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Predictors of Attitudes Towards Mental Health Treatment in the Orthodox Jewish Population

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Abstract

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by

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MA, Touro College, 2010

BS, Touro College, 2008

Dissertation Submitted in Partial Fulfillment

of the Requirements for the Degree of

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Abstract

Within the Orthodox Jewish (OJ) community, there is a hesitation among those in need of mental health services to seek treatment, primarily due to stigmatized views toward mental illness. The theory grounding this study was Goffman's theory of social stigma, which defines social stigma as the result of an attribute, behavior, or reputation being discredited by others in a way that puts a person or group of people in an undesirable light. The purpose of this study was to examine the reasons underlying negative attitudes toward mental health treatment in the OJ community by examining variables that might explain those attitudes. The variables examined included stigma, familiarity with mental health treatment, endorsement of OJ marriage structure and family system, geography, and age. Data on these variables were collected from a sample of 83 OJ adults using quantitative surveys, including the Attitudes toward Seeking Professional Psychological Help Scale-Short Form, the Self-Stigma of Seeking Help Scale, the Family/Marriage Stigma Scale, and the Parental Influence on Mate Choice Scale. Using multiple regression analysis, results suggested that stigma was a significant predictor of negative attitudes towards seeking mental health services. The OJ marriage structure was a trend towards a significance predictor of negative attitudes towards seeking mental health services. However, familiarity with mental health treatment, endorsement of the OJ marriage family system, geography, and age did not significantly predict negative attitudes towards seeking mental health services. This study can effect positive social change by providing community organizations and activists a better understanding of the risk factors to help them improve the attitudes towards seeking mental health services within the community.

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Dedication

I dedicate this dissertation to my best friend, my wife Miriam. Without your support, love, dedication, I would not have been able to get to this point. This is our accomplishment! I also would like to dedicate this to my dear children, Rivka, Mechel, Dov, Leah, and Hudy. I would not have been able to go on without your support, love, and patience. I want to thank all my friends (who do not want to be mentioned by name) who helped me in many different ways throughout this process. Finally, I want to thank Hashem for blessing me with so much!

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Chapter 1: Introduction to the Study

Introduction

Throughout history, mental illness has been associated with shame and disgrace (Corrigan, Edwards, et al, 2001). The stigma, or badge of shame, associated with mental illness and seeking professional help for mental-health related concerns has been well documented up to the current day. Although researchers have suggested that negative attitudes towards mental illness have decreased (Corrigan, Edwards, et al, 2001), these stigmatic attitudes towards mental health professional help continue to exist (Lauber, 2008), particularly within minority, insular, or traditional subgroups (Conner et al., 2010; Diala et al., 2000; Leong & Lau, 2001; Margolese, 1998; U.S. Department of Health & Human Services, 2001).

Researchers have indicated that mental health services are underused in minority communities (U.S. Department of Health & Human Services, 2001) and that the negative attitudes within these communities are a major contributor to health service underutilization (Knifton et al., 2010; Leong & Lau, 2001; Margolese, 1998). Another factor potentially related to the negative attitudes toward seeking mental health among minorities is the lack of knowledge and familiarity with mental health and with mental health treatment (Sharp, Hargrove, Johnson, & Deal, 2006). Within the Orthodox Jewish (OJ) community in particular, a minority and insular community, negative attitudes towards mental health treatment has been well-documented (see Feinberg & Feinberg, 1985; Loewenthal, 2006; Schnall, 2006). Seeking professional help is often still viewed as shameful and is frequently only done in secrecy (Lowenthal, 2006; Rosen, Greenberg,

Schmeidler, & Shefler, 2007). The reasons for the negative attitudes toward seeking mental health treatment within the OJ community are unclear, with many factors cited and explored in the documented research and literature (Schnall, 2006). In this study, I examined a number of variables that may be associated with negative attitudes toward seeking mental health treatment. In so doing, I sought to elucidate the exact predictive model of how theoretically related variables relate to negative attitudes towards mental health treatment within the OJ community.

Background

Previous researchers have focused on a number of variables associated with seeking professional help for mental health related difficulties (Corrigan, Edwards, et al, 2001). Some scholars have specifically focused on stigma within minority communities, wherein stigmatic attitudes toward mental illness and negative attitudes toward seeking mental health treatment are more prevalent (Knifton et al., 2010; Leong & Lau, 2001; U.S. Department of Health & Human Services, 2001). In addition to stigma, researchers have found that another key variable associated with mental health help-seeking is a lack of knowledge regarding mental health and its treatment (Jorm, 2000). Others researchers have suggested that within minority communities, age is a key variable associated with seeking mental health services, although here findings are more mixed (Choi & Gonzales, 2005; Conner et al., 2010; Knight, 2004; Snowden, 1999). Specifically, Conner et al. (2010) found that negative attitudes mental health services are more prevalent among older adults in minority populations. However, Snowden (1999) found that in minority communities, the levels of underutilization is the same among all ages. Additionally,

older adults may be less likely to identify their psychological problems and may not be aware of the services offered to them (Knight, 2004); as a result, they may experience more negative attitudes toward seeking mental health treatment. Another variable that has been studied in relation to negative attitudes towards mental health treatment in minority populations is geographical location. Hayslip, Maiden, Thomison, and Temple (2010) found attitudinal differences between rural and urban older adult populations. Older adults in urban areas expressed more positive attitudes toward seeking mental health treatment than their rural counterparts. In addition to differences in attitudes, people from rural communities are more isolated and have less access to mental health services (Hayslip et al., 2010) as well as fewer mental health services available to them (Gamm, Stone, & Pittman, 2009) than people from urban areas. Therefore, this may contribute to hesitation towards seeking help.

An additional body of literature has focused on the factors contributing to the attitudes of seeking mental health services within the OJ community specifically (see Loewenthal, 2006; Loewenthal & Rogers, 2004; Schnall, 2006). Loewenthal and Rogers (2004) suggested that the OJ community's family-centric system may lead to greater general family stress and shame when an individual within the family seeks professional mental health help. This in turn would contribute to increased levels of stigma toward mental illness. Other researchers proposed that prearranged marriages and the unique dating style among OJs (Rosen et al., 2007; Witzum & Buchbinder, 2001) contributes to the secrecy and fear associated with mental illness. The dating and marriage system within the OJ community is somewhat dependent on personal and family background,

which is largely investigated prior to dating. It is possible that individuals and families are afraid to seek professional help for mental health-related difficulties due to the fear that others will determine that an individual and/or family is sick and not suitable for marriage (Rosen et al., 2007; Witzum & Buchbinder, 2001). OJs hesitate to seek mental health help, and as a result, do not get the help they need (Lowenthal, 2006; Rosen et al., 2007; Witzum & Buchbinder, 2001). Moreover, those who do seek help may experience stigma from others and as a result suffer overt and subtle discrimination (Rosen et al., 2007).

Problem Statement and Purpose of the Study

Although negative attitudes toward seeking mental health treatment are prevalent in many communities and cultures, it is a greater problem within minority communities (Knifton et al., 2010; Leong & Lau, 2001; Margolese, 1998; U.S. Department of Health & Human Services, 2001). A variety of researchers have examined the possible variables contributing to the development of treatment seeking within minority communities. According to this research, stigma levels, lack of familiarity with mental health treatment, age, and geographical location appear to be key variables in attitudes towards mental health treatment within minority communities. In addition to these variables, the OJ community may have unique features that contribute to lack of help-seeking behaviors (Rosen et al., 2007; Schnall, 2006), including the OJ family-centric system and the community's system of prearranged marriages (Loewenthal & Rogers, 2004; Rosen et al., 2007).

There is no existing literature that has concurrently addressed all the unique variables that may predict help-seeking within the OJ community using standardized measures with valid psychometric properties. As a result, it is unclear as to the relative impact of each of these potential variables in predicting attitudes toward seeking mental health treatment. In this quantitative study, therefore, I first tested the identified combination of variables specific to both minority communities and the OJ community that contribute to attitudes toward seeking mental health treatment within the OJ community. Second, I simultaneously tested all the variables that have been previously shown to be related to attitudes towards mental health treatment to elucidate which factors are most predictive of attitudes towards mental health treatment among OJ.

Research Questions and Hypotheses

Research Question 1: Can attitudes toward seeking mental health treatment in the OJ community be predicted by stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography?

Null Hypothesis *(H_0):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography do not predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Alternative hypothesis *(H_1):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Research Question 2: Among the variables identified as potential predictors of mental health treatment seeking within the OJ community (i.e., stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography), which variables will be most predictive of attitudes of mental health treatment?

Null Hypothesis *(H_0):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography equally predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Alternative hypothesis *(H_1):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ

marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography do not equally predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Theoretical Framework

The theoretical framework for this study was Goffman's (1963) theory of social stigma. Goffman's theory states that an attribute, behavior, or reputation that is discredited by the social environment causes the individual to be mentally classified by others in a stereotypical and negative way. Inzlicht and Good (2006) explained Goffman's theory that stigma not only impacts the individual in a singular way but rather in countless ways. In the context of this study, Goffman's theory guided me as to what particular groups of people have more negative attitude toward mental health treatment than others.

Crocker, Major, and Steele (1998) believed that stigma takes place within social interactions and stigma occurs when "some attribute or characteristic that conveys a social identity…is devalued in a particular social context" (p. 505). In other words, Crocker et al. believed that what may be stigmatizing in one particular social context may not be stigmatizing in another. Major and O'Brien (2005) explained the basic assumption that all theories of stigma share: Stigma "marks" people feeling devalued in the eyes of "their" society (p. 505). The authors further proposed that based on this interpretation, stigma can come in many different forms, which may affect behavior, appearance, or group affiliations.

Operational Definitions

Attitudes toward seeking mental health help/attitudes toward seeking mental health treatment: People who experience psychological and/or interpersonal concerns do not pursue treatment due negative beliefs about the mental health profession or people have negative beliefs about the mental health profession, in general (Corrigan, 2004).

Mental health treatment or mental health help: A service that is provided by a mental health professional (i.e., psychologist, psychiatrist, social worker, mental health counselor, marriage and family therapist) to help the person to decrease or cope with mental illness or psychological distress.

Mental illness: A psychological, cognitive, distress, or behavioral pattern classified by the DSM-V as a disorder (American Psychiatric Association, 2013).

Orthodox Jewish family system: OJs typically put a high value on having large families and being emotionally close to them (Schnall, 2006).

Orthodox Jewish marriage structure: A process where prospective partners date only after their parents have agreed and arranged for the meeting.

Orthodox Jews (OJ): Within Judaism, there are varying levels of observance (Cohen & Horenczyk, 2012). OJs strictly believe in the Torah (Old Testament) and adhere to the Oral Law, which defines the 613 commandments from the Torah (Huppert, Siev, & Kushner, 2007). Some of the common laws are the observance of the Sabbath (Saturday, which is observed by resting, praying, and gathering the family), dietary restrictions (kosher food), and laws of separation from ritual impurity (niddah). Due to

the nature of their laws and lifestyles, OJs typically live in a close-knit community (Huppert et al., 2007).

Rural area: A nonurban area (Matthews, 2017).

Stigma towards mental illness: A social devaluation or negative attitude towards a person with mental illness or a person seeking help for mental illness (Corrigan, Edwards, et al, 2001; Corrigan & Watson, 2002).

Urban areas: "Territory, population, and housing units located within an urbanized area (UA) or an urban cluster (UC), which has: a population density of at least 1,000 people per square mile; and surrounding census blocks with an overall density of at least 500 people per square mile" (Matthews, 2017).

Assumptions of the Study

In this study, I took certain assumptions into consideration: (a) The study population was recruited from the OJ community and was an appropriate representative of that community, (b) all participants honestly and accurately answered all study questions, and (c) the self-administered surveys, including the Attitudes toward Seeking Professional Psychological Help Scale-Short Form (ATSPPH-SF), The Self-Stigma of Seeking Help Scale (SSOSH), the Family/Marriage Stigma Scale (FMSS), Level of Familiarity (LOF), and Parental Influence on Mate Choice scale (PIM) appropriately measured the variables in this study.

Limitations of the Study

There are several possible limitations to this study. The sample population might have been limited by the use of an Internet-based survey, which may have excluded some

highly observant Ultra-Orthodox Jews who do not have access to the internet. In addition, the sample population was selected from OJ communities in the northeast area of the United States, which is a relatively distinct geographic population, and thus may not be generalized to other OJ communities in other parts of the country or the world.

Scope and Delimitations of the Study

A quantitative approach was used with a survey design. Using self-administered surveys, I examined the variables that predict the attitudes toward seeking help within the OJ community. These factors were assessed by the ATSPPH-SF (Fischer & Farina, 1995), the SSOSH (Vogel, Wade, & Haake, 2006), the FMSS (Pirutinsky, Rosen, Shapiro-Safran, & Rosmarin, 2010), LOF (Corrigan, 2008) and PIM (Buunk, Park, & Duncan, 2010).

I used a convenience sample of 83 OJ males and females ages 18 and older. Prior to the survey, participants answered a qualifying question about whether they considered themselves to be OJs; they were then directed to the screening questions if they answered in the affirmative. In the screening questions, participants were asked to identify if they lived in a rural or urban area. The participants were asked to report their age.

Significance of the Study

In this study, I researched the key variables that predict the attitudes toward seeking help (among stigma, familiarity, geography, age, family system, and marriage structure) within the OJ community. Results provide information that can be used to develop possible solutions to improve treatment seeking for mental health related difficulties in the OJ community. In so doing, this study may benefit various individuals

who struggle with mental illness and have thus far hesitated to seek professional help due to the stigma associated with mental illness (Lowenthal, 2006; Rosen et al., 2007; Schnall, 2006; Witzum & Buchbinder, 2001). This information can potentially provide the leaders and activists within the OJ community a greater understanding of the variables impacting negative attitudes towards mental health services so that they may begin addressing these variables. Moreover, this can assist mental health clinics and professionals to more effectively reach out (via proper advertisement, targeted audiences, and so on) to individuals who may benefit from professional help. Finally, there have been organizations who have recently attempted to address the attitudinal problem within the OJ community (Nefesh, 2014; Relief Resources, 2014); this information will help such organizations to better understand the contributing factors to stigma. In turn, these organizations may better provide the proper resources, such as giving lectures and publishing articles, to the appropriate audiences so as to effectively improve this problem.

Summary

In this chapter, I introduced the study addressing predictors of mental health-help seeking attitudes in the OJ community. There is a disinclination to seek mental health help among OJs. There are many factors that may predict attitudes towards mental health treatment; however, the different variables have never been studied concurrently within a single sample. I sought to elucidate the key factors and which factors primarily predict mental health treatment seeking. In this chapter, I also introduced the theoretical framework, operational definitions, assumptions of the study, limitations of the study, and scope and delimitations of the study. In Chapter 2, I review the literature of mental

health treatment seeking as well as the current literature on the different variables in this study. In Chapter 3, I discuss the methodological approach to this study and clarify the research questions. In Chapter 4, I discuss the results of the study. Finally, in Chapter 5, I discuss and interpret the results and describe the limitations, recommendations for future research, and implications for social change.

Chapter 2: Literature Review

Introduction

In this study, I sought to examine the different variables (stigma, familiarity with mental health, geography, age, family system, and marriage structure) that may predict attitudes toward seeking mental health help within the OJ community. The literature review is divided into several sections: attitudes toward seeking mental health help within minority communities, theories on the development of social stigma, stigma towards mental illness, stigma towards help-seeking, different attitudes among age groups, different attitudes among geographic locations (rural-urban areas), lack of familiarity and utilization of mental health services, negative attitudes toward mental illness of mental health services in the OJ community, family system, and marriage structure.

The literature for this study was obtained from multiple databases and scholarly search sites. Most data were gathered from the following databases: ProQuest Central, Laureate University's Thoreau Database, PsyARTICLES, PsycINFO, and Google Scholar. Articles were verified to be peer-reviewed through Ulrich's Periodicals Directory. Some of the key phrases used to find the articles were *negative attitudes towards mental health treatment, attitudes toward seeking mental health help and minorities, attitudes toward seeking mental health help and Orthodox Jews, utilization of mental health services and minorities, utilization of mental health services and Orthodox Jews, stigma and mental health or illness, stigma and mental health and Orthodox Jews, stigma and mental health and minorities, stigma and mental health and religion, and negative attitudes toward mental illness*.

Negative Attitude Toward Mental Health Treatment by Minorities

Although the negative attitudes toward seeking mental health help is found across all cultures (Corrigan, 2004), negative attitudes of those services is more prevalent within minority communities (U.S. Department of Health & Human Services, 2001; Diala et al., 2000). Negative attitudes towards mental illness have been found to be a barrier toward seeking mental health services in both qualitative and quantitative studies (see Alvidrez et al. 2009; Keating & Robertson 2004). As such, a plethora of literature exists documenting the negative attitudes towards mental illness within minority communities (Alvidrez et al. 2009; Knifton et al., 2010; Leong & Lau, 2001; Margolese, 1998; Ojeda & McGuire 2006; U.S. Department of Health & Human Services, 2001).

Numerous researchers found that individuals from minority communities hesitate to seek psychological or psychiatric help (Harris, Edlund, & Larson, 2005; Snowden & Cheung, 1990; Thompson, Bazile, & Akbar, 2004), thereby underutilizing mental health services (Knifton et al., 2010; Leong & Lau, 2001; Margolese, 1998; U.S. Department of Health & Human Services, 2001). In a national study, Harris et al. (2005) compared the attitudes of mental health services by adults who suffered from mental health-related concerns across a variety of cultures, races, and ethnic groups, including Caucasians, Native Americans, Mexican Americans, Latinos, African Americans, Asian Americans, and other ethnic groups. The results indicated that minority ethnic groups underutilized mental health services when compared to Caucasians and Native Americans (Harris et al., 2005).

Researchers have indicated that within the African-American and Latino communities, there is a significant negative attitude towards mental health treatment (Ojeda & McGuire 2006; Wells, Klap, Koike, & Sherbourne, 2001), despite the fact that the prevalence rates of mental illness are similar to the rates of mental illness within Caucasian communities (U.S. Department of Health & Human Services, 2001). Ojeda and McGuire (2006) studied adults with depressive disorders in the Latino and African American communities. They found that Latinos and African Americans are less likely to seek mental health treatment than their white counterparts (Ojeda & McGuire, 2006). The results of this study were uniform across gender and economic status, ruling out financial concerns as a variable in treatment-seeking behaviors (Ojeda & McGuire, 2006). Similarly, Wells et al. (2001) found that African American and Latino populations have lower access to care, as compared to Whites, leading to a decrease in treatment-seeking behavior for mental health related concerns.

Snowden (1999) noted that early research findings regarding the negative attitude towards mental health treatment within the African American population were not consistent. Some studies showed that African Americans were more likely than Caucasians to seek professional help for their mental illness while some research showed that they were less likely to seek help (Snowden, 1999). However, Snowden asserted that in more recent decades, the literature has been more consistent in finding that African Americans are less likely to seek professional help.

Similar attitudes have been found among Asian-Americans (Leong & Lau, 2001). Mental health needs among Asian Americans have been found to be vastly undertreated

(Leong & Lau, 2001; Yang, Phelan, & Link, 2008). In a recent study conducted among Asian American college students, Eisenberg, Golberstein, and Gollust (2008) found that they view mental health services less favorably than their Caucasian counterparts. Masuda, Price, Anderson, Schmertz, and Calamaras (2009) found that Asian American students use mental health services less frequently than do other student groups on college campuses. Within Asian populations, the negative attitude towards mental health services has been found to be associated with stigma and shame (Yang et al., 2008).

Corrigan and Watson (2002) conducted a national study with a large representative sample (N = 968). Participants were given a vignette that described an individual who had some form of mental illness. The authors found that minorities (i.e., African Americans and Latino Americans) were more likely than Whites to endorse negative attitudes towards mental illness. Similarly, Anglin and colleagues (2006) found that the majority of African-Americans believed that individuals with depression or schizophrenia would behave violently to others, while the majority of Caucasians did not believe so (Anglin, Link, & Phelan, 2006).

According to Gary (2005), individuals from ethnic minority groups who suffer from mental illness have a double stigma. In addition to the prejudices and discrimination directed at their particular ethnicity, they experience the stigma towards mental illness. Therefore, individuals from minority populations are more reluctant to seek treatment, and the stigma may continue to impede treatment should individuals decide to pursue mental health services. On a perhaps related note, individuals from minority communities are reluctant to seek professional mental-health treatment from a professional of a

different culture (Schnall, 2006). Moreover, the individuals who do seek professional treatment may terminate prematurely (Margolese, 1998). Additionally, perhaps as a result of ethnic discrimination, ethnic minority populations additionally struggle with poor access, poor quality, or unavailability of mental health services (Wells et al., 2001). Similarly, Thomson, Bazile, and Akbar (2004) interviewed African Americans and noted these individuals endorsed stigma, lack of knowledge about mental illness, lack of affordability for care, lack of trust in health care professionals, and impersonal service and lack of cultural understanding as factors interfering with their willingness to seek and remain committed to mental health services.

Theories on the Development of Social Stigma

The origin of the word *stigma* traces back to the ancient Greeks and refers to a type of marking or tattoo, used to physically mark animals, criminals, poor laborers, slaves, or traitors by cutting or burning skin in order to identify these individuals as visibly blemished or morally corrupted (Jones, 1987). Additionally, the mark informed the public of the necessity of avoiding and shunning these individuals. Since ancient Greece, the term stigma has evolved to refer to a social construction of shame and discrediting associated with specific attributes, characteristics, or behavior (Jones, 1987). Stigma can occur across different cultures and can appear in many forms, such as social rejection, social avoidance, depersonalization, and discrediting of others individuals (Dovidio, Major, & Crocker, 2000; Herek & Capitanio, 1999). Furthermore, social stigma can be overt and/or subtle (Bos, Pryor, Reeder, & Stutterheim, 2013). For

instance, stigma can be expressed through verbal (overt) cues or through nonverbal (subtle) cues such as avoiding eye contact (Bos, Pryor, Reeder, & Stutterheim, 2013).

Goffman's (1963) theory on the development of social stigma defined stigma as an attribute, behavior, or reputation that is discredited by a greater social environment. As a result of being discredited, individuals with such attributes, behaviors, or reputations are likely to be rejected and perceived through the lens of stereotypes. According to Goffman, the development of stigmas is caused by the gap between the assumptions and demands imposed upon individuals and cultures, labeled virtual social identity, and the attributes that an individual or culture actually possesses, labeled actual social identity. When actual social identity proves different from virtual social identity in a manner that is less desirable, weak, bad, or dangerous, stigma develops, tainting and discrediting the whole person or group, labeled by Goffman a "spoiled social identity."

Goffman's (1963) theory categorized social stigma into three major categories:

1. Overt physical or bodily deformations, such as scars, physical manifestations of anorexia nervosa, and physical disabilities.
2. Deviations in personal traits, including mental illness, addictions, and criminal behavior.
3. Tribal stigmas, referring to traits associated with particular ethnic groups, nationalities, or religions, determined to be deviant and aberrant from the dominant, normative ethnicity, nationality or religion (Goffman, 1963).

According to Goffman, there is a difference between discredited and discreditable types of stigmatization. Discreditable stigma refers to stigma towards attributes or

characteristics that may not be readily apparent to the public. In such cases, an individual is potentially discreditable, such that his/her differences have not yet been revealed but may be revealed either intentionally or unintentionally (Goffman, 1963). Conversely, discredited stigma refers to a stigma that has already been revealed to others. While discreditable stigma affects individual choice to conceal or to reveal differences, discredited stigma also affects the public's reaction to the individual with the stigma (Goffman, 1963).

Crocker et al. (1998) expanded Goffman's work and emphasized that social stigma occurs within particular social interactions and social contexts. What may be valued within a particular social interaction or context may be devalued within another social interaction or context (Crocker et al., 1998). As such, the social context determines the extent of esteem and/or devaluation associated with particular attributes and characteristics, and the stigma attached to various attributes and characteristics likely varies across communities, cultures, and subcultures (Crocker et al., 1998).

Major and O'Brien (2005) explained that the above theories on stigma share an assumption that stigmatization is a process that marks individuals to be different and as a result feel devalued in the eyes of their society. Stigma can come in many different forms that may affect behavior, appearance, or group affiliations. In other words, stigma is a feeling of shame that is linked to the social context.

Based on the aforementioned theories regarding the development of social stigma, Pryor and Reeder (2011) categorized social stigma into four separate levels:

1. Public stigma is the affective, cognitive, and behavioral reactions of society to individuals with stigmatized conditions or characteristics.
2. Self-stigma refers to individuals' internalized sense of shame and incompetence as a result of their stigmatized condition or characteristic.
3. Stigma by association is the stigmatic attitudes toward individuals associated with other individuals with stigmatized conditions or characteristics.
4. Structural stigma refers to the greater society's legitimization of stigmatic attitudes toward various stigmatized conditions or characteristics.

They explained that depending on the specific level of stigma experienced, the social and emotional repercussions of the experience of stigma will vary (Pryor & Reeder (2011).

Other theories address not just the development of social stigma but how stigma may serve various functions within society and can be used to achieve other end goals. Stigma can function as a device to exploit individuals, maintain social norms, maintain inequality, and avoid diseases (Kurzban & Leary, 2001; Phelan, Link, & Dovidio, 2008).

Building on Goffman's (1963) foundations, a number of researchers have investigated the experience of stigma as it relates to different factors (Logie & Gadalla. 2009; Livingston & Boyd, 2010). For example, Logie and Gadalla (2009) conducted a meta-analysis of research on the association between HIV, stigma, and various other factors such as social, mental, and physical health. They found consistent, high HIV-stigma levels across most sociodemographic groups, while stigma was linked to a lack of social support, poor physical health, and mental illness (Logie & Gadalla, 2009).

Stigma Towards Mental Illness

Throughout history, mental illness and individuals associated with mental illness have been stigmatized; mental illness has been perceived as a mark of shame, discretization, and weakness (Corrigan, River et al., 2001). Interest in the prevalence of stigma toward mental illness and the effects of such stigma on individuals with mental illness has recently increased. Multiple studies document the continued, current worldwide prevalence of stigma towards mental illness and its ramifications (Corrigan, River et al., 2001; Lauber, 2008; Roman & Floyd, 1981). Link, Yang, Phelan, and Collins (2004) reviewed the literature from 1995 to 2003 and found hundreds of quantitative and qualitative studies examining stigma within the mental health field. More recently, Brohan, Slade, Clement, and Thornicroft (2010) reviewed 57 studies and found that research on the intersection between stigma and mental illness has increased during the past decade.

Stigma toward mental illness is prevalent even among those who are informed about and exposed to individuals with mental illness (Horsfall, Cleary, & Hunt, 2010). Multiple researchers have found that even professionals who work with people with mental illness have stigmatizing attitudes toward mental illness (Newton-Howes, Weaver, & Tyrer, 2008; Rao et al., 2009; Ross & Goldner, 2009; Horsfall et al., 2010). In fact, mental health professionals sometimes view individuals with long-term mental illness negatively (Newton-Howes, Weaver, & Tyrer, 2008; Rao et al., 2009; Ross & Goldner, 2009) and are less optimistic about outcomes for people with long-term mental illnesses in comparison to the general public (McDaid, 2008).

Newton-Howes et al. (2008) assessed the attitudes of professionals working with clients who have personality disorders. They found that clinicians had more negative attitudes towards clients who were labeled with a personality disorder diagnosis versus other clients who did not have a personality disorder diagnosis (Newton-Howes et al., 2008). According to another study, among mental health professionals treating individuals with schizophrenia and substance abuse, there were higher levels of stigma towards patients experiencing recurring symptoms than towards patients in recovery (Rao et al, 2009).

Stigmatic attitudes toward mental illness and associated individuals have led to ridicule, marginalization, and discrimination with social and emotional ramifications for individuals affected by such stigma. Such attitudes cause individuals with mental illness to experience discrimination in the areas of education, jobs, and housing, among others (Pope, 2011). These forms of discrimination may also lead to increased rates of homelessness among the mentally ill (Horsfall et al., 2010). Corrigan (2004) summarized the impact stigma has on people with mental health as follows:

> *"Stigma harms people who are publicly labeled as mentally ill in several ways. Stereotype, prejudice, and discrimination can rob people labeled mentally ill of important life opportunities that are essential for achieving life goals. People with mental illness are frequently unable to obtain good jobs or find suitable housing because of the prejudice of key members in their communities: employers and landlords."* (p. 616)

Chan et al. (2011) noted that the stigma associated with mental illness does not merely impact the individual suffering with mental illness, but also impacts the individual's family and community. In a pilot study, they found that parents with mental illness worry that their children may be taken into foster care to the point that they are reluctant to bring them outside of their home (Chan et al., 2011).

Stigma Toward Help-Seeking

One of the more tragic outcomes of mental health stigma is that it adversely affects the decision to seek professional mental health help, to determine appropriate diagnoses and to maintain ongoing psychotherapeutic treatment. Thus, although approximately 20 percent of the American public suffers from some form of mental disorder or illness, many hesitate to seek professional care and/or have difficulty maintaining ongoing effective treatment (U.S. Department of Health & Human Services, 2001). After a review of the research, Corrigan (2004) concluded that there is a direct inverse relationship between the public social stigma associated with mental illness and the likelihood that an individual with mental illness will seek professional help. Several studies found that people who maintain blaming attitudes toward individuals with mental illness and/or negative attitudes toward mental illness in general are less likely to seek professional help for their own mental health needs (Cooper, Corrigan, and Watson, 2003; Leaf, Bruce, Tischler, & Holzer, 1987).

Furthermore, even once an individual with mental illness decides to seek treatment, stigmatic attitudes toward mental illness are likely to decrease treatment adherence. Sirey and colleagues (2001) studied the association between stigma and

discontinuation of treatment in a sample of both younger and older adults ($N = 52$) with major depressive disorders. Patients were questioned about stigma at admission and three months later. They found that higher levels of stigma at admission significantly predicted discontinuation of treatment three months later.

There are higher levels of negative attitude towards mental health treatment within minority populations (Corrigan & Watson 2007, Harris, Edlund, & Larson, 2005; Snowden & Cheung, 1990; Thompson, Bazile, & Akbar, 2004). While negative attitude towards mental health treatment was found across socioeconomic classes and among various age groups in minority communities (Corrigan & Watson, 2007), studies show that there are also variations in inter-community stigma depending on age group and geographic location.

Different Attitudes Among Age Groups

Research suggests that the negative attitude toward mental health treatment within minority populations and stigma attitudes may be associated with the age of the individual potentially seeking such services (Choi & Gonzales, 2005; Conner et al., 2010; Knight, 2004; Snowden, 1999). Specifically, within minority populations, a negative attitude towards mental health treatment is more prevalent among older adults (Conner et al., 2010). Choi and Gonzales (2005) studied mental health professionals' experiences and perceptions of minority (African American and Mexican American) geriatric populations' access to mental health services. The mental health professionals confirmed that older adults in minority communities hesitate to seek mental health services.

Although Snowden (1999) found that within minority populations, negative attitude toward mental health treatment occurs across all ages, it is possible older adults within minority populations experience more psychological distress due to their lifelong struggles with discrimination, racism and poverty (U.S. Department of Health and Human Services, 2001). Additionally, older adults may also be less likely to identify their psychological problems, have less understanding about mental illness, may not be aware of the services offered to them, and may distrust the mental health system; as a result, they may experience higher levels of stigma towards seeking treatment for mental health related difficulties (Choi & Gonzales, 2005; Knight, 2004).

Lack of Familiarity With Mental Health Treatment

Research suggests that lack of education about and familiarity with mental illness is related to the negative attitudes of professional help. For example, Sharp, Hargrove, Johnson, and Deal (2006) conducted an intervention discussing the myths and about mental illness and mental illness treatment effectiveness. Participants in the study showed significant attitudinal changes about seeking professional psychological help.

In research, this is referred as "mental health literacy," a concept developed by Jorm and colleagues (1997). Jorm includes in "mental health literacy," knowledge and beliefs about mental health disorders, risk factors, and knowledge about preventions. According to the initial study in Australia, low levels of mental health literacy are closely associated with low mental health treatment seeking (Jorm et al., 1997). Furthermore, Jorm found in a later paper that knowledge about mental health is associated with treatment quality and appropriate treatment decisions (Jorm et al., 2006).

Research by Mendenhall (2011) has indicated that parental knowledge of mental health predicted quality and quantity of treatment utilization for children with mental health problems. Other papers have found that improving parent knowledge about mental health can improve treatment seeking attitudes, and eventually lead to a reduction in child's mental health symptoms (Mendenhall, Fristad, & Early, 2009).

Different Attitudes Among Geographic Locations

Research suggests that geographic location may be a variable contributing to the attitudes towards mental health treatment (Hayslip et al., 2010; Rost, Smith, and Taylor, 1993). Among the general population, individuals with depression from rural areas reported more stigmatic attitudes toward mental illness and mental health treatment than individuals from urban areas (Rost, Smith, and Taylor, 1993). Similarly, Hayslip et al. (2010) found that older adults in rural areas versus older adults from urban areas endorsed lower Openness to Seeking Help and Breadth of Conception Scores on the NEO-PI (Neuroticism-Extraversion-Openness Personality Inventory) and therefore, were less likely to seek mental health services than older adults in urban areas. It is possible that the lack of anonymity within rural communities contributes to an increase in negative attitude towards mental health treatment. Another potential contributing factor is that individuals from rural communities are more isolated and have less access to mental health services than people from urban areas (Hayslip et al., 2010). According to a literature review by Gamm, Stone, and Pittman (2009), there is higher negative attitude towards mental health treatment in rural areas. They also found that in rural areas there

are a limited number of clinicians specializing in mental health. Additionally, there are physicians who practice but have lack of training in all disciplines of mental health.

Differences in levels of stigma towards seeking mental health help were found between younger and older adults in minority communities (Conner et al., 2010, Knight, 2004). Additionally, geographic location seems to interact with age to predict attitude towards mental health treatment (Hayslip et al., 2010). Older adults in rural areas were more likely to endorse negative views towards seeking help than older adults in urban areas. These studies were conducted in minority communities such as African Americans and Mexican Americans. However, there is also research conducted in the OJ community regarding attitudes towards mental health treatment.

Negative Attitudes Towards Mental Health Treatment in the Orthodox Jewish Community

Empirical research regarding mental health and mental illness within the OJ community was scarce until several decades ago (Levitz, 1979). Levitz (1979) pointed out that there was very little empirical data on mental health among Orthodox Jews and laid out some guidelines for conducting research on the topic. A few years later, Feinberg and Feinberg (1985) were among the first to study stigma towards mental illness and the negative attitude towards mental health treatment within the OJ community. Research on the OJ community has consistently confirmed that the community is similar to other minority communities in that there are higher rates of negative attitudes towards mental illness and as a result, individuals within the OJ community are reluctant to seek professional help (Feinberg & Feinberg, 1985; Loewenthal, 2006; Schnall, 2006).

Greenberg and Witztum (2001) documented that individuals with mental illnesses are highly stigmatized among the OJ community. Furthermore, in a comprehensive study of religion and views on mental illness, Rosen et al., (2007) interviewed Orthodox Jews and evaluated their responses based on a scale that measures stigma toward mental illness. The results revealed a significant correlation between the degree of the religiosity of an individual's upbringing and stigmatizing attitudes toward individual with mental illness.

Perhaps as a result of negative attitudes toward individuals with mental illness, individuals within the OJ community are reluctant to seek help and tend to underutilize mental health services. Feinberg and Feinberg (1985) distributed a questionnaire to 240 OJ mental health professionals about the state of mental health services among their community. The majority of these professionals reported that the community's mental health needs were not being met, and the utilization of mental health services was poor compared to the general population. Moreover, individuals within the OJ community who do seek mental health services do so in extreme secrecy (Lowenthal, 2006; Rosen et al., 2007). Most individuals who seek professional treatment do so after exhausting all other options (Witztum & Buchbinder, 2001). Research suggests that that individuals within the OJ community are concerned about stigma and are therefore more likely to first turn to and trust a rabbi about concerns regarding social or emotional difficulties (Goshen-Gottstein, 1984; Loewenthal & Rogers, 2004; Schnall, 2006). However, rabbis are not likely to send individuals to professional therapists (Schnall, 2006).

Loewenthal (2006) documents some of the barriers interfering with the attitude towards mental health treatment within the OJ community. He notes that in addition to stigma toward mental illness, Orthodox Jews may also fear violating specific Jewish religious laws and morals by seeking professional mental health services (Loewenthal, 2006). For example, there is a specific section of Jewish Law known as *Yichud*, seclusion, regarding sexual and social behaviors. A similar Jewish law known as *shomer negiah* which forbids unrelated men and women to touch each other and to be alone together. Another related Jewish law states "A Jewish child should not be given to a non-Jew to be instructed in some literature, or to be taught a profession, and needless to add he should not be given to a Jewish heretic who is much worse, and there is apprehension that he may follow him" (Kitzur Shulchan Aruch, Vol. 4). Further, there are Jewish Laws related to unconditional respect for parents and proscribing speaking ill about another. Taken together, these laws may be interpreted by individuals within the OJ community as curtailing their ability to seek mental health services in an effective manner, particularly with a non-OJ mental health professional (Loewenthal, 2006).

Orthodox Jews tend to have negative views towards seeking mental health services (Feinberg & Feinberg, 1985; Rosen et al., 2007). There are a variety of reasons why Orthodox Jews have more stigmatized views, including fear of violating Jewish religious laws (Loewenthal and Rogers, 2004) and importance of a liaison with rabbinical authorities (Schnall. 2006). Thus, there are cultural factors that contribute to a stigma against utilizing mental health treatment (Schnall, 2006).

Family System

Research suggests that that the family system in the OJ community may influence the development of negative attitude towards mental health treatment (Margolese, 1998; Schnall, 2006). According to Wieselberg (1992), "most Ultra-Orthodox Jewish families live in tightly knit communities in which there is religious and cultural congruence between the structure of their communal organizations, their families, and the way individual members construe their world (p. 306)." As a result of this family-centric system, stigma toward mental illness increases since the nature of mental illness typically involves the functioning and stability of the family and may affect other family members (Margolese, 1998). Additionally, Strean (1994) suggests that individuals within the OJ community may fear that mental illness will be viewed as a weakness and may reflect badly on their religion and community.

Marriage Structure

Another variable associated with the development of negative attitude towards mental health treatment within the OJ community is the nature of the dating and marriage system among Orthodox Jews (Rosen et al., 2007; Witzum and Buchbinder, 2001). Specifically, many Orthodox Jews get married through a process that is known as a *shidduch* (prearranged marriage). Margolese (1998) describes the process as following:

> *"Potential mates are suggested, taking family background, scholarship, and physical appearance into account. The couple will meet on several occasions, with both the number and setting of encounters differing greatly among the various groups. After these encounters, the final decision rests with the couple.*

Most often a youngster will meet several potential mates before deciding to marry." (p. 11)

Margolese (1998) also describes a phenomenon in the Orthodox community known as *shidduch anxiety*. The process of *shidduch* dating can contribute to the social stress of finding a "good match." *Shidduch anxiety* is often found among parents of young individuals who have reached a potentially marriageable age.

At this anxiety-ridden juncture, seeking mental health services may present a challenge. Individuals and/or parents may be afraid that potential *shidduch* matches with the individual seeking mental health services will be avoided due to perceived lowering of social status (Rosen et al., 2007; Witzum and Buchbinder, 2001).

Methodological Considerations

In research studying attitudes of mental health help seeking in other communities, quantitative approaches are often used to examine the association of variables. Multiple regression analyses were used in numerous studies that looked into negative attitude towards mental health treatment and associated variables. For example, researchers studying predictors of mental health treatment attitudes in the United States who were looking at multiple sociodemographic variables used a regression analysis to construct their model (Wang et al., 2005). Another national study researched the variables predicting the attitudes towards mental health treatment among Latino Americans also used a regression analysis to predict attitude towards mental health treatment (Alegría et al., 2002). More specifically, a study that looked at stigma as a predictor of attitude

towards mental health treatment was analyzed using a regression model (Golberstein, Eisenberg, & Gollust, 2008).

Summary

Researchers have found negative attitudes towards mental health treatment in minority communities (U.S. Department of Health & Human Services, 2001), including the OJ community (Schnall. 2006). There are increased prevalence rates of stigma towards utilizing mental health services among minority communities (Corrigan & Watson 2007; Harris, Edlund, & Larson, 2005; Snowden & Cheung, 1990; Thompson, Bazile, & Akbar, 2004). Although there are many variables associated with the negative attitudes towards mental health treatment (Loewenthal, 2006; Schnall, 2006), one of the primary factors is stigma (Lowenthal, 2006; Rosen et al., 2007). Existing literature regarding negative attitude towards mental health treatment within the OJ community does not address the primary variables associated with stigmatic attitudes.

Within other minority populations, age and geographic location appear to be associated with seeking mental health treatment, such that older adults and individuals from rural areas hesitate to seek treatment (Conner et al., 2010; Hayslip et al., 2010; Knight, 2004). Specific to the OJ community, the family structure (Loewenthal & Rogers, 2004) and the system for marriage (along with a unique dating protocol) (Rosen et al., 2007; Witzum and Buchbinder, 2001) may contribute to the negative attitudes towards mental health treatment. To date, no study has examined the attitudes towards mental health treatment among OJ by collecting data on the key predictive variables

associated with minority communities along with those variables unique to the OJ community using established measures with valid psychometric properties.

In this chapter I presented a thorough review of the various factors that impact negative attitudes towards mental health treatment within the OJ community. I first presented the definitions of stigma and the theoretical basis of stigma, based on Goffman (1963). Research on how stigma impacts the attitudes towards of mental health treatment was then discussed. Studies on mental health treatment in minority communities, including in Orthodox communities, were reviewed. Research on the various factors associated with seeking metal health help was then explored. The results of the literature review suggest that the following factors might impact treatment seeking: stigma, lack of familiarity with mental health, OJ family system endorsement, OJ marriage structure endorsement, age, and geographic location. However, no existing paper has concurrently studied this combination of factors. Chapter Three will discuss the research methodology that is used to study the impact of these several factors on Orthodox stigma towards mental health services.

Chapter 3: Research Method

Research Methods

In this chapter, I present the research design that was used to concurrently examine a number of possible variables that might be related to OJ negative attitudes towards mental health treatment and clarify which variables are most predictive of these attitudes. I describe the sample population, instrumentation, and data. I also include the data analysis plan. Ethical considerations and limitations are discussed.

Research Design and Sample

In this study, I used a quantitative approach with a survey design to identify a combination of variables specific to the attitude toward mental health treatment in the OJ community. Second, I simultaneously tested all the variables that have been previously shown to be related to a negative attitude towards mental health treatment to elucidate which factors are the most predictive of such attitudes among OJ. As I sought to predict the key variables associated with attitudes towards treatment seeking, a quantitative methodology was most appropriate (see Creswell, 2009). Additionally, because this study was an inquiry into a social problem in which I sought to understand multiple predictive variables and how they are interrelated, a quantitative approach was appropriate (see Creswell, 2009). The study was conducted using a survey method.

A self-administered survey was used to measure the dependent variable: attitudes towards treatment seeking. Additional self-administered surveys measured the independent variables: stigma towards mental illness, OJ family structure endorsement, and OJ dating system endorsement. Demographic data on age and geographical location

were also collected. The surveys were posted online using the survey hosting website Survey Monkey.

Results were analyzed using multiple regression. These analyses are appropriate when clarifying predictive variables (Creswell, 2009). Other studies exploring the attitudes towards mental health treatment-seeking have used ANOVAs (analysis of variance) to analyze data (Wang et al., 2005; Alegría et al., 2002; Golberstein, Eisenberg, & Gollust, 2008). In this study, I sought to explore the main variables that predict seeking mental health treatment.

Study Population

The population in the study was OJ adults 18 years old and older. I looked at both males and females from a range of socioeconomic backgrounds using a convenience sample of adults from rural and urban communities. I gained access to the participants through an OJ website with visitors from the OJ community in a rural area in the Northeast and in an urban area in the Northeast.

Sampling Procedures

According to the U.S. Census Bureau (2012), there are roughly 6.5 million people who identify as Jews in the United States, roughly 2.2 million of which reside in the northeastern states. In this research study, I used a multiple regression, with 5% error (Alpha of 0.05), power (1 – β) of .80, and looked for an estimated effect size of $r = .25$. The CI was set at 80%.

Sample size was determined using a power analysis that estimated the number of participants needed to detect a given effect within 80% of random samples of this size

(Faul, Erdfelder, Buchner, & Lang, 2009). Given the limited research in this area, it was difficult to quantify the hypothesized effect sizes. However, the limited previous research suggested that effect sizes in mental health attitudes and treatment seeking research tend to be of medium size (Loewenthal, 2006; Pirutinsky et al., 2010; Witztum & Buchbinder, 2001), and therefore I relied on Cohen's (1998) rule of thumb for a medium effect size (*r* = .30). A power analysis conducted in G*Power Software 3.1 (Faul et al., 2009), using seven variables, indicated that a sample size of 81 was needed to detect a linear effect of medium size in 80% of random samples, so, therefore, a sample of at least 81 participants was obtained.

Procedures for Recruitment, Participation, and Data Collection

A convenient sample population was recruited through an OJ website (JP Updates). This institution consented to participate and cooperate in this research. It is important to have a website that has visitors from a variety of OJ communities (New York City and Upstate New York) because the nature of the study required having participants in rural and urban areas. This website posted a link that invited participants to take the surveys. Prior to taking the surveys, participants read information about the study, explaining its importance and clarifying that I was conducting the research, not the website or organization. Participants were also provided with my contact information for future questions, and all exiting participants as well as those who chose to drop out prior to completing the survey, were given the number of a mental health hotline for support and resources if they felt distressed. They were also informed that they could exit the surveys at any time and without any penalty (See Recruitment Letter in Appendix A) .

The participants were then asked an identifying data question, and only those who considered themselves as Orthodox were able to enter the survey site. The data were collected using surveymonkey.com and were entered in SPSS 19.0 for data analysis.

Instrumentation

All measures used in this study have been previously validated and found to be reliable. Variables, scales that used, and type of scales are included in Table 1.

Table 1

Study Variables

	IV/DV	Scale	Type of data	Type of scale
Stigma	IV	SSOSH	Continuous	Ratio
Familiarity with mental health Treatment	IV	LOF	Continuous	Ratio
Endorsement of OJ marriage structure	IV	PIM	Continuous	Ratio
Endorsement of OJ family system	IV	FMSS	Continuous	Ratio
Geography	IV	Demographic Questionnaire	Categorical	Ordinal
Age	IV	Demographic Questionnaire	Categorical	Ordinal
Attitudes toward treatment seeking	DV	ATSPPH-SF	Continuous	Ratio

Independent Variables

The SSOSH (Vogel et al., 2006; see Appendix C) was developed to measure stigma towards seeking mental health help. The SSOSH is a 10-item, Likert-type scale that asks questions such as, “If I went to a therapist, I would be less satisfied with myself.” The participants answer the questions ranging from (1) *strongly disagree* to (3) *agree and disagree equally* to (5) *strongly agree*. The answers are scored on 5 to 37 points. A higher total score indicates higher levels of stigma toward seeking mental health help. The scale was found to be reliable (Cronbach’s alpha varied from 0.86 to 0.91 and test-retest reliability 0.72; Vogel et al., 2006). Although this measure was not

used for this study's population, it has been used in different cultures (Brohan et al., 2010). The full scale is published online with permission to use for research purposes.

The FMSS (see Appendix C; also called the Orthodox Jewish Stigma Mental Illness) is based on the Explanatory Model Interview Catalogue Interview for Outpatient Psychiatry and Stigma designed by Raguram and Weiss (1997), which has been used to study stigma in the Orthodox community (Pirutinsky et al., 2010; Rosen et al., 2007). According to Pirutinsky et al. (2010), this scale "addresses culture-specific concerns about marriage, family, and social status" (p. 509). Pirutinsky et al. adapted the interview into a vignette-based measure to specifically measure family and marriage concerns. This measure focuses on questions regarding family concerns. Items include "If others were to find out about Binyamin's problem, might it cause any problems for his family?" and "If people knew about it, might his problem make it more difficult for Binyamin to marry?" Participants indicate agreement or disagreement with each statement on a 4-point scale. Higher total scores in the whole scale indicate greater endorsement of family image importance. Previous researchers indicated that these items load on a single factor representing Orthodox-specific family and marriage concerns and form an internally consistent family/marriage stigma scale (Pirutinsky et al., 2010). Pirutinsky et al. added up the specific items that loaded on family and marriage concerns and found an internally consistent family/marriage stigma scale (0.86). Rosen et al. (2007) used a method previously developed for analysis of indicator of stigma (Weiss et al., 2001), and Items 5 and 7 of the 13 individual items of the scale were deleted from the scale since they had an item-to-total correlation below the cutoff of 0.2 suggested by Weiss et al. (2001). Rosen

et al. found that the stigma scale with the 13 items had good internal consistency reliability (Cronbach's alpha = 0.725). This measure was also tested for OJ adults. The full scale is published in the original article (Weiss et al., 2001).

The PIM (Buunk et al., 2010; see Appendix C) was used to measure participants' attitudes towards family involvement in marriage and dating. This scale includes 10 items scored on a 5-point Likert-type scale ranging from 1 (*disagree completely*) to 5 (*agree completely*). Items assess the degree to which respondents feel their parents should be involved in their choice of mates and include statements such as "When selecting a partner, children should take into account the wishes of their parents" and "Children should always consult their parents in their choice of a partner." Items are summed to yield one overall score, with higher total scores indicating a greater degree of parental influence on the choice of mate. Although this measure was not normed in OJ, it has been normed and found to be valid in other cultures. The scale has demonstrated adequate reliability and validity in multiple contexts (Buunk et al., 2010). It has an internal consistency of $\alpha = .78$ (Buunk et al., 2010). However, when measuring the scale, the mean was well below the scale midpoint ($M = 1.45$, $SD = 0.49$, Minimum = 1, Maximum = 3.30). Thus, Buunk et al. (2010) found a substantial correlation between the PIM scores and one of the measure's questions, "How do you think you will end up with a marriage partner?" ($r = –.53$, $p < .001$). This indicates that people with a higher endorsement of parental marriage influence also are inclined to anticipate that the parents will play a major role in their marriage decision making (Buunk et al., 2010). This measure is available in the original published article (Buunk et al., 2010).

The LOF (see Appendix C) was developed by Corrigan (2008) to measure people's familiarity with mental illness. The questionnaire asks participants to self-report their familiarity with people with mental illness. The scale was published by Corrigan online with permission to use for research purposes.

Dependent Variable

To quantify my outcome variable, attitudes, and openness towards seeking psychological treatment, I used the ATSPPH-SF (Fischer & Farina, 1995; see Appendix E). The ATSPPH - SF is a short form of the 29-item ATSPPHS developed by Fischer and Turner (1970). The 29-item ATSPPHS was found to have some "unstable" factors; it was modernized and redesigned to yield a single, unitary scale that specifically measures attitudes toward seeking psychological help (Fischer & Farina, 1995). The measure includes 10 statements regarding seeking professional help, such as "I would obtain professional help if having a mental breakdown" and "I might want counseling in the future." Respondents indicate their level of agreement with the statements using a Likert-type scale that ranges from 0 (*disagree*) to 3 (*agree*). Respondents with higher total scores are considered to have less negative attitudes about seeking mental health help.

According to Fischer and Farina (1995), the ATSPPH-SF has good internal consistency reliability ($\alpha = .84$) and good test-retest reliability ($r = .80$) over a 4-week interval. Elhai, Schweinle, and Anderson (2008) found an internal consistency reliability of .77. Although the ATSPPH-SF was developed and normed in the general U.S. population, it has been successfully used before within cross-cultural populations (see

Kim, 2007; Kim & Omizo, 2003; Ramos-Sánchez & Atkinson, 2009). This measure is published in a paper reviewing the norms by Elhai et al. (2008).

A demographic questionnaire (see Appendix B) was given to all participants prior to answering the questionnaires. The questionnaire gathered basic research data. I asked participants their gender, age range, area of residence, Jewish Affiliation, and household income.

Data Collection

The dependent variable in this study, attitude towards treatment seeking, was studied using the answers from the ATSPPH-SF. The variable was analyzed to determine the mean score. The data on the ATSPPH-SF were analyzed to determine percentage of responses varying from (1) *strongly disagree* to (3) *agree and disagree equally* to (5) *strongly agree*. The SSOSH provided data on the stigmatization of mental illness. The FMSS provided data about the OJ family system. The LFS provided data for the familiarity of mental illness. Finally, the Attitudes Towards Dating and Marriage Scale provided data on the OJ marriage structure. Multiple regression analysis was used to determine if the independent variables, stigma, familiarity with mental health treatment, endorsement of OJ marriage structure and family system, geography, and age predict attitudes towards mental health treatment.

Research Questions and Hypotheses

Research Question 1: Can attitudes toward seeking mental health treatment in the OJ community be predicted by stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography?

Null Hypothesis *(H_0):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography do not predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Alternative hypothesis *(H_1):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography predict attitudes toward seeking mental health treatment as measured by the Attitudes toward Seeking Professional Psychological Help Scale in the OJ community.

Research Question 2: Among the variables identified as potential predictors of mental health treatment seeking within the OJ community (i.e., stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography), which variables will be most predictive of attitudes of mental health treatment?

Null Hypothesis *(H_0):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage

structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography equally predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Alternative hypothesis (H_1): Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography do not equally predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Data Analyses

Preliminary Analyses

Before analyzing data of the multiple regression, the assumptions of the multiple regression were assessed. The statistical technique used in this study assumes a linear relationship between variables. Multicollinearity is when the IVs are very highly correlated and singularity is when the IVs are perfectly correlated and one IV is a combination of one or more of the other IVs (Pallant, 2013). The assumption of the absence of multicollinearity was assessed by viewing Variance Inflation Factors (VIFs) (Pallant, 2013). Bivariate scatterplots were examined to assess linearity between two variables which is found to be an effective method According to Meyers, Gamst, and Guarino (2006). I checked data for outliers (i.e., an extreme value on a particular item)

and outliers were removed (Pallant, 2013). I assessed the assumption of normality by viewing a P-P scatterplot of the residuals (Pallant, 2013). I also assessed the homogeneity of variance of the dependent measure by observing across the levels of the independent variables (Pallant, 2013).

Main Analyses

Data were analyzed using the data analysis software program SPSS. Descriptive statistics, with the means and standard deviations are provided for stigma, mental health familiarity, OJ family system endorsement, and OJ marriage structure endorsement. Frequencies was reported for age and geographic locations. SSOSH, LOF, PIM, FMSS, and ATSPPH-SF scales' reliability within the sample was confirmed using internal consistency analyses. The data were analyzed using a multiple regression model, as I am examining more than one independent variable (IVs) and a singular dependent variable (DV) (Freedman, 2009). This data analysis method also conferred the ability to shed light on the most predictive variables of attitudes toward mental health help. Multiple regression has another advantage in that the analyses "are based on certain assumptions, which should be checked and satisfied to consider the results valid" (Utts & Heckard, 2005, p. 651). One of the major drawbacks of using a multiple regression is that it only describes the linear relationship, which means that the data might be skewed if there is a high frequency of outlier data.

Threats to Validity

When looking at the internal and external validity, one might want to know the confidence of the results of the study. There are internal validity threats which deal with

selection bias, history, maturation, and instrumentation, while external threats often include population generalization, situational/contextual factors, and experimenter effects (Brewer, 2000).

External Validity

When using survey questionnaire in research, there might be certain external validity such as population generalization and environment concerns (Mitchell & Jolley, 2004). At this study, racial and cultural biases was not present due to the fact that I looked at a specific culture and race. Group power or the influence of one participant over another was likewise not considered a threat, because of the isolation and heterogeneity of respondents. There was a risk that participant that will be chosen randomly from an OJ website and participate in the websites comments sections. This might have been a threat to external validity; however, it was an essential consequence of random sampling. It seemed relatively unlikely that it occurred as questionnaires were randomly distributed via email. The topic of seeking mental health treatment might be somewhat controversial. Thus, participants were assured of proper confidentiality during the informed consent process. However, there is a little risk that this aspect would cause validity issues (Brewer, 2000).

Participants agreed that in order to participate in the research, they must be an adult older than 18 years of age and identify as an Orthodox Jew. Before entering the survey, participants needed to identify their age range and religious affiliation, and were only routed to the rest of the survey questions if they identify as Orthodox Jew above 18

years of age. This cautioned about making inferences about the results other than the Orthodox Jewish Adults.

Internal Validity

Threats to internal validity in survey research include selection bias, history, maturation, and instrumentation. This study also looked at reverse causation where the independent and dependent variables are too closely associated (Mitchell & Jolley, 2004). In this study, reverse causation was not an issue because it looked at attitudes in relationship with different variable and not the causes.

Of the internal validity threats, maturation was not an issue as the survey was sent out at one point in time, and, once it had been completed, the data were analyzed and finalized. History, however, could have been an issue if a participant had had a negative experience with mental health treatment. To avoid such risks, participants were assured that they may choose to drop out prior to completing the survey without any penalty and were offered the use of a mental health hotline for support and resources if they felt distressed and. Selection bias was assured that there is a random sample. From the original population, all participants were given an equal chance of being selected to respond to the survey.

Participants agreed that in order to participate in the research, they must be an adult older than 18 years of age and identify as an Orthodox Jew. Before entering the survey, participants needed to identify their age range and religious affiliation, and were only routed to the rest of the survey questions if they identify as Orthodox Jew above 18

years of age. This cautioned about making inferences about the results other than the Orthodox Jewish Adults.

Protection of Human Participants

Institutional Review Board (IRB) approval from Walden University was obtained before conducting research (approval # 12-02-15-0246627). I invited participants from the OJ communities via an OJ websites that linked to the study. The surveys were posted online on Surveymonkey. To ensure confidentiality, the surveys did not reveal the names or computer IDs of the participants (Surveymonkey, 2015). Participation in this study was on a voluntary basis and participants were informed that they may exit the surveys at any time without any penalty. Participants were also informed, my contact information for future questions, they were offered the use of a mental health hotline for support. Participants were asked to mark off if they consider themselves to be an Orthodox Jew; if they answer yes, they were directed to the surveys. Before completing the surveys, participants were informed of their rights and informed that all data will be treated with confidentiality and protected (i.e., stored in a computer with antiquate spyware and anti-virus protection software).

Summary

This chapter presented the study design used to examine the various predictive factors of seeking mental health services. A quantitative approach with a survey design was used. The study design, including the multiple instruments and the population, was discussed in detail. The research question and hypotheses were analyzed using a multiple regression model.

Chapter 4: Results

Introduction

This purpose of this study was to examine predictors of mental health-help seeking attitudes in the OJ community. There is a reluctance to seek mental health help among OJs, and there are many factors that may predict attitudes towards mental health treatment. These variables include stigma, familiarity with mental health treatment, endorsement of OJ marriage structure and family system, geography, and age. However, the different variables have never been studied concurrently within a single sample. In this study, I sought to clarify what the key factors are and which factors primarily predict mental health treatment seeking with an OJ community. In this chapter, I discuss the data collection procedure, studies used, and the results of this study.

Research Questions and Hypotheses

Research Question 1: Can attitudes toward seeking mental health treatment in the OJ community be predicted by stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography?

Null Hypothesis *(H_0):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography do not predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Alternative hypothesis *(H_1):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography predict attitudes toward seeking mental health treatment as measured by the Attitudes toward Seeking Professional Psychological Help Scale in the OJ community.

Research Question 2: Among the variables identified as potential predictors of mental health treatment seeking within the OJ community (i.e., stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography), which variables will be most predictive of attitudes of mental health treatment?

Null Hypothesis *(H_0):* Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography equally predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Alternative hypothesis (H_1): Stigma as measured by the Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ

marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography do not equally predict attitudes toward seeking mental health treatment as measured by the Attitudes Toward Seeking Professional Psychological Help Scale in the OJ community.

Data Collection

Upon approval from Walden University's IRB to conduct this study, I collected data. A local OJ website sent out an email to subscribers and had a link on the website that directed to an invitation to the study. Participants were asked to answer a series of surveys. Over a period of 3 months, from December 2015 to March 2016, a total of 107 participants answered the survey, and 24 were excluded due to incompletion of the surveys. The final number of participants was 83 (*N= 83*), which was greater than the minimum sample size determined by a priori power analysis and as presented in Chapter 3, of 81. The sample population included adults from all ages and socioeconomic backgrounds and only self-described OJs were able to enter the surveys. Descriptive statistics with detailed description are presented in this chapter. Survey data were collected and stored via SurveyMonkey and the SPSS for storage and analysis. All data were collected in accordance with the procedures described in Chapter 3.

Demographic characteristics are presented in Table 2. Table 2 includes the frequency and percentage for each variable, which includes stigma, familiarity with mental health treatment, endorsement of OJ marriage structure and family system, geography, and age. The majority of the sample was in the 26 to 39 age group, which represented 56.4% of the sample. There were 41% female participants and 59% males.

The target population consisted of OJ adults in the United States. The current sample population were all self-identified OJs. Those who answered any other Jewish denomination were not given access to the survey pages. There were four participants who indicated other denominations than Orthodox. The population is consistent with the U.S. Census (2010) data that specify that there are 113,000 people who identify as Jews in the urban area in the Northeast and 13,500 people who identify as Jews in the urban area in the Northeast. However, regarding gender and age, it was not possible to determine if this sample accurately represented the sample population, due to a lack of studies among OJs.

Table 2

Demographic Characteristics (N = 83)

Variable	Frequency	Percent
Age		
18-25	16	15.0%
26-39	57	53.3%
40-59	19	17.8%
60-79	9	8.4%
Gender		
Female	41	38.3%
Male	59	55.1%
Income		
Less than $25,000	10	9.3%
$25,000-$49,999	23	21.5%
$50,000-$74,999	20	18.7%
$75,000-$99,999	21	19.6%
$100,000-$199,999	19	17.8%
$200,000+	5	4.7%
Geographic area		
Rural	39	36.4%
Urban	58	54.2%

Preliminary Analyses

Data Cleaning

A total of 107 participants answered the survey. Data were screened for missing data. Twenty-four participants missing excessive data were removed. The presence of outliers was assessed by looking at the *z* scores for all continuous variables. Outliers were measured using Tabachnick and Fidell's (2013) number that values should be above 3.29 and below -3.29. Outliers can manipulate to have Type I and Type II errors. There were no outliers is this category; therefore, no participants were removed for outliers. Frequency distributions were assessed to ensure that data were within the possible range. Therefore, cases needed to be removed. The final data analysis contained 83 participants.

All participants were given access to all the surveys. However, there were missing answers to questions in some of the questionnaires. For the missing data in the FMSS, PIM, and SSOSH measures, a pairwise exclusion was used as recommended by Pallant (2013). During this procedure, the participants with missing data were excluded only from the specific analysis where the data were missing. The ATSPPH and LOF measures had all data required for this study. However, the FMSS, PIM, and SSOSH measures had some missing data, and, therefore, participants who had missing information in these surveys were excluded from those variables using a pairwise deletion. The descriptive statistics for study instruments and scales are presented in Table 3.

Descriptive Statistics and Frequencies

Table 3

Descriptive Statistics for Study Instruments and Scales: Current Study

	N	*Minimum*	*Maximum*	*M*	*SD*
ATSPPH	83	10.00	38.00	21.0241	4.85893
FMSS	78	11.00	36.00	25.7821	6.13410
LOF	83	2.00	2.00	2.0000	.00000
PIM	77	11.00	43.00	28.2078	6.61803
SSOSH	64	10.00	41.00	27.0625	6.65922

Note. ATSPPH = Attitudes Toward Seeking Professional Psychological Help Scale; FMSS = Family/Marriage Stigma Scale; LOF = Level of Familiarity; PIM = Parental Influence on Mate Choice scale; SSOSH = The Self-Stigma of Seeking Help Scale.

Assumption Testing

Prior to the analsysis, the data were assessed for the assumptions of normality, linearity, homoscedasticity, independence of errors, and absence of multicollinearity (Tabachnick & Fidell, 2013). Normality was assessed by examining values of skew and kurtosis. According to Tabachnick and Fidell (2013), for normality to be met, the skew should be $-2 < x < 2$ and the kurtosis values must be $-4 < x < 4$ (Tabachnick & Fidell, 2013). The assumption of normality was met. The assumption of normality is presented in Table 4.

Table 4

Assumption of Normality

Instrument	Skewness	Kurtosis
ATSPPH	.199	.623
FMSS	-.054	-.320
LOF	.	.
PIM	-.200	.228
SSOSH	-.500	.096

The linearity and homoscedasticity were also assessed. To assess the residuals, a scatterplot was examined. The linearity assumes a straight line relationship between the predictor variables and willingness to respond. Homoscedasticity assumes scores are normally distributed about the regression line. The residuals scatterplot indicating the assumptions of linearity and homoscedasticity were met (Pallant, 2013). The normal P-P plot for the ATSPPH is presented in Figure 1. The normal P-P plot for the PIM is presented in Figure 2. The normal P-P plot for the SSOSH is presented in Figure 3. The normal P-P plot for the FMSS is presented in Figure 4.

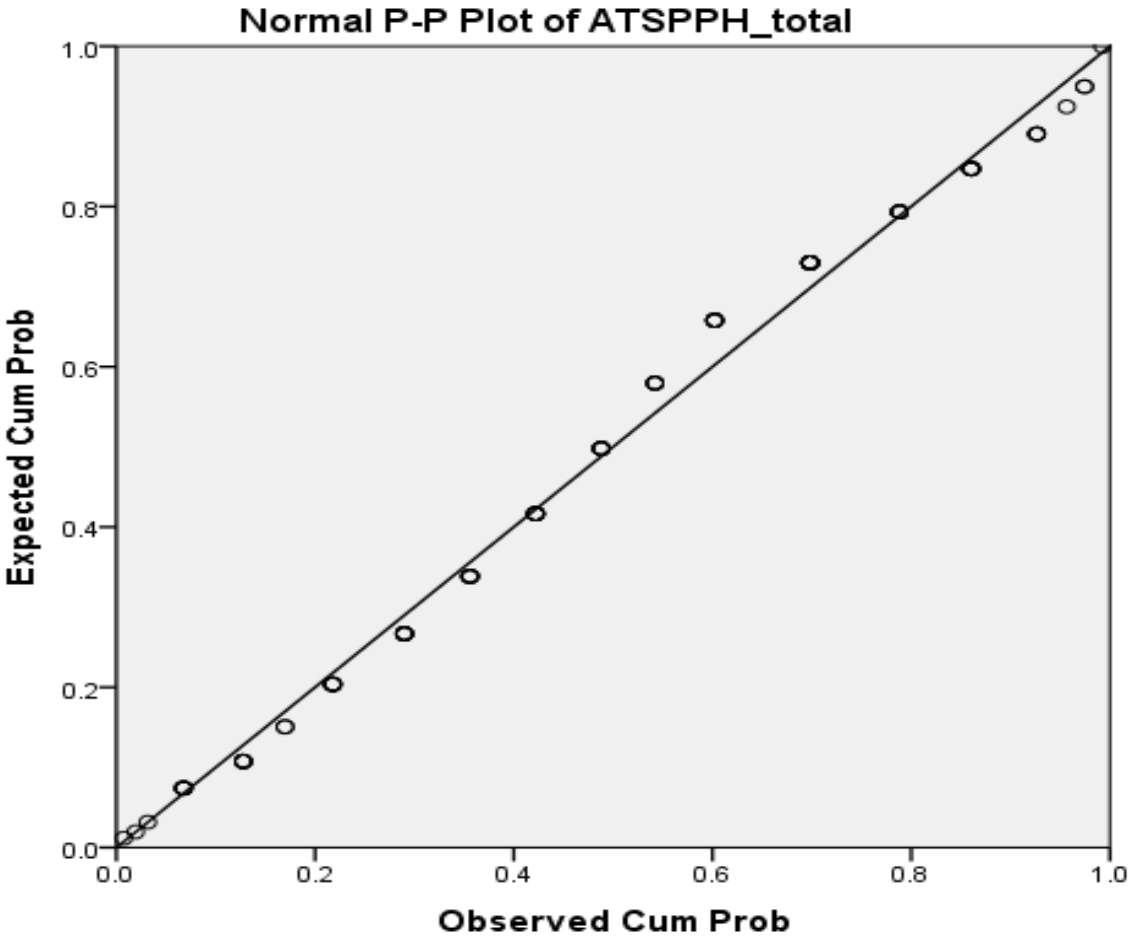

Figure 1. The normal P-P plot for the ATSPPH

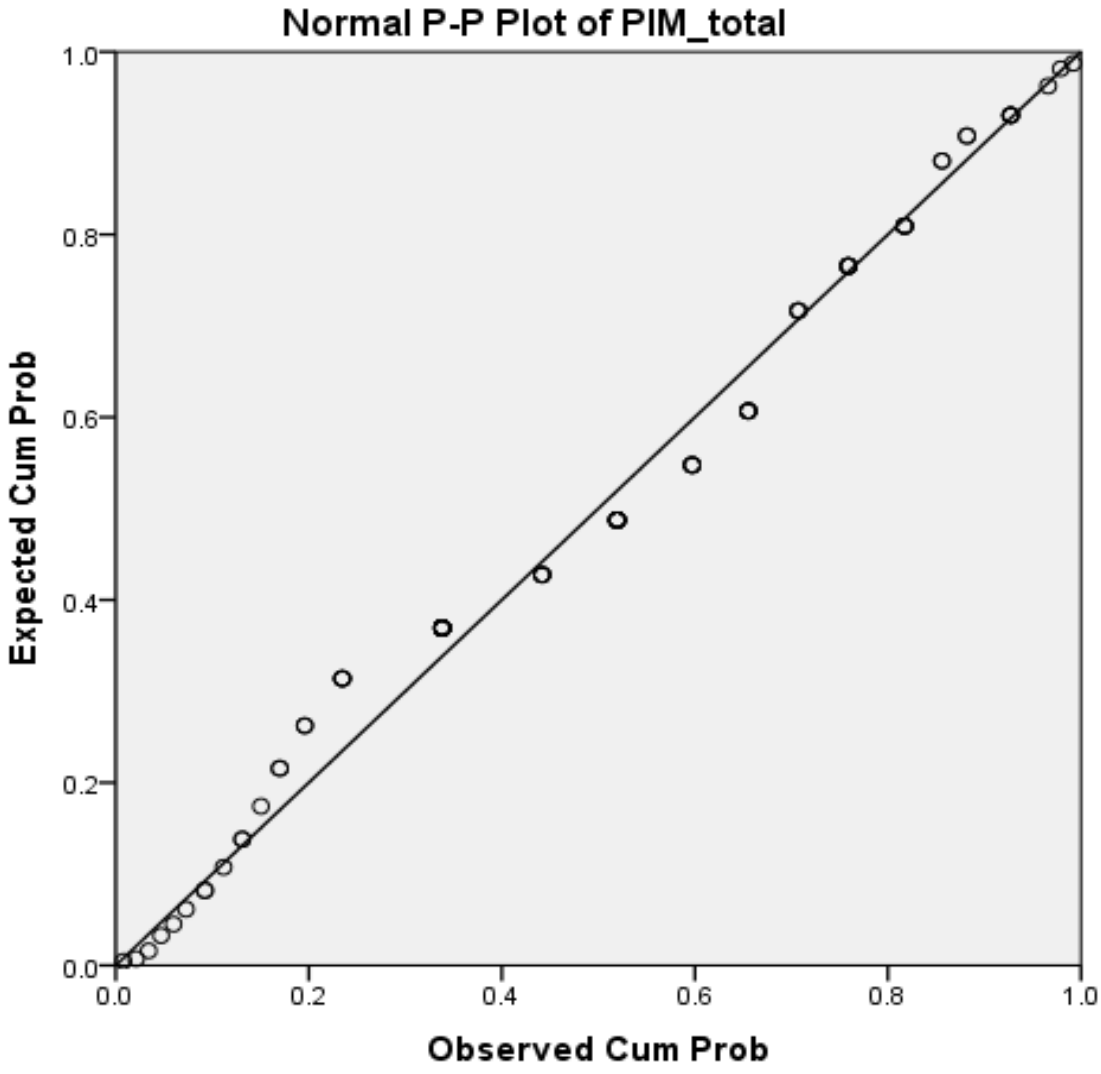

Figure 2. The normal P-P plot for the PIM

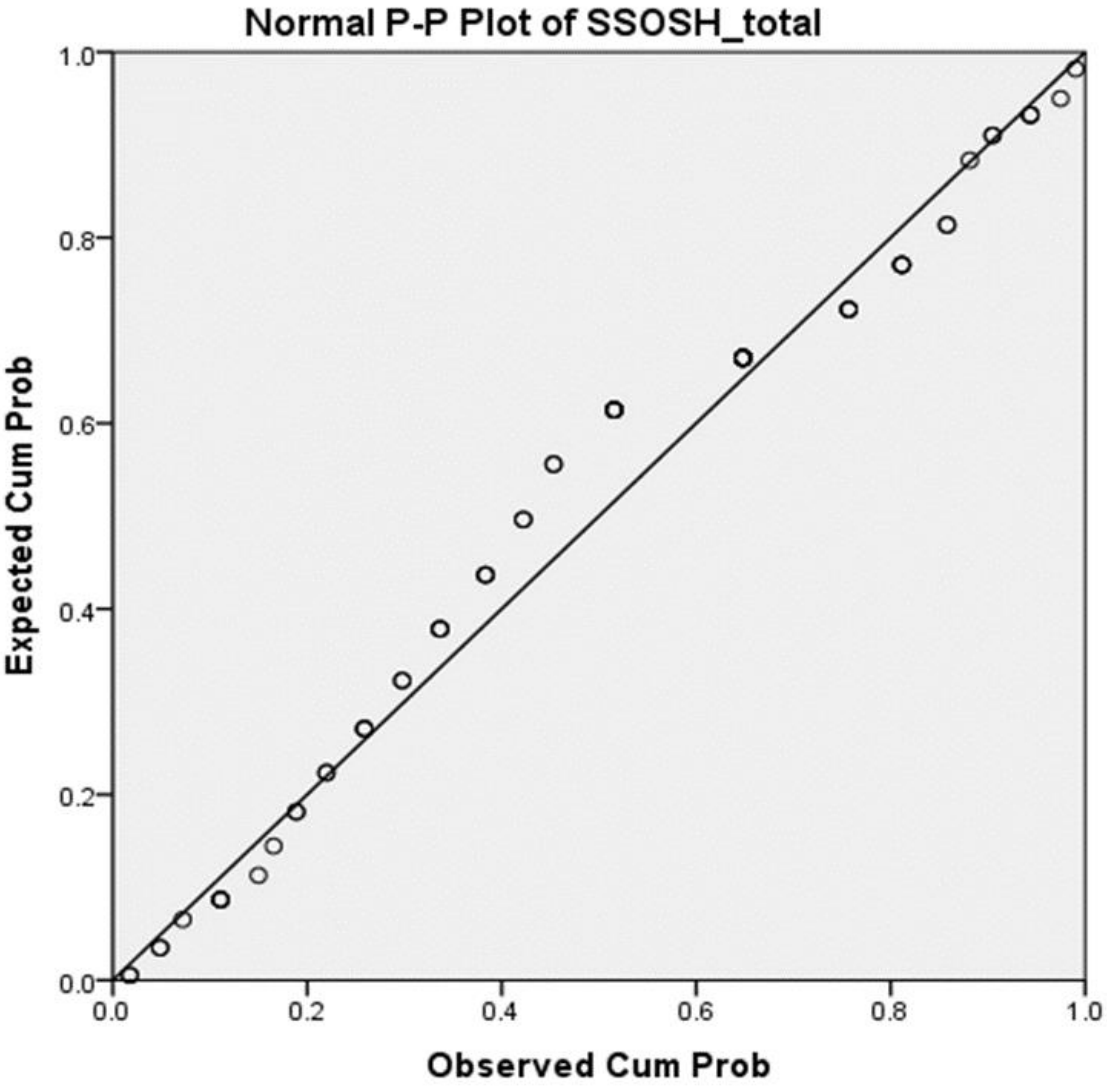

Figure 3. The normal P-P plot for the SSOSH.

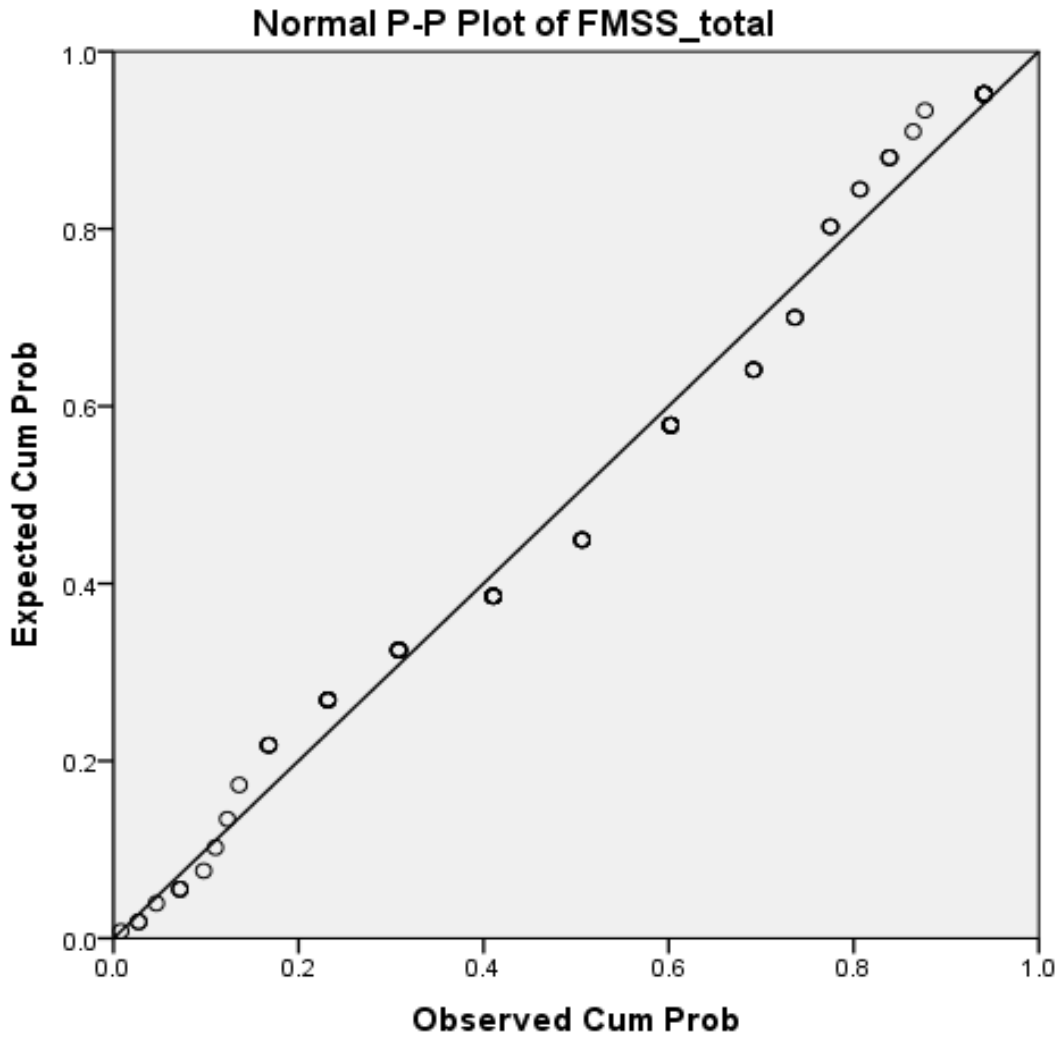

Figure 4. The normal P-P plot for the FMSS.

The absence of multicollinearity assumes the predictor variables in the analysis are not too related (Pallant, 2013). The absence of multicollinearity was assessed with VIF values. None of the VIF values were > 2, indicating the assumption was met. The variance inflation factors are presented in Table 5.

Table 5

Variance Inflation Factors

Variables	VIF values
Age	1.049
Gender	1.011
Area	1.085

The independence of residuals was assessed with the Durbin-Watson statistic (Tabachnick & Fidell, 2013). The Durbin-Watson statistic was found to be 3.4, which indicates that there is no autocorrelation.

Reliability

The measures used in this study to measure attitude towards mental health help, stigma, familiarity with mental health treatment, endorsement of OJ marriage structure, and family system have been assessed and found to be reliable. The attitude towards mental health help scale, ATSPPH, was measured using Cronbach's alpha and yielded .677. The FMSS yielded a Cronbach alpha of .87. The PIM scale yielded Cronbach alpha of .656. The SSOSH yielded a Cronbach alpha of .787. The purpose of using the Cronbach's on these scales was to confirm the they reliability for usage with this population.

Main Analysis

Research Question and Hypothesis 1

The first research question asked if attitudes toward seeking mental health treatment in the OJ community can be predicted by stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography. The predictive variables were mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography. I hypothesized that stigma as measured by SSOSH, mental health familiarity as measured by the LFS, OJ family system endorsement as measured by the FMSS, OJ marriage structure endorsement as measured by the PIM, age, and geography would not predict attitudes toward seeking mental health treatment as measured by ATSPPH in the OJ community.

A multiple regression was used to assess the ability of these control measures (FMSS, LOF, PIM, SSOSH, Age, Geography) to predict attitudes toward seeking mental health treatment in the OJ community (ATSPPH). The results of this analyses indicated that stigma was a highly significant predictor of negative attitudes towards seeking mental health help, OJ marriage structure was a slightly significant predictor, and OJ family system endorsement, age, gender, geographic area were not significant predictors. These finding indicates that the null hypothesis was rejected. The predictors of attitudes toward seeking mental health treatment in the OJ community is presented in Table 6.

Table 6

Predictors of Attitudes Toward Seeking Mental Health Treatment in the OJ Community

Variable	*B*	*SE*	β	*t*	*p*
FMSS	-.063	.094	-.081	-.666	.509
PIM	.162	.094	.200	1.727	.091
SSOSH	.376	.090	.507	4.177	.000
Age	.151	.742	.024	.203	.840
Gender	-.411	1.128	-.042	-.365	.717
Area	-1.767	1.168	-.178	-1.513	.137

Note. ATSPPH = Attitudes Toward Seeking Professional Psychological Help Scale; FMSS = Family/Marriage Stigma Scale; LOF = Level of Familiarity; PIM = Parental Influence on Mate Choice scale; SSOSH = The Self-Stigma of Seeking Help Scale.

Research Question and Hypothesis 2

The second research question asked among the variables identified as potential predictors of mental health treatment seeking within the OJ community (i.e. stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure

endorsement, age, and geography), which variables will be most predictive of attitudes of mental health treatment? I hypothesized that Stigma as measured by Self-Stigma of Seeking Help Scale, mental health familiarity as measured by the Level of Familiarity Scale, OJ family system endorsement as measured by the Family/Marriage Stigma Scale, OJ marriage structure endorsement as measured by the Parental Influence on Mate Choice Scale, age, and geography will equally predict attitudes toward seeking mental health treatment as measured by Attitudes toward Seeking Professional Psychological Help Scale in the OJ community.

A multiple regression was used to assess the ability of these control measures (FMSS, LOF, PIM, SSOSH) to predict attitudes toward seeking mental health treatment in the OJ community. This analysis suggest that only the two control measures were statistically significant, with the stigma being were highly significant predictor of negative attitudes towards seeking mental health help and OJ marriage structure being slightly significant predictor of negative attitudes towards seeking mental health help. These finding indicates that the null hypothesis was rejected as two of the measures were predictive of negative attitudes. The predictors of attitudes toward seeking mental health treatment in the OJ community is presented in Table 7.

Table 7

Predictors of Attitudes Toward Seeking Mental Health Treatment in the OJ Community

Variable	B	SE	β	t	p
FMSS	-.063	.094	-.081	-.666	.509
PIM	.162	.094	.200	1.727	.091
SSOSH	.376	.090	.507	4.177	.000
Age	.151	.742	.024	.203	.840
Gender	-.411	1.128	-.042	-.365	.717
Area	-1.767	1.168	-.178	-1.513	.137

Summary

In summary, this study hypothesized that attitudes toward seeking mental health treatment in the OJ community can be predicted by stigma, mental health familiarity, OJ family system endorsement, OJ marriage structure endorsement, age, and geography. This hypothesis found partial support, with stigma being a statistically significant predictor and OJ marriage structure being a slightly significant predictor. However, all other variables were not significant predictors of attitudes toward seeking mental health

treatment in the OJ community. I also hypothesized that there will be no difference in the relative strength among these predictors in hypothesis one regarding attitudes of mental health treatment. This hypothesis did not find any support variation in significance among the variables.

The significance of these findings as well as the ramifications of the missing data among some participants will be discussed in Chapter 5. In chapter 5, the results will be discussed and interpreted, as well as the limitations to generalizability will be described. Additionally, recommendations for future research and implications for social change will be detailed in Chapter 5.

Chapter 5: Discussion, Conclusions, and Recommendations

Introduction

This purpose of this study was to examine a number of variables that may be associated with negative attitudes toward seeking mental health treatment. In so doing, I sought to clarify what the exact predictive model is of how theoretically related variables relate to negative attitudes towards mental health treatment within the OJ community. To further clarify which variable impacts negative attitudes toward seeking mental health treatment as well as which variable is most predictive, I focused on two research questions: (a) Does stigma, familiarity with mental health treatment, endorsement of OJ marriage structure and family system, geography, and age predict attitudes towards seeking mental health help, and (b) among those variables, which variable is most predictive of attitudes of mental health treatment?

Interpretation of the Findings

The findings of this study suggest that stigma is a significant predictor of negative attitudes towards seeking mental health help within this the OJ community. Additionally, OJ marriage structure and the unique dating style variable was at the slightly significant ($p < .10$) level, suggesting they may have also impact negative attitudes. However, among all variables, stigma was the most significant predictor among all variables. All other variables, familiarity with mental health treatment, endorsement of OJ family system, geography, and age, were not significant predictors.

This research sheds light on the factors potentially impacting negative attitudes towards mental health help within the OJ community. There are many studies that seek to

understand the reason why people have negative views towards seeking professional help for mental health related difficulties (see Corrigan, River et al., 2001; Lauber, 2008; ; Link et al., 2004; Roman & Floyd, 1981). There has been a lot of research that has addressed stigma within minority communities that seeks to explain these negative views (Knifton et al., 2010; Leong & Lau, 2001; U.S. Department of Health & Human Services, 2001). Within the OJ community, some researchers have focused on the OJ community's family-centric system, which may lead to greater general family stress and shame when an individual within the family seeks professional mental health help (Loewenthal & Rogers, 2004). Other researchers have focused on prearranged marriages and the unique dating style among OJs (Rosen et al., 2007; Witzum & Buchbinder, 2001), as these may contribute to the secrecy and fear associated with mental illness. To date, there has been no study that has examined in depth the attitudes towards mental health treatment among the OJ community. Moreover, no researcher has looked at the key predictive variables associated with minority communities along with those variables unique to the OJ community using established measures with valid psychometric properties. By studying all these variables associated with negative attitudes towards seeking mental health help, this helps clarify the research question, which factor is predictive and which is the most predicative of attitudes of mental health treatment.

Stigma and Attitudes Towards Seeking Mental Health Help

The first research question addressed if stigma, familiarity with mental health treatment, endorsement of OJ marriage structure and family system, geography, and age predict attitudes towards seeking mental health help. Results indicated that stigma was a

highly significant predictor of negative attitudes towards seeking mental health help, OJ marriage structure was a slightly significant predictor, and OJ family system endorsement, age, gender, and geographic area were not significant predictors.

This finding that stigma is most predictive is consistent with the plethora of studies done by Corrigan and his colleagues (i.e. Corrigan, Edwards, et al, 2001; Corrigan, 2004; Corrigan 2008). According to Mittal and colleagues (2012) “Stigma may undermine adherence to treatment recommendations and decrease help-seeking behavior ” (Mittal, Sullivan, Chekuri, Allee, & Corrigan, (2012)., p 974). Link et al. (2004) reviewed the literature from 1995 to 2003 and found hundreds of quantitative and qualitative studies examining stigma within the mental health field. Clement et al. (2015) reviewed 144 studies and found that the stigma being most often associated with hesitation mental health help-seeking.

Stigma attitudes toward mental illness has been a major cause for people with mental illness to be ridiculed, marginalized, and discriminated, with social and emotional ramifications for individuals affected by such stigma (Gaudiano & Miller, 2013; Pope, 2011). Such attitudes cause individuals with mental illness to experience discrimination in the areas of education, jobs, and housing, among others (Pope, 2011). These forms of discrimination may also lead to increased rates of homelessness among the mentally ill (Horsfall et al., 2010).

This might be explained by Goffman’s (1963) theory of social stigma, which states that an attribute, behavior, or reputation that is discredited by the social environment causes the individual to be mentally classified by others in a stereotypical

and negative way. Goffman's theory not only impacts the individual in a singular way but in countless ways (Inzlicht & Good, 2006).

Furthermore, the second research question addressed among those variables, which variable is most predictive of attitudes of mental health treatment. Results indicated that stigma was a highly significant predictor of negative attitudes towards seeking mental health help. This finding is also consistent with a widespread amount of research pointing to stigma as one of the primary reasons of people not going for mental health treatment (Mackenzie et al., 2006).

Prearranged Marriages and Attitudes Towards Seeking Mental Health Help

The findings to the first research question indicate that prearranged marriages among the OJ community were a slightly significant predictor of negative attitudes towards seeking mental health help. That prearranged marriages and the unique dating style among OJs may impact negative attitudes is also consistent with researchers such as Rosen et al. (2007) and Witzum and Buchbinder (2001) who suggested that this has an effect on people's mental health views.

According to Margolese (1998), in the Orthodox community, this may be referred to as Shidduch Anxiety in which one can experience social stress of finding a "good match". At this anxiety-ridden juncture, seeking mental health services may present a challenge. Individuals and/or parents may be afraid that potential shidduch matches with the individual seeking mental health services will be avoided due to perceived lowering of social status (Rosen et al., 2007; Witzum & Buchbinder, 2001).

Because the dating and marriage system within the OJ community is somewhat dependent on personal and family background, which is largely investigated prior to dating, it is possible that individuals and families are afraid to seek professional help for mental health-related difficulties due to the fear that others will determine that an individual and/or family is sick and not suitable for marriage.

Limitations of Study

This study had multiple limitations. The sample population was limited by the use of an internet-based survey, which might exclude some highly observant Ultra-Orthodox Jews who do not have access to the Internet. This will always remain a limitation when using an Internet-based survey, affecting the study's external validity (Walliman, 2006). Thus, for further studies, I would suggest using print out surveys in order to reach the more ultra-Orthodox Jews who might not have access to the Internet.

Another limitation may have been that the study was conducted in English. This remains a limitation because some OJs do not speak, read, or write English. However, most people from the community read English fluently. Thus, for further research, translated surveys might be helpful.

Finally, this sample population targeted OJs from the United States. However, there might be OJs from other parts of the world who answered the survey, and, therefore, this might not be a well representative sample. Thus, the website where the invitation to the survey was posted primarily has visitors from this country. Thus, it would be worthwhile to study this in other OJ communities in other parts of the world.

Recommendations

The findings of this study may greatly be enhanced by further research and follow-up studies. Future studies of negative attitudes towards seeking mental health help should focus on studying the specific factors of stigma and the community's system of the prearranged marriage structure and how those factors predict negative attitudes. Additionally, future studies of negative attitudes towards seeking mental health help in the OJ community should focus on the prevalence and scope of negative attitudes and, therefore, have a more defined way to improve it.

Moreover, future studies of negative attitudes towards seeking mental health help should be conducted, specifically among different groups within the OJ community. The OJ community has different levels of observance, such as Ultra-Orthodox, Orthodox, Modern Orthodox, Yeshsivish, and/or Hassidic. Although they fall into one category of OJs, these subgroups might have little cultural differences and nuances such as religious emphasis and dress codes (Pirutinsky et al., 2012). These small cultural differences might be a factor of having negative views towards seeking mental health help (Loewenthal & Rodgers, 2004; Schnall, 2006).

It would also be beneficial to expand this study to other OJ communities around the word. Other OJ communities have their own subcultures and community challenges. Negative attitudes toward seeking mental health help has been found in the OJ community in Israel (Coleman-Brueckheimer & Dein, 2011; Freund & Band-Winterstein, 2013) and in the United Kingdom (Lowenthal, 2006, 2012).

Another recommendation would be to do this study in paper form and in Yiddish or in Hebrew. This would help to reach other OJs who do not speak English and those who do not have access to the Internet. There are some Ultra-Orthodox Jews who have a negative view of the Internet and as a result do not use it (Lev-On & Shahar, 2011). There are also some Ultra-Orthodox Jews who do not speak English (Benor, 2009).

Implications for Social Change

In this study, I examined key variables as predictors of attitudes toward seeking help (among stigma, familiarity, geography, age, family system, and marriage structure) within the OJ community. The findings of this study may potentially influence positive social change in the OJ community by potentially informing community leaders, mental health professionals, and/or local mental health clinics who seek to improve the negative attitudes towards seeking mental health help. Results may support organizations and activists who work to improve mental health awareness to develop possible solutions to improve treatment seeking for mental health related difficulties in the OJ community. This information can potentially provide a greater understanding of the variables impacting negative attitudes towards mental health services so that they may begin addressing these variables and can be used in articles, campaigns, and effective advertising of these organizations and activists. In so doing, this study may potentially benefit various individuals who struggle with mental illness and have thus far hesitated to seek professional help due to the stigma associated with mental illness (Lowenthal, 2006; Rosen et al., 2007; Schnall, 2006; Witzum & Buchbinder, 2001).

Moreover, the findings of this study can assist mental health clinics and professionals to more effectively reach out (via proper advertisement, targeted audiences) to individuals who may benefit from professional help. Finally, there have been organizations who have recently attempted to address the attitudinal problem within the OJ community (Nefesh, 2014; Relief Resources, 2014); this information will help such organizations to better understand the contributing factors to stigma. In turn, these organizations may better provide the proper resources, such as giving lectures and publishing articles, to the appropriate audiences to effectively improve this problem.

Conclusion

In conclusion, this study helps shed some light on some potential reasons for negative attitudes of mental health treatment in the OJ population. Historically, mental illness has been associated with shame and disgrace (Corrigan, River et al., 2001). Negative attitudes towards seeking mental health help continue to a problem in the United States. Moreover, within minority, insular, or traditional subgroups, negative attitudes towards seeking mental health help are more prevalent. The same negative attitudes are found among the OJ community. As a result of these negative attitudes, people may hesitate to obtain proper treatment, causing them and their family with unnecessary pain.

Among the OJ community, negative attitudes towards seeking mental health help have never been studied using the variables associated with the hesitation to seeking help. In this study, I sought to study all the primary variables associated with negative attitudes towards seeking mental health help. This finding indicates that stigma is a statistically

significant predictor of seeking mental health services among the OJ community. Stigma has been well documented and researched as a significant problem in contributing to negative attitudes and hesitation to seek mental health help among the general population.

I also found that OJ marriage structure was a slightly significant predictor. OJ marriage has been associated with people from the community having negative views towards seeking mental health help. Perhaps the most interesting finding is that all other factors were not significant predictors of attitudes toward seeking mental health treatment in the OJ community. Finally, I found that there is a difference in the relative strength among these predictors, with mental health stigma being the strongest predictor.

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Appendix A: Recruitment Letter

Dear Prospective Respondent:

I am a doctorate student at Walden University conducting research as part of my degree requirements for a Doctor of Philosophy (Ph.D.) in Clinical Psychology. The aim of the study is to explore mental health in the Jewish community. You may ask any questions you have now or if you have questions later, you may contact the researcher via XXX@waldenu.edu.

If you choose to participate, you will be asked to complete a brief demographic survey and a series of questions related mental health. The estimated time to complete this study is 15 minutes. However, if you feel you cannot answer all of the questions, or if you simply wish to stop, you may discontinue the research at any point without penalty. I have attached a copy of the informed consent for you to keep. It is not necessary to return this to me. It reviews all details pertaining to this study.

As you might already know, there is limited research on the mental health in the Jewish community. I believe that this research study will increase awareness of mental health concerns within the Jewish community. The results could also lead to the expansion of mental health services provided to the Jewish community. In closing, I would like to thank you for your assistance in this much needed project.

Sincerely,

Shlomo Bineth, Doctoral Student

Walden University

Appendix B: Demographics Questionnaire

1) Please indicate your gender.

A. Female

B. Male

2) Please indicate your age.

A. 18-25

B. 26-39

C. 40-59

D. 60-79

E. 80+

4) What is your current annual income level?

A. Less than $25,000

B. $25,000-$49,999

C. $50,000-$74,999

D. $75,000-$99,999

E. $100,000-$199,999

F. $200,000+

5) How would you describe your area of living

A. rural

B. urban

6) Which of the following best describes your Jewish denominational group?

A. Orthodox

B. Conservative

C. Reform

D. Unaffiliated

Appendix C: Scales

ATSPPH-SF

Directions: For the following statements, please circle the item that most closely fits your response.

1. If I believed I was having a mental break down, my first inclination would be to get professional attention.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears *without* resorting to professional help.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

5. I would like to get psychological help if I were worried or upset for a long period of time.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

6. I might want to have psychological counseling in the future.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

7. A person with an emotional problem is not likely to solve it alone; he or she *is* likely to solve it with professional help.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

9. A person should work out his or her own problems; getting psychological counseling would be a last resort.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

10. Personal and emotional troubles, like many things, tend to work out by themselves.

-Agree

-Partly Agree

-Partly Disagree

-Disagree

FMSS

Binyamin is 19 years old and lives at home while learning at an ‘in-town’ yeshiva (center for Jewish religious studies)1. Binyamin has difficulty with davening (prayer). He thinks that he does not have enough kavana (concentration), and as a result he feels compelled to repeat the first line of the Shema (a part of davening) over and over again. In one part of davening, he feels unable to continue unless he repeats the words five times. Consequently, shacharis (the morning service) can take him an extra hour to complete, and yet when finished, Binyamin still feels that he did not have enough kavana and that his prayers were not niskabel (accepted). Recently, Binyamin saw a sign in shul (synagogue) that warned of the importance of tefilin (phylacteries) and explained in detail the relevant halachos (laws). Since then, he has become preoccupied with ensuring that his tefilin are properly positioned, that they are lying directly on his head, and that the retzu’os (straps) are completely black with no stains or marks. Binyamin checks his tefilin, their position, and his retzu’os throughout davening and he finds himself worrying about them while learning. These worries increasingly consume his daily life, and those around him have become concerned.

The following nine questions ask you to imagine how Binyamin feels. Answering these questions accurately requires honest reflection on you think he would act and feel in these situations.

1 - No

2 - Uncertain

3 - Possibly

4 – Yes

1. If they knew about it, do you think Binyamin's neighbors, colleagues or others in his community think less of him because of his problem?

2. Do you feel others would avoid Binyamin because of his problem?

3. Would some people refuse to visit his home because of this condition?

4. If they knew about it, would Binyamin's neighbors, colleagues or others in his community think less of his family because of his problem?

5. If others were to find out about Binyamin's problem, might it cause any problems for his family?

6. Would Binyamin's family prefer to keep others from finding out about his condition?

7. If people knew about it, might his problem make it more difficult for Binyamin to marry?

8. Might his condition cause problems in Binyamin's marriage?

9. Could his problem make it more difficult for someone in Binyamin's family to marry?

LOF

Each item below has been coded in the level of intimacy: 11= most intimate contact with a person with mental illness, 7= medium intimacy, 1= little intimacy. The index for this contact was the rank score of the most intimate situation indicated. If a person checks more than one item, rank their HIGHEST level of intimacy.

__ I have watched a movie or television show in which a character depicted a person with mental illness.

__ My job involves providing services/treatment for persons with a severe mental illness.

__ I have observed, in passing, a person I believe may have had a severe mental illness.

__ I have observed persons with a severe mental illness on a frequent basis.

__ I have a severe mental illness.

__ I have worked with a person who had a severe mental illness at my place of employment.

__ I have never observed a person that I was aware had a severe mental illness.

__ A friend of the family has a severe mental illness.

__ I have a relative who has a severe mental illness.

__ I have watched a documentary on television about severe mental illness.

__ I live with a person who has a severe mental illness.

PIM

1. If he has good reasons for it, a father has the right to give his daughter away for marriage

2. It is the duty of parents to find the right partner for their children, and it is the duty of children to accept the choice of their parents

3. If they take into account the wishes of their children, parents have the right to demand that their children accept the partner they have chosen for them

4. Even though children have the right to look for a partner themselves, in the end, the parents have the last say in this matter

5. Children have the right to reject a partner their parents have chosen for them (R)

6. If their parents have serious objections against someone their children prefer as a partner, children should break off the relationship with that person

7. When selecting a partner, children should take into account the wishes of their parents

8. Children should always consult their parents in their choice of a partner

9. Parents have the right to say how they feel about it, but in the end, it is up to the children to select their own partner (R)

10. Children have the right to select their own partner without any interference by their parents (R)

Note: (R) = reverse coded. Responses were given on a 5-point scale (1 = *I disagree completely*, 2 = *I disagree partially*, 3 = *I neither agree nor disagree*, 4 = *I agree partially*, 5 = *I agree completely*).

SSOSH

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1 = Strongly Disagree 2 = Disagree 3 = Agree & Disagree Equally 4 = Agree 5 = Strongly Agree

1. I would feel inadequate if I went to a therapist for psychological help.
2. My self-confidence would NOT be threatened if I sought professional help.
3. Seeking psychological help would make me feel less intelligent.
4. My self-esteem would increase if I talked to a therapist.
5. My view of myself would not change just because I made the choice to see a therapist.
6. It would make me feel inferior to ask a therapist for help.
7. I would feel okay about myself if I made the choice to seek professional help.
8. If I went to a therapist, I would be less satisfied with myself.
9. My self-confidence would remain the same if I sought professional help for a problem I could not solve.
10. I would feel worse about myself if I could not solve my own problems.

Items 2, 4, 5, 7, and 9 are reverse scored.