**An Application of the ACCESS Model for Transcultural Nursing to Understand How Religious Disaffiliates Approach Healthcare**

**Keywords: Religion, Well-being, ACCESS Model, Religious Disaffiliation**

**Introduction:** Religious disaffiliates have a high likelihood of poor well-being and mental health. Few studies have been conducted on how their experiences affect their health and how healthcare staff can assist these individuals in their new lives.

**Methodology:** This qualitative study includes interviews with thirty-four Israeli adult participants, who disaffiliated with Haredi (ultra-orthodox) Judaism after the age of 18. Major themes emerging from the interviews were identified by two researchers working simultaneously and the transcript of each interview was screened for coherent statements the analyzed using the ACCESS Model.

**Results:** Each component of the model highlighted the unique needs of this population when approaching and engaging with the healthcare system.

**Discussion:** Each component of the ACCESS Model should be considered when providing care for this population. Certain components should be given special consideration, namely assessment, for risky health behaviors, and safety, particularly in terms of mental health.

Within the ultra-orthodox Jewish community, there is a subpopulation who disaffiliate. The prevalence of this religious-social separation is not known. However, previous studies suggest that there are cultural, educational, and health implications as a result of disaffiliation (Berger, 2014; Pinchas-Mizrachi & Velan, 2022). This study uses the ACCESS Model of Transcultural Nursing to describe aspects of their engagement to the healthcare system.

**BACKGROUND**

**Religious Disaffiliation**

Religious disaffiliation, leaving religious tradition, has become more common over the past few decades (Vargas, 2012). This can be a traumatizing process as these individuals learn to navigate their new life, often without social support. Similar to new immigrants, disaffiliating can affect their mental and physical health and well-being, especially if ‘push’ factors (those that compel a person to leave) outweigh ‘pull’ factors (those that compel a person towards a new community) (Engelman et al., 2020).

Disaffiliation can leave a person with a reduced capacity to cope with stressful situations, as well as poorer overall well-being compared to their religious counterparts, likely due to a loss of community and social support (Fenelon & Danielsen, 2016). It is well-established that religious individuals have better health outcomes compared to non-religious individuals (Pinchas-Mizrachi et al., 2020; Sullivan, 2010), so it is not surprising that disaffiliation can negatively affect well-being. Furthermore, some religions dictate health behavior; disaffiliates may no longer want to subscribe to this behavior (Upenieks & Schafer, 2020). Disaffiliates may engage risky behaviors once they leave, resulting in poorer health. A significant minority also report suicidal ideation (Berger, 2014; Horowitz, 2018; Velan & Pinchas-Mizrachi, 2019).

**Ultra-Orthodox Judaism**

Ultra-orthodox Jews are characterized by their strict observance of Jewish law and insularity. Their strict observance dictates how they dress, what they learn, how they interact with the opposite sex, and what foods are allowed. Access to the internet and secular media and books is limited (Berger, 2014; Friedman, 2018). Rabbis play a key role in decision-making, including decisions related to everyday life (Coleman-Bruekheimer et al., 2009).

Ultra-orthodox Jews in Israel, known as ‘Haredim’ (‘Haredi’ sing.) comprise around 12% of Israel’s population. The majority live in closed community enclaves. Many men learn full-time in *yeshivot*, schools of religious studies, and do not enter the labor force or academia. (Malach & Cahaner, 2019).

**Disaffiliation with the Ultra-Orthodox Community – ‘Off the Derech’**

Ultra-orthodox who disaffiliate with their community are known colloquially, as "off the derech" (OTD), which translates to off the [right] path (Berger, 2014). In Hebrew, they are known as yotzim be’she’elah, meaning those who go out in question (Shenfeld, 2015). Inquiries about disaffiliating are part of an internal conflict or misconception of life without boundaries (Moran, 2021). Transitioning to a secular lifestyle is dependent on a personal desire to fulfill a bio-psycho-emotional gap (Little et al., 2016).

Haredi Jews who disaffiliate with ultra-orthodox Judaism face many challenges, similar to new immigrants (Berger, 2014; Engelman et al., 2020). They have to adjust to new societal rules and usually lack basic education and skills needed to survive and thrive in the non-Haredi world, including how to interact with the opposite sex (Berger, 2015). Often, they are also rejected by their families and former communities (Berger, 2014; Shenfeld, 2015).

**The Scope of the Ultra-Orthodox Disaffiliation Phenomenon in Israel**

There is not much data measuring the extent of this phenomenon in Israel. Even among collected data, it is hard to quantify this phenomenon as data collection is subjective. This is partially due to the fact that some individuals who disaffiliate may eventually ‘return’ to a religious lifestyle (Horowitz, 2018). Further complicating this are the political ramifications of acknowledging the scope of the phenomenon among Haredi lawmakers (Horowitz, 2018).

Based on data from surveys conducted by the Israel Central Bureau of Statistics (CBS), 10% of Haredi adults reported that they are disaffiliated, and among adults between the ages of 20 and 40, 7.8% reported that they disaffiliated (Shenfeld, 2015). Organizations that assist disaffiliates estimate that annually, several hundred individuals disaffiliate (Horowitz, 2018).

Few studies have been conducted on the healthcare needs of disaffiliates, barriers to their ability to access the healthcare system, and how medical, psychological, and social work staff can assist these individuals in overcoming these barriers. To address this lacuna, this study, which is the continuation of a previous study (Velan & Pinchas-Mizrachi), applies the ACCESS Model for Transcultural Nursing to describe findings from a sample of Israeli disaffiliates in order to highlight the special needs of this population while engaging with the healthcare system.

**METHODS**

This study began in 2018 with the aim of investigating the health-related needs of disaffiliates and their experiences with the healthcare system by interviewing disaffiliates from formerly Haredi homes. During the first round of interviews, 12 participants were included. These participants disaffiliated sometime in the last ten years, when they were 18 years or older. At this stage, we identified the following health needs: mental health, health behaviors, and sexual health. Afterwards, an additional 11 participants were interviewed. The findings from these additional 11 interviews strengthened the findings from the first round of interviews. An analysis was conducted to identify barriers facing the disaffiliates when turning to the healthcare system (Pinchas-Mizrachi & Velan, 2022; Velan & Pinchas-Mizrachi, 2019).

These findings also led to the question of how the healthcare system could be made more accessible for this group. To outline the issues that need to be considered for this issue, we applied the ACCESS model for Transcultural Care. The ACCESS model provides a framework for transcultural nursing care. There are six components of the model: Assessment, understanding the patient’s background; Communication, understanding differences in communicative methods; Cultural negotiation and compromise, being aware of the cultural differences; Establishing respect and rapport, creating a therapeutic relationship built on respect; Sensitivity, delivering culturally sensitive care; and Safety, ensuring the patient feels culturally safe (Narayanasamy, 2002). We further expanded the number of interviewees in order to better understand the degree of fit of the ACCESS model to the findings. The findings from the third round of interviews strengthened the earlier findings, as well as the fit of the model as a method of describing barriers and facilitators.

*Participants*

We conducted interviews in Hebrew using a semi-structured format. First interviewees were recruited with the help of several organizations that help disaffiliates, including "Out for Change", "Hillel", and others. Later on, recruitment continued through 'snowballing', where interviewees recruited other people for the study. All participants received an explanation as to the aims of the study and were asked to sign an Informed Consent form. The ethics committee of the Academic College of Ramat-Gan approved the study in November 2018 (approval number 1318).

The study sample was comprised of 22 males, 22-34 years old and 12 females, 20-29 years old. All participants were raised in Haredi Ashkenazi (of Eastern and Central European origin) Jewish families. Twelve participants defined their background as Hasidic, 18 defined their background as Litvish, and four defined their background as ‘mixed – Hasidic-Litvish’.

*Interviews:*

The interviews took place between November 2018 and December 2020. Thirty interviews were conducted at the interviewers’ offices in Ramat Gan or Jerusalem, or at nearby coffee shops (based on the preference of the interviewee). Due to the COVID-19 pandemic, four interviews were conducted over Zoom. The interviews were conducted in Hebrew and were semi-structured, with two central questions. The first asked the interviewee to evaluate which medical issues may affect them as a disaffiliate. Findings related to this question have been reported in an earlier article (Velan & Pinchas-Mizrachi, 2019). For the second central question, the interviewees were asked to address accessibility to the health system in Israel, and to identify factors that affected their access to the healthcare system.

The interviews were translated from Hebrew into English by a professional translator. All the names mentioned below in the results section are pseudonyms. The interviews were recorded and these recordings were stored securely on the researchers work computer. (For more information on the participants, please see the table in Appendix 1).

*Content Analysis*

After the interviews were transcribed, content analysis was conducted using two simultaneous methods: the first was a manual method, interpretive phenomenological approach conducted by two researchers (Giorgi, 1997); the second method utilized Atlas software. Each interview was thematically analyzed. First the transcribed interviews were coded, yielding lists of 20-30 statements per interview related to accessing healthcare. Examination of the statements enabled the identification of themes related to the access to health of the participants. After reviewing the themes, themes were defined as meaningful if it was identified in at least three different interviews.

These statements were then divided into categories based on three criteria: the nature of the effect (barrier or facilitator); effect of the motive on health-seeking behavior (recognizing the need for help, decision to seek treatment, managing contact with the healthcare system, communication with the provider and carrying out recommendations); the underlying source of each theme (related to upbringing, process of disaffiliation, specific traits of disaffiliates).

These analyses enabled the identification of themes that related to barriers in accessibility of the healthcare system to disaffiliates, and the need to bridge between disaffiliates and the healthcare system. Each researcher classified these themes individually. In most cases, the classification was similar; in the few instances where the classification was different, there would be a discussion to overcome the differences. To demonstrate the different barriers and highlights the needs of this population, these findings were applied to the ACCESS model of Transcultural Nursing.

**RESULTS**

To describe disaffiliate engagement with the healthcare system, both barriers and facilitators, each of the six ACCESS model components, assessment, communication, cultural negotiation and compromise, establishing respect and rapport, sensitivity, and safety, were applied to the findings from the personal interviews.

**Assessment**

This component describes the importance of understanding the life perspectives, lifestyle, and treatment beliefs of the patient (Narayanasamy, 2002). For a caregiver to provide optimal care, it is essential that they understand who they patient is, how they live, and what they believe. Life perspectives of disaffiliates include disparities in education and knowledge, while their lifestyle many times includes poverty, loneliness, and stigmas, all of which are likely to affect their engagement with the healthcare system.

Disaffiliates were sent to Haredi schools, which do not encourage higher education. Boys, in particular, were sent to yeshivot, where the majority of the learning is Judaic studies. The interviewees remarked their lack of understanding of the medical world, particularly among boys:

*“A Haredi boy …does not know how to manage his life, not even the world of healthcare… knowledge of the outside [secular] world, including the world of health is considered to be a negative thing.”*

Alongside the lack of knowledge and education, all interviewees noted the poverty they struggled with when they first disaffiliated. Some saw this as a potential barrier in their ability to access the healthcare system, noting that they were more concerned with making a living then trying to figure out how to navigate the healthcare system (Pinchas-Mizrachi & Velan, 2022).

*“You’re working two, three jobs in order to survive so… how are you supposed to have time to manage your [personal] problems…”*

A person who chooses to disaffiliate with the Haredi community, characterized by strong familial and community support, experiences severe loneliness in the unknown secular world. Most of the interviewees connected this loneliness to their [poor] emotional well-being.

*“You don’t always belong, you’re always not part of something. You can’t suddenly, at age 20-something, become part of a community that you don’t know, where you don’t know the culture, or the small nuances… you’re alone! Completely alone!”*

This study found that a desire to break with convention and difficulty following instructions was common among disaffiliates. This needs to be recognized by caregivers. From their perspective, they were raised in a closed society where they were expected to obey everyone – their parents, their teachers, and rabbis. Now that they were on their own, many described difficulty in obedience that stayed with them even after disaffiliating.

*“If God can’t tell me what to do, you want me to listen to a doctor?”*

Finally, many disaffiliates raised the issue of negative health behaviors and a risk-taking lifestyle adopted after disaffiliating, such as alcohol, drugs, and smoking.

*“...hard drugs… alcohol… lots of crap … you left the world of walls and endless boundaries, you want to do extreme things, yeah you’re at a higher risk level for sure.”*

**Communication**

This component refers to the communication process with the patient and highlights the need on the part of the caregiver to use sensitive verbal and non-verbal communication (Narayanasamy, 2002). Non-verbal communication includes dress and body language. Our study found that effect of the years of modesty education was still prevalent among disaffiliates, despite their inherently different and newly adopted dress and body language. There is the risk that a caregiver may read body language incorrectly.

*“no one told me to look down, but this is something I’ve been doing since I was a little girl …. It’s not accepted here [in the secular society] and is even considered rude.”*

This juxtaposition of new body language and dress is also found related to dress. Many interviewees, particularly women, would dress in a manner considered provocative, even for the secular world, and they express being uncomfortable revealing themselves to caregivers.

*“Up until a year ago, I was a Haredi girl going out on prearranged dates [for marriage matches]. How can I go alone to a gynecologist and tell him… and get undressed…”*

There is also a language gap with disaffiliates. They will frequently use words not known or commonly used in the secular world. During the interviews, there was frequent use of these words, such as “Baruch Hashem” [Thank God]. Furthermore, the Ashkenazi Haredi community will frequently use Yiddish in everyday conversations. The interviewees addressed the lack of understanding the secular language, as well as the inability of the secular society to understand their language. This has the potential to impede on their ability to communicate with providers.

*“…. It’s like being a new immigrant, but no one knows you’re a new immigrant. You look Israeli, you dress Israeli, and you speak Hebrew …, but you’re not really…*

**Cultural Negotiation and Compromise**

This component describes the importance of learning about different cultures and languages and reaching a common ground (Narayanasamy, 2002). Despite an outwardly secular appearance, the disaffiliate still embodies the culture from which they came. They are unfamiliar with the cultural rules and norms of the place to which they arrived.These rules include the degree of openness with which one may speak to their caregiver.

*“With all the modesty rules, there is a tendency to protect personal privacy among disaffiliates. It’s harder for them to expose themselves during treatments and check-ups.”*

*“He comes to the psychologist and doesn’t understand what to stay… what can he expose… it’s really hard to share… the education we received at home really closes you off...”*

*“We were raised in a way that we don’t really know how to communicate or express our feelings... It’s hard to discuss feelings, even when you are speaking to a professional…”*

The interviewees themselves discussed the importance of training professionals how to approach disaffiliates.

*“Professionals need to be trained, especially those in mental health, so they understand our issues… they should know it’s hard for us to open up… we’re pros at being mute…”*

**Establishing Respect and Rapport**

This component describes the importance of creating a relationship based on respect with a patient who comes from a different cultural background (Narayanasamy, 2002). This is especially important for disaffiliates, who feel that they do not belong in any world. Some interviewees raised the issue of the difficulty in seeing a Haredi or modern orthodox caregiver. Others remarked that they had a harder time opening up to secular physicians who are unfamiliar with the Haredi community, and even disparage it.

*“I got COVID-19 and went to the hospital … there were Haredi men in the room and a doctor comes in and spoke so condescendingly to them… I never thought I would defend Haredim, but I was so angry at him. I’m not Haredi now, but there are some good things in that community. We weren’t raised on trees…”*

**Sensitivity**

The Sensitivity component describes the importance of providing culturally sensitive treatment to the patient, based on his beliefs (Narayanasamy, 2002). The interviewees described the health-related stigmas with which they were raised as a barrier to accessing healthcare. In particular, disaffiliates stated a fear of words that begin with ‘psycho’, due to stigmas of mental health.

*“…The disaffiliate, who was raised on that stigma, is terrified of going to a psychologist…”*

Interviewees emphasized their willingness to be independent, and not be dependent on anyone or anything from their old world. In other words, they do not want favors.

*“I got COVID-19, and … suddenly my parents are looking for me… they must’ve thought I was going to die, and would need to ensure I had a Jewish burial… Suddenly, people from Haredi charity organizations were coming to me … I don’t know who sent them, but… I wouldn’t borrow anything … and thank God, I managed…”*

**Safety**

The Safety component is the ensuring that the patient feels comfortable making decisions based on his beliefs and without being judged (Narayanasamy, 2002). The basic level of safety for a disaffiliate, particularly during the beginning stages of disaffiliation, is low. This insecurity may become more pronounced when a disaffiliate accesses healthcare, due to an added fear of privacy. The privacy of a disaffiliate is of utmost important to him, for a number of reasons. The stigmas on which he was raised may cause him to feel that if people were to know about his poor well-being, they may judge him for it, and it may hurt his future.

*“You’re more concerned that someone may find out, than you are that you won’t get help…”*

Furthermore, the disaffiliate may fear that his family will be judged in the Haredi community, and marriage matches will be tainted.

*“It’s not enough that I hurt my siblings’ marriage matches by disaffiliating, I will hurt them even more by being crazy?”*

Some disaffiliates defined what caregiver makes them feel safe. This was primarily a caregiver of the same sex, likely due to the modesty education with which they grew up.

*“It doesn’t matter what treatment; I always prefer a woman. Not just a gynecologist... I’m sure that boys who grew up in yeshiva prefer a man.”*

*“On one hand I don’t want a Haredi doctor, or even an [modern] orthodox one. I don’t want to be judged... But someone secular, who doesn’t know our world can also be a problem.....”*

**DISCUSSION**

This qualitative study examined the views of Haredi disaffiliated adults with regard to their health and well-being and their experiences with the healthcare system. Their responses were applied to the ACCESS Model of Transcultural Nursing (Narayanasamy, 2002) to understand their specific needs and barriers in seeking care. Disaffiliation is complex and can cause reduced mental well-being and adoption of risky health behaviors. All of this needs to be considered when providing care to disaffiliates (Fenelon & Danielsen, 2016).

The assessment of the community found that many disaffiliates have poorer overall well-being and experience loneliness, isolation, and lack of knowledge of secular social rules. Haredi disaffiliates come from a community where the community is central, and families are relatively large (Malach & Cahaner, 2020). Studies have also shown that the social capital gained by actively participating in a community can lead to better overall (subjective) health status (Lim, 2016). Therefore, disaffiliates who lose their origin social capital, but have a hard time creating new social capital due to difficulty in adjusting to secular life may suffer from poorer overall health and a less successful transition (Pinchas-Mizrachi & Velan, 2022). This, in turn, can lead to bad decision-making. This has been shown in studies from other religious close-knit communities (Scheitle & Adamczyk, 2010).

Disaffiliates are also at high risk of engaging in risky health behavior. This was more common among men compared to women and is likely due to the difference in exposure to the secular world between Haredi men and women. Haredi women do enter the workforce, unlike most men, and are more likely to have a better understanding of social and cultural norms (Engelman et al., 2020). However, women found it more challenging to feel safe in new situations in relation to modesty requirements with which they were raised. This was evident in their preference for female physicians and caregivers as a feeling of safety, and their lack of comfort in communicating with male caregivers.

Men, on the other hand, were more likely to be unfamiliar with the social code of the new culture and require cultural negotiation, which likely contributed to a high rate of engagement with risky health behaviors, such as drugs, alcohol, and unsafe sex. This is also line with the findings from Byrnes et al. (1999) study whereby men are more likely to engage in riskier health behaviors.

Safety stood out as a barrier to seeking care. A number of disaffiliates discussed the issue of privacy, and making sure that no one knows they need care, particularly for mental health issues. The issue of mental health is extremely stigmatized among the ultra-orthodox; ultra-orthodox are less likely to openly seek care for fear of bringing shame on their family and hurting family member’s chances of arranged marriages (shidduchim) (Greenberg & Witztum, 2013; Rosen et al., 2008). A survey conducted in Israel in 2018 found that ultra-orthodox “wish to maintain a greater social distance from people with psychiatric illnesses” (Struch et al., 2018, p. X). It is no surprise then that disaffiliates, even after leaving their community, are so reluctant to seek care.

Being uncomfortable around ultra-orthodox or even modern orthodox clinicians for fear of being judged is another aspect of safety that must be considered. Disaffiliates pay a high price in leaving their community, losing their social support (Berger, 2014). They are learning the new social norms and testing boundaries (Pinchas-Mizrachi & Velan, 2022). Therefore, they may be reluctant to put themselves back in a situation whereby they may be subjected to feeling judged by someone from their former community for the choices made in their current life. These issues demonstrate that disaffiliates have cultural gaps related to the access of healthcare. Providers who care for this population should be aware of these gaps in order to ensure that the provided care is suited to their unique needs.

**LIMITATIONS**

There are several limitations of this study. First, the use of snowball sampling may mean that our sample is not representative of all disaffiliates. It is also possible that our participants felt compelled to speak about their experiences, introducing volunteer bias. Furthermore, our study only included disaffiliates from one sect of Judaism and did not include other disaffiliated Jews, or other religions, nor did it include disaffiliates who chose a modern orthodox or traditional lifestyle as opposed to a secular one. These disaffiliates may have different experiences in accessing the healthcare system. Finally, the majority of participants are from two cities with large Haredi populations; there may be differences in the experiences of disaffiliates who come from smaller cities or communities.

**CONCLUSIONS**

Disaffiliation among Haredi adults can affect how they access the healthcare system. Providers who frequently care for the disaffiliate population must be aware of their unique needs, such as how stigmas with which they grew up may affect how they approach care, from whom they are willing to receive care, and how they view the role of a physician. Mental health professionals have an added challenge of encouraging Haredi disaffiliates or others who grew up in a culture shunning mental health care, to open up. Special courses, provided by organizations that aid disaffiliates, may be a welcome addition for caregivers and help them bridge these cultural differences.

**Conflict of Interest:** The Authors declare that there is no conflict of interest.

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