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Religion and Gender-Based Preferences in Therapist Selection Among Orthodox Jews

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Walden University

College of Allied Health

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Yehuda Rosen

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Review Committee
Dr. Mark Arcuri, Committee Chairperson, Psychology Faculty
Dr. J. Ryan Kennedy, Committee Member, Psychology Faculty

Chief Academic Officer and Provost
Sue Subocz, Ph.D.

Walden University
2024

Abstract

Religion and Gender-Based Preferences in Therapist Selection

Among Orthodox Jews

by

Yehuda Rosen

BA Touro College, 2020

Proposal Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

Clinical Psychology

Walden University

July 2025

Abstract

The preferences of Orthodox Jews when choosing a therapist are important to understand, as they can inform practice for individuals, clinics, and referral agencies. The purpose of this study was to determine the preferences for gender-matched therapists, Orthodox Jewish therapists, and specific therapist characteristics among Orthodox Jews. The study was based on Bordin's working alliance model of psychotherapy, which contends that a strong working alliance is necessary for effective psychotherapy. The research questions were used to explore whether Orthodox Jewish men and women differed in their preferences for gender-matched or Orthodox Jewish therapists, whether religiosity predicted a preference for gender-matched or Orthodox Jewish therapists, and which therapist characteristics Orthodox Jews rank as most important. This study included a quantitative cross-sectional self-report survey, and a chi-square test for independence to examine these preferences. Seventy percent of Orthodox Jews preferred a gender-matched therapist, and 74% of Orthodox Jews preferred an Orthodox Jewish therapist. No significant difference was found between men and women in the strength of these preferences. Religiosity predicted a preference for an Orthodox Jewish therapist and predicted a preference for gender-matched therapists for women, but not men. The most preferred therapist characteristics were nonjudgmental, experienced, trustworthy, good communication skills, and sensitive to my culture. Future research may focus on the reasons for these preferences, as well as preferences for specific modalities. The results can promote positive social change by helping individuals, clinics, and referral agencies to better accommodate their patients' preferences.

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Chapter 1: Introduction to the Study

Introduction

In this paper, I will discuss the therapeutic preferences of Orthodox Jews – including therapist religion, gender, and characteristics. Although the therapeutic preferences of the general population and other religious groups have been studied, there is no recent research on the therapist preferences of Orthodox Jews. My goal was to fill this gap in the literature regarding this topic. The findings of this study may result in social change by informing therapists of the preferences of patients in the Orthodox Jewish community. Additionally, this information can be used by referral organizations understand these preferences and provide better referrals for the Orthodox Jewish population.

In this chapter, I provide a background for this study, including a synopsis of the literature on this topic and the gap in the literature. Next, I describe the purpose of the study, including the problem it addresses, the nature of this study, and the independent and dependent variables. The research questions and hypotheses are examined next. I also define many of the terms used in this study and describe the assumptions of this research paper. Next, I describe the scope and boundaries of this study and address issues of generalizability. Finally, I discuss this study's potential contributions to the discipline of psychology.

Background

This study is predicated on the importance of the working alliance in therapy and is based on the theoretical framework of the working alliance model. The working

alliance, or the therapeutic alliance, is the cooperative relationship between the therapist and patient in the common struggle to help the patient overcome their negative behavior and suffering (Bordin, 1979). The strength of the working alliance is a strong predictor of therapeutic outcomes, regardless of the therapy modality (Baier et al., 2020). Accommodating the preferences of psychotherapy patients can help increase the strength of the working alliance (Windle et al., 2020), thus improving therapy outcomes.

Racial and ethnic matching between the patient and therapist can affect therapeutic outcomes. Kim and Kang (2018) found that patients matched with a therapist of the same ethnicity attended more sessions and had a more significant improvement in global functioning. Although matching Orthodox Jewish patients with Orthodox Jewish therapists does not necessarily improve therapy outcomes (Rosmarin & Pirutinsky, 2020), this would likely differ if the patient expressed a preference for meeting with an Orthodox Jewish therapist.

The religion and gender-based preferences of different ethnic and religious groups have been well-researched. About 66% of Muslim women prefer a therapist of the same gender, and about 56% prefer a therapist from the same ethnic background (Grey et al., 2020). Among Muslims living in the United States, 41% of the participants preferred to meet with a therapist of the same religion. Additionally, 34% of participants indicated that they preferred a therapist with a similar ethnicity. Finally, 53% preferred a therapist of the same gender (McLaughlin et al., 2022). Among Latter-Day Saints (LDS), increased religiosity is associated with a preference for working with LDS therapists (Dimmick et al., 2020).

Race and ethnicity can affect patients' preferences for gender matches with their therapist. The extent to which a person identifies with their culture directly correlates with a preference for a racial match. Similarly, patients from minority cultures are more likely to prefer meeting with gender and ethnically matched therapists than white patients (Ilagan & Heatherington, 2022). The preferences of men and women regarding the gender of their potential therapist are equivocal. Seidler et al. (2022) found that men prefer male and female therapists equally, while Liddon et al. (2018) found that women prefer to meet with female therapists. Conversely, Black and Gringart (2019) found that both men and women preferred to meet with male therapists over female therapists.

Although the therapeutic preferences of these and other populations have been studied, the therapeutic preferences of Orthodox Jews have not been examined, except in an exploratory study by Wikler (1989). In this study, 45% of the subjects preferred Orthodox Jewish therapists, 20% preferred Jewish but not necessarily Orthodox therapists, 20% preferred Jewish non-Orthodox therapists, 0% indicated that they preferred a non-Jewish therapist, and 15% indicated that they had no preference (Wikler, 1989). However, this study only had 33 subjects, 13 of whom were therapists, and was conducted 34 years ago, thus limiting its validity and reliability. Furthermore, it did not examine other variables like the gender, and characteristics of the therapist. Accordingly, my goal was to build on Wikler's (1989) study and fill the gap in the literature regarding the therapeutic preferences of Orthodox Jews. The information gleaned in this study can be used by referral agencies and therapists serving the Orthodox Jewish community to better serve their patients through a more robust understanding of their preferences.

Problem Statement

Accommodating the therapeutic preferences of therapy patients can improve therapeutic outcomes (Ilagan & Heatherington, 2022; Seidler et al., 2022; Windle et al., 2020). Thus, it is essential to understand the therapist preferences of different groups. These preferences have been well-studied among other religious groups, such as (LDS) (Dimmick et al., 2020) and Muslims (Grey et al., 2020; McLaughlin et al., 2022; Salem & Hijazi, 2019), as well as racial and ethnic groups (Ilagan & Heatherington, 2022). However, the therapist preferences of Orthodox Jews are not well studied.

McEvoy et al. (2017) conducted a review examining mental health care in the Orthodox Jewish community in Britain. However, the section on the preferences of Orthodox Jews relies on qualitative data gleaned through interviews with 12 informants. The small sample size in this study makes it difficult to generalize the results to the broader Orthodox Jewish community. Similarly, Rosmarin and Pirutinsky (2020) conducted a study on the effect of matching Orthodox clients with Orthodox patients. However, this study does not study the preferences of Orthodox Jews when choosing a therapist. My goal was to fill the gap in the literature and examine the preferences of Orthodox Jews when choosing a therapist.

Purpose of the Study

The purpose of this study was to describe the therapeutic preferences of Orthodox Jews—including religion, gender, and therapist characteristics—and determine their relationship with gender and religious identity. The independent variables in this study

were participant gender and religious identity. The dependent variables in this study were participant preferences regarding the gender and religion of their therapist.

Research Questions and Hypotheses

Research Question 1 (RQ1)*:* Is patient gender associated with a preference for a specific gender therapist?

Null Hypothesis ($H_0$1): Gender is not associated with a preference for a specific gender therapist.

Alternative Hypothesis (H_a1): Gender is associated with a preference for a specific gender therapist.

Research Question 2 (RQ2)*:* Is patient gender associated with a preference for meeting with an Orthodox Jewish Therapist?

Null Hypothesis ($H_0$2): Gender is not associated with a preference for meeting with an Orthodox Jewish therapist.

Alternative Hypothesis (H_a2): Gender is associated with a preference for meeting with an Orthodox Jewish therapist.

Research Question 3 (RQ3): Is the patient's religious identity associated with a preference for meeting with a specific gender therapist?

Null Hypothesis ($H_0$3): Religious identity is not associated with a preference for meeting with a specific gender therapist.

Alternative Hypothesis (H_a3): Religious identity is associated with a preference for meeting with a specific gender therapist.

Research Question 4 (RQ4): Is patient religious identity associated with a preference for meeting with an Orthodox Jewish therapist?

Null Hypothesis ($H_0$4): Religious identity is not associated with a preference for meeting with an Orthodox Jewish therapist.

Alternative Hypothesis (H_a4): Religious identity is associated with a preference for meeting with an Orthodox Jewish therapist.

Theoretical Framework of the Study

The theoretical framework that I used to guide this study was the working alliance model proposed by Bordin (1979). The working alliance, or therapeutic alliance, is a cooperative relationship between the therapist and patient in the common struggle to help the patient overcome their negative behavior and suffering (Bordin, 1979). According to the working alliance model, all modalities of psychotherapy have implicit working alliances and can be differentiated by the nature of the working alliance that each modality requires.

This theoretical approach was directly applicable to this study because the therapeutic alliance is one of the strongest predictors of positive outcomes (Ardito & Rabellino, 2011). An ideal therapeutic alliance is achieved when the patient and therapist agree on the goals of the treatment and view these methods as effective and relevant. This can only develop once there is a personal relationship of confidence and regard (Ardito & Rabellino, 2011). Patients may feel that the religious background and gender of the therapist can directly affect the nature of the therapeutic alliance and prefer a therapist with a similar background.

Nature of the Study

I used a quantitative cross-sectional self-report survey to gather data for this study. Surveys are a standard data collection instrument for this research type and have been used in several similar studies (Dimmick et al., 2020; Grey et al., 2020). The anonymous questionnaire format was used so that participants could respond freely without fear of stigma or disapproval. The independent variables in this study were participant gender and religious identity. The dependent variables in this study were participant preferences regarding the gender and religion of their therapist.

The target population for this study was English-speaking, Orthodox Jewish adults. Populations were given a questionnaire to assess their therapist-based preferences. The data were then organized with Microsoft Excel, and a chi square test of independence was performed to examine whether gender or religious identity correlates with a preference for a gender or religious match with the therapist.

Definitions

In this paper, I use the terms *Orthodox Jew*, *Modern Orthodox*, *Orthodox*, *Chasidish (Hasidic)*, *Yeshivish*, *Ultra-Orthodox*, and *religious identity*. For the sake of clarity, I define these terms below. Orthodox Jews comprise about 10% of American Jews (Rosmarin & Pirutinsky, 2020). They believe that God gave the Torah (the Hebrew Bible) to the Jews at Mount Sinai, along with its divinely ordained interpretation of the commands. They apply religious practices and rituals to all areas of their lives, including interpersonal interactions, financial dealings, and other daily routines (Golker & Senior, 2021).

The Orthodox Jewish community cannot be divided into neat categories – it is more accurately described as a spectrum. The Orthodox community is often grouped into categories, such as Modern Orthodox, Orthodox, Yeshivish, and Chasidish. While these categories can function as useful frameworks for understanding Orthodox Jews, they are somewhat fluid. In this study, religious identity refers to whether the participant identifies as Modern Orthodox, Orthodox, Yeshivish, or Chasidish. The Yeshivish and Chasidish categories were then combined to create the Ultra-Orthodox subgroup.

Modern Orthodox Jews believe that Jewish values and rituals can in some ways be synthesized with being a citizen of the modern, secular world. Thus, they may have a television in their homes, read secular newspapers, and consume other popular media. Additionally, they may send their children to non-Jewish afterschool programs and sometimes to nonreligious schools (Mirkin & Okun, 2005). However, although these Jews have increased contact with the modern world, they still believe that Jewish law must be interpreted literally and applied to one's life. (Holliman & Wagner, 2015).

The terms Chasidish and Yeshivish refer to two subcategories of Ultra-Orthodox Jews. These Jews tend to emphasize stringent religious practices and rituals, firm religious philosophies, and separation from modern secular culture. The typical dress of both men and women is traditional and modest. Men often wear white shirts and dark pants, and women wear long sleeved shirts with high necklines, and long skirts. With this sense of modesty, the genders do not typically mix during religious services, school, or social events. Finally, Ultra-Orthodox Jews may restrict all or some aspects of secular

media in their home, such as books, television, periodicals, and the internet (Holliman & Wagner, 2015).

Chasidish Jews practice Chasidus, a branch of Orthodox Judaism founded in the eighteenth century. These Jews have historically emphasized prayer, song, and dance. Chasidish men often have long curly *peyos* or sidelocks, and wear frock coats and *shtreimels,* fur hats, on the Sabbath and holidays. Many of these Jews speak Yiddish as a first language. Yeshivish Jews emphasize the study of the Talmud and often wear black fedora-like hats and dark suits (Ukeles, 2022). However, they usually speak English as their first language and are more likely than Chasidish Jews to get a college degree.

A philosophical difference between Chasidish and Yeshivish Jews is that Chasidim place more of an emphasis on connection to God, while Yeshivish Jews put more of an emphasis on service of God. Additionally, Chasidish Jews are often seen as more insular and traditional than the Yeshivish community, as is reflected in their style of dress. However, these external attributes are not always accurate, and one cannot necessarily know how an individual identifies without asking them.

The Orthodox category of Orthodox Jews refers to people who do not identify with either the Modern Orthodox, Yeshivish, or Chasidish categories of Orthodox Jews. The level of Orthodox observance for these individuals falls somewhere in between that of Yeshivish and Modern Orthodox Jews.

It is important to note that these labels are both cultural and religious. Although Chasidish and Yeshivish Jews are often considered more religious than other Orthodox Jews, a person can be culturally part of one group, and religiously part of another. Thus,

there are some Modern Orthodox Jews who are more religious than Yeshivish and Chasidish Jews.

Assumptions

I made several assumptions when conducting this study. First, that the participants would take the survey in good faith, carefully considering their options. Second, that this survey accurately and reliably measures the constructs of this study. Although this survey was pilot tested and reviewed by an expert panel, it has not been empirically validated. This was necessary, as there is no extant survey that measures these constructs. My third assumption was that Orthodox Jews have different preferences than the general population when choosing a therapist. This is likely because other religious and ethnic groups have specific therapist preferences. For example, LDS are more likely to prefer a religious rather than a secular therapist (Dimmick et al., 2020). Similar findings have been found among Muslims (Grey et al., 2020; McLaughlin et al., 2022; Salem & Hijazi, 2019) and racial and ethnic groups (Ilagan & Heatherington, 2022). This assumption was necessary because the therapist preferences of Orthodox Jews have not been quantitatively studied before.

Scope and Delimitations

The scope of this study was limited to the therapist preferences of English-speaking Orthodox Jews over the age of 18. The theoretical model that I used in this study was the working alliance model posited by Bordin (1979). My specific focus in the study was the nature of Orthodox Jews' preferences regarding the gender and religious status of the therapist, as these are readily measurable. However, I did not examine the

effect of matching Orthodox Jewish patients with their preferred therapist, as this was beyond the scope of the current study.

Additionally, I did not examine the reasons behind these preferences experimentally in this study, although some possibilities are suggested in Chapter 5. Furthermore, while patient preferences regarding the characteristics of a potential therapist is included as a survey question and reported in the results, an in-depth analysis of these preferences is beyond the scope of this study. Finally, a large portion of Orthodox Judaism is based on binary gender roles, and the prevalence of nonbinarism and transgenderism in the community is not well studied. Accordingly, for the sake of simplicity, I focused exclusively on male and female genders.

Limitations

The advantage of anonymous research is that it allows participants to respond to sensitive topics freely without fear of disapproval or stigma. This is particularly appropriate for the tight-knit Orthodox Jewish community. However, this anonymity makes it impossible to ensure that participants do not fill out the survey multiple times. Nevertheless, it is unlikely that this occurred, as no incentives were offered for completing the surveys. This study was limited to adults, so the results may not be generalizable to children. Additionally, due to possible cultural differences, these results may not be generalized to non-English-speaking Orthodox Jews.

Another limitation was related to selection and sampling bias. Because I used snowball sampling, the sample selected may not be representative of Orthodox Jewry. I sought to counteract this bias by sending the survey to a diverse group of *seeds* to recruit

participants from their subpopulations (Kirchherr & Charles, 2018). Additionally, due to the use of convenience sampling, the research findings may not be able to be generalized to a larger population. Similarly, some Ultra-Orthodox Jews do not use the internet regularly, which made it difficult to get responses from that subgroup. Finally, because this study relied on self-report measures, it may contain some social desirability response biases. Patients may have indicated that they preferred specific therapist attributes to appear more religious or acculturated. However, this is less likely, considering the anonymous nature of the study.

Significance

This research fills a gap in the literature in understanding the preferences of Orthodox Jews when choosing a therapist. This is important because while there is ample research on the therapeutic preferences of other populations (Dimmick et al., 2020; Grey et al., 2020; Ilagan & Heatherington, 2022; McLaughlin et al., 2022; Salem & Hijazi, 2019), there is little extant research on the preferences of Orthodox Jewish patients. On a policy level, accommodating the therapeutic preferences of therapy patients can improve therapeutic outcomes (Ilagan & Heatherington, 2022; Seidler et al., 2022; Windle et al., 2020). Thus, understanding the therapist preferences of Orthodox Jews can help individuals, agencies and clinics better accommodate these preferences, thereby improving therapeutic outcomes. Further research may be influenced by this study regarding the reasons behind these preferences and the impact accommodating these preferences can have on therapeutic outcomes in the Orthodox Jewish community.

Understanding these preferences can have crucial social change implications by increasing cultural competence around Orthodox Jewish cultures. Cultural competence is defined as a process where individuals and systems respectfully and effectively respond in a manner that recognizes, affirms, values, and preserves the dignity of people of all cultures, races, ethnic backgrounds, languages, classes, spiritual traditions, religions, immigration status, and other diversity factors (Danso, 2016). Thus, this study may impact social change by increasing the knowledge base of cultural competence in the Orthodox Jewish community.

Summary

In this study, I examined the gender and religion-based preferences of Orthodox Jews when choosing a therapist. I sent sent out surveys to Jews across the spectrum of Orthodoxy to gather data for this study. The theoretical framework that I used to guide this study was the working alliance model proposed by Bordin (1979). I filled a gap in the literature regarding the preferences of Orthodox Jews. Additionally, referral agencies may be able to use the findings in this study to better understand this population's needs, thus serving them better. In the next chapter, I conduct a comprehensive review of the literature regarding therapist preferences in different populations. Additionally, I present the theoretical model that guides this study and describe Orthodox Jewish society and practices.

Chapter 2: Literature Review

Introduction

The therapist preferences of Orthodox Jews are not well studied. The purpose of this study was to determine the therapeutic preferences of Orthodox Jews, including therapist religion, gender, and characteristics. This chapter begins with a discussion of the working alliance theoretical framework (see Bordin, 1979), which I used to guide the study. Next is a review of the literature on religion, ethnicity, and gender-based preferences when choosing a therapist. Additionally, I describe the unique needs of the Orthodox Jewish population in therapy to provide a possible explanation for why Orthodox Jews may prefer to meet with a therapist of the same religion. Finally, I describe the strengths and weaknesses of the current research on the therapy preferences of Orthodox Jews.

Literature Search Strategy

I used the Walden University library to identify and retrieve peer-reviewed articles via electronic databases. I searched databases including Psychology Databases Combined Search, which includes PsycARTICLES, PsycINFO, PsycBOOKS, and PsycEXTRA, as well as SocINDEX, and Google Scholar. The beginning date range for the search was 2018 to 2023. This range was also expanded to encompass more relevant articles. Most of the articles cited have been published within the past 5 years, except for seminal articles, or where there was a significant gap in the literature and newer articles were nonexistent. The search engines, databases, and search terms I used are shown in Table 1.

Table 1

Search Engines and Terms Used to Conduct Research

Search engines and databases	Search terms
Psychology Databases Combined Search (PsychINFO, PsychARTICLES, PsychBOOKS, PsychEXTRA)	Theoretical alliance, conceptual framework, theoretical framework, patient-therapist relational factors, Orthodox Jews, preferences, religious congruence in therapy, therapist preferences, counseling, counselling, therapy, psychotherapy, mental health, behavioral health, the effect of client-therapist gender match, preferences racial ethnic.
SocINDEX	Psychotherapy with Orthodox Jews, Racial ethnic matching, transference, mental illness and Orthodox Jews, gender preference and psychotherapy, ethnic preference and psychotherapy.
Google Scholar	Racial/ethnic matching of clients and therapists, transference and therapeutic alliance, patient-therapist relationship, therapeutic alliance, therapist racial preferences, therapist gender preferences, patient-therapist preferences Muslim Population, patient-therapist relationship.

Theoretical Framework

Bordin's (1979) working alliance model was the theoretical framework for this study. The working alliance, or therapeutic alliance, is a cooperative relationship between the therapist and patient in the common struggle to help the patient overcome their

negative behavior and suffering (Bordin, 1979). This collaborative relationship is influenced by the extent to which there is a formation of a positive emotional bond, agreement on treatment goals, and a defined set of therapeutic tasks or processes to achieve these goals (Baier et al., 2020). The working alliance model contends that all kinds of psychotherapy have implicit working alliances and can be meaningfully differentiated by the nature of the working alliance that each modality requires.

Distinct psychotherapy methods are distinguished by the divergent demands they make on therapist and patient. The efficacy of any therapeutic modality is primarily the function of the strength of the working alliance. The strength of the working alliance is a consequence of the closeness of fit between the personal characteristics of the patient and therapist and the therapy modality (Bordin, 1979). An ideal therapeutic alliance is achieved when the patient and therapist agree on the goals of the treatment and view these methods as effective and relevant. Agreement on goals and agreement on tasks can only develop once there is a personal relationship of confidence and regard. This is because agreement on tasks and goals necessitates the patient's belief in the therapist's ability to help them and the therapist's confidence in the patient's resources (Ardito & Rabellino, 2011).

This theoretical approach is directly applicable to this study because the therapeutic alliance is one of the strongest predictors of positive outcomes (Ardito & Rabellino, 2011). This study does not examine the effect of the therapeutic alliance on patient outcomes. However, patients may feel that the religious background and gender of

the therapist can directly affect the nature of the therapeutic alliance and prefer a therapist with a similar background.

The Working Alliance and Therapeutic Outcomes

The working alliance (sometimes called the therapeutic alliance) is the collaborative relationship between the patient and therapist that is mediated by the extent to which there is agreement on the goals of treatment, a defined set of therapeutic tasks and processes to attain the declared goals, and the development of a positive emotional bond (Baier et al., 2020). Researchers conducted a meta-analysis of 37 studies to examine whether the therapeutic alliance is a specific mediator of change and establish the therapeutic alliance as a mechanism underlying psychotherapy response. The therapeutic alliance mediated therapeutic change in 70.3 percent of the studies despite substantial heterogeneity between statistical analytic procedures, study designs, and overall quality. Thus, a strong patient–therapist alliance is necessary for successful psychotherapy, irrespective of the therapeutic modality (Baier et al., 2020).

The therapeutic alliance is associated with positive outcomes in face-to-face and internet-based psychotherapy (Flückiger et al., 2018; Kaiser et al., 2021). For example, Shattock et al. (2018) conducted a systemic review on the therapeutic alliance in psychotic disorders studying the quality of the alliance, the effect of the alliance on therapeutic outcomes, and the variable associated with creating an alliance. The strength of the therapeutic alliance was correlated with treatment outcomes in psychotic disorders. Similarly, preliminary evidence showed that the therapeutic alliance predicts medication use, rehospitalization rates, and self-esteem outcomes. Client-related factors were linked

to different views of alliance. For example, negative symptoms were associated with worse therapist-rated alliance, while previous sexual abuse and poorer insight were associated with lower client alliance ratings. Therapist-related factors, like trustworthiness, genuineness, and empathy, were associated with better client-rated alliance. Finally, attendance, homework compliance, and suitability for therapy were associated with better therapist-rated alliance (Shattock et al., 2018).

The treatment alliance is also associated with better outcomes in eating disorders. Werz et al. (2022) reviewed 26 studies on patients with anorexia and bulimia. They found that with adolescents, the strength of the therapeutic alliance was positively associated with therapy completion and outcomes in both anorexia and bulimia. With adults, the therapeutic alliance was positively associated with outcomes and therapy completion with anorexic patients. However, some samples of adult bulimia patients did not find any relation between the therapeutic alliance and outcomes (Werz et al., 2022).

Cameron et al. (2018) conducted a meta-analysis of 13 articles, studying the effect of the treatment alliance on cognitive behavioral therapy (CBT) for depression. Results indicated that the therapeutic alliance was moderately correlated with outcomes for CBT for depression. The strength of this effect depended on who was rating the strength of the therapeutic alliance. The correlation was weaker when the therapist rated the therapeutic alliance compared to when the client or an observer rated the alliance. Additionally, the correlation between the therapeutic alliance and the outcome increased marginally throughout CBT treatment (Cameron et al., 2018).

Although the therapeutic alliance is strongly associated with treatment outcomes, there is an exception to this rule. The treatment modality is significantly more associated with treatment outcomes than the therapeutic alliance when treating obsessive-compulsive disorder (OCD; Strauss et al., 2018). With OCD, the development of a strong therapeutic alliance is more likely a consequence of symptom reduction than a cause of it.

Transference

The therapeutic alliance can also facilitate the development of transference, or the patients' behavior toward the therapist, which is affected by the dysfunctional patterns, beliefs, and assumptions that affect a patient's perception of others. In other words, the dysfunctional patterns, beliefs, and assumptions in the patient's life transfer onto the therapist (Prasko et al., 2022). Transference works by reenacting common themes of the patient's life here and now (Kernberg, 2021). Patient therapy congruence, and the ensuing transference, are particularly important for patients with severe personality disorders and interpersonal issues. Transference works by causing common themes in the patient's interpersonal life to play out within the therapeutic relationship. The patient can then relearn their interpersonal style within the safe space of the therapist's office (Meehan, 2019).

Accommodating patient preferences can increase the development of the therapeutic alliance (Windle et al., 2020). Thus, it is important to understand the preferences of different populations, so that they can be better served.

Preference Accommodation, Therapist-Patient Matching, and Therapeutic Outcomes

In this section, I examine the effect of gender, ethnic, religious, or cultural matching on therapeutic outcomes. Similarly, I will discuss the effect accommodating the preferences of patients has on therapeutic outcomes. These are important topics to examine because they can be used to understand relative importance of therapist-patient matching and accommodating patient preferences.

Accommodating Patient Preferences

Overall, accommodating patients' preferences is associated with improved treatment outcomes. For example, in a meta-analysis of 53 studies, Swift et al. (2018) found that accommodating a patient's preferences regarding the therapist and therapeutic modality positively affects therapeutic outcomes. However, the strength of this effect depends on the nature of the mental health disorder being treated. Accommodating patient preferences is correlated with positive outcomes in anxiety disorders and depression. However, this effect is less significant with psychotic, substance use, or behavioral disorders (Swift et al., 2018).

Accommodating patient treatment preferences is associated with higher treatment completion rates and a stronger therapeutic alliance. In a meta-analysis of 34 studies, Windle et al. (2020) assessed the correlation between accommodating patient treatment preferences and clinical outcomes in seven areas. These were therapeutic alliance, depression and anxiety outcomes, attendance, dropout, global outcomes, treatment satisfaction, and remission. Patients who received their preferred mental health treatment

had lower dropout rates and a stronger therapeutic alliance. In other words, accommodating patient preferences positively affects the therapeutic alliance (Windle et al., 2020) and thus, therapeutic outcomes.

Racial/Ethnic Matching

Patient/therapist racial and ethnic matching can also affect therapy outcomes. Kim and Kang (2018) conducted a study exploring the effects of ethnic/racial matching on therapeutic outcomes, measured through the number of sessions attended, and global functioning. The sample included 499 White Americans, 81 Black Americans, 31, Hispanic Americans, and 33 Asian American patients. Results indicated that the patients who were matched with a therapist of the same ethnicity came to more sessions than those who were not matched with a therapist of the same ethnicity. These patients also had a greater improvement in global function than the unmatched patients (Kim & Kang, 2018).

Patients who have a therapist with the same ethnic background trust their therapists more and participate more actively in the sessions (Kim & Kang, 2018). Additionally, communication preferences and perceptions of personal space tend to vary in different cultures, and thus affect the therapeutic alliance. Additional research indicates that the therapeutic alliance increases as the number of sessions increases. Accordingly, the explanatory mechanism of action for this study is that patient/therapist ethnic matching causes patients to attend more sessions, which improves the therapeutic alliance, thereby improving therapeutic outcomes (Kim & Kang, 2018).

Therapist-Patient Matching Among Orthodox Jews

Preliminary research indicates that Orthodox Jews do not benefit from having Orthodox therapists over any other therapist. Rosmarin and Pirutinsky (2020) conducted a naturalistic study of 117 Orthodox Jewish, and 91 control patients who received therapy from Orthodox Jewish (n = 15) and other (n = 7) psychotherapists at an outpatient clinic in New York City. The groups had similar diagnoses and numbers of therapy sessions. Although the Orthodox patients reported lower initial anxiety and depression at the start of therapy, they did not differ from the controls at termination. This study was limited because it occurred in a clinic that is run by an Orthodox Jewish director and caters to both Orthodox and non-Orthodox populations. Thus, the staff at this clinic may be uniquely suited to support Orthodox Jewish patients with religion-sensitive care. Orthodox patients who present at clinics where all or most clinicians have no knowledge or understanding of their religious needs, may not have comparable therapeutic outcomes (Rosmarin & Pirutinsky, 2020).

In summary, accommodating patient preferences positively affects therapeutic outcomes, albeit more so with depression and anxiety disorders than psychotic, substance use, and behavioral disorders (Swift et al., 2018). This is thought to occur because patients who have their preferences accommodated attend more sessions, and have a stronger therapeutic alliance (Windle et al., 2020). Furthermore, patient/therapist ethnic matching causes patients to attend more sessions and leads to a greater increase in global functioning (Kim & Kang, 2018). However, research indicates that Orthodox Jews do not benefit more from having Orthodox Jewish therapists than other therapists (Rosmarin &

Pirutinsky, 2020). This would likely differ if the patient expressed a preference for meeting with an Orthodox Jewish therapist.

Religion and Gender-Based Preferences in Different Populations

In this section, I will examine the religion and gender-based preferences of other ethnic and religious populations. Some populations have strong preferences for religious, ethnic, and religious matching, while other populations do not express these preferences. This is an important topic to consider because accommodating these preferences can positively affect therapeutic outcomes (Swift et al., 2018).

Therapist Preferences in Muslim Populations

Grey et al. (2020) explored the preferences of Muslim women when choosing a therapist. The most common preference expressed in this population was confidentiality. About 66% of the patients preferred a therapist of the same gender. Slightly more than half (56%) of the participants preferred a therapist from the same population. Religiosity was not one of the most expressed desirable attributes of the therapist (Grey et al., 2020). In a study of 187 Christian and Muslim students, participants were asked to rate a therapist based on their description and picture. The picture was manipulated to include a veil, cross pendant, or neither. There were no significant differences in ratings based on the match of the participants' religion and the therapist's picture (Salem & Hijazi, 2019).

McLaughlin et al. (2022) conducted a study of 350 Muslims living in the United States (MLUS) and found that 41% of the participants preferred to meet with a therapist of the same religion, 53% indicated that they had no preference, and 5% indicated a preference for a therapist of a different religion. Additionally, 34% of participants

indicated that they preferred a therapist with a similar ethnicity, 61% indicated no preference, and 5% indicated that they would prefer a therapist with a different ethnicity. Concerning gender, 53% of the MLUS participants preferred a therapist of the same gender, 42% indicated that they had no preference, and 5% preferred a therapist of a different gender (McLaughlin et al., 2022).

Therapist Preferences in LDS

Dimmick et al. (2020) used a probability discounting method to assess whether people who identify as LDS preferred a religious match with their therapist. The probability discounting method allowed the researchers to examine the strength of this preference by asking the patients if they would be willing to work with LDS, Christian but not LDS, religious but not Christian, and not religious therapists. The efficacy of the treatment modalities of these hypothetical therapists was also manipulated. This allowed researchers to see how much LDS patients were willing to sacrifice to meet with LDS therapists.

Patients were willing to sacrifice 13.70% in treatment efficacy to meet with an LDS therapist over a Christian non-LDS therapist. Patients were willing to sacrifice 17.37% in treatment efficacy to meet with an LDS therapist over a religious but non-LDS therapist. Finally, patients were willing to willing to sacrifice 20.35% in treatment efficacy to meet with an LDS therapist over a nonreligious therapist. Additionally, religiosity was strongly correlated with a preference for working with LDS therapists. In other words, the more religious the patient was, the more likely they were to prefer to work with an LDS therapist (Dimmick et al., 2020). This article was comprehensive and

informative because the LDS population is similar in many ways to the Orthodox Jewish population. However, critical differences between the two populations make it difficult to generalize the results.

Therapist Preferences in Racial and Ethnic Populations

Race and ethnicity can affect patients' preferences for gender matches with their therapist. Indeed, the extent to which a person identifies with a particular culture is directly correlated with a preference for a racial match (Ilagan & Heatherington, 2022). However, different ethnicities display different preferences. For example, Asian American patients are more willing than White Americans to forgo a more effective therapy with an unmatched counselor in favor of a match with a counselor of their gender. Similarly, Asian Americans prefer to meet with a therapist with the same ethnicity, and Black Americans patients predominately prefer to meet with therapists with the same racial background. Black Americans patients are more willing to give up treatment effectiveness than any other group in order to have a racial match with their therapist (Ilagan & Heatherington, 2022).

In another study, Swift et al. (2015) asked participants from Asian, Black, Hispanic, and multiracial backgrounds how much treatment efficacy they were willing to sacrifice to have one or more of the following four cultural variables present in therapy: (a) working with a counselor whose race/ethnicity matches their own, (b) working with a counselor with multicultural experience and training, (c) utilizing a treatment adapted for their culture, and (d) working with a therapist who is a member of a racial/ethnic minority group but not the same group as the participant. Participants were willing to sacrifice

between 8% and 32% of treatment efficacy to ensure that these treatment variables were present. Several reasons are suggested for this preference, including the belief that these variables are more important than empirical treatment support and the belief that their specific case needed cultural competence. One important finding is that participants rated culturally adapted treatment as more valuable than race/ethnicity match. Additionally, the strength of the participants' preferences was positively correlated with the extent to which they identified with their culture (Swift et al., 2015).

Patient Preference for Therapist Gender

Accommodating patient preferences in therapy can improve therapy outcomes (Swift et al., 2018; Windle et al., 2020). Similarly, potential therapy clients are more likely to seek help if they can see a therapist who matches their preferred gender (Black & Gringart, 2019). While it is true that, in the absence of patient preferences, matching therapists and clients based on their gender has little to no effect on therapeutic alliance (Behn et al., 2018), retention, or therapeutic outcome, many patients still prefer meeting with therapists of a specific gender (Seidler et al., 2022). Accordingly, in this section, I discuss the preferences of men and women regarding the gender of a prospective therapist.

Men

The preferences of men regarding the gender of their potential therapist are equivocal. In a study conducted in Australia, Seidler et al. (2022) asked 2002 men aged 16-85 (M = 43.8) whether they had a preference regarding the gender of a potential therapist. About 60% of men did not indicate a preference, and among those who did

express a preference, an equal number of men preferred female (20.4%) and male therapists (19.4%). Similarly, in a cross-sectional online survey of 115 men and 232 women, 62% percent of the men expressed no preference regarding the gender of a prospective therapist. However, of the men who did express a preference, 57% preferred to meet with a female therapist. In contrast, Black and Gringart (2019) found that men preferred to meet with male therapists over female therapists.

Severely depressed men are more likely to prefer meeting with female therapists, while non-heterosexual, more masculine, and college-educated men are more likely to prefer male therapists (Seidler et al., 2022). Meeting with a therapist who matched the patient's preference predicted satisfaction with therapy. Men who preferred male therapists expressed that they felt more comfortable talking to men and would be better understood by them. In contrast, those men who preferred to meet with female therapists expressed that they felt more comfortable talking to women because of a previous negative experience with a male therapist or because they preferred qualities stereotypically found in women, such as warmth and empathy (Seidler et al., 2022).

Women

The preferences of women regarding the gender of their potential therapist are indeterminate. Liddon et al. (2018) found that 61% of women indicated that they had no preference for the gender of the therapist. However, among those who did have a preference, 34% preferred to meet with a female therapist, and 5% preferred to meet with a male therapist. In other words, 87% of the women who indicated a preference preferred to meet with female therapists. Similarly, Ilagan and Heatherington (2022) report that

women prefer to meet with female therapists, especially when discussing sex-specific problems. Additionally, some women preferred and felt more comfortable self-disclosing to a female therapist than a male therapist. However, other research contradicts this – Black and Gringart (2019) surveyed 456 Australian participants through social media and found that the women who indicated a preference (43%) preferred to meet with a male therapist over a female therapist.

In summary, about 60% of men and women do not express a preference for the gender of their therapist (Liddon et al., 2018; Seidler et al., 2022). However, among those who do express a preference, the literature is divided. Some research indicates that those men equally prefer male and female therapists (Seidler et al., 2022), other research indicates that men prefer female therapists (Liddon et al., 2018), while still other research indicates that men prefer male therapists (Black & Gringart, 2019). Similarly, some research suggests that women who express a preference prefer meeting with female therapists (Ilagan & Heatherington, 2022; Liddon et al., 2018), while other research suggests that women prefer male therapists (Black & Gringart, 2019).

Orthodox Jewish Society

In this section, I will describe the basic structure of Orthodox Jewish society, as well as therapeutic adaptations, and best practices for working with Orthodox Jews. Understanding the best practices for treating Orthodox Jews can help therapists better serve Orthodox Jewish individuals and the community as a whole.

Orthodox Jews are part of a subculture within the broad American culture. They live much of their lives separate from American society – they pray at synagogues, shop

at kosher grocery stores, and attend religious schools (Holliman & Wagner, 2015). However, they also participate in American culture – they may shop at malls, visit the library, and attend sports events. Being that the community is central to Orthodox Jewish life, many, if not most, interactions occur within the Jewish community. However, Orthodox Jews may have non-Jewish colleagues, friends, and classmates. In this sense, the American Orthodox Jew simultaneously dwells in two worlds. For many Orthodox Jews, this self-imposed semi-insularity is an essential value. Thus, a multiculturally competent therapist must respect this separateness, as it is usually viewed positively by the patient, not negatively (Holliman & Wagner, 2015).

Orthodox Jewish society places a strong emphasis on modesty as well as the sanctity of the marital relationship. Thus, physical touch is prohibited between unrelated or unmarried men and women. Likewise, schools, synagogues, celebrations, and social gatherings, are often separated by gender, with separate areas for men and women (Holliman & Wagner, 2015). Regarding marriage, Orthodox Jews usually date for a short term (i.e., several weeks to several months) to ascertain whether this is an appropriate match. If they believe that it is, they often marry within a few months (Golker & Senior, 2021). Thus, many Orthodox Jews are most comfortable with their own gender and may prefer to meet with a gender-matched therapist (Rabinowitz, 2014).

The Centrality of Family and Religion

In Orthodox Jewish society, the family system is central – there is a strong emphasis on childrearing, which is considered a sacred responsibility (Holliman & Wagner, 2015). Large families are typical – the average Orthodox Jewish family has 4.1

children (Wormald, 2015). Childlessness or divorce can be especially challenging because much of Orthodox life revolves around family life. Similarly, family discord can be extremely agonizing because of the centrality of family in the community. In these cases, therapists may be called on to help facilitate family interactions (Holliman & Wagner, 2015).

Religion is central to the Orthodox Jewish family – an estimated 98% of Orthodox parents raise their children as Orthodox (Wormald, 2015). Much of Orthodox Jewish life is governed by Halacha – the Jewish law codified in the Torah. To the Orthodox Jew, these laws are commandments, not mere suggestions. A therapist who underestimates the importance of Halacha and religious issues to the Orthodox Jew risks losing their patient's trust (Rabinowitz, 2014). Thus, therapists counseling Orthodox Jews must first ascertain the importance of Judaism to their clients, as religion is often the single most important factor in their lives. In sum, the counselor must determine which aspects of the client's religious life are absolute and which aspects are more flexible (Holliman & Wagner, 2015).

Approach Toward Mental Health in the Orthodox Jewish Community

Orthodox Jews may sometimes hesitate to seek mental health treatment due to a sense of shame and embarrassment associated with mental health issues (McEvoy et al., 2017). Likewise, some Orthodox Jews may feel that if it becomes known that they sought mental health treatment, they will have a tougher time getting married. Seeking help from someone outside the Jewish community may be a new experience for the Orthodox Jewish patient and may cross an internal boundary difficult for some to surmount

(Holliman & Wagner, 2015; McEvoy et al., 2017). Some Orthodox Jews may first seek help from their rabbi, who would then refer them to an appropriate mental health professional (McEvoy et al., 2017).

Because of the overlap between spirituality and psychology, it can be challenging to differentiate between spiritual and psychological issues (Holliman & Wagner, 2015). Judaism has many laws and rituals that pertain to every aspect of life; a therapist who is unfamiliar with these traditions may erroneously misinterpret normative practice as maladaptive (Horwitz et al., 2019). For example, there is a law that one must properly concentrate on the first blessing of the daily *Shmoneh Esreh*, (a long, whispered prayer, said thrice daily). Patients with scrupulosity may have doubts about the strength of their concentration in that blessing and restart it repeatedly (Horwitz et al., 2019).

Oftentimes, these patients will have poor insight and believe that scrupulosity is an expression of piety, not OCD. In some cases, the rabbi may give the patient leniency in Jewish law, to help them fight the obsession. For example, a rabbi may sometimes, exempt a congregant from the obligation of checking eggs for blood, if this person 'sees' blood where none exists (Horwitz et al., 2019). In these types of cases, a competent rabbi may work in tandem with a psychotherapist to help the patient. For this reason, there must be a strong working relationship between psychotherapists and the clergy (Holliman & Wagner, 2015).

There are several mental health organizations geared toward the Orthodox Jewish community. For example, Brooklyn, NY-based Relief Resources, founded in 2001, focuses on providing therapy referrals to Orthodox Jewish clinicians or clinicians familiar

with the unique needs of Orthodox Jews (Relief, 2023). Amudim, also based in Brooklyn, NY, helps treat patients with all mental health issues, focusing on addiction, sexual abuse, and other crisis-related matters (Amudim, n.d.).

Common Presenting Issues

While Orthodox Jews often present with the same mental health issues as the broader population, there are some common themes. For example, some Orthodox Jews present with a feeling of anxiety and inferiority because of their perceived spiritual shortcomings. This may occur when the patient has inflated expectations of themselves. Orthodox Jews may also unknowingly insert religious themes into purely psychological issues, thus obscuring the problem (Rabinowitz, 2014). Therapists serving the Orthodox Jewish community may encounter religious perfectionism. In such cases, the patient may be referred to a competent, sensitive rabbi who can help the patient develop a healthy view of spiritual expectations and growth, thus accelerating the healing process (Rabinowitz, 2014).

Therapeutic Adaptations for Orthodox Jews

Orthodox Jews often respond to the same kinds of psychotherapy as other patients. For example, Rosmarin et al. (2019) evaluated the effectiveness of CBT in treating depression and anxiety among Orthodox Jews (N=65) and other patients (n=42). Both groups improved from the beginning to mid-treatment and from mid-treatment to the end of treatment. No significant differences were found between the two groups at any time. However, there are some cultural adaptations of therapy for this community.

For example, it is sometimes standard practice for the therapist to greet the patient at the door and shake their hand (Kada, 2019). However, Judaism prohibits physical contact with members of the opposite sex, with the exception of immediate family. Therapists should keep this in mind to avoid putting the patient in an uncomfortable position. In addition, some Orthodox Jews do not follow pop culture or watch movies or television. A competent therapist should know their patient's view on this before using pop-culture references. Similarly, therapists may benefit from asking culturally relevant questions, such as about synagogue attendance or sabbath observance, to help understand the patient's level of function within their culture (Kada, 2019).

In addition, certain behavioral techniques may not be appropriate for the Orthodox Jew. For example, if a patient has an irrational fear that he may eat non-kosher, the therapists cannot encourage him to eat non-kosher as a behavioral technique to work through this fear, even if exposure therapy is the most effective therapeutic technique. Thus, the culturally competent therapist must understand that what is appropriate for the general population may not be suitable for Orthodox Jews (Kada, 2019).

Therapists who engage in couples therapy with Orthodox Jews may use several different therapeutic modalities. However, regardless of the specific modality used, the therapists must also be prepared to engage in discussions about God, levels of observance, and spirituality to help facilitate communication. In many cases, the husband, wife, and therapist all have different views of ideal observance, and they bring that into the therapeutic relationship. A therapist must be comfortable discussing these topics and help the couple work through related disagreements (Cohen-Davidovsky, 2019).

In summary, many of the typical therapy modalities created for the general population can work for Orthodox Jews. However, therapists must have a basic understanding of the unique culture of Orthodox Jews to make their patients most comfortable. Furthermore, therapists must be comfortable addressing topics like God, religion, and spirituality, even if they are not religious themselves. Finally, the therapist must be well versed in the religious norms within the Orthodox community to understand their patient's level of function compared to their peers.

Religion and Gender-Based Preferences in Therapist Selection Among Orthodox Jews

The religious and gender-based preferences of Orthodox Jews in therapist selection have been studied before. Wikler (1989) conducted semi-structured interviews with 33 Orthodox Jewish patients and psychotherapists to determine whether they would prefer to meet with either Orthodox Jewish therapists, Jewish but not necessarily Orthodox, non-Jewish therapists, or no preference. These interviews were then divided into 55 treatment episodes because some patients indicated they felt differently at various stages of their lives. Of these patients, 69% felt that the religious affiliation of the therapist played a significant role in their treatment. Of these 55 treatment episodes, 45% preferred Orthodox Jewish therapists, 20% preferred Jewish but not necessarily Orthodox, 20% preferred Jewish Non-Orthodox, 0% indicated that they preferred a non-Jewish therapist, and 15% indicated that they had no preference (Wikler, 1989).

As part of the semi-structured interview, Wikler asked the patients to explain the reasons for their preferences. The patients who preferred Orthodox Jewish therapists

expressed several themes to explain their preferences. Including, that Orthodox Jewish therapists have a more intimate understanding of their cultural beliefs and practices, fear of outside influences, and fear that non-Orthodox Jewish therapists would misunderstand common religious practices leading to incorrect judgment. Other patients preferred therapists with greater (for stronger validation) or lesser degrees of Orthodoxy (for fear of being judged). The patients who preferred Jewish – not necessarily Orthodox therapists expressed similar themes to this (Wikler, 1989). However, this finding is likely less relevant today as non-Orthodox Jews have less experience with traditional Judaism than they had in the past (Mitchell, 2022).

The patients who preferred to meet with non-Orthodox Jewish therapists expressed several themes to explain their preferences. These included the belief that Orthodox Jewish therapists are more likely to break confidentiality, or are not as well trained or ethical as non-Orthodox Jewish therapists. Other patients had negative experiences with Orthodox Jews and felt that they would have had negative transference. Still, others felt that Orthodox Jewish therapists would be dogmatic or judgmental, which would stop them from discussing sensitive topics. Finally, some patients had personal conflicts with Orthodoxy and did not want to have to explain themselves to Orthodox Jewish therapists (Wikler, 1989).

This was the seminal work on this topic and the only study directly examining this question. However, this study was exploratory – only 33 participants were interviewed, and 13 were psychotherapists. Furthermore, this study was reported in 1989, and the world has changed dramatically in the past 34 years.

Summary

In summary, patient preferences for therapeutic gender and race/ethnicity are essential to study because they can directly impact the working alliance. This, in turn, can affect the outcome of therapy through transference and other mechanisms. The research on religion, ethnicity, gender, and racial matching between patient and therapist is mixed – some groups prefer to be matched, while others do not. Furthermore, while some groups benefit from religion, ethnicity, gender, and racial matching, others do not. The existing literature on the preferences of Orthodox Jews for religion/gender matches is either outdated or nonexistent. Accordingly, this paper, I aim to fill the gap in the literature as it relates to this question. In Chapter 3, I discuss the research method designed for this dissertation, as well as the population, setting, sample, and survey instruments used in this study. I also discuss the research questions, and present the statistical analyses.

Chapter 3: Research Method

Introduction

The purpose of this study was to describe the therapeutic preferences of Orthodox Jews—including therapist religion, gender, and characteristics—and determine their relationship with gender and religious identity. In this chapter, I detail the research design and rationale for this study. Next, I discuss the methodology, including the population, sampling procedure, recruitment procedure, and data collection. The research questions, hypotheses, instrumentation, and operationalization are then discussed. Finally, I describe the data analysis plan and ethical procedures.

Participants were divided into Chasidish/Yeshivish (Ultra-Orthodox), Orthodox, and Modern Orthodox through a self-report question that asked which group they most strongly identify with. Patients were then asked to rate what was more important to them: A gender match, a religious match, or no preference. A chi-square analysis was then conducted to establish correlations between gender and participant religious identity, and preferences for religion and gender matching with the therapist.

Research Design and Rational

I used a quantitative cross-sectional self-report survey to gather information for this study. Participants were asked about their age, gender, and whether they identified as Orthodox. They were also asked which Orthodox group they most strongly identify with. Next, participants were asked to choose whether they had a preference regarding a gender-matched or religious-matched therapist. Finally, participants were given a list of

14 therapist characteristics and asked to list the five most important characteristics. The survey is included in the appendix.

Surveys are a standard data collection instrument for this research type and have been used in several similar studies (Dimmick et al., 2020; Grey et al., 2020). The anonymous survey format is also a good option because psychotherapy can be a sensitive topic. Thus, I used an anonymous questionnaire format so that the participants could respond more freely and accurately without fear of stigma, disapproval, or other negative effects.

The independent variables in this study were participant gender and religious identity. The religious identity of the participants was measured through a self-report question which asked whether the participant identified as Modern Orthodox, Orthodox, Yeshivish, or Chasidish. Those who identified as Chasidish or Yeshivish were put in the Ultra-Orthodox category (see Wormald, 2015), while those who identified as Modern Orthodox or Orthodox remained in their respective categories. The dependent variables in this study were participant preferences for a gender match with their therapist and a participant preference for a religious match with their therapist.

Methodology

Population and Sampling Procedures

The target population for this study was English-speaking Orthodox Jewish adults. About 7.5 million Jews live in the United States, approximately 17% of whom identify as Orthodox, totaling roughly 1,275,000 (Mitchell, 2022). I used G*Power to conduct an a priori power analysis to determine the number of participants needed for this

study (Faul et al., 2007). It was difficult to determine an expected effect size due to the lack of research on the therapeutic preferences of Orthodox Jews. Accordingly, I chose a standard effect size of .5, an alpha level of .05, and a power level of .95. The results indicated that an appropriate sample size would be 112 participants. To be eligible for the study, participants had to identify as Orthodox Jewish and be at least 18 years of age. The participants were not expected to come from vulnerable populations, and no limits were placed on their current place of residence. However, this study was limited to English-speaking individuals.

I used convenience sampling, which is a nonprobability technique. The surveys were sent out via email, which were then forwarded through snowball sampling to maximize the number and variety of participants. A potential bias of snowball sampling is that it can make it challenging to get a diverse sample (Kirchherr & Charles, 2018). One method for counteracting this bias is maintaining a diverse group of *seeds* by which to recruit participants. My relatives, friends, colleagues, and acquaintances span the spectrum of Orthodoxy, from non-Orthodox to ultra-Orthodox. Accordingly, I asked these people to specifically send the survey to other members of their circles. This diversified the population sample. Another potential bias of snowball sampling is that it tends to exclude those who are least keen to answer surveys. To counteract this potential bias, I conducted the survey in multiple waves to remind more reluctant participants to take the survey and help increase the likelihood that they fill it out (see Kirchherr & Charles, 2018).

Procedures for Recruitment, Participation, and Data Collection

Before being given access to the survey, participants signed an informed consent form. Participants were advised that participation is entirely voluntary, and that they could withdraw from the study at any time without penalty. They were further informed that they would not receive any compensation for participating, monetary or otherwise. Additionally, subjects were notified that their participation in the study was entirely anonymous. Anonymity was ensured by using Google Forms to gather data, as it does not collect personal identifying information or IP addresses. I told the participants that they could obtain the study results and request more information by me via the email address posted in the survey. There were no expected risks associated with participating in the study.

Instrumentation and Operationalization of Constructs

A search of the literature yielded no extent surveys that measured patient preferences regarding the gender and religion of the therapist. Accordingly, I created a survey based on the questions asked in several similar studies, including those conducted by Grey et al. (2020), Dimmick et al. (2020), and Ilagan and Heatherington (2022). This survey was reviewed by an expert panel consisting of a methodology expert, a psychologist, and a knowledgeable person who reviewed it as a prospective participant. The expert review panel ensured that the survey had face validity, answered the research question, and was free of ambiguity. Additionally, I sent the survey to five individuals as a pilot study to elicit feedback on clarity and ease of use.

For this study, an Orthodox Jew was anyone who self-identified as Orthodox Jewish. Similarly, participants were considered Modern Orthodox, Orthodox, Yeshivish, or Chasidish based on the group they most strongly identified with. The Yeshivish and Chasidish participants were combined to create the Ultra-Orthodox category, while those who identified as Orthodox and Modern Orthodox remained in their respective categories. This is consistent with previous research on the same population (Wormald, 2015). Each of these variables is measured categorically.

Data Analysis Plan

I used Microsoft Excel and a chi-squared test for independence to examine whether gender or religious identity correlates with a preference for a gender or religious match with the therapist. I screened and cleaned the data for integrity using several methods. I did not collect the data from secondary sources, and I was able to ensure spurious integrity by carefully entering the data. Finally, I searched for and examined outlier data to ensure data integrity.

Chi-Square Test for Independence

I used a chi-square test of independence to measure the extent to which gender and religious identity are associated with a preference for a religious or gender match with a therapist. A chi-square test for independence is a statistical test used to evaluate if there is a relationship between two categorical variables (Laerd Statistics, 2018). This is also called a Pearson's chi-square test or a chi-square test of association. The assumptions of a chi-square test are that the variables are categorical, and that there are two or more independent, categorical groups. The variables in this study meet both assumptions

because the variables are categorical [e.g., male, female; Modern Orthodox, Ultra-Orthodox; religious match; gender match] and independent. Thus, a chi-square test is appropriate for this study (Laerd Statistics, 2018).

Research Questions and Hypotheses

RQ1*:* Is patient gender associated with a preference for a specific gender therapist?

$H_0$1: Gender is not associated with a preference for a specific gender therapist.

H_a1: Gender is associated with a preference for a specific gender therapist.

RQ2*:* Is patient gender associated with a preference for meeting with an Orthodox Jewish Therapist?

$H_0$2: Gender is not associated with a preference for meeting with an Orthodox Jewish therapist.

H_a2: Gender is associated with a preference for meeting with an Orthodox Jewish therapist.

RQ3: Is the patient's religious identity associated with a preference for meeting with a specific gender therapist?

$H_0$3: Religious identity is not associated with a preference for meeting with a specific gender therapist.

H_a3: Religious identity is associated with a preference for meeting with a specific gender therapist.

RQ4: Is patient religious identity associated with a preference for meeting with an Orthodox Jewish therapist?

$H_0$4: Religious identity is not associated with a preference for meeting with an Orthodox Jewish therapist.

H_a4: Religious identity is associated with a preference for meeting with an Orthodox Jewish therapist.

Ethical Procedures

Protection of Participants' Rights Privacy and Confidentiality

I obtained approval from the Walden University Institutional Review Board (IRB) before data collection commenced (IRB # 08-29-23-1037235). This study followed the ethical standards outlined in the ethics code of the American Psychological Association (2017), which require nonmalfeasance and integrity in conducting research, and necessitates researchers to protect the privacy and confidentiality of their participants. Participants were not asked to provide any identifying information, thus ensuring their anonymity. I stored the data electronically in the cloud, and they were password protected. I and my committee members are the only individuals with access to the data.

Informed Consent

Before being given access to the survey, participants read an informed consent form and indicated their consent. Participants were advised that participation is entirely voluntary and that they could withdraw from the study at any time without penalty. Furthermore, they were informed that they would not receive any compensation for participating, monetary or otherwise. Additionally, subjects were told that their

participation in the study was entirely anonymous. No significant harm was expected during participation in this survey. However, participants were provided with my contact information to tend to emotional or psychological distress if needed.

Summary

I used a quantitative cross-sectional self-report survey to determine about the therapeutic preferences of Orthodox Jewish individuals. I used Convenience snowball sampling to recruit Ultra-Orthodox, Orthodox, and Modern-Orthodox participants for this study. Next, I conducted a chi-square analysis to establish correlations between religious identity and gender and a preference for a religious- or gender-match with a therapist. Finally, I gathered the data anonymously to protect the participants. Chapter 4 includes a description of the results of the study, descriptive statistics, the results of the chi-square analysis, and an evaluation of the hypotheses.

Chapter 4: Results

Introduction

The purpose of this study was to describe the therapeutic preferences of Orthodox Jews and determine their relationship with gender and religious identity. Specifically, my goal was to ascertain whether there is a correlation between gender and religious identity, and a preference for a specific gender, or religious-matched therapist. Four hypotheses were posited: patient gender is associated with a preference for a specific gender therapist, patient gender is associated with a preference for meeting with an Orthodox Jewish therapist, patient religious identity is associated with a preference for meeting with a specific gender therapist, and patient religious identity is associated with a preference for meeting with an Orthodox Jewish therapist.

In this chapter, I review the data collection procedures for the study, including the time frame for recruitment, and descriptive and demographic characteristics of the sample. Next, I provide the results of the survey, including descriptive statistics, organized by each hypothesis. Finally, I provide a summary of the results of the statistical analyses.

Data Collection

Data collection commenced on September 3rd, 2023, and was completed on October 22nd, 2023, when the survey was closed. Two hundred and seventy-four people completed the survey. However, because this survey used snowball sampling and was anonymous, it is impossible to know how many people were recruited. The age range of the sample was as follows. Fifty-three respondents (19.3%) were between the ages of 18

and 24, 153 respondents (55.8%) were between the ages of 25 and 39, 64 respondents (23.4%) were between the ages of 40 and 64, and four respondents were 65 years or older. According to the Pew Research Center, about 20% of the Orthodox Jewish population is aged between 18 and 30, 28% is aged between 30 and 49, and 12% is aged 65+ (Wormald, 2013). One hundred eighty respondents (65.7%) were female, and 94 (34.3%) were male.

Results

Overall, 60.9% of the Orthodox Jews studied in this survey had been to a psychotherapist, including about 60% of women, and 60.77% of men. Regarding their Orthodox identity, 10.58% of participants identified as Modern Orthodox, 49.64% identified as Orthodox, and 39.78% identified as Ultra-Orthodox. Women were most likely to identify as Orthodox (53.89%), then Ultra-Orthodox (35.56%), while men were most likely to identify as Ultra-Orthodox (47.87%), then Orthodox (41.49%). Modern Orthodoxy was by far the least popular category, with only 10.64% of males, and 10.56% of females choosing that category. These results are summarized in Table 2.

Around 74% of Orthodox Jews preferred meeting with a gender-matched therapist, and around 74% of Orthodox Jews preferred meeting with an Orthodox Jewish therapist. Around 55% of men and 62% of women preferred both a gender-matched and an Orthodox Jewish therapist. Regarding the preferred personality traits of the therapist, the most common personality traits that were endorsed were nonjudgmental and experienced, with 164 responses, followed by trustworthy at 138 responses, good communication skills at 108 responses, and sensitive to my culture at 97 responses. The

same gender as me received 69 responses, and Orthodox Jewish received 78 responses. The complete results are included in Table 3.

Table 2

Age Range and Religious Identity of the Participants

How do you most strongly identify?	What is your age range?	*n*	%
Modern Orthodox	18-24	2	0.73%
	25-39	22	8.03%
	40-64	5	1.82%
Modern Orthodox total		29	10.58%
Orthodox	18-24	33	12.04%
	25-39	64	23.36%
	40-64	35	12.77%
	65+	4	1.46%
Orthodox total		136	49.64%
Ultra-Orthodox	18-24	18	6.57%
	25-39	67	24.45%
	40-64	24	8.76%
Ultra-Orthodox total		109	39.78%
Grand total		274	100.00%

Table 3

Preferred Personality Traits of Potential Therapists

Personality trait	Number of responses
Nonjudgmental	164
Experienced	164
Trustworthy	138
Good communication skills	108
Sensitive to my culture	97
Recommended by someone I trust	79
Orthodox Jewish	78
Empathetic	74
Good listener	70
The same gender as me	69
Reliable	66
Optimistic/gives hope	55
Warm	46
Patient	44

Research Question 1

The first analysis examined whether patient gender is associated with a preference for a specific gender therapist among Orthodox Jews. The H_0 and H_a for this analysis were as follows:

$H_0$1: Patient gender is not associated with a preference for a specific gender therapist.

H_a1: Patient gender is associated with a preference for a specific gender therapist.

The results indicated that 77.78% of women preferred a female therapist, 1.67% preferred a male therapist, and 20.56% had no preference. Similarly, 65.96% of men preferred a male therapist, 7.45% preferred a female therapist, and 26.60% had no preference. The results are summarized in Table 4.

Table 4

Patient Gender and Preference for a Specific Gender Therapist

Do you identify as male or female?	Would you prefer a therapist who identifies as:	*n*	%
Female	Female	140	51.09%
	Male	3	1.09%
	No preference	37	13.50%
Female total		180	65.69%
Male	Female	7	2.55%
	Male	62	22.63%
	No preference	25	9.12%
Male total		94	34.31%
Grand total		274	100.00%

A chi-square test of independence was performed to examine the relationship between gender and a preference for a specific gender therapist. The relationship between these variables was significant at $p < .05$ (X^2 [2, N = 274] = 165.5233, p = .00001). Thus, the null hypothesis can be rejected: male Orthodox Jews prefer to meet with male therapists and female Orthodox Jews prefer to meet with female therapists. In other words, Orthodox Jewish patients are most likely to prefer meeting with a gender-matched therapist.

Research Question 2

The second analysis examined whether patient gender is associated with a preference for meeting with an Orthodox Jewish therapist. The H_0 and H_a for this analysis were as follows:

$H_0$2: Gender is not associated with a preference for meeting with an Orthodox Jewish therapist.

H_a2: Gender is associated with a preference for meeting with an Orthodox Jewish therapist.

Results indicated that 76.11% of women preferred an Orthodox Jewish therapist, 8.33% preferred a non-Orthodox Jewish therapist, and 15.56% had no preference. Similarly, 70.21% of men preferred an Orthodox Jewish therapist, 7.30% preferred a non-Orthodox Jewish therapist, and 18.61% had no preference. The results are summarized in Table 5.

Table 5

Gender and Preference for Meeting With an Orthodox Jewish Therapist

Do you identify as male or female?	Would you prefer a therapist:	*n*	%
Female	Who identifies as an Orthodox Jew	137	50.00%
	Who does not identify as an Orthodox Jew	15	5.47%
	No preference	28	10.22%
Female total		180	65.69%
Male	Who identifies as an Orthodox Jew	66	24.09%
	Who does not identify as an Orthodox Jew	5	1.82%
	No preference	23	8.39%
Male total		94	34.31%
Grand total		274	100.00%

A chi-square test of independence was performed to examine the relationship between gender and a preference for meeting with an Orthodox Jewish therapist. The relationship between these variables was not significant at $p < .05$. (X^2 [2, N = 274] = 3.6939, p = .137717). Thus, the null hypothesis cannot be rejected: men and women are equally likely to prefer to meet with an Orthodox Jewish therapist.

Research Question 3

The third analysis examined whether a patient's religious identity is associated with a preference for meeting with a specific gender therapist. The H_0 and H_a for this analysis were as follows:

$H_0$3: Religious identity is not associated with a preference for meeting with a specific gender therapist.

H_a3: Religious identity is associated with a preference for meeting with a specific gender therapist.

Among women who identified as Modern Orthodox, 52.63% preferred a female therapist, 5.26% preferred a male therapist, and 42.11% had no preference. Similarly, among men who identified as Modern Orthodox, 30% preferred a male therapist, 20% preferred a female therapist, and 50% had no preference. However, only 10 men who identified as Modern Orthodox participated in this survey, so these results should be interpreted with caution.

Among women who identified as Orthodox, 78.35% preferred a female therapist, 2.06% preferred a male therapist, and 19.50% had no preference. Similarly, among men who identified as Orthodox, 64.10% preferred a male therapist, 7.69% preferred a female therapist, and 28.21% had no preference.

The Yeshivish and Chasidish categories were combined to create the Ultra-Orthodox category. Among women who identified as Ultra-Orthodox, 84.38% preferred a female therapist, 0% preferred a male therapist, and 15.63% had no preference. Similarly, among men who identified as Ultra-Orthodox, 75.56% preferred a male therapist, 4.44% preferred a female therapist, and 20% had no preference. The results are summarized in Tables 6 and 7.

Table 6

Religious Identity and Gender Match Among Females

How do you most strongly identify?	Would you prefer a therapist who identifies as:	*n*	%
Modern Orthodox	Female	10	5.56%
	Male	1	0.56%
	No preference	8	4.44%
Modern Orthodox total		19	10.56%
Orthodox	Female	76	42.22%
	Male	2	1.11%
	No preference	19	10.56%
Orthodox total		97	53.89%
Ultra-Orthodox	Female	54	30.00%
	Male	0	0%
	No preference	10	5.56%
Ultra-Orthodox total		64	35.56%
Grand total		180	100.00%

Table 7

Religious Identity and Gender Match Among Males

How do you most strongly identify?	Would you prefer a therapist who identifies as:	*n*	%
Modern Orthodox	Female	2	2.13%
	Male	3	3.19%
	No preference	5	5.32%
Modern Orthodox total		10	10.64%
Orthodox	Female	3	3.19%
	Male	25	26.60%
	No preference	11	11.70%
Orthodox total		39	41.49%
Ultra-Orthodox	Female	2	2.13%
	Male	34	36.17%
	No preference	9	9.57%
Ultra-Orthodox total		45	47.87%
Grand total		94	100.00%

Two chi-square tests of independence were performed to examine the relationship between religious identity and a preference for meeting with a specific gender therapist – one for male participants, and one for female participants. Because there are two independent variables in this analysis, this was the only way to examine preference for a specific gender therapist using a chi-square analysis.

Among females, the relationship between these variables was significant at $p <$ .05: X^2 [4, N = 274] = 9.663, p = .0471). Thus, the null hypothesis can be rejected – religious identity is associated with a preference for meeting with specific gender

therapist in females. More specifically, in all groups, female Orthodox Jews preferred female (gender-matched) therapists. However, Ultra-Orthodox females were most likely to prefer a female therapist, followed by Orthodox, and Modern Orthodox identifying females, respectively.

Among males, the relationship between these variables was not significant at $p < .05$, (X^2 [4, N = 274] = 8.1067, p = .087745). Thus, the null hypothesis cannot be rejected – religious identity is not associated with a preference for meeting with gender-matched therapist among male Orthodox Jews. In other words, religious identity does not predict a preference for a specific gender therapist among male Orthodox Jews. Thus, while Orthodox Jewish males prefer to meet with male [i.e., gender-matched] therapists, the strength of this preference is not related to religious identity. It is important to note that only 10 Modern Orthodox males participated in this study, so these results must be interpreted with caution.

Research Question 4:

The fourth analysis examined whether a patient's religious identity is associated with a preference for meeting with an Orthodox Jewish therapist. The H_0 and H_a for this analysis were as follows:

$H_0$4: Religious identity is not associated with a preference for meeting with an Orthodox Jewish therapist.

H_a4: Religious identity is associated with a preference for meeting with an Orthodox Jewish therapist.

Among Modern Orthodox Jews, 34.48% preferred an Orthodox Jewish therapist, 13.79% preferred a non-Orthodox Jewish therapist, and 51.72% had no preference. Among Jews who identified as plain Orthodox, 73.53% preferred an Orthodox Jewish therapist, 8.82% preferred a non-Orthodox Jewish therapist, and 17.65% had no preference. Among Ultra-Orthodox Jews, 85.32% preferred an Orthodox Jewish therapist, 3.67% preferred a non-Orthodox Jewish therapist, and 11.01% had no preference. The results are summarized in Table 8.

Table 8

Religious Identity and Preference for Meeting With an Orthodox Therapist

How do you most strongly identify?	Would you prefer a therapist:	n	%
Modern Orthodox	Who identifies as an Orthodox Jew	10	3.65%
	Who does not identify as an Orthodox Jew	4	1.46%
	No preference	15	5.47%
Modern Orthodox total		29	10.58%
Orthodox	Who identifies as an Orthodox Jew	100	36.50%
	Who does not identify as an Orthodox Jew	12	4.38%
	No preference	24	8.76%
Orthodox total		136	49.64%
Ultra-Orthodox	Who identifies as an Orthodox Jew	93	33.94%
	Who does not identify as an Orthodox Jew	4	1.46%
	No preference	12	4.38%
Ultra-Orthodox total		109	39.78%
Grand total		274	100.00%

A chi-square test of independence was performed to examine the relationship between gender and a preference for meeting with an Orthodox Jewish therapist. The relationship between these variables was significant at $p < .05$ (X^2 [4, N = 274] = 32.6131, p = .00001). Thus, the null hypothesis can be rejected - religious identity is associated with a preference for meeting with Orthodox Jewish therapist. Specifically, Modern Orthodox Jews are least likely to prefer meeting with an Orthodox therapist (34.48%), followed by Orthodox Jews (75.53%), and Ultra-Orthodox Jews (85.32%).

Summary

In summary, the results of the analyses were mixed. In Research Question 1, patient gender was associated with preference for a specific gender therapist – Orthodox Jews prefer to meet with gender-matched therapists. Although 74% of Orthodox Jews indicated that they would prefer to meet with an Orthodox therapist, the null hypothesis in Research Question 2 could not be rejected; male and female Orthodox Jews prefer Orthodox Jewish therapists at similar rates. In Research Question 3, patient religious identity was associated with a preference for meeting with gender-matched therapist among females, but not among males. The null hypothesis in Research Question 4 was rejected – religious identity is associated with a preference for meeting with an Orthodox Jewish therapist. Specifically, Modern Orthodox Jews are least likely to prefer meeting with an Orthodox therapist (34.48%), followed by Orthodox Jews (75.53%), and Ultra-Orthodox Jews (85.32%). Chapter 5 contains a discussion of these findings, including interpretations, limitations, recommendations for further study, and the social change implications of this study.

Chapter 5: Discussion

Introduction

The purpose of this study was to determine the therapist preferences of Orthodox Jews. Several themes emerged from this study. Orthodox Jews largely preferred to meet with gender-matched therapists, although no difference between men and women was found in the strength of this preference. Orthodox Jews generally preferred to meet with Orthodox therapists, and religious identity was associated with the strength of this preference. Ultra-Orthodox Jews were most likely to prefer to meet with an Orthodox Jewish therapist, followed by Orthodox-identifying and Modern Orthodox-identifying Jews, respectively. The most preferred therapist characteristics among all categories of Orthodox Jews were nonjudgmental and experienced, with 164 responses, followed by trustworthy at 138 responses, good communication skills at 108 responses, and sensitive to my culture at 97 responses.

Interpretation of the Findings

The results of this study provide insight into the therapeutic needs of Orthodox Jews. Around 74% of Orthodox Jews prefer meeting with a gender-matched therapist. This is a higher percentage than that of the general population, or Muslims living in the United States (Liddon et al., 2018; McLaughlin et al., 2022; Seidler et al., 2022). Similarly, around 74% of Orthodox Jews prefer meeting with an Orthodox Jewish therapist. There was no significant difference between men and women in a preference for gender- or religious- match (Research Questions 1 and 2). The exact percentage of people who prefer religious-matched therapists in other ethnic and religious groups is not

known. Therefore, it is difficult to know how the results of the present study compare to other religious groups.

The high percentage of people who prefer to meet with a gender- or religious-matched therapist denotes the importance of gender roles within Orthodox Judaism. The gender segregation within Orthodox Judaism is by design, as it is an expression of the belief that men and women have distinct roles. Thus, it is possible that many Orthodox Jews feel that an individual who is either non-Orthodox or of the opposite sex will not understand their unique experience as an Orthodox Jewish man or woman. Additionally, the emphasis on modesty within the Orthodox Jewish community may cause some to be uncomfortable being secluded with unrelated members of the opposite sex, especially within a relationship as intimate as the therapeutic relationship (Augenbaum, 2019; Rabinowitz, 2014). This may result in Orthodox Jewish therapists who only see patients of the same sex.

Around 14% of the patients surveyed preferred to meet with a non-Orthodox therapist. Several possible reasons may be posited for this preference, including fear that Orthodox Jewish therapists are more likely to break confidentiality, belief that Orthodox Jewish therapists are not as well trained as their non-Orthodox counterparts, previous negative experiences with Orthodox Jews, fear that an Orthodox therapist would be dogmatic or judgmental, and personal conflicts with Orthodox Judaism (Wikler, 1989). Additionally, many Orthodox communities are small and insular, and participants may feel that a therapist from within their community is too close for comfort.

While the focus of this study was on gender or religious matching, the results indicate that these factors are not the most important therapist characteristic to Orthodox Jews. On the list of 14 preferred therapist factors, of which the participants were to choose five, the same gender as me, and Orthodox Jewish were picked seventh and 10th most often, respectively. Nonjudgmental, experienced, trustworthy, good communication skills, sensitive to my culture, and recommended by someone I trust, were all picked more often than Orthodox Jewish. In addition to these characteristics, empathetic, and good listener were picked before the same gender as me. Thus, it is possible that a gender and/or religious match is less important to this population than therapist experience, reputation, and personality characteristics.

Theoretical Framework

The working alliance model, the theoretical base grounding this study, contends that all kinds of psychotherapy have implicit working alliances and can be meaningfully differentiated by the nature of the working alliance that each modality requires, (Bordin, 1979). A strong patient–therapist alliance is necessary for successful psychotherapy, irrespective of the therapeutic modality (Baier et al., 2020). This theoretical framework can be used to explain why Orthodox Jews overwhelmingly prefer religious- and gender-matched therapists. They may feel that they can connect better with a therapist who shares their experience, thus strengthening the therapeutic alliance and improving therapeutic outcomes.

Religious Identity and a Preference for Religious- or Gender-Matched Therapist

Religious identity was associated with a preference for meeting with an Orthodox therapist. Ultra-Orthodox Jews were most likely to prefer meeting with an Orthodox therapist, followed by Orthodox Jews, and Modern Orthodox Jews. As a broad generalization, Ultra-Orthodoxy is associated with the highest levels of religiosity and insularity, followed by Orthodoxy, and Modern Orthodoxy. It follows that Ultra-Orthodox Jews are most likely to prefer an Orthodox therapist. This is consistent with research on LDS, whose preference for meeting with a religious therapist is mediated by their religious level (Dimmick et al., 2020).

Religious identity was associated with a preference for meeting with gender-matched therapists among women, but not among men. However, because so few Modern Orthodox men participated in this study (n = 10), it is impossible to interpret this discrepancy with any degree of confidence.

Religious Self-Identification

An incidental finding of this study was that of the three religious identity categories, Orthodox was by far the most popular category (n = 136), followed by Ultra-Orthodox (n = 106), and Modern Orthodox (n = 29). This is not consistent with the Orthodox Jewish population stratification of previous studies, which found that Ultra-Orthodox Jews outnumber Modern Orthodox Jews two to one (Wormald, 2015). Because this study used a convenience sampling design, the survey may have reached mainly the Orthodox, and Ultra-Orthodox populations. Additionally, it is possible that individuals who would have identified as Modern Orthodox, or Ultra-Orthodox when not given a

middle option (as in the Pew Research Study), chose the Orthodox category in the present study, which did include a middle option. Another possibility is that people prefer not to label themselves as Modern Orthodox or Ultra-Orthodox, and Orthodox provided a judgment-free compromise between Ultra-Orthodox and Modern-Orthodox.

Limitations

The main limitation to generalizability in this study was the sampling strategy. Because I used convenience sampling, the study did not yield a representative sample of Orthodox Jewry. Thus, some subgroups may be overrepresented in the results, while others may be underrepresented. Additionally, some Ultra-Orthodox Jews do not use the internet regularly, so it was impossible to get responses from that subgroup. Similarly, very few Modern Orthodox men participated in this study, which makes the results about this subgroup unreliable. A limitation of trustworthiness in the current study was that since the survey relied on self-report measures, it may contain some social desirability response biases. For example, participants may have indicated that they identify with a particular religious identity to appear more religious or acculturated. Due to the anonymous nature of the study, it is impossible to know whether this issue occurred.

Recommendations

In this study, I described some of the preferences of Orthodox Jews when choosing a therapist. However, due to the sampling strategy used in this paper, the results have limited generalizability. Future research may benefit from using more statistically rigorous sampling strategies. Additionally, while the present study explained the nature of some of the preferences of Orthodox Jews when choosing a therapist, more research is

needed to understand the reasons behind these preferences. A qualitative analysis of Orthodox Jews' experience in psychotherapy may add some insight. Future researchers can also focus on the impact of accommodating these preferences on therapeutic outcomes. Finally, future researchers can examine preferences for specific types of psychotherapists and therapy modalities among Orthodox Jews.

Implications

In this study, I addressed a gap in the literature in understanding the preferences of Orthodox Jews when choosing a therapist and complements the research on the therapeutic preferences of other populations (see Dimmick et al., 2020; Grey et al., 2020; Ilagan & Heatherington, 2022; McLaughlin et al., 2022; Salem & Hijazi, 2019). This can create social change by being useful for individuals, clinics, and referral agencies to better match their Orthodox Jewish patients with appropriate therapists, as accommodating the therapeutic preferences of patients can improve therapeutic outcomes (Ilagan & Heatherington, 2022; Seidler et al., 2022; Windle et al., 2020). Additionally, therapists can use information about preferred therapist characteristics to improve their competency in those areas.

While the results research study is not a replacement for asking individual patients what they want in their therapist, the present study may bring awareness to the fact that Orthodox Jewish patients have unique needs in therapy. Thus, the present study adds to the knowledge base of cultural competence in the Orthodox Jewish community. Finally, the present study may be used by future researchers as a guide to explore the reasons

behind these preferences and the impact that accommodating these preferences can have on therapeutic outcomes in the Orthodox Jewish community.

Conclusion

I used a quantitative cross-sectional self-report survey and chi-square analyses to examine the preferences of Orthodox Jews when choosing a therapist. The results indicated that Orthodox Jews most often prefer a gender-matched, Orthodox Jewish therapist. The most preferred therapist characteristics for this population were nonjudgmental, experienced, trustworthy, good communication skills, and sensitive to my culture. The same gender as me, and Orthodox Jewish, the preferences studied in this paper, were ranked seventh and 10th in a list of 14 characteristics. This indicates that while religious- and gender-matching is important to Orthodox Jews, it is not as important as other therapist characteristics.

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Appendix A: Survey Questions and Variables Assessed

Survey Question	Variable Assessed/Purpose of the Question
1. Informed Consent (see Appendix B for full text.) Do you understand and consent to the above? Yes No	Qualifying Question (note: if a participant responds no to any of the qualifying questions, they will not be able to take the survey)
2. Are you over the age of 18? Yes No	Qualifying question
3. Do you identify as an Orthodox Jew? Yes No	Qualifying question
4. Have you ever been to a psychotherapist? Yes No	Establish correlations between history of psychotherapy and patient preferences
5. What is your age range? 18-24 25-39 40-64 65+	Establish correlations between age and patient preferences
6. Do you identify as: Male Female	Patient gender
7. How do you most strongly identify: Modern Orthodox Orthodox Yeshivish Chasidish	Patient religious identity
8. Would you prefer a therapist who identifies as: Male Female	Patient preference for gender-match with therapist

No Preference	
9. Would you prefer a therapist: Who identifies as an Orthodox Jew Who does not identify as an Orthodox Jew No Preference	Patient preference for a religious match with a therapist
10. Do you have a preference regarding the gender and religion of your therapist? Yes No	Qualifying question for question number 11.
11. Rank therapists with these attributes by your order of preference: Non-Orthodox Jewish male Non-Orthodox Jewish female Orthodox Jewish male Orthodox Jewish female	Order of importance between religious-match and gender-match with therapist.
12. Choose the five most important characteristics you would seek in a therapist, and rank them from one to five, with five being the most important: Confidential/Trustworthy Good listener Nonjudgmental/Makes me feel safe Experienced Good communication skills Optimistic/Gives hope Sensitive and respectful to my culture Warm Empathetic Reliable Patient Orthodox Jewish The same gender as me Recommended by someone I trust	The relative importance of these attributes

Appendix B: Recruitment Email

Subject line:

5 Minute Survey

Email message:

There is a new study about the therapy preferences of Orthodox Jews. You are invited to complete a 5-minute anonymous survey.

Seeking volunteers that meet these requirements:

- 18 years old or older
- Identify as an Orthodox Jew

This study is part of the doctoral program for Yehuda Rosen, a Ph.D. student at Walden University. The survey will be open until the end of November.

Please click here to view the consent form and begin the survey.