**Non-Haredi Art Therapists' Perceptions of Therapy in Ultra-Orthodox Children**

**Abstract**

Studies have underscored the complexity of the encounter between ultra-Orthodox society and psychotherapy, as well as the challenges involved in developing a therapeutic relationship in cross-cultural therapy. However, there is scant research on therapy for ultra-Orthodox children, especially when it comes to art therapies that take place in an cross-cultural setting. The current study examined the perceptions of 17 art therapists (including visual art therapists, dance/movement therapists, psychodramatists, music therapists and bibliotherapists) who are not ultra-Orthodox, and who currently work or have previously worked with ultra-Orthodox children. Semi-structured interviews were conducted with the therapists and analyzed using the principles of consensual qualitative research.

The study covered four domains: 1) perceptions of the significance and objectives in treating ultra-Orthodox children; 2) the influence of the cultural difference between therapist and client on the emotional experience and the therapeutic relationship; 3) the use of art in therapy; 4) systemic aspects. The study’s findings emphasize the influence of cultural differences on cross-cultural art therapy in ultra-Orthodox children. It would appear that this kind of therapy involves dealing with perceptual and values-based disparities, which makes the endeavor highly challenging for all participating parties. Nevertheless, the study’s findings also point to some advantages stemming from that very same cultural difference between patient and therapist, as well as the inherent advantage of art as a medium allowing for psychological externalization. The study’s findings likewise attest to the multifaceted process of change that is taking place within Haredi society in its attitude towards psychotherapy in general and art therapy in particular.

**Introduction**

Haredi Jews are a distinct segment within Jewish society in Israel and in the world, representing the most ultra-Orthodox factions of Judaism. Haredi society is extremely traditionalist, collectivist, and patriarchal, conducting itself as a closed community with emphasis on faith in God, strict obedience to Jewish law, and staunch loyalty to the community (Freund & Band-Winterstein, 2017; Nadan & Ganz, 2018). Even though Haredi society is composed of different groups (Zicherman & Kahaner, 2012), it is possible to establish a clear system of values common to all of them, such as adherence to religious norms and decrees alongside resistance to a secular lifestyle (Freund & Band-Winterstein, 2017).

The present research examines the perceptions of non-Haredi art therapists regarding work with children from the Haredi community. This kind of therapy is defined as cross-cultural therapy, a term that points to the significant influence that the cultural difference between the different parties has on the process (Fung & Lo, 2017). The client’s system of cultural beliefs affects their self-perception, their expectations from relationships, their willingness to expose their inner self, as well as their perception of the treatment and its objectives (Cross & Blomer, 2010; Fung & Lo, 2017). Patients from different cultures may have different ways of expressing distress, or even different ways of understanding the source of their distress and how it might be alleviated (Fung & Lo, 2017). Likewise, cultural beliefs regarding the subject of mental illness and health sometimes lead to the development of a stigma, which presents an obstacle and amplifies the feelings of shame attached to experiencing mental distress and seeking treatment (Cross & Bloomer, 2010; Gopalkrishnan, 2018). A patient’s traditionalist-collectivist cultural background may present significant challenges in the course of treatment, since the Western system of cultural values underlying the practice of psychotherapy is fundamentally different from the traditionalist system of cultural values (Qureshi & Collazos, 2011).

Studies examining psychotherapy in Haredi society show that despite the progress in terms of openness to psychotherapy and the validity of receiving aid from outside the Haredi world (Freund & Band-Winterstein, 2013), there is still noticeable ambivalence, suspicion and hostility towards external sources of mental health support (Freund & Band-Winterstein, 2017; Popovsky, 2010). These attitudes are sometimes reflected in a restricted ability to cope with doubts, a hard time engaging in introspection (Hess & Pitariu, 2011), and an expectation that the client will be provided with practical recommendations (Hess, 2018). Furthermore, the fact that the community occupies such a central position in the life of the individual may undermine the very legitimacy of focusing on one’s individual identity (Freund & Band-Winterstein, 2017; Schlesinger & Russo-Netzer, 2017). It may also lead a client to be unwilling to expose hardships or cooperate during therapy due to fears of harming their own or their family’s social status within the community (Barth & Ben-Ari, 2014; Greenberg & Witztum, 2013). On the other hand, other studies suggest that the therapist’s provenance from outside the community may increase the patient’s sense of trust and engagement due to the decreased possibility of exposure within the community (Freund & Band-Winterstein, 2013; Stolovy, Levy, Doron & Melamed, 2012). In the case of child therapy, the parents’ involvement can give rise to significant challenges stemming from their sense of responsibility for the child’s spiritual and religious upbringing (Schnitzer, Loots, Escudero & Schechter, 2011).

The complexity involved in the Haredi individual’s encounter with therapy may be especially high when it comes to art therapy. Beyond the fact that there are multiple Halachic ordinances restricting the practice of various art forms, the Haredi community tends to perceive art as a means of cultural, spiritual and moral education; the possibility of using art as a language to express one’s inner world, on the other hand, remains fairly limited (Sari, 2013; Sperber; 2010).

Nevertheless, art therapy exists in the Haredi community, and has in fact been increasing in popularity in recent years. Research on the subject, however, is still extremely scant and consists exclusively of studies that focus on therapy by means of visual art (Padolski-Kroper & Goldner, 2020) and dance (Souskin & Carnieli, 2015). These studies indicate that Haredi society views art therapy as a less legitimate form of therapy, because they consider it less practical or constructive. Moreover, this kind of therapy expects patients to engage in playfulness and creative expression, things that Haredi patients find difficult and which make them nervous about the possibility of losing control and exposing themselves. At the same time, it would seem that having recourse to art in therapy makes it possible to bypass the patients’ defense mechanisms and allows them to express emotions through externalization (Padolski-Kroper & Goldner, 2020).

In light of the paucity of research on the subject, the current study sought to conceptualize the therapeutic act in cross-cultural art therapy for Haredi children by examining the experiences and perceptions of art therapists from outside the Haredi community.

**Methodology**

**Design**

The present study was conducted in accordance with the qualitative research approach, which places the focal point of research on the participants’ experiences and perceptions with the aim of describing and explaining phenomena from their subjective points of view (Creswell, 2014; Denzin & Lincoln, 2013). As dictated by the principles of qualitative research, data was collected by way of semi-structured in-depth interviews which made it possible to identify the ways in which participants perceived or experienced a phenomenon (Parahoo, 2006), while also revealing the complexities of their descriptions (Miller & Crabtree, 1999). Qualitative research is a common method of conceptualizing the knowledge accumulated by clinicians working in a given field in order to form a theory (e.g., Daly & Mallinckrodt, 2009; Edwards & Kennelly, 2004), especially in fields that are relatively new in the academic research arena, such as the field of art therapy (e.g., Gerlitz, Regev, & Snir, 2020; Klein, Regev & Snir, 2020).

**Participants**

The study’s sample consisted of 17 art therapists between the ages of 31–62 (M=43.52), who are presently working or have previously worked with children from the Haredi community. All the therapists were non-Haredi women, most of them secular with the exception of three participants who identify as Religious Zionist. Their areas of specialization consisted of: dance/movement (six therapists), bibliotherapy (four therapists), visual arts (three therapists), psychodrama (two therapists), and music (two therapists). The demographic data pertaining to the participants are detailed in Table 1. The information is presented in purposefully broad terms (age is presented in terms of decades, professional experience in terms of five year ranges) in order to give an overview of the participants’ demographic characteristics without allowing for their identification.

Table 1. Demographic details of the art therapists

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| --- | --- | --- | --- | --- |
| **N.** | **Specialty** | **Age** | **Experience treating ultra–Orthodox children** | **Religious outlook** |
| 1 | Dance | 31–40 | 1–5 | Secular |
| 2 | Dance | 31–40 | 1–5 | Secular |
| 3 | Dance | 31–40 | 6–10 | Secular |
| 4 | Dance | 31–40 | 1–5 | Secular |
| 5 | Dance | 51–60 | 6–10 | Secular |
| 6 | Dance | 51–60 | 16–20 | Secular |
| 7 | Bibliotherapy | 31–40 | 1–5 | Secular |
| 8 | Bibliotherapy | 31–40 | 1–5 | Secular |
| 9 | Bibliotherapy | 41–50 | 16–20 | Secular |
| 10 | Bibliotherapy | 51–60 | 1–5 | Secular |
| 11 | Visual arts | 31–40 | 6–10 | Religious Zionist |
| 12 | Visual arts | 51–60 | 11–15 | Secular |
| 13 | Visual arts | 61–70 | 21–25 | Secular |
| 14 | Psychodrama | 31–40 | 1–5 | Religious Zionist |
| 15 | Psychodrama | 41–50 | 1–5 | Religious Zionist |
| 16 | Music | 41–50 | 1–5 | Secular |
| 17 | Music | 51–60 | 26–30 | Secular |

**Procedure**

Participants were recruited by means of the snowball sampling method. Initially, the lead researcher contacted therapists who had worked at a therapy facility designated to treating members of the Haredi community in the North of Israel, nine of whom agreed to be interviewed for the study. In the second phase of recruitment, several of the therapists who had been interviewed put the lead researcher in touch with other therapists who had worked at the clinic in the past. The researcher contacted these therapists and four of them agreed to join the study. Later the lead researcher contacted four more therapists working in other regions in Israel.

**Data collection**

The semi-structured interviews used in the study were written by the first author of the present article, who is likewise an art therapist. The author had no previous personal or professional interactions with any of the study’s participants. The author utilized an interview guideline consisting of open-ended questions to interrogate the therapists about their general perceptions regarding the practice of art therapy with Haredi children. The interview’s focal points included the participant’s outlook on therapy objectives, specific issues and challenges, the effects of cultural differences on the therapy and the therapeutic relationship, and the role of art in the course of treatment. As part of the effort to streamline the process, the interviewer used probes such as asking the therapists to give examples and repeating the participants’ answers in her own words. Having introduced herself, the first author asked the participants a few background question, then continued on to the main research questions. The interviews took place between October 2019 and March 2020. Each interview took approximately one hour. Eleven of the interviews were conducted face to face, and the remaining six were conducted via phone. With the participants’ consent, the interviews were recorded and transcribed, and once all the participants were interviewed, the transcriptions underwent data analysis and processing.

**Data analysis**

The study applied the protocols and data analysis principles of Consensual Qualitative Research (CQR), which is based on phenomenological elements with the aim of conducting an in-depth examination of the participants’ subjective experiences and perspectives, while striving to paint an overall picture that is consensually agreed-upon by the research team (Hill, 2015). In accordance with the precepts of the CQR approach, data processing was conducted in three stages. In the first stage, three interviews were analyzed separately by each member of the research team, all of whom are art therapists themselves, with the aim of identifying the central fields of investigation emerging from the data for each of the interviews separately. At the end of this stage of analysis the researchers came together to compare their findings and reach a consensus concerning the definition of the central fields of investigation for the three interviews (cross analysis). Following that, the lead researcher analyzed the rest of the interviews while categorizing the data according to the consensually agreed-upon fields and adjusting as necessary based on the new materials. In the next stage of analysis, the research team went over the materials that had been categorized under each field separately, defined core ideas for each field and then assembled to discuss in order to reach a consensus.

The prevalence of the core ideas is defined on a three-tier scale: the term “most therapists” is used to describe a phenomenon that was identified in 75% of all interviews, that is to say, it was expressed by 13 therapists or more. The term “some therapists” describes a prevalence of 25%–75%, that is to say, the idea was expressed by 5–12 therapists, and the term “a few therapists” describes a prevalence of less than 25% of cases, that is to say, 4 therapists or less (Hill, 2015).

**Ethics and privacy**

Both the researcher contacting the therapists and the consent form they were asked to sign explicitly stated that the therapists were not obligated to participate in the study and that they were free to withdraw from it at any stage. Furthermore, they were promised that their identity would remain confidential throughout the study and the publication process. There was particular emphasis placed on protecting the privacy of the clients, and the therapists were instructed to give only general and anonymous examples. Any identifying details were redacted in the interview transcription stage and the recordings were destroyed at the end of the transcription process. The present study was approved by the ethics committee for the Faculty of Social Welfare and Health Science at the University of Haifa.

**Findings**

**Perceptions of the significance and objectives in treating ultra-Orthodox children**

**The overall perception of therapists treating Haredi children is that it is no different from treating children from outside Haredi society.** Despite the unique specificities of this population, most therapists claimed that administering art therapy to ultra-Orthodox children is in large part similar to administering art therapy to children in general. While recognizing their particularity, the therapists found it important to underline that the clients’ being children is more important and central than the culture in which they were brought up: “The conduct of Haredi children is singular and very culture-dependent. However, in general, they’re just children like any other.” Some therapists described common therapeutic objectives that in their opinion were not necessarily typical of Haredi children, and some even specified that they don’t see a significant difference in the therapeutic objectives they set when treating Haredi children as opposed to non-Haredi children.

**The therapists did identify unique objectives in treating Haredi children which are influenced by cultural factors.** Notwithstanding the statements above, most therapists identified a few objectives which they perceive as specific to administering art therapy to Haredi children. One main objective which emerged from some of the interviews focused on bolstering the child’s self-expression. This objective revolves around developing the ability to express the self, including encouraging flexibility and broadening the child’s range of reactions to include ones that do not stem from cultural norms or are even opposed to them, such as refusal: “To allow another kind of expression, to allow me to connect to what it is I’m feeling.” The therapists expounded that children from ultra-Orthodox society often find it difficult to be authentic, to express thoughts and feelings as individuals in the context of strict cultural norms: “It is very hard for them to talk about the self…they can talk about themselves in the space of their school, about what happened that day, but not about how they felt or what they thought.”

Another objective that came up in the statements of some therapists touched on the need to develop and evolve the children’s emotional vocabulary. According to these therapists, in many of these children’s households, especially ones that belong to certain ultra-Orthodox factions, the language of emotion is either impoverished or lacking entirely: “You can feel that there is no validation at home of the experiences the child is going through… the overall impression is that the whole mode of conduct at home is very technical.” As a result, Haredi children often display difficulties in recognizing and expressing emotions, especially complex emotions such as jealousy. The children, especially ones of primary school age, tend to express themselves through their behavior rather than talking about their feelings, a blockage that manifests itself in behavioral problems: “When there is no emotional vocabulary and it’s hard for me to express and say how I feel, that’s where the problem starts. The child acts out the thing rather than speaking the thing.”

Some therapists referenced growing up in a large family as a dominant cultural attribute which affects other therapy objectives. Thus, for example, one objective linked to the fact of growing up with multiple siblings is dealing with the feeling of inability to handle the responsibility of taking care of younger brothers and sisters. Another objective is dealing with problems of wetting or soiling themselves as a result of the social acceptance of late toilet training, which possibly stems from the parents’ inability to toilet train when there is a large number of children in the house and they are preoccupied with household maintenance tasks. The therapists underscored the significance of therapy in this context as an opportunity to provide the child with exclusive and undivided attention: “To give them a warm place where the child can feel themselves again, which is hard when there are so many children at home.”

A few of the therapists shared their perception of bolstering the child’s ability to make choices as being an important therapy objective. These therapists suggested that the children’s incapacity to choose is likewise due to the realities of living in large families from a low socio-economic background: “They might say – I’ll take whatever there is… Because a lot of the time there is nothing, or they have to share with a lot of other children.” Moreover, the therapists insisted that children in Haredi society have a strong need to please which is most likely developed by their upbringing: “The desire to please is there all the time. That’s how they are raised.”

A few of the therapists also mentioned working on anxieties in general and on Obsessive Compulsive Disorders (OCD) in particular as an additional objective. These therapists claimed that the anxieties have to do with the feeling of inability to uphold the strict precepts of religious law: “They have very severe anxieties around the whole subject of upholding the Halachot and the Mitzvot.”

**Perceptions of art therapy and its significance in the eyes of Haredi society.** When the therapists were asked to describe the manner in which, in their opinion, art therapy is perceived in Haredi society by parents, educators and rabbis, their responses yielded quite a few contradictions and disparities. Some of the therapists agreed that there has been a vast improvement over recent years in terms of the willingness and desire to participate in therapy, both in the context of educational frameworks, and in private clinics and institutes. The therapists described a certain degree of respect accorded to the therapist, who is perceived as a professional, and mentioned that rabbis too seem to have a greater understanding of the importance of therapy, and their opinion has an influence on the disposition of the Haredi population as a whole: “Today there is a kind of understanding that therapy is not just for crazy people, there is an understanding that, especially for children, it does them good.” Nevertheless, a few of the therapists argued that the stigma of receiving therapy is still widespread, since it attests to the person or the family suffering a deficiency: “It is a great shame to go to therapy, it means that there’s something wrong with you.” These therapists also implied that even when there is a certain willingness to receive therapy, there is still a staunch objection to psychiatric evaluation.

A similar disparity arose in relation to the Haredi population’s understanding of the significance of therapy, with a few of the therapists claiming that despite a willingness to receive treatment, those seeking treatment do not have a good understanding of what the treatment entails. Others, on the contrary, opined that today there is a greater understanding of the meaning of therapy, and that some clients even have clear objectives and requests pertaining to coping tools when they come in for their first session. These therapists claim that sometimes parents bring their children to therapy with the expectation that it will solve all of the child’s and the family’s problems: “Just straighten out some of the kinks in their kid for them…they want you to fix their child.” According to them, the parents demand quick solutions for the therapy objectives that drove them to send their child to therapy, and if the desired results fail to be obtained, they seek to understand the kind of work that has been done in the course of therapy. The therapists were divided among themselves with regards to the ability of parents to perceive therapy as a process, however, most therapists expressed encountering difficulties in this respect: “There is a great desire for some kind of recipe that would explain how things are or what’s working, and less of a willingness to understand that it’s a process.”

In describing the perceptions of the significance of therapy among Haredi educators, once again opinions were conflicted. Thus, alongside descriptions of narrow and dogmatic outlooks that focused on the direct benefits of treatment, there were also perceptions of a great deal of appreciation accorded to the therapists’ work.

**Therapy referral entities and reasons for referral in the eyes of Haredi society.** In talking about therapy referral entities, a few of the therapists underlined the fact that most parents do not seek treatment for their children of their own initiative, but rather following the suggestion of educators – school and kindergarten teachers, or rabbis.

The main reason for referral which came up in some therapists’ statements was social problems, such as introversion and loneliness. There are even cases where the parents insist on focusing on social problems despite the background presence of far more complex issues such as severe sexual abuse. It is manifest that the parents find it very important for their children to fit in well socially, which the therapists consider largely the result of the community being central to the life of the Haredi individual: “The issue of being really well adjusted socially is very strong for them… the importance accorded to how you are perceived is very much magnified.”

Another principal cause of referral mentioned by some therapists had to do with learning deficiencies, attention and concentration deficits, and difficulties with organization, which are often accompanied by outbursts of anger, violence and lack of emotional control. The therapists described the great deal of pressure parents put on their children with regards to their scholastic achievements, and added that often times parents turn to therapy following displays of behavior that they perceive as abnormal and disruptive to the child’s studies: “The idea that the child has to behave properly when it comes to school… there is much more stress placed on that on the family level.” Nevertheless, a few of the therapists described parents who focus on the child’s emotional wellbeing even in children with attention and concentration disorders, and seek to bolster the child’s confidence: “I have a few kids who are attention and concentration deficient, but the parents bring them to therapy because they want to raise their confidence.”

One cause of referral particular to this population, which was mentioned by a few of the therapists, was behaviors that were incompatible with the rules and norms of Haredi society, such as modest dress, respecting one’s parents and elders or upholding the Halacha: “They want good kids who do as they should.”

Most therapists claimed to often notice disparities between the therapy objectives as they perceive them as opposed to the perception of the parents. However, it would seem that in most cases, the therapists place the parents’ perceived objectives at the center of their work, and either hold off on working on their own perceived objectives or work on them indirectly, while maintaining a realistic perspective on the practical reality to which the client returns at the end of the therapy session: “I can’t open up big gaps because at the end of the day they go back to their parents…it would be irresponsible of me.”

**Influence of the cultural difference between therapist and clients on the emotional experience and the therapeutic relationship**

**Cultural disparity as an opening for candor including revelation of secrets.** Most therapists addressed the influence of their non-belonging to Haredi society on the willingness of the children and the parents to reveal things about themselves. Some therapists talked about parents and children sharing experiences and dreams during therapy sessions which include content that is forbidden or frowned upon in Haredi society. These therapists explained that the revelation of such content can only take place due to the fact that the therapist does not belong to the ultra-Orthodox community and therefore there is little risk of her exposing the secret revealed to her: “I’m not part of the community, and therefore the fact that I am holding on to their secret can’t lead it to be exposed in some way , which might influence all kinds of things that have to do with their wellbeing down the line.” These therapists added that candor also takes place due to the therapist’s lack of judgment toward the revealed content, since she does not espouse the ethical standards and the value system of Haredi society: “I came with a slightly more relaxed and less rigid attitude into this vice of the rules and regulations of the Haredi world.” As a result the clients are more willing to share and reveal even very traumatic experiences, such as multi-generational sexual abuse. A few of the therapists suggested that sharing takes place out of a perception of the therapist as a window of opportunity to experiment with fantasies and forbidden wishes: “I live their dream. I allow them this window of being without judgment.”

Even so, it is evident that the fear of exposure is very much present during the therapy sessions. Even though a few of the therapists claimed that there is less secrecy and aversion to revealing complex content than before, most therapists shared having the sensation that there were things being kept from them: “There is a feeling of secrecy.” Thus, for instance, the children tend not to share much about their family and the dynamics at home, and the parents sometimes avoid sharing such vital content as sexual assault or psychiatric evaluations, which the therapist only discovers during treatment. The reason for this, according to them, may have to do with the Halachic ordinance against defamatory speech which prevents the clients and their parents from speaking about the bad deeds committed by others, and the claim was put forth that some use religion as an excuse for concealing the truth. Furthermore, a few of the therapists mentioned that in some more complicated cases, such as ones involving sexual assault or fear of the client leaving the religion, the community put an end to the therapy and the client was transferred for treatment by a therapist within the Haredi community.

**Cultural differences lead to missed nuances and difficulties understanding on the part of the therapist.** Some therapists revealed that significant language barriers exist in art therapy with ultra-Orthodox children. Beyond the obvious linguistic obstacles that arise when the clients speak a different language (Yiddish), language barriers appear even in treatments where the client and therapist speak the same language (Hebrew). The therapists expounded that barriers can arise following their own lack of familiarity with the meaning of certain expressions, symbols, sayings, codes and rules, as well as disparities in body language: “We just don’t speak the same language. A lot of it is in the subtext, in the ability to decipher both the hidden messages and the body language.” The therapists’ statements indicate that these disparities and barriers have an effect on the therapy and the therapeutic relationship. Thus, for example, the therapists described cases where they acted based on their conceptual world, a world is often in conflict or mismatched with the conceptual world of the client, which led to misinterpretations, created disaffection, and even unintentionally caused the client distress. In some cases, the cultural disparity created a veritable disconnect and led to the cessation of treatment. It would appear then that language barriers sometimes prevent the possibility of professional discourse: “Something about our lack of knowledge silences us… it’s very hard to stand up as a professional and explain…it’s something, it’s as if they bring a different kind of knowledge which belittles us.” A few of the therapists, on the other hand, opined that missing out on nuances may also serve as an advantage, since it forces the therapists to be more intuitive in their work.

**The therapists try to sensitively adapt themselves to the clients’ culture.** As shared by some therapists, the linguistic disparities force them to adapt their language to that of their interlocutors: “I feel like I choose my words very carefully…Beyond the processes of introspection, of looking at what’s going on, I also adapt my language to theirs.” The therapists explained that they use expressions taken from the world of religion in order to describe and mediate therapeutic terms, and that they likewise adjust their language to resemble the Haredi way of speaking, which is more proper and less casual. This way of speaking does not allow for the use of slang, on the one hand, but on the other hand, it also sometimes lacks words and expressions of a higher register. Moreover, the use of certain words is forbidden or frowned upon, such as words describing bodily functions and secretions, and the therapists must adapt their speech accordingly.

Some therapists said that in order to adapt themselves they mostly consult with the parents, and sometimes with the children themselves, with the rabbis of the community, or with other therapists. In some cases they have recourse to training. Another focal point of adaptation mentioned by some therapists is the therapeutic content. The therapists explained that they frequently check what is allowed and what is forbidden in Haredi society, and consult with parents about any specific boundaries which the therapist mustn’t overstep, or if there is any specific content that they do not wish to be included in the therapy sessions.

Likewise, they are careful about revealing content from their own personal lives, out of the assumption that exposure to content that does not fit in with the client’s worldview may have an adverse effect on the therapy: “There is more attention paid to the details of what I say and what I do…and how much I share.” Furthermore, the therapists explained that they must exercise caution about applying their own set of values in their approach to the client, since this may provoke internal conflict in the client and cause them further distress: “This automatic approach that I come from, of encouraging her to rebel and to kick off this oppression she lived through, it was very problematic and could have gotten her in trouble.” Nevertheless, the therapists qualified this notion and stated that in some cases they mustn’t lose sight of their professionalism and that some things must be said even though they might go against the Haredi worldview.

Two additional areas in which the therapists have to adjust themselves include the need to adapt their clothing in order to comply with the rules of modesty customary in Haredi society (long skirts, long sleeves, closed shoes), as described by some therapists, and the need to uphold the laws of Kashrut when it comes to food served in the context of therapy, as referenced by a few of the therapists.

Some therapists also spoke of the need to respect the client and their worldview, even in instances when they feel the urge to disagree: “There are a lot of red lines, you have to know about them, you have to respect them when they differ from your own worldview or even when you disagree with them.” In addition, some therapists mentioned the importance of being familiar with the heterogenic nature of Haredi society, and the need to distinguish between different groups in terms of what they allow and what they forbid: “There is so much variance that you have to learn to get to know who you are working with.” These therapists emphasized the need to be humble and patient, and to be willing to constantly learn from the mistakes they make in the course of therapy.

**The therapists experience distress as a result of the cross-cultural encounter.** Some of the therapists shared that they experience a measure of distress as a result of having to adapt themselves. Thus, for instance the therapists revealed that the need to change the way they dress was sometimes experienced as an invasion of privacy, especially when the children asked questions about their dress or resorted to touch: “The questions the children asked me, why am I not wearing a wig or long socks, and they would even touch me physically, it embarrassed me and felt extraordinarily invasive.” The discomfort described by the therapists was exacerbated by the feeling that they were meticulously scrutinized by the clients’ parents: “I may have imagined it, and I may have not, but they would also scan me with inquisitive glances.” Moreover, the therapists shared that having to make adaptations impedes their ability to act authentically, and increase their alertness and caution which hampers their ability to treat the clients: “The main difficulty I experienced was the whole issue of being cautious, of not being able to be authentic.”

Alongside the aforementioned causes of distress, some therapists pointed out difficulties in dealing with their own critical outlook on different aspects of Haredi society. For instance, some of the therapists shared their criticisms of the high expectations placed on children in Haredi society, the great levels of responsibility and restrictions they have to deal with, which prevent them from being able to behave like children: “Everything has to be meticulous and organized, she has to act a certain way and she has to help her mother… and all those chores… she’s an old woman before her time.” The therapists went on to speak about the distress they feel when dealing with young parents who have a large number of children even in cases where there are genetic problems present or difficulties in fulfilling parental functions. The therapists felt that these situations put the children at risk and hamper their emotional capacities. And yet, despite their intense feelings on the subject, the therapists cannot discuss these issues with the parents and the criticism remains unspoken: “It’s a criticism, it’s a dilemma, and it’s like something you can’t touch on. There’s no discussion about what are you doing bringing so many children into the world.”

Some therapists expressed feeling critical of the tendency to hide things in the Haredi community, and mentioned experiencing unease in situations where children had been charged with keeping a family secret, and especially in situation where vital information is being kept from the child, such as the mother’s pregnancy until the day she comes back from the hospital with an infant. According to the therapists, such situations are distressful to the child who then has to adapt quickly and without support or mediation: “There is a very prominent tendency not to ask, or not to know in a sense… It’s an experience of a lack of control, which manifests itself later in very severe reactions on the part of the children.” The therapists’ discomfort is increased when they are asked to cooperate with the family’s conduct and their policy of secrecy.

In addition, some therapists also talked about difficulties dealing with their own criticism towards the general attributes of Haredi society, including political issues, displays of hierarchical thinking and racism: “It’s moments when you feel that most basic stigma in your heart. That point of thinking: you are not a just society.” A significant and dominant point of distress raised by a few of the therapists stemmed from disparities in nationalist ideology. These therapists described situations, which they found particularly distressful, wherein they felt a lack of respect and a disparagement of aspects related to their nationalist-Zionist values, an ideology towards which there is resistance in Haredi society. Thus, for example, the therapists described cases where clients’ parents would stare at them as they stood up to observe a moment of silence during the alarm sounded on Memorial Day, as well as instances of clashes between the clients and themselves around the subjects of Independence Day and mandatory military service. The therapists explained that the anger and hostility they felt in these instances stemmed from the fact that they were not being treated with the esteem that their efforts to adapt themselves and to provide a sensitive and respectful treatment deserved: “We’re expected to respect the religion and all the rules…but something that is so significant to us…it was very problematic for me this whole subject.”

Another difficulty that emerged from some therapists’ statements touched on the way Haredi parents deal with any problem or issue they have with the therapist herself. The therapists said that in many instances parents addressed their complaints directly to the authority above the therapist (the management), without ever coming to her and discussing the matter with her. Such instances undermine the therapist’s status and often end up terminating the treatment: “They went straight to the manager and didn’t talk to me, they complained about me to the manager and so she got involved, with the best of intentions, but it did kind of demolish my authority.”

**The cross-cultural encounter affects the therapeutic relationship.** The findings show that the cultural disparity between therapists and ultra-Orthodox clients is significant and affects the therapeutic relationship. However, despite the prominent difference, the therapists expressed finding themselves struggling with the dilemma of whether to address the difference directly or to repress it: “It’s a real issue, do you lay it out on the table with the child, and it’s a dilemma. Is my identity something that should be discussed during therapy.” Some therapists said that the parents and the children know that they come from outside Haredi society, but others pointed out that the children are not fully aware of the cultural difference which is a source of confusion: “The kids over there find it really confusing: so they think of my hair as a wig, and let’s say if I get a haircut or something they’ll say ‘you’ve changed wigs!’”

Some therapists addressed the positive influence of the cultural difference on ultra-Orthodox children’s participation in therapy. For example, the children feel the need to teach the therapist about Haredi society and by doing so they experience a feeling of control thanks to their ability to teach the other: “It gives the kids the feeling that they can teach someone something.”

Nevertheless, some therapists spoke of the obstacles the cultural difference places in the way of the developing therapeutic relationship. These therapists described a difficulty on the part of the clients to trust and bond with the therapist who is perceived as a foreigner. This is especially true for clients whose distress is underlain by an impaired ability to trust, such as victims of sexual assault: “She just couldn’t survive this kind of attitude with which I’m talking to you right now… It was much too aggressive for her, too direct for her, very un-Haredi.” According to the therapists, the cultural disparity often times provokes a resistance to treatment on the part of the children and puts a strain on the relationship: “That’s the initial resistance… He says to me something like: you also want to lead me astray from my religion…what’s your value system compared to my value system.” The cultural difference also makes it harder for the therapists to establish a therapeutic relationship, since they often feel disdain on the part of the clients in regard to their lifestyle. They expressed an overall feeling that they cannot be their natural selves, and that they need to be somewhat cautious about displaying any signs of closeness or intimacy. In order to bridge the cultural gap and allow the therapeutic relationship to flourish, the therapists described looking for the common elements between the two worlds and emphasizing the transition from the outside world into the therapy room.

**The use of art in therapy**

**Art therapy enables to broach content that cannot be verbally discussed by means of externalization.** Some therapists stated that art plays a significant part in bringing up content from the child’s inner world, with emphasis on content that the child cannot talk about directly, such as everyday hardships, violence and sexual abuse: “The playing and the text and the creative work bring out the more difficult content… which, a lot of the time, it is hard to talk about directly.” Likewise, through art, the children are enabled to explore and deal with their inner wishes and with issues that matter to them. The therapists expounded that art is a non-verbal projection medium which allows for the expansion of experience and an indirect, softened approach to internal content: “That whole sophisticated mechanism of ‘I’m not talking about myself, I’m talking about this other thing.’ It goes a long way to breaking down their defense mechanisms.”

**The children’s artistic expressions draw on their unique world of content.** Some of the therapists’ statements indicate that the unique world of content proper to children from the Haredi community is expressed in all the different kinds of art therapy. Thus, for example, in visual art therapy, the children often draw stories, motifs and elements from the Old Testament, such as the temple and the sacrificial altar. Moreover, drawings that depict subject matter from the children’s daily lives, such as drawings of their family, feature culturally marked choices in the character design, in the adherence to modesty codes both in the way they are drawn and in the separation on the page between male and female characters. In psychodrama and bibliotherapy, the images and metaphors are drawn from the world of religion, the plot of the play or the story often includes events from the history of the Jewish people, and the characters the children portray are biblical characters, such as the High Priest. Music therapy often features music the children hear at home, including Sabbath chants and holiday songs. In dance/movement therapy, mundane items are infused with meaning that corresponds to the Haredi lifestyle: “A bag of sand becomes a prayer book and a handkerchief always goes directly on the head.”

On the other hand, the therapists sought to emphasize that despite the uniqueness of the children’s sphere of content, the art allows them to express their emotional experience and inner world. For example, a recreation of the destruction of the Temple reflects a sense of failure and division in the family, whereas feelings of mental imbalance are often reflected in references to *yetzer hara* (the biblical term designating humanity’s inclination to do evil). In order to understand the emotional story behind the work, the therapist resorts to phenomenological observation and discussions with the child about what the work means to them: “I try to understand together with the child… and the truth is that it opens up completely different things, things that have nothing to do with religion.”

**Haredi children’s ability to engage in symbolic play is a matter of controversy.** The therapists’ opinions were divided in regard to the ability of ultra-Orthodox children to engage with symbolism and play. Some therapists claimed that Haredi children are no different from any other children in their ability to play symbolic games, and that their main particularity in this respect is not related to the ability to play, but to the world of content expressed in the game: “I don’t think there’s a difference. It’s another world of content… the characters will look different, the story will utilize a different kind of language.” Contrary to this, some therapists described difficulties engaging in play among a large part of Haredi children, which manifest themselves in play that is mainly based on concrete references and in a limited capacity for imagination: “There are very well defined limits of the imagination there… the play tends to be very concrete sometimes.” It would appear that when the game, the story or the artwork draw on motifs from the world of Judaism, a world that is very familiar to the children, they find it especially hard to see past the rules and moral standards of Haredi society, and their imagination is blocked: “It was impossible to have a conversation with him that went beyond the moral of the story… He wasn’t at all open to something more free.”

**The otherness of the therapeutic space allows for a different, less inhibited behavior.** Most therapists spoke about the difficulty children from the Haredi community have letting loose, a difficulty which manifests itself during therapy in the children’s tendency to act in a restrained and stilted manner, a preference to sit at a table, occupying themselves with gathering up and arranging objects, and a focus on creating precise and aesthetically pleasing work. On the one hand, the therapists addressed the unease felt by the children faced with the uninhibited behavior of the therapist, as well as problems in experimenting with letting loose and a tendency to instead cling to rules and norms: “It scares them, they don’t like it…it’s very hard for them to be in that space.” On the other hand, according to the therapists, the children recognize therapy as a different space, apart from the one they are used to, where one can act more freely, and they react to it in different ways. The therapists described the children’s’ excitement, which manifests itself in initial regressive reactions and in displays of enjoyment and curiosity: “They’re excited because I open the door for them to something they’re not really exposed to in their day-to-day lives.” Based on the therapists’ statements we can surmise that the children’s reaction to the therapeutic space ranges between two extremes, with the first stage characterized by the children’s confusion and struggle to let go, which then leads them to behave in ways diametrically opposed to their normal behavior, running amuck and getting overexcited: “You can feel that sometimes it makes them get into overdrive mode of running wild.” For this reason, the therapists have to vacillate between granting opportunities to cut loose and activities reflecting the need for restraint or balancing out the children’s reaction to liberation.

**The delicacy of dealing with the body and sexuality during therapy.** Some of the therapists described various limitations in working with the body during treatment, such as the need to adjust, minimize and suppress their body movements to match the acceptable norms in Haredi society, which hampers their ability to be relaxed and natural. The therapists added that the range of movement available to the children during therapy is also limited, due to the children’s tendency to play more spatially restricted games, such as table-top games, and their modest clothing which limits the potential for free motion: “She can’t roll over on the floor because she constantly has to hold her dress in place.” The therapists also went on to describe the singular nature of the children’s movement, which involves less motion of the body core, with smaller and more restricted movements overall, and less freedom and flow. Moreover, the therapists explained that there are significant limitations in terms of language that references the body, to the point where the children have no words to describe various body parts, especially when it comes to private parts: “Between the belly and the legs, that whole part is missing. Which part of you touches the chair? The legs. What else? The back.” Accordingly, the therapists find hard to address the body in their work. They tend to avoid making movements that necessitate a discussion of the taboo body parts, and minimize work on content that has to do with the body, such as body image.

A few of the therapists reported being very much preoccupied with their distance from the clients and the possibility of touching them: “I am extremely aware of how far and how close I am. I can say that I am more careful about touch here than with other children.” The possibility of touch exists to a limited extent with children under the age of nine; it is more restricted with boys and it is absolutely forbidden with the fathers. The therapists clarified that for the most part they cannot work with boys over the age of nine. Nonetheless, a few of the therapists claimed that the limitations on touch do not detract from the quality of the treatment or the ability to connect with the clients.

Some therapists recounted that contents related to sex and sexuality almost never arise during therapy sessions, even with adults. The therapists underscored that when there is any mention of sexuality they tend to see it as a red flag: “A child who broaches sexual content is a child who is going through something.” Moreover, the therapists described ambivalence and apprehension on behalf of the parents in cases where they need to focus on this area, such as incidents of sexual assault or unusual preoccupation with sex on the part of the child: “The mother was really startled and was not willing to let me get into it.” Nevertheless, one of the therapists offered a contrary viewpoint on the subject and described a validation and openness toward sexuality among the Haredi community, based on their perception of sex as a mitzvah as opposed to a carnal urge.

**The therapist makes adjustments or avoids using certain artistic tools due to the laws and norms of Haredi society.** Most therapists stated that part of the adaptations they have to make for their Haredi clientele is centered around the artistic activities and involves making adjustment or even avoiding certain tools or contents that may invoke content that is unacceptable in Haredi society. Thus, for instance, in working with text, the therapist has to check whether the text is appropriate and get approval to use it. The therapists emphasized that they cannot use books that feature impure (non-kosher) animals, or fantasy elements such as fairies, witches or dragons, and that sometimes they resort to changing the story’s content and replacing certain elements with names and concepts familiar to the Haredi population: “When I tell a story I will often change it. That is to say, I’ll make it more ‘Jewish.’” Moreover, the therapists also check the illustrations featured in the story books or in the games used in treatment and edit them to make them match the cultural symbols and modesty codes of Haredi society.

The therapists pointed out that they very rarely use technological means such as smartphones or computers, and that they particularly avoid using recorded music. When they do use music, they make sure to use either instrumental tracks without lyrics or songs popular in the Haredi community. Rarely do they feel that a certain song from their world can be of help to a client, and in those instances they may use the song only if the text bears no conflict with the norms of Haredi society and only after receiving the direct approval of the client’s parents. Furthermore, the therapists stated that they only sing with young children and refrain from singing with older boys or in the presence of parents, due to the Halachic ordinance which prohibits men from listening to women singing.

Similarly, the therapists avoid using artistic materials such as paintings, magazines or miniatures that feature elements which Haredi society finds unacceptable. Sometimes the therapists will hide tools through which children can express less adequate content, such as aggression: “There is a lot of aggressive content that the kids want to engage with during treatment and they can’t because I make sure hide that kind of stuff in the room in advance.” It is interesting to note that when the therapists make the arts accessible by using terminology that is customary in Haredi society, even things that are problematic in terms of the Halacha, such as making statues or masks, can take place during therapy without unease or apprehension: “I’ve changed the terminology. The statues are called dolls, the totems are models or structures, the masks are called funny faces.”

The therapists share that they make these adjustments out of the comprehension that if they should allow the children to engage with things that are forbidden at home, they may provoke a resistance to treatment, ambivalence or confusion: “I didn’t bring any things that might destabilize or provoke any kind of ambivalence on the part of the patient in an interventionist manner.”

**Systemic aspects**

**The relationship with the parents is built up gradually.** When a Haredi child undertakes art therapy, there is continuous contact with the client’s parents, including meeting at the beginning and end of the treatment, ongoing instructions given to parents by the therapists, as well as occasional chats. The statements of most therapists revealed that the process of establishing a relationship with the parents takes place in stages. The stage of initial contact is often a problematic one because the parents are apprehensive about the therapist as an outsider to Haredi society. The cultural disparity makes the relationship with most parents cold, pragmatic and official. Sometimes it even leads to cessation of treatment: “A lot of treatments have ended because of suspicion, or didn’t take place because of suspicion… They don’t want the child to be in therapy alone with you.” These therapists revealed that parents scrutinize the therapist thoroughly in the first stages of contact out of the desire to protect the children and their upbringing for fear that the therapist might legitimize things that are not suitable to the lifestyle of the Haredi community: “They are automatically suspicious of me… That I’ll be some kind of factor that gives legitimacy to straying off the straight and narrow.” As a result, the therapists are forced to make an extra effort to prove their professionalism and sensitivity: “You need to prove yourself, both that you’re looking out for them and that you’re worth something, to get them on your side.” In order to gain the parents’ trust and establish a relationship with them, the therapists encourage frank and direct discussions of the cultural difference: “I very much encourage talking about our differences…After we talk about it, it gets better.”

According to some therapists, once the parents learn to trust the therapist, they often express gratitude and appreciation. At this stage, the parents transition from suspicion to trust and dependency. They efface themselves before the therapist, whom they now perceive as a figure of authority: “The moment they begin to trust you, it is full on trust on the most absolute level. Any word I say is almost sacred.” Accordingly, the parents wish for the therapists to make decisions for them on various issues and have a hard time participating in joint deliberations: “They want me to decide…The Lord says, the rabbi says, the principal says, and now the therapist will say.” It is important to note, however, that more often than not the rabbi’s opinion still remains the most influential factor in the parents’ decision-making process.

In most cases, establishing a relationship allows for a more open dialog about a variety of subjects. However, it would seem that when it comes to parents from certain ultra-Orthodox factions that are still certain topics and issues that the therapist cannot address freely even when the relationship is relatively well-established: “It really depends on the faction…There were some with whom I had a very open dialog, but enough others where there was nothing I could do.” In most instances where trust has been established, the parents are able to commit and dedicate themselves to the therapy, even when it is long and intensive, and the therapists can see that they apply the ideas emerging from the sessions: “Parents commit themselves…Some parents say to me ‘now it’s something that belongs to me and my child’… There are even parents who do it with their other children.”

**The role of the father in therapy is variable.** The therapists’ statements indicate that the faction to which the parents belong have a great effect on the role the father plays in the treatment. Thus, for example, while some therapists shared that they see fathers rarely and even when they are present, they do not make eye contact with the therapist and project a sense of discomfort, other cases had both parents in attendance: “I’ve had many families where only the mom ever came in. There were also those cases where the father would be in the room but not look at me, which was a nightmare in and of itself. But there were also lots of cases where both parents showed up.” It is interesting to note that in certain factions the situation is the exact opposite: the father plays a significant role in the child’s therapy, he dominates the discussion, makes eye contact and exhibits more responsibility and commitment than the mother.

**Therapy for the child paves the way for therapy for the parent.** Another unique point that emerged from the statements of some therapists is that parents will frequently continue treatment with the therapist who treated their child, after the child’s therapy has concluded. In some cases, during the child’s therapy course, the therapist with recognize a need for one of the parents to get treatment and makes the suggestion to the parent. In other cases it is the parent who recognizes, at some point in their child’s process, that they themselves require treatment and asks the therapist to provide it: “We get half way through the treatment and the parents see a real change for the better in their child, so the dad says ‘I’m going to start therapy myself.’” The therapists remarked that often it is easier for the parent to send the child to therapy rather than invest family resources in themselves, and therefore sending the child to therapy is perceived by the therapist as a cry for help on the part of the parent: “A lot of times they bring the child to therapy but it’s the mother who’s crying out for help…And it’s happened more than once or twice that when the kid goes out the mother goes in.” Nevertheless, a few therapists noted that there are many parents who are unwilling to look at themselves and realize they are the ones who need help.

**Characteristics of work with the parents.** Some therapists maintained that the work they do with the parents includes teaching them what therapy is: “I am constantly trying to make therapy accessible to them.” For instance, they have to explain to the parents that therapy is a gradual process that may take a long time, as well as describing in detail the kind of work they do and the techniques involved.

Another aspect of working with the parents pertains to cultivating their ability to observe the child. Some therapists explained that since many parents are primarily focused on the technical day-to-day functioning rather than the emotional state of their child, they have to teach the parents to observe the child’s distress and to help them understand what causes it, what makes it more frequent or acute, and how it relates to the processes they are undergoing. The therapists related that a central part of their work revolves around getting parents to understand that behavior is an expression of mental states. There is often a need to communicate the client’s emotional needs to the parents, help them recognize these needs as normal even in cases where they differ from their own personal needs or diverge from the norms of Haredi society, and together figure out how they can satisfy these needs and thereby alleviate the child’s emotional distress: “The most important thing in my eyes, always, is to show them how every external act is an expression of something happening in the psyche… To get parents to understand that the child is different from them… and to show what can be done to help the child.” The therapists talked about teaching the parents to observe the child’s uniqueness and strengths, and working with them on their ability to admire their child and to show their admiration explicitly and emphatically: “That feeling of enthusiasm about the child, it’s not always put into words, and that’s something I often find myself working on with them.”

Some therapists added that they focus on the parents’ participation as partners in therapy. They expounded that even though they often respond to the parents’ requests for guidelines and practical tools, they invest most of their resources in encouraging joint deliberation: “They want me to decide, me to tell them… So I say – let’s see together, it’s not my decision… I’m here to deliberate with you.” These therapists make sure the parents understand the importance of joint guidance sessions, which sometimes come at the expense of sessions with the child, while emphasizing the significance of their cooperation for the treatment’s success: “I always tell them: ‘Without you, it’s impossible.’”

**Objectives in working with educators and spiritual figures.** Some therapists spoke about their ties with educators and spiritual figures, such as teachers, rabbis and community leaders. According to the therapists, for the most part they maintain good working relationships with these figures, albeit not close or personal ones. The relationships are often closer with female figures, and less close with rabbis, however, it appears that the therapists consistently view this matter as largely dependent on the individual personality of each such figure. Sometimes they engage in direct dialog with the educators and spiritual figures; other times, however, the dialog take place through the mediation of the parents, which is the case when certain rabbis refuse to speak to the therapist directly due to her being a woman. Furthermore, sometimes the therapists experience difficulties in getting in touch with these figures due to technical issues such as lack of telephone access.

It appears that work with these figures revolves around three main objectives. As stated previously, the first objective mentioned by some of the therapists is consulting with them in complex cases or when they encounter problems in the course of therapy, in order to learn about certain Halachic or cultural aspects and understand how they must behave. These therapists emphasized the important of having a consulting agent within the Haredi community: “It’s very important to have guidance about cultural sensitivity… to have someone who knows the population instruct you.” Another objective that emerged out of the statements of a few therapists is to obtain information, for example about the child’s family background and their functioning in different areas of life: “It’s not just about seeing the child from another angle, but also about understanding how they are seen.” The third objective described by some therapists is to provide information. These therapists stated that educators and spiritual figures sometimes consult with them when they need to make decisions pertaining to complex issues, and they are then sometimes required to explain concepts from their world to the Haredi society. The therapists create a discourse focused on the client’s capacities and intended to communicate the mental motivations driving their behaviors, as well as instruct the interlocutors about the possible actions they can undertake in response to these behaviors.

**Discussion**

The present study examined the perceptions of non-Haredi art therapists regarding work with children from the Haredi community, thereby joining a previous study that examined the perceptions of non-Haredi dance/movement therapists working with Haredi children (Suskin & Karnieli, 2015) as well as other studies which examined psychotherapy (e.g., Freund & Band-Winterstein, 2017; Hess, 2018) and art therapy (Padolski-Kroper & Goldner, 2020) in adults from the Haredi community.

The study offers a glimpse into the encounter between fundamentally different cultures and value systems – the traditionalist-collectivist culture of the clients and their parents, on the one hand, and the Western culture that forms the basis of psychotherapy and to which the non-Haredi therapists belong, on the other (Gopalkrishnan, 2018; Schwartz, 2017). The study’s findings indicate that the disparities between therapists and clients in terms of perceptions and values, such as the disparity in self-perception that emerged in the study and is also described in the literature (Yaffe, 2001; Schlesinger & Russo-Netzer, 2017), disparities in family structures and the number of children in the family, as well as the therapists’ perception of various behaviors presenting themselves in some children – including difficulties in making choices, the desire to please and overall restraint – as focal points for therapeutic work, as opposed to the perception described in the literature of these behaviors as conforming to the values and norms of ultra-Orthodox society (Goodman, 2003; Frosh, 2004; Hakak, 2011), are fundamental to the experience of all parties involved in the therapy (therapists, parents and children) and present them with extremely complex challenges. Therefore, the present study is likewise an addition to the body of research dealing with the complexity typical of cross-cultural therapy (e.g., Qureshi & Collazos, 2011).

With regard to parents, it would seem that these disparities cause them apprehensions which often express themselves in difficulties trusting the therapist, the tendency to over-scrutinize her, and sometimes even a cessation of therapy due to the cultural difference. The reason for this seems to be rooted in the fear that values opposed to those of the Haredi worldview might penetrate through to the child (Band-Winterstein & Freund, 2015), as well as the parents’ dread of potential harm to their child’s spiritual upbringing (Schnitzer et al., 2011). Similarly, the children also sometimes struggle to trust and bond with the therapist, and they too find themselves preoccupied with the disparities that sometimes charge the therapeutic relationship with tension. The interviews indicate that the therapists choose to accord a central place to the values and norms of the cultural world of the child and their parents, which imposes various restrictions and strains on their experience. Thus, for example, they sometimes feel limited in terms of the artistic content and tools they can use, they find it hard to be authentic, and in many cases they find themselves adapting to societal norms to which they are opposed, while suppressing reactions arising from their own sets of values. These findings are consistent with previous research that also described the difficulties of experienced by non-Haredi therapists due to the need to consider Haredi culture and values, and to some extent compromise their professional outlook and worldviews (Suskin & Karnieli, 2015). Moreover, the findings of the present study show that the challenges faced by therapists due to cultural disparities amount not only to setting their own values aside, but sometimes to actual distress and harm, as reflected in their descriptions of dealing with feelings of intrusion and invasion of privacy, as well as disdain towards their lifestyles. The therapists also described dealing with situations of conflicts of values, on the subject of nationalist ideology for instance, which caused them distress out a sense of disrespect and contempt for values that are important to them, despite the respect and sensitivity they display towards ultra-Orthodox culture. It seems that despite their sincere attempts to treat in accordance with the cultural competence approach (Qureshi & Collazos, 2011; Sue & Sue, 2013), the therapists encounter inevitable problems.

Nonetheless, it is imperative to note that the therapists also mentioned advantages directly linked to the cultural difference between themselves and their clients. These include the opportunity for candor that is often made possible because the therapist does not belong to the Haredi community and therefore cannot lead to the exposure of secrets, as well as the sense of control that children sometimes experience due to their ability to teach the therapist about their world. The therapist too may benefit from the cultural gap in the shape of personal growth, including introspection and the development of capacities such as humility and patience. These findings are in line with previous descriptions of cross-cultural therapies in the literature, suggesting that alongside challenges and difficulties, these encounters may strengthen the patients' sense of security and thereby increase engagement and facilitate candor (Potash et al., 2015; Stolovy, Levy, Doron & Melamed, 2012), as well as the parents’ ability to maintain a therapeutic relationship (Snir et al., 2017), and promote personal and professional growth in the therapists (Kapitan, 2015; Lee, 2017).

The study’s findings point to areas of struggle and challenge that are unique to art therapy in ultra-Orthodox children, including difficulties engaging in symbolic play and letting loose, which may be expressed as a tendency to stick to the boundaries of concrete reality, restrained and stilted conduct, and focus on precision and aestheticism in their creative work. A similar picture, albeit with respect to older female clients from the Haredi population, emerged from a previous study which found that these clients had difficulty entering a play space, feared uncontrolled exposure, and displayed limited ability to create expressive art (Padolski-Kroper & Goldner, 2020). Furthermore, the findings shed light on additional problematic areas such as the challenge of dealing with the body and the need to adapt the artistic activities to the laws and customs of Haredi society. At the same time, the therapists who participated in the study sought to emphasize that in most cases the children are able to express emotional experiences and engage with content and issues that are meaningful to them. According to the therapists, the main advantage of administering art therapy to children from the ultra-Orthodox community lies in the externalization made possible by the artistic activities. As argued by the literature, since the art is separate from the creator, it renders the threatening content external to them (Schaverien, 1994) and thereby allow the client to engage with content that they would not have engaged with directly with the therapist (Lewis, 1992).

The study’s findings point to a multi-faceted process of change taking place in Haredi society in relation to therapy in general, and to art therapy in particular. Similarly to previous studies that have pointed out the complexity involved in this process of change (e.g., Freund & Band-Winterstein, 2013), the present study suggests that by the very nature of change being a process, shifts in attitudes can be identified alongside the perseverance of past perceptions regarding therapy. For example, the therapists who participated in the study did point to an improvement in the perception of the therapy as positive and beneficial by parents, community rabbis and members of the educational staff, which is also reflected in the fact that the patients’ parents often turn to therapy themselves, following the child’s experience, even though, according to the therapists, some of them still do not quite grasp the full meaning of therapy or perceive it as a tool for fixing the child’s and the family’s problems. The therapists talked about parents who do commit themselves to the therapy and implement its emergent conclusions, but at the same time, similarly to educators and spiritual figures, they tend to focus more on the effective benefits of treatment, expect quick results and seem to have difficulties perceiving the treatment as a process. Moreover, alongside the therapists’ descriptions of incidents in which children and parents share content that is not acceptable in Haredi society, there are reports of a general sense of secrecy and difficulties in revealing things, probably out of the fear of stigma, which often engenders an aversion to exposing problems or deficiencies (Barth & Ben-Ari , 2014; Greenberg, Buchbinder & Witztum, 2012). The therapists also noted that sometimes, in particularly sensitive and complex cases, the treatment is stopped prematurely and the client is transferred to care within the ultra-Orthodox community. This reality is in line with the preference for receiving treatment from professionals belonging to Haredi society that appears in the literature (Mozes, Aviner-Kirschenbaum and Goldberger, 2010; Schlesinger and Russo-Netzer, 2017). These mixed attitudes, which may indicate a multifaceted process amounting to gradual change, are also reflected in the parents’ relationship with the therapist. In many instances, the process of establishing a relationship with the parents is challenging, and accompanied by various apprehensions and careful scrutiny of the therapist by the parents. However, in cases where the therapist manages to form a relationship, some parents perceive her as a professional and an authority figure, and show her respect and appreciation. According to the therapists, the perception of the therapist as an authority figure can lead parents to become dependent on her for decision-making regarding their child's upbringing, and this sometimes prevents them from acting as partners in the therapy and engaging in joint deliberations. This finding is explained in the literature, which describes how the entrenched norm of subordination to authority in Haredi society leads to a projection of responsibility on the therapist based on her perception as an authority figure. But while the references to this issue in the literature pertain to cases where instructions given by therapists have the potential to provoke conflict (Hess, 2018), the present study expands and clarifies that dependence on the therapist may be broader and deeper in the case of child therapy. Once the relationship with the parents is established, it often leads to a more open dialog, however, even then, some issues remain precluded from discussion, such as content that the parents are not willing for the child to engage with due to cultural or religious reasons, as well as any issues they may have with the therapist herself. These findings appear to be consistent with the literature, which claims that the restrictions on lifestyle in ultra-Orthodox society delimit the therapeutic discourse within the boundaries of the permissible and the forbidden according to religious laws and cultural norms (Hess & Pitariu, 2011).

The present study sought to examine art therapy in Haredi children from the perspective of therapists outside of this society. It is important to note that the study is based on interviews with art therapists and therefore reflects their subjective perceptions. Examining cross-cultural art therapy in children from ultra-Orthodox communities through the perceptions of the other partners in the therapy, including the children themselves, the parents, as well as educators and spiritual figures, would enrich this perspective and help cross-validate the findings. Likewise, further research that involves gathering quantitative information through an attitude survey based on the perceptions and experiences of the therapists described in the present study, may provide an overview of the prevalence of the experiences described in the study and help assess development and change over time.

**Conflict of Interest**

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

**Author Contributions**

This research is part of a Ph.D. dissertation, which was initiated, planned, coordinated and conducted by LK. She collected the data, carried out the analyses, and wrote the manuscript. DR and SR supervised the Ph.D. dissertation and assisted in all stages.

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**Contribution to the field**

By focusing on the case of art therapy by non-Haredi therapists in ultra-Orthodox children, the present study provides a glimpse into the meaning, contribution and great complexity of administering therapies that are fundamentally Western in traditionalist-collectivist societies. The findings of the study shed light on the challenges of applying the cultural competence approach, and on the price that this approach may extoll from therapists. In doing so, the study corroborates previous research on the subject and emphasizes the necessity of programs and strategies aimed at maintaining a balance between cultural sensitivity and the therapist’s professional identity. Furthermore, the present study contributes to the development of the body of knowledge pertaining to the characteristics, uniqueness and challenges of psychotherapy in general and art therapy in particular in Haredi society. The main innovation and importance of this study, however, stems from its focus on child therapy. The findings of the study highlight the delicacy of the subject for the clients’ parents, which sharpens and deepens the challenges and complexities described in the existing literature. In this way, the present study emphasizes the hypersensitivity required in child therapy, and especially in cross-cultural child therapy. Specifically, the study allows for an in-depth look at art therapy in children from ultra-Orthodox communities. As confirmed by the literature, there is great importance in deepening the knowledge about the uniqueness of therapy patients’ cultural groups (Fung & Lo, 2017; Qureshi & Collazos, 2011), because patients whose culture is different from the culture of the therapist may not fully benefit from the treatment or leave prematurely (Sue & Sue, 2013). This underlines the importance of the present study, which focuses on a population that has so far garnered very little research attention. With that in mind, the present study may help therapists working with Haredi children to adjust their methods out of an understanding of the unique aspects that treating these children entails. Although the study was conducted in Israel, it is worth noting that the study population exists in other places in the world, including a large concentration of ultra-Orthodox Jews in the U.S., namely in the states of New York and New Jersey (Greenberg & Witztum, 2013).