

Effectiveness of Cognitive Behavioral Therapy for Anxiety and Depression Among Orthodox Jews

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Several clinical papers have provided clinical recommendations for how to provide cognitive behavioral therapy (CBT) for obsessive-compulsive symptoms among Orthodox Jewish individuals. However, no published studies have described culturally adapted CBT for anxiety or depression in this population or quantified the effectiveness of such approaches. We evaluated the effectiveness of CBT for symptoms of generalized anxiety and depression in a sample of Orthodox Jews ($n = 65$) and a comparison sample ($n = 42$) presenting to the Center for Anxiety, a private outpatient clinic with three offices in the New York area (www.centerforanxiety.org). A chart review revealed that all patients received CBT-based interventions with appropriate religious-cultural adaptations of treatment, which we present in two case studies. We observed statistically and clinically significant treatment gains from pretreatment to midtreatment (anxiety: $t = 8.56, p < .001$; depression: $t = 8.01, p < .001$), and again from midtreatment through termination (anxiety: $t = 3.68, p < .001$; depression: $t = 3.62, p < .001$). No significant differences in anxiety or depression were observed between Orthodox Jewish patients and controls at any time point or for treatment effects (anxiety: Wilks' $\Lambda = .950, F = 2.65, p = .076, \eta_p^2 = .050$; depression: Wilks' $\Lambda = .99, F = 2.00, p = .49, \eta_p^2 = .014$). This paper offers clinical insight into delivery of CBT to Orthodox Jewish patients, as well as preliminary support for the effectiveness of CBT in treating symptoms of generalized anxiety and depression within this population.

Anxiety and depression are leading causes of worldwide disability (World Health Organization, 2008), with lifetime prevalence in the general U.S. population of 28.7% (Michael, Zetsche, & Margraf, 2007) and 28.8% (Hofmann & Smits, 2008), respectively. Further, these conditions continue to be undertreated and under-researched, especially among minority groups. Cognitive behavioral therapy (CBT) has been established as an effective short-term treatment for anxiety and depressive disorders in adults by multitudes of clinical studies and randomized trials (e.g., DiMauro, Domingues, Fernandez, & Tolin, 2013; Hofmann & Smits, 2008; Norton & Price, 2007; Stewart & Chambless, 2009). It is also the preferred treatment by psychologists (Hays & Iwamasa, 2008). However, most studies on CBT have been conducted on non-Hispanic White samples (Hays & Iwamasa, 2008), and as a result such treatments have not been sufficiently adapted or tested with ethnic or religious minorities despite the fact that minorities account for

nearly a third of the United States population, with that number steadily growing over time (Hall, 2001; Social Science Data Analysis Network, 2004). Furthermore, studies that do focus on minority groups rarely explore differential treatment outcomes for minority participants (Weersing & Weisz, 2002).

Several clinical reports have illustrated methods for culturally adapting CBT for anxiety and depression (e.g., Dana, 2000; Ginsburg & Drake, 2002; Hwang et al., 2015). Such methods are important clinical innovations, since minority groups tend to be at a higher risk of dropping out of treatment (Miranda, Azocar, Organista, Dwyer, & Areane, 2003), and specialized treatment methods are not readily available (Shafran et al., 2009). This latter point highlights the necessity of getting treatments out of the lab and into communities in order to service individuals of diverse cultures and backgrounds, and also to better understand the specific cultural needs of minority groups. Beyond dissemination, studying the effectiveness of treatments in naturalistic settings optimizes generalizability, since findings are more ecologically valid than lab-based clinical trials (Minami et al., 2008).

One aspect of diversity that has been particularly ignored in CBT is religion (Rosmarin, 2018). This is unfortunate, since a large volume of empirical literature has functionally linked this domain to mental health.

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Broadly speaking, religious belief and practice is tied to marginally but significantly less depression (Smith, McCullough, & Poll, 2003) and substantially less alcohol/substance abuse (Kendler et al., 2003) and suicidality (VanderWeele, Li, Tsai, & Kawachi, 2016) in the general population. Several aspects of religion are also tied to better treatment outcomes for anxiety (Bowen, Baetz, & D'Arcy, 2006) and depression (Rosmarin, Bigda-Peyton, Öngur, et al., 2013) in clinical settings. Furthermore, an extensive body of literature suggests that religious coping, which involves drawing on spiritual/religious resources to cope with life stressors, is not only highly common (Pargament, Koenig, & Perez, 2000) but can also be beneficial for mental health and adjustment (Pargament, 2001). However, as with all facets of life, religion can also have negative effects on mental health. Specifically, spiritual struggles (also known as "negative religious coping") predict substantially lower levels of mental health (Ano & Vasconcelles, 2005), especially in clinical samples (e.g., Rosmarin, Malloy, & Forester, 2014; Rosmarin, Bigda-Peyton, Kertz, et al., 2013). Regardless of whether religion is psychologically adaptive or maladaptive, one thing is certain: This domain is often clinically important for mental health and this domain demands further exploration and attention by CBT clinicians. There have been some efforts to translate this body of research into CBT clinical innovations for specific religious communities (e.g., Propst, Ostrom, Watkins, Dean, & Mashburn, 1992; Pearce et al., 2014; see Hook et al., 2010, and Smith, Bartz, & Scott Richards, 2007), and meta-analytic findings suggest that religion-accommodative CBT is as effective as standard treatment (McCullough, 1999). However, virtually all published studies have been within Christian samples, thus encumbering dissemination of spiritually sensitive CBT to other religious groups.

The Jewish population of the United States is a sizable 5.3 million, and greater New York City is home to 1.5 million Jews, making it the second largest Jewish metropolitan community in the world, second only to Tel Aviv, Israel (Cohen et al., 2011). Approximately 10% of American Jews and 20% of Jews in New York identify with Orthodox Judaism (Cohen et al., 2011), which believes in the perpetuity of the Torah and Oral Tradition (Schnall, 2006), while the remainder are non-Orthodox and share a common Jewish ancestry, heritage, and identity, but do not view scriptural or foundational commandments as legally binding (Meyer, 1988). Assuming standard base rates for anxiety and depressive disorders apply to this population² (19.1% and 6.7% per annum, respectively; Ahrensbrak,

Bose, Hedden, Lipari, & Park-Lee, 2017), over 136,000 Orthodox Jewish Americans meet criteria for an anxiety/depressive disorder in each calendar year, of which over 77,000 reside in greater New York City. All of this speaks to a need for research on specialized evidence-based mental health services for this population. However, we are aware of just one book chapter and four peer-reviewed publications that have outlined clinical methods for delivering CBT to Orthodox Jewish individuals. Of these contributions, three focus exclusively on use of CBT to treat religious forms of obsessive-compulsive and related disorders (Huppert & Siev, 2010; Huppert, Siev, & Kushner, 2007) including compulsive prayer (Bonchek & Greenberg, 2009), and one focuses solely on psychotic disorders (Rosen, Rebata, & Rothschild, 2014), leaving just one (Paradis, Cukor, & Friedman, 2006) book chapter outlining methods for utilization of CBT within this population for a broader set of symptoms. More notably, all of these five contributions present case studies and rich clinical wisdom for how to deliver CBT for common symptoms among Orthodox Jews; however, none of them empirically evaluate treatment effects of CBT within this population.

The overall goals of this study were two-fold: (a) to present two case studies describing clinical methods for implementation of CBT for anxiety and depression among Orthodox Jews, and (b) to evaluate the effectiveness of CBT for generalized anxiety and depression among Orthodox Jews ($n = 65$), relative to a control sample ($n = 42$). More broadly, we sought to expand the field's current understanding of delivering CBT to religious minority groups in several ways: First, our interventional approach adapted traditional CBT approaches to be not only culturally but religiously sensitive. Second, our study was conducted at the Center for Anxiety (www.centerforanxiety.org), a private outpatient clinic with three offices in the New York area servicing a broad spectrum of individuals, including a sufficient volume of Orthodox Jews. This naturalistic setting was seen to have greater ecological validity compared to a conventional university-based laboratory, while facilitating dissemination of evidence-based treatments to a community in need. And finally, our study is the first to systematically examine the effectiveness of CBT within an Orthodox Jewish context, and one of the first to evaluate the relative efficacy of culture-adapted CBT with a control group of nonminorities.

Case Studies

Case 1

Batsheva B. was a 25-year-old, single, non-Hispanic White, Orthodox Jewish female who presented with major depression and generalized anxiety disorder. Batsheva was living at home with her parents and five younger siblings, while attending her second year of an

²At the time of writing, no prevalence estimates of mental disorders exist within the Orthodox Jewish world; however, several studies have found no differences in anxiety or depression when comparing Orthodox Jews to other individuals (e.g., Rosmarin, Krumrei, & Andersson, 2009).

occupational therapy master's degree program. However, shortly prior to intake she initiated a medical leave of absence due to her depression and anxiety. Batsheva reported several distinct depressive episodes dating back to her teenage years, and stated that her most recent episode had started shortly after the beginning of her most recent semester. Batsheva shared that her depression was interfering with her ability to focus during a clinical internship, and she became worried that she would unintentionally harm her patients as a result. However, Batsheva's anxiety and depression had in fact worsened since taking leave from her school program, primarily due to rumination about whether she had made the right decision. She had also become more worried about her future in general, specifically her career potential, her ability to succeed in school, and, most of all, her prospects for marriage. At home, Batsheva felt that her parents did not understand her depression or anxiety, and she felt that her relationship with them had worsened since she initiated the leave of absence. In the context of these stressors, Batsheva reported depressed mood for most of each day, as well as significantly decreased pleasure and appetite, and, as a result, weight loss. She also struggled with (under-)sleeping, a lack of energy, irritability, and passive suicidal ideation with no plan or intent. Batsheva also disclosed a history of trichotillomania (eyelash and eyebrow pulling) but reported that these symptoms were well managed and she did not wish to address this further in treatment.

Batsheva's treatment plan involved weekly individual CBT sessions to facilitate skill acquisition and practice targeting her depression and anxiety symptoms. Specifically, treatment included psychoeducation about cognitive and behavioral models of anxiety and depression (e.g., the notion that thoughts are highly relevant to emotional states; the concept that avoidance tends to lead to worsening of symptoms over time), behavioral activation techniques, sleep hygiene, sleep restriction and relaxation training for sleep difficulties, worry-exposure as well as in-vivo exposure (e.g., to social situations), mindfulness training and cognitive restructuring to target rumination, as well as interpersonal effectiveness strategies to manage family dynamics. In delivering this course of treatment, a number of religious-cultural considerations were taken into account.

First, at the start of treatment Batsheva's motivation to engage in sleep hygiene was low, since she felt that her time would be "better spent" engaging in religious-cultural pursuits such as caring for other people than spending the necessary time to prepare for sleep. Batsheva cited stories about great Torah sages and their families, who dedicated their lives to others at the expense of their sleep. Through a series of psychoeducational discussions, Batsheva was presented with data about basic

human sleep needs and encouraged to experimentally see whether sleeping more would increase her mood and efficiency and ultimately help her to be more caring for others. By framing the purpose of treatment in this way, Batsheva was motivated to engage, and she ended up responding very well to these strategies. However, managing Batsheva's sleep proved somewhat complicated during the Sabbath each week as well as Jewish holidays, when Batsheva's schedule was tied to family gatherings, meal times, and the frequent presence of guests. These issues were navigated successfully, however, by identifying socially acceptable ways for Batsheva to excuse herself from gatherings for sleep, and by implementing some additional environmental changes such as relocating Batsheva to another area of the house coupled with use of earplugs, so that she could maintain as consistent a sleep schedule as possible.

Second, a more significant religious-cultural issue pertained to Batsheva's perceived lack of emotional support from her family, and a sense of emotional invalidation, specifically from her mother. Batsheva felt guilty for resenting her mother, as she viewed her sentiments as contravening the religious injunction to "honor your father and mother" (Exodus 20:12). To make matters worse, Batsheva's feelings tended to flare during Sabbaths/holidays when the family was together. As such, Batsheva reported a sense of guilt and shame for feeling sad and down during "holy days" that are traditionally viewed by Orthodox Jewish religious culture as times of happiness and family connection. As a starting point, Batsheva's feelings of resentment towards her parents were validated by her clinician. Batsheva was then encouraged to think about whether "honor your father and mother" referred to her thoughts and feelings, or her behaviors. Batsheva struggled with this question, since she remembered learning in Seminary that having genuine respect for parents requires feeling positively towards them, as well as showing respect in deed. Batsheva articulated that she felt "stuck" because she felt obligated to have warm feelings towards her parents, but she simply could not given the nature of her relationship with them. Instead of reframing or countering Batsheva's thinking, her clinician simply validated these concerns, clarifying that it must be very challenging for Batsheva to feel that she is falling short of a religious standard that seems impossible to keep. This validation was very helpful to Batsheva and enabled her to acknowledge that she was being too hard on herself. Subsequently, Batsheva was encouraged to disclose her feelings of invalidation and disconnection to her parents, as well as her sense of religious guilt and shame for feeling distanced. While Batsheva was initially reluctant to take this approach, with in-session rehearsal as well as support and coaching she was successful in speaking with her parents about these

concerns. Batsheva emerged from this discussion pleasantly surprised to find both her mother and father to be validating, supportive of her needs, and even apologetic.

A third religious-cultural consideration related to the fact that Batsheva felt socially isolated and religiously guilty because she was still single while almost all of her fellow female Orthodox friends (e.g., from high school, college, and the neighborhood) were either seriously dating, engaged, or already married. Knowing the prime importance of marriage and family life within Orthodox Jewish culture, Batsheva's therapist, a single Jewish female herself but with a Reform (non-Orthodox) Jewish background, was careful to navigate this matter with copious amounts of validation alongside cognitive restructuring and reappraisal. As far as Batsheva was concerned, she was "behind" as she should already have been married by age 25 and she was quickly growing past her prime candidacy for dating and engagement, especially since she was now "failing" out of school. Moreover, Batsheva felt religiously responsible for remaining unmarried, and reported that she was "wasting her life." In reality, there was some religious-cultural validity to the social aspects of Batsheva's marital status, in that she was indeed more isolated than her friends and the processes of dating for marriage within the Orthodox Jewish world are legitimately stressful for "older" singles. However, Batsheva's religious guilt seemed out of place and psychologically problematic. Her therapist therefore helped Batsheva reframe these thoughts by pointing out that she had made significant efforts to get married since her early 20s. Batsheva was also asked point blank whether her faith expected her to simply marry "anyone" or whether she was simply waiting for a life-partner to come along. Batsheva found this alternative perspective to be very helpful. Finally, Batsheva's therapist encouraged her to identify and think about other Orthodox Jewish women who successfully married in their late 20s and even early 30s, and have seemingly happy family lives today. Batsheva continued to struggle with concerns related to marriage; however, targeting her religious guilt about being single seemed a key step in countering her depression and anxiety.

Overall, Batsheva fared very well in treatment. Her GAD-7 scores went from a 17 at baseline to a 10 posttreatment, and her PHQ-9 scores went from a 20 at baseline to a 9 posttreatment, over a course of 35 sessions. She also had dramatically improved sleep quantity and quality, reporting 7–8 hours of restorative sleep per night by the midpoint in treatment. More important, in addition to these reductions in symptoms, Batsheva's functioning improved in that her concentration and ability to focus dramatically improved, and she returned to school the following semester and graduated from her master's program. She also benefited from a significantly

closer and less acrimonious relationship with her parents, and more self-compassion and acceptance of her own negative feelings.

Case 2

Avrohom P. was a 22-year-old, single, non-Hispanic White, Orthodox Jewish male who presented with symptoms of panic disorder with agoraphobia and depression. At the time of intake, Avrohom reported experiencing all of these symptoms for about 5 years, though they had worsened significantly over the prior month such that he left his job and became unemployed, due to increased panic and agoraphobic avoidance of traveling by subway. Avrohom reported that prior to leaving his job, he would "mentally prepare" for days in advance to go to appointments and scheduled shifts at work, and after such outings he felt depressed, drained, and debilitated. Avrohom's core fear centered around a fear of dying from a heart attack, stroke, or other medical ailments, and he would routinely scan his body for pain, discomfort, and other signs of impending danger. These fears were particularly pronounced during panic attacks, which Avrohom reported occurred several times weekly and included heart palpitations, sweating, and shallow breathing, accompanied by lightheadedness, numbness, and thoughts that he was dying. Avrohom's agoraphobia focused on areas in which he felt closed or stuck. His depression involved chronically low mood coupled with increased appetite/eating, excessive sleeping, feeling fidgety, difficulty concentrating, and feelings of hopelessness, but he did not report passive or active suicidal ideation. In addition, Avrohom reported some social anxiety and he also showed evidence of some vocal tics when particularly anxious, but he reported that these symptoms were not as serious as his panic, agoraphobia or depression. Avrohom's treatment involved individual CBT sessions focused on understanding the cognitive-behavioral model of panic and agoraphobia, followed by interoceptive and in-vivo exposure as well as behavioral activation. Given the severity of Avrohom's symptoms and dysfunction, he was offered twice-weekly sessions for the first few weeks of treatment, with the hope of him achieving a sudden gain. This course of treatment required a number of religious-cultural adaptations.

First, Avrohom's therapist utilized religious framing, in which treatment was explained using religious-cultural idioms, terms, phrases, and concepts (Rosmarin, 2018). Avrohom was of above-average intelligence and understood the "standard" CBT model of panic/agoraphobia, but struggled to fully buy into the rationale for exposure therapy. "Why would I put myself through panic? God wants me to take care of my body. What if something happens to me? It's not worth the religious risk," he

initially responded. Avrohom's (non-Orthodox) therapist therefore turned to Avrohom's faith for a potential answer. "You know your faith better than I ever will, so let me ask: Do you truly believe that God wants you to live this way? Isn't that a risk as well? I would bet that you could identify plenty of sources within Orthodox Judaism to support this approach for treatment."³ Avrohom accepted his therapist's challenge and discussed the prospect of engaging in exposure therapy with his rabbi. Fortunately, the latter was supportive of the approach, and in fact said it was a "mitzva" (fulfilment of a religious commandment) for Avrohom to do whatever his therapist suggested may be helpful. Avrohom's rabbi also blessed him that his efforts would be successful, which Avrohom took as a spiritual sign from God that he should truly exert himself to engage in exposure therapy as directed. From this point forward, Avrohom's motivation to engage in treatment was virtually unwavering. In retrospect, had Avrohom's rabbi *not* been supportive, this approach could have backfired and Avrohom may have dropped out of treatment. However, in discussing this case with our clinical team, we identified that if Avrohom's religious-cultural authority had concerns about his treatment, it would be culturally and religiously sensitive to listen to those concerns and attempt to address them directly with Avrohom and/or through collaboration and consultation with his rabbi. We further identified that attempting to ignore or "work around" such concerns without addressing them directly would likely lead to suboptimal treatment effects.

Second (unlike Batsheva B.), Avrohom reported that the weekly Sabbath was a relatively calm and pleasant day for him, primarily because subway travel and going to work on the Sabbath are religiously proscribed by Orthodox Judaism. This posed somewhat of a conundrum for treatment, as Avrohom's therapist needed to strategize with him in designing treatment activities that he could do without transgressing his religious standards. Through a series of collaborative discussions, Avrohom and his therapist identified that Avrohom could read books about panic disorder/agoraphobia and depression, practice interoceptive exposures, and also engage in behavioral activation by going to synagogue, attending religious study sessions, and engaging socially with others. Given the severity of Avrohom's panic, these latter activities proved difficult, but he was able to move ahead with them and face his fears in a moderately challenging way each Sabbath, while nurturing his social and spiritual supports. In addition, Avrohom's therapist identified that it could be beneficial for him to lead Sabbath services at his local synagogue, since he would be singing the melodies out

loud and thereby need to regulate his breathing, and effectively be "trapped" since it would be socially inappropriate for him to stop in the middle of services if he were to have a panic attack. This obviously represented an advanced exposure exercise for Avrohom, but over the course of treatment he worked up to it with intermittent steps (e.g., singing at Sabbath meals with friends, positioning himself in the front pews or in the middle of heavily occupied rows during synagogue services), and shortly prior to his final session he was able to achieve this significant milestone.

Over the course of 20 sessions conducted over a period of 13 weeks, Avrohom experienced clinically significant gains across the board, with his GAD-7 scores decreasing from 20 at baseline to 11 posttreatment, and PHQ-9 scores dropping from 24 to 10. Relatively early in treatment, Avrohom's agoraphobia dramatically reduced such that he would accept virtually any opportunity to face his panic attacks, and concurrently his depression remitted substantially, though not completely. Avrohom's panic remitted much less quickly, but he did report diminished intensity of his panic attacks, specifically his fears related to death and dying. Concurrent with these reductions in symptoms, Avrohom reengaged in his life and was able to make and keep appointments, run errands, take the subway virtually anywhere and at any time, and ultimately he went back to work. Avrohom's social life also improved significantly, due to his increased engagement with others in his community on the Sabbath and holidays, and he reported an increased sense of spiritual connection and gratitude as well.

Methods

Overview of Treatment

All treatment was provided by Center for Anxiety clinicians. A comprehensive review of each patient's clinical chart revealed that a wide variety of CBT techniques were utilized, including both second- and third-wave strategies such as psychoeducation, ongoing monitoring of triggers as well as symptoms and target behaviors (e.g., thought records, panic records, diary cards), chain analysis, exposure (imaginal, in-vivo, and interoceptive), response prevention, behavioral activation, behavioral scheduling, stimulus control, sleep hygiene, sleep restriction, relaxation training, problem solving, identifying thoughts/assumptions, identifying and restructuring cognitive distortions, acceptance, mindfulness, distress tolerance, emotion regulation, and interpersonal effectiveness. Sessions were held within the Center for Anxiety's Manhattan, Brooklyn, or Rockland County offices, however out-of-office sessions (e.g., in home, school) were implemented as needed in accordance with patients' treatment plans to facilitate treatment approaches within naturalistic contexts. Where

³ The authors would like to thank Dr. Jonathan Grayson for sharing this technique.

clinically indicated and desired by patients, aspects of patients' religious lives were integrated into treatment techniques following the guidelines of Rosmarin (2018). Such adaptations included (a) religious framing, in which CBT techniques are presented using religious idioms and language to describe and explain established treatment concepts/approaches; (b) harnessing religious beliefs to facilitate cognitive reappraisal and restructuring of maladaptive thinking patterns; (c) religion-based behavioral activation, which involves direct utilization of religious practices to modulate affective states; (d) psychoeducation to demarcate distinctions between bona-fide aspects of religious life versus religious symptoms which are manifestations of psychopathology that co-opt facets of religious life; and (e) identification and validation of spiritual struggles.

Procedures and Participants

Upon intake and at each treatment session, patients completed primary measures (described below) using Psych-Surveys™ software, which allows for seamless electronic administration of measures as well as reporting and graphic illustration of symptoms to clinicians throughout treatment. At intake, all patients received the Miniature International Neuropsychiatric Interview (Sheehan et al., 1998); a structured diagnostic interview for DSM-5; as well as a general psychosocial interview to assess for relevant clinical, demographic, familial, cultural, and religious factors that may impact treatment delivery and care. Diagnoses were conferred and treatment plans reviewed in consultation with a licensed clinical psychologist during weekly clinical rounds meetings. Master's-level clinicians received weekly supervision from doctoral-level clinicians, as well as ad hoc consultation as needed throughout the treatment process.

All adult patients aged 18 years or older presenting to the Center for Anxiety's Manhattan, Brooklyn, and Rockland County offices for outpatient CBT (not intensive outpatient treatment, or one-time consultations) between March 2017 and March 2018, who completed Psych-Surveys™ electronic assessments to provide pretreatment and termination values of anxiety and/or depression, were included in analyses. This yielded a total sample of 107 patients ranging in age from 18–67, of which 63.6% were female. All patients had symptoms meeting criteria for generalized anxiety disorder and/or major depression; however, primary diagnoses included anxiety disorders (46.1%), mood disorders (28.4%), obsessive-compulsive related disorders (24.5%), and other disorders (1.0%). In measuring the number of DSM-5 diagnoses for which criteria were met upon admission, 42.1% of patients met criteria for one diagnosis, 34.6% for two diagnoses, and the remainder met criteria for three or more diagnoses. Upon

admission, 88% of patients presented with clinically significant anxiety (as measured by the GAD-7, described below), with over 60% presenting with “moderate” to “severe” anxiety. Similarly, at admission 77% of patients presented with clinically significant depression (as measured by the PHQ-9, described below), with 38% in the “moderate” or “severe” range. A total of 14 clinicians provided treatment, of which 64% were trained at the doctoral level and the remaining 36% at a master's level. Of the $n = 107$ patients, 65 (60.7%) identified as Orthodox Jews and 42 (39.3%) identified as either affiliated with another religious group or religiously unaffiliated. This study was approved by the McLean Hospital/Partners Healthcare Institutional Review Board, and data was deidentified prior to analyses.

Measures

Generalized anxiety was assessed using the GAD-7 (Spitzer, Kroenke, Williams, & Löwe, 2006), a widely used seven-item patient self-report measure of generalized anxiety symptoms and used more broadly to assess for anxiety in a variety of clinical settings. The scale yields a single total score between 0 and 21, but can also be interpreted using four validated levels of anxiety severity (Ware & Sherbourne, 1992): “Minimal” (0-4), “Mild” (5-9), “Moderate” (10-14), and “Severe” (15-21). Previous research has shown excellent internal consistency ($\alpha = .92$) and in the current study this was similarly robust ($\alpha = .88$). Strong validity and reliability have been upheld by subsequent research (Löwe et al., 2008).

Depression was assessed using the Patient Health Questionnaire Depression Scale (PHQ-9; Kroenke, Spitzer, & Williams, 2001), a widely used nine-item patient self-report of depressive symptoms. The scale yields a single total score between 0 and 27, but can also be interpreted using four validated levels of depression severity (Ware & Sherbourne, 1992): “Minimal” (0-4), “Mild” (5-9), “Moderate” (10-14), “Moderately Severe” (15-19), and “Severe” (20-27). Previous research has shown excellent internal consistency ($\alpha = .89$), and in the current study this was similarly robust ($\alpha = .89$). Strong validity and reliability have been upheld by subsequent research (Löwe et al., 2004).

Religion was assessed with a series of single items to reflect four aspects of spiritual/religious identity: Importance of religion (“To what extent is religion important in your life?”), belief in God (“To what extent to you believe in God?”), frequency of private prayer, and frequency of religious service attendance. All four items were scored using a Likert-type scale ranging from 1–5 (importance of religion, belief in God) or 1–7 (frequency of prayer/service attendance). Items were primarily used

descriptively and thus analyzed separately, without being summed to produce an overall index.

Analytic Plan

First, we computed descriptive statistics for the sample as a whole ($n = 107$), including demographics, clinical and spiritual/religious characteristics, and we compared these across Orthodox Jewish ($n = 65$) and control participants ($n = 42$). We then computed and compared levels of generalized anxiety and depression for both groups at three time points: prior to treatment, after five sessions, and at termination. Finally, we utilized Repeated-Measures Analyses of Variance with a 3 (time) \times 2 (group) within-between factorial design, to examine overall treatment effects as well as potential interaction effects between Orthodox Jewish affiliation and treatment outcomes, for both generalized anxiety and depression.

Results

Table 1 displays demographic and clinical characteristics for the study sample stratified according to Orthodox Jewish and non-Orthodox Jewish subsets. Characteristics of the total sample are discussed above (see Participants and Procedures) and were similar between subgroups; however, Orthodox Jewish participants were more likely to be married (49.3% vs. 23.3%, $X^2 = 9.31$, $df = 4$, $p = .05$). Across the board, religion was greater among Orthodox Jewish patients relative to controls, $F(1, 68)$ ranging from 18.34 to 96.44, $p < .001$, for all four variables. Number of sessions was equivalent between groups; however, Orthodox Jews completed treatment over a slightly longer time period relative to controls, $F(1, 105) = 4.57$, $p < .05$, owing perhaps to interruptions due to religious holidays. (See Figs. 1 and 2.)

Table 2 displays mean scores of generalized anxiety and depression at pretreatment, after five sessions, and at posttreatment, for Orthodox Jewish and control participants. No significant differences were noted between the two subgroups on either outcome for any time-point. Table 3 displays two repeated-measures analyses of variance examining treatment effects for generalized anxiety and depression across all the three time-points, as well as potential interaction effects between the subgroups on outcome measures across time. For generalized anxiety, the main effect of treatment was significant (Wilks' Lambda = .43, $F = 65.23$, $p < .001$, $\eta_p^2 = .57$), while the interaction effect of Treatment \times Orthodox Jewish was not significant (Wilks' Lambda = .95, $F = 2.65$, $p = .08$, $\eta_p^2 = .05$). Similarly, for the analysis of depression across treatment, the main effect of treatment was significant (Wilks' Lambda = .50, $F = 50.34$, $p < .001$, $\eta_p^2 = .504$), while the interaction effect of Treatment \times

Orthodox Jewish was not significant (Wilks' Lambda = .99, $F = 2.00$, $p = .49$, $\eta_p^2 = .01$).

Discussion

This paper supports and extends a small but important body of clinical literature on CBT with Orthodox Jews, by briefly describing some methods for delivering CBT to Orthodox Jews experiencing a variety of symptoms (e.g., depression, generalized anxiety, panic disorder, agoraphobia) through two case studies. Our illustrative approach demonstrates several religious-cultural adaptations of CBT when working with Orthodox Jews, including framing the importance of sleep hygiene through a religious lens; modifying sleep/self-care routines around the Sabbath and holidays; validating and using cognitive restructuring to target religious guilt and shame; supporting patients in navigating family-related conflicts (Orthodox Judaism is a family-centric religious culture); collaborating with patients/clergy to frame a rationale for CBT in spiritual/religious terms; creatively working around religious limitations that can impact treatment adherence; and exploring/identifying opportunities within religious-cultural life to engage in treatment targets.

Our clinical approach shows the potential that CBT holds for cross-cultural applications in general, and to specific religious groups in particular. Regrettably, the vast majority of CBT research has been conducted with non-Hispanic White individuals, and clinical methods for culturally adapting CBT clinical methods are not fully developed (Horrell, 2008). Regarding religion, while some have developed methods for addressing this domain of life within CBT, such approaches are rare and almost all have focused on the Christian religion. Furthermore, the majority of CBT literature on religious matters has focused specifically on religious symptoms such as scrupulosity (religious OCD) and religious presentations of psychosis. As our case studies illustrate, religious life can shape patients' patterns of thought, emotion, and behavior in many ways beyond simply coloring symptom presentations. Our ability to service religious minorities with evidence-based care—within the Orthodox Jewish world or otherwise—hinges on navigating religious issues in a broader manner. Given proliferation of minorities within the U.S. population today, and the sheer prevalence of religious beliefs and identity, it is reassuring that the core methods of CBT are readily amenable to religious-cultural adaptation.

Our paper also presents the first systematic empirical analysis of the effectiveness of CBT among Orthodox Jews. Further, we targeted both generalized anxiety and depression, thus examining the effects of CBT to a range of symptoms. Notably, and unlike most other cross-cultural CBT research, we included a sample of (non-

Table 1
Demographic, Spiritual/Religious and Clinical Characteristics of the Sample

	<i>Orthodox Jews (n = 65)</i>	<i>Controls (n = 42)</i>
Age	32.08 (13.07)	30.56 (12.52)
Gender [#] (% Female)	59.2%	69.8%
Marital Status [#]		
Single	45.1%	65.1%
Married	49.3%	23.3%
Divorced	4.2%	2.3%
Other	1.4%	7.0%
Ethnicity		
White	92.5%	73.5%
Black/African American	—	2.9%
Latino or Hispanic	—	11.8%
Asian American	—	5.9%
Multi-Racial	2.5%	—
Other	5.0%	5.9%
Education		
High school	21.4%	2.9%
College	57.1%	61.8%
Graduate School	21.4%	32.4%
Income		
< \$25,000	12.7%	29.4%
\$25-50,000	21.1%	17.6%
\$50-100,000	28.9%	23.5%
> \$100,000	26.3%	29.4%
Spirituality/Religion		
Importance of Religion***	4.73(0.69)	2.33(1.29)
Belief in God***	4.89(0.52)	2.94(1.75)
Private Prayer***	5.08(1.32)	1.94(1.43)
Service Attendance ***	2.70(1.82)	1.27(0.63)
Office Location**		
Manhattan	23.9%	53.5%
Brooklyn	62.0%	46.5%
Rockland County	14.1%	—
Treatment Length		
Number of Sessions	14.30(8.58)	11.3(6.28)
Number of Weeks*	26.08 (19.44)	18.52 (15.01)
Psychiatric Diagnoses		
1 diagnosis	46.5%	39.5%
2 diagnoses	33.8%	34.9%
3 or more diagnoses	15.5%	20.9%
Primary Diagnosis		
Anxiety Disorder	44.1%	48.8%
Mood Disorder	27.9%	27.9%
Obsessive-Compulsive Disorder	26.2%	18.6%
Pretreatment Anxiety Severity		
Minimal	12.3%	11.9%
Mild	32.3%	19.0%
Moderate	26.2%	28.6%
Severe	29.2%	40.5%
Pretreatment Depression Severity		
Mild	27.7%	21.4%
Moderate	20.0%	33.3%
Moderately Severe	15.4%	9.5%
Severe	12.3%	16.7%

Table 1 (continued)

	Orthodox Jews (n = 65)	Controls (n = 42)
Current Psychopharmacology	52.5%	50.0%

Notes: # $p < .10$; * $p < .05$; ** $p < .01$; *** $p < .001$. ANOVA was utilized to compare age, religious variables, time in treatment and number of sessions. *Chi-square* statistics were utilized to compare all remaining variables. All tests examined for presence any significant differences between the two study groups (Orthodox Jewish and Control patients). Data of primary study measures as well gender were contained in medical records and were recorded for all participants. Other demographic variables were collected as part of a long-form electronic survey at the beginning of treatment, and consistent with the naturalistic setting of this study, most items were not included as required fields and could be skipped. Therefore, response rates for some items range from 56-80% of the sample. Regarding spirituality/religion, as reported in the text, "importance of religion" and "belief in God" were scored using a 5-point scale, whereas frequency of prayer and service attendance were scored using a 7-point scale.

Regarding length of treatment, number of sessions represents number of actual clinical meetings whereas number of weeks represents the amount of time spent in treatment (from calendar start- to end-date). Current psychopharmacology represents the % of patients prescribed medication at the start of treatment.

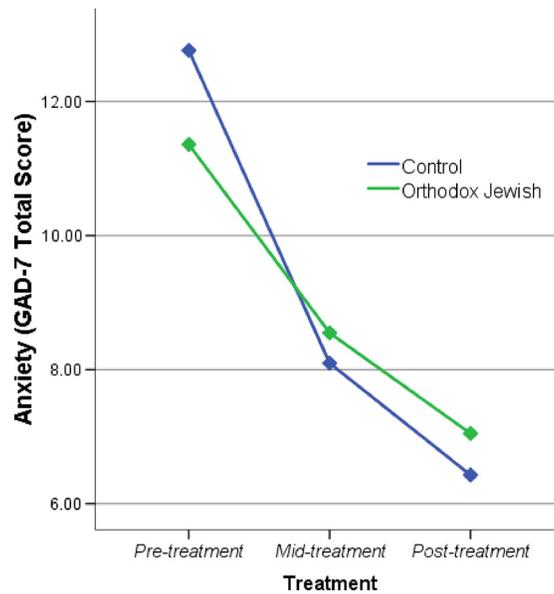


Fig. 1. CBT for Generalized Anxiety among Orthodox Jews and Controls

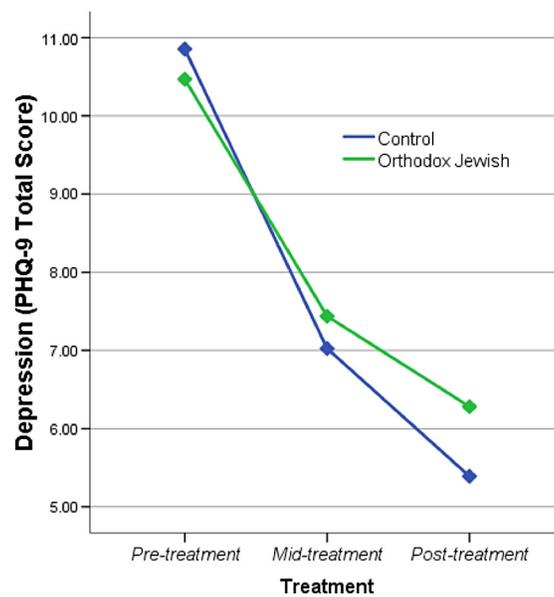


Fig. 2. CBT for Depression among Orthodox Jews and Controls

Table 2
Generalized Anxiety and Depression at Pre- Mid- and Posttreatment

	Orthodox Jews (n = 65)	Controls (n = 42)
GAD GAD-7 Score	M (SD)	M (SD)
Pre-Treatment	11.48 (5.44)	12.42 (5.66)
Mid-Treatment	8.65 (5.55)	7.90 (5.89)
Post-Treatment	7.13 (5.01)	6.15 (5.54)
PHQ PHQ-9 Score	M (SD)	M (SD)
Pre-Treatment	10.66 (7.17)	10.85 (7.11)
Mid-Treatment	7.59 (6.61)	7.02 (6.52)
Post-Treatment	6.38 (5.92)	5.39 (6.69)

Notes: Orthodox Jews and Control participants were not different from one another in levels of anxiety or depression, at pre- mid- or post-treatment. See text for interpretation and explanation of these results.

Orthodox) control participants in our sample in order to compare treatment effects. Results of our analyses support the use of CBT among Orthodox Jews, in that participants reported statistically significant and clinically meaningful degree of change over the course of treatment. Specifically, on average, patients in our sample started treatment with moderate anxiety and depression and terminated with low-mild levels of these symptoms. We further observed a “dosing” effect, with mid-treatment scores after five sessions in the mid to mild range for both anxiety and depression. Interestingly, we observed no differences between Orthodox Jewish and control participants at any time point or in terms of overall treatment trajectories, suggesting that CBT was equally effective across the board.

Another implication of our study is that CBT can be effective outside of controlled laboratory settings. Most CBT research (cross-cultural or otherwise) has been conducted with regulated samples controlling for comor-

Table 3
Main Effects of Treatment, and Interaction Effects of Treatment × Orthodox Jewish Identity, on Anxiety and Depression

	Wilks' Lambda	F	p	η_p^2
Anxiety (GAD-7)				
Treatment	.434	65.234	< .001	.566
Treatment x OJ	.950	2.651	.076	.050
Depression (PHQ-9)				
Treatment	.496	50.336	< .001	.504
Treatment ¹ x OJ	.986	0.726	.487	.014

Notes: Treatment effects represent trajectories of anxiety/depression over the three measurement time-points (baseline, session-5 and termination). OJ = Orthodox Jewish Identity. Treatment effects were statistically significant for both anxiety and depression. Interaction effects were non-significant for both anxiety and depression. See text for interpretation and explanation of these results.

bidities and various demographic factors, and thus generalizability is often lacking. Our approach suggests that CBT methods can be culturally adapted and translated into the “real world.” One tradeoff for this benefit, however, is a methodological limitation of our study: Our clinical approach was heterogeneous in that a broad array of CBT methods was employed without a systematic method for selecting treatment components or determining treatment length (beyond general clinical judgment, clinical need, and level of patient interest/motivation). Furthermore, we did not employ religious-cultural adaptations of CBT across the board; rather, such modifications were tailor made to each patient according to their clinical needs and personal preferences. Participants were similarly diverse in that we included individuals with a wide variety of diagnoses and comorbidities, and a broad range of age, socioeconomic status, and other demographic variables. In light of these facets of our study, however, our findings have particular ecological validity and speak to the great promise CBT holds as a solution to mental distress in underserved populations.

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David H. Rosmarin, PhD, ABPP, affirms that this manuscript is an honest, accurate, and transparent account of the study being reported; that no important aspects of the study have been omitted; and that any discrepancies from the study as planned have been explained. Though names and other identifying details in the case studies have been changed, in order to protect patient privacy and confidentiality. The authors have no conflicts of interest to disclose.

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