	P = 0.01
Attitudes towards seeking psychological help	0.38	3.79	P < 0.001
Subjective norm	0.12	1.48	P = 0.63
Religiosity	-0.02	-0.27	P = 0.79
Beliefs about the causes of mental illness:			
a) Stress-related causal beliefs	0.09	0.94	p = 0.35
b) Western-physiological causal beliefs	0.05	0.46	p = 0.65
c) Non-Western physiological causal beliefs	-0.09	-0.77	p = 0.45
d) Supernatural causal beliefs	0.06	0.50	p = 0.62
Level of education	-0.09	-1.26	P = 0.21

Final model of intention to seek professional help

The backwards selection procedure subsequently removed six of the predictor variables (e.g. subjective norm, religiosity, Western Physiological causal beliefs, Non-Western physiological causal beliefs, supernatural causal beliefs and level of education), resulting in a final model with only three predictors presented in Figure 3. This model explained 44% of the variance in intention to seek professional help and was statistically significant, $F(3, 121) = 31.10$, $p<0.001$.

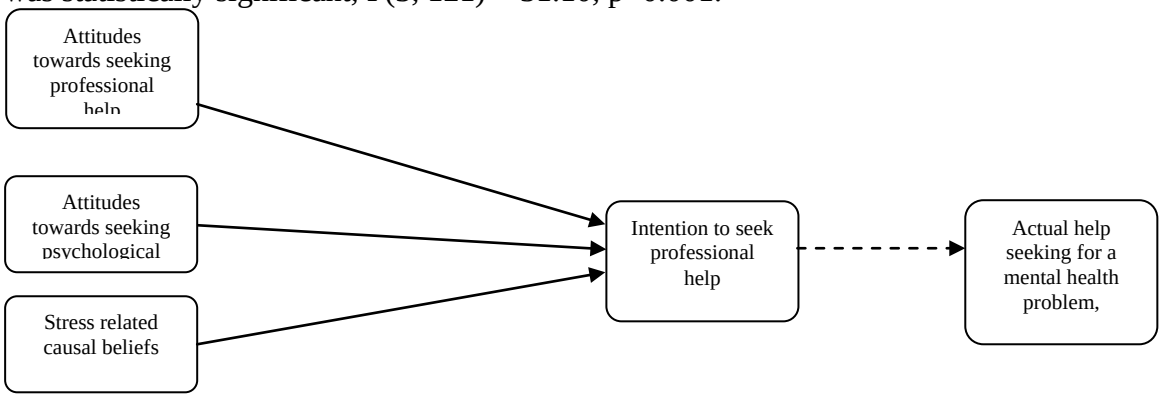

Figure 3: Final model of the three predictors of intention to seek professional help

As shown in Table 15, the Beta weights pertaining to the attitudes towards seeking professional and psychological help were around 0.30 indicating that these were greater predictors of intention to seek professional help than stress-related causal beliefs about mental illness which, according to its relatively low Beta weight, appeared to make a very minor contribution to the final model.

Table 15: Beta values and levels of significance of the three strongest predictors of intention to seek help (N=126)

Predictor	Beta	T	Significance
Attitudes towards seeking professional help	0.29	3.13	$p = 0.002$
Attitudes towards seeking psychological help	0.40	4.17	$p < 0.001$
Stress-related causal beliefs	0.13	1.86	$p = 0.065$

4.6 Identifying reliable predictors of actual seeking professional help: A Subgroup analysis

A subgroup analysis of participants was conducted in order to determine important predictors for the actual behaviour of professional help seeking. This subgroup included 68 participants who reported that they had suffered from a mental health problem in the past and were willing to share information about their experiences of seeking help. The majority of this group, 85% (N=58) indicated that they had sought professional help at a time when they had experienced a mental health problem. Given that the variable representing 'actual help seeking' was dichotomous (i.e. it represented sought help or not sought help), point-biserial correlations were performed and are displayed in Table 16.

Point-biserial correlations of variables associated with having sought help

In line with the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975), intention to seek professional help was substantially correlated with actual help seeking. Furthermore, attitudes towards seeking psychological help were also strongly correlated with the behaviour of help seeking. Other significant correlations included supernatural causal beliefs, stress related causal beliefs and

subject norm, which were all moderate in terms of the strength of their correlations with help seeking behaviour.

Table 16: Point-biserial correlation coefficients of variables associated with having sought help or not (N=68)

Predictor variable	**Strength of correlation Pearson's *r* coefficient**	**Level of significance**
Attitudes towards seeking professional help	0.18	p = 0.15
Attitudes towards seeking psychological help	0.47	p<0.001
Subjective norm	0.28	p = 0.02
Religiosity	0.07	p = 0.58
Beliefs about the causes of mental illness:		
Stress-related causal beliefs	0.23	p = 0.06
Western-physiological causal beliefs	0.17	p = 0.17
Non-Western physiological causal beliefs	0.19	p = 0.12
Supernatural causal beliefs	0.22	p = 0.07
Level of education	-0.12	p = 0.35
Intention	0.42	p<0.001

4.7 A path analysis of help seeking behaviour

The Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) provides a good rationale for investigating two important questions concerning people's decision to consult a professional because of their mental health problem and to behave accordingly (i.e. make an appointment). One question relates to the role of intention as the central mediator in this model essential for the transformation of a decision into action. Although it was assumed that the behaviour of help seeking depended entirely on intention formation, it would be important to initially identify those predictors that strongly impacted on intention since without their influence on intention no action/behaviour would follow. This 'strong mediator model' is presented in Figure 4, which indicates that none of the predictors (i.e. attitudes, subject norm, supernatural causal beliefs and stress-related causal beliefs) contribute to help-seeking behaviour directly. Rather, any impact of these predictors on action is only indirect and mediated via intention.

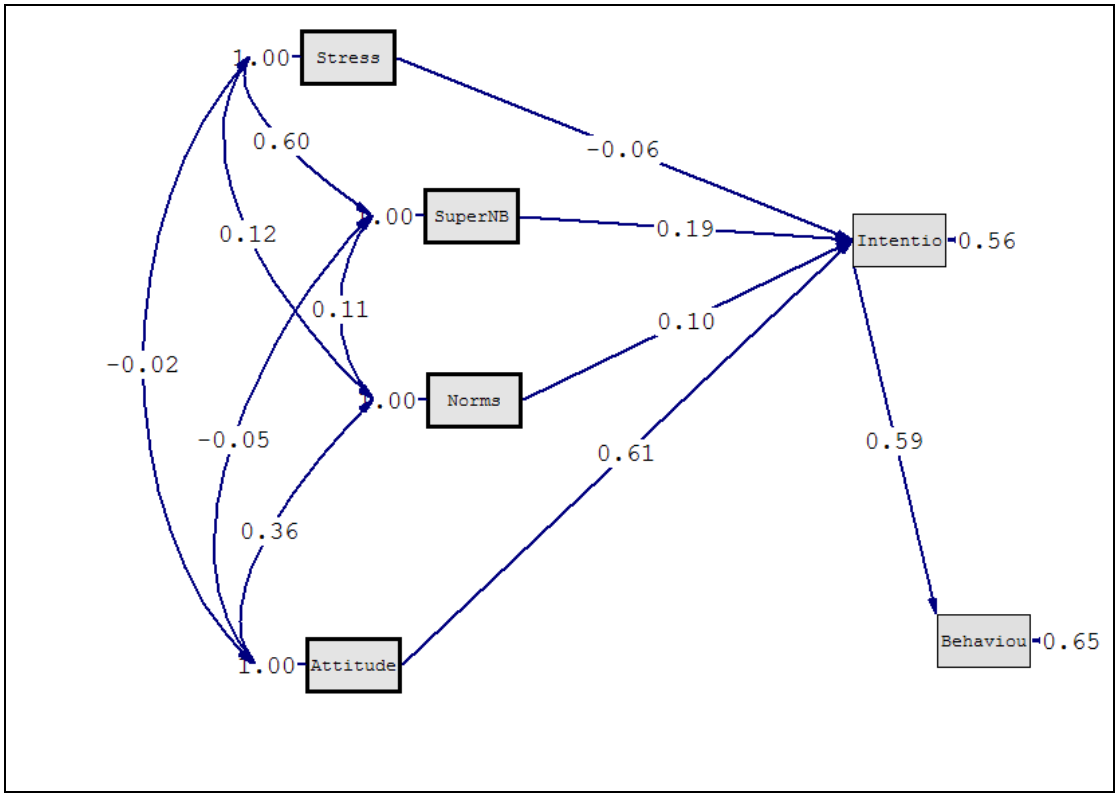

Figure 4: A strong mediator model of intention showing path coefficients for the strong mediator path model (N.B. 'Stress' = stress-related causal beliefs, 'Norms' = subjective norm, 'SuperNB' = supernatural causal beliefs)

The path analysis considered only five predictors because the previous regression and point-biserial correlational analyses had identified that it was only these predictors which had statistically significant relationships with intention (i.e. attitudes and stress-related causal beliefs) or behaviour (i.e. attitudes, subject norm, supernatural causal beliefs, stress-related causal beliefs and intention). A second question which could be addressed by the path analysis concerned the notion of 'automated behaviour' or an action that does not depend on a clear process of intention formation. Could it be that specific attitudes, stress experiences or specific beliefs lead directly to action? If that was true, those predictors should have a direct impact on help seeking behaviour even when intention to act was also included in the model. Such a model would allow predictors to influence behaviour in two ways - directly as well as indirectly via intention as a mediator.

These two questions were investigated using path analysis. Given that help seeking was a dichotomous dependent variable and therefore not normally distributed, the statistical programme LISREL 8.80 was used to carry out these analysis using

polyserial correlations between help seeking behaviour and the other predictors. A robust ML estimation procedure appropriate for these types of correlation was used. As the two measures of attitudes towards seeking psychological help and professional help were considerably correlated (r = 0.56), they were added up to a total attitude score to keep the problem of colinearity under control as the sample size was rather small (N = 68) for path analysis. The correlation matrix of all the variables involved in this path analysis is shown in Table 17.

Table 17: Correlation Matrix of the variables for the path analysis (N = 68)

	Intention	Behaviour	Stress[14]	SuperNB[15]	SNorms[16]	Attitude
Intentio	1.00					
Behaviou	0.59	1.00				
Stress	0.05	0.34	1.00			
SuperNB	0.14	0.38	0.60	1.00		
SNorms	0.34	0.42	0.12	0.11	1.00	
Attitude	0.63	0.43	-0.02	-0.05	0.36	1.00

The strong mediator model described above was tested first and the result of the 'goodness of fit' test for this model suggested that it should be rejected, $\chi^2(4df) = 16.6$, $p < .0001$, with the fit indices RMSEA = 0.22, AGFI = 0.60, NFI = 0.89 all confirming that it was a poor fitting model. Several comments are worth making. As this model was rejected, it highlights that at least one predictor must affect behaviour directly, suggesting that help seeking behaviour may under some circumstances be triggered automatically without prior formation of a clear intention. Furthermore, attitude appears to be the single most important predictor, and the link between intention and behaviour also seems very strong. However, due to the very small sample size and some colinearity amongst the predictors, the path coefficients for stress and subjective norms did not reach an acceptable level of significance (i.e. a t-value < 1.65).

The next step in the path analysis involved the fitting of a full model allowing all four predictors to not only effect intention but also behaviour. This was done to identify those paths that were small and irrelevant and could therefore be removed from the model via a model trimming approach. Since the full model is a saturated model, its

[14] 'Stress' is an abbreviation for stress-related causal beliefs
[15] 'SuperNB' is an abbreviation for supernatural causal beliefs
[16] 'SNorms' is an abbreviation for subjective norm

goodness of fit is perfect and needs therefore no statistical evaluation. It merely served as the starting point for the search for an acceptable final model after the strong mediation model above had been rejected. The results for all the path coefficients of this full model are presented in Figure 5 below.

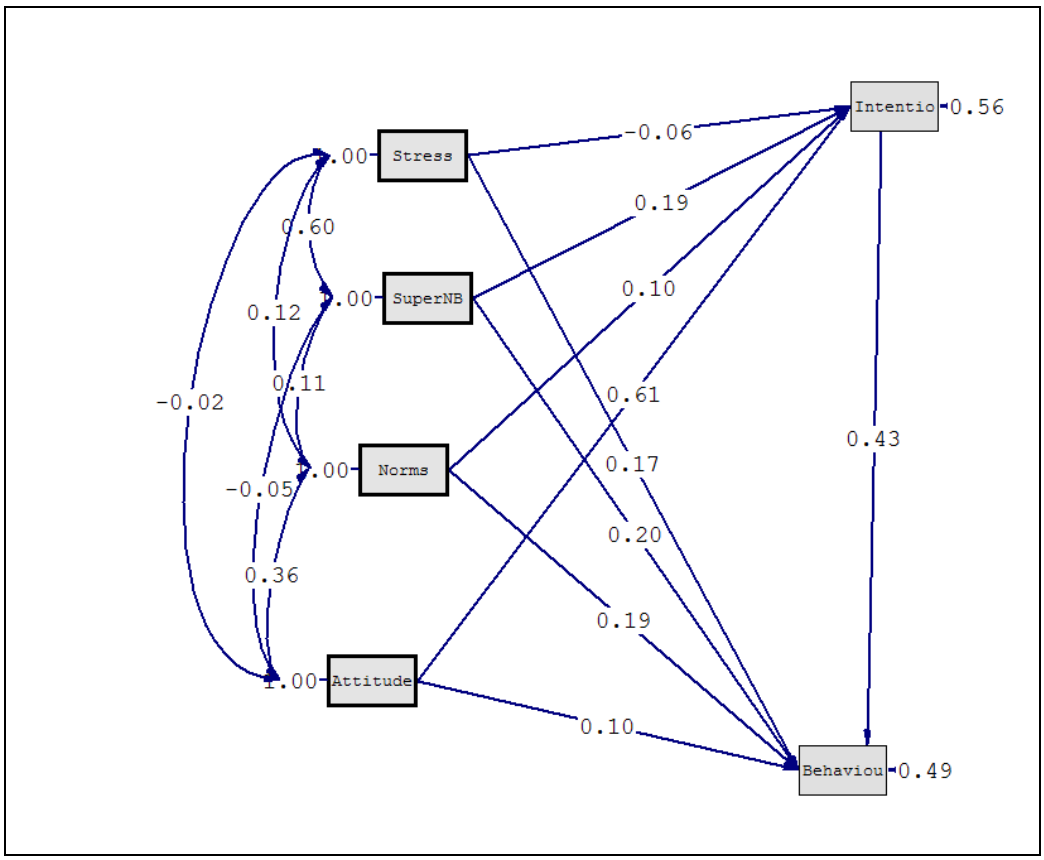

Figure 5: Path coefficients of the full path model (N.B. 'Stress' = stress-related causal beliefs, 'Norms' = subjective norm, 'SuperNB' = supernatural causal beliefs)

As is evident from Figure 5, several paths coefficients are very small and they were not statistically significant. In order to simplify this model, these paths were consequently removed one after the other from the model until a final model with only significant path coefficients emerged. During the process of model trimming the predictor of stress-related causal beliefs was removed entirely.

The final model is shown in Figure 6. The 'goodness of fit' test suggested that this model was fully acceptable, $\chi^2(2df) = 1.80$, $p = 0.41$, and relevant fit indices were excellent. RMSEA = 0.001, AGFI = 0.92, NFI = 0.98. The two remaining predictors of intention, i.e. attitudes and supernatural beliefs, explained together 43% of the

variance of intentions, with attitudes being the much stronger predictor. Similarly, 48% of the variance of help seeking behaviour was explained by the three predictors of intention, supernatural beliefs and subjective norms, with intention as the strongest predictor.

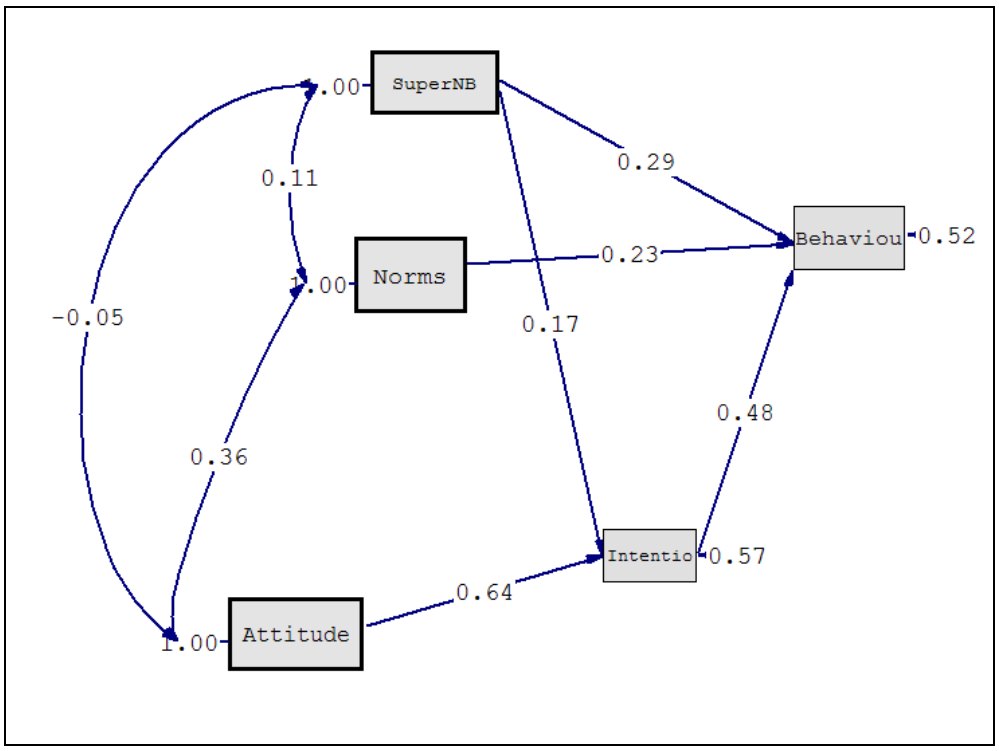

Figure 6: The final trimmed path model (N.B. 'Stress' = stress-related causal beliefs, 'Norms' = subjective norm, 'SuperNB' = supernatural causal beliefs)

The path analysis estimated the indirect effect of attitudes on behaviour mediated via intentions to be 0.31 and statistically reliable. The other indirect effect in the model associated with supernatural beliefs was very small in comparison, just 0.08 but still statistically reliable.

4.8 Exploratory analyses investigating why people did not seek professional help

Exploratory analyses were carried out in order to establish possible reasons why a small group of individuals (N=10) did not seek professional help despite reporting that they suffered a mental health problem. This involved examining demographic and religious differences between those who did seek help and those who did not seek help.

Gender

On first glance it appeared as though there may have been differences in the gender distribution between the two both groups; of those who sought help, 63.8% were female and 36.2% were male, whereas of those who did not seek help, 50% were female and 50% were male. However a Chi-squared test[17] provided no evidence that there were of there being significant differences in the numbers of men and women between these two groups, Chi-square = 0.69, (df = 1), p = 0.49.

Level of education

For the purposes of the Chi-square test, educational level was recoded into three broad categories which are shown in Table 18.

Table 18: Percentages of participants who sought help/did not seek help according to their educational qualifications

Level of education		Did they seek professional help or not?	
		Did not seek professional help (N=10)	Did seek professional help (N=58)
GCSEs or below	Count	1	10
	%	10.0%	17.2%
ALevels - Undergraduate degree	Count	4	31
	%	40.0%	53.4%
Postgraduate qualification (e.g. Masters, PhD)	Count	5	17
	%	50.0%	29.3%
Total	Count	10	58
	%	100.0%	100.0%

A Chi-Square test was used to compare whether there were significant differences amongst those who did seek/did not see professional help in terms of education level.

[17] Due to the small cell frequencies of these variables (i.e. gender, age, level of education, etc) Chi-square was calculated using the exact method.

The result of this test, Chi Square = 1.71, (df = 2), p = 0.52, revealed that there were no significant differences in terms of educational achievement between those who chose to seek professional hep and those who did not seek help. However the percentages in Table 18 suggest that those who did not seek help had the highest educational qualifications (e.g. Postgraduate).

Age

The mean age of individuals who sought professional help was 45 years-old (SD = 20.37) and similarly the mean age of those who did not seek professional help was 44.5 years old (SD = 17.06). An independent samples t-test confirmed that there were no significant differences in age between those who sought help and those who did not (t = -0.09, df = 66, p = 0.93).

Jewish denomination

Due to the small number of participants of particular denominations for the purposes of the Chi-square test, the variable of Jewish denomination was recoded into two broad categories which are shown in Table 19.

Table 19: Percentages of participants who sought help/did not seek help according to Jewish denomination

Jewish denomination		**Did they seek professional help or not?**	
		Did not seek professional help (N=10)	**Did seek professional help (N=58)**
Orthodox and Modern Orthodox	**Count**	6	37
	%	60.0%	63.8%
Reform/Liberal – Secular/Culturally Jewish but not practising	**Count**	4	21
	%	40.0%	36.2%
Total	**Count**	10	58
	%	100.0%	100.0%

According to the percentages shown in Table 19, it appears that there were roughly equal percentages of Jewish denominations amongst those who sought help and those who did not seek help. Furthermore, results of the Chi-Square, confirmed that there were no significant differences between the two groups (those who sought help/did not seek help) in terms of Jewish denomination, Chi Square = 0.05, (df = 1), one sided p = 0.54).

Additional or alternative sources of support

Religious-based help

It was also of interest to explore whether there were differences between those who sought help and those who did not seek help in terms of whether they also/alternatively sought religious based help (e.g. talking to a Rabbi, the use of prayer). Table 20 shows the percentages of participants in each group who sought religious based help which suggest that those who sought professional help also sought religious help, whereas those who did not seek professional help did not appear to seek religious help either. A Phi-correlation confirmed that there was a significant relationship between seeking religious help and seeking professional help, (Phi = 0.24, p = 0.05), suggesting that people may use multiple sources of help.

Table 20: Percentages of participants who sought/did not seek professional help and religious based support

Sought religious based help (e.g. support of Rabbi, prayer, etc.)		**Did they seek professional help or not?**	
		Did not seek professional help (N=10)	**Did seek professional help (N = 58)**
Sought religious based help	**Count**	10	41
	%	19.6%	80.4%
Did not seek religious based help	**Count**	0	17
	%	.0%	100.0%
Total	**Count**	10	58
	%	14.7%	85.3%

Personal and social support network

According to Table 21, it appears that people who did not seek professional help sought the support of family and friends to a greater extent than those who sought professional mental health care. However, a Phi-correlation indicated that there were no significant differences between those who sought and those who did not seek professional help in terms of the extent to which they made use of personal and social support (Phi = -0.06, p = 0.73).

Table 21: Percentages of participants who sought/did not seek professional help and personal and social support.

Sought support from family and/or friends		**Did they seek professional help or not?**	
		Did not seek professional help (N =10)	**Did seek professional help (N = 58)**
Did not seek support from family and/or friends	**Count**	3	22
	%	30.0%	37.9%
Did seek support from family and/or friends	**Count**	7	36
	%	70.0%	62.1%
Total	**Count**	10	58
	%	100.0%	100.0%

5. Discussion

5.1 Overview of hypotheses

The present study aimed to determine the strength of Jewish people's attitudes and intentions towards seeking professional help for mental health problems. Several findings suggest that this sample of Jewish people were positively inclined towards professional mental health services, not least because approximately three-quarters of participants indicated that they would seek a mental health professional in the event of experiencing a mental health problem. This study also investigated Jewish people's actual experiences of mental health problems and help seeking. This revealed that there was a remarkably high prevalence of mental health problems within this sample. 63% of individuals reported that they have had a mental health problem, and the majority of participants who reported their experiences had sought professional help for their mental health difficulties. Given that this signified that a large proportion of participants had previously had to consider whether to seek professional help or not, it was possible to conduct a subgroup analysis investigating the factors which contributed to them acting on their intentions to seek help.

A major focus of this study's hypotheses specifically related to testing an adapted model of the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975). In line with the original theoretical model, attitudes towards seeking professional and psychological help and subjective norm (i.e. the perceived influence of close others) were both associated with intention to seek professional help and intention was strongly associated with actual help seeking behaviour. Given that attitudes were strongly associated with intention it suggests that the more favourable one's attitudes towards seeking professional and psychological help, the more inclined a person would be to seek these forms of help. In terms of the moderate association between subjective norm and intention, this finding also indicated that the greater the degree of perceived social pressure to seek professional help, the stronger one's intention to seek professional help.

Given that this study aimed to identify the factors which predict help seeking behaviour specifically within the Jewish community, the TRA was adapted to include additional variables which were considered to potentially contribute to this phenomenon, for example, level of religiosity and causal explanations of mental illness. Although it was predicted that intention to seek professional help would be associated with one's level of religious observance and belief, there was no evidence of any significant relationship between religiosity and intention to seek professional help, nor people's actual help seeking behaviour. Although there were a number of hypotheses made concerning associations between types of causal beliefs and intention to seek help, the data indicated that these were only partially supported. As predicted, stress-related causal beliefs (e.g. bad experiences during childhood, too much work or study, etc) were positively associated with intention to seek help, yet there was no evidence that Western physiological explanations (e.g. genetic disorder, brain damage, etc) were significantly associated with intention. There was also no evidence that non-western physiological explanations (e.g. body out of balance, being hot, etc) and supernatural causal beliefs (e.g. dangerous unprovoked spirit, karma, etc) were negatively associated with intention to seek help. In summary, it appeared that attitudes towards seeking professional help and psychological help, subjective norm and stress-related causal beliefs were all positively associated with intention to seek professional help.

5.1.1. Findings of the Multiple Regression Analysis

The multiple regression analysis was primarily performed to identify which variables within the adapted model of the TRA were the strongest predictors of intention to seek professional help. Results indicated that attitudes towards seeking help and stress-related causal beliefs were the strongest predictors of intention to seek professional help. Moreover, 44% of the variance in intention to seek professional help was explained by attitudes towards seeking professional and psychological help and stress-related causal beliefs. This figure is comparable to other studies which have used the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) and Theory of Planned Behaviour (TpB; Ajzen, 1991) to explain various health-related behaviours. For example, Schomerus et al. (2009) reported that attitudes, subjective norm and perceived behavioural control accounted for 41-61% of

the variance in intention according to their model which used the TpB to predict intention to seek psychiatric help for depression.

5.1.2 The path analysis

Given that there was data available on people's attempts to seek professional help this provided the opportunity to test whether the adapted model of the TRA (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) could also predict Jewish people's actual help seeking behaviour. A path analysis was performed in order to establish which variables included in the adapted TRA model had a direct or indirect effect on actual help seeking behaviour. Only those variables which had been shown to be significant predictors of intention in the regression analyses or had significant point-biserial correlations with actual help seeking were included in the path analysis.

The results of the path analysis showed mixed support for the adapted model of the TRA. The adapted model of the TRA assumed that attitudes, subjective norms, religiosity and causal beliefs would have an indirect effect on actual help seeking behaviour which would all be mediated by intention. The path analysis tested this assumption, referred to as the 'strong mediator model', yet results showed that this model did not fit the data, indicating that actual help seeking was not always mediated by intention. In terms of psychological processes this suggested that behaviour was not always preceded by a rational thought process which takes into account one's intention towards the behaviour in question. Alternatively, it suggested that behaviour may be the result of more automatic processes not involving a clearly formed intention. These potential routes to behaviour were confirmed in the final model tested by the path analysis.

In accordance with the main assumption of the adapted model of the TRA, the final path model indicated that intention to seek help was the strongest predictor of actual help seeking behaviour. Interestingly the final model also indicated that other variables (e.g. subjective norm and supernatural causal beliefs) which were originally considered to pose an indirect effect on behaviour (as they would be mediated by intention) also had a direct effect on behaviour. In other words it appeared that there were two routes influencing help seeking behaviour; one pathway indicated that

seeking professional help was directly determined by an individual's intention, which was underpinned by attitudes towards seeking professional help and supernatural causal beliefs. The path analysis indicated that attitudes and supernatural beliefs explained together 43% of the variance of intentions, with attitudes being the much stronger predictor. According to this pathway, attitudes and beliefs in supernatural causes indirectly determined an individual's attempts to seek help as these factors were mediated by their intention to seek help. However, there was another pathway which indicated that an individual's beliefs in supernatural causes and to a lesser extent their subjective norm (i.e. perceived social pressure) had a direct effect on behaviour without intention being a mediating factor. In other words decision to seek professional help was directly determined by one's beliefs in supernatural causes of mental illness and perceived social pressure, regardless of formation of intention. Overall, it appeared that 48% of the variance of help seeking behaviour was explained by the three predictors of intention, supernatural beliefs and subjective norms, with intention being the strongest predictor.

It is surprising that actual help seeking appeared to be directly determined by influences of close others (i.e. subjective norm) and supernatural causal beliefs, particularly as the TRA assumes that intention directly precedes behaviour. It is also somewhat puzzling that these variables did not appear to predict intention to seek professional help across the sample as a whole (i.e. including those who have not had mental health problems and sought help). However, these findings suggest that these variables (i.e. subjective norm and supernatural causal beliefs) represent more complex and possible unconscious emotional processes beyond rational control which may be required to form intention. It must also be reiterated that the findings of the path analysis apply only to those individuals who reported that they had a mental health problem and sought help. Thus, conclusions from the path analysis are limited in their generalisability as they can only be applied to Jewish people who have mental health problems rather than the wider non-clinical Jewish community.

5.2 Implications of the findings: Theoretical considerations

The present study aimed to use the Theory of Reasoned Action (Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) to understand intention to seek professional help for

mental health problems but also to identify the factors which predict intention and actual help seeking behaviour amongst British Jewry. Overall the results provided general support for the TRA as strong relationships were found between some of the main components of the model. However the findings also suggested that some aspects of the model were not necessarily applicable to this sample and additional factors should be taken into account. More specifically, intention to seek professional help was most strongly predicted by relevant attitudes and stress-related causal beliefs, whilst subjective norm (i.e. one of the main elements of the original TRA model) did not appear to significantly predict intention. This suggests that for this sample, the model could be adapted with the component of subjective norm (i.e. the influence of close others) being replaced with stress-related causal beliefs.

With regard to the data from those who had sought help, the path analysis revealed that intention was the strongest predictor of actual help seeking. This finding almost undoubtedly provides support for the main assumption of the TRA, namely that intention provides an accurate prediction of subsequent behaviour (Ajzen & Fishbein, 1980). However, it is important to highlight that the path analysis also showed that supernatural causal beliefs and subjective norms had a direct effect on help seeking attempts.

According to the final model proposed by the path analysis, it appeared that actual attempts to seek help could be directly determined by the influence of supernatural causal beliefs, regardless of a person's intentions to seek professional help. In other words, it appears that beliefs in supernatural causes of mental illness were sufficient in their own right to persuade a person to seek professional help, without any mediating effect of intention regarding this behaviour. This finding warrants further consideration given that existing research has argued that Western cultures (to which this sample appear to be well assimilated within) are more likely to favour stress-related and physiological causal beliefs over supernatural explanations (Jorm, 2000). Moreover, existing research has demonstrated that belief in supernatural causes of mental distress is usually associated with reduced compliance with treatment offered by mental health professionals. This observation is at odds with the current finding which suggests that beliefs in supernatural causes of mental distress promoted attempts to seek professional help (Jorm, 2000; Razali, Khan, & Hasanah, 1996).

So how does one explain this unexpected finding? A range of studies have indicated that individuals who believe in causes which are beyond religious control (e.g. evil spirits) have higher levels of psychopathology than people who believe in other causal explanations (McConnell, Pargament, Ellison, & Flanelly, 2006). Therefore, at first glance one could argue that people who believed in supernatural causes of their mental illness were perhaps experiencing a particularly high level of distress and it is this high level of distress which drives a person to seek help. However, it is equally possible that this sample largely believe in stress-related causes of mental illness yet for some people their level of mental distress may have reached such a level that they then turned to consider supernatural causes and it is at this point they thought, "I must get myself to the GP, psychiatrist, etc…..". Either way, both of these explanations suggest that the direct effect of supernatural causal beliefs may reflect the individual's level of psychological distress which was not a measured variable within the present study.

Although supernatural causal beliefs appear to directly determine actual help seeking, the path analysis demonstrated that perceived social pressure (theoretically known as 'subjective norm') also appeared to directly effect attempts to seek professional help. According to Ajzen and Fishbein (1980) 'subjective norm' refers to a person's beliefs that most people who are important to them should/should not perform the behaviour in question. Initially one could argue that this finding suggests that when an individual is mentally unwell, the perceived social pressure from others to seek professional help is so strong that their influence alone is enough to drive them to see a professional. Again it may be that this pathway to professional help also reflects the individual's level of mental distress. It is possible that for some individuals when their level of distress reached a certain level, important people close to them may have demanded that they seek professional help and this was adhered to regardless of the individual's own personal intentions towards these forms of support.

These explanations suggest that both supernatural causal beliefs and subjective norm were strong drivers of behaviour because they reflect that an individual had reached a high level of distress and it was in fact their distress, rather than e.g. supernatural beliefs/subjective norm as such which drove them to seek professional help. It is

relevant at this point to reflect on criticisms of the TRA which have argued that it is too concerned with rational behaviour whilst inadequately acknowledging the role of affective and emotional reactions (Fishbein & Ajzen, 2009). Therefore, it could be argued that a more relevant and comprehensive model of the TRA which specifically addresses help seeking for mental health problems should also include a component that accounts for an individual's level of emotional distress. Given that this study demonstrated the application of the TRA to understand help seeking behaviour amongst Jewish people, it could also be used as a framework to help identify the factors which contribute to access/engagement with mental health services amongst other ethnic/religious groups.

5.3 Links to previous research

Given the scope of the present study, it was not possible to compare this sample with the general population nor another religious/ethnic minority group. However, it was possible to compare mean scores of attitudes towards seeking psychological help with a sample of American Jewish people (which one could assume to be the best available normative group in the absence of any other) as reported by Kaminetzky and Stricker (2000). Based on comparisons between these two groups in terms of their mean scores on the relevant attitudinal scale, the current sample appeared to have similarly favourable attitudes towards psychological help as those indicated by American Jewish people. Yet, in the absence of specific attitudinal data relating to a UK normative sample or other religious/ethnic minority groups, it is difficult to gauge the extent to which Jewish people's attitudes are more favourable than other groups and/or the general population towards professional help. Given that the study did not obtain any comparative data one cannot entirely support previous research (e.g. Bowling & Farquhar, 1993; Loewenthal, MacLeod, Lee, Cook, & Goldblatt, 2002) which has indicated that Jewish people in the UK are more inclined than the general population and other religious/ethnic minority groups to seek professional help.

Nevertheless, the present data concerning intention to seek professional help and actual help seeking behaviour, lends support to a more general view that Jewish people readily seek professional help in order to achieve recovery from a mental health problem. Furthermore, the current sample's high percentage of attempts to

seek professional mental health care, is broadly consistent with national data from the 2008 Count Me In[18] survey pertaining to their use of statutory mental health services, indicating that Jewish people are significantly involved with inpatient services.

Whilst it could be argued that this sample's positive inclinations towards seeking professional help arise as a result of high levels of mental distress, it does not explain the high percentage of people (77%) across the overall sample who indicated they would be willing to seek this form of help, including individuals who have not had a mental health problem. Therefore it is appropriate to return to alternative explanations underpinning these findings which were originally referred to in the introduction of this thesis. For example, Srole and Langer (1962) have previously argued that Jewish people have strong cultural values which promote a 'survival-insurance process'. This regards good mental and physical health as vital to survival and in order to maintain this, an individual must endeavour to prevent (and failing that) heal ailments of the body and mind. Furthermore, Srole and Langer (1962) identified that such a process is illustrated in Jewish people's response to mental illness which prescribes that an individual must not only seek (or receive) help from family and friends, but they must additionally seek out help beyond these resources, including professional mental health services, if true recovery from mental ill health is to be achieved. This course of action was somewhat reflected in the present sample by the finding that nearly 84% individuals who sought help from their family and friends, also sought professional help.

5.3.1 The prevalence of mental health problems

Although the present study primarily aimed to investigate professional help seeking in the general (and non-clinically recruited) Jewish community, in doing so it has hinted at the high prevalence of mental health problems in this religious/cultural group. In many ways this finding is unsurprising given that previous literature has argued that Jewish people are at higher risk of developing affective disorders than other religious groups (Levav, Kohn, Golding, & Weissman, 1997). The range of psychiatric

[18] The 'Count Me In' census records information pertaining to all in-patients of mental health and learning disability services in the UK. It specifically records information pertaining to the ethnicity of all in-patients in order to highlight inequalities in access and outcomes that may affect in-patients from Black and minority ethnic communities, or their carers.

disorders reported in this sample indicated that the majority suffered from affective disorders (e.g. 47% reported anxiety and depression), whereas rates of psychotic disorders and alcohol problems were significantly lower. These findings are broadly consistent with previous research which has consistently reported that Jewish people are more susceptible to affective disorders (e.g. dysthymia and major depression) than other disorders such as schizophrenia and alcoholism (Sanua, 1992; Yeung & Greenwald, 1992). Similarly in a more recent study of a non-clinical Jewish community sample in Chicago, Benjamins et al. (2006) reported that a substantial number of mental health problems were discovered, with depression being particularly common in this population.

However it is worth cautioning that the high prevalence of certain diagnostic categories (e.g. affective disorders) over others (e.g. alcoholism and psychotic disorders) within Jewish populations may simply reflect diagnostic biases amongst mental health professionals rather than the true number of cases of specific mental disorders amongst Jewish people. For example Littlewood and Lipsedge (1997) describe evidence suggesting that psychiatrists are biased towards diagnosing Afro-Caribbean patients with schizophrenia when they present with symptoms of depression. Diagnostic biases could work in a similar way with Jewish patients, with mental health professionals favouring affective diagnoses over psychotic ones when working with Jewish people.

Despite the high prevalence of mental health problems in this sample of Jewish people, at the same time, this sample were predominantly highly educated[19] and high socio-economic achievers[20] which paints a paradoxical picture of Jewish mental health/illness. However, some literature has hypothesised that it is Jewish cultural norms which promote high educational and socio-economic achievement that contribute to mental health problems. According to Lynn and Kanazawa (2008) Jewish people have cultural values which place high importance on success in education and subsequently in occupational spheres. These values have been linked to the prominence of psychopathology in Jewish people as both Gilman (1984) and

[19] 77% of the sample had obtained A-Levels and higher educational qualifications including undergraduate degrees and postgraduate qualifications.
[20] 74% of the sample were assigned to the highest socio-economic classes, namely ‘Managerial & professional’ and ‘Intermediate’ occupational categories.

Kohn et al. (1999) have asserted that Jewish mental health problems arise out of their way of life which emphasises the need to overachieve in business, commerce and politics. Furthermore, Gilman (1984) elaborated on this theme by describing how susceptibility to mental health problems arises through Jewish people's constant desire, drive and quest for success and happiness causing over exertion and exhaustion of the brain and nervous system, resulting in high vulnerability to affective disorders (Kohn, et al., 1999).

Other aetiological explanations of Jewish mental ill health have centred around the long-term impact of the Holocaust. There is a breadth of research which has intensely debated the transgenerational transmission of Holocaust trauma on second and third generation offspring of survivors and how this may explain the prevalence of affective disorders in Jewish people (Kohn & Levav, 2000). However, in his review of the research, Kellermann (2001) reported that evidence for this relationship is mixed with much research identifying that offspring in general do not present any more or fewer signs of psychopathology than comparable groups. On the contrary, Kellermann (2001) has suggested that for some individuals their historical family background concerning the Holocaust has influenced the personal lives of survivor offspring in a positive manner by making it more meaningful and by increasing their compassion for human suffering.

An associated yet more general aetiological explanation of Jewish mental ill health concerns their status as a persecuted minority. Jewish people have for centuries endured discrimination and persecution in the form of anti-Semitism which continues to exist in Britain today. According to the Community Support Trust (2010), 924 anti-Semitic incidents were recorded in 2009 (including threatening and abusive behaviour and physical attacks) which is the highest annual total since it began recording anti-Semitic incidents in 1984. Some writers have argued that it is the enduring impact of discrimination and persecution for being Jewish, which causes the internalisation of anti-Semitism, generating feelings of self-hatred and inferiority contributing to affective disorders (Gilman, 1984; Kohn, et al., 1999). By emphasising the determination and resilience of Jewish people demonstrated by their cultural and intellectual achievements this suggests extremely good health, yet at the same time, it appears that Jewish people suffer poor mental health as a result of a prolonged

persecuted existence as a discriminated minority (Bilu & Witzum, 1997). Again this portrays a very mixed picture of Jewish mental health which possibly requires further clarification.

Whilst the current data appears to fit with the paradoxical picture of Jewish mental health (i.e. high levels of mental health problems amongst people with high levels of educational and socio-economic achievement) this finding should be interpreted cautiously as it may simply reflect sampling bias. For example, the sample in the present study did not include members of Ultra Orthodox Jewish communities which often reflect much lower levels of socio-economic status and formal educational achievements. Further issues relating to sampling bias will be discussed later in this chapter.

5.4 Clinical relevance of the findings

5.4.1 Implications for mental health services

It would appear that there are several findings which have specific clinical implications which are based both on the data of the overall sample and those derived from the smaller sample of people who shared their experiences of help seeking. Overall, given that this sample appeared to hold favourable attitudes towards seeking professional help and many in fact had sought help in the past, one could conclude that Jewish people readily seek help and have good access to statutory mental health services. Given the latter observation it becomes more understandable why Jewish mental health issues have not reportedly been the focus of statutory mental health initiatives aimed at encouraging inclusion and diversity which appear standard practice when considering other ethnic minority groups and their engagement with mental health services. Moreover, the findings suggest that it would be unnecessary to place a particular focus on Jewish mental health issues as Jewish people appear willing to report their mental health difficulties and are already accessing the services they need. At the same time however, one could argue that more could be done in terms of preventative mental health interventions amongst the Jewish community in order to reduce the number of Jewish people requiring professional mental health services.

Despite the data suggesting that access to mental health services within the Jewish community is not an immediate concern for statutory mental health service providers, this should not detract from the observation that many of this sample had experienced mental health problems indicating that there are high levels of distress requiring appropriate treatment. Given the high numbers of Jewish people who had sought help, and/or intend to if they experience a mental health problem, it is perhaps a useful exercise to consider how services could improve the cultural sensitivity of the treatment provided. For example, there could be a greater emphasis placed on encouraging mental health professionals to be aware of the culturally specific issues which may be pertinent in contributing to and/or maintaining a Jewish individual's mental health problems e.g. cultural expectations regarding socio-economic and educational success and experiences of anti-Semitism and discrimination. These recommendations build on those made by the British Psychological Society, Division of Clinical Psychology (DCP) which provides guidelines for the implementation of good practice by Clinical Psychologists when undertaking psychotherapeutic intervention, research and audit relating to clients from culturally diverse backgrounds.

With regard to therapeutic practice, the DCP recommends adherence to these guidelines which stipulate that all clinical psychologists must contribute to, "directly providing psychological therapies which take into account cultural differences, the impact of racism on psychological health and the specific needs of Black and Ethnic Minority People." (p.6, British Psychological, 1998). BPS Guidelines also advocate that Clinical Psychologists should develop equality and diversity 'competencies' which will enable them to undertake such practice. Competencies range from acknowledging different perspectives based on people's cultural backgrounds, to evaluating the allocation and availability of psychotherapeutic resources for ethnically and linguistically diverse clients (British Psychological Society, 2005). Although the BPS do not specify who they consider to be 'Black and Ethnic Minority People', these guidelines suggest that Clinical Psychologists should do their utmost to consider cultural factors in all aspects of their work, including when they are involved with the Jewish community. Across mental health professionals more generally, it is possible

that paying more attention to Jewish issues within treatment may improve outcomes, ultimately reducing the need for further use of mental health services.

5.4.2 Religiosity and help seeking

One of the main areas of exploration for this study investigated whether religiosity is related to seeking professional help. In their study of American Jewish people, Kaminetzky and Stricker (2000) initially proposed that more religiously observant individuals would be less inclined to seek professional help due to their traditional values which may be more in favour of making use of religious based help (e.g. Rabbinical advice). Furthermore, less religiously minded individuals who are more immersed in the secular culture would have more positive inclinations towards seeking professional help. Just as Kaminetzky and Stricker (2000) subsequently discovered that there were no significant differences between Jewish affiliated groups (which appeared to reflect different levels of religiosity), similarly the current study also found that that one's level of religious belief and observance had little bearing on attitudes, intentions and the behaviour of professional help seeking.

However, there were two further findings which warrant consideration in relation to religiosity and help seeking, namely the moderate positive correlation found between religiosity and intention to seek religious help, and the weak positive correlation between seeking religious help and professional help. When these findings are also considered alongside the previously discussed conclusion that there was no significant relationship between religiosity and intention to seek professional help (i.e. greater religiosity is not related to lower intention to seek professional help), it may suggest that greater religiosity does not preclude people from seeking professional help. Moreover, it may indicate that people who were more religiously minded may value both religious and professional help. This would support Abe-Kim et al.'s (2004) findings relating to the influence of religious affiliation, religiosity and spirituality on help-seeking from religious clergy and mental health professionals. Their findings demonstrated that high religiosity was associated with more help-seeking from religious clergy but not less help-seeking from mental health professionals. This is also consistent with findings reported by Pirutinsky et al. (2009) who investigated attitudes towards Obsessive Compulsive Disorder in an Orthodox Jewish sample.

Pirutinsky et al. (2009) reported that participants expressed support for both professional and religious help, suggesting that more religiously inclined individuals may simultaneously utilise and value both psychological and religious help. Furthermore, as proposed by Kaminetzky and Stricker (2000) it may also be the case that more religiously oriented Jewish people have a slightly different pathway to mental health services, with help being initially sought from religious sources, prior to making contact with formal mental health care services.

5.4.3 Implications for other religiously/culturally diverse populations

Thus far the clinical implications regarding Jewish people and their mental health have been outlined. It is possible that some of the findings may also be relevant to developing a greater understanding of the help seeking patterns of other ethnically and religiously diverse communities. Much of the existing research on ethnically diverse populations has investigated attitudes towards help seeking in the hope that this will provide a reasonable estimation of their use of professional help seeking in the event of a mental health problem (e.g. Aloud, 2004; Diala, et al., 2000; Fung & Wong, 2007). Whilst these studies have largely focused on a range of culturally/non-culturally based factors which predict attitudes towards help seeking, it could be argued that this study has gone considerably further by identifying whether attitudes and other factors predict intention and attempts to seek professional help. Moreover this study has demonstrated the relative importance of each of these factors (e.g. religiosity, causal beliefs, etc) in addition to attitudes, which contribute not only to intention to seek professional help but actually performing this behaviour. For example, whilst Sheikh and Furnham (2000) demonstrated a relationship between beliefs about the causes of mental illness and attitudes towards seeking professional help, the present study went further to reveal that stress-related causal beliefs predicted intention to seek professional help and supernatural beliefs predicted actual help seeking. Although none of the causal beliefs presented to participants in this study were specifically reflective of Jewish religious explanations, this study did show the general importance of causal beliefs in determining intentions and attempts to seek professional help. Thus, this study has shown that it is possible to draw conclusions about what contributes to a community's access/engagement with mental health

services based on data pertaining to beliefs, attitudes, intentions and actual service use.

5.5 Limitations of the present study

The high numbers of mental health problems which were reported by this sample may largely be a reflection of self-selection bias rather than a true picture of the Jewish community's mental health. It is possible that people who had experienced a mental health problem were more likely to complete the questionnaire because the subject matter was of personal relevance to them. Furthermore, it is also likely that people with positive attitudes towards professional services were also more likely to volunteer to participate in the study, thereby skewing the sample in the direction of those who held positive attitudes towards help-seeking from professional services. Thus, both high levels of mental health problems and favourable attitudes towards professional help seeking could reflect sampling bias. However it is still worth considering more comprehensive and clinical relevant explanations of these findings particularly given that they echo previous studies concerning historical factors and Jewish mental health.

One should also be cautious about generalising the findings of this study to the entire Jewish population in the UK. Whilst the findings suggest that Jewish people are generally well engaged with mental health services, this conclusion is at odds with research referred to in the introduction which reported that the Ultra-Orthodox Jewish community appear to have very limited contact with statutory mental health professionals. Despite many attempts to make contact with the Ultra-Orthodox community the researcher was unsuccessful in recruiting its members to the study. Furthermore, the researcher was also warned by the small number of contacts that were made within the Ultra Orthodox community, that community members would be unlikely to take part in the study due to the great taboo and stigma which exists concerning mental health problems and that some questionnaire items may offend members of the community (specifically the questionnaire concerning causal beliefs about mental illness).

In many ways these observations speak for themselves, suggesting that the Ultra-Orthodox community would be unlikely to seek professional help due to stigma and religious explanations of mental ill health based on Jewish teachings. It is also likely that this group would be particularly in favour of seeking religious help according to the recommendations of Ultra-Orthodox Jewish leaders who view psychotherapy and psychiatry as undermining of Jewish teachings, and alternatively advocate that Jews must seek guidance from Rabbis and the Torah (i.e. the Jewish bible) (Greenberg & Witzum, 2001). Therefore, whilst the current data indicated that Jewish people's intentions to seek help is not related to religiosity, this finding cannot be generalised to Ultra Orthodox Jewish people who have the highest level of religious observance amongst British Jewry. Moreover, Ultra Orthodox Jewish people represent a population who is significantly different to other Jewish communities not least in terms of its religious observance but also in terms of its significantly lower socio-economic status and level of formal education. It is therefore likely that based on religiosity, demographic variables and issues of stigma, Ultra Orthodox Jewry may display significantly different attitudes, intentions and actual help seeking behaviour compared to the sample of Jewish people described here.

Another important methodological limitation of this study relates to its use of an opportunity sample. More specifically, within the limited time frame in which the study had to be completed participants were recruited from synagogues and community centres to which the researcher was associated. Clearly this limits the random nature of the sample as those recruited may be more likely to have, for example, a certain level of participation/involvement with Jewish cultural activities similar to the researcher, which is not generalisable to wider British Jewry.

It could also be argued that the sample are highly skewed in terms of their high level of educational achievement and their high socio-economic status which may reduce the external validity of the current findings. According to Graham et al. (2007) many surveys have identified that Jewish people outperform the general population in educational achievement across several countries from Hungary to the United States. Furthermore, data from the last census in 2001 showed that Jewish people were 80% more likely to have higher level educational qualifications that the general population (Graham, et al., 2007). It is difficult to obtain the exact percentage of Jewish people

who had higher educational qualifications from the census data as that which is available is based on percentages which were stratified according to age. However, according to this data, for example, of those aged between 25-34 years, nearly 56% had higher level qualifications (including first degree, higher degree, medical doctor, qualified dentist). In the present study 69% of participants, regardless of age, had higher level qualifications which suggests that this sample's level of educational achievement was a little higher than the wider Jewish population in the UK. However figures may be more similar if one specifically compared this national data to 25-34 year-olds in this study. Similarly, Graham et al. (2007) refer to data from the 2001 census showing that approximately 25% of all Jewish people were 'managers and senior officials' and one out of five Jews (i.e. 20%) worked in the 'professional occupations'. Taken together these percentages indicate that 55% of British Jewry could be assigned to the highest socio-economic class of 'managerial and professional occupations'. This figure is broadly consistent with the percentage reported in relation to the current sample which showed that 62% of the sample were assigned to the highest socio-economic class (i.e. managerial and professional occupations). These figures suggest that despite the highly skewed levels of educational achievement and socio-economic status of Jewish people within this opportunity sample, they appear to be a reasonable representation of the overall British Jewish population. Moreover, although the current study used an opportunity sample, it was broadly typical of the wider Jewish population in Britain in terms of educational achievement and socio-economic status, thus providing support for the external validity of the findings.

A further limitation of this study concerns the way in which causal beliefs were measured using Eisenbruch's (1990) inventory of causal explanations. Correlational analysis showed that all four categories of causal beliefs were inter-correlated which was somewhat unexpected given that the categories are supposed to represent very different causal explanations of mental illness. For example, one would expect that if an individual believes in non-western physiological explanations, they would be less likely to also endorse western physiological explanations. However, it is possible that inter-correlations were found because participants were asked to rate every type of causal belief they thought to be relevant, which encouraged endorsement of multiple causal beliefs. This in turn made it very difficult to identify which category of causal explanations this sample of Jewish people considered to be the most likely or most

important cause of mental health problems. It would have been possible to achieve this type of data had participants been asked to rank order each causal belief in terms of the degree to which they believed one explanation more strongly contributed to mental health problems than others.

Although the present study identified that this sample of Jewish people believe in multiple causes of mental health problems, the extent of their beliefs in religious based causal explanations remains unknown. In other words, the items included in Eisenbruch's (1990) inventory of potential causes did not reflect specifically Jewish based explanations of mental health problems, for example, that it results from disobeying Biblical teachings. It is possible that analysis of these types of beliefs may have provided a more comprehensive picture of the factors which contribute to seeking religious based help. Moreover, Cinnirella and Loewenthal (1999) have identified that when examining a religious group, more needs to be known about religiously-based beliefs in relation to the causes and cures of mental health problems in order to inform the development of appropriate mental health care. However, in order to include religiously based causal beliefs in a future study of Jewish people, the researcher would need to liaise with Rabbinical sources and Talmudic[21] experts as there appear to be inconsistent accounts in more mainstream literature about how Judaism conceptualises causes of mental illness.

5.6 Areas for further research

Thus far this discussion has not yet attended to the analyses which were conducted on the small amount of data pertaining to the differences between individuals who sought professional help and those who did not despite both groups having reported that they suffered a mental health problem. According to this limited data it appeared that those who did not seek professional help did not seek religious help either, yet they did appear to seek the support of friends and family. Although there were no significant differences between these two groups according to demographic variables, namely sex, age, educational achievement and Jewish denomination, it is worth pointing out

[21] The Talmud refers to a comprehensive collection of ancient rabbinical writings and commentaries on Jewish law.

that based on percentages alone, it appeared that those who did not seek help had the highest level of educational qualifications (e.g. Postgraduate).

A breadth of research has consistently shown that educational achievement is significantly related to intelligence (Charlton, 2009; Deary, Strand, Smith, & Fernandes, 2007; Kaufman, Kaufman, Xin, & Johnson, 2009). If one therefore assumes that high educational achievement is related to high intelligence, it is possible that this descriptive finding may suggest that individuals with high levels of intelligence do not seek professional or religious help. One potential explanation of this finding relates to the debated relationship between high intelligence and emotional resilience. There is a small body of research which has identified that high intelligence is an important factor contributing to the development of emotional resilience (Friborg, Barlaug, Martinussen, Rosenwinge, & Hjemdal, 2005; Svarc-Hopkins, 2007; Varvin, 2007). Moreover, Friborg et al. (2005) reported that various studies have shown that individuals with higher intelligence who have greater knowledge are more likely to cope when faced with stress and have better self-help skills. In accordance with these observations, it could be argued that the individuals in this study who did not seek help (and who are assumed to have a high level of intelligence as demonstrated by their educational level), were more able to deal with their problems on their own and thus did not require professional help or religious based support. However this conclusion could be more accurately drawn if it were based on a larger sample size. It is therefore possible that in future research, if a larger amount of data was gathered from individuals who do not seek help despite having a mental health problem, this may help to identify the factors that reduce the likelihood that people will seek professional mental health care. Moreover, research investigating the factors which predict help seeking may be bolstered by research which at the same time can also predict what contributes to an individual deciding not to seek professional help.

Given that the present study was unable to draw conclusions about the most religious denominations of British Jewry, further research would ideally want to include the Ultra-Orthodox Jewish community. This would allow for more accurate conclusions to be made concerning the contribution of religious observance and beliefs to help seeking behaviour. Moreover, this may undermine the much cited generalisation that

Jewish people are over subscribers of mental health care, whilst emphasising that Ultra-Orthodox Jewish people are under-represented in statutory mental health services. Although it was beyond the scope of the present study, it would be also be useful to obtain comparative data based on other religious/ethnic minority groups, in addition to the general population in the future in order to be able to conclude that British Jewry are significantly more inclined to seek professional help than others. A study of this type would also need to control for demographic variables and/or include a comparison group with similar socio-economic and educational variables given that the Jewish community often represent a skewed sample according to these potentially confounding factors.

The present study was largely based on the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980; Fishbein & Ajzen, 1975) in its original form comprising of the elements of *attitudes towards the behaviour*, *subjective norm* and *behavioural intention.* However, it is worth recalling that the TRA was revised by Ajzen (Ajzen, 1991, 2002) to include the additional component called *'perceived behavioural control'* which refers to the degree to which an individual perceives they have personal control to perform the behaviour in question. This component was not included in the present study due to Fishbein and Ajzen's (2009) observation that it rarely contributes to the additional variance in intention/behaviour particularly when people have a high degree of control over the performance of a specific behaviour. However, by not including this component in the present study, it assumed that all Jewish people have the means to access to professional mental health care and are within a context which enables them to do so. However, in Jewish communities, e.g. Ultra-Orthodox communities, where reporting mental health problems is very taboo, stigmatising and often denied by religious leaders (Talking Matters, 2007), perceived behavioural control may be significantly lower than for more assimilated Jewish people. Therefore in a future study examining more religiously inclined Jewish people it would be worth measuring perceived behavioural control within an adapted TRA framework.

This study supported the usefulness of the TRA in providing a theoretical model on which to predict help seeking for mental health problems amongst Jewish people. Generally speaking this suggests that future research investigating other forms of help

seeking or help seeking in other communities would also be wise to use this model. Nevertheless, it is worth highlighting that the current findings showed that some aspects of the original TRA model were not entirely applicable and therefore needed revising in order to more fully explain help seeking intention and behaviour in this sample of Jewish people. Based on the findings which suggest that it may have been an individual's level of distress which ultimately drove a person to seek professional help, future research should measure this as an additional predictor variable of intention and attempts to seek professional help for mental health problems.

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7. Appendices

Appendix 1: Information sheet for participants

INFORMATION SHEET FOR PARTICIPANTS

Introduction

People from the Jewish community are being invited to take part in a research study to explore their beliefs about mental illness and attitudes towards seeking help for mental health problems. Before you decide to take part in the study please take time to read the following information which I have written to help you understand why the research is being carried out and what it will involve.

The researcher

The research is being carried out by Esther Rose, Trainee Clinical Psychologist, as part of a Doctoral qualification in Clinical Psychology. The researcher is herself Jewish. The study is supervised by Dr. Barbara Mason, Senior Clinical Tutor & Chartered Clinical Psychologist, University of Hertfordshire, Dr. Simon Dein, Consultant Psychiatrist and Senior Lecturer, University College London and Joerg Schulz, Senior Lecturer in Research Methods and Statistics, University of Hertfordshire.

What is the purpose of the study?

This study is looking at what people in the Jewish community believe causes mental health problems and what types of help they would be likely to seek if they had a mental health problem. A large body of research has reported that Jewish people are more likely than the general population to seek help from mental health professionals, such as psychiatrists and therapists. However, on the contrary, some studies have argued that Orthodox Jewish people are less likely to use these forms of help. Much of this research has been conducted in the USA and therefore these findings may not reflect how Jewish people in the UK deal with mental health problems. This is an important area of investigation as it may help to understand and identify what type of support Jewish people in the UK would like/not like to use when mental health problems arise.

What is involved?

If you decide to take part you will be required to complete a set of questionnaires which should take approximately 15 minutes to complete. The questionnaires will ask you about your beliefs about the causes of mental health problems and your attitudes towards seeking different forms of help in the event of experiencing a mental health problem. You can also answer questions about your own experiences of seeking help or someone known well to you if you feel comfortable sharing this information. You will also be asked for some background information about yourself such as your

age, where you are from, your level of education and occupation and your Jewish background.

Who is taking part?

This study will include Jewish adults (above the age of 18 years) who live in the UK.

Do I have to take part?

No. If you do not want to take part, or you change your mind *at any time* during your participation in this study, you do not need to give a reason. Participation in this study is entirely voluntary and you can withdraw at any time.

What do I have to do?

If after reading this information sheet you would like to take part in the research, you will be given this sheet to keep and you will need to sign the consent form. Once you have completed the questionnaires you can send them back to the researcher in the stamped addressed envelope provided with the questionnaires. You will also be given a de-briefing sheet, describing the study again in case you have any questions after you have completed the questionnaires.

Will taking part be confidential?

Yes. If you do decide to take part, you will not be required to put your name or any other identifiable information on the questionnaires in order to ensure your answers will remain anonymous. Instead each questionnaire is given a number before it is given out to participants. Completed questionnaires will be confidential to the researcher and kept at a secure location which will only be accessible to the researcher. To further ensure confidentiality, consent forms will be kept separately from the actual questionnaires. The overall findings of the project may be published in a research paper, but no individual and their details will be identifiable.

What will happen to the results of the study?

The overall results of the study will be written up as a thesis for the requirements of the Doctorate of Clinical Psychology at the University of Hertfordshire. It is expected that the study will be written up and submitted for publication in a relevant psychology research journal. As stated previously, no individual and their details will be identifiable in written or published material

What are the benefits of taking part?

Taking part in this study may not benefit you personally. However, it is hoped that this research will help develop a greater understanding of how Jewish people think about mental health problems. This is relevant to everyone in the Jewish community as everyone, at some point in their lives, may be affected by, or know someone close to them, who experiences emotional/psychological problems.

What if I have questions or concerns?

If you have any further questions about the research, please feel free to contact the researcher via email, telephone or post, details of which are below. In the unlikely event that participating in this research causes you distress in some way, please do

not hesitate to contact the researcher who will be able to advise you on where you may be able to access further help.

Who has reviewed this study?

The study has been reviewed and approved by the University of Hertfordshire Psychology Ethics Board (Ethical approval protocol no.: PSY/10/09/ER).

Thank you for taking the time to read this information sheet.

Contact details of the researcher:

Name:	Esther Rose
Email address:	E.D.Rose@herts.ac.uk
Telephone number:	07795106541
Postal address:	Doctorate of Clinical Psychology Training Course University of Hertfordshire College Lane Campus Hatfield Hertfordshire AL10 9AB

Appendix 2: Consent form

CONSENT FORM

Title of Project: *Beliefs about mental illness and attitudes towards seeking help: A study of British Jewry*

Name of researcher: Esther Rose, Trainee Clinical Psychologist

1) I confirm that I have read and understood the information sheet for the above study and I have had the opportunity to consider the information, ask questions and had these answered satisfactorily.

(Please tick box) ☐

2) I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without any healthcare or legal rights being affected.

(Please tick box) ☐

3) I agree to take part in the study

(Please tick box) ☐

Please remember that all of your responses are confidential and anonymous.

However, if you wanted your data to be withdrawn from the study at a later time please devise a code that will enable me to identify and remove your data from the dataset. Your code should be unique to you, created by using the first three letters of your mothers maiden name, and the first three letters of the name of the first street you lived in.

For example, if your mother's maiden name was 'Smith' and the street name was 'Roundway', your unique code would be 'smirou'

My unique code is:

_____

Appendix 3: Personal background questionnaire

a) Gender: Male ☐ Female ☐ (tick the box which applies to you)

b) Age (in years): _____

c) Which city/town do you live in?: (please write)_____

e) What is your first language? (please write)_____

f) If you were not born in the UK, what is your country of origin?

(please write)_____

g) How would you describe your marital status? (Tick all the boxes which apply to you)

Single	☐	In a relationship	☐
Married	☐	Divorced/Separated	☐
Widowed	☐	Other (please write)_____	

i) Do you have children? (Please tick the appropriate box) Yes☐ No☐

j) Level of education

How old were you when you left school?: (please write)_____

Have you ever attended a yeshiva or seminary?

(Please tick the appropriate box) Yes☐ No☐

What is the highest educational qualification you have obtained (e.g. Undergraduate degree, Masters, PhD, etc.)? (please write)

_____

k) What is your occupation? (please write)

_____

Appendix 4: Religious background questionnaire

a) How would describe your Jewish background? (Tick the boxes which apply to you)

Traditional	☐	Culturally Jewish but not practising	☐
Modern Orthodox	☐	Liberal/Reform	☐
Orthodox	☐	Chassidic	☐
Lubavitch	☐	Satmar	☐
Belz	☐	Other (please write)_____	

b) Are you Ashkenazi or Sephardi? (Tick the box which applies to you)

Ashkenazi ☐ Sephardi ☐ Do not know ☐

b) How often do you attend shul? (Tick the box which applies to you)

More than once a week	☐
Every week or more often	☐
Once or twice a month	☐
Every month or so	☐
Once or twice a year	☐
Never	☐

c) How often do you pray privately in places other than at shul? (Tick the box which applies to you):

More than once a day	☐
Once a day	☐
A few times a week	☐
Once a week	☐
A few times a month	☐
Once a month	☐
Less than once a month	☐
Never	☐

d) How often do you read religious literature and/or holy texts, e.g. The Chumash? (Tick the box which applies to you):

More than once a day ☐

Once a day ☐

A few times a week ☐

Once a week ☐

A few times a month ☐

Once a month ☐

Less than once a month ☐

Never ☐

e) Do you keep kosher? (Tick the box which applies to you):

Yes, I only eat kosher produce/products ☐

I only eat kosher meat but I am happy to buy other not strictly kosher foods ☐

I do not keep kosher ☐

Other (please write)_____

f) Are you Shomrei Shabbat? (Tick the box which applies to you):

Yes ☐ No ☐

g) How much do you agree/disagree with this statement? (Tick the appropriate box):
"I try hard to carry my religious beliefs over into all my other dealings in life."

Strongly agree ☐

Agree ☐

Disagree ☐

Strongly disagree ☐

g) To what extent do you consider yourself a religious person? (Tick the box which applies to you)

Very religious ☐

Moderately religious ☐

Slightly religious ☐

Not religious at all ☐

Appendix 5: Mental Distress Explanatory Model Questionnaire (MDEMQ; Eisenbruch, 1990)

Many people suffer mental distress at some time in their lives. Such distress can be mild or severe. People can experience and manifest mental distress in many ways. Sometimes they feel sad or anxious. Sometimes they are unable to cope. Or sometimes they are out of touch with what is going on around them. They may have experiences of strange beliefs. Sometimes their behaviour becomes disorganised. They may become destructive towards themselves or others.

Please think about how, any person, including yourself, might suffer mental distress and imagine what you might regard as the causes. There are no right or wrong answers; for each item, please tick how likely it is that each of the listed causes could contribute to mental distress:

	Not at all likely	*Unlikely*	*Neither likely or unlikely*	*Likely*	*Highly likely*
1. Bad experiences during childhood					
2. Exposure to a fright or shock					
3. Doing the wrong thing during pregnancy					
4. Contact with something or someone taboo					
5. Movement wind/drafts/gas/milk/air flowing through the person's body					
6. Bad luck or chance					
7. Conflict with family or friends					
8. Physical illness					
9. Someone unwittingly casting a spell e.g. the evil eye					
10. Genetic or inherited defect					
11. Bad or ominous dream					
12. Doing the wrong thing when menstruating					
13. Dangerous unprovoked spirit					
14. Effects of old age					
15. Eating food that is wrong for the person (not socially forbidden food)					
16. Person's karma (what happened to him/her in previous lives)					
17. Vital organ disrupted e.g. liver/blood/bone					
18. Pace of "modern life"					
19. Contact with something or someone unclean, contagious or polluted					
20. Body out of balance or harmony (e.g. yin/yang, hot/cold)					

	Not at all likely	*Unlikely*	*Neither likely or unlikely*	*Likely*	*Highly likely*
21. Seeing, hearing or feeling something ominous					
22. Person's soul leaving the body temporarily or becoming scattered					
23. Brain damage or head injury					
24. Unemployment					
25. Astrological destiny					
26. Break up of family or a failed relationship					
27. Someone wanting to hurt a person, engaging a witch/shaman to cast a spell					
28. Failure to properly observe rituals after giving birth					
29. Not having enough money					
30. Chemical imbalance in the brain					
31. Someone wanting to hurt a person by casting a spell					
32. Doing something forbidden by social or cultural rules					
33. Bad nerves in the body					
34. Spirit who was angry because someone did wrong					
35. Being harmed intentionally by another person					
36. Birth control against the religion or culture					
37. General life stress or trauma (e.g. grief)					
38. Too much work or study					
39. Having had an accident					
40. Migration to a new country					
41. Being born this way, e.g. inheriting bad/weak/low/cold blood					
42. Death of a relation or close friend					
43. Infection					
44. Bad or ominous sensations					
45. Being hot (but not from fever or weather)					

Appendix 6: Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Mackenzie et al., 2004)

The term *"professional"* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *"psychological problems"* refers to reasons one might visit a professional. Similar terms include *mental health concerns, emotional problems, mental troubles, and personal difficulties.*

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

	Disagree				Agree
1. There are certain problems which should not be discussed outside of one's immediate family……..	[0	1	2	3	4]
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems..	[0	1	2	3	4]
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems .. . .……..	[0	1	2	3	4]
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.	[0	1	2	3	4]
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional..	[0	1	2	3	4]
6. Having been mentally ill carries with it a burden of shame.	[0	1	2	3	4]
7. It is probably best not to know *everything* about oneself..	[0	1	2	3	4]
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy.	[0	1	2	3	4]
9. People should work out their own problems; getting professional help should be a last resort.	[0	1	2	3	4]
10. If I were to experience psychological problems, I could get professional help if I wanted to..	[0	1	2	3	4]
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems..	[0	1	2	3	4]
12. Psychological problems, like many other things, tend to work out by themselves…….	[0	1	2	3	4]

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

	Disagree				Agree
13. It would be relatively easy for me to find the time to see a professional for psychological problems…….	[0	1	2	3	4]
14. There are experiences in my life I would not discuss with anyone…….	[0	1	2	3	4]
15. I would want to get professional help if I were worried or upset for a long period of time…….	0	1	2	3	4]
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it. . . .	[0	1	2	3	4]
17. Having been diagnosed with a mental disorder is a blot on a person's life.	[0	1	2	3	4]
18.There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help..	[0	1	2	3	4]
19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention..	[0	1	2	3	4]
20. I would feel uneasy going to a professional because of what some people would think.	[0	1	2	3	4]
21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.	[0	1	2	3	4]
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family.	[0	1	2	3	4]
23. Had I received treatment for psychological problems, I would not feel that it ought to be "covered up." . . .	[0	1	2	3	4]
24. I would be embarrassed if my neighbour saw me going into the office of a professional who deals with psychological problems..	[0	1	2	3	4]

Appendix 7: Attitudes Toward Seeking Professional Psychological Help: A Shortened Form (ATSPPH:SF; Fischer & Farina, 1995)

In this section you will be asked about your attitudes and intentions toward seeking psychotherapy for psychological problems (as before, the term *"psychological problems"* is term for what many people describe a *mental health concerns, emotional problems, mental troubles, and personal difficulties).*

There are no right or wrong answers; for each item, please tick the box which corresponds to the extent to which you agree or disagree with each statement.

	Agree	Partly agree	Partly disagree	Disagree
1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.				
2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.				
3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.				
4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help				
5. I would want to get psychological help if I were worried or upset for a long period of time				
6. I might want to have psychological counselling in the future				
7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help				
8. Considering the time and expense involve in psychotherapy, it would have doubtful value for a person like me				
9. A person should work out his or her own problems; getting psychological counselling would be a last resort				
10. Personal and emotional troubles, like many things, tend to work out by themselves				

Appendix 8: Intention to Seek Help Scale

When someone has a psychological problem they may ask the advice of their friends and family and/or their Rabbi, as well as, or instead of, seeking the help of professionals. It is also possible that they may seek help from Jewish community-based mental health centres if they are available in the local area.

Please think about what you would do if you were suffering from a psychological problem, in terms of who you might seek help from. There are no right or wrong answers; for each item, please tick the box which corresponds to the extent to which you agree or disagree with each statement. (Remember: The term *"professional"* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians).

	Disagree	Somewhat disagree	Undecided	Somewhat agree	Agree
1. I would seek the help of a Rabbi if I thought I had a mental health problem					
2. Most people who are important to me would think I should see a professional if I were experiencing emotional distress					
3. I would see a professional if I was experiencing emotional distress					
4. I would avoid seeing a professional as they may challenge my religious beliefs					
5. I would see a professional regardless of their religious background					
6. I would ask for help from my friends and family if I had emotional problems					
7. I would be more likely to see a professional if they had a similar religious background to me					
8. Many people like me would turn to G-d and prayer to help with their mental health concerns					
9. I would be more likely to see a professional if I thought they understood my religious beliefs and practices					
10. I would turn to G-d to help me deal with emotional problems					
11. I would prefer to use Jewish community based mental health services than those provided by statutory services (e.g. the NHS)					
12.The people in my life whose opinions I value would think I should see the Rabbi if I had emotional problems					

Appendix 9: Experiences of different forms of help and support questionnaire

1. Many people have either experienced their own emotional and psychological problems and/or know somebody else who has had these difficulties.

Have you ever experienced emotional/psychological problems? (please tick the appropriate box)

Yes ☐ No ☐

2. During the next set of questions you will be asked to think about either your own experiences of emotional/psychological problems or someone well known to you who has had these difficulties. Please indicate what you feel comfortable with by ticking the appropriate box:

I will answer the following questions in relation to my own experiences ☐

I will answer the following questions in relation to a person well known to me ☐

I do not wish to answer any further questions (go straight to the bottom of Page 13) ☐

3. What kind of problems did you/person you know experience (e.g. reliance on alcohol, difficulties sleeping, unable or unwilling to eat, excessive worrying, etc.)? Write down a brief description of the problem and/or its formal name if you know it (e.g. anxiety, panic attacks, phobia, post-natal depression, anorexia, etc.)

_____

_____

4. Did you/they want to get help for these issues? (please tick the appropriate box)

Yes ☐ No ☐ Do not know ☐

5. What help or advice did you/they seek?

	Tick all boxes which apply:
a) Rabbinical advice	
b) Mekubal advice	
c) Prayer	
d) Support from friends	
e) Support from family	
f) Support from GP	
g) Psychiatrist	
h) Psychologist	
i) Counsellor/Therapist	
j) Social worker	
k)Jewish mental health organisation/service	
l) Other (please write):	

6. If you/they did not seek help or advice, why do you think this was?

	Tick all boxes which apply:
a) Didn't want to burden others with difficulties	
b) I/they felt ashamed	
c) I/they hoped the problems would go away on their own	
d) I/they felt embarrassed	
e)I/they worried what friends and family would think	
f) Other reason/s(please write):	

7. If you/they sought help, what was recommended? (please tick all the boxes which apply)

	Tick all boxes which apply
a) Daven (Pray)	
b) Say Tehilim (Psalms)	
c) Rabbinical advice	
d) Advice from Mekubal	
e) Counselling or psychotherapy in NHS	
f) Counselling or psychotherapy within Jewish mental health organisation	
g) Private psychotherapy	
h) Support group within Jewish mental health organisation	
i) Support group in NHS /non-Jewish organisation/service	
j) Medication	
k) Regular outpatient attendance (e.g. at psychiatric clinic)	
l) Admission to hospital	
m) Social worker	
n) Other (please write):	

8. What services or help did you/they eventually use?

	Tick all boxes which apply
a) Support from family	
b) Support from friends	
c) Support from GP	
d) Daven (Pray)	
e) Say Tehilim (Psalms)	
f) Rabbinical advice	
g) Advice from Mekubal	
h) Counselling or psychotherapy in NHS	
i) Counselling or psychotherapy within Jewish mental health organisation	
k) Private psychotherapy	
k) Attend NHS mental health services (e.g. Community Mental Health Team)	
l) Attend Jewish mental health organisation/service	
m) Support group within Jewish mental health organisation	
n) Support group in NHS /non-Jewish organisation/service	
o) Medication	
p) Admission to hospital	
q) Advice/involvement of social worker	
r) Other (please write):	

9. Were there any services/sources of help that you/they would have used but were not available?
(Please write here)_____

10. Were there any services offered that were refused or not taken up? (please tick the appropriate box)

Yes ☐ No ☐ Do not know ☐

11. If yes, what were the reasons given for not taking up services offered?
(please tick all boxes which apply)

	Tick all boxes which apply
a) Service not available	
b) Did not wish to use the service offered	
c) It did not suit your/the person's life style	
d) It was not culturally or religiously appropriate	
e) Other (please write):	

12. Overall, how did you/they the feel about the services received? (please tick the appropriate box)

	Very positive	Positive	Neither positive or negative	Negative	Very negative
How did you/they feel about the services or help received?					

If you wish, please write any further comments you have about how you/they felt about the services/help that was accessed:

_____
_____
_____
_____
_____

*********You have now reached the end of the questionnaire. Many thanks for your time*********

Appendix 10: Debrief sheet

DEBRIEF SHEET:

**** PLEASE READ ONLY WHEN YOU HAVE COMPLETED THE QUESTIONNAIRES ****

Thank you very much for making this study possible!

The purpose of the study is to investigate Jewish people's beliefs about mental illness and their attitudes towards seeking different forms of help (e.g. friends, family, doctor, Rabbi, etc) in the event of experiencing a mental health problem. Previous research on Jewish populations in the USA has concluded that Jewish people tend to have very positive attitudes towards seeking professional help (e.g. a psychologist), yet on the contrary, studies based on specifically Orthodox Jewish people has indicated that they are less likely to seek these forms of help. Whilst this study aims to identify whether these observations are true of British Jewry, the present study will examine why these differences may exist between different Jewish affiliated groups. Existing literature suggests that there are a variety of factors which may contribute to these differences, namely differences in people's beliefs about the causes of mental illness, stigma and the influence of one's social networks, i.e. friends and family.

However, to the best of the researcher's knowledge, no previous studies in the UK have investigated the extent to which Jewish people's religious beliefs and their level of observance predict what forms of help they seek/would seek if they had a mental health problem. Therefore, this study is particularly concerned with assessing the extent to which Jewish people's help seeking for mental health problems is related to their level of religious belief and practice.

It is hoped that this research will lead to a greater understanding of the way in which Jewish people think about mental health problems which may provide useful information for services who work with the Jewish community to develop more culturally appropriate help and support.

If you would like to access the overall findings of the study once it is completed and written up, please feel free to contact me (Esther Rose), either via email, post or telephone:

Name:	Esther Rose
Email:	E.D.Rose@herts.ac.uk
Telephone number:	07795106541
Postal address:	Doctorate of Clinical Psychology Training Course University of Hertfordshire, College Lane Campus Hatfield, Hertfordshire, AL10 9AB

It is possible that by participating in this study has made you aware of your own mental health concerns. If you feel that you need to discuss these issues further you can access the following sources of support:

- **Your local GP**

- **The Jewish Association for the Mentally Ill (JAMI)**
  16a North End Road
  London NW11 7PH
  Telephone: 020 8458 2223
  Fax: 020 8458 1117
  Email info@jamiuk.org

- **Chizuk - The Mental Health Organisation of the Orthodox Jewish Community**
  91-93 Stamford Hill
  London N16 5TP
  Telephone: 020 8800 7494
  Fax: 020 8802 5677
  Email: info@chizuk.org.uk

- **MIND - The national mental health charity**
  Telephone: 0845 7660163
  Website: www.mind.org.uk

- **The Samaritans**
  Telephone: 08457 90 90 90.

Appendix 11: Ethics application form and approval certificate

SCHOOL OF PSYCHOLOGY ETHICS APPLICATION FORM

Status: STAFF PhD MSc BSc (delete inapplicable categories)

Course code (if student): MPSY0037 (Clinical Psychology)

Title of project:

Beliefs about mental illness and attitudes towards seeking help: A study of British Jewry

Name of researcher(s): Esther Rose, Trainee Clinical Psychologist
Contact Tel. no: 07795106541
Contact Email: E.D.Rose@herts.ac.uk

Name of supervisor
Principle Academic Supervisor: Dr. Barbara Mason, Clinical Tutor, Doctorate of Clinical Psychology, University of Hertfordshire.
Additional Academic Supervisor: Joerg Schulz, Senior Lecturer in Research Methods and Statistics, School of Psychology, University of Hertfordshire
Field Supervisor: Dr. Simon Dein, Senior Lecturer in Anthropology and Medicine, University College London

Start Date of Study: September 2009

End Date of Study: May 2010

Number of participants: minimum 120 – maximum 250

		YES	NO	N/A
Q1	Will you describe the main experimental procedures to participants in advance, so that they are informed about what to expect?	X		
Q2	Will you tell participants that their participation is voluntary?	X		
Q3	Will you obtain written consent for participation?	X		
Q4	If the research is observational, will you ask participants for their consent to being observed?			X
Q5	Will you tell participants that they may withdraw from the research at any time and for any reason?	X		
Q6	Will you tell participants that their data will be treated with full confidentiality and that, if published it will not be identifiable as theirs?	X		
Q7	Will you debrief participants at the end of their participation (i.e., give them a brief explanation of the study)?	X		

IMPORTANT NOTE: If you have indicated **NO** to any question from **1-7 above**, but do not think this raises ethical concerns (i.e., you have **ticked box A** on page 3), please give a full explanation in **Q19** on page 2.

		YES	NO	N/A
Q8	Will your project involve deliberately misleading participants in any way?		X	
Q9	Will your project involve invasive procedures (e.g. blood sample, by mouth, catheter, injection)?		X	
Q10	Will the study involve the administration of any substance(s)?		X	
Q11	Will the study involve the administration of a mood questionnaire (e.g. BDI) containing a question(s) about suicide or significant mental health problems? (If yes, please refer to Psychology Ethics Guidelines for a standard protocol)		X	
Q12	Is there any realistic risk of any participants experiencing either physical or psychological distress or discomfort?		X	

Q13	Does your project involve work with animals?			X	
Q14	Do participants fall into any of the following special groups? If they do, please refer to BPS guidelines. **Note that you may also need to obtain satisfactory CRB clearance (or equivalent for overseas students)**	Schoolchildren (under 18 years of age)		X	
		People with learning or communication difficulties		X	
		Patients		X	
		People in custody		X	
		People engaged in illegal activities (e.g. drug-taking)		X	

IMPORTANT NOTE: If you have indicated **YES** to any question from **8 - 14** above, you should normally **tick Box B** below. If you ticked **YES** but think that your study does not raise ethical concerns, please, provide a full explanation in **Q19 in** the section below.

There is an obligation on the lead researcher to bring to the attention of the Psychology Ethics Committee any issues with ethical implications not clearly covered by the above checklist

Please answer **Q15-19** below. Provide appropriate information with sufficient detail. This will enable the reviewers to assess the ethical soundness of the study without asking you additional questions and will speed up the review process **(PLEASE, PROVIDE AT THE END OF THIS FORM AN EXAMPLE OF THE INFORMATION AND CONSENT FORMS, QUESTIONNAIRE(S), IF USING, AND ANY OTHER RELEVANT FORMS, E.G., DEBRIEF SHEET, ETC.)**

Q15	**Purpose of project and its academic rationale (preferably between 100 - 500 words):** The purpose of the study is to investigate Jewish people's beliefs about mental illness and their attitudes towards seeking different forms of help (e.g. friends, family, doctor, Rabbi, etc) in the event of experiencing a mental health problem. Jews have been strongly associated in the literature concerning the history of psychiatry and psychotherapy, which has often indicated that they are over-represented both as practitioners and clients (Ball & Clare, 1990; Mishne, 2006). The relationship between Jews and mental illness has been an issue of debate for centuries, which has frequently argued that Jews are more prone to developing mental illness (Gilman, 1984; Kohn et al., 1999; Sanua, 1992). However, over the past 50 years, more recent research has explained that Jews appear to have higher rates of mental illness because they are more likely to report their difficulties and seek professional help, i.e. psychiatric and psychological support (Levav et al., 1997, Srole & Langer, 1962; Yeung & Greenwald, 1992). Despite the apparent inclination of Jews to seek professional mental health care, this observation is not entirely generalisable to the Jewish population as a whole. For example, it has been reported that Ultra-Orthodox Jews (i.e. very religiously observant Jews) would use professional mental health services as a last resort and they tend to be under-represented as statutory mental health service users (Talking Matters, 2007). Therefore, it appears that there are big discrepancies in help seeking attitudes and behaviours between different groups/affiliations of Jewish people according to their level of religious observance. Predominantly qualitative research has suggested that there are a number of factors which contribute to these apparent differences in seeking help which exist between different Jewish affiliated groups. For example, in a recent study of Orthodox Jews in Hackney, London, it was found that this population feared that mental illness would attract social stigma and their religious beliefs and practices would be pathologised by professionals (Talking Matters, 2007). However, a small body of research has also suggested that one's degree of "religiosity" i.e. one's level of religious belief and observance may account for these differences. In one such

study of American Jews, Kaminetzky and Stricker (2000) investigated whether religiosity (i.e. their degree of religious belief and observance) predicted attitudes towards seeking psychotherapy and they found no significant differences between different affiliations of Jews. However, they highlighted that an individual's level of religiosity influenced their pathway to care for mental health concerns. For instance, despite Orthodox Jewish participants being equally likely to see a mental health professional as those in less religiously observant groups, many indicated that they also view a Rabbi as being capable of solving psychological problems.

Research on other religious groups/ethnic communities suggests that there may be other factors which could also explain help seeking patterns in British Jewry. Moreover, a range of studies have suggested that in order to understand the help seeking attitudes and behaviour of ethnically diverse groups, their beliefs about the causes of mental illness also need to be taken into account. For example, in their study, Sheikh and Furnham (2000) examined the relationship between cultural beliefs about the causes of mental illness and attitudes associated with seeking professional between British Asian, Western European and Pakistanis. They found that causal beliefs of mental distress were significant predictors for attitudes towards seeking professional help for the British Asian and Pakistani groups. They also reported that significant predictors of positive attitudes towards help seeking were sex, level of education and religion. Fung and Wong (2007) also considered the influence of causal beliefs about mental illness, together with beliefs about perceived accessibility to services and their relationship with attitudes towards seeking professional help in five ethnic minority groups of South Asian Women. They found that when other variables were controlled for, the most significant predictor of attitudes towards seeking professional help was perceived accessibility to services (e.g. the extent to which they felt they would be allocated a mental health worker of their own culture).

To the best of the researcher's knowledge, there are no existing quantitative studies in the UK which have investigated beliefs about the causes of mental illness and their attitudes towards seeking professional help for mental health problems amongst Jewish people. Furthermore, there appears to be little, if any research which has directly examined which factors (including causal beliefs about mental illness and level of religious observance) predict what forms of help Jewish people are likely to seek. Therefore, this study is particularly concerned with assessing the extent to which Jewish people's help seeking for mental health problems is related to their level of religious beliefs and observance, in addition to their causal beliefs about mental illness

	and attitudes towards help seeking. ***Aims and research questions*** This study aims to: ● Explore Jewish people's beliefs about mental illness and attitudes towards seeking professional help for mental health problems, particularly psychotherapy. ● To examine their attitudes towards seeking other forms of help for mental health problems, including religious help (e.g. from a Rabbi) and community based (Jewish) mental health services. ● To examine how these beliefs about mental illness not only relate to their attitudes towards seeking help, but to additionally examine how they relate to their behavioural intention to seek professional help. ● To measure whether religiosity predicts their attitudes and intentions to seek professional help. ● To compare the Jewish attitudes towards seeking professional help with the general population (using published data, e.g. Sheikh & Furnham, 2000; Rüdell et al., 2008). It is hoped that this research will lead to a greater understanding of the way in which Jewish people think about mental health problems which may provide useful information for services who work with the Jewish community to develop more culturally appropriate help and support.
Q16	**Brief description of methods and measurements:** The study will use a non-experimental research design, which will involve a survey of the Jewish community using questionnaires. The following questionnaires will be used: **1) Personal background questionnaire**: This has been developed by the researcher and will include items to gain demographic information about the participant including their sex, age, current location, marital status, level of education and occupation. **2) Religious Background questionnaire** This is a 9-item questionnaire which has been developed by the researcher to specifically obtain information about the participant's Jewish background/group affiliation and their level of religious observance and practice. Some of these items have been adapted from the Multidimensional Measurement of

Religiousness/Spirituality Scale (Fetzer Institute, 2003).

3) Mental Distress Explanatory Model Questionnaire (Eisenbruch, 1990)

The Mental Distress Explanatory Model Questionnaire (MDEMQ) is a 45-item questionnaire used for surveying non-clinical research participants' explanatory beliefs about the causes of mental distress or morbidity (Eisenbruch, 1990). Participants are asked to rate how likely each of the listed causes could contribute to mental distress on 5-point Likert scale from 'Not at all likely' to 'Highly likely'. The MDEMQ has been used in similar studies assessing causal beliefs about mental illness including studies by Fung and Wong (2007) and Sheikh and Furnham (2000).

4) Inventory of Attitudes Toward Seeking Mental Health Services (Mackenzie et al., 2004)

The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) is a 24-item questionnaire which is based on Fischer and Turner's (1970) 'Attitudes Toward Seeking Professional Psychological Help Scale' (ATSPPHS). It was developed in order to address several conceptual and methodological concerns apparent in the ATSPPHS. On the IASMHS participants are asked to rate on a 5-point Likert scale how much they agree with attitudinal statements relating to seeking professional help for mental health problems and the stigma of mental illness and its treatment.

5) Attitudes Toward Seeking Professional Psychological Help: A Shortened Form (Fischer & Farina, 1995)

The Attitudes Toward Seeking Professional Psychological help: Shortened Form is a 10-item questionnaire which is an adaptation of Fischer and Turner's (1970) 'Attitudes Toward Seeking Professional Psychological Help Scale' (ATSPPHS). Fischer and Farina's (1995) scale asks participants how much they agree with attitudinal statements specifically relating to seeking psychotherapy. Participants are asked to rate on a 4-point Likert scale how much they agree with each of these statements.

6) Intentions to Seek Help scale

This scale contains 14-items which have been designed by the researcher to specifically measure key concepts of the Theory of Reasoned Action (TRA; Ajzen & Fishbein, 1980), specifically, the participant's behavioural intention to seek different sources of help (including both professional and non-professional forms of help such as Jewish/religious based support). The items have been based on Bayer and Peay's (1997) questionnaire which measured aspects of the TRA in order to predict intentions to seek help from professional mental health services. This measure also contains

	statements which intend to reflect therapeutic preferences which have been identified in qualitative studies of Orthodox Jewish people. Participants are asked to rate on a 5-point Likert scale how much they agree with each statement about one's intentions to seek different forms of help and therapeutic preferences. **7) Experiences of different forms of help and support** This measure has been designed by the researcher in order to give the participant an opportunity to provide information about their actual experience of help seeking for mental health problems. Alternatively participants are also given the option of answering questions about a person who is known well to them if they would prefer.
Q17	**Participants: recruitment methods, age, gender, exclusion/inclusion criteria:** Participants must be over the age of 18 years and define themselves as Jewish. It is hoped that participants will be recruited through a number of ways: d) The researcher will write to synagogues in major cities where there are known to be Jewish communities, e.g. London, Manchester, Birmingham and Leeds. She will request if possible, that each synagogue either release contact details of their members (see Appendix 5) so that she can write to members asking them to contact her to take part in the study (see Appendix 6 and Appendix 2b), or if the synagogue will not pass on these details, she will ask the synagogues to contact their members on the researcher's behalf to ask them if they would like to take part in the study. e) The researcher will also recruit from Jewish community centres by initially writing to centres (Appendix 8) asking if she can visit the centres and ask attendees if they would like to take part in the study. Potential participants will then be given Appendix 2a when approached and asked if they will take part in the study. f) The researcher also hopes to recruit participants by contacting by post or email personal contacts and acquaintances she knows to be Jewish and asking them if they would be interested in taking part in the study (Appendix 6 and Appendix 2b). For all those who have indicated that they would like to take part in the study, they will be asked to complete the consent form (Appendix 1). They will also be given/sent Appendix 2a (Information sheet), Appendix 4 (the questionnaires) with Appendix 7 (covering letter) and Appendix 3 (Debriefing sheet)
Q18	**Consent and participant information arrangements, debriefing:** Written consent will be obtained from all participants (Appendix 1). All participants

	will be given a debriefing sheet (Appendix 3) which will be attached to the questionnaires and is clearly labelled that it should be read once questionnaires have been completed.
Q19	**Any other relevant information:**

PLEAE TICK **EITHER** *BOX A* **OR** *BOX B* BELOW AND PROVIDE RELEVANT ADDITIONAL INFORMATION IF YOU TICK **BOX B**. THEN PASS THE FORM TO YOUR SUPERVISOR

	Please tick
A. I consider that this project has **no** significant ethical implications to be brought before the Psychology Ethics Committee.	
B. I consider that this project **may** have ethical implications that should be brought before the Psychology Ethics Committee	√

Please provide a clear but concise statement of the ethical considerations raised by the project and how you intend to deal with them.

If a YES answer has been given to any of the questions 8-12 above, please state previous experience of the supervisor, or academic staff applying for a standard protocol, of investigations causing hazards, risks, discomfort or distress. If it is likely that medical or other aftercare may be needed by participants, please, indicate who will provide the aftercare, and whether they have confirmed that the aftercare can be provided free of charge to the participants.

It is possible that there are ethical implications which need highlighting and addressing. More specifically, it is possible that through the process of completing the questionnaires, participants may become aware of their own mental health needs and/or it may have raised issues relating to their own mental health. Therefore, the researcher has included on the Debrief Sheet (Appendix 3) suggestions for sources of support that participants can access should they feel that they would like some assistance with their mental health concerns.

This form (and all attachments) should be submitted (via your Supervisor for MSc/BSc students) to the Psychology Ethics Committee, psyethics@herts.ac.uk where it will be reviewed before it can be approved.

I confirm I am familiar with the BPS Guidelines for ethical practices in psychological research.

Name…..ESTHER ROSE ..Date……28.08.09
(Researcher(s))

Name…DR BARBARA MASON……..Date……28.08.09
(Supervisor)

CHECKLIST FOR REQUIRED APPENDICES (appended at the end of this form)

1. YOUR CONSENT FORM
2. YOUR INFORMATION SHEET
3. YOUR DEBRIEF SHEET
4. QUESTIONNAIRE(S) IF USED
5. SAMPLE MATERIAL(S) IF USED (e.g. pictures, stories, etc)
6. LETTERS TO HEADTEACHERS (if study is conducted in schools)
7. A SAMPLE LETTER TO PARENTS (if the study is conducted in schools)

Appendices attached:

Appendix 1 - Consent form

Appendix 2a - Information sheet to participants recruited face-to-face e.g. at community centres/sent with questionnaires when person has said they would be willing to take part

Appendix 2b - Information sheet to synagogue members/personal contacts

Appendix 3 – Debrief sheet

Appendix 4 – Questionnaires

Appendix 5 – Letter to synagogues (enclose with Appendix 2b – Information sheet)

Appendix 6 – Letter to synagogue members/personal contacts (enclose with Appendix 2b – Information sheet)

Appendix 7 – Covering letter with questionnaires (enclose with Appendix 2a – Information sheet)

Appendix 8 – Letter to Jewish community centres (enclose with Appendix 2a – Information sheet)

Ethical approval certificate

SCHOOL OF PSYCHOLOGY ETHICS APPLICATION FORM - 3

For minor modifications to an existing protocol approval

Status: PhD

Course code (if student): MPSY0037 (Clinical Psychology)

Title of project: ***Beliefs about mental illness and attitudes towards seeking help: A study of British Jewry***

Name of researcher(s): Esther Rose, Trainee Clinical Psychologist

Contact Tel. no: 07795106541
Contact Email: e.d.rose@herts.ac.uk

Name of supervisor: Dr. Barbara Mason, Clinical Tutor, Doctorate of Clinical Psychology, University of Hertfordshire.
Additional Academic Supervisor: Joerg Schulz, Senior Lecturer in Research Methods and Statistics, School of Psychology, University of Hertfordshire
(for undergraduate and postgraduate research)

Start Date of Study (if the end date of the existing approval has expired)**:** N/A

End Date of Study: (May 2010)

Details of modification:
I have made amendments in light of suggestions made following receipt of Ethical Approval Protocol Ref: **PSY/10/09/ER** and I would also like to make the survey available on line using 'Survey Monkey. Com' which will store individual questionnaire data on a secure and confidential database only accessible to myself through the use of a password. Please follow this link to view the survey online:
http://www.surveymonkey.com/s.aspx?sm=bV6VKQurDUBD6xijKjU95w_3d_3d
It is expected that individuals who contact me via email to register their interest in the study will then be sent this internet link to complete the survey online. Furthermore, I intend to ask local community centres and synagogues if they would be able to include the link to my survey on their website so that people who are browsing the site can also follow this link to the survey:
http://www.surveymonkey.com/s.aspx?sm=bV6VKQurDUBD6xijKjU95w_3d_3d

Does the modification present additional hazards to the participant/investigator? *(delete an inappropriate option category)*	NO
If yes, please provide a clear but concise statement of the ethical considerations raised by the project and how you intend to deal with them.	

This form should be submitted (via your Supervisor for MSc/BSc students) to the Psychology Ethics Committee, psyethics@herts.ac.uk where it will be reviewed before being approved by chair's action.

PLEASE ATTACH COPY OF ORIGINAL PROTOCOL APPLICATION

Name ……ESTHER ROSE……..…..Date……29.10.09
(Researcher(s))

Name…Barbara Mason……..Date……29.10.09
(Supervisor)

APPROVAL OF PROTOCOL APPLICATION FOR MODIFICATION

We **support** the approval of modification of the above protocol	
We do not support the modification of the above protocol for the following reasons:	

Signature …… Date ……

Chair of Ethics Committee

Ethics LK/CH/2006
Created: 19/09/06

Revised (September 2006)

SCHOOL OF PSYCHOLOGY ETHICS COMMITTEE APPROVAL

Student Investigator: Esther Rose

Title of project: Beliefs about mental illness and attitudes towards seeking help: A study of British Jewry

Supervisor: Barbara Mason and Joerg Schulz

Registration Protocol Number: PSY/10/09/ER

The approval for the above research project was granted on 14 October 2009 by the Psychology Ethics Committee under delegated authority from the Ethics Committee of the University of Hertfordshire.

Signed: Kvavilashvili **Date**: 14 October 2009

Dr. Lia Kvavilashvili
Chair
Psychology Ethics Committee

STATEMENT OF THE SUPERVISOR:

From my discussions with the above student, as far as I can ascertain, s/he has followed the ethics protocol approved for this project.

Signed (supervisor): .....

Date: 13 Nov 2009

PEC Form Version 2005

This form should be submitted (via your Supervisor for MSc/BSc students) to the Psychology Ethics Committee, psyethics@herts.ac.uk where it will be reviewed before being approved by chair's action.

PLEASE ATTACH COPY OF ORIGINAL PROTOCOL APPLICATION

Name ……ESTHER ROSE……..Date……29.10.09
(Researcher(s))

Name……..……..Date……
(Supervisor)

APPROVAL OF PROTOCOL APPLICATION FOR MODIFICATION

We support the approval of modification of the above protocol	√
We **do not** support the modification of the above protocol for the following reasons:	

Signature **Date 2 November, 2009**

Chair of Ethics Committee

Ethics LK/CH/2006
Created: 19/09/06