Client: American Psychiatric Association https://www.psychiatry.org/psychiatrists/cultural-competency/education/stress-and-trauma/jewish-americans

Stress & Trauma Toolkit

for Treating Jewish Americans in a Changing Political and Social Environment

A total of 6.7 million, or 2%, of Americans self-identify as "Jewish." Approximately 80% of this population self-identify as Jewish based on practiced religion (Judaism), compared with 22% who self-identify based on ancestry, ethnicity, and culture.

Jewish people have existed in North America since colonial times and experienced a major population increase between 1800 and 1914 with the influx of Jewish immigrants from Eastern and Central Europe. Another large migration from the Soviet Union arrived starting in the late 1970s.

Anti-Semitism—hostile or discriminatory acts or thoughts towards Jews—has also existed in the U.S. for centuries. Although anti-Semitic incidents in the U.S. have overall decreased since World War II and the 1960s Civil Rights Movement, from 2016 to 2018 there was a 48% increase in anti-Semitic incidents, according to the Anti-Defamation League, a Jewish nongovernmental organization based in Washington, D.C.

The Holocaust, which claimed 6 million Jewish lives between 1941 and 1945, casts a dark shadow over Jews and forms a stark backdrop to recent attacks and group murders of Jews in Pittsburgh, Kansas City, France, Germany and Argentina. These anti-Semitic incidents incite anxiety and posttraumatic stress disorder (PTSD) in some, and for many others, create a sense of insecurity and instability.

The current Boycott, Divestment and Sanctions movement is another source of stress and anxiety for Jewish Americans. The movement, which started in 2005 but has made headlines more recently, calls for countries, businesses and educational institutions to boycott, divest and impose sanctions on Israel until it ends occupation of the West Bank, grants full equality to Palestinian citizens, and recognizes the right of Palestinian refugees and their descendants to return to homes. Some American Jews feel intimidated, or at least conflicted, by this movement which many believe de-legitimizes the existence of the Jewish state, rather than criticizes it.

Anti-Semitism has also emerged in the Women's March that took place on January 21, 2017, to protest the incoming administration's policies on reproductive, civil, and human rights. While Jewish women and groups participated enthusiastically in the first march, many cut ties with the 2019 reprise because one of the march leaders would not disavow anti-Israel remarks and ties to the Nation of Islam and Louis Farrakhan who has repeatedly made offensive statements about Jews and Israel. Bans on Jewish stars at other events is also disturbing to Jewish Americans as a sign of rising (previously latent) animosity towards Jews in the U.S. that goes beyond disagreements with Israeli government.

Clinical Vignette

Ms. A, 29 years old

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Ms. A is a 29-year-old single Jewish post-doctoral fellow in marine biology who was referred for psychiatric follow-up after discharge from a tertiary care medical hospital.

Months earlier, Ms. A had consulted Student Health Services because of weakness and weight loss. The triage nurse attributed her symptoms to depression and put her on a waiting list for psychotherapy. Before beginning therapy, she suddenly lost vision in one eye. She went to the ER and was admitted to the hospital.

When asked about her hospital stay, Ms. A. said her memory was hazy, but she recalled that when the nurse asked about dietary restrictions and Ms. A. requested kosher food, the nurse retorted, "Why would you need kosher food? You don't dress like other people in Brooklyn who eat kosher." Too weak to argue, she told the nurse that even Jews who are not Hasidic (with identifiable garb) sometimes observe Jewish dietary laws and other Jewish traditions.

Ms. A felt unsettled by the nurse's comment but soon had other worries as she received a diagnosis of optic neuritis and was told that her tests suggested systemic disease. Her panic peaked when told that her symptoms might progress and interfere with her teaching fellowship at the aquarium.

When the nurse offered to contact a psychiatry fellow who specializes in psychiatric treatment of people who are medically ill, Ms. A accepted. The psychiatry fellow began by asking about her request for kosher meals. Amy was taken aback when the fellow said, "I'm surprised that a scientist like you follows traditions based on outdated hygienic issues."

At her post-discharge office appointment, she explained that she informed her campus Hillel rabbi of these interchanges. He had referred her to a rabbi with a Ph.D. in pastoral counseling with whom she would continue therapy instead of continuing care through a psychiatrist. Ms. A explained that the psychiatry fellow's dismissive comments pushed her to pursue that path.

Factors that Put Jewish Americans at Risk for Mental Health Problems:

Continued traumatic effects of Holocaust and other oppression: Many Holocaust survivors experience mental health disorders, including PTSD and survivor guilt. Even second and third generation descendants of Holocaust survivors also show a higher prevalence of PTSD and other psychiatric symptoms. Debates about biologically based epigenetic changes in survivors persist, but there is consensus that survivor behavior impacts family dynamics and molds family members' stress responses.

Jewish asylum seekers from the former Soviet Union who endured religious repression under Communism and suffered persecution even after the Soviet Union disbanded, arrived en masse in the U.S. in the late 1970s and onward. Some Soviet-Jewish refugees are "double-survivors" whose families fled Nazi-controlled countries, only to encounter discrimination, harassment and even executions in the Soviet Union and Russia. In America, these refugees have faced acculturation challenges in addition to language and vocational obstacles, leading to feelings of hopelessness, distress and demoralization. Cultural confusion stemming from intermarriage and increasing diversity among Jewish populations. With intermarriage rates as high as 58% among

American Jews (and even higher among non-Orthodox Jews), many self-identified Jews have surnames or appearances that suggest different ethnic or religious affiliations, prompting some other Jews to question their authenticity or employers to deny time off work for Jewish holidays or Shiva. Some spouses who convert to Judaism on marriage feel alienated from their non-Jewish families of origin or unaccepted by the Jewish community. Some children of intermarriages or adoptees are of mixed race and endure both anti-Semitism and racism as well as stress-inducing questions about their identities even from strangers.

Stigma of mental illness in some Jewish communities: Mental illness carries considerable stigma in some Jewish communities, especially Hasidim, a small but growing segment of the Jewish population in the United States. With a tradition of "shiddach" (matchmaking) to arrange marriages, Hasidic families are vetted by the community and by marriage brokers for history of mental illness before making introductions. Members of this community may shun psychiatric treatment, particularly medications, for fear of limiting opportunities for marriage. Those who do seek treatment may choose non-Jewish providers or Catholic hospitals to avoid waiting room encounters with others in the community or name recognition by off-site Hasidic billing services.

Hesitancy to seek psychiatric services or some types of treatment: For various reasons, some Jews who seek help for mental health issues may choose to avoid psychiatrists in general, psychiatrists of certain backgrounds, and some modalities of treatment. Some religious adherents perceive psychiatrists in general are hostile to religion, and therefore may only seek services from psychiatrist who are Orthodox or observant Jews.

The field of psychoanalysis was developed by a group of predominantly Jewish physicians who felt marginalized by anti-Semitism in Austrian society. Jews may be more accustomed to seeking psychoanalysis or psychotherapy and therefore bypass needed psychiatric evaluations to identify possible medical/organic contributors to psychiatric symptoms.

Jewish Americans may have lower rates of alcoholic use disorders than some other populations—with rates of substance abuse for Jews reporting to average around 20%. However, many Jews who do need treatment for substance use disorders may avoid 12-step meetings because of the Christian roots of the program, the common location of meetings in church buildings, and the recitation of the Christian Lord's Prayer in some meetings. Jews in need of treatment—and health professionals referring them for treatment—may not be aware of Jewish Alcohol & Chemically Dependent Persons & Significant Others (JACS) or synagogue-based Alcohol Anonymous (AA) or Narcotics Anonymous (NA) meetings.

Discrimination against and limited opportunities for women in some Jewish communities: Women in some traditional branches of Judaism encounter gender-segregated activities or discrimination that conflict with their own beliefs about the role of women in society and in religion. Jewish women who support defined gender roles and view their primary function as mothers and homemakers may experience anxiety or shame if unable to conceive quickly.

Prevalence of eating disorders: The Jewish community—especially Orthodox women—may be at higher risk for eating disorders and may also face barriers to treatment. Stigma about mental illness as well as a link between thinness and marriage arrangements in some Jewish community

may lead to under-reporting of the illness and delayed treatment. The central role food plays in Jewish culture and religious observations may also complicate diagnosis and treatment. To stem the rise of eating disorders among Jewish and Israeli women an Israeli law passed in 2012 mandates a minimum body mass index of 18.5 for women in the modeling industry to discourage unhealthy weight aspirations. Clinicians treating Jewish women with eating disorders should be aware that differentiating dietary laws or religious fasting from eating disorders requires knowledge of Jewish practices.

Discrimination against same-sex relationships in some Jewish communities: Jews from traditional backgrounds that prohibit same-sex relationships may feel guilt and shame about same-sex attractions or relationships and may feel unwelcome in their families or their families' synagogue. This can lead to feelings of abandonment or alienation. Some may migrate to more liberal branches of Judaism or seek LGBTQ-specific synagogues to practice Judaism, but this may not solve their inter-family issues.

Stress from emphasis on high academic achievement: Jewish-Americans who are not academically inclined or who have learning disorders (such as ADHD or dyslexia) may feel shame or loss of social status in a community that stresses high academic achievement. Difficulties in reading or learning can impede participation in many traditional Jewish rituals and milestones—such as Hebrew school and Bar/Bat Mitzvah—leading parents and children to feel marginalized in their own communities.

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Suggested Assessment and Treatment Recommendations

- Please see Suggested Assessment and Treatment Recommendations for Marginalized Populations
- Take a comprehensive social, cultural and religious history with all patients, including questions such as:
  - Do you identify with a religion/race/culture/ethnicity?
  - Does your family identify with a specific religion/race/culture/ethnicity?
  - How does your religion/culture offer solace in times of stress?
  - How does your religion/culture create conflicts/stress for you?
  - Did you or your relatives ever seek asylum for religious or political persecution?
  - Which holidays do you and your family of origin (or your acquired family) observe?
  - Have you, your family, or your friends experienced direct or indirect threats or assaults related to your religion or cultural affiliation? Do you fear that such assaults could occur?
  - What safeguards are in place to prevent or mitigate such events, should they occur?
  - When inquiring about suicidal ideation, always ask about the role that their religion (and other supports) play in such plans.

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- Screen and assess using appropriate instruments and terminology, asking clarifying questions when appropriate, and avoiding assumptions.
    - Consider the use of validated measures to assess trauma, PTSD, depression, anxiety.
    - Become familiar with the patient's background, attitudes and affiliations, noting that "being Jewish" is defined and experienced differently by different individuals. Some view Judaism as a religion; some identify with "Jewish culture." Attitudes toward Israel vary.
    - Avoid references to the "Jewish race," since the Nazis identified "Jews" as a race.
    - Be aware that official and unofficial Jewish subgroups exist, and that observances vary from subgroup to subgroup, and from individual to individual. Asking about synagogue attendance, community or charity affiliations, dietary observances, Sabbath-keeping rituals, or dress codes help reveal individual attitudes and lifestyle. Note the patient's choice of dress, hat, hair and hemline may not be reliable signifiers of religious affiliation.
    - Be aware that people who are otherwise observant or religious may also engage in sexual practices that put them and their families at risk of serious, undetected sexually transmitted infections (STIs).
- Incorporate the strengths of patients in treatment plan. The following can help empower patients to recognize and gain strength from their religious background.
    - Listen to the patient and validate—rather than devalue—religious or cultural identification and cultural concepts of distress to improve doctor-patient alliance and outcomes.
    - Encourage support from immediate and extended family, friends, and/or community when appropriate.
    - Incorporate religious or spiritual values of patients into the treatment plan when appropriate. Consult a religious leader or pastoral counselor if needed to tailor specific approaches to assessment and interventions.
    - If appropriate for a particular patient, consider discussing how their traditions can combine with or reinforce contemporary techniques that support mental health. For example, traditional Jewish prayer practices that may decrease stress by simulating meditation and adding structure and routine.
- Provide psychoeducation about the potentially protective role of religion in mental health
    - Some Jewish-Americans may had bad experiences in the past with other therapists or health care professionals who looked down on religious beliefs, disagreed with the tenets of Judaism, or even considered adherence to religion to be a mental disorder itself. Alerting patients to your own openness to learn and hear about their religion and to contemporary psychiatry's attitudinal shifts of acceptance to religion can encourage trust, discussion and alliance.
    - Talk to religious patients, including Jews, about how religion can provide strength that can assist in adherence to treatment and protect against suicide.
- Offer medication, if clinically indicated.
    - Prescribe medication as needed and discuss medication use during ritual fasts or Passover food restrictions and address pork products in gelatin (which is sometimes used in medications, especially capsules).

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- Ask questions, avoid assumptions: When it comes to religion, culture, or race, it is best to ask questions rather than making assumptions before offering answers.

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Resources

APA Mental Health: A Guide for Faith Leaders (2015) https://www.psychiatry.org/psychiatrists/cultural-competency/faith-community-partnership

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