A R T I C L E

COMMUNITY ATTITUDES TOWARDS CULTURE-INFLUENCED MENTAL ILLNESS: SCRUPULOSITY VS. NONRELIGIOUS OCD AMONG ORTHODOX JEWS

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Culture may particularly influence community attitudes towards mental illness, when the illness itself is shaped by a cultural context. To explore the influence of culture-specific, religious symptoms on Orthodox Jewish community attitudes, the authors compared the attitudes of 169 Orthodox Jews, who randomly viewed one of two vignettes describing either religious or nonreligious obsessive–compulsive disorder (OCD). Results indicate that though participants were equally likely to perceive both vignettes as mental illness, they were less likely to endorse psychological/medical explanatory models and help-seeking, and conversely more likely to endorse social–religious explanations, religious help-seeking, and stigma in relation to religious OCD. Nevertheless, psychological/medical models and help-seeking were more strongly endorsed for both religious and nonreligious OCD. Beyond implications for Orthodox Jewish community actions, these findings suggest that attitudes towards mental illness may depend on how symptoms relate to community culture. © 2009 Wiley Periodicals, Inc.

Today's multicultural reality necessitates recognition of culture's influence on many aspects of mental health, including the stressors individuals confront, their coping styles and social supports, and their expression of symptoms (U.S. Department of Health and Human Services [USDHHS], 2001). Culture may impart unique

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explanatory models, or beliefs and attitudes concerning mental illness (Kleinman, 1988), and can determine the motivations, barriers, and pathways to help (Rogler & Cortes, 1993; USDHHS, 2001). Community researchers have consistently linked diverse cultural variables, such as concerns with personal dignity and prestige (Gong, Gage, & Tacata, 2003), willingness to disclose (Nguyen & Anderson, 2005), and acculturation (Paris, Añez, Bedregal, Andrés-Hyman, & Davidson, 2005) with attitudes towards mental illness. In fact, research incorporating cultural factors is central to the development of empirically based and culturally sensitive community education, services, and ñinterventions (Bernal & Sáez-Santiago, 2006).

Beyond influencing mental health attitudes, culture can exert a profound influence by interacting with psychosocial difficulties, and distinctively altering their expression. Culture can alter the idioms used to communicate distress, impart a unique facet to symptoms, or even produce entirely culture-bound difficulties (American Psychiatric Association, 2000). Attitudes towards these culture-influenced difficulties may differ markedly from attitudes towards other expressions of mental illness. Consequently, understanding culture's impact on attitudes towards mental illness may require exploring attitudes toward distinctive psychosocial difficulties present within a particular community. One possible interaction of this type is Orthodox Jewish community attitudes towards scrupulosity in obsessive–compulsive disorder (OCD), an inextricably cultural bound difficulty.

SCRUPULOSITY AMONG ORTHODOX JEWS

Obsessive–compulsive disorder is characterized by obsessions—persistent and intrusive thoughts, impulses, or images—and/or compulsions—repetitive driven behaviors that aim to reduce distress or prevent a dreaded situation—which are time consuming, distressful, or interfering with normal functioning (American Psychiatric Association, 2000). In scrupulosity, a subtype of OCD, obsessions and compulsions focus on religious or moral fears reflective of an individual's beliefs, practices, and rituals (Abramowitz, Huppert, Cohen, Tolin, & Cahill, 2002). Common religious obsessions include intrusive and blasphemous mental images, fear of committing sins, and fear of punishment from God. Correspondingly, common religious compulsions include excessive prayer, repeated crossings, and looking at the sky towards God (Olatunji, Abramowitz, Williams, Connolly, & Lohr, 2007). Among Orthodox Jews, scrupulosity generally focuses on adherence to Judaism's detailed religious laws such as dietary restrictions (e.g., not mixing milk and meat), praying and studying correctly, and family purity (Greenberg & Shefler, 2002; Huppert, Siev, & Kushner, 2007). These laws, based on rabbinic interpretation of the *Torah* (Jewish Bible) and *Talmud* (5th century compendium), infuse Orthodox daily life with religious responsibilities and significance.

Given the complexity and detailed scope of these laws, those unfamiliar with Orthodox Judaism may find it difficult to distinguish normative community practices from scrupulosity. For example, the *Shulchan Aruch* (Caro, 16th century/1959), an authoritative codification of traditional law, describes donning *Tefillin* (phylacteries):

> The position for the arm-*Tefillin* is on the left arm, on the biceps, between the
> elbow joint and armpit. The box should lean slightly towards the body, so that

when the hand extends downward the *Tefillin* will be opposite the heart (27:1). There should be nothing separating between the *Tefillin* and the skin (27:4). The position for the head-*Tefillin* is on top of the head, above the hairline, but below the anterior fontanel (27:9). The *Tefillin*-straps must be completely black on the outside, but on the inside can be any color other than red (33:3). [Authors' translation]

As these instructions illustrate, adherence to normative traditional Jewish law requires meticulousness and attentiveness, which those unfamiliar with Orthodox Judaism can misinterpret as scrupulosity (Huppert et al., 2007). Nevertheless, OCD may "co-opt" these practices, resulting in scrupulous behavior exceeding community standards. For instance, while checking *Tefillin* during prayer is normative, maladaptive behavior such as a constant preoccupation with *Tefillin*, or repetitive, time-consuming checking of them is typical of Orthodox scrupulosity.

Orthodox Attitudes Towards Scrupulosity

Because of these profound cultural associations, attitudes towards scrupulosity in the Orthodox Jewish community may differ from those towards clinically comparable, but nonreligious OCD. For instance, anecdotal reports indicate that some Orthodox individuals with scrupulosity view their religious upbringing as causal to its development (Greenberg & Shefler, 2002; Huppert et al., 2007), despite empirical evidence to the contrary (e.g., Greenberg & Shefler, 2002; Hermesh, Masser-Kavitzky, & Gross-Isseroff, 2003; Zohar, Goldman, Calamary, & Mashiah, 2005). Similarly, research suggests that Orthodox individuals with OCD may be more likely to approach religious sources of help for religious difficulties, while preferring psychological/medical sources for similar nonreligious symptoms (Greenberg & Shefler, 2002). However, we are unaware of empirical studies directly examining whether attitudes towards culture-influenced symptoms differ from those towards nonreligious symptoms of OCD. Accordingly, the present research compared Orthodox Jewish attitudes towards scrupulosity versus nonreligious OCD through experimental manipulation.

METHOD

Materials and Measures

Vignettes. We created two vignettes portraying moderate to severe symptoms of religious and nonreligious OCD. The religious vignette described difficulties related to specific religious rituals (e.g., morning prayers and donning *Tefillin*); the nonreligious vignette presented symptoms involving safety concerns and checking (see the Appendix). Three Orthodox and three non-Orthodox psychologists/psychology graduate students, all of whom have published peer-reviewed articles on OCD in the past 5 years, reviewed these vignettes, and indicated that the symptoms described meet criteria for a diagnosis of OCD and were equally severe. Furthermore, three

ordained Orthodox rabbis reviewed the religious vignette, and deemed the behaviors described in excess of Orthodox Jewish community standards.

Perception of mental illness. A single item, "How likely do you think it is that Binyamin is experiencing a mental illness?" measured perception of mental illness using a 4-point scale (*very likely, somewhat likely, somewhat unlikely,* and *very unlikely*).

Explanatory models. Using an identical scale, participants responded to the question "How likely is it that Binyamin's situation might be caused by the following?" in relation to seven items: "bad character," "a chemical imbalance in the brain," "the way he was raised," "stressful circumstances in his life," "a genetic or inherited problem," "God's [Hashem's] will," and "being too religious." These items were drawn from the General Social Survey (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999), with the addition of "being too religious."

Help-seeking. Participants indicated how likely they would be to recommend various sources of psychological/medical and religious help on the previously described 4-point scale. A principal components analysis of responses to these items—direct oblimin (oblique) rotation and O'Connor's (2000) parallel analysis—identified two clearly interpretable factors accounting for 53.95% of the scale variance. Factor 1 consisted of six items describing religious sources of help: Rebbe (Hassidic Rabbi), Rosh Hayeshiva/Kollel (dean of religious school), Mashgiach (supervisor in religious school), Rebbetzin (Rabbi's wife), Rav (non-Hassidic Rabbi), Religious advisor. Factor 2 consisted of six items describing psychological/medical sources of help: Psychiatrist, Social worker, Psychotherapist, Psychologist, Other medical doctor, and Family physician. Accordingly, we formed two subscales reflecting religious help-seeking ($\alpha = .73$) and psychological/medical help-seeking ($\alpha = .84$).

Stigma. Participants completed a five-item scale previously used to measure social distance (Link et al., 1999), which relates to willingness to socially engage with a hypothetical individual with mental illness (e.g., "How willing would you be to spend an evening socializing with Binyamin?"). Response anchors ranged from *definitely* to *definitely not* on a 4-point scale, and scores on each item were averaged to form a single stigma measure ($\alpha = .89$).

Participants and Procedure

One hundred sixty-nine individuals (113 women and 56 men) ranging in age from 18 to 63 years ($M = 37$, $SD = 13.34$) participated in the study. In September 2008, participants were recruited through a mass e-mail utilizing the list of a Jewish community Web site dedicated to psychological research (www.jpsych.com), as well as posts on several Internet outlets (e.g., Synagogue announcement groups, Orthodox event listings, and religious discussion forums). In addition, participants were asked to inform their friends and family members about the study to aid recruitment. After giving informed consent, participants were directed to complete items relating age, gender, and religious affiliation, and were then randomized, without any restriction, blocking or stratification, to be presented with either the religious or nonreligious vignette. Analyses were conducted using data from participants who self-identified as Orthodox Jews (Lubavitch = 3, Yeshiva Orthodox = 60, Modern Orthodox = 104, Sephardic-Religious = 2), of which 78 viewed the religious vignette and 91 viewed the nonreligious vignette. The resulting religious and nonreligious vignette groups did

not differ significantly in age, $t(167) = .67$, *ns*, gender, $\chi^2(1, N = 169) = .71$, *ns*, or religious affiliation, $\chi^2(3, N = 169) = .13$, *ns*. Participants completed the remainder of the questionnaire in respect to this vignette, and this study was approved by the Human Subjects Review Board of Bowling Green State University.

RESULTS

The majority of participants, both of those given the nonreligious OCD vignette and those given the scrupulosity vignette, perceived the vignettes as representing mental illness (Table 1). The vast majority also supported medical/psychological explanatory models (e.g., chemical imbalance, genetic problem, stressful circumstances), whereas far fewer supported social–religious models (e.g., bad character, way raised, too religious) for both nonreligious OCD and scrupulosity. Similarly, participants expressed significantly greater support for psychological/medical help-seeking than religious help-seeking in both the nonreligious, $t(90) = 12.50$, $p < .001$, $d = 2.64$, and religious conditions, $t(73) = 4.60$, $p < .001$, $d = 1.08$.

To test our hypothesis that attitudes towards culture-influenced symptoms would differ from those towards clinically analogous, nonreligious symptoms, we conducted a series of comparisons between the two vignettes. Because response anchors to perception of mental illness and the explanatory model items were not perfectly continuous, these were examined using Mann–Whitney U tests. Stigma and help-seeking, which were continuous measures, were examined using *t* tests. Results indicated that participants were equally likely to view scrupulosity and nonreligious OCD as mental illness; however, attitudes towards these expressions differed significantly in a manner consistent with our hypotheses. In particular, participants presented with the scrupulosity vignette were less likely to attribute symptoms to "a chemical imbalance in the brain," and more likely to attribute symptoms to "the way he was raised" and "being too religious" (Table 1). Furthermore, participants responding to the scrupulosity vignette were less likely to support professional/medical help-seeking, and conversely more likely to support religious help-seeking and stigma compared to participants presented with the nonreligious OCD vignette (Table 2).

Table 1. *Orthodox Jewish Community Perception of Mental Illness and Explanatory Models: Nonreligious Obsessive–Compulsive Disorder (OCD) Versus Scrupulosity Vignettes*

	Mean rank (% likely[a])			
	Nonreligious OCD	*Scrupulosity*	*U*	*P*
Perception of mental illness	84.69 (89%)	73.88 (84%)	2683	.08
Explanatory models				
Bad character	82.62 (1%)	85.65 (3%)	3333	.48
Chemical imbalance	94.07 (95%)	71.95 (90%)	2542	.001
Genetic problem	87.40 (79%)	79.93 (83%)	3149	.27
God's will	89.75 (61%)	77.34 (43%)	2952	.09
Stressful circumstances	82.26 (78%)	86.09 (86%)	3300	.56
Too religious	79.06 (4%)	89.91 (7%)	3009	.04
Way he was raised	75.53 (35%)	94.14 (53%)	2687	.009

[a]Represents percentage of participants endorsing *somewhat likely* or *very likely* response.

Table 2. Orthodox Jewish Community Support for Help-Seeking and Stigma: Nonreligious Obsessive–Compulsive Disorder (OCD) Versus Scrupulosity Vignettes

	M (SD)		t	p	d
	Nonreligious OCD	*Scrupulosity*			
Help-seeking					
Psychological/medical	3.28 (.85)	3.08 (.77)	2.28	.045	.18
Religious	2.13 (.47)	2.51 (.62)	2.97	.04	.23
Stigma	2.15 (.71)	2.38 (.75)	2.02	.045	.16

Note. Scales ranged from *very unlikely* (1) to *very likely* (4). $df = 162$ for each t test.

DISCUSSION

As cultures' extensive influence on mental health is increasingly acknowledged (e.g., USDHHS, 2001) a growing number of community researchers broadly link cultural variables with community attitudes towards mental illness (e.g., Gong, Gage, & Tacata, 2003; Nguyen & Anderson, 2005; Paris, Añez, Bedregal, Andrés-Hyman, & Davidson, 2005). The purpose of the current study was to extend this research by examining whether community attitudes towards culture-influenced mental illness differ from attitudes towards nonreligious expressions of mental illness. We examined this question in an Orthodox Jewish context, hypothesizing that Orthodox individuals presented with a vignette describing culture-bound, religious OCD would differentially endorse explanatory models, help-seeking preferences, and stigma—as compared to those given a nonreligious OCD vignette. Consistent with these ideas, we found that although Orthodox Jewish individuals were equally likely to perceive scrupulosity and nonreligious OCD as mental illness, other community attitudes differed significantly.

Implications for Interventions Within the Orthodox Jewish Community

In this study, a majority of Orthodox Jewish participants endorsed medical (e.g., chemical imbalance, genetic causes) and psychological (stressful circumstance) explanatory models of mental illness, whereas few supported social–religious models (the way he was raised, being too religious, bad character), even when addressing culture-bound, religious OCD symptoms. This willingness to accept medical/psychological models, however, does not obviate the need to address social–religious concerns because both our results and previous research indicate that Orthodox individuals simultaneously endorse multiple explanatory models (Rosen, Greenberg, Schmeidler, & Shefler, 2007; Shaked & Bilu, 2006). Furthermore, particular symptoms may alter these preferences, as evidenced by our finding that Orthodox individuals decrease their support for some medical explanatory models, and increase their support for some social–religious models, when addressing culture-bound, religious symptoms. Consequently, psychotherapy with Orthodox Jews may require integration of religious beliefs and values to address social–religious concerns, enhance motivation, and distinguish scrupulosity from normative community practices (Huppert et al., 2007). Furthermore, like any cultural-sensitive community-based intervention (e.g., Marín, 1993), psychoeducation, outreach, and prevention should explicitly include culture-influenced examples of mental illness, and address

social–religious concerns and values, because attitudes towards these expressions appear to be distinct from those towards other, nonreligious forms of mental illness.

Similarly, although Orthodox participants expressed greater support for psychological/medical assistance than religious assistance in both conditions, many endorsed both categories, suggesting that Orthodox individuals may simultaneously utilize both psychological/medical and religious help (see Coleman-Brueckheimer et al., 2009; Schnall, 2006; Shaked & Bilu, 2006). Furthermore, this relative difference narrowed for scrupulosity because participants given the scrupulosity vignette expressed less support for medical/psychological help-seeking, and more support for religious help-seeking. This may relate to decreased endorsement of medical/psychological explanatory models and increased endorsement of social–religious models (American Psychiatric Association, 2000; Kleinman, 1988); however, explicitly testing explanatory models mediating role in help-seeking attitude changes requires additional research employing continuous measures. In addition, help-seeking for scrupulosity may be influenced by beliefs that mental health professionals are unable to understand or treat difficulties involving religion, or by desires for treatment that is consistent with both Jewish law and values (e.g., Huppert & Siev, 2009; Loewenthal, 2006). In fact, Orthodox Jewish individuals often consult with religious authorities before commencing any medical treatment (Coleman-Brueckheimer et al., 2009), and a rabbinic referral may be a primary pathway to psychological help (Bilu & Witztum, 1993). Therefore, successful culturally competent interventions necessitate the establishment of working relationships between mental health professionals and community religious leaders (Pargament, 2007; Huppert & Siev, 2009). Furthermore, by expanding community research and action to include religious settings and institutions, it may be possible to reach individuals who turn to their religious leaders when distressed (Kloos & Moore, 2000).

In addition, Orthodox participants in our study expressed more stigma towards the hypothetical individual with religious OCD symptoms, as compared to an individual exhibiting clinically equivalent, but nonreligious OCD symptoms. As previously suggested (USDHHS, 1999), this may be related to increased use of social–religious explanatory models and decreased use of medical/psychological models. Furthermore, because individuals with scrupulosity may have difficulty distinguishing compulsions from normative religious practices (Huppert et al., 2007), community members may fear that they have less insight, and are therefore more "unreasonable" than those with nonreligious OCD.

Limitations and Future Directions

This study was limited by the use of an Internet-based recruitment and participation strategy, which may have excluded the more traditional subgroups of Orthodox Judaism, who generally do not access the Internet (Barzilai-Nahon & Barzilai, 2005). Furthermore, although this research examines multiple dimensions of community attitudes, these aspects are clearly interrelated. Untangling these complex relationships requires further research using continuous scales, larger samples, and more precisely defined a priori theoretical models. In addition, to fully explore the implications of culture-bound symptoms, research exploring community attitudes' influence on actual behaviour is necessary.

In conclusion, our findings indicate that Orthodox community attitudes towards scrupulosity differ from attitudes towards nonreligious OCD. We believe that this difference is not at all unique to Orthodox Jews, but represents a widely prevalent

phenomenon. Specifically, attitudes towards culture-influenced symptoms of mental illness may be markedly different from attitudes towards general symptoms within many sociocultural and ethnic populations. Thus, there is a need to examine similar cultural interactions within other community contexts, such as a somatic presentation among Asian Americans (Lee & Stanley, 2000), or "ataque de nervios" among Latino individuals (Lu, Lim, & Mezzich, 1995). Beyond specific implications for Orthodox community interventions, our results demonstrate that attitudes towards culture-influenced expressions of mental illness may differ from attitudes towards other expressions.

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APPENDIX

Scrupulosity Vignette

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

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[1] Translation in parentheses was provided to participants.

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.

Nonreligious OCD Vignette

Binyamin is 19 years old and lives at home while learning at an 'in-town' yeshiva (center for Jewish religious studies). Binyamin has difficulty with his front door. Whenever leaving his house, he thinks that he has not locked the door and he feels compelled to return to his door over and over again to check that it is locked. He also feels unable to leave his home unless he looks over his front windows five times, to check that they are not broken. Consequently, it can take Binyamin an extra hour to leave his house and get to yeshiva, and yet, when he leaves, he is still concerned that his door is not locked. Recently, Binyamin saw a sign in the street warning about open manhole covers during construction. Since then, he has become preoccupied with ensuring that all the manhole covers in the street are closed, that they are lying flat and level with the road, and that there are no gaps between the covers and the holes. Binyamin checks manhole covers whenever he goes to yeshiva and he finds himself worrying about them throughout his way to yeshiva. These worries increasingly consume his daily life and those around him have become concerned.