Value-Sensitive Psychiatric Rehabilitation

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Abstract  Psychiatric rehabilitation contains value-laden concepts that may be unacceptable to certain cultures and many individuals. The concepts of independence and work are examined in a clash between mental health professionals in charge of national policies in psychiatric rehabilitation in Israel and a rehabilitation center for the severely mentally ill within the ultra-orthodox Jewish community. The government professionals considered that having the living quarters and work site in the same building deemed it unsuitable for rehabilitation, and too few progressed to independent living and working. As such, they ordered the center to be closed. Clients’ families turned to the Supreme Court and the claims and counter claims reveal value-laden positions. The bases for misunderstanding and lack of cooperation between the government professionals and the rehabilitation center are explained in the context of everyday life and values in the ultra-orthodox Jewish community and attitudes in the general population. Fruitful cooperation is based on appreciating core values, identifying and working with the community’s figures of authority, and accepting...
that the role of the mental health professional is to advise the community, within which the professional has no status.

Key words  Israel • psychiatric rehabilitation • religion • severe mental illness • ultra-orthodox Jews

Introduction

The aims of psychiatric rehabilitation are to help people who are impaired, disabled or handicapped by a mental disorder to reach an optimum level of independent functioning in the community (WHO, 1996). This often involves developing the emotional, social and intellectual skills needed to live, learn and work in the community with the least amount of professional support (Rössler, 2006). Both of these definitions emphasize independence and cover a range of domains, including work, social, leisure and self-care activities.

Psychiatric rehabilitation was developed in the Western world. As such, it should be considered whether these definitions are applicable to all cultures and all its members. Deva (2006) has observed that not all aspects of psychiatric rehabilitation are relevant in the developing countries. For example, independent housing and developing social and pastime skills may be less critical for someone who lives with his family, with its busy social, religious and cultural life. In contrast, working in order to add to the family income may be more important to gain acceptance, appreciation and even survival in a society where there are no sickness benefits.

The ideology implicit in psychiatric rehabilitation in the West was stressed by Leighton (2002). Wishing to understand the impasse that occurred when trying to move people with severe mental illness out into the community from a psychiatric rehabilitation unit, Leighton interviewed patients and staff in a hospital in northern England. He concluded that “care on the unit was focused on physical, psychological, familial and socialization issues, and that it did little to address the socio-cultural matters of lifestyle choice, spiritual development, meaning in work, group relationships, or other aspects of personal ideology” (p. 451). Patients expressed a preference to be part of a small group or community, as opposed to the “individualized” approach, that is, independence, that was encouraged in this unit. “Individualized care policy was presented as liberal and objective, but its underlying values were biased towards a materialist-individualist culture” (p. 452). Leighton concluded with a call for more attention to spiritual and culture-sensitive issues, and the provision of more collective options for communal living. More recently, Pernell-Arnold contrasted the limitations of a melting pot as opposed to a multicultural approach to psychiatric rehabilitation and concluded: “we accept that as professionals we must develop the ability to change
perspectives according to the belief system of the consumer we are serving in order to find a solution that fits her life” (Pernell-Arnold, 1998, p. 227).

Recent developments conceptualize psychiatric rehabilitation as a means to promote recovery in severe mental illness. From the above, however, it appears to be an approach with implicit values that may neither be appropriate to all cultures nor suited to all individuals. In this paper, we analyze a clash between government professionals in charge of national policies of psychiatric rehabilitation in Israel and a rehabilitation institution in the ultra-orthodox Jewish community in Jerusalem to investigate the cultural and religious applicability of some of the principles of rehabilitation of the severely mentally ill to a specific religious community. Aspects of ultra-orthodox life are selected to demonstrate features that may not be compatible with the aims of psychiatric rehabilitation.

**THE ULTRA-ORTHODOX JEWISH COMMUNITY: A RELIGION AND A WAY OF LIFE**

The ultra-orthodox are distinguishable from other streams of Judaism in several ways. Don-Yehia (2005) has suggested that there are more types of Jewish identification outside of Israel, while within Israel the main streams are secular, traditional, religious (in Hebrew, *dati*) and ultra-orthodox (*haredi*). These definitions are differentiated by their participation in religious practice and the degree they consider it binding. For the secular Jew in Israel, the laws of Judaism are of little significance or even a nuisance (for example, limited public transport on the Sabbath or the restrictive marital laws). For the traditional Jew, many practices are maintained, especially if they have family or social components, such as the *Seder* supper on Passover or the lighting of candles and blessing of wine on Friday nights. Religious Jews are committed to religious observance, but also participate in the secular world. Religious Jews in Israel usually have a complete secular education, serve in the army and will consider any form of occupation.

For the ultra-orthodox in Israel, the performance of the commandments in the *Torah* is their pre-eminent concern, and the study of *Torah* their highest value (Greenberg & Witztum, 2001). Aspects of secular life are viewed with suspicion as they may have a negative effect on the religious way of life. To preserve its way of life, the ultra-orthodox community lives in separate enclaves, without television, internet and secular newspapers. Ultra-orthodox clothing is distinctive and emphasizes modesty: men wear black suits and white shirts, usually have beards and side curls, women wear quiet colors, long sleeves and below knee skirts, no stockings and do not wear trousers. Married women cover their hair. The ultra-orthodox family places great importance on having children,
and the average family has around eight children (Gurovich & Cohen-Kastro, 2004).

Consistent with the value placed on Torah study, 72% of ultra-orthodox married men in Jerusalem study full-time in kollel (an institute for study of the Talmud for adult males) (DeHaan, 1997). Once the family size increases, women usually have to stop working and stay at home. The wage paid by the average kollel is low, so that with a large family, the average family lives very modestly, usually dependent on the government child allowance. Their apartments are small and crowded. Gurovich and Cohen-Kastro (2004) found the average density of apartments in Israel to be 1.0 person per room, while in ultra-orthodox areas it was 1.4 per room, and in some areas up to 1.9 per room.

The upbringing of an ultra-orthodox child reflects the society’s values. Education is single sex from the age of two. Education includes a small amount of secular material (basic mathematics), which ceases at the age of 13 for boys, although girls continue to study subjects that may facilitate employment. After the age of Bar-mitzva (13 years for boys), mixing of the sexes is largely curtailed until marriage; boys attend yeshiva (an institute for religious study for unmarried males), where they sleep, pray and study in one building away from extraneous influences. If the child studies at a distance from home, door-to-door bussing will be provided.

Marriages are by introduction, and the couple will meet a few times before they decide. Boys usually marry aged 19–23, and girls in their late teens (Gurovich & Cohen-Kastro, 2004). After marriage, the husband will study in a kollel, and the couple will move into an apartment, either rented or bought by their parents. Young men who do not marry will remain in the yeshiva, although as the age gap widens with each influx of unmarried young men, they will feel increasingly uncomfortable. If a couple divorces, a less common event than in the general population, the young man will usually return to his parental home.

Although many ultra-orthodox adults do venture outside their community, the city is viewed in a negative light as a place with values incompatible with ultra-orthodox life. The catchment area of the community mental health center in which two of us work in north Jerusalem includes one of the two large concentrations of the ultra-orthodox in Israel (Gurovich & Cohen-Kastro, 2004).

**Hesed Ve’Emuna Center for Psychiatric Rehabilitation**

As an expression of the importance of the religious commandment to help the sick, there have been religious institutions providing protected employment and hostels for people with severely mental illness for nearly 40 years – well before the beginning of deinstitutionalization and the
development of psychiatric rehabilitation in Israel. These centers had limited facilities, usually a printing press (for men) or a sewing class (for women). The occupational tasks were not varied, but were often supplemented by visits to holy sites and lessons of religious study.

*Hesed Ve’Emuna* (literally, “loving kindness and faith”) opened its doors in 1989. Initially in two rooms for work alone, a hostel followed until they moved into their third and latest facility in 1995. This is a large building in the ultra-orthodox neighborhood of north Jerusalem. Initially a hostel and printing workshop for men in the same building, on acquiring an extra floor, a workshop for women was opened. Today, the workspace for men caters for 55 men, and the upper floor for 62 women. On the site there is a hostel for 28 men, and in nearby apartment blocks there is a hostel for seven women and an apartment of supported housing for another four. *Hesed Ve’Emuna* is directed by a husband and wife who are ultra-orthodox. Neither trained in mental health, the husband was the manager of the first printing press for people with mental illness for 20 years before asking his wife, a headmistress trained in special education, to join him in this venture.

The local community mental health center has provided *Hesed Ve’Emuna* with psychiatric and nursing care from the day it opened. A psychiatrist visits every month, joins the morning prayers, and then sits in an adjoining room where he sees clients. Parents and siblings often join the visit, and the social worker or the work supervisors may join if there are issues to be discussed.

A typical day at *Hesed Ve’Emuna* begins when the night supervisor wakes the men at 06:45. By 07:15 most are entering prayers in the synagogue section at the end of the main work hall. The prayers are lead by a client. At the end of prayers, a client gives a brief lesson of religious study. Breakfast is served by clients, who also clear and wash up. All are at work by 08:30, joined by those who attend the workplace from outside the hostel. The doors of the women’s section open at 08:00. The women’s work area has two areas, one for simple repetitive work, the other – opened at the recommendation of government professionals – a club for creative activities, making decorative objects that are sold. The men work on a range of printing-related activities, mostly repetitive, some on machines. During the week there are hours of music, dance, dieting, sport, Judaica handiwork, religious study, social skills, domestic skills, and individual sessions with a psychologist and social workers.

For most, work stops at 13:00, followed by afternoon prayers. After lunch, for men there are religious studies, not compulsory, until 16:00, while some continue working. In the last years, a program of studying a page of Talmud daily has become popular throughout the religious Jewish world, and eight clients have such a “daily page” group at 17:30. For the others a rabbi gives
a lesson on the weekly Torah portion or upcoming festivals. A local community center provides separate-sex activities twice a week, a choir and a handiwork group. There are weekly outings to museums, concerts, the Western Wall or interesting sites and areas of the city. Every two months, there are full day or overnight trips, and an annual weekend in a hotel, visiting sites of interest, and a separate annual weekend to Meron, the burial site of a famous Kabbalist, a popular “resort” for the ultra-orthodox.

**The Seeds of Conflict**

In its early years, Hesed Ve’Emuna received financial help from the national insurance fund. Supervision was brief and superficial. In 2000, as part of the policy and process of deinstitutionalization of psychiatric care, the government passed a Law for the rehabilitation of the mentally disabled in the community (Roe, Hasson-Ohayon, Lachman, & Kravetz, 2007). Money was allocated, and criteria were defined for the facilities that could provide PR. A wide range of activities were defined to assure that utilization of budgets was compatible with government policy. This required regular inspections of all facilities by teams composed of a range of mental health rehabilitation professions, guided by the criteria. Institutions that did not meet the criteria either made the necessary changes or their financial support ceased.

**The Inspector Calls**

Ever since inspections began, there have been difficulties with certain aspects of Hesed Ve’Emuna: (a) each client must have a specified minimum amount of living space; (b) too few of the clients move on to independent accommodation or employment; and (c) the living and working spaces must not be in the same building. In response to these concerns, the number of clients per room was reduced, and a group sent to work across the city daily. This was not uneventful as the clients, all single ultra-orthodox men, and their families, were upset at their traveling by public transport across the city, which they found unsettling. It was not financially feasible to arrange private transport, which would have been counter-productive to the original aim of “independent living.” However, most of those in the hostel continued to work in the original site, and the officials still found this unsatisfactory, and informed the directors that the center must be closed. At this point four families took the Ministry of Health to the Supreme Court to stop the closure of the center and the transfer of their relatives.

In the lawyer’s letter, the families claimed that transfer would lead to a worsening of their relatives’ mental states following years of progress made
at Hesed Ve’Emuna. They asked: “Considering the special conditions necessary for the ultra-orthodox community, is it reasonable to demand a total separation between the living and working environments? Did the Ministry not consider the impact of the decision to close on the lives of their relatives?”

The issue of ideology and values in psychiatric rehabilitation is remarkable in the written reply to the court by the director of psychiatric rehabilitation of the Ministry of Health, in which the justification for closure is explained:

The main failing was that the organization (Hesed Ve’Emuna) maintained in one building a rehabilitation hostel and an occupational site, contrary to the professional approach and the guidelines of the Ministry of Health. . . According to guidelines of the Ministry of Health, and with the purpose of furthering the good of the rehabilitees and to bring them as much as possible to a normative lifestyle, the situation in which a person lives and works in the same space is untenable. This structure limits the exposure of the rehabilitee to the outside world and his coping with it, including the requirement of traveling to work. In fact, the whole principle of rehabilitative occupation is to simulate a regular work environment and coping with it, which also includes, as mentioned, traveling to work. This purpose is unachievable when the living quarters and occupational site (in this case, the printing press) are in the same structure. Furthermore, this situation encourages the rehabilitees not to leave the structure at all and to remain completely uninvolved in communal life, so that whereas it is obvious that the rehabilitees should be encouraged to interact with the community, a structure in which living and occupational functions are contained together is a hindrance to their rehabilitation.

Among other reasons for its closure, the director of rehabilitation at the Ministry noted:

The rate of progress of the clients from the hostel to protected housing, which is one of the indicators of (effective) rehabilitation, was noticeably lower than the norm. . . We will add that the guidelines that the organization was required to fulfill were formulated by mental health professionals, and their purpose is to further the welfare of the rehabilitee. . .

The Supreme Court judge asked the directors to respond in writing:

Although we never understood the insistence of the Ministry of Health on the separation of the places of occupation and living, and making this criterion more important than all other considerations, we have gone to great lengths and expense to meet these demands, in transferring the main section of the printing press to the south of the city, and have taken architectural advice, with the knowledge of the Ministry, and intend placing the entrances to the two areas on different sides of the building in separate streets.
Concerning the claim that few transfer out of the hostel to more independent living situations:

Professionals in the Ministry are well aware that there are many additional indications for the success or otherwise of any hostel – indications that in the world of the ultra-orthodox have far broader significance than the single indicant brought before the court. Among these indications: number of re-hospitalizations, progress in medication, outcome of occupational program, percentage of those who get up in the morning and go to work. According to all of these, our hostel is among the most successful in Israel. All our rehabilitees get up early every morning for communal prayer, while a representative figure in other hostels is that about 30% get to protected work each day.

The directors close with an emotional and fascinating reply, considering the differing ideologies:

No reason in the world can justify the strange position taken by the Ministry of Health. . . Even if someone in the Ministry of Health is of the opinion that it is of colossal importance that a resident should travel to work, we have no doubt that for the ultra-orthodox community there are criteria for (effective) rehabilitation of far greater import. Integration in a daily schedule that includes communal prayer, study of the “daily page” (of Talmud), communal meals and many other activities – all these are of far greater import than the question of traveling to work.

**The Supreme Court Judge’s Decision: District Psychiatrist as Arbiter**

The Supreme Court judge deferred the closure of *Hesed Ve’Emuna* until a recommendation was sent to the court by the District Psychiatrist of Jerusalem, who is responsible for the standards of all mental health services. The District Psychiatrist convened a meeting of all parties concerned: officials from the rehabilitation department of the Ministry, members of the district office, the directors of *Hesed Ve’Emuna* with staff members, and a representation of consumers: eight family members and three clients. All of the authors attended, one as the psychiatrist accompanying the center since its inception, another as having an interest in culture-sensitive psychiatry. The quotations presented are taken from the minutes of the District Psychiatrist.

At the meeting, one psychiatrist spoke of the need for rehabilitation to be culture-sensitive:

The main claim is that there is no separation between the living and working environment. This may be appropriate for a Western society, but who found it to be applicable to ultra-orthodox Jewish society? I have found no research supporting the need for such a separation. . . Aiming for greater
personal independence is an expectation in a capitalist society, and it is a cultural error to project these values onto clients from other societies. A gap has been shown between the expectations of those who create the criteria and those for whom they are meant to apply. The service must adapt itself to the cultural and religious framework of the client and not vice versa.

After some relatives spoke, one client was given the floor:

I am a resident at Hesed Ve’Emuna, I know the place, I live there. Others speak from somewhere else, but I have the honor to represent the hostel. I have made the most amazing progress; I have been there about two and a half years. I really, really love the place; we have music sessions, prayers, and conversations with the psychologists that restore us to life. I am very satisfied with the place, and I represent everyone there, although others wanted to come. It is our home, and we love it a lot, it is the Garden of Eden on earth, and it is very important to us that the place remains open, for the patient’s good should be above all else.

The subjects selected by a second client are again revealing of what is important in an ultra-orthodox lifestyle:

I am full of wonder at the place, the lessons in Torah, I try to get to prayers on time. The importance of arriving on time, the Torah lessons are very important. I have been there quite a few years and am much improved. There is physical education, the lessons and the prayers, they really help.

Family members described their relatives’ previous lives, whether at home in the shadow of violence and fear, or in a range of rehabilitation centers (where the square meterage per bed was correct) but they just regressed further. One stated: “My brother was at a range of rehabilitation facilities and he did not put on his tefillin (phylacteries, worn for weekday morning prayers) for years and I am sure this upset him.” All were overjoyed at the progress made and the respect for the religious way of life, and were fearful of the proposed closure.

The meeting was followed a few days later by an unannounced visit to Hesed Ve’Emuna by the District Psychiatrist, inspecting the facility, meeting staff and residents. The District Psychiatrist recommended to the Court that the center remains open, with a committee overseeing its future functioning. At subsequent meetings between the rehabilitation officials and center, a list of 12 demands for change was presented and the difficulties are far from resolved.

Outcome Measures

There are many ways to evaluate psychiatric rehabilitation. Two external criteria are presented: the number of hospitalizations and the number of days spent in hospital in the same period before admission to Hesed.
Ve’Emuna compared with the same period after arriving there. Thirty one patients in the men and women’s sections are presently in the care of DG at the community mental health center. One male and three females are living in the community, the remaining 27 (18 males and 9 females) live in the hostels and supported apartments. All are diagnosed as having chronic schizophrenia. Two cases were removed from the sample as unduly influencing the findings: one patient who was discharged to Hesed Ve’Emuna after 20 years in hospital, and was never rehospitalized for over 13.5 years after arriving; a second patient had a three year hospitalization shortly after arrival. He was discharged back to Hesed Ve’Emuna in a very psychotic state, and on reevaluation clozapine treatment was initiated with significant improvement. The sample thus comprises 29 patients, with an average age of 39.0 years (median 32 years, range 22–59 years) who had been at Hesed Ve’Emuna for an average of 73 months. This sample had been hospitalized 2.03 times during the 73 months before versus 0.41 times during the same period at Hesed Ve’Emuna ($t = 3.92$, $df = 28$, $p < .001$) and spent 286 days in hospital before versus 11.2 days in hospital after entering Hesed Ve’Emuna ($t = 3.22$, $p < .005$).

This type of data has certain limitations. The sample consists of those still in care, which may select the successful cases. However, the drop out rate from Hesed Ve’Emuna is very low. Further, comparing pre and post arrival at Hesed Ve’Emuna may be argued not to be a fair comparison, favoring a positive result as the patients are likely to have been in a poor condition prior to referral. Other variables may have influenced the results, such as changing policy on length of hospitalization. However, it may be argued that a stay in Hesed Ve’Emuna has no advantages over being at home or in an alternative rehabilitation framework.

The sample was asked about the facilities for religious observance (organized and individual prayer, religious study, dietary requirements [kashruth], modesty in dress and behavior) at the center in contrast with where they had been before arrival. Of the 31, about one-third (11) had lived at home with their family, two had been in an ultra-orthodox foster family, four had been in a hostel, and 14 had been in hospital prior to coming to Hesed Ve’Emuna. Twelve of the 13 who had been at home or in a foster family experienced no difficulties in maintaining their level of observance in either setting. One was critical of the standards at Hesed Ve’Emuna, explaining: “I am used to stricter standards in Judaism,” complaining that some women at the center wash dishes on the sabbath and some wear pajamas with trousers, while she only wears a night dress as trousers are considered male apparel. One patient who had previously lived in a mixed-sex hostel described sitting alone in her room as men and women sat together in the salon. While she now prays and studies daily, she had done neither at the mixed hostel.
Ten of those transferred from hospital had experienced difficulties in the hospital. All but one noted no opportunities for communal prayer in hospital, and praying alone was uncomfortable (“I took my tefillin and prayed outside,” “They stared at me when I prayed,” “I was told off for praying at the time of a group meeting”). Sabbath observance was particularly difficult as the TV was on (noted by four), one commented: “It was hard enough to get wine for Friday night Kiddush!” (at the start of the Sabbath, a blessing is said over a cup of wine). As was noted earlier, televisions are forbidden in ultra-orthodox homes, and electrical appliances are not turned on during the Sabbath. Four women had been upset by male patients starting conversations with them. One reported it to her father who arranged her transfer to a hospital with separate-sex wards the next day. One recounted that she was touched in “all sorts of places” while indicating her breasts. One patient was very pleased with the relaxed religious atmosphere in the hospital as it gave him the impulse to be less religious that he had been seeking. Born ultra-orthodox, he continues to live and work at Hesed Ve’Emuna, and has stopped attending prayers and religious studies.

Discussion

The issues arising in this presentation are not unique to psychiatric rehabilitation. In discussing three cases from the ultra-orthodox community in psychotherapy, Heilman and Witztum (1997) stated: “The therapist must pursue a therapeutic strategy that is sensitive to the patient’s values, even when this seems to oppose commonly accepted therapeutic approaches, so that patients do not emerge from the encounter having not only been healed but also ‘converted’ to a new set of values that undermine a sacred or social order that matters deeply to them” (p. 523). Kirmayer (2007) describes the basic differences in the concepts of person and the goals of psychotherapy in varied cultures and, while contrasting North American psychotherapy with Naikan psychotherapy in Japan, in which gratitude towards one’s parents are emphasized, he adds: “It is hard to imagine a similar decentering of the individual meeting widespread acceptance in contemporary North America, although, in a return to Biblical individualism, there are religious communities that certainly encourage such a reorienting of the self to duty and obligation” (pp. 249–250). An awareness and sensitivity towards cultural values are critical for effective interactions in all helping professions, and particularly in the area of mental health (Kleinman, 1988). In the following discussion, the main difficulties in applying psychiatric rehabilitation to the ultra-orthodox Jewish community will be presented.
The Primacy of Work or Torah Study

A dispute in the Talmud weighs the relative importance of work and the study of Torah and concludes whenever “the study of Torah was the main occupation and one’s work was treated as temporary, both succeeded, while if one’s work was the main occupation and one’s Torah study treated as temporary, then neither succeeded” (Babylonian Talmud, Tractate Berachot 35b). This dispute presents a fundamental attitude of the ultra-orthodox community: faith in God and Torah study are of overriding importance, while work is but a necessary feature of life.

It would appear that the two central concepts of psychiatric rehabilitation stressed by the Ministry officials, independence and work, may be perceived and valued differently by the ultra-orthodox in comparison with the dominant secular culture. The average ultra-orthodox single male does not move out of a dormitory unless he marries. If he is expected to remain dependent, it then appears culturally inappropriate to expect a single person with severe mental illness to strive for independence.

An important justification for the insularity of the ultra-orthodox lifestyle is an avoidance of temptation. This is particularly so for the single male, who spends his adolescence in an all-male environment and is encouraged not to talk to women. Indeed, even married men should limit their conversation with their wives (Greenberg, Stravynski, & Bilu, 2003). Premarital relations are forbidden, as is masturbation, and some even try to “guard their eyes,” meaning that they will not even look at women in the street in order to overcome temptation. To facilitate this abstinence, even married men will be bussed to their place of studies if it is far from their home, so that a single male with severe mental illness should not be expected to accept the value of “traveling to work.”

In most ultra-orthodox families, the father will remain in full-time study all his life, and his sons will follow his example. Only someone unable to sit and study will be grudgingly allowed to work, and even then this is usually deferred until after marriage and the birth of children, so as not to damage the marriage prospects of other siblings and avoid the necessity of army service. In these circumstances, work is neither a normative activity, nor is working to earn a living a particularly valued behavior.

Even the matter of the sharing of rooms is seen to have a different norm in ultra-orthodox life. Ultra-orthodox children spend their unmarried lives sharing rooms with their same-sex siblings or fellow students, and grow up in a densely populated environment. For example, an ultra-orthodox couple with eight children living in five rooms, the standard family size and apartment density noted by Gurovich and Cohen-Kastro (2004) will mean that four children share a modest-sized bedroom. The
government professionals were insisting on a detail uncharacteristic of the society they were treating.

**Ideology and Psychiatric Rehabilitation**

We assume that the professionals responsible for the provision of psychiatric rehabilitation to the community at large are aware that different communities have different needs, and are seeking to provide what is best for each individual with severe mental illness. Rehabilitation is perceived as a continuum, with its aim to ensure that people with severe mental illness do not remain in hospital and achieve their optimum level of functioning. If work is not valued by the community, yet full-time religious study is not possible, appropriate goals of rehabilitation must be developed. If independence is inappropriate in a single male, then it is important to consider how to motivate a person with severe mental illness from the ultra-orthodox community.

Two years ago, aware of the poor relations between the ultra-orthodox community and the rehabilitation services, a government professional responsible for local rehabilitation services arranged a series of meetings. To each meeting a senior figure from the community was invited. However, each meeting began with a long presentation from the professional, with little time left for discussion and exchange. The government professional, acting in a way consistent with majority cultural attitudes, saw their position as one of imparting the news, with no need to listen. At this moment an important opportunity was lost. The ultra-orthodox society is hierarchical, and while professionals may be highly appreciated, this does not place them on the hierarchy, which is for insiders. The government professionals, like ourselves in our function as community psychiatrists, are useful, our knowledge is valued, but we do not have status. Our role, then, is to work with people from the community (Pernell-Arnold, 1998), learn their goals, and establish ways of working together – while accepting that it is the community’s rabbis, teachers and parents who have positions of influence. Our role is to educate and facilitate, but a role of limited power must be accepted by professionals for there to be effective collaboration. As professionals, we can advise but must appreciate we are outsiders. This perception of an essentially subsidiary role was expressed by Sims et al. (1998): “Psychosocial rehabilitation practitioners accept that the solutions to problems are to be sought within consumers, their families, and their cultures. Alternatives identified by practitioners are to be offered as supplementary or educational” (p. 221).

Psychiatric rehabilitation by the ultra-orthodox in Jerusalem was begun four decades ago by a spiritual leader of the community, Rabbi Osher
Freund. He had a deep connection with the suffering of the mentally ill, and brought a message of hope and value. Although he died some years ago, his work continues, his followers perpetuating his ideas. It is important to sit with these community workers and understand their aims. As a positive example, the suggestion of a club for creative activities was presented by government professionals to Hesed Ve’Emuna and adopted with enthusiasm, very suited to the model of behavior of a modest but creative Jewish woman.

What then are appropriate goals for psychiatric rehabilitation in the ultra-orthodox community? Much can be gained by listening to the clients at Hesed Ve’Emuna. Those who progress emphasize the satisfaction at getting up on time for prayer, often overcoming compulsive pre-prayer ablutions so that they arrive at the beginning of the service. Saying the complete prayers gives a sense of achievement and normalcy. One client usually recites Psalms at the end, and collects money for charity during the prayers, another gives a brief Torah lesson after the prayers. Despite what has been written here, many are happy when they are able to work. It is notable, however, that the type of task most often mentioned positively is one with an interpersonal aspect: being a messenger, working closely with a supervisor they admire. The women’s department has established a connection with a local store that sells inexpensive articles to the poor. Women who have progressed start to work in the shop, and receive a small wage. In all these activities, the rehabilitees feel they are doing charitable work, fulfilling a commandment (mitzvah).

The hours of study are a source of great satisfaction; the clients appreciate the scholars who study with them, the sense of achievement with the “daily page,” but most of all as it is a mitzvah, fulfilling one of God’s commandments, the purpose of ultra-orthodox religious life. Extracurricular activities have been encouraged by the center: the diet group to counter the risk of weight gain from atypical anti-psychotics, physical exercise, a choir that sings entirely religious songs (the women’s choir will only sing to an all-female audience).

Families are very important in ultra-orthodox life and in the work of Hesed Ve’Emuna. The staff maintains close contact with parents and siblings, and clients regularly spend Sabbaths and religious holidays with their parents and siblings. In the ultra-orthodox life style with large numbers of siblings, weddings, births, and funerals are frequent and important events. As marriage and procreation are a mitzvah, the weddings of siblings and nephews and nieces are often moments of great joy and personal sadness. Staff often accompany the clients to these events so that they can, on the one hand, participate as a regular family member, but leave with the staff if they find the situation becomes difficult for them. Family members regularly attend the monthly meeting with the attending
psychiatrist, eager to give their impressions and understand changes in treatment.

It is important to realize that it is the encouragement of spiritual leaders, parents, siblings and staff of Hesed Ve’Emuna, all ultra-orthodox, that give value to the activities that advance the lives of the clients (see principle 9, p. 222, Sims et al., 1998). The Mishna states: the world stands on three things: Torah, service, and charity (Ethics of the Father 1:2). Work and independence are not represented here. The first foundation of ultra-orthodox life is the study of Torah. This is severely affected by mental illness so that normative yeshiva study is not possible. This does not completely rule out any form of study, and its primacy must be appreciated. Service refers to the Temple sacrifice, and today means the performance of prayer, observance of the Sabbath and festivals. Charity here represents the entire gamut of interpersonal behavior. To be effective with ultra-orthodox clients, psychiatric rehabilitation must appreciate and live within this structure.

**Antagonism and the Ultra-Orthodox**

This presentation arose out of a clash between government mental health professionals and an institution for psychiatric rehabilitation. One of the government supervisory committees visited Hesed Ve’Emuna at a time when one of the authors was present. Although for years women from the ultra-orthodox community have trained as social workers, none of the members of the supervisory committee was ultra-orthodox. All were confident they knew a lot about the community, although few had first-hand clinical experience. In a discussion about working outside the center, it was pointed out that such work is not a highly valued behavior. One of the committee responded with authority: “Nowadays men in the ultra-orthodox community go out to work, just as many of them are beginning to serve in the army.”

Israel is a country with no shortage of conflicts. Many non-ultra-orthodox people are very concerned at the growing population of ultra-orthodox, who have large families and on the whole do not work or serve in the army. For the members of the dominant secular culture these are worrisome and even infuriating issues, as the non-ultra-orthodox see themselves as financing and risking their lives to defend a growing minority. As a result of the large ultra-orthodox community in Jerusalem, it is the poorest city in the country. The central issue of the elections for the Jerusalem municipality in 2008 was whether the city can be led by an ultra-orthodox mayor, who would look after his own followers, while there was a continuing deterioration in the facilities for the rest of the community, including employment, housing and culture.
It is unlikely that people from the dominant secular culture have come to terms with the thoughts and emotions aroused by these issues before the professional meetings described here. However, it would seem that a forum aimed at helping people undergoing psychiatric rehabilitation is not the place to vent such weighty sociopolitical issues. Effective psychiatric rehabilitation will require leaving personal opinions and feelings for other occasions (Sims et al., 1998).

**Implications for Future Planning**

As occurs in most countries, psychiatric rehabilitation services in Israel were developed for the majority secular culture. This article has focused on the unique aspects of the ultra-orthodox community, including features that clash directly with aspects valued by secular professionals, such as independence and work. The main pitfall has been that the initiative and control over the development of psychiatric rehabilitation for the ultra-orthodox have not been the property of the community. Our own experience as mental health experts has shown us that the community sees great value in the provision of rehabilitation services. The government authorities should approach the community’s committed workers and religious authorities, understand their aims and concerns, utilize professionals from within the community, and find ways of working together based on common goals.

**Declaration of Conflicting Interests**

DG and EW are community psychiatrists. Neither is employed by Hesed Ve’Emuna, nor have they received any form of benefit from them. DG is indirectly, and EW directly employed partially by the Ministry of Health. MK is the District Psychiatrist of Jerusalem, employed by the Ministry of Health. None are ultra-orthodox.

**References**


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