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THE IMPACT OF A BRIEF GRATITUDE JOURNALING INTERVENTION ON THIRD GRADE STUDENTS ATTENDING AN ORTHODOX JEWISH ELEMENTARY SCHOOL IN NEW YORK

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ABSTRACT

THE IMPACT OF A BRIEF GRATITUDE JOURNALING INTERVENTION ON THIRD GRADE STUDENTS ATTENDING AN ORTHODOX JEWISH ELEMENTARY SCHOOL IN NEW YORK

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Research in the field of positive psychology has focused on the beneficial effects of gratitude on overall wellbeing. Recent studies have demonstrated that anxiety and depressive disorders are increasingly common among youth in the United States. Further, both anxiety and depression have been linked to other comorbid mental health conditions, such as dysthymia, disruptive disorder, and substance abuse disorder. Moreover, anxiety and depression are associated with negative social and academic outcomes. Considering the prevalence of anxiety and depressive disorders among youth and the associated comorbidities, it is vital to direct efforts towards prevention and early intervention. The literature supports a positive relationship between gratitude and improved mental health status, as well as improvements in academic performance. Still, a void exists in terms of research on gratitude interventions among specific populations, including Modern Orthodox Jewish youth. The present study seeks to investigate the impact of a brief gratitude journaling intervention to assess changes in gratitude, mental health status, and academic performance among third grade students attending a private Modern Orthodox Jewish elementary school in Lawrence, New York. Study findings included no significant change in gratitude within either group. Math and reading scores improved in both the experimental and control group. There was no significant change in mental health status within either group. Limitations impacting the findings included the brevity of the intervention and young age of participants. The results point to a need for future studies

to explore interventions that occur over a longer period of time, as well as alternative gratitude interventions that may be more impactful for younger children.

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Literature Review

According to the Diagnostic and Statistical Manual of Mental Disorders (5th ed.; DSM-5; American Psychiatric Association, 2013), symptoms of depression include depressed mood, loss of interest or pleasure, weight loss or weight gain, insomnia or hypersomnia, psychomotor agitation or retardation, fatigue or loss of energy, feelings of worthlessness or guilt, diminished ability to think or concentrate, indecisiveness, and recurrent thoughts of death or suicide. Among children, irritable mood may also be present. Anxiety is characterized by persistent and excessive worry about various domains, as well as physical symptoms, such as restlessness or feeling keyed up or on edge, being easily fatigued, difficulty concentrating or mind going blank, irritability, muscle tension, and sleep disturbance (American Psychiatric Association, 2013). In younger children, somatic symptoms (e.g., headaches, stomachaches, nausea, and vomiting) may play a more dominant role in symptomology.

More than half of adults diagnosed with a mental health disorder report mixed symptoms of anxiety and depression, and, among all adults diagnosed with a mental health disorder, approximately 50% experienced the onset of symptoms prior to 14 years of age (British Psychological Society, 2011; Dawson, 2018). Studies have demonstrated that anxiety disorders are also among the most common mental health disorders diagnosed in children and adolescents (Rockhill et al., 2010). In fact, an estimated 7.1% of children aged 3-17 in the United States score in excess of the identified clinical cut-offs for one or more anxiety disorders (Ghandour et al., 2019), and an estimated 3.2% of children aged 3-17 are diagnosed with depressive disorders associated with at least minimum impairment (Ghandour et al., 2019). This translates into more than

5.5 million children aged 3-17 years experiencing either depression or anxiety, and the prevalence of both disorders has been steadily increasing since 2003 (CDC, 2020).

Several longitudinal studies of community samples have found that children diagnosed with anxiety or depressive disorders are also at an increased risk for additional mental health disorders (CDC, 2020; Ghandour et al., 2019; McLaughlin & King, 2015). Among children aged 3-17 years, nearly seventy-five percent (73.8%) diagnosed with depression have a comorbid anxiety disorder, and nearly half (47.2%) have concomitant behavior problems (CDC, 2020; Ghandour et al., 2019). Similarly, approximately one third of children aged 3-17 years diagnosed with anxiety have comorbid diagnoses, most commonly depression, dysthymia, disruptive disorder, or substance abuse disorder (CDC, 2013).

Research has consistently demonstrated the negative impact of anxiety and depression during childhood on a broad range of psychosocial variables. For example, anxiety disorders in youth have been linked to school refusal, as well as both social and academic difficulties (Maynard et al., 2018), and depression has been associated with personal distress, poor interpersonal relationships and reduced social functioning, having fewer friends and a smaller support network, missed educational opportunities, increased somatic symptoms, deteriorating or poor school performance, and increased risk for drug, alcohol and nicotine use or abuse (Chun et al., 2016; Thapar et al., 2012). Both anxiety and depression have been linked to an increased risk of suicide attempts and completed suicides in children (Chun et al., 2016; Kendall et al., 2010; Wagner, 2009). Given the prevalence of anxiety and depressive disorders among youth and the associated risks, it is essential to direct efforts towards prevention and early intervention.

Factors impacting mental health among children

A multitude of factors have been found to be associated with children's mental health. Numerous risk factors have been identified in children as young as 7 years of age. For instance, low socioeconomic status has been shown to negatively affect children's mental health (CDC, 2020; Guzman et al., 2011; Wille et al., 2008). Among children living below 100% of the federal poverty level, more than 1 in 5 (22%) are diagnosed with a mental, behavioral, or developmental disorder (Cree et al., 2018). In addition, maternal education level has been associated with children's mental health (CDC, 2020; Guzman et al., 2011). Parenting style, parental depression, and family environment have also been shown to impact the mental health of children (Cobham et al., 2016; Pfefferbaum et al., 2014). Specifically, parental psychopathology or alcohol abuse, hostile and anxious parenting styles, parent-child and/or family conflict, and low perceived family connectedness have all been found to be associated with negative mental health outcomes in children. Moreover, neonatal health problems in the first 4 weeks of life, family conflict, parent psychiatric symptoms, having a single parent or a stepparent, parental strain, and physical and psychological health issues (as measured on the 12-item Short Form Survey [SF-12]) have been identified as risk factors. Additionally, child or parent physical illness, family breakdown, large family size and overcrowding in the home, early parenthood, and experiences of violence or sexual molestation have all been identified as environmental risk factors for mental illness in children (Wille et al., 2008). Some biological risk factors include premature birth as well as maternal smoking or drinking during pregnancy (Wille et al., 2008). School-related stressors, such as a lack of teacher empathy and unsupportive teacher-student

relationships, as well as a poor classroom or school climate, also increase the risk of children developing mental health problems (Schulte-Körne, 2016). Furthermore, it was found that low self-efficacy, worse family climate, and less social competence were associated with an increased risk of externalizing disorders in children. At the same time, low self-efficacy, worse family climate, and more severe parental mental health problems were associated with an increased risk of internalizing disorders in children (Plass-Christl et al., 2018). Regarding the likelihood of having a mental illness, children with no risk factors were found to have a 13% chance of having a mental health disorder. Children with 1 risk factor had a 16% chance of mental illness. Those with 2 risk factors had a 24% chance of having a mental health disorder. Those with 6 risk factors had a 55% chance of mental illness, and those with >6 risk factors had a 67% chance of mental illness.

Numerous personal, familial, and social protective factors for children's mental health have been identified as well. For instance, possessing higher levels of self-efficacy, self-concept, and optimism have been associated with positive mental health outcomes (Wille et al., 2008). Moreover, positive and supportive parent-child relationships, authoritative parenting styles, and good family climate/cohesion have been found to be protective factors for children's mental health (Wille et al., 2008). Positive teacher relationships, peer competence, and social support from friends, sports clubs, and religious institutions such as churches and synagogues have been identified as protective factors as well (Wille et al., 2008). Regarding the impact of protective factors on mental health, children with no protective resources had a 30% likelihood of mental illness. Those with 1 resource had a 24% chance of having a mental health disorder. Children

with 2 resources had a 22% chance of mental illness. Those with 3 resources had a 14% chance of mental illness. The largest effect sizes were found for the protective factors of self-concept and family climate. An examination of the interaction between risk and protective factors revealed that children with no exposure to risks did not benefit from protective factors. Those with high-risk exposure did not either benefit from protective factors. Children with low-risk exposure benefited most from protective factors (Wille et al., 2008). These findings point to a need for differential prevention and intervention strategies.

Religious Beliefs and Mental Health

Overall, the evidence regarding a relationship between religiosity and depression is equivocal. While some studies suggest that religion acts as a protective factor against symptoms of anxiety and depression (Lamba & Ellison, 2012; McCullough & Larson, 1999; Smith et al., 2003; Pargament & Lomax, 2013), the research demonstrates a far more complex relationship (Iyer & Zhang, 2019). Considerable evidence exists suggesting that religion can be alternatively a significant resource for people in times of distress as well as a source of struggle and strain in everyday life (Rosmarin et al., 2010).

One meta-analysis examining the relationship between religiosity and depression (Smith et al., 2003) found that a positive association between religiosity and depression was heightened in studies involving people who were undergoing stress due to recent life events. Depressive symptoms might encourage some individuals to seek comfort in religion, increasing their apparent religiosity (Idler et al., 2009). In contrast, other studies suggest that religious involvement of individuals with high levels of depressive symptoms may erode over time as a result of experiencing decreased pleasure from

formerly pleasurable activities, including religious involvement. Additionally, since depressive symptoms may include a lack of energy, individuals may find themselves unable to engage in religious pursuits, causing them to appear less religious on measures such as self-reported evaluations of religiosity or attendance at religious services (Smith et al., 2003).

One can also consider that religion may merely exacerbate underlying mental health issues, such as a worsening of depressive symptoms associated with guilt at having transgressed religious prohibitions (Loue, 2010) or an increase in anxiety about adhering to precise religious practices. Some recent research has focused on the correlation between religion and scrupulosity, a subtype of obsessive-compulsive disorder (OCD), suggesting that individuals with scrupulosity-related OCD symptoms experience increased anxiety about their religious observance (Siev et al., 2011).

Contributing to the difficulty in understanding the relationship between religiosity and mental health are varying definitions of religiosity. For example, in a review by Hill and Pargament (2008), a negative association between level of religiosity and depressive symptoms was strong when religiosity was measured in terms of private religiosity, such as the strength with which people held particular religious beliefs, but not when measured in terms of public religious involvement (Hill & Pargament, 2008). Smith et al. (2003) found that extrinsic religious orientation (in which religion is used as a tool to serve self-seeking as opposed to spiritual ends) and negative religious coping (e.g., engaging in counterproductive religious behaviors, blaming God for difficulties), were both associated with higher levels of depressive symptoms, while intrinsic religious orientation and positive religious coping were associated with fewer depressive

symptoms and a quicker abatement of depressive episodes. Pargament and Lomax (2013) similarly found extrinsic religious orientation to be predictive of mental illness. Krumrei et al. (2013) found that trust in God and positive religious coping were associated with fewer depressive symptoms, while mistrust in God and negative religious coping were associated with an increase in depressive symptoms.

The Orthodox Jewish Community

Judaism is among the world's oldest monotheistic religions. The fundamental belief in one transcendent God as the source of creation is a central tenet of the faith (Corrigan et al., 2016). One of the foundations of Judaism is to "love your neighbor as yourself" (Leviticus 19:18), which requires of the Jew to be ethical, selfless, and other-centered. Based on this notion, countless charitable and support organizations can be found in Jewish communities around the globe (Plant & Weiss, 2015). Within the religion of Judaism are several subgroups, one of which is Orthodox Judaism. Orthodox Jews believe that God revealed fundamental teachings to humanity via Moshe [Moses], and that these teachings were passed down and elaborated upon by generations of pious scholars (Ethics of the Fathers, 1:1). In general, Orthodox Jews affirm and observe certain laws and customs including an adherence to kashrus [dietary laws], Shabbos and Yomim Tovim [Sabbath and festivals], the sanctity of marriage [strict monogamy], and encouragement of regular prayer and religious study. Orthodox Judaism places great value upon the Jewish home and family as the center of religious life (Loewenthal, 2006). The chinuch [education] of children is strongly emphasized, and children are considered great blessings. Orthodox families tend to be large, and it is not uncommon among the Orthodox to have six to ten children per family (Schnitzer et al., 2011). In contrast, non-

Orthodox Jewish families average fewer than two children per household (Holman & Holman, 2002). Another significant feature of the Orthodox Jewish community is their manner of dress. This commonly includes skull-caps [yarmulkes] for the men and an adherence to the laws of tznius [modesty] for women (Silverman, 2013). While Orthodox Judaism is a collective term for traditionalist branches of Judaism advocating a strict observance of Jewish Law, Orthodox Judaism may be divided into two categories: The Ultra-Orthodox and the Modern-Orthodox. The Ultra-Orthodox are more conservative, while the Modern Orthodox are relatively more open to secular values. Orthodox Jewish adults between the ages of 40-59 reported an average of 4.1 children as compared to 1.7 children for all Jews, and the majority (81%) of Orthodox Jews enroll children in a Jewish religious day school or yeshiva, as compared to 11% of other Jews (Pew Research Center, 2015). Given this information, it would seem important that interventions addressing anxiety and depression among Orthodox Jewish children be administered within a religious school setting, so as to increase the likelihood of reaching the vast majority of this target population.

Perceptions of mental health. Historically, there has been a reluctance in the Orthodox Jewish community to talk openly about mental illness, leaving individuals and families alone in shame and secrecy (Selekman, 2012). This has been due in part to the perception of mental illness as a sign of weakness or a character defect, rather than an illness on par with physical illness. The stigma of mental illness within the Orthodox community raises particular fears that such information, if not concealed, will damage marriage prospects not only for the mentally ill person, but also for his/her siblings or even extended family

members (Augenbaum, 2019; Pirutinsky et al., 2010; Popovsky, 2010; Rosen et al., 2008; Selekman, 2012).

In general, Orthodox Jews do tend to be underserved when it comes to mental health treatment (McEvoy et al., 2017; Paradis et al., 2006). In some cases, members of the community may relate less to mental illness as a "medical" condition than a special opportunity to receive "divine messages," gain forgiveness, or seek improvement of one's soul (Selekman, 2012). Yet this, in itself, is also descriptive of an individual who does not fit within the normative community, and thus is potentially stigmatizing. Baruch et al. (2014), in an investigation of stigma toward depression and treatment preference among 391 Orthodox and non-Orthodox Jews, found high depression stigma among Orthodox Jews, indicated by elevated levels of secrecy, treatment-seeking stigma, and family/marriage stigma. Bloch et al. (2018) noted that hesitance among the Orthodox Jewish population to seek out mental health services derives from communal stigmatization of mental illness, as well as fear of the secularizing influence of psychotherapy, or the belief that religion and psychology are in conflict with one another (Feinberg & Feinberg, 1985; Schnall et al., 2014). Orthodox patients might anticipate that practitioners will fail to understand their worldview (Popovsky, 2010; Rube & Kibel, 2004). Thus, Jewish individuals might choose to consult a rabbi instead of a mental health professional (Weiss, 2000), or, if it comes to it, seek out a mental health referral from their rabbi (Popovsky, 2010; Silverman, 2014). Silverman (2014) found that among Orthodox Jewish English-speaking immigrants in Jerusalem, individuals who became religiously observant but were not raised observant were more likely to utilize mental health services that those raised observant. This is likely due to the fact that those not

raised religiously observant were exposed to less of the stigma in the religious community and thus did not internalize that stigma.

Being that there is a strong family-centric value system operating within the Orthodox community (Margolese, 1998; Loewenthal & Brooke-Rogers, 2004; Schnall, 2006), it makes sense that stigma regarding mental illness would extend to perceived consequences on family functioning, stability, and children. Given these unique cultural factors, it is understandable why the Orthodox Jew might be more concerned about confidentiality than the typical secular patient. Additionally, several authors have described the desire of Orthodox Jewish individuals to view themselves as the 'perfect Jew' (Loewenthal, 1998; Goshen-Gottstein, 1994). It can therefore be difficult to admit to deviations from this ideal and seek out mental health treatment. Unfortunately, within the Orthodox Jewish community, help is often only sought in extreme cases due to the aforementioned factors.

One effective strategy used by practitioners to increase patients' comfort is that of utilizing a patient's frame of reference to create familiarity with the therapeutic process (Bloch et al., 2018). In an examination of attitudes towards mental health treatment among Jewish university students, Levkovich (2020) found that overall, greater perceived social support, previous treatment, having a family member or friend with a mental illness, and the study of a mental health-related area were associated with more positive attitudes toward treatment. These findings were overall consistent with the research focusing on general attitudes towards mental health treatment (Alexander & Link, 2003; Angermeyer & Dietrich, 2006; Mackenzie et al., 2006; Mojtabai, 2007; Vogel et al., 2005).

In present-day Orthodox and Modern Orthodox Jewish culture, mental health issues are more openly acknowledged and there appear to be increased efforts to foster more candid discussions about mental illness within the community (Flasch & Fulton, 2019; Loewenthal, 2006). A number of newer Jewish organizations focus exclusively on mental health issues within the Orthodox community, including Refuat Hanefesh, which seeks to destigmatize mental illness among the Orthodox, Chazkeinu, which offers supportive phone meetings for women struggling with mental illness, Refa'enu, which runs educational programs in Jewish schools and support groups, and Elijah's Journey, a national Jewish nonprofit organization focusing on suicide prevention. In addition, in some larger Orthodox communities, primarily located in metropolitan areas, Orthodox Jews have begun establishing formal referral organizations within the Orthodox community (e.g., "Relief Resources") that "pre-approve" therapists who are drawn from within the community, or therapists from outside the community who have demonstrated an understanding of and respect for the values of the community. Furthermore, virtually every local Jewish federation in North America has a Jewish Family Services agency that provides counseling and other assistance to families and individuals suffering with mental health issues, including those in the Orthodox community (Flasch & Fulton, 2019; "Judaism and Mental Illness", n.d.). While not a primary focus, more recently, attention has begun to shift toward prevention and early intervention (Loewenthal, 2006).

Margolese (1998), in his review of the literature on engaging in psychotherapy with Orthodox Jewish patients, found several themes. The establishment and maintenance of a therapeutic working alliance with an Orthodox Jew requires a therapist to flexibly work within the patient's unique religious framework. It is vital that the therapist not

directly challenge the patient's beliefs unless it is certain that they are outside the realm of Jewish law, and even then, it may be beneficial to do so with rabbinic consultation. It is also helpful for therapists working with Orthodox Jews of the opposite sex to be aware of the laws of modesty followed by Orthodox Jews. In general, it is beneficial for therapists to educate themselves about specific practices of Orthodox Jews prior to treating them. Overall, Margolese (1998) stresses the importance of patience and flexibility in working with Orthodox Jews. Similarly, McEvoy et al. (2017) found that among Ultra-Orthodox individuals living in an Orthodox Jewish community in England, there were almost no attempts to access mental health care. There was much stigma surrounding mental illness, and many individuals reported worry that people within the community would find out about their mental health issues. Additionally, the doctors within the community were reluctant to refer their patients for mental health services, only referring the most severely mental ill, so as to avoid labeling people as having mental illnesses as much as possible. The researchers found that self-improvement was a common idea that was encouraged within the community. Thus, if therapy was presented as an opportunity for self-improvement, individuals may be more likely to come. Overall, Orthodox individuals expressed concern that practitioners from outside of their religion would fail to understand their lifestyle, as well as concerns about their confidentiality being breached if they used a practitioner from within their community.

Treatment of mental disorders. Judaism places a strong emphasis on preservation of life, loving others, protection against self-harm, and a physician's duty to heal (Kinzbrunner, 2004). Historically however, many classical rabbinic sources are ambivalent towards doctors and medicine (Preuss, 1978). Nevertheless, much is written

about medical issues in the Talmud and throughout Jewish literature (Rashi, Exodus 21:18-19), and rabbinic leaders commonly referred those suffering to medical practitioners. Moreover, the long tradition of great physicians throughout Jewish history, who were also great rabbis (the most famous being Rabbi Moshe ben Maimon – Maimonides), would appear to affirm Judaism's positive attitude towards medicine and physicians. Ultimately, this tension between faith in Divine healing versus seeking the help of a physician was resolved by various Talmudic statements such as "doctors are messengers of God" or "instruments of God" (Bilu & Witztum, 1993). The idea of seeking treatment for one's challenges is hinted at in the Talmud which states that "a person cannot heal himself, because a prisoner cannot free himself from prison" (Babylonian Talmud Berachos 56). In fact, Maimonides urged those suffering from mental illness to utilize the services of a "physician of the mind" (Code 1:2). Because religion and spirituality can play a critical role in healing, people experiencing mental health concerns often turn first to a faith leader (American Psychiatric Association, 2016; American Psychological Association, 2013; U.S. Department of Health & Human Services, 2019).

Thus, Orthodox Jews may initially turn to their rabbi when faced with mental health challenges, and rabbis, regardless of their level of formal psychological training, may serve in the role of "first responders" (American Psychiatric Association, 2016). In this capacity, rabbis can facilitate access to treatment for those in need, reduce stigma associated with mental illness and treatment, and dispel misunderstandings, for example, when religiously observant individuals believe that their symptoms are a "punishment from G-d", that they should "depend on God" for healing, or when they perceive

receiving psychological services as a "lack of faith" (Greenberg & Witztum, 2001). For those whose religious orientation may be a source of resistance to treatment, a faith leader, such as a rabbi, can affirm, for example, that "God has given us the ability to develop medicines that are helpful in keeping us well" (American Psychiatric Association, 2016).

Spiritual leaders of minority or ethnic groups with strong religious traditions are commonly regarded as interpreters of the secular world and its institutions (Slanger, 1996). Thus, the attitudes of these leaders toward therapy and the field of mental health will significantly influence prospective patients' opinions of therapy and its practitioners. After consulting with a rabbi, those experiencing mental health challenges might pursue treatment with a religious or secular mental health professional who has been "approved" by the rabbi, often of the same gender as the individual seeking treatment (McEvoy et al., 2017). Rabbi Moshe Feinstein, a prominent 20th century authority on Jewish law, ruled that under certain circumstances, religious guidelines allow for obtaining mental health care from practitioners outside the community (Wikler, 1989). However, it is apparent that for the Ultra-Orthodox individual, seeking psychotherapeutic services is often considered a last resort.

Once the decision is made to engage in therapy, Orthodox Jewish patients may come with several cultural preconceptions. The closest experience to therapy they may have experienced would be their relationship with their Rabbi, a dynamic typically characterized as providing a teshuva [response] to a posed shaila [question]. This sort of exchange differs significantly from the self-exploration often evident in therapy and may

confuse or disappoint a patient who has different expectations (Greenberg, 1991). Psychoeducation about the goals and processes of therapy might help prevent such unnecessary confusion and disappointment (Augenbaum, 2019).

Unfortunately, there may be some religious leaders who discourage community members from seeking outside help, especially in more isolated communities, where fear of interacting with non-religious professionals (Jewish or non-Jewish) who may be ignorant or worse, perceived as dismissive of traditional Jewish values, might appear to pose a threat to the stability of the community and the upholding of traditional standards. In fact, there are some in the Jewish community who believe that secular psychology, and specifically psychoanalysis, should be entirely discredited and replaced with psychotherapeutic concepts and practices that are more in line with Jewish religious values. For instance, Amsel (1970) writes, "The implications of this conflict for the individual is the destructive influence psychology has exerted on our entire society." Some Jewish authorities may view psychoanalysis as excusing or even encouraging immoral behavior by attributing it to unconscious and uncontrollable desires. Furthermore, the deterministic concept of man in both psychoanalytic and behavioral theories is antithetical to the concepts of free will and accountability, which are fundamental in religious Judaic thought (Bulka, 1983; Schimmel, 1997). Therefore, some rabbinic authorities might worry that sending individuals to therapy may cause them to abandon their religion (Bulka, 1983).

Unfortunately, research conducted to date on the manner in which Orthodox Jews pursue treatment for mental health challenges has focused primarily on adults. Thus,

there is a clear need to investigate how children from the Orthodox community manage symptoms of anxiety and depression, and how their families, teachers, and religious community members help or hinder their ability to address these issues.

Private religious education. In recent years, private Orthodox Jewish schools have begun to hire mental health professionals as part of their staff, as well as offer health and wellness programs, counseling services, and mental health resources (Frabutt, et al., 2011; Eisen, 2018). These professionals include social workers, mental health counselors, and/or licensed psychologists, whose roles typically encompass both assessment and counseling. However, significant mental health issues that students may struggle with are not routinely addressed in school settings. Instead, if identified - which is not always the case - these students are referred for individual treatment with a therapist outside of the school setting (Frabutt et al., 2011).

Considering the data on the prevalence of anxiety and depression in children, and the large percentage of Orthodox children enrolled in religious schools, within-school universal prevention programs that align with religious principles and spirituality may present a unique opportunity to address mental health concerns among youth within the Orthodox community. One possible avenue for this type of programming can be found within the positive psychology movement, the latter having contributed a significant amount of research to the profession regarding gratitude-focused interventions that increase well-being in children and adults. The following section summarizes these findings and how they will be utilized in the present study.

Positive Psychology and Gratitude

The sub-field of positive psychology focuses on strengths that enable individuals and communities to thrive. It is founded on the belief that individuals want to lead meaningful and fulfilling lives, to cultivate strengths, and to enhance life experiences, and emphasizes well-being, contentment, and satisfaction, optimism, flow, and happiness (Seligman & Csikszentmihalyi, 2000). The principles of positive psychology have been demonstrated to align well with elements of religious and spiritual life (Joseph et al., 2006). This would appear to be true of Judaism, a religion that places a significant emphasis on living a life of meaning, developing positive traits and attributes, and promoting hope, faith, and optimism (Wertheimer, 2005).

Gratitude. Emerging from the field of positive psychology is an expanding body of research focused on the psychological health benefits of gratitude (Wood et al., 2010). Gratitude is an emotion preceded by the perception that one has benefitted from the efforts of another (Emmons & Mishra, 2011). Individuals can feel gratitude towards others – hence gratitude's reputation as an "other-oriented" emotion; or towards God, fate, nature, etc. (Allen, 2018). Gratitude can be further categorized into three types: gratitude as an "affective trait" or overall disposition, gratitude as a mood which can fluctuate daily, and gratitude as an emotion or a more temporary feeling in response to receiving a gift or favor from another (Allen, 2018). Gratitude may generate a desire to repay a benefactor, thereby reinforcing the benefactor's generosity, and/or motivate the beneficiary to further extend generosity to others (McCullough et al., 2008). Gratitude, as a positive and prosocial emotion enabling the continuity of both offering and receiving help, is fundamental to the survival of humanity (McCullough et al., 2008).

Gratitude may be distinguished from the related emotion of happiness. While both are positive emotions, happiness generally stimulates helping in situations where it is not costly to the helper, whereas gratitude promotes prosocial behavior even when it is costly (McCullough et al., 2008). Bartlett and DeSteno (2006) found that participants in an experimentally induced state of gratitude voluntarily spent more time completing an uninteresting survey as a favor to their benefactor than did participants in a happy emotional state. Moreover, while engaging in prosocial behavior in response to gratitude is associated with feelings of contentment and well-being, engaging in these behaviors out of a sense of indebtedness and obligation, even in a happy state of mind, are often associated with negative and uncomfortable feelings (McCullough et al., 2001).

Some variability exists in the relationship between gratitude and positive outcomes such as improved mental health, life satisfaction, and positive affect, and decreased symptoms of mental illness and negative affect. One longitudinal study found a small but significant relationship between gratitude and a sense of purpose, suggesting that gratitude may play a role in developing purpose (Malin et al., 2017). McCullough et al. (2002) found that among participants aged 11-13, those scoring higher on the Gratitude Adjective Checklist (GAC) reported greater positive affect, optimism, social support, and satisfaction with school, family, community, friends, and self, compared to students scoring lower on the GAC. Zhen et al. (2019) found that gratitude in children aged 8-13 was positively correlated with academic engagement, which in turn predicted academic success. However, some studies have suggested that booster sessions may be necessary to achieve long term sustainable benefits (Davis et al., 2016).

Shoshani and Steinmetz (2014) studied the effects of a one-year gratitude school-based intervention on the mental health and well-being of a sample of 537 seventh to ninth graders matched to a control group of 501 students in a demographically similar wait-list control school. All children were attending Jewish schools in Israel, with 4% of participants identifying as Orthodox[1], 21% as traditional, and 75% as secular. The gratitude intervention, a biweekly gratitude list and letter writing program, was administered by educational staff trained in positive psychology. Results from the study supported a relationship between gratitude and improved mental health, with significant decreases in symptoms of distress, anxiety, and depression occurring among participants in the experimental gratitude group as compared to increasing symptoms among participants in the wait-list control group. While the results of the study by Shoshani and Steinmetz (2014) appear to indicate a strong positive relationship between gratitude and mental health and well-being, the study contains a strong potential confounding factor based on the Hawthorne effect. Specifically, in the study, it is not clear whether it was the actual intervention or the fact that the intervention group received something (i.e., extra attention) that was responsible for the change in mental health status. If the control school had implemented some other non-gratitude intervention (as was done in the present study), the Hawthorne effect could be ruled out. In the Shoshani and Steinmetz (2014) study, however, it remains a viable explanation. Another limitation in the study by Shoshani and Steinmetz (2014) is the method they utilized to select schools. Their method was not a random selection, but rather was specific to a geographical area and to principals who were interested in the subject. That may reflect a number of differences in

[1] Note that Ultra-Orthodox schools were excluded from this study.

both the school environment (very supportive of good mental health) or in the student body (perhaps, having a lot of mental health issues initially as a motivator for the study).

Kwok et al. (2016) researched the effects of a positive psychology intervention focusing on hope and gratitude among students aged nine to eleven in Hong Kong. Following the intervention, participants in the experimental group demonstrated significant increases in life satisfaction and decreases in depression as compared to those in the control group. In another study, Froh et al. (2008) examined the effects of a "counting blessings" intervention on 221 sixth and seventh grade students, who were randomly assigned to either a gratitude condition, hassles condition, or control condition for a period of two weeks. Students in the gratitude condition were asked to list up to five things they were grateful for each day, while participants in the hassles condition were instructed to recall up to five hassles that annoyed or bothered them in the previous day. Control group participants received no intervention. Counting blessings, in comparison with focusing on hassles or no intervention, was associated with increased gratitude, optimism, and life satisfaction, and decreased negative affect. Similarly, Emmons and McCullough (2003) found that participants who wrote about their blessings weekly for 10 weeks reported feeling more optimistic about the following week. A second trial found that those who counted their blessings daily for 14 days reported higher levels of positive affect and were more likely to report helping another. Other studies using variations of the "counting blessings" intervention have found that counting blessings increased people's life satisfaction and self-esteem (Rash et al., 2011); mitigated symptoms of depression, and increased positive affect, though only in participants who started off with a high level of depressive symptoms (Harbaugh & Vasey, 2014). Another study that

instructed 7- to 11-year-old students to “write down 2 or 3 things that you are thankful and grateful for today at school” found that these students reported experiencing more gratitude and felt a greater sense of belonging in their school than students assigned to write about neutral topics (Diebel et al., 2016). Another study found that 8- to 19-year-old students who wrote a gratitude letter and read it to the person to whom they were grateful reported more gratitude and positive affect following the intervention and more positive affect at a two-month follow up than students assigned to journal about their day. Yet, these positive outcomes were only found in students who had low positive affect at the start of the study (Froh et al., 2009). Lo et al. (2017) found that gratitude had a significant moderating effect on suicidal ideation, suggesting the importance of including elements of gratitude in preventive and clinical interventions.

However, not all studies have yielded such positive results from gratitude journaling. A relatively small study by Sheldon and Lyubomirsky (2006) compared the effectiveness of counting blessings with an intervention that asked participants to visualize their best possible selves, along with a control activity in which participants wrote about details of their day. The researchers found that the completion of any of the activities (including the control activity) immediately decreased negative affect in the participants, but only the “best possible selves” visualization immediately increased positive affect (Sheldon & Lyubomirsky, 2006). The researchers suggest that the participants may have found the gratitude activity to be more demanding and less enjoyable than visualizing their future. Another study found that students who counted blessings once a week experienced greater improvements in well-being than those who counted blessings three times a week (Lyubomirsky et al., 2005). In fact, those who

counted blessings three times a week actually reported a decrease in their well-being (as did those in the no-intervention control group). It seems plausible to suggest that counting blessings less frequently may make for a more meaningful activity that is sustainable over the long-term. As suggested by Lyubomirsky et al. (2005), perhaps individuals become numb to the novelty and benefits of counting blessings if it is done on a more frequent basis.

In a study by Toepfer et al. (2012), participants who were asked to write a gratitude letter once a week for three weeks reported higher levels of happiness and life satisfaction, as well as fewer symptoms of depression, at the conclusion of the intervention. Another study, led by Seligman et al. (2005), found that participants who wrote a letter of gratitude and read it in person to their benefactor reported higher levels of happiness and fewer symptoms of depression one month later. However, it is important to note that the subjects in this study were recruited from Seligman's website, and were informed that they were participating in a study intended to enhance well-being. This process of recruitment may have led to self-selection effects, which might explain why the results reported in this study were stronger than those from other studies. In another study, Froh et al. (2014) examined the effects of an intervention that trained fourth and fifth grade students in social-cognitive perceptions designed to elicit gratitude (i.e., benefit appraisals). Participants in the treatment condition participated in classroom discussions, writing assignments, and role-playing activities directed toward understanding a benefactor's positive intention, the cost experienced by benefactors when providing a benefit, and the benefits of receiving a gift bestowed by a benefactor. Students in the control group received similarly structured lessons focused on

emotionally neutral topics, such as the students' daily activities. The results indicated that children who were taught to be aware of social cognitive appraisals when receiving help were more grateful than those in the control group, as assessed by the three emotion items of the Gratitude Adjective Checklist (GAC; McCullough et al., 2002). Those in the experimental condition also experienced benefits to their well-being in terms of increased general positive affect, as measured by the Positive and Negative Affect Scale for Children (PANAS-C; Laurent et al., 1999). Similarly, 11- to 14-year-old students attending two schools in North India who received benefit appraisal lessons for five weeks reported higher levels of well-being, positive affect, life satisfaction, and gratitude than did students in a control group (Khanna & Singh, 2016). However, Layous and Lyubomirsky (2014) suggest that the benefit appraisal curriculum would likely be less effective with younger children who lack a developed theory of mind and thus would have difficulty appraising the benefactor's intentions and emotions.

Freitas et al. (2011) studied the effects of expressing gratitude in children and adolescents. Four hundred and thirty children, aged 7 to 14 years old, were asked: "What is your greatest wish?" and "What would you do for the person who granted you this wish?" The participants' responses to the second question were coded into four types of gratitude: verbal, concrete, connective and finalistic. Verbal gratitude, i.e. saying "thank you", might simply reflect what the child has been taught to say, without necessarily including the feeling of gratefulness. Concrete gratitude denotes a type of gratefulness where children repay their benefactor with something that they themselves consider to be valuable, but not necessarily something of actual value to the benefactor, reflecting the egocentric nature of this type of gratitude. Connective gratitude describes the creation of

a relationship with the benefactor, either by repaying with something of value to the benefactor or by expressing specific feelings, such as honoring the benefactor or considering him or her a great friend. The fourth type of gratitude, finalistic gratitude, is characterized by a child repaying a favor with an action that promotes the child's own personal development. The researchers found a decline in the frequency of concrete gratitude and an increase in connective gratitude as the age of respondents increased. Similarly, Tudge et al. (2015) examined the development of gratitude in youth, relating their gratitude to their wishes. The researchers asked 358 7- to 14-year-old North American participants to write their greatest wish and what they would do for their benefactor. The researchers found that younger participants (aged 7 to 10) were significantly more likely to express hedonistic wishes (desire for immediate gain) and concrete gratitude (not taking the benefactor's wishes into account), while older youth (aged 11 to 14) were significantly more likely to wish either for something involving future well-being for themselves or the well-being of others and connective gratitude (taking into account the benefactor's wishes). Within both age groups, there was a significant inverse relation between hedonistic wishes and connective gratitude. Chopik et al. (2019) found that the experience of gratitude was greatest in older adults and lowest in middle aged and younger adults. They also found that associations between gratitude and well-being remained relatively constant across the lifespan.

The optimal time to foster gratitude in children appears to be between the ages of seven and ten, as the experience of gratitude is thought to mature during that period (Froh & Bono, 2011). Research indicates that children are able to understand, experience, and express gratitude (Freitas et al., 2009a, 2009b; Gordon et al., 2004; Paludo, 2008).

Therefore, it would seem fitting to begin cultivating gratitude in childhood. Wang at al. (2015) took a developmental perspective in examining changes with age in types of wishes and gratitude. The researchers found that the expression of connective gratitude, which is considered the most sophisticated form of gratitude and theorized to promote personal well-being and social relationships, increased with age in American and Chinese children. Moreover, an inverse relationship between hedonistic wishes and connective gratitude was found in the U.S. sample, indicating the importance of encouraging and facilitating the development of connective gratitude in children as a possible means to reducing materialism in our youth. Merçon-Vargas et al. (2018) suggest that more attention be paid to within-culture variation in gratitude (particularly related to socioeconomic but also ethnic, regional, political, or religious factors).

It is important to note the research on children's cognitive and social-emotional development throughout the lifespan. Moral development refers to the process through which children develop the standards of right and wrong within their society. Gratitude is considered to be a moral virtue. Piaget (1965/1977) conceptualized gratitude as a feeling that emerges between a beneficiary and a benefactor when the former values both the favor received as well as the benefactor him- or herself. Because gratitude develops throughout childhood (Piaget, 1954), it would be expected that children of different ages understand gratitude with different degrees of complexity. Piaget (1932) conceptualizes moral development as a constructivist process, whereby the interaction of action and thought builds moral concepts. Piaget was mostly interested not in what children do (i.e., in whether they break rules or not) but in what they think, or in their moral reasoning. Piaget studied three main aspects of children's understanding of moral issues, namely,

children's understanding of rules, moral responsibility, and justice. Piaget found that children's notions regarding rules, moral judgements and punishment changed as they got older. He suggested two main types of moral thinking: heteronomous morality (moral realism), where morality is imposed from the outside, which is present from about ages 5-9, and autonomous morality (moral relativism), where morality becomes based on one's own rules, and children recognize that there is no absolute right or wrong. This second stage of autonomous morality develops at around age 9 or 10. This development involves a decentration of the self, allowing children to coordinate different points of view and to engage in more reciprocal relationships. Thus, gratitude involves cognitively complex abilities and degrees of moral understanding that develop over the course of childhood and adolescence (Do Vale, 2012; Freitas et al., 2012; Nelson et al., 2013). Time, experience, and encouragement are necessary for gratitude to fully develop, with less complex forms of gratitude being present during this process of development (Baumgarten-Tramer, 1938; Freitas et al., 2011; Tudge et al., 2015; Wang et al., 2015).

Kohlberg (1958) sought to further develop the ideas of Piaget's (1932) theory of moral development. Kohlberg's theory proposes that there are three levels of moral development, with each level divided into two stages. Kohlberg suggested that people move through these stages in a predetermined order, and that moral understanding is linked to cognitive development. The three levels of moral reasoning include pre-conventional, conventional, and post-conventional. By using children's responses to a series of moral dilemmas, Kohlberg established that the reasoning behind the decision was a greater indication of moral development than the actual answer. According to Kohlberg, at the pre-conventional level children don't have a personal code of morality.

Instead, moral decisions are shaped by the standards of adults and the consequences of following or breaking their rules. Thus, in this stage, children often make moral decisions based on the consequences of actions. Conventional morality, the second stage of moral development, is characterized by an acceptance of social rules concerning right and wrong. At the conventional level, we begin to internalize the moral standards of adult role models. It is in this stage that gratitude is experienced and expressed. Post-conventional morality, the third stage of moral development, is characterized by an individuals' understanding of universal ethical principles. According to Kohlberg, only 10-15% are capable of the kind of abstract thinking necessary for post-conventional morality.

Li (2016) outlined a mechanism of parental moral education for gratitude development in children in China. The researcher claims the mechanism to be aligned with fundamental psychological and sociological theories, including Piaget's theory of moral development and Kohlberg's moral stages theory. Interestingly, neither Piaget nor Kohlberg claimed that moral understanding or thinking naturally leads to moral acting. Although Kohlberg (1976) considered moral reasoning to be a prerequisite for the next moral stage in his theory, there is not necessarily a direct connection between moral reasoning and moral actions, particularly when it comes to such factors as costs (Bee, 1994; Li, 2014a). Gratitude, as a moral virtue, is more of an act of returning kindness received than merely a thought (Bee, 1994; Li, 2014a), and can be costly in such situations as filial piety. It has been found that household chores can act as a vital means for the development of moral character in a child (Kohlberg, 1984; Piaget, 1965). Research indicates that housework can help children's moral development of justice,

which in turn leads to the cultivation of gratitude for their parents' sacrifices for their benefit.

Nelson et al. (2013) notes that while most research on gratitude in youth has included children 7 years of age and older, and some have suggested it emerges only after this age (Froh et al., 2011), there are studies indicating that children as young as 4 have some understanding of the concept of gratitude. Other research has stated that 5 is the earliest age at which children can understand and respond to stories about gratitude (Castro et al., 2011; Freitas et al., 2009a). Some researchers have studied children's verbal responses as an early indicator of children's understanding of gratitude. Baumgarten-Tramer (1938) found that verbal gratitude (saying "thank you") was a common response at all ages, including at age 7, the youngest aged children studied. Other studies have found that spontaneous thanking increases with age (Becker & Smenner, 1986; Gleason & Weintraub, 1976). However, it is important to note the distinction between behaving politely and experiencing genuine feelings of gratitude. Nelson et al. (2013) found in their study that at age 5, almost all of the children appeared to have some understanding of what it means to be grateful and some had a relatively complete understanding.

Because gratitude includes positive emotions linked to a specific event (a benefit received), one skill thought to be involved in understanding gratitude is an ability to recognize emotions and connect them appropriately to social situations. In order to feel grateful, an individual must recognize that another person (the benefactor) has identified and acted to fulfill one's own need or desire (Froh et al., 2010; McConnell, 1993). The

wish to return the favor stems from the recognition that the benefactor acted with the intent to satisfy a need or desire of the beneficiary (Bonnie & de Waal, 2004; Freitas et al., 2009a). Thus, there is an assumed connection between children's mental state knowledge and their understanding of gratitude. The acquisition of an understanding of mental states has been studied mainly through tasks labelled "theory of mind".

Allen (2018) discusses potential mechanisms for how gratitude supports happiness and psychological well-being. One proposed explanation is that gratitude counteracts hedonic adaptation, or the phenomenon where people acclimate to positive developments in their lives and thus do not enjoy them as much, by encouraging people to deliberately focus on what is good in their lives rather than take them for granted. Another possibility is that gratitude, like other positive emotions, can broaden a person's array of thoughts and actions, and can build a person's psychological and social resources on which they can rely in difficult times (Fredrickson, 2004). Research has in fact found positive associations between trait gratitude and a number of positive strategies for coping with challenges, including seeking support, reinterpreting situations through a positive lens, and engaging in problem-solving. Moreover, negative associations have been found between gratitude and maladaptive coping strategies such as substance use, denial, and self-blame (Wood et al., 2007). When people experience gratitude, they reframe negative experiences in a more positive light and experience more positive emotion, both of which reduce the pain of negative emotions (Lambert et al., 2012). Another study found evidence that trait gratitude may have positive effects on well-being partially via its ability to increase self-esteem (Lin, 2015). When a person feels grateful they often view themselves as benefiting from another person's generosity, leading them

to feel valued. This increases self-esteem, which in turn leads to higher levels of psychological well-being.

In looking to determine the efficacy of gratitude interventions specifically with youth, a meta-analysis of studies concluded, "On the whole, gratitude exercises for promoting youths' subjective well-being and decreasing subjective distress are generally ineffective, although isolated studies have deemed them effective for select outcomes" (Renshaw & Olinger Steeves, 2016). A 2015 meta-analysis of 26 studies of various gratitude interventions (Davis et al., 2015) found that individuals who participated in gratitude interventions showed greater psychological well-being, but not gratitude, than those in control groups who did not complete an intervention. Additionally, those who completed gratitude interventions showed greater improvements in psychological well-being and gratitude, but not reduced levels of anxiety, when compared with people in control groups who completed non-gratitude activities. The study also found that gratitude interventions generally performed about as well as other psychologically active interventions, such as acts of kindness. The meta-analysis suggests that gratitude interventions may actually work primarily through the placebo effect. A more recent meta-analysis study that analyzed the results of 38 gratitude studies concluded that "gratitude interventions can have positive benefits for people in terms of their well-being, happiness, life satisfaction, grateful mood, grateful disposition, and positive affect, and they can result in decreases in depressive symptoms" (Dickens, 2017). However, it also notes that the findings regarding negative affect and stress were mixed, and there were not significant findings around improvements in physical health, sleep, prosocial

behavior, or self-esteem. Additionally, gratitude interventions were rarely more effective than other kinds of positive interventions.

In the educational context, researchers caution that many of the gratitude interventions utilized lack sufficient concern for the complexities of gratitude and the many variables that could impact the ways in which students experience gratitude (Morgan et al., 2015). They also suggest that it might not benefit students to convey that gratitude is absolutely positive and worthy of cultivating without bringing to their attention that there are situations where gratitude may not be an appropriate response. Morgan et al. (2015) propose that future gratitude interventions for children should incorporate more reflection and analysis, including of benefactors' often mixed motives.

Chapter 2
Statement of the Problem

As depression and anxiety disorders are among the most common childhood mental health disorders (Mills & Baker, 2016), they are essential targets for prevention and early intervention. Additionally, targeting depression and anxiety disorders is vital due to their early onset, broad-reaching health consequences, negative impact on academic and social functioning, comorbidity with other mental health disorders, and persistence into adulthood (Dawson, 2018; Kendall et al., 2010; Maynard et al., 2018; McLaughlin & King, 2015; Thapar et al., 2012; Wagner, 2009).

Overall, the relationship between religious factors and mental health is equivocal, with some studies suggesting that religion is protective against symptoms of anxiety and depression, and others suggesting the opposite. Regardless, minimal research has been conducted examining mental health interventions among religious youth who may be at equal risk to their secular counterparts, but at greater risk of not receiving psychological services (American Psychiatric Association, 2016). Among Jewish Orthodox youth, school-based mental health interventions that are scientifically supported, yet respectful of community values and with Orthodox Jewish theology, may serve as an ideal means for providing prevention and early intervention services for youth. In this regard, Jewish schools may prefer to implement brief positive psychology-based interventions over other more psychologically framed interventions, since gratitude and other themes within positive psychology align well with Jewish theology.

In general, in private schools, it is preferable to implement brief interventions because, unlike public schools benefitting from ongoing government funding, private schools rely upon more precarious funding in the form of tuition, grants from charitable

organizations, and in the case of religious schools, contributions from other community-based religious organizations (FindLaw, 2016). Thus, private Jewish schools might opt to implement a brief, cost-effective, gratitude journaling intervention that could be easily implemented under the direction of school staff. In this way, students attending private Jewish schools could benefit from psychological interventions that are aligned with community values and within the financial means of their schools.

Chapter 3
Purpose & Hypotheses

The goal of the present study was to evaluate the feasibility and effectiveness of a brief, cost-effective, culturally sensitive gratitude intervention for Jewish Modern Orthodox elementary school children. More specifically, the present study aimed to investigate the impact of a brief gratitude ("counting blessings") journaling intervention on mental health, as well as academic achievement, among third grade students attending a private Modern Orthodox Jewish elementary school in Lawrence, New York. The control group consisted of third grade students who engaged in parallel brief journaling activities unrelated to gratitude. Mental health status and academic achievement were assessed before and after the intervention period for all participants. Expected changes, to include improvements in measures of mental health, as well as math and reading performance, would directly benefit students, families and teachers. In addition, if successful, school psychologists working with Orthodox Jewish students would be able to manage student care with fewer outside referrals to expensive off-site intervention services.

Hypotheses:

Hypothesis 1: Students participating in a brief journal-based gratitude intervention will experience a significant increase in gratitude as compared to students not participating in the brief journal-based gratitude intervention.

Hypothesis 2: Students participating in a brief journal-based gratitude intervention will demonstrate a significant improvement in math performance as compared to students not participating in a brief journal-based gratitude intervention.

Hypothesis 3: Students participating in a brief journal-based gratitude intervention will demonstrate a significant improvement in reading performance as compared to students not participating in a brief journal-based gratitude intervention.

Hypothesis 4: Students participating in a brief journal-based gratitude intervention will experience significant benefits to their mental health, as compared to students not participating in a brief journal-based gratitude intervention.

Chapter 4
Methods

Participants & Sampling Method

Participants were 68 third-grade students drawn from classes at a private Modern Orthodox Jewish elementary school in Lawrence, New York. The grade level chosen for participation was designated by the school principal. The selected sample was comprised of 39 males and 29 females. All students were Jewish and Caucasian and were between the ages of eight and nine years at the time of the intervention. Participants came from families of varying sizes with the total number of children ranging from one to five (M=3.35, SD=0.94, Mdn=3). Participants from two classes (3A, 3B) were assigned to the intervention group (n=36); participants from the other two classes (3C, 3D) were placed on a "wait-list" alternative activity control group (n=32). Students from two classes (3A and 3C) shared one teacher. Students from the other two classes (3B and 3D) also shared a different teacher.

Inclusion and Exclusion Criteria

The only inclusion criterion was enrollment as a third grade student. All third-grade students in the school were invited to participate in the study, and parents were provided with informed consent documents. The only exclusion criterion was parent refusal of consent. Two parents declined to provide consent, and thus their children were not included in the study. Parents of 68 third grade students provided informed consent prior to the onset of data collection, and thus their children were included in the study. All 68 participants provided assent prior to the onset of data collection.

Intervention

The intervention consisted of a twice-weekly written "counting blessings" gratitude journaling activity, wherein students were asked to list at least three things for

which they were grateful in a journal provided by the researcher. At the start of each session, the researcher delivered a brief introduction to the activity, adapted from Emmons and McCullough (2003), saying "There are many things in our lives, both large and small, that we might feel grateful for. We might feel grateful for a person, a possession, or an event that happened to us. Please take a few minutes to write down at least three things that you are feeling grateful or thankful for today." The researcher then allowed 10 minutes for the students to list things or events for which they were grateful. The intervention lasted for one month and was administered twice-weekly by the researcher. The students were required to complete a journal entry during each session. To ensure treatment integrity, the researcher circulated around the classroom as the students wrote in their journals, confirming that each student was writing something. This effort to ensure treatment integrity was unique to the present study. On occasion, a student was reluctant to write, and would choose to draw three things for which they were grateful. The students were given the opportunity to share what they had written with the researcher or with the whole class if they wished. However, this was not mandatory, and students were advised that their entries were private and would not be read by the researcher or other school staff. At the end of each session, the researcher collected the journals and stored them until the following session. When the intervention concluded, the students were allowed to take their journals home with them. These elements as well were original methodologies unique to the present study.

Students in the active control group participated in a brief written journaling activity unrelated to gratitude twice weekly during the first month.[2] The active control

[2] At the end of one month, wait-list controls were transitioned into the brief gratitude-based journaling activity and the control group journaling activity was discontinued.

activities were administered by the researcher in a manner similar to that of the intervention group and each lasted for 10 minutes. The researcher began with a brief introduction, informing the students of the topic they would be asked to write about that day. For instance, “Today we will be writing in our journals about what we did yesterday, from when we woke up until we went to sleep.” Other topics included describing any person, describing any place, and writing about what the student had done over the weekend.

Unfortunately, after the start of the data collection period, the researcher was informed that all third-grade students were participating in a separate verbal gratitude activity initiated independently by classroom teachers, but not stated in the regular school curriculum. This activity, which involved students verbally sharing something they were grateful for, was administered most days of the week by classroom teachers immediately prior to daily prayer services. Two to three students would generally volunteer to share something for which they were grateful, in an activity with a duration for two to three minutes (C. Garfinkel, personal communication, 2019).

Data Collection Methods

Gratitude and mental health were assessed for all participants at baseline (T1) and one month later at the conclusion of the intervention period (T2). The assessments were administered in the classrooms during class time under the supervision of the researcher, with classroom teachers present. Assessments of academic performance (reading, math) were administered in a similar timeframe. The reading assessment scores were based on a single reading assessment administered once pre-intervention and once post-intervention. Since math assessments were given more frequently, the pre-intervention and post-intervention math assessment scores used for this study were each calculated as an

average of two math assessments given before and two math assessments given after the intervention.

Assessment Instruments

To assess gratitude, both the experimental and control groups were administered a modified version of The Gratitude Questionnaire (GQ-6) Instrument (McCullough, 2013; see Appendix A). The GQ-6 is a six-item measure of gratitude using a 7-point Likert scale ranging from one (strongly disagree) to seven (strongly agree). GQ-6 scores have demonstrated good internal consistency among both adults and children, as well as a robust one-factor solution in both adult and youth samples (McCullough et al., 2002; Froh et al., 2011). In order to account for the younger age of the sample, the measure was adapted so as to omit some items deemed to contain advanced vocabulary.3 The final assessment instrument contained three items (see Appendix A).

To assess mental health, both the experimental and control groups were administered a mental health assessment containing select items from measures of the American Psychiatric Association (2018). Items were taken from the PROMIS Emotional Distress – Depression – Pediatric Item Bank and the PROMIS Emotional Distress – Anxiety – Pediatric Item Bank. Items were selected according to their appropriateness for third grade students. The final assessment instrument contained six items focused on identifying symptoms of depression and anxiety (see Appendix B).

[3] The original intent of the researcher was to administer the intervention to four fifth grade classes; however, in the last two weeks prior to the start of the study, the school principal made the decision to allow third graders to participate in the study, rather than fifth graders, as she believed that the third grade teachers would be more forthcoming in terms of cooperation.

Students completed all assessment measures manually, using paper and pencil, with the researcher as well as the teacher present in the classroom. The researcher read all items of the assessment instruments aloud to the students as they worked through the items. Students who had questions regarding the items were allowed to ask the researcher for help once all of the items had been read aloud to the class. Students were given up to 30 minutes to complete all assessment measures, although most students finished well before the allotted time was up.

Missing Data

For the variables Gratitude and Mental Health, missing data due to omitted or incomplete responses on the measures led to a decrease in sample size and therefore differing degrees of freedom. For the variable Gratitude, data from 9 participants were removed. For the variable Mental Health, data from 11 participants were removed. There was no missing data for the variables Math and Reading. Overall, missing data ranged from 13.24% to 16.18%. A Missing Values Analysis indicated that Little's (1988) Missing Completely at Random (MCAR) test was not significant, $X^2 = 8.551$, DF = 13, $p = .806$. When significant, this test suggests that the hypothesis that the data are MCAR can be rejected. Therefore, there was no evidence to suggest that the data were not MCAR.

Chapter 5
Results

Data Analysis Procedures

An analysis of variance was conducted to determine whether there were significant differences between the four classes at baseline for all variables. Specifically, a one way analysis of variance compared differences between the groups on number of children in the family, as well as the four measures at pretest, namely, gratitude, mental health, math, and reading. There were no significant differences between the experimental group and control group at baseline for any of the variables (see Table 1 below). Specifically, the two groups did not differ significantly on number of children in the family, $F(3,64) = 0.883$, $p=0.455$, gratitude, $F(3,62) = 1.155$, $p=0.334$, mental health, $F(3,61) = 1.281$, $p=0.289$, math, $F(3,64) = 1.194$, $p=0.319$, or reading $F(3,64) = 2.678$, $p=0.054$.

Table 1

Analyses of Variance in Number of Children in Family, Gratitude, Mental Health, Math, Reading

		Sum of Squares	df	Mean Square	F	Sig.
# of Children in Family	Between Groups	2.366	3	.789	.883	.455
	Within Groups	57.163	64	.893		
	Total	59.529	67			
Gratitude-T1 (max. score=21)	Between Groups	52.841	3	17.614	1.155	.334
	Within Groups	945.598	62	15.252		
	Total	998.439	65			

Mental Health-T1 (max. score=30)	Between Groups	173.654	3	57.885	1.281	.289
	Within Groups	2757.361	61	45.203		
	Total	2931.015	64			
Average Math Score Pre-Intervention	Between Groups	386.718	3	128.906	1.194	.319
	Within Groups	6907.352	64	107.927		
	Total	7294.070	67			
Reading Pre-Intervention	Between Groups	30.971	3	10.324	2.678	.054
	Within Groups	246.720	64	3.855		
	Total	277.691	67			

To test for any differences between the groups on gender, a Chi-Square Test of Independence was conducted. No association was found between gender and group, X^2 (3, N = 68) = 0.715, p=0.87.

Pre-Post Intervention Differences

Within and between group analyses were performed to examine changes in outcome variables pre/post intervention. Specifically, Mixed Factorial Analyses of Variance (ANOVA) were conducted in order to compare changes over time as well as compare the two groups to one another at post-test for each variable. The assumption of homogeneity of variance was met for all variables (number of children in family, gratitude, mental health, math, and reading).

Gratitude

There was no statistically significant change in gratitude over time within either of the groups, F=.010, p=.920. There was also no statistically significant change in

gratitude over time between the intervention and control groups, *F*=.005, *p*=.946. The interaction effect (Time x Condition) was non-significant as well, *F*=.269, *p*=.606 (see Table 2). It is possible that no significant change in gratitude scores was detected due to the fact that participants' gratitude scores were already in the average to high range.

Table 2
Within and Between Subject Changes in Gratitude

	Treatment Condition	Mean	SD	N
Gratitude-T1 (max. score=21)	Treatment	16.30	3.584	33
	Control	16.46	3.962	26
	Total	16.37	3.723	59
Gratitude-T2 (max. score=21)	Treatment	16.48	4.893	33
	Control	16.19	3.805	26
	Total	16.36	4.413	59

Note. Data from 9 participants were removed due to omitted or incomplete responses on the measure.

Mental Health

There was no statistically significant change in mental health over time within either of the groups, *F*=.006, *p*=.938. There was also no statistically significant change in mental health over time between the intervention and control groups, *F*=.259, *p*=.613. However, the interaction effect (Time x Condition) was significant, *F*=5.825, *p*=.019, indicating an increase in mental health scores (worsening mental health status) in the experimental group and a decrease in mental health scores (improving mental health status) in the control group (see Table 3). These results, which are contrary to the hypothesis, warrant further attention and discussion.

Table 3
Within and Between Subject Changes in Mental Health

	Treatment Condition	Mean	SD	N
Mental Health-T1 (max. score=30)	Treatment	12.35	7.069	31
	Control	13.15	6.892	26
	Total	12.72	6.938	57
Mental Health-T2 (max. score=30)	Treatment	14.16	8.699	31
	Control	11.46	7.179	26
	Total	12.93	8.086	57

Note. Data from 11 participants were removed due to omitted or incomplete responses on the measure. Higher scores indicate worse mental health.

Math

There was a statistically significant change in math scores over time within both groups, F=9.218, p<.05. However, there was no statistically significant difference in math scores over time between the intervention and control groups, F=2.941, p=.091. Both groups improved in math performance to a similar degree. The interaction effect (Time x Condition) was non-significant, F=.189, p=.665 (see Table 4).

Table 4
Within and Between Subject Changes in Math

	Treatment Condition	Mean	SD	N
Average Math Score Pre-Intervention	Treatment	90.014	7.6350	36
	Control	85.844	12.6481	32
	Total	88.051	10.4339	68
Average Math Score Post-Intervention	Treatment	92.847	7.9622	36
	Control	89.625	11.1051	32
	Total	91.331	9.6334	68

Reading

There was a statistically significant change in reading scores over time within both groups, F=134.640, p<.05. However, there was no statistically significant difference in reading scores over time between the intervention and control groups, F=.373, p=.544. Both groups improved in reading performance to a similar degree. The interaction effect (Time x Condition) was significant, F=6.537, p=.013, indicating a greater increase in reading performance in the control group than in the experimental group (see Table 5). These results, which are contrary to the hypothesis, warrant further attention and discussion.

Table 5
Within and Between Subject Changes in Reading

	Treatment Condition	Mean	SD	N
Reading Pre-Intervention	Treatment	5.22	2.072	36
	Control	5.34	2.026	32
	Total	5.28	2.036	68
Reading Post-Intervention	Treatment	5.86	2.219	36
	Control	6.34	1.877	32
	Total	6.09	2.064	68

Chapter 6

Discussion

Contrary to the initial hypothesis, there was no significant within group change in gratitude following a brief gratitude journaling intervention. Between group differences in change in gratitude pre/post intervention also did not rise to the level of significance. One plausible explanation for the lack of significant findings may be the brief length of time (one month) participants were exposed to the intervention. One could speculate that perhaps, if the intervention had lasted for a longer period of time, the intervention may have proven more successful in improving gratitude. Additionally, the relatively small sample size in the present study may have impacted the results. It is possible that with a larger sample size the findings would have proved significant. Another possible explanation is the young age of study participants. As mentioned previously, the original study was designed for fifth grade students. However, at the time the study was scheduled to begin, the principal made the decision to permit only the third-grade classes to participate. This created several challenges. First, three of the items on the GQ-6 contained language or concepts that, in the view of this researcher, extended beyond the social-emotional and cognitive development of children of that age and, as a result, only three of the original six questions could be used. Second, as discussed in the literature (Kohlberg, 1958; Layous & Lyubomirsky, 2014; Piaget, 1954), younger children have a less complex understanding of gratitude and morality than older children, as well as a less developed theory of mind. In the present study, despite the researcher's efforts to ensure treatment integrity, it is possible that students in the experimental group wrote entries in their journals that were unrelated to gratitude. Anecdotally, however, the researcher notes

that often, students were eager to share what they had written and their entries were in fact things for which they were grateful. Several similar studies that yielded significant results (Froh et al., 2008; Froh et al., 2014; McCullough et al., 2002; Shoshani & Steinmetz, 2014; Zhen et al., 2019) utilized longer interventions, larger sample sizes and/or older children than in the present study. Perhaps these variables impacted the results in the present study and can explain the lack of significant changes in gratitude. Moreover, perhaps including booster sessions would have led to significant findings, since booster sessions might be required in order to attain long term sustainable benefits (Davis et al., 2016).

In addition, the researcher was informed after the start of the data collection period that all third-grade students were participating in a separate brief (2-3 minute) verbal gratitude activity initiated independently by the classroom teachers. This activity, which involved two or three students verbally sharing something they were grateful for, was administered most days of the week immediately prior to daily prayer services (C. Garfinkel, personal communication, 2019). This activity was not stated in the school curriculum, nor mentioned by the principal or teachers prior to the start of the intervention. This represents an important possible confounding variable. It can be speculated that the supplemental verbal gratitude activity impacted the results, essentially turning the control group into a “reduced dose” gratitude intervention group. That is, both the control group and the experimental group were exposed to a gratitude intervention; with the difference being that the experimental group received both the verbal intervention and the written intervention, while the control group only received the verbal intervention.

It is possible that for the intervention group, a twice-weekly written intervention in addition to the verbal intervention implemented by the classroom teachers was simply too much and therefore backfired. Support for this comes from Sheldon & Lyubomirsky (2006), who found that gratitude activities may be more demanding and less enjoyable for participants than other interventions, such as visualizing their future. Additionally, Lyubomirsky et al. (2005) found that students who counted blessings once a week experienced greater improvement in well-being than those who counted blessings three times a week. In fact, those who counted blessings three times a week actually reported a decrease in their well-being (as did those in the no-intervention control group), possibly because counting blessings less frequently may make for a more meaningful and sustainable activity. Perhaps individuals become numb to the novelty and benefits of counting blessings if it is done on a more frequent basis (Lyubomirsky et al., 2005). This might explain the puzzling decrease in mental status of the experimental group and increase in the control group. Perhaps the intervention group experienced an "overdose" of gratitude interventions and thus the results backfired for them. For the control group, it is possible that the Hawthorne effect led to positive outcomes in terms of their mental health.

In terms of the academic outcomes, both the control and experimental groups improved to a similar degree in math, while the control group experienced greater improvements in reading than the experimental group. While it is expected that math and reading skills would improve over the course of the academic year, the findings may be attributable to the brevity of the intervention. Gratitude in children has been linked to academic engagement (Zhen et al., 2019). However, there may have been a multitude of

other factors impacting the students' grades that were not measured in this study. If the intervention had been longer, perhaps different results would have been observed.

There exist a multitude of potentially confounding factors that can impact the mental health of children that were not measured in the present study and may have impacted the results. For instance, low self-efficacy, worse family climate, less social competence, and more severe parental mental health problems are associated with an increased risk of mental health disorders in children (Cobham et al., 2016; Pfefferbaum et al., 2014; Plass-Christl et al., 2018). These factors were not examined in the present study and may represent confounding variables impacting the findings. Additionally, socioeconomic status, which is shown to play a role in children's mental health (CDC, 2020; Guzman et al., 2011; Wille et al., 2008), was not measured. Furthermore, child or parent physical illness, family breakdown, large family size and overcrowding in the home, early parenthood, experiences of violence or sexual molestation, premature birth, and maternal smoking or drinking during pregnancy, which have all been identified as risk factors for mental illness in children (Wille et al., 2008), were not examined. Stress factors at school, such as unsupportive teacher-student relationships and poor school climate, which have been shown to increase the risk of mental illness in children (Schulte-Körne, 2016), were not examined. Moreover, protective factors for children's mental health, such as possessing higher levels of self-efficacy, self-concept, and optimism, having positive and supportive parent-child relationships, authoritative parenting styles, and good family climate/cohesion (Wille et al., 2008) were not assessed. Positive teacher relationships, peer competence, and social support from friends, sports clubs, and religious institutions such as churches and synagogues have been identified as

protective factors as well (Wille et al., 2008). These too, were not measured in the present study, and therefore we cannot know their impact on the results. The aforementioned variables, which were outside the scope of this study, may have played a strong role in the students' outcomes, eclipsing benefits that otherwise might have occurred.

Chapter 7

Limitations of the Study

This study was originally designed for a sample of fifth grade students attending a Jewish Modern Orthodox elementary school. However, due to factors outside of the researcher's control, two weeks prior to the start of the study, the school principal decided that only third grade students would be allowed to participate. As a result, the original assessment instruments had to be modified and adapted so as to be developmentally appropriate for children ages eight to nine years. Additionally, the supplemental verbal gratitude activity conducted without the researcher's knowledge in both the experimental and control groups may have diluted the results of the present study. Additionally, the gratitude intervention was brief in nature. Perhaps a longer intervention, carried out over several months, would have led to significant results. Furthermore, perhaps if the intervention had been more targeted toward the measured variables, the findings would have proven significant. Additionally, including booster sessions may have changed the outcome of the study. Lastly, perhaps with a larger sample size, the results would have been significant.

Chapter 8

Closing Thoughts & Future Directions

Implications for School Psychologists

If the brief gratitude journaling intervention had had a significant positive impact, reducing symptoms of anxiety and depression in this sample of students attending a Jewish Modern Orthodox elementary school, the potential implications for school psychologists would have been considerable. Teachers in Jewish Modern Orthodox private schools would have available to them an evidence-based, cost-effective school-based intervention, aligned with religious values, and feasible to implement in a classroom setting. The lack of significant findings points to a need for further study of gratitude interventions among religious youth. While gratitude is recognized as a value closely aligned with Jewish religious values, future research might examine whether religious individuals, or children who attend religious schools, score higher on measures of gratitude. Furthermore, future research might seek to determine whether religious Jews are more grateful than those of other religions. Future studies might opt to implement longer interventions with booster sessions, use larger sample sizes, as well as take into account the multitude of factors that can impact the mental health of today's children.

Appendices

Appendix A

The Gratitude Questionnaire-Six Item Form (GQ-6)-Adapted

Using the scale below as a guide, write a number beside each statement to indicate how much you agree with it.

1 = strongly disagree

2 = disagree

3 = slightly disagree

4 = neutral

5 = slightly agree

6 = agree

7 = strongly agree

____1. I have so much in life to be thankful for.

____2. If I had to list everything that I felt grateful for, it would be a very long list.

____3. When I look at the world, I don't see much to be grateful for.*

*Item 3 is reverse-scored.

Appendix B

PROMIS Emotional Distress—Anxiety & Depression—Pediatric Item Bank-Adapted

The questions below ask about how often you have been bothered by a list of symptoms during the past 7 days. Please respond to each item by marking (□ or x) one box per row.

In the past SEVEN (7) DAYS.…

1. I felt worried. □ 1 □ 2 □ 3 □ 4 □ 5

2. I felt alone. □ 1 □ 2 □ 3 □ 4 □ 5

3. I felt sad. □ 1 □ 2 □ 3 □ 4 □ 5

4. I felt unhappy. □ 1 □ 2 □ 3 □ 4 □ 5

5. I thought that my life was bad. □ 1 □ 2 □ 3 □ 4 □ 5

6. I felt stressed. □ 1 □ 2 □ 3 □ 4 □ 5

References

Alexander, L., & Link, B. (2003). The impact of contact on stigmatizing attitudes toward people with mental illness. *Journal of Mental Health, 12*(3), 271-289.

Allen, S. (2018). The science of gratitude. Greater Good Science Center at UC Berkeley. https://thegratitudeconcept.com/wp-content/uploads/2018/10/GGSC-JTF_White_Paper-Gratitude-FINAL.pdf

American Jewish Religious Denominations Archived 2012-01-18 at the Wayback Machine., United Jewish Communities Report Series on the National Jewish Population Survey 2001-01, (Table 2, pg. 9)

American Psychiatric Association. (2013). Diagnostic and statistical manual of mental disorders (5th ed.). https://doi.org/10.1176/appi.books.9780890425596

American Psychiatric Association. (2018). Online Assessment Measures. Retrieved from https://www.psychiatry.org/psychiatrists/practice/dsm/educational-resources/assessment-measures

American Psychiatric Association Foundation. (2016). Mental Health: A Guide for Faith Leaders. Arlington, VA, American Psychiatric Association Foundation.

American Psychological Association. (2013). What Role Do Religion and Spirituality Play In Mental Health? Retrieved from https://www.apa.org/news/press/releases/2013/03/religion-spirituality

Amsel, A. (1970). Judaism and psychology. *Tradition, 11*, 60-73.

Angermeyer, M. C., & Dietrich, S. (2006). Public beliefs about and attitudes towards people with mental illness: a review of population studies. *Acta Psychiatrica Scandinavica, 113*(3), 163-179.

Augenbaum, S.C. (2019). *Psychotherapy from the perspective of the Orthodox Jewish patient.* [Doctoral dissertation, Institute for Clinical Social Work]. ProQuest. https://search.proquest.com/openview/dd7c81ce12603c25dc3f72b92353f879/1?pq-origsite=gscholar&cbl=18750&diss=y

Bartlett, M.Y., & DeSteno, D. (2006). Gratitude and prosocial behavior: Helping when it costs you. *Psychological Science*, 17, 319–325

Baruch, D. E., Kanter, J. W., Pirutinsky, S., Murphy, J., & Rosmain, D. H. (2014). Depression stigma and treatment preferences among orthodox and non-orthodox Jews. *Journal of Nervous and Mental Disease*, *202*(7), 556–556.

Baumgarten-Tramer, F. (1938). "Gratefulness" in children and young people. *The Journal of Genetic Psychology, 53*, 53-66. doi:10.1080/08856559.1938.10533797

Becker, J. A., & Patricia, C. S. (1986). The spontaneous use of thank you by preschoolers as a function of sex, socioeconomic status, and listener status. *Language in Society*, *15*(4), 537–545.

Bee, H. L. (1994). *Lifespan development*. New York, NY: HarperCollins College.

Bilu, Y., & Witztum, E. (1993). Working with Jewish Ultra-Orthodox patients: Guidelines for a culturally sensitive therapy. *Culture, Medicine and Psychiatry, 17*, 197-233.

Bloch, A. M., Gabbay, E., Knowlton, S. F., & Fins, J. J. (2018). Psychiatry, cultural competency, and the care of ultra-orthodox Jews: achieving secular and theocentric convergence through introspection. *Journal of Religion and Health*, *57*(5), 1702–1716. https://doi.org/10.1007/s10943-018-0678-z

Bonnie, K.E., & de Wall, F.B.M. (2004). Primate social reciprocity and the origin of gratitude. In: Emmons, RA.; McCullough, ME., editors. The psychology of gratitude. New York: Oxford University Press. p. 213-229.

Bulka, R. P. (1983). *Dimensions of Orthodox Judaism*. New York: Ktav Publishing House.

Carballo, J., García-Nieto, R., Álvarez-García, R., Caro-Cañizares, I., López-Castromán, J., Muñoz-Lorenzo, L., . . . Baca-García, E. (2013). Sibship size, birth order, family structure and childhood mental disorders. *Social Psychiatry and Psychiatric Epidemiology, 48*(8), 1327-33. doi:10.1007/s00127-013-0661-7

Castro, F.M.P., Rava, P.G.S., Hoefelmann, T.B., Pieta, M.A.M., Freitas, L.B.L. Deve-se retribuir? Gratidão e dívida simbólica na infância [Should one return a favor? Gratitude and symbolic debt in childhood]. Estudos de Psicologia [Studies of Psychology]. 2011; 16:75–82.

Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. (2013). Mental health surveillance among children–United States, 2005–2011. Retrieved from https://www.cdc.gov/mmwr/pdf/other/su6202.pdf.

Centers for Disease Control and Prevention: Data and Statistics on Children's Mental Health. U.S. Department of Health & Human Services, 2020.

Chopik, W. J., Newton, N. J., Ryan, L. H., Kashdan, T. B., & Jarden, A. J. (2019). Gratitude across the life span: age differences and links to subjective well-being. *The Journal of Positive Psychology*, *14*(3), 292–302. https://doi.org/10.1080/17439760.2017.1414296

Chun, T., Mace, S., Katz, E., American Academy Of Pediatrics Committee on Pediatric Emergency Medicine, & American College Of Emergency Physicians Pediatric Emergency Medicine Committee. (2016). Evaluation and management of children with acute mental health or behavioral problems. Part II: Recognition of clinically challenging mental health related conditions presenting with medical or uncertain symptoms. *Pediatrics, 138*(3). doi:10.1542/peds.2016-1573

Cobham, V. E., McDermott, B., Haslam, D., & Sanders, M.R. (2016). The role of parents, parenting and the family environment in children's post-disaster mental health. Current Psychiatry Reports, 18(6), 53.

Corrigan, J., Denny, F. M., Jaffee, M. S., & Eire, C. M. (2016). Jews, Christians, Muslims: A comparative introduction to monotheistic religions. Upper Saddle River, NJ: Prentice Hall.

Cree, R.A., Bitsko, R.H., Robinson, L.R., Holbrook, J.R., Danielson, M.L., Smith, D.S., Kaminski, J.W., Kenney, M.K., Peacock, G. Health care, family, and community factors associated with mental, behavioral, and developmental disorders and poverty among children aged 2–8 years — United States, 2016. *MMWR*, 2018; 67(5):1377-1383.

Davis, D., Choe, E., Meyers, J., Wade, N., Varjas, K., Gifford, A., Quinn, A., Hook, J.N., Van Tongeren, D.R., Griffin, B.J., Worthington, E. (2016). Thankful for the little things: A meta-analysis of gratitude interventions. *Journal of Counseling Psychology, 63*(1), 20-20.

Dawson, R. (2018). Depression in children and adolescents: The pediatrician at the front lines. *Pediatric Annals*, 47(7), 265. doi:10.3928/19382359-20180618-01

Dickens, L. R. (2017). Using Gratitude to Promote Positive Change: A Series of Meta-Analyses Investigating the Effectiveness of Gratitude Interventions. *Basic and Applied Social Psychology, 39*(4), 193-208. https://doi.org/10.1080/01973533.2017.1323638

Diebel, T., Woodcock, C., Cooper, C., & Brignell, C. (2016). Establishing the effectiveness of a gratitude diary intervention on children's sense of school belonging. *Educational and Child Psychology, 33*(2), 117–129.

Do Vale, L. G. (2012). Desenvolvimento moral: A generosidade relacionada à justiça e à gratidão sob a ótica das crianças [Moral development: Generosity related to justice and gratitude from children's perspectives] (Unpublished master's thesis). Universidade de São Paulo, São Paulo, Brazil. Retrieved from http://www.teses.usp.br/teses/disponiveis/47/47131/tde-25072012-100222/pt-br.php

Eisen, H. (2018). 5 trends in private education. Retrieved from http://www.ourkids.net/school/5-trends-in-private-education.php

Emmons, R. A., & McCullough, M. E. (2003). Counting blessings versus burdens: An experimental investigation of gratitude and subjective well-being in daily life. *Journal of Personality and Social Psychology, 84*(2), 377–389. https://doi.org/10.1037/0022-3514.84.2.377

Emmons, R.A., & Mishra, A. (2011). Why gratitude enhances well-being. In K.M. Sheldon, T.B. Kashdan, & M.F. Steger (Eds.), Designing positive psychology: Taking stock and moving forward (pp. 458–485). New York, NY: Oxford University Press.

FindLaw (2016). Types of Schools: Private and Parochial School. Retrieved from https://education.findlaw.com/education-options/types-of-schools-private-and-parochial-school.html

Flasch, P., & Fulton, C. L. (2019). Counseling Jewish Americans: considerations for practice. *Counseling and Values*, *64*(1), 2–19. https://doi.org/10.1002/cvj.12091

Frabutt, J., Clark, W., & Speech, G., (2011) Supporting Mental Health and Wellness among Private School Students: A Survey of Catholic Elementary and Secondary Schools, *Advances in School Mental Health Promotion*, 4:3, 29-41, doi: 10.1080/1754730X.2011.9715634

Fredrickson, B. L. (2004a). Gratitude, Like Other Positive Emotions, Broadens and Builds. In The Psychology of Gratitude (pp. 144–166). Oxford University Press. https://doi.org/10.1093/acprof:oso/9780195150100.003.0008

Fredrickson, B. L. (2004b). The broaden-and-build theory of positive emotions. Philosophical Transactions of the Royal Society B: Biological Sciences, 359(1449), 1367–1377. https://doi.org/10.1098/rstb.2004.1512

Freitas, L. B., O'Brien, M., Nelson, J. A., & Marcovitch, S. (2012). A compreensão da gratidão e teoria da mente em crianças de 5 anos [The understanding of gratitude and theory of mind in 5-year-old children]. Psicologia: Reflexão E Crítica, 25, 330-338. doi:10.1590/S0102-79722012000200015

Freitas, L. B., Pieta, M. A. M., & Tudge, J. R. H. (2011). Beyond politeness: the expression of gratitude in children and adolescents. *Psicologia: Reflexão E Crítica*, *24*(4), 757–764. https://doi.org/10.1590/S0102-79722011000400016

Freitas, L. B., Silveira, P. G., & Pieta, M. A. M. (2009a). Sentimento de gratidão em crianças de 5 a 12 anos [The feeling of gratitude in 5- to 12-year-old children]. *Psicologia em Estudo, 14*(2), 243-250.

Freitas, L. B., Silveira, P. G., & Pieta, M. A. M. (2009b). Umestudo sobre o desenvolvimento da gratidão na infância [A study about the development of gratitude in childhood]. *Revista Interamericana de Psicologia [Interamerican Journal of Psychology], 43*(1), 22-29.

Froh, J., & Bono, G. (2011). Gratitude in youth: A review of gratitude interventions and some ideas for applications. National Association of School Psychologists. *Communique*, 39(5), 26-28.

Froh, J. J., Bono, G., & Emmons, R. (2010). Being grateful is beyond good manners: gratitude and motivation to contribute to society among early adolescents. *Motivation and Emotion*, *34*(2), 144–157.

Froh, J., Bono, G., Fan, J., Emmons, R., Henderson, K., Harris, C., … Wood, A. (2014). Nice thinking! An educational intervention that teaches children to think gratefully. *School Psychology Review, 43*(2), 132-152.

Froh, J., Fan, J., Emmons, R., Bono, G., Huebner, E., & Watkins, P. (2011). Measuring gratitude in youth: Assessing the psychometric properties of adult gratitude scales in children and adolescents. *Psychological Assessment, 23*(2), 311-311.

Froh, J. J., Kashdan, T. B., Ozimkowski, K. M., & Miller, N. (2009). Who benefits the most from a gratitude intervention in children and adolescents? Examining positive affect as a moderator. The Journal of Positive Psychology, 4(5), 408–422. https://doi.org/10.1080/17439760902992464

Froh, J., Sefick, W., & Emmons, R. (2008). Counting blessings in early adolescents: An experimental study of gratitude and subjective well-being. *Journal of School Psychology, 46*(2), 213-233. doi:10.1016/j.jsp.2007.03.005

Froh, J., Yurkewicz, C., & Kashdan, T. (2009). Gratitude and subjective well-being in early adolescence: Examining gender differences. *Journal of Adolescence*, 32(3), 633-633. doi:10.1016/j.adolescence.2008.06.006

Geraghty, A. W. A., Wood, A. M., & Hyland, M. E. (2010a). Attrition from self-directed interventions: Investigating the relationship between psychological predictors, intervention content and dropout from a body dissatisfaction intervention. *Social Science and Medicine, 71*(1), 30–37. https://doi.org/10.1016/j.socscimed.2010.03.007

Geraghty, A. W. A., Wood, A. M., & Hyland, M. E. (2010b). Dissociating the facets of hope: Agency and pathways predict dropout from unguided self-help therapy in opposite directions. *Journal of Research in Personality, 44*(1), 155–158. https://doi.org/10.1016/j.jrp.2009.12.003

Ghandour RM, Sherman LJ, Vladutiu CJ, Ali MM, Lynch SE, Bitsko RH, Blumberg SJ. Prevalence and treatment of depression, anxiety, and conduct problems in U.S. children. The Journal of Pediatrics, 2019; 206:256-267.

Gleason, J. B., & Weintraub, S. (1976). The acquisition of routines in child language. *Language in Society*, *5*(2), 129–136.

Gordon, A. K., Musher-Eizenman, D. R., Holub, S. C., & Dalrymple, J. (2004). What are children thankful for? An archival analysis of gratitude before and after the

attacks of September 11. *Journal of Applied Developmental Psychology, 25*(5), 541-553.

Goshen-Gottstein, E. (1994). Is psychotherapy possible in unbelievers? *Israel Journal of Psychiatry, 31*, 232-233.

Greenberg, D. (1991). Is psychotherapy possible with unbelievers? The care of the Ultra-Orthodox community. *Israel Journal of Psychiatry and Related Science, 28*, 19-30.

Greenberg, D., & Witztum, E. (2001). *Sanity and Sanctity*. New Haven: Yale.

Guzman, M. P., Jellinek, M., George, M., Hartley, M., Squicciarini, A. M., Canenguez, K. M., ... & Murphy, J. M. (2011). Mental health matters in elementary school: First-grade screening predicts fourth grade achievement test scores. European Child & Adolescent Psychiatry, 20(8), 401-411.

Harbaugh, C. N., & Vasey, M. W. (2014). When do people benefit from gratitude practice? The Journal of Positive Psychology, 9(6), 535–546. https://doi.org/10.1080/174397 60.2014.927905

Hesketh, T., Ding, Q., & Jenkins, R. (2002). Suicide ideation in Chinese adolescents. *Social Psychiatry and Psychiatric Epidemiology, 37*(5), 230-5. doi:10.1007/s00127-002-0536-9

Hill, P., & Pargament, K. (2008). Advances in the conceptualization and measurement of religion and spirituality: Implications for physical and mental health research. *Psychology of Religion and Spirituality, S* (1), 3-17. doi:10.1037/1941-1022.S.1.3

Holman, C., & Holman, N. (2002). Torah, worship and acts of loving kindness: Baseline Indicators for the Charedi Community in Stamford Hill. Leicester: De Montfort University.

Idler, E., McLaughlin, J., & Kasl, S. (2009). Religion and the quality of life in the last year of life. *The Journals of Gerontology, 64b* (4), 528-537. doi:10.1093/geronb/gbp028

Iyer, S., & Zhang, A. (2019). Religion and depression in adolescence. *The Journal of Political Economy*, *127*(3), 1178–1209. https://doi.org/10.1086/701425

Joseph, S., Alex Linley, P., & Maltby, J. (2006). Positive psychology, religion, and spirituality. *Mental Health, Religion & Culture*, *9*(3), 209–212.

Judaism and Mental Illness. (n.d.). Retrieved from https://www.myjewishlearning.com/article/judaism-and-mental-illness/

Kendall, P., Compton, S., Walkup, J., Birmaher, B., Albano, A., Sherrill, J., . . . Piacentini, J. (2010). Clinical characteristics of anxiety disordered youth. *Journal of Anxiety Disorders, 24*(3), 360-5. doi:10.1016/j.janxdis.2010.01.009

Khanna, P., & Singh, K. (2016). Effect of Gratitude Educational Intervention on Well-Being Indicators Among North Indian Adolescents. *Contemporary School Psychology, 20*(4), 305–314. https://doi.org/10.1007/s40688-016-0087-9

Kinzbrunner, B. M. (2004). Jewish Medical Ethics and End-of-Life Care. *Journal of Palliative Medicine, 7*(4).

Kohlberg, L. (1958). The Development of Modes of Thinking and Choices in Years 10 to 16. *Ph. D. Dissertation*, University of Chicago.

Krumrei, E. J., Pirutinsky, S., & Rosmarin, D. H. (2013). Jewish spirituality, depression, and health: an empirical test of a conceptual framework. *International Journal of Behavioral Medicine*, *20*(3), 327–36. https://doi.org/10.1007/s12529-012-9248-z

Kwok, S., Gu, M., & Kit, K. (2016). Positive psychology intervention to alleviate child depression and increase life satisfaction: A randomized clinical trial. *Research on Social Work Practice*, 26(4), 350-361.

Lamba, G., & Ellison, J. (2012). Religion/spirituality and depression. *The American Journal of Psychiatry, 169*(4), 433-433.

Lambert, N. M., Fincham, F. D., & Stillman, T. F. (2012). Gratitude and depressive symptoms: The role of positive reframing and positive emotion. *Cognition & Emotion, 26*(4), 615–633. https://doi.org/10.1080/02699931.2011.595393

Laurent, J., Catanzaro, S. J., Joiner, T. E., Jr., Rudolph, K. D., Potter, K. I., Lambert, S., Osborne, L., & Gathright, T. (1999). A measure of positive and negative affect for children: Scale development and preliminary validation. *Psychological Assessment, 11*(3), 326–338. https://doi.org/10.1037/1040-3590.11.3.326

Layous, K., & Lyubomirsky, S. (2014). Benefits, Mechanisms, and New Directions for Teaching Gratitude to Children. *School Psychology Review, 43*(2), 153–159.

Levkovich, B. (2020). *Attitudes towards mental health treatment: an assessment of Jewish young adults.* [Doctoral dissertation, Hofstra University]. ProQuest. https://search.proquest.com/openview/07b136f729c45255c944c9a3f8a8711f/1?pq-origsite=gscholar&cbl=18750&diss=y

Li, S. (2014a). “All good is of parents” and its Chinese context. *China Report*, *50*(4), 1–12. doi: 10.1177/0009445514549277

Li, S. (2016). A mechanism for gratitude development in a child. *Early Child Development and Care*, *186*(3), 466–479.

Lin, C. C. (2015). Self-esteem mediates the relationship between dispositional gratitude and well-being. *Personality and Individual Differences, 85*(October), 145–148. https://doi.org/10.1016/j.paid.2015.04.045

Lo, H. H., Kwok, S. Y., Yeung, J. W., Low, A. Y., & Tam, C. H. (2017). The moderating effects of gratitude on the association between perceived parenting styles and suicidal ideation. *Journal of Child and Family Studies*, *26*(6), 1671–1680.

Loewenthal, K. M. (1998). Haredi women, Haredi men, stress and distress. *Israel Journal of Psychiatry, 35*, 217-224.

Loewenthal, K. M. (2006). *Orthodox Judaism: Features and Issues for Psychotherapy.* In E. T. Dowd & S. L. Nielsen (Eds.), *The psychologies in religion: Working with the religious client* (p. 203–217). Springer Publishing Co.

Loewenthal, K. M., & Brooke-Rogers, M. (2004). Culture sensitive support groups: how are the perceived and how do they work? International Journal of Social Psychiatry, 50(3), 227-240.

Loue, S. (2010). Faith-based mental health treatment of minors: A call for legislative reform. *The Journal of Legal Medicine, 31*(2), 171-201. doi:10.1080/01947641003800203

Lyubomirsky, S., Sheldon, K. M., & Schkade, D. (2005). Pursuing happiness: The architecture of sustainable change. *Review of General Psychology, 9*(2), 111–131. https://doi. org/10.1037/1089-2680.9.2.111

Mackenzie, C. S., Gekoski, W. L., & Knox, V. J. (2006). Age, gender, and the underutilization of mental health services: the influence of help-seeking attitudes. *Aging and mental health, 10*(6), 574-582.

Malin, H., Liauw, I., & Damon, W. (2017). Purpose and Character Development in Early Adolescence. *Journal of Youth and Adolescence, 46*(6), 1200–1215. https://doi.org/10.1007/s10964-017-0642-3

Margolese, H. C. (1998). Engaging in psychotherapy with the Orthodox Jew: A critical review. *American Journal of Psychotherapy, 52*, 37-53.

Maynard, B., Heyne, D., Brendel, K., Bulanda, J., Thompson, A., & Pigott, T. (2018). Treatment for school refusal among children and adolescents. *Research on Social Work Practice, 28*(1), 56-67. doi:10.1177/1049731515598619

McConnell, T. C. (1993). *Gratitude*. Temple University Press.

McCullough M.E. (2013). The Gratitude Questionnaire (GQ-6). Measurement Instrument Database for the Social Science. Retrieved from www.midss.ie

McCullough, M. E., Emmons, R. A., & Tsang, J. A. (2002). The grateful disposition: a conceptual and empirical topography. *Journal of Personality and Social Psychology*, *82*(1), 112–127. https://doi.org/10.1037/0022-3514.82.1.112

McCullough, M.E., Kilpatrick, S.D., Emmons, R.A., & Larson, D.B. (2001). Is gratitude a moral affect? *Psychological Bulletin*, 127, 249–266.

McCullough, M., Kimeldorf, M., & Cohen, A. (2008). An adaptation for altruism. *Current Directions in Psychological Science*, 17(4), 281-285. doi:10.1111/j.1467-8721.2008.00590.x

McCullough, M. E., & Larson, D. B. (1999). Religion and depression: a review of the literature. *Twin Research and Human Genetics*, *2*(2), 126–136.

McEvoy, P., Williamson, T., Kada, R., Frazer, D., Dhliwayo, C., & Gask, L. (2017). Improving access to mental health care in an orthodox Jewish community: A critical reflection upon the accommodation of otherness. *Bmc Health Services Research, 17*(1), 1-15. doi:10.1186/s12913-017-2509-4

McLaughlin, K., & King, K. (2015). Developmental trajectories of anxiety and depression in early adolescence. *Journal of Abnormal Child Psychology: An Official Publication of the International Society for Research in Child and Adolescent Psychopathology, 43*(2), 311-323. doi:10.1007/s10802-014-9898-1

Merçon-Vargas E. A., Poelker, K. E., & Tudge, J. R. H. (2018). The development of the virtue of gratitude: theoretical foundations and cross-cultural issues. *Cross - Cultural Research*, *52*(1), 3–18. https://doi.org/10.1177/1069397117736517

Midlarsky, E., & Pirutinsky, S. (2012). Religion, ethnicity, and attitudes toward psychotherapy. *Journal of Religion and Health, 51*(2), 498-506.

Mills, S., & Baker, L. (2016). Childhood depression. *Innovait: Education and Inspiration for General Practice, 9*(9), 524-530. doi:10.1177/1755738016658676

Mojtabai, R. (2007). Americans' attitudes toward mental health treatment seeking: 1990–2003. *Psychiatric Services, 58*(5), 642-651.

Morgan, B., Gulliford, L., & Carr, D. (2015). Educating gratitude: Some conceptual and moral misgivings. *Journal of Moral Education, 44*(1), 97–111. https://doi.org/10.1080/03057240.2014.1002461

National Collaborating Centre for Mental Health (UK). Common Mental Health Disorders: Identification and Pathways to Care. Leicester (UK): British Psychological Society; 2011. (NICE Clinical Guidelines, No. 123.) 2, Common Mental Health Disorders. Available from: https://www.ncbi.nlm.nih.gov/books/NBK92254/

National Institute of Mental Health. (2017). Statistics. Retrieved from https://www.nimh.nih.gov/health/statistics/any-anxiety-disorder.shtml#part_155096

Nelson, J. A., de Lucca Freitas, L. B., O'Brien, M., Calkins, S. D., Leerkes, E. M., & Marcovitch, S. (2013). Preschool-aged children's understanding of gratitude: relations with emotion and mental state knowledge. *British Journal of Developmental Psychology*, *31*(1), 42–56.

Ng, W. (2016). Use of positive interventions: Does neuroticism moderate the sustainability of their effects on happiness? *The Journal of Positive Psychology, 11*(1), 51–61. https://doi.org/10.1080/17439760.2015.1025419

Paludo, S. S. (2008). *Emoções morais e gratidão: Uma nova perspectiva sobre o desenvolvimento de jovens que vivem em situação de risco pessoal e social* [Moral emotions and gratitude: A new perspective on youths who live at personal and social risk]. Retrieved April 24, 2010 from http://hdl.handle.net/10183/14289

Paradis, C. M., Cukor, D., & Friedman, S. (2006). Cognitive-Behavioral Therapy with Orthodox

Jews. In P. A. Hays & G. Y. Iwamasa (Eds.), *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision* (p. 161–175). American Psychological

Association.

Pargament, K. I., & Lomax, J. W. (2013). Understanding and addressing religion among people with mental illness. World psychiatry: official journal of the World Psychiatric Association (WPA), 12(1), 26-32.

Pew Research Center. (2015). A Portrait of American Orthodox Jews. Retrieved from http://www.pewforum.org/2015/08/26/a-portrait-of-american-orthodox-jews/

Pfefferbaum, B., Tucker, P., North, C. S., Jeon-Slaughter, H., & Nitiéma, P. (2014). Children of terrorism survivors: Physiological reactions seven years following a terrorist incident. Comprehensive Psychiatry, 55(4): 749–754.

Piaget, J. (1932). *The moral judgment of the child*. London: Kegan Paul, Trench, Trubner & Co.

Piaget J. *Les relations entre l'affectivité et l'intelligence [The relations between emotion and intelligence]* Paris: Sorbonne; 1954.

Piaget J. *Études sociologiques.* 3 . Genève: Droz; 1977. Sociological studies. (Original work published 1965)

Plant, S., & Weiss, D. H. (2015). Christian and Jewish approaches. The Routledge Handbook of Religions and Global Development.

Plass-Christl, A., Otto, C., Klasen, F., Wiegand-Grefe, S., Barkmann, C., Hölling Heike, … Ravens-Sieberer, U. (2018). Trajectories of mental health problems in children of parents with mental health problems: results of the BELLA study. *European Child & Adolescent Psychiatry*, *27*(7), 867–876. https://doi.org/10.1007/s00787-017-1084-x

Popovsky, R. M. (2010). Special issues in the care of ultra-orthodox Jewish psychiatric in-patients. Transcultural Psychiatry, 47(4), 647–672. https://doi.org/10.1177/1363461510383747.

Preuss, J. (1978). *Biblical and Talmudic medicine*. (F. Rosner, Trans.) New York: Hebrew Publishing Co.

Rash, J. A., Matsuba, M. K., & Prkachin, K. M. (2011). Gratitude and well-being: Who benefits the most from a gratitude intervention? Applied Psychology: Health and Well-Being, 3(3), 350–369. https://doi.org/10.1111/j.1758- 0854.2011.01058.x

Renshaw, T. L., & Olinger Steeves, R. M. (2016). What good is gratitude in youth and schools? A systematic review and meta-analysis of correlates and intervention outcomes. *Psychology in the Schools, 53*(3), 286–305. https://doi.org/10.1002/pits.21903

Riordan, D., Morris, C., Hattie, J., & Stark, C. (2012). Family size and perinatal circumstances, as mental health risk factors in a Scottish birth cohort. *Social Psychiatry and Psychiatric Epidemiology, 47*(6), 975-83. doi:10.1007/s00127-011-0405-5

Rockhill, C., Kodish, I., DiBattisto, C., Macias, M., Varley, C., & Ryan, S. (2010). Anxiety disorders in children and adolescents. *Current Problems in Pediatric and Adolescent Health Care, 40*(4), 66-99. doi:10.1016/j.cppeds.2010.02.002

Rosen, D. D., Greenberg, D., Schmeidler, J., & Shefler, G. (2008). Stigma of mental illness, religious change, and explanatory models of mental illness among Jewish patients at a mental-health clinic in North Jerusalem. *Mental Health, Religion & Culture, 11*(2), 193-209.

Rosmarin, D. H., Pirutinsky, S., & Siev, J. (2010). Recognition of scrupulosity and non-religious OCD by orthodox and non-orthodox Jews. *Journal of Social and Clinical Psychology*, *29*(8), 930–944. https://doi.org/10.1521/jscp.2010.29.8.930

Rosmarin, D., Pargament, K., Pirutinsky, S., & Mahoney, A. (2010). A randomized controlled evaluation of a spiritually integrated treatment for subclinical anxiety in the Jewish community, delivered via the internet. *Journal of Anxiety Disorders, 24*(7), 799-808. doi:10.1016/j.janxdis.2010.05.014

Schimmel, S. (1997). *The seven deadly sins: Jewish, Christian, and classical reflections on human psychology*. New York and Oxford: Oxford University Press.

Schnall, E. (2006). Multicultural counseling and the Orthodox Jew. *Journal of Counseling and Development*, 276.

Schnitzer, G., Longman, C., Loots, G., & Valdebenito, C. (2011). Beyond segregation? About (im)possible encounters between Flemish social youth workers and the strict Jewish Orthodox community. Ethnographica Journal on Culture and Disability, 1(1), 25-43.

Schulte-Körne, G. (2016). Mental health problems in a school setting in children and adolescents. Deutsches Ärzteblatt International, 113(11), 183.

Sergeant, S., & Mongrain, M. (2011). Are positive psychology exercises helpful for people with depressive personality styles? *Journal of Positive Psychology, 6*(4), 260–272. https://doi.org/10.1080/17439760.2011.577089

Selekman J. People of Jewish heritage. In: Purnell LD, editor. Transcultural Health Care: A Culturally Competent Approach. 4th ed. Philadelphia, PA: FA Davis; 2012. pp. 338–356

Seligman, M., & Csikszentmihalyi, M. (2000). Positive psychology: An introduction. *American Psychologist, 55*(1), 5-14. doi:10.1037/0003-066X.55.1.5

Seligman, M. E. P., Steen, T. A., Park, N., & Peterson, C. (2005). Positive Psychology Progress: Empirical Validation of Interventions. *American Psychologist, 60*(5), 410–421. https://doi.org/10.1037/0003-066X.60.5.410

Sheldon, K. M., & Lyubomirsky, S. (2006). How to increase and sustain positive emotion: The effects of expressing gratitude and visualizing best possible selves. *Journal of Positive Psychology, 1*(2), 73–82. https://doi.org/10.1080/17439760500510676

Shoshani, A., & Steinmetz, S. (2014). Positive psychology at school: A school-based intervention to promote adolescents' mental health and well-being. *Journal of Happiness Studies: An Interdisciplinary Forum on Subjective Well-Being*, 15(6), 1289-1311. doi:10.1007/s10902-013-9476-1

Siev, J., Baer, L., & Minichiello, W. (2011). Obsessive-compulsive disorder with predominantly scrupulous symptoms: Clinical and religious characteristics. *Journal of Clinical Psychology, 67*(12), 1188-1196. doi:10.1002/jclp.20843

Silverman, E. (2013). A cultural history of Jewish dress, body, culture. New York: Bloomsbury.

Silverman, I. (2014). *Help-Seeking in English-Speaking Orthodox Jewish-Israelis: A Qualitative Study*. [Doctoral dissertation, University of California]. ProQuest. https://alexandria.ucsb.edu/downloads/ff365549t

Slanger, C. (1996). Orthodox rabbinic attitudes to mental health professionals and referral patterns. *Tradition, 31*(1), 22-32.

Smith, T., McCullough, M., & Poll, J. (2003). Religiousness and depression: Evidence for a main effect and the moderating influence of stressful life events. *Psychological Bulletin, 129*(4), 614-636. doi:10.1037/0033-2909.129.4.614

Thapar, A., Collishaw, S., Pine, D., & Thapar, A. (2012). Depression in adolescence. *The Lancet, 379*(9820), 1056-67. doi:10.1016/S0140-6736(11)60871-4

Toepfer, S. M., Cichy, K., & Peters, P. (2012). Letters of Gratitude: Further Evidence for Author Benefits. *Journal of Happiness Studies, 13*(1), 187–201. https://doi.org/10.1007/ s10902-011-9257-7

Tudge, J. R. H., Freitas, L. B. de L., Mokrova, I. L., Wang, Y. C., & O'Brien, M. (2015). The wishes and expression of gratitude of youth. *Paideía*, *25*(62), 0281–0288. https://doi.org/10.1590/1982-43272562201501

U.S. Department of Health & Human Services. (2019). For Community and Faith Leaders: Creating Community Connections for Mental Health. Retrieved from https://www.mentalhealth.gov/talk/faith-community-leaders

Vogel, D. L., Wester, S. R., Wei, M., & Boysen, G. A. (2005). The Role of Outcome Expectations and Attitudes on Decisions to Seek Professional Help. *Journal of Counseling Psychology, 52*(4), 459-470.

Wagner, K. (2009). Consequences of childhood-onset conditions. *Psychiatric Times, 26*(7), 14-14.

Wang, D., Wang, Y. C., & Tudge, J. R. H. (2015). Expressions of gratitude in children and adolescents: insights from china and the United States. *Journal of Cross -*

Cultural Psychology, *46*(8), 1039–1039. https://doi.org/10.1177/0022022115594140

Wertheimer, J. (2005). Jews and the Jewish Birthrate. *Aish HaTorah*. Retrieved from http://www.aish.com/jw/s/48899452.html

Wikler, M. (1989). The religion of the therapist: Its meaning to Orthodox Jewish clients. *Hillside Journal of Clinical Psychiatry, 11*, 131-146.

Wille, N., Bettge, S., Ravens-Sieberer, U. (2008). Risk and protective factors for children's and adolescents' mental health: results of the BELLA study. *European Child and Adolescent Psychiatry*, *17*(1), 133–147.

Wood, A., Froh, J., & Geraghty, A. (2010). Gratitude and well-being: A review and theoretical integration. *Clinical Psychology Review, 30*(7), 890-905. doi:10.1016/j.cpr.2010.03.005

Wood, A. M., Joseph, S., & Linley, P. A. (2007). Coping Style as a Psychological Resource of Grateful People. *Journal of Social and Clinical Psychology, 26*(9), 1076–1093. https:// doi.org/10.1521/jscp.2007.26.9.1076

World Health Organization. (2005). *Atlas: Child and adolescent mental health resources*. Geneva: World Health Organization.

Yap, K., Mogan, C., & Kyrios, M. (2012). Obsessive-compulsive disorder and comorbid depression: The role of ocd-related and non-specific factors. *Journal of Anxiety Disorders, 26*(5), 565-73. doi:10.1016/j.janxdis.2012.03.002

Zhen, R., Ding, Y., Jiang, R., Jiang, S., & Hong, W. (2019). Gratitude and academic engagement among primary students: examining a multiple mediating

model. *Current Psychology*, *1-9*, 1–9. https://doi.org/10.1007/s12144-019-00202-3

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