

TANHAN, AHMET, Ph.D. Mental Health Issues and Seeking of Formal Mental Health Services Among Muslims in the Southeastern U.S.: Preliminary Investigation of a Contextual Theoretical Framework Based on the Theory of Planned Behavior/Theory of Reasoned Action and the Social Ecological Model. (2017)
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The Muslim community in the Southeastern U.S., being a small part of the larger Muslim population in the U.S., faces many psychosocial issues and underutilizes mental health services. Muslims' underutilization of mental health services to address their psychosocial issues affect both Muslims and non-Muslims alike. Given today's highly interconnected world, the issues of one individual or community often impact others in ways not experienced at other times in history. However, there is lack of research on Muslims and especially for those in the Southeastern U.S. regarding their approach toward mental health issues and seeking formal mental health services. Researchers stress the necessity to understand Muslims' approach toward mental health issues and seeking the services by utilizing well-grounded theories to create and/or shape contextual theoretical frameworks (models). However, few researchers have utilized clear theoretical frameworks to ground their studies, which creates an unsystematic approach to research and clinical practice for this vulnerable population. In their study with 88 counselors in the U.S. Cashwell et al. (2013) found that although the participants rated the integration of religious/spiritual aspects into counseling as very important, they integrated these aspects less frequently into their counseling practice than how ratings of importance would suggest. Young and Cashwell (2011) stressed attending to client's spiritual/religious perspective by stating, "meeting the client where [they] are, without

judgment and with compassion, is the foundational building block” (p. 22) to address issues in counseling.

The purpose of this study was to understand how Muslims in the Southeastern U.S. approach mental health issues and seeking formal mental health services. A second purpose was to partially test (examine) the proposed contextual theoretical framework based on Theory of Planned Behavior/Theory of Reasoned Action (TPB/TRA) and Brofenbrenner’s Social Ecological Model (SEM) to answer the eight research questions. In total 209 participants’ responses were used for statistical analyses. The results indicated that the participants had slightly higher than the moderate/favorable level on the five constructs: cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-cultural beliefs), knowledge about formal mental health services (KFMHS-knowledge), and perceived behavioral control toward seeking formal mental health services (PBC) constructs; and a moderately favorable level on attitudes toward seeking formal mental health services (ATFMHS-attitudes) construct; and slightly under the moderate level (meaning participants had a little stronger stigma than moderate level) for perceived social stigma toward seeking formal mental health services (PSTSMHS-stigma) construct. Meaning that, the participants did not strongly favor or disfavor the five constructs. In addition, the participants strongly aligned with a medical/scientific explanation of mental health issues and their causes and treatments based on responses to the measure of CBMHP-cultural beliefs. The paths (relationships/analyses) among the five main constructs were positively or negatively significant except for one. In an open-ended question, the largest group of the participants defined mental health providers from

a medical/psychopathology perspective while the others fell under three other categories. In addition, majority of the participants did not feel safe and attributed it to the current climate of exosystem and macrosystem systems in which they live.

In sum, nearly all researchers in the Muslim mental health literature have stressed the importance of understanding contextual factors for more culturally, spiritually, and structurally appropriate interventions and services. Therefore, it was first necessary to assess and understand how Muslims in the Southeastern U.S. approach to mental health issues and seeking formal mental health services through a well-grounded theoretical framework. In this way, mental health providers and researchers will be able to understand Muslims within a more culturally and structurally contextual perspective and address the mental health issues of this population more effectively by utilizing the results of this study.

MENTAL HEALTH ISSUES AND SEEKING OF FORMAL MENTAL HEALTH
SERVICES AMONG MUSLIMS IN THE SOUTHEASTERN U.S.:
PRELIMINARY INVESTIGATION OF A CONTEXTUAL
THEORETICAL FRAMEWORK BASED ON THE
THEORY OF PLANNED BEHAVIOR/THEORY
OF REASONED ACTION AND THE
SOCIAL ECOLOGICAL MODEL

by

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Approved by

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بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

In the Name of Allah (God), the Entirely Merciful, The Especially Merciful

Humbly, this work is dedicated to all of us as humanity— especially to the ones of us who are oppressed/exploited in so many different ways including, yet not limited to, economically, physically, spiritually— starting from here the USA, Muslims, and all across the globe. May Allah make/keep all of us striving for a more livable world for all.

APPROVAL PAGE

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*Hearken [attend, listen] to reed-flute [human being and universe], how it
complains,*

Lamenting its banishment from its home.

and he adds in the same book

our home is not this or that city or another,

our home is the hearts of the people

and the pleasantness of

Allah.

and he adds so often in his book by saying

and it is better to stop talking and thinking to be quiet and have peace.

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CHAPTER I

INTRODUCTION

Muslim populations have received increased attention worldwide over the last 15 years, particularly in western countries including the U.S. (Bagasra, 2010; Martin, 2015). The size of the Muslim population varies based on reports, yet resources indicate that Islam is the fastest growing religion in the U.S. (Pew Research Center, 2016). According to the Council on American-Islamic Relations (CAIR, 2015), there are between six and seven million Muslims in the U.S..

The attention that U.S. Muslims receive is generally not positive, which results in negative attitudes and reactions toward Muslims that cause psychosocial issues at the global, local community, interpersonal, and intrapersonal/individual levels (Ali & Milstein, 2012; Francisco & Tanhan, 2015; Martin, 2015; Nadal et al., 2012; Strack, Orsini, & Tanhan, 2016). In fact, Chaudhry and Li (2011) stated that U.S. Muslims are more likely to have mental health issues than any other minority group because of the challenging psychosocial issues they encounter. Unfortunately, Muslims in the U.S. face physical and verbal discrimination, harassment, and physical and verbal attacks in schools and the workplace (Francisco & Tanhan, 2015; Nadal et al., 2012; Strack et al., 2016), and even in health care settings (Martin, 2015).

Francisco and Tanhan (2015) found that Muslim students at a university in the Southeastern U.S. reported a range of psychosocial issues. For instance, only 39% of the

participants indicated that they “feel safe” while only 40% indicated that they “[are] safe.” In the same study, about 56% of the participants indicated their dissatisfaction due to experiencing verbal and/or physical insults, or abuse. Strack et al. (2016) identified that the majority of Muslim participants at a university in the Southeastern U.S. expressed many psychosocial and academic issues largely due to discrimination, physical and verbal attacks, and the lack of support and resources to complete obligatory daily prayers while on campuses. Similarly, qualitative researchers have revealed that the majority of the Muslim participants in universities in the Northeastern U.S. report facing subtle, overt, intentional, and unintentional discrimination (Bhattacharyya, Ashby, & Goodman, 2014; Nadal et al., 2012; Tummala-Nara & Claudius, 2013).

Muslims and Mental Health

Although Muslims in the U.S. face many psychosocial issues, they do not tend to utilize formal mental health services (Aloud, 2004; Khan, 2006). Previous researchers suggest that among the reasons for the underutilization of services are cultural beliefs and lack of knowledge about mental health issues and formal mental health services. Most researchers have indicated that Muslims hold strong cultural beliefs that shape their conceptualization of mental issues and treatments, rather than a Western/scientific conceptualization. Additionally, Muslims are also less likely to acknowledge mental health issues unless the issues are out of control (Aloud & Rathur, 2009; Tanhan, 2014). For example, Muslims are more likely to acknowledge and accept mental issues if the person is not functioning in normal life (e.g., hallucinations, delusions, or severe depression) (Youssef & Deane, 2006). Muslims are more likely to normalize or deny

mild or moderate mental health issues like depression, anger or anxiety issues, and/or interpersonal conflicts, physical violence toward children and spouse (Cook-Masaud & Wiggins, 2011). They tend to view these problems as normal life issues rather than perceiving them as disorders, illnesses, and/or problems worthy of professional treatment. Therefore, in this study, *problems*, *issues*, and *disorders* are used as synonymously. Muslims tend to conceptualize mental health issues from a cultural perspective, in which supernatural causes such as sin, disobedience to Allah, jinn possession, or evil eyes are responsible for mental health issues. Due to these cultural beliefs and lack of knowledge of mental health issues and services, Muslims attempt to address issues within one of the most important institutions for Muslims, the extended family. If an issue cannot be addressed within the family, then help is sought from spiritual/religious leaders and/or traditional healers rather than from formal mental health providers. Seeking professional mental health services is the final option, if it is considered at all (Aloud, 2004). Due to these factors (e.g., cultural beliefs about mental issues and their causes and treatments), researchers report that Muslims hold negative attitudes toward seeking formal mental health services (ATFMHS-Attitudes), lack knowledge about the services, possess social stigma about seeking help from outside of the family (i.e., from professional mental health providers) (Aloud & Rathur, 2009; Soheilian & Inman, 2009). Related to these realities, and especially due to cultural background and lack of knowledge about the services, Muslims are more likely to have low sense of Perceived Behavioral Control (PBC), defined as perceived self-efficacy, toward seeking formal mental health services. Seeking formal mental health services becomes even more complex among women and

family leaders primarily due to a deep concern for damaging the family honor. These factors lead Muslims to underutilize formal mental health services and overuse of family, spiritual/religious sources, traditional healers, and/or general physicians to address their psychosocial issues. The concept map in Appendix A, developed by the primary research of this study, is based on a thorough review of Muslim mental health literature, and depicts the main factors that affect Muslims' approach toward seeking formal mental health services.

Muslims and Mental Health Service Utilization

Researchers studying Muslim mental health have found that Muslims face many psychosocial issues across five domains including (a) global (e.g., political, wars, international), (b) larger community (e.g., jobs, neighborhood, institutions), (c) local community (e.g., family, faith community, friends, home, interpersonal, educational institutions), (d) interpersonal (e.g., significant other, friend, spouse), and (e) intrapersonal/individual (e.g., searching for meaning of life, life goals, personality issues) (Ahmed, Abu-Ras, & Arfken, 2014; Ali & Milstein, 2012; Amri & Bemak, 2013; Aprahamian, Kaplan, Windham, Sutter, & Visser, 2011; Bagasra, 2010; Bagasra & Mackinem, 2014; Bektas, Demir, & Bowden, 2009; Ciftci, Jones, & Corrigan, 2013; Cook-Masaud & Wiggins, 2011; Franciso & Tanhan, 2015; Goforth, Oka, Leong, & Denis, 2014; Herzig, Roysircar, Kosyluk, & Corrigan, 2013; Khan, 2006; Martin, 2015; Nadal et al., 2012; Soheilian & Inman, 2009; Strack et al., 2016; Tanhan, 2014). Further, researchers further suggest that because Muslims in the U.S. face serious issues across these five psychosocial domains, they need greater attention from mental health

professionals, yet the Muslim population remains significantly underserved. Therefore, more systematic and contextual empirical studies are necessary to understand the factors that influence Muslims' approach toward mental health services. Researchers within the Muslim mental health literature has identified numerous factors affecting Muslims' approach to mental health services (e.g., cultural beliefs, stigma, economic factors, acculturation). To date, however, there has been a noticeable lack of research based on a clear theoretical framework that incorporates the range of factors that affect Muslims' approach to seek the services. Therefore, the proposed study will focus on the influence of a set of constructs (cultural beliefs, knowledge, attitudes, stigma, and PBC) and demographic (background) variables (education, sex, past behavior, race/ethnicity) as outlined in the framework below.

Theoretical Framework for Understanding Muslims' Approach to Mental Health Services

Figure 1 outlines a proposed contextual theoretical framework that includes seven factors that impact Muslims utilization of mental health services. The current researcher utilized two main underlying theories/models as lenses for the proposed contextual theoretical framework. The first lens is the Theory of Planned Behavior and the Theory of Reasoned Action (TPB/TRA; see Appendix B). *In this study TPB/TRA means one lens/theory rather than two separate ones* because TPB (see Appendix C) and TRA (see Appendix D) are the same theories with only some subtle differences. The second lens is Bronfenbrenner's Social Ecological Model (SEM; see Appendix E). In addition to these two main lenses, the current researchers also paid utmost attention to the Muslim mental health literature (Concept Map) while constructing the framework. The framework is

designed to aid in understanding the factors that impact how Muslims' approach formal mental health services from a comprehensive contextual perspective. The framework consists of seven main constructs.

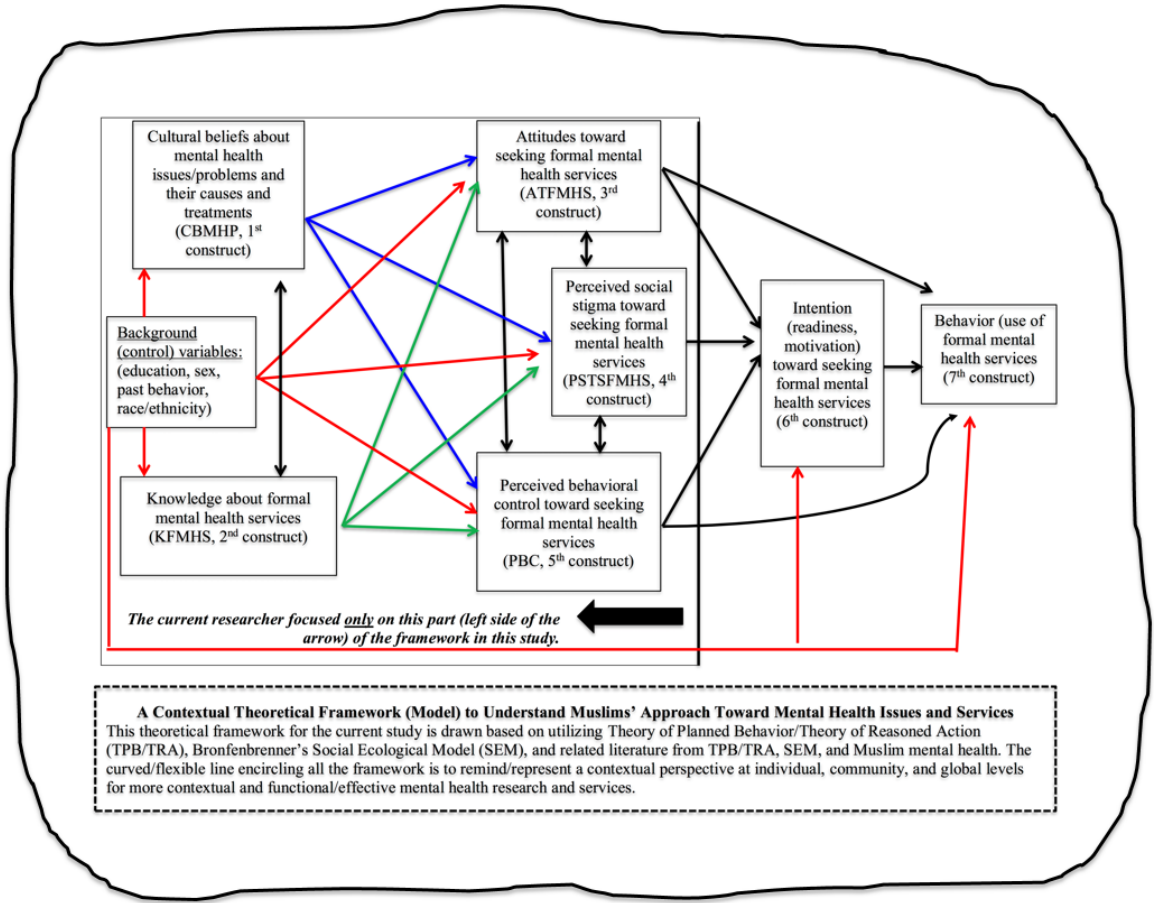


Figure 1. Proposed Contextual Theoretical Framework for Understanding Muslims' Approach toward Mental Health Issues and Services.

In the framework, cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-Cultural Beliefs) and knowledge about formal mental health services (KFMHS-Knowledge) are the first two constructs, and it is hypothesized that they explain attitudes toward seeking formal mental health services (ATFMHS-

Attitudes; 3rd construct), perceived social stigma toward seeking formal mental health services (PSTSMHS-Stigma; 4th construct), and perceived behavioral control toward seeking formal mental health services (PBC; 5th construct). These five constructs taken together are hypothesized to explain intention toward seeking mental health services (6th construct). The first six constructs together are hypothesized to explain the use of formal mental health services (7th construct).

TPB/TRA and SEM are the two underlying theoretical lenses for the current study to explore Muslims' approach toward seeking mental health services. A brief description of these two theories are provided below and in more details in chapter II.

Theory of Planned Behavior/Theory of Reasoned Action (TPB/TRA)

For this current study, TPB and TRA together constitute the first underlying theoretical lens (TPB/TRA) for the framework. TPB and TRA are the same theories only with some subtle differences; *therefore, in this study, TPB/TRA means only one theory.* TPB emerged from the first version of TRA as one can see in Appendix F (Fishbein & Ajzen, 1975) after Ajzen (2006) had focused on the first version of TRA and found that PBC as a new and very important construct. Therefore, he called the new model *TPB*. In further steps, Fishbein and Ajzen (2010) updated the first version of the TRA model so that the current/recent version of TRA conceptually includes PBC and also background factors (e.g., education, culture, knowledge, family, economic situation). Though researchers have used different names for the models (e.g., TPB, TRA, TPB/TRA), these are the same thing with minor differences. In the current study, TPB and TRA are combined and named as *TPB/TRA* to be used as one theory/lens for the framework.

Romano and Netland (2008) also stated that TPB and TRA are very similar with some minor changes, and the authors called for the use of them together as one lens in counseling research and practice. The authors did not use the theory for empirical research but rather provided a literature review of how the use of the model is common in health sciences for prevention and psychoeducation. They stressed how the theory is sensitive to multicultural consideration with the “elicitation process” (p. 796) that suggests the researcher must be mindful of contextual factors (e.g., cultural and individual differences) especially while improving instruments and interventions. The authors highlighted how the counseling profession has heavily stressed remediation but not prevention theories, while prevention has recently started to get more attention in counseling. Therefore, they recommended the use of TPB/TRA in counseling for prevention, research, and practice so that counselors gain more knowledge about the theory, use it in research, improve interventions based on the theory, and advance the practice of prevention rather than just focusing on remediation. Similarly, Amri and Bemak (2013) suggested researchers consider TRA (e.g., to understand the role of social stigma, cultural barriers) in order to improve more culturally sensitive approaches while studying Muslim mental health. Aloud (2004) and Aloud and Rathur (2009) also stressed the use of TPB to understand Muslims’ approach to mental health services so that the research and services are more evidence-based. Though these researchers suggested the use of TPB/TRA, none used the theory for their empirical studies.

TPB/TRA as theory focuses on predicting an individual’s voluntary action regarding a possible choice by focusing on their attitude, perceived social stigma, PBC,

and intention (i.e., motivation or readiness). For example, in order to predict ones' energy saving behavior, a researcher using the TBP/TRA perspective would measure one's personal attitude, perceived social stigma, PBC, and intention toward saving energy to predict one's actual behavior. TPB/TRA comes from a psychological perspective that values intrapersonal/individual processes rather than other contextual or physical/actual factors (Ajzen, 1991; Cottrell, Girvan, McKenzie, & Seabert, 2015). Although TPB/TRA includes important contextual factors (e.g., background, knowledge, culture, education), the researchers have not clearly addressed background or contextual variables, such as cultural beliefs, sex, education, and race. Therefore, inclusion of SEM is important because the need for a comprehensive and contextual perspective has been stressed throughout the Muslim mental health literature. A novel element within the proposed study is the inclusion of and TPB/TRA and SEM to create and partially test the proposed contextual framework for understanding Muslims' approach to mental health services.

Social Ecological Model (SEM)

Social Ecological Model (SEM) serves as the second underlying model for the current study. Urie Bronfenbrenner proposed SEM in 1970 as a conceptual model to consider environmental conditions in addition to intrapersonal/ individual and genetic factors. SEM was a reaction to individual approaches in psychology that focused on individuals isolated from their contexts (McLeroy, Bibeau, Steckler, & Glanz, 1988). Bronfenbrenner (1977) stressed the importance of viewing a person and/or community within their contexts to understand the dynamic relationships/factors impacting people.

SEM consists of four levels including the microsystem (e.g., individual's sex, age, health; peers; family; school), mesosystem (interactions/connections among the systems in the microsystem; interaction between family and school), exosystem (e.g., industry, social services, mass media), and macrosystem (e.g., culture, subcultures, economical structures; Bronfenbrenner, 1977). These levels are interrelated and have a dynamic relationship, which means change in one affects the others. Although few researchers in the Muslim mental health literature utilized a contextual perspective similar to SEM, nearly all the researchers stressed the importance of such a contextual perspective and its integration in research and practices (Ackerman, Ali, Dewey, & Schlosser, 2009; Ahmed, 2012; Bhattacharyya et al., 2014; Martin, 2015). Therefore, it is necessary to include SEM as one of the lenses for the current study to shape the proposed contextual theoretical framework. In light of the overall literature of Muslim mental health, TPB/TRA, and SEM, the following sections explain the first five constructs, which are the focus of the current study.

Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments (CBMHP-Cultural Beliefs)

The literature that addresses Muslim mental health makes it clear that the most important construct is cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-Cultural Beliefs) (Ahmed, 2012; Ali & Milstein, 2012; Bagasra, 2010; Bektas et al., 2009; Cook-Masaud & Wiggins, 2011; Tanhan, 2014; Thomas, Al-Qarni, & Furber, 2015; Youssef & Deane, 2006). Muslims' CBMHP-cultural beliefs include aspects, such as the effect of supernatural entities, and jinns that do not fit within the contemporary scientific biomedical model of mental health issues. In fact, the

majority of researchers argue that such beliefs lead Muslims to have a negative orientation toward formal mental health services and to overuse cultural resources and general/medical physicians to address their issues. There are, however, a few contradictory findings. For example, Bagasra (2010) found that half of the Muslims she surveyed held both biomedical (e.g., genetic, chemical) and cultural understandings for explaining mental health issues. The participants also held a positive disposition toward the use of mental health services, although this finding is atypical. Thus, considering cultural beliefs is important from a TPB/TRA perspective and even more so from a SEM perspective.

Knowledge about Formal Mental Health Services (KFMHS-Knowledge)

The majority of researchers examining Muslim mental health have noted that most Muslims in the U.S. are immigrants and it is unlikely that they had formal mental health services in their home countries/cultures (Ali & Milstein, 2012; Amri & Bemak, 2013; Bektas et al., 2009; Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Tanhan, 2014). Therefore, many Muslims lack adequate knowledge of the mental health issues and formal mental health services available in the U.S. In fact, most Muslims view mental health services as necessary only for extreme cases such as when someone is uncontrollable, violent, and/or has delusions or hallucinations (Thomas et al., 2015; Youssef & Deane, 2006). Researchers suggest that this lack of knowledge leads to a negative approach toward seeking the services. Therefore, inclusion of the KFMHS-knowledge construct is crucial.

Attitudes Toward Seeking Formal Mental Health Services (ATFMHS-Attitudes)

One's attitude toward seeking formal mental health services is among the most commonly studied constructs in the Muslim mental health literature. Researchers report that Muslims in the U.S. and/or some other cultures (e.g., Australia, United Arab Emirates) tend to hold negative attitudes toward mental health services mainly due to strong cultural beliefs, lack of knowledge, and high levels of perceived social stigma toward using mental health services (Ali & Milstein, 2012; Aloud, 2004; Aloud & Rathur, 2009; Amri & Bemak, 2013; Tanhan, 2014; Tummala-Narra & Claudius, 2013; Yousef & Deane, 2006). There are, however, some contradictory findings in which Muslim participants held positive attitudes (Bagasra, 2010; Khan, 2006; Kelly, Aridi, & Bahkhtiar, 1996; Soheilian & Inman, 2009; Tanhan, 2014; Thomas et al., 2015). Therefore, more contextual and empirical studies are needed to understand U.S. Muslims' overall attitudes about mental health service utilization. Examining this construct, then, is important and congruent with both a TPB/TRA and SEM perspective.

Perceived Social Stigma Toward Seeking Formal Mental Health Services (PSTSMHS-Stigma)

Many researchers (Aloud, 2004; Ciftci et al., 2013; Thomas et al., 2015; Yousef & Deane, 2006) stress that cultural beliefs and lack of knowledge toward mental health issues and formal mental health services lead to a high level of negative social stigma about utilizing mental health services. The protection of the family honor/name is an important value for many Muslims. Accordingly, they may struggle to accept that they or someone from their family has a mental health issue. Similarly, the individual with a mental health concern does not want to damage the name of the family. Even if the

family accepts the issue, they first think of it as a family concern that should be addressed inside the family. Utilizing outside resources like formal mental health services would likely lead the family to feel a loss of family honor. This creates a negative social stigma toward mental issues and the use of services to treat these issues. Examining PSTSMHS-stigma is crucial from both lenses TPB/TRA and SEM perspectives.

Perceived Behavioral Control Toward Seeking Formal Mental Health Services (PBC)

Perceived Behavioral Control (PBC) is synonymous with perceived self-efficacy, meaning the degree to which a person believes that they can take the steps necessary to identify and utilize mental health services if and when needed. Researchers who have utilized TPB/TRA in empirical studies found PBC to be one of the most important constructs that affects the behavior of interest. Interestingly, researchers in the Muslim mental health literature do not discuss PBC directly, though some researchers do discuss the construct indirectly. Although empirically not well studied in the literature, researchers have found that CBMHP-cultural beliefs, lack of KFMHS-knowledge, and perceived social stigma about mental health issues and services are among the main reasons for Muslims' low PBC toward seeking mental health services. Therefore, including and directly naming this construct as PBC is a unique contribution of the proposed study.

Statement of the Problem

Researchers have made it clear that U.S. Muslims face many psychosocial stressors and that overall Muslims have a negative perception of mental health services utilization, which directly impacts their overall wellbeing. To date, researchers have

explored various factors that contribute to how Muslims perceive mental health issues including cultural beliefs about mental health, and knowledge of Western mental health services, attitudes about formal mental health services, and perceived social stigma. To date, however, there has been no research that has brought these factors together in one study along with measures of participants perceived behavioral control to act on the need for mental health services. Subsequently, it remains unclear how the key factors work together to impact U.S. Muslims understanding of and utilization of mental health services particularly among Muslims living in the Southeast of the U.S. Therefore, it is critical to understand these issues from within contextual and empirically rigorous perspectives, as this knowledge would aid mental health providers and researchers in meeting the needs of this population in more effective ways (Ali & Milstein, 2012; Aloud, 2004; Amri & Bemak, 2013; Aprahamian et al., 2011; Bagasra & Mackinem, 2014; Bektas et al., 2009; Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Goforth et al., 2014; Herzig et al., 2013; Kelly et al., 1996; Khan, 2006; Thomas et al., 2015; Tummala-Narra & Claudius, 2013).

Most research conducted on the U.S. Muslims has occurred in the Northern U.S., and most of the participants were Arabs. This line of research has revealed that CBMHP-cultural beliefs, PSTSFMHS-stigma, and KFMHS-knowledge are the most important factors in understanding the Muslims' approach toward seeking mental health services. However, virtually no research has focused on Muslims in the Southern U.S., which has many immigrants not only from Arabs but also including Muslims from many other countries and especially from Africa (e.g., Nigeria, Sudan, Somalia) and unique cultural

influences (Islamic Center of Triad, Islamic Center of Greensboro, Zakat Foundation of America- North Carolina, The Center for New North Carolinians, personal communication, 2016). The social, historical, economic, and political context of the South and North of the U.S. also have been different from one another which might have affect Muslims' approach to mental health issues and services. Therefore, it is important to understand Muslims in the Southeast of the U.S. who are part of larger Muslims in the South. Furthermore, the extant research has generally failed to utilize a clear contextual and empirical theoretical framework to understand Muslims' approach toward mental issues and seeking formal mental health services. Figure 1 shows the contextual theoretical framework, which is based on two well-grounded lenses TPB/TRA and SEM, to understand Muslims' approach toward mental health issues and seeking formal mental health services. By employing this contextual theoretical framework, multiple gaps in the literature will be addressed including improving a contextual theoretical framework based on TPB/TRA, SEM, and the Muslim mental health literature; testing a part of the framework; and examining Muslims' approach to mental health issues and services. Therefore, the proposed study is designed to examine the relationship among the first five constructs (CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSMHS-stigma, and PBC) and the four background variables (education, sex, past behavior, and race/ethnicity). This would be the first study to explore these variables, through such a contextual theoretical framework, among a sample of Muslims in the Southeast U.S.

Purpose of the Study

The purpose of the proposed study is to understand how Muslims in the Southeastern U.S. approach seeking formal mental health issues and services. The proposed study will partially test the proposed theoretical framework and will provide basic descriptive statistics of the participants in terms of each construct. Five constructs, including CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSMHS-stigma, and PBC will be examined. This research will also help to clarify the relationship among these five constructs and the four background variables (education, sex, past behavior, and race/ethnicity). The results will help both mental health providers and researchers to understand this vulnerable and underserved population and provide more effective services that are contextually and culturally more appropriate.

The research will improve understanding of how participants CBMHP-cultural beliefs and KFMHS-knowledge explain attitudes, perceived social stigma, and PBC toward seeking formal mental health services. The research will also help to explore how background variables (i.e., education, sex, past-behavior, and race/ethnicity) explain the participants' approach toward mental health issues and services. Additionally, the results will provide a more descriptive understanding of how participants conceptualize/define mental health providers (e.g., counselors). This research will produce more systematic and contextual research, with the purpose of understanding the five constructs, the interaction among them, and ultimately to improve culturally and contextually appropriate mental health services.

Significance of the Study

The proposed study will improve the understanding of how Muslims living in the Southeastern U.S. approach mental health issues and services based on testing the proposed contextual theoretical framework. This study is essential due to the current lack of research on how Muslims in the Southeastern U.S. approach mental health issues and services. This is important because the Muslim community in the Southeastern U.S., like the larger Muslim community in the country, face many psychosocial issues. Utilizing the framework and testing part of the framework will address important gaps in the literature, which have been voiced by numerous researchers, and may aid mental health providers as researchers and/or practitioners design and provide more effective research and services. Understanding what affects Muslims' approach to mental health issues and services will also help key people in the Muslim community, such as spiritual/religious leaders and other health providers like general physicians have a more comprehensive picture of this vulnerable and underserved community.

An additional impact of the proposed study is testing a part of the theoretical framework. The existing research on the Muslim mental health has emphasized the effect of CBMHP-cultural beliefs on attitudes and social stigma toward mental health services; therefore, understanding these realities among a sample of Southeastern U.S. Muslims is needed. Earlier researchers (Bektas et al., 2009; Ciftci et al., 2013) have stressed the importance of Muslims possessing KFMHS-knowledge, an idea that is discussed in many intrapersonal/individual, interpersonal, and community theories (e.g., health belief model, TPB/TRA, SEM). Therefore, understanding how the Muslims' KFMHS-knowledge

explains attitudes, perceived social stigma, and PBC toward seeking the services is important given that many writers have stressed the need for culturally appropriate psychoeducation, training, and collaboration among mental health providers, researchers, Muslim communities, and community leaders. Although perceived behavioral control is not directly addressed in the Muslim mental health literature, understanding this construct as well as the other four constructs (cultural beliefs, knowledge, attitudes, and stigma) and the background variables is unique.

The proposed research will be based on a comprehensive, contextual, systematic, and well-established theoretical framework drawn from the Muslim mental health literature, TPB/TRA, and SEM. Through testing of this framework, the current study can help mental health professionals to understand how the Muslims, a vulnerable minority group facing multiple psychosocial issues, approach mental health issues and services. It is hoped that the proposed study will assist mental health providers to determine the need to pay closer attention to cultural factors, level of knowledge, attitudes, perceived social stigma, PBC, the relationship among them, and the other variables (e.g., sex, education) to address the psychosocial issues the Muslims face. Finally, a clear conceptualization of how Muslims define mental health providers is lacking. Therefore, this study will provide rich and descriptive depictions of how Muslims describe mental health providers.

Research Questions

There are eight research questions that the proposed study will address.

Research Question 1: What are the descriptive statistics (e.g., mean, standard deviation) for the participants' scores in terms of the five constructs including CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSMHS-stigma, and PBC?

Research Question 2: Do participants' CBMHP-cultural beliefs scores explain participants' ATFMHS-attitudes scores when controlling for background (control) variables and KFMHS-knowledge?

Research Question 3: Do participants' CBMHP-cultural beliefs scores explain participants' PSTSFMHS-stigma scores when controlling for background (control) variables and KFMHS-knowledge?

Research Question 4: Do participants' CBMHP-cultural beliefs scores explain participants' PBC scores when controlling for background (control) variables and KFMHS-knowledge?

Research Question 5: Do participants' KFMHS-knowledge scores explain participants' ATFMHS-attitudes scores when controlling for background (control) variables and CBMHP-cultural beliefs?

Research Question 6: Do participants' KFMHS-knowledge scores explain participants' PSTSFMHS-stigma scores when controlling for background (control) variables and CBMHP-cultural beliefs?

Research Question 7: Do participants' KFMHS-knowledge scores explain participants' PBC scores when controlling for background (control) variables and CBMHP-cultural beliefs?

Research Question 8: How do participants conceptualize/define mental health providers (e.g., counselors)?

Definition of Terms

Mental Health Issues—Bagasra (2010) identified mental issues as a dysfunction related to thoughts, perceptions, emotions, or behaviors that causes distress, impaired functioning, or an increased suffering in one's life. The dysfunction also must be viewed as abnormal within the individual's cultural context. Mackenzie, Knox, Gekoski, and Macaulay (2004) identified psychological issues as reasons a person might visit a professional, and similar terms might include mental health concerns, emotional problems, mental troubles, and personal difficulties. In the current study, mental health

issues and psychological issues hold the same meaning. Therefore, the terms *issues*, *problems*, *concerns*, *illnesses*, and *disorders* are used interchangeably. *Mental issues* refer to any disturbance, pain, dissatisfaction, and/or unpleasantness (mild, moderate, or severe) that a person feels/experiences because of difficult life conditions (e.g., forced or volunteer migration, searching for meaning of life, difficulties at job or school, difficulties with relationships, unpleasant emotions, exposure to violence/war) so that the issues decrease the quality (i.e., wellness, functionality) of life for the person and/or other people around them.

Formal Mental Health Services—Aloud (2004) identified mental health services as “public and private mental health services staffed with mental health and human service professionals” (p. 9). Therefore, for this study, mental health services include counseling, therapy, psychoeducation, and/or any other type of services/collaboration to address any mental health issues and/or to increase the quality (i.e., wellness, meaning, functionality) of life at any intrapersonal/individual, interpersonal, group, community, and/or global levels.

Formal Mental Health Providers—Barker (1999) identified mental health providers as people who have specialized training and skills about the process and treatment of mental health issues. Mackenzie et al. (2004) explained mental health professionals as “individuals who have been trained to deal with mental health [issues]” (p. 2434). For this study, mental health provider includes professional counselors, psychologists, therapists, clinical social workers, psychiatrists, and/or some other mental

health providers who attend people at individual, group, and/or community levels to address mental health issues and/or to enhance the quality of life.

Cultural Beliefs About Mental Health Issues/Problems and Their Causes and Treatments (CBMHP-Cultural Beliefs)—The current researcher utilized Aloud’s (2004) definition of cultural beliefs: “a state of mind characterized in part by a traditional or religious view of the causes and treatment of mental health [issues]” (p. 11). Bagasra (2010) noted that traditional Islamic causes of mental illness are defined as supernatural or supra-natural factors that originate from theological basis and have the capacity to cause symptoms of contemporary mental health issues. Therefore, in this study, CBMHP-cultural beliefs construct means any beliefs about the cause and treatment of mental issues that are not aligned with the contemporary scientific (biomedical) model of mental issues and their treatments.

Knowledge about Formal Mental Health Services (KFMHS-Knowledge)—For the current study, Aloud’s (2004) definition is adopted. KFMHS-knowledge is defined as the extent to which participants a) acknowledge the role of formal mental health providers; b) acknowledge the availability of formal mental health services in their community; c) have knowledge about descriptions of mental health issues; and d) have knowledge about the intervention and treatment models associated with mental health issues.

Attitudes Toward Seeking Formal Mental Health Services (ATFMHS-Attitudes)—For this study, ATFMHS-attitudes is defined as Muslim participants’ tendency/approach toward supporting (favorableness) or to not supporting (unfavorableness) seeking of mental health services.

Perceived Social Stigma Toward Seeking Mental Health Services (PSTSMHS-Stigma)—Ajzen (2006) defined perceived social stigma as how much one perceives social pressure to engage or not to engage in a behavior, and Fisher and Turner (1970) defined “societal stigma” as an effect on an individual, either visible or invisible, that causes a negative view of them. The operational definition of PSTSMHS-stigma for this study will be the participants’ perception of social disgrace (i.e., dishonor, disapproval, and/or disrespect from family, friends, community, others) toward seeking formal mental health services.

Perceived Behavioral Control Toward Seeking Formal Mental Health Services (PBC)—Ajzen identified PBC as one’s perceptions of their ability to perform a given behavior (2006) and/or one’s perception of the ease or difficulty of performing the behavior of interest (1991). Ajzen (1991) further stated that PBC “is most compatible with Bandura’s concept of *perceived self-efficacy*” (p. 184). The operational definition of PBC for this study will be the Muslim participants’ perception of themselves and/or their ability to seek mental health services to address mental health issues when needed.

CHAPTER II

REVIEW OF RELATED LITERATURE

In this chapter, the current researcher provides a thorough review of the literature on the factors affecting Muslims' approach toward mental health issues (illnesses, problems, concerns, and difficulties) and toward seeking formal mental health services. The researcher provides information regarding definitional elements of Islam and Muslim, cultural perspectives that may affect Muslims' seeking mental health services, and a thorough description of the theoretical framework (model) and constructs that will be researched in the current study.

Understanding Islam and Muslims

In order to understand the effects of mental health on the lives of Muslims, readers must first understand the influence of the terms Islam and Muslim. Tanhan (2014) reported that in general mental health providers in the U.S. were not familiar with basic aspects of Islam and how this unfamiliarity potentially affected service delivery and relationships with their Muslim clients. Young and Cashwell (2011) explained that the integration of clients' spiritual/religious aspects into counseling is important. They stressed that mental health providers who have expertise and knowledge may train client and "the key component is that the practice should be consistent with the client's personal beliefs" (p. 18). Therefore, it is necessary for mental health providers be familiar with Islam and the unique needs of the Muslim community. The probability of counselors

encountering a Muslim consultee/client has increased considering the sociopolitical contexts (e.g., hate speech, invasion and exploitation of countries where majority is Muslims, terrorist attacks) of the country and of the world.

The importance of possessing basic knowledge and familiarity with Muslim belief systems is supported by the Association for Spiritual, Ethical, and Religious Values in Counseling (ASERVIC) competencies (Young & Cashwell, 2011). The American Counseling Association (ACA, 2014) code of ethics clearly states the importance of being familiar with the client/consultee's belief system. As Wiggins (2011) explained, "prejudice is likely to be the biggest challenge for Western counselors working with Muslims" (p. 47). According to Wiggins, Western people, including mental health providers, are more likely to be influenced by the media and perceive Muslims in inaccurate ways. Yet due to prejudice and racial profiling, Muslims in the Western countries (e.g., the U.S.) may seek out counseling services to deal with such psychosocial issues, which requires mental health providers to be more sensitive and competent in attending to their Muslim clients. Holmes (2013) similarly indicated that health providers and those with different privileges (e.g., race, socioeconomic conditions, origin of the country) might disserve immigrants and non-white people due to a lack of cultural knowledge and a poor understanding of the sociopolitical and economic conditions minority populations face. Therefore, he strongly suggested comprehensively learning about minority groups in order to understand how socioeconomic and political systems or conditions affect all people, especially minority groups. He named this process "structural competency" with the intent of placing a higher value in understanding people

in the context of their communities and the systems within which they live. In the following sections, the current researcher provides some basic facts and components of Islam and Muslims so that readers, and especially mental health providers, can improve their own cultural, spiritual, and structural competencies in order to serve in more effective ways.

Islam and Muslim Defined

The word “Islam” is Arabic and comes from the root word “*silm*,” which means “peace” and “submission.” Therefore, Islam means submission or surrender of one’s will to Allah; anyone who does so is identified as a Muslim. It is crucial to understand that Islam, especially within the context of Muslims and the Quran, is not a new religion. Rather, it is considered Allah’s last revelation. Many writers, including Muslim researchers, state that Islam is a new religion started by the Prophet Muhammad (Peace Be Upon all the Prophets, PBUT) in 570 AD; however, this view is incorrect according to primary Islamic resources. From the Islamic perspective, Adam was the first prophet and Muhammad was the last (PBUT). The Qur’an is seen as the last Holy Book from Allah, not the advent of a new religion. Therefore, the messages from the Prophets Adam, Noah, Abraham, Jacob, Solomon, David, Moses, Jesus, Muhammad and all other prophets (PBUT) are Islam, as it is explained in Qur’an and Sunnah (the teachings and deeds of Prophet Muhammad). Respect for and belief in all of these prophets and holy books is a requirement for Muslims. Muslims believe that the messages that were sent to previous prophets (Psalms, Torah, and Bible), with the exception of the final prophet (Prophet Muhammad), were changed by people throughout history and therefore no longer

represent Islam. The following table outlines the foundations of Islam that affect Muslims' daily lives.

Table 1

Foundations of Islam

| Foundations of Islam | |
|--|---|
| <p>Primary Sources Quran (the holy book of Islam) Sunnah (what Prophet Muhammad said and did, PBUT)</p> <p>Secondary Sources <i>Ijma</i> <i>Qiyas</i> (or aql)</p> | <p style="text-align: center;">Five Pillars of Islam (Based on the primary sources)</p> <ol style="list-style-type: none"> 1. Declaration of faith (<i>shada</i>) 2. Prayer (<i>salah</i>) 3. Obligatory charity (<i>zakah</i>) 4. Fasting (<i>sawm</i>) 5. Pilgrimage (<i>hajj</i>) <p style="text-align: center;">Six Principles of Faith (Based on the 1st Pillar of Islam: <i>Shada</i>)</p> Faith in <ol style="list-style-type: none"> a) Allah b) Allah's angels c) Allah's books d) Allah's prophets e) The hereafter f) The divine decree and destiny <p style="text-align: center;">If a person believes in all these components of Islam, they are called Muslim, meaning one who submits to Allah.</p> |

The Qur'an, the first primary source for Muslims, is considered the last holy book. The word Qur'an literally means "the recitation." It is the main and primary source for Islam. The Qur'an was revealed to the Prophet Muhammad (PBUT) in 610 AD in

Mecca, Saudi Arabia. It consists of 114 chapters and 6236 verses. The original language of the Qur'an is Arabic, and Muslims recite it in Arabic in their daily prayers (*salah*). Muslims view reciting and understanding the Qur'an as a direct way to receive healing from Allah (Padela, Killawi, Forman, DeMonner, & Heisler, 2012). The "Quran is the essential core of Islam and the source of doctrine, law, knowledge, and spiritual experiences of Muslims across the globe" (Hedayat-Diba, 2000, p. 291). The second primary resource is the Sunnah, which includes both *hadith* (recorded words of Prophet Muhammad through an oral and written process) and actions (prayer, ablution, eating, drinking) of the Prophet Muhammad (PBUT).

As shown in Table 1, the five pillars of Islam include the declaration of faith (*shada*), prescribed prayers (*salah*), obligatory charity (*zakah*), fasting (*sawm*), and (if a Muslim can afford to go) pilgrimage to Mecca (*hajj*).

Declaration of faith (*shahada*) is the first pillar of Islam, and it states there is no deity worthy of worship except Allah and that Prophet Muhammad is Allah's servant and messenger. This pillar is comprehensive and includes the six principles of faith including: faith in Allah, Allah's angels, Allah's books, Allah's prophets, the hereafter, and divine decrees and destiny. The second pillar of Islam is the prescribed prayer (*salah*). Muslims have to practice these prescribed prayers five times a day. In addition to that, Muslim men have to pray the Friday prayer with a congregation. The next pillar of Islam is the purification of wealth (*zakah*), which involves the giving of alms (at least 2.5% of one's wealth) to people in need if one has sufficient wealth. Islamic law explains what constitutes sufficient wealth. The fourth pillar is the obligatory fasting (*sawm*), which is

abstinence from eating, drinking, sexual activity, and bad actions (such as lying, insulting, etc.) from dawn to sunset during the month of Ramadan, the ninth month of the Islamic lunar calendar. The last pillar is a pilgrimage (*hajj*) to Mecca at least once in a lifetime if one can afford it.

The pillars of Islam are embedded into the daily lives of Muslims who practice their religion. Muslims' beliefs are not something that are practiced once a week, month, or year. They are practiced throughout every day and are a way of life for Muslims. Many writers discuss Islam based on aspects of faith; however, one of the most important elements of Islam is a concept of justice that includes fundamental economic regulations (e.g., the concept of money, interest, profit), which Prophet Muhammad and all other prophets (PBUT) explained and followed for the benefit of all, not just the believers. This is related to what Holmes (2013) called structural competency. However, even though it is related to Muslim's beliefs the current researcher will not elaborate as it is beyond the topic and there is lack of place and time.

Overview: Muslims and Mental Health Issues

As a minority group, Muslim Americans are growing fast and face many psychosocial issues (Bagasra, 2010; Martin, 2015). Although the exact number of U.S. Muslims varies across resources, all indicate that Islam is the fastest growing religion in the U.S. According to one study, there were about 3.3 million Muslims in the U.S. in 2015 (Pew Research Center, 2016); however, according to the Council on American-Islamic Relations (CAIR, 2015) there are about six to seven million Muslims in the U.S.

Research reveals this is a population in need of greater attention, including mental health issues and services (Amri & Bemak, 2013).

Researchers argue that the attention Muslims receive is generally not positive, and this negative reaction causes numerous psychosocial issues for Muslims (Ahmed & Reddy, 2007; Ali & Milstein, 2012; Francisco & Tanhan, 2015; Martin, 2015; Nadal et al., 2012; Strack et al., 2016). Chaudhry and Li (2011) noted that U.S. Muslims are more likely to have mental health issues than any other minority group because of the psychosocial stressors they face in daily life. Muslims in the U.S. face physical and verbal discrimination, harassment, and physical and verbal attacks in schools, the workplace, and other social contexts (e.g., health care settings; Francisco & Tanhan, 2015; Nadal et al., 2012; Strack et al., 2016; Martin, 2015). Ahmed and others (2014) identified that risk behaviors (e.g., use of alcohol, illicit drugs, tobacco, smoking, and gambling) were very common among Muslim college students. The authors also stressed psychosocial issues, such as discrimination and acculturation issues, lead Muslim students to abuse substances as a coping mechanism. Francisco and Tanhan (2015) found that a Muslim community at a university in the Southeast of the U.S. experienced many psychosocial issues based on a 33-item survey. The authors expressed that it is uncommon to find such a high dissatisfaction with so many psychosocial aspects of life within other communities on college campuses. In the study, only 39.06% of the Muslim participants indicated that they “feel safe,” while only 40.36% indicated that they “[are] safe.” In the same study, nearly 56% of the participants indicated experiencing verbal and/or physical insults or abuse. Similarly, Strack and others (2016) identified that the

majority of Muslim participants at a university in the Southeast U.S. reported psychological, social, and academic issues due to discrimination, physical and verbal attacks, and a lack of resources/tools to practice their daily prescribed prayers (*salah*) on campus. In other qualitative studies, researchers found that the majority of Muslim participants in universities in the Northeast U.S. faced subtle, overt, intentional, and unintentional discrimination (Bhattacharyya et al., 2014; Nadal et al., 2012; Tummala-Nara & Claudius, 2013). Moreover, Martin (2015) found that Muslims across the country faced discrimination and other social issues, including being misunderstood and lacking appropriate places to pray.

The psychosocial issues faced by Muslims in the Northeast includes interpersonal issues with their parents, relatives, and friends mainly due to the lack of communication skills and cultural struggles (e.g., American individualistic culture versus Islamic collectivistic culture; Tanhan, 2014). Tanhan also explained how some Muslim clients/inmates in a correctional facility in the Northeast faced difficulties because mental health providers and other staff were unaware of the religious needs of Muslims. Clearly, Muslims in the U.S. face many mental health issues, which are often unrecognized and/or unacknowledged.

Researchers who study Muslims and their mental health concerns found that Muslims in the U.S. face many psychosocial and academic issues (Ahmed et al., 2014; Ali & Milstein, 2012; Amri & Bemak, 2013; Aprahamian et al., 2011; Bagasra, 2010; Bagasra & Mackinem, 2014; Bektas et al., 2009; Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Franciso & Tanhan, 2015; Goforth et al., 2014; Herzig et al., 2013; Khan,

2006; Martin, 2015; Nadal et al., 2012; Soheilian & Inman, 2009; Strack et al., 2016; Tanhan, 2014). These concerns can be categorized under five groups: a) global (political, wars, international), b) larger community (jobs, neighborhood, institutions), c) local community (family, faith community, friends, home, interpersonal), d) interpersonal (significant other, friend, spouse), and e) intrapersonal/individual (lifestyle, values, life goals). The psychosocial issues Muslims face are complex and multidimensional; therefore, it is important to understand that the categories of concerns are interrelated as the authors have stressed (Holmes, 2013; Prilleltensky, 2008, 2012; Prilleltensky & Prilleltensky, 2003). This means issues at one level affects other levels, especially for such a vulnerable minority. For example, Cook-Masaud and Wiggins (2011) explained how a Muslim client, who was a recent immigrant to the U.S., faced serious interpersonal relationship issues including physical abuse. However, the client did not utilize mental health services due to inadequate information about resources and lacking the communication skills to navigate the mental health system.

Muslims' Conceptualization of Mental Issues

Muslims have culturally specific ways of explaining illness and healing. Researchers argue that Muslims' possess inadequate knowledge of the biomedical/chemical explanations for mental illness but hold more cultural explanations, which are explained more in the following paragraphs. Similar to these researchers, Bagasra (2010) found that Muslims held cultural as well as biomedical (scientific, biological, chemical) explanations for conceptualizing mental issues. Similar to all the other researchers in the literature of Muslim mental health, she stressed that it is

important to understand how Muslims might conceptualize mental issues from their cultural perspectives.

Bagasra (2010) outlined three categories for how Muslims conceptualize mental illness related to their traditional perspectives: a) concepts based on the primary sources (Quran and Sunnah) of Islam; b) theoretical concepts developed by Muslim scholars, religious leaders, and philosophers based on Islamic resources; and c) lay (public) Muslims' beliefs about mental illness.

Concepts Based on the Primary Sources (Quran and Sunnah) of Islam about Mental Issues

According to Islam and its primary resources, Allah controls both health and illness, and Allah is the ultimate doctor (Padela et al., 2012). There are many teachings within Islam that affect how Muslims view mental health issues and their treatment. However, in this first category the current researcher only elaborated on three key concepts including: seeing issues as a test, as arising from a lack of belief or having a weak faith, or from the influence of supernatural entities, such as jinns and evil processes that can cause mental issues.

Mental health issues as a test. There are many verses and *hadiths* that stress how all issues or illnesses at the biopsychosocial level could instead be a test. For example, Allah says in Qur'an (2: 155-156)

And certainly, We [Allah] shall test you with something of fear, hunger, loss of wealth, lives, and fruit, but give glad tidings to the patient, who when disaster strikes them, they say, "Indeed we belong to Allah, and indeed to Allah we will return."

There are many hadiths which deliver the same message, such as; Prophet Muhammad (PBUH) said,

No fatigue, nor disease, nor sorrow, nor sadness, nor hurt, nor distress befalls a Muslim, even if it were the prick they receive from a thorn, but that Allah expiates some of his sins for that. (University of Southern California-Muslim Student Association [USC-MSA], n.d.a, vol. 7, book 70, #545)

Muslims with an in-depth knowledge of Islam are more likely to consider mental illnesses from a spiritual perspective and to perceive them as a test. For example, Muslims who align with the spiritual (one's internal process) aspect of Islam, such as the Sufis, often interpret mental issues as a message from Allah. These Muslims believe that the sufferer can receive spiritual gifts as a result of moving through their struggles to an upper stage of nafs (self/ego) and achieve peace with Allah.

Lack of belief or a weak faith. Researchers of the literature on Muslims and mental health note that many Muslims may consider their illnesses or difficulties as a result of lack of faith or weak faith due to not having enough knowledge about their religion. This belief is pervasive because most Muslim scholars, community leaders, and/or traditional healers stress that a lack of faith and/or weak faith causes mental issues. Many Muslims often use phrases such as "*Alhamdulillah*" (thanks/praise to Allah), I am Muslim, and Muslims are strong and do not have stress, depression, or mental issues (Tanhan, 2014). Such cultural core beliefs lead some Muslims to view mental issues as a result of personal faults that bring shame to them and their families. Related to mental issues being perceived as the result of a personal fault is the lack of knowledge of mental issues. Researchers report that Muslims are more likely to express mental health issues

alongside other biological/medical issues (e.g., somatic and dissociative issues/disorders), which leads to use of medical doctors rather than mental health providers. Visiting a medical doctor because of a biological illness is more socially acceptable than visiting mental health providers.

Influence of supernatural entities. The existence of jinns, Shaytan (evil), evil eye (nazar or al-ayn), and black magic are concepts found in both the Quran and Sunnah. According to the Quran, Allah created jinns from smokeless fire before human beings existed. Similar to human beings, jinns have free will, including the freedom to choose the faith they want. There are verses stating that jinns can interact with people, either to harm or benefit them. Although there are no any clear explanations about how jinns harm people, there are verses that explain that they helped the Prophet Solomon (PBUT).

The second concept, Shaytan (evil, which is also noted as Iblis in Quran) is a jinn who lived in Paradise with the Prophet Adam and Mother Eve (PBUT) and deceived them into rebelling against Allah (eating from the forbidden tree). Evil (Shaytan or Iblis) has the power to whisper to people and convince them to commit sin.

The third word, the evil eye known as nazar (in Arabic, al-ayn) is a gaze (glance, thought, word) that is filled with jealousy that might cause a difficult, unpleasant, bad, or negative effect on a person. Many Muslim scholars also interpret this evil eye, or nazar, as the power of words/speech and sight/gaze. The word “evil” occurs many times in the Quran in the context of seeking refuge in Allah from the ones creating the evil.

The next concept is magic, which is present in the Quran. Allah recommends people stay away from it. According to some Muslim scholars, magic was used against

some prophets, including the Prophet Moses and Muhammad (PBUH). The magic or sorcery is more present in association with the Prophet Moses (PBUH), and Allah states it is a test to determine whether people will avoid it or use it to harm people. According to Islam, jinns, evil, and magic are factors (but not the sole reason) leading to mental health issues. These concepts in Islam are largely not taken into consideration by the contemporary scientific/biological mental illness perspective, yet they are important factors in understanding how Muslims conceptualize mental illness and health.

Attributing mental health issues to these concepts is much more likely when the situation (e.g., thoughts, behaviors) is deviant and the person is extremely dysfunctional. The influence of jinns, magic, and evil has been stressed by some traditional Muslim healers and Muslim scholars to such an extent that they call on contemporary formal mental health providers to focus on these aspects during formal mental health services, while some scholars complain that some Muslims attribute all mental health issues to supernatural entities and processes. All these Muslim scholars and traditional healers call for a more holistic approach to serve Muslims.

Theoretical Concepts from Key People about Mental Issues

The second category of factors impacting Muslims' view of mental health consists of theoretical concepts developed by key people like Muslim scholars, religious leaders, and philosophers based on Islamic sources (Bagasra, 2010). This category builds upon the first category (e.g., concepts such as supernatural entities and processes). Muslim scholars who do not embrace the contemporary scientific/biological model of mental illness have identified several concepts to explain mental illnesses (Bagasra,

2010). For example, the struggle with and within the *nafs* that corresponds with psyche/ego/self in contemporary psychology is one such explanation. *Nafs* is a word that occurs about 28 times in Quran (Bagasra, 2010). Dharamsi and Maynard (2012) explained that Allah describes *nafs* in seven various stations/types including Nafs Al-Ammara (the commanding self, which means the inciting/lower self that recommends acting on bad impulses), Nafs Al-Lawwama (the blaming self, meaning the conscious self that is aware of the individual's good and bad actions), Nafs Al-Mulhamah (the inspired self, an artistic, creative, loving self that struggles with authority, rules, and disciplines), Nafs Al-Mutma'innah (the certain self, meaning the self that reached peace and left bad actions/intentions behind), Nafs Al-Radiyah (the content self, meaning the self that is content with whatever situation they are in), Nafs Al-Mardiyah (the self that is pleased with everything that they experience), and lastly Nafs Al-Kamila (the completed self, the self who lives on the level of the Prophets and living by Divine Love). Beyond these seven fundamental *nafs*, Muslim scholars added some different types/subtypes and explained the struggle moving through the *nafs* as a normal process (i.e., experiencing difficultness and some anxiety). In doing so they also described how progression between *nafs* could lead to some dysfunctional behaviors, thoughts, and feelings, especially if the struggles are not addressed or the process is not managed well or in balance.

In addition to *nafs*, Muslim scholars, in particular those aligned with the more spiritual aspects of Islam (e.g., the Sufis), stress two additional concepts including *qalb*, meaning heart, and *ruh*, meaning soul/spirit. In relation to the spirit (*ruh*), Bagasra (2010) reported that many Sufi scholars interpret the struggle and psychological issues as a result

of the separation (*firaq*) of humanity from its original nature, Allah. This is traced to when the first humans (Prophet Adam and Mother Eve, PBUT) were sent to earth from heaven and lost the privileges of directly communicating with Allah and living in Paradise. The Sufis, the Muslims who are more aligned with *tasavvuf*, meaning more spiritual aspects of Islam, see this separation from God and daily God-consciousness as one of the sources of mental issues (Barks, 2004). Bagasra (2010) also noted that the Muslim scholars also used the word “sickness of the heart” or “disease of the heart” (*amrad al-qalb*) to explain deviant/dysfunctional behaviors, thoughts, and feelings. This terminology is close to contemporary definitions of mental illness (Bagasra, 2010). The Muslim scholars also identified mental issues as a possible test from Allah or a result of not practicing one’s faith/Islam.

Laity’s Beliefs about Mental Issues

In the third category (laity’s, meaning those not in the mental health profession, beliefs about mental illness), it is important to keep in mind what cultural diversity, lack of education, and individual differences Muslims might bring into the room. Kobeisy (2007) argues that it is not enough to know general information about Islam to effectively treat Muslims in counseling. Rather, mental health providers must attend to a range of cultural elements as well. Sociodemographic elements such as age, class, education, and citizenship status play a crucial role in Muslims’ experience of Islam and their understandings of mental health. This is also significant in the Social Ecological Model (SEM). However, it is difficult to identify the specific cultural factors for each Muslim or Muslim subgroup and how these may affect their conceptualization of mental illness.

Therefore, this study focusses on the influence of concepts from primary Islamic sources and theoretical concepts developed by Muslim scholars as both are quite influential for many Muslims.

Almost all the researchers in the literature of Muslims and mental health stressed these three categories, and especially the first two, in identifying how Muslims conceptualize mental illness. Most researchers in the Muslim mental health literature have found that Muslims do not conceptualize mental issues from the contemporary scientific (i.e., a biological disease process) perspective, although there are a few researchers who found that Muslims conceptualize mental issues from a more holistic perspective, including from spiritual, cultural, biological, and/or environmental aspects (e.g., Bagasra, 2010).

From an Islamic perspective, having a mental, medical, and/or any other biopsychosocial issue may occur from a lack of faith or weak faith. However, weak or nonexistent faith is not considered the sole reason for health issues. In general, Islam stresses the importance of a balanced lifestyle (e.g., balance eating, not wasting, giving to charity, working to earn rather than stealing/cheating, treating one's family and others well, prayer, reflection and meditation). Therefore, when a person who lacks other functional values strays from core Islamic values or who is bound to a distorted view of Islamic values (e.g., rather than praying and bonding to Allah they pray/bond to a religious leader) it is more likely s/he will develop a more inflexible/rigid lifestyle and views. This may lead to more mental health issues. As Young and Cashwell (2011) and Hayes, Strosahl, and Wilson (2012) argue, one's religious/spiritual faith can both

facilitate and block one's exploration of the meaning and value of their life. Nevertheless, illnesses or mental health issues are typically considered a test, as explained in the Qur'an and Sunnah. The prophets, including Prophet Muhammad (PBUH) and other great Muslim scholars, all experienced difficult times in their lives even while being considered the strongest Muslims in both their faith and practice. From an Islamic perspective, when one strives to live a healthy/functional life and avoid harmful ways and actions (e.g., use of substances), mental health challenges are considered a spiritual test. Islam considers mental health issues to be a burden sent by Allah so that the bearer will develop a deeper understanding of the universe, human nature, and Allah.

Cultural Treatments of Mental Health Issues

Traditional Muslim healers and medical doctors both in the U.S. and Arabic countries consign people to mental health providers for mental issues and collaborate with medical doctors for medical issues. However, there appears to be a significant underutilization of mental health services and over-reliance on cultural treatments. Therefore, it is important to understand commonly used cultural treatments (e.g., servanthood, prayer/Salah, and charity).

Servanthood

In Islam, any good intentions or actions are considered a form of prayer and a good deed. When a Muslim is sick, it is strongly recommended they go and do some good deeds (e.g., helping others, praying, reflection known as *tadabbur*, paying attention to the universe, and protecting the environment; Tanhan, 2014). It is also strongly recommended in the primary resources of Islam to visit people and especially people who

have any difficult issues (e.g., health, social) so that the visitor prevents more calamity both for themselves and their community.

Healing through *Salah* (Daily Prescribed Prayers), *Duaa* (Invocation), and Recitation of Quran (*al-Ruqyah*)

Salah (the five daily obligatory prayers) is a foundational concept in Islam, one that is repeated hundreds of times in the Qur'an and Sunnah. However, in addition to the daily prayers Allah recommends Muslims pray when they face difficulties. In order to facilitate this aspect of the Muslim faith, it is important for mental health providers to be aware that Muslims practice prayers throughout the day. Tanhan (2014) reported that as a counselor he came across many counselors-in-training, site supervisors, and counselor educators who did not have basic information about Islam and how Muslims pray. Tanhan suggests that the Muslim clients found it helpful to talk about their practice of *salah*. In fact, Muslim clients reported that religious practices, such as prescribed prayers and rituals following prayer (known as *tasbihat*), were helpful (Tanhan, 2014). Other researchers report that Muslims perceive prayers (*salah*) as a way to address personal issues. Researchers studying Muslim college students found that participants felt uncomfortable and stressed when they could not pray (Francisco & Tanhan, 2015; Strack et al., 2016). Padela et al. (2012) report that many Muslims believe that Allah has a direct role in healing through worship (e.g., reciting Qur'an (*al-Ruqyah*) and invocation (*duaa*)). In addition, Muslims view *Tibb-i Nabavi* (Prophetic Medicine), *dhikr* (remembrance of Allah), and *tafakkur* and/or *tadabbur* (reflection) as means of addressing issues and seeking help from Allah.

Charity

Good deeds done for the pleasure of Allah (e.g., helping people, cleaning the streets, saving energy) are considered an act of worship in Islam. Doing good deeds is an important way Muslims prevent psychosocial issues from developing and as a means of addressing such issues when they occur. Many scholars interpret this as charity. The Prophet Muhammad recommended that those faced with psychosocial issues give to charity, do good deeds, and be patient. The concept of charity is well known in Islam and by Muslims around the world. *Sadaqah* or *sadaka* means the voluntary giving to others of materials, attitudes, or actions (e.g., money, compassion, love, mercy, visit, even a smile). In addition, Muslims believe that Allah has a role in psychological healing through help provided by health care and mental health providers, imams or scholars, family members, and friends.

Spiritual Leaders, Rituals, and Diet

Working with a spiritual/religious leader (sometimes called sheikh) individually or in a group is another important means for addressing mental health issues. Spiritual leaders, in general, provide space in their own house or a mosque both for individual and group meetings/conversations. In general, these meetings or gatherings happen by visiting the sheikh to seek their wisdom on specific issues and illnesses and to increase their quality of life, especially through inner peace. During these conversations, it is likely the spiritual leader (sheikh) sits (on the ground, cushion, or sofa, though generally not on a chair) across or close (especially if they are the same sex) to the person and listens to their issues. If the spiritual leader and the person seeking help are of a different

sex, then it is more likely that the person meets with the spiritual leader alongside a family member or friend. Additionally, it is also likely the spiritual leader and the person interact through a barrier or screen that prevents direct contact but enables both parties to hear each other. In Islam, a man and a woman who are not married or are not from the same family (i.e., parent, sibling, aunt, uncle) are not allowed to sit alone in a closed area unless it is necessary.

During such meetings, the spiritual leader attends the person and utilizes different approaches based on their knowledge, experience, and resources. After listening to the person's issues, the spiritual leader may provide one or more options for healing. They might elaborate on the stages of nafs (self, ego) and how the suffering person is struggling through those stages (explained in the following paragraphs). The spiritual leader may share some stories and metaphors originating from Islamic texts (e.g., the pain and stories of the prophets) or Tasavvuf/Sufism (e.g., the conference/conversation/ journey of the birds), or recommend some religious rituals (e.g., nightly prayers known as *tahajjud*, reciting and reflecting on the Quran, remembrance of Allah known as *tasbihat*, offer a reflection on life and the universe, or doing good deeds). Additionally, the sheikh may recommend joining some Tasavvuf/Sufi gatherings (e.g., reading poems, joining conversation circles known as *halaqa*). Sometimes they may recommend the person stay at a mosque or religious center and invest their time in reading, reflecting, working to serve others/community, or recommend some other spiritual/religious or culturally significant actions in order to help the person understand their issues (provided in greater detail in following paragraphs).

Sometimes spiritual leaders who have knowledge of other sciences (e.g., math, law, literature, medical) follow an approach that invites the suffering person to examine their life in order to understand their issues rather than assigning blame to them.

However, it is also very common to come across some charlatans, so-called spiritual/religious leaders, who do not have an accurate knowledge of Islam and who try to make money or to stroke their ego. These charlatans can cause harm to those suffering from mental health issues with approaches not based in wisdom or an accurate understanding of Islam (e.g., blaming the person for their mistakes or sins, making people dependent on them in order to get money from them, or telling them to do un-Islamic things). In general, those seeking wisdom from spiritual leaders will meet with them on specific, religiously dictated days and times. For example, visits often occur on Thursday evening or Friday afternoon since these two times are important in Islam. During this time, the larger Muslim community (in groups from two to hundreds) will meet with the spiritual leader at their house, mosque, or an open area to listen to a spiritual discussion. People might also get some time to talk individually with the spiritual leader while others are around. During these gatherings, it is also very common for people to bring some humble gifts (e.g., some food) and for the religious leader to share among the attendees. The primary sources of Islam highly recommend giving gifts and providing food.

A variety of religious rituals provide another cultural approach to mental issues. The most widely known among these, after the five daily prescribed prayers, is *tasbeehat*. Although this is not obligatory, it is strongly recommended by the Prophet Muhammad (PBUH). In these rituals, Muslims are recommended to sit quietly (though in some

cultures people do this in a group together with guidance) and recite chapters and prayers from primary Islamic texts. For example, saying three or more times *astaghfirullah* (I seek forgiveness from Allah), reciting chapters from the Quran and reflecting on their meaning, remembering Allah by mentioning some of Allah's attributes (*subhanAllah*: Allah is far away from any deficiency or Allah is glorious; *alhamdulillah*: all praise to be Allah; and *Allahuakbar*: Allah is the greatest) each for 33 times, or by making some *duaa* (supplication). While the majority of Muslims who practice Islam are very familiar with these rituals, such rituals are more common among the more spiritual Muslim groups (e.g., sufis). The rituals are performed with more reflection and intentionality among these groups. Such groups also have additional rituals that aid in becoming more conscious of Allah.

Other cultural treatments include the use of special plants, fruits, or vegetables (e.g., za'atar, black seed, dates) and other healthy products or actions (e.g., spending time at spas and thermal baths, spending time in nature, at mosques or spiritual places, visiting relatives or spiritually important people, performing charitable works, or helping others in their duty).

It is necessary for mental health professionals to understand the above cultural and religious needs in order to reach the Muslim population. For example, Tanhan (2014) noted an instance in which a Muslim woman wanted to see a Muslim counselor. Throughout the sessions, the Muslim client reported that her previous counselors did not explore how her faith could be used to address her issues. The author explained how Acceptance and Commitment Therapy (ACT) might be a more appropriate approach to

use with Muslims clients. This is especially true for new counselors or counselors-in-training because the approach gives enough space to how religion/spirituality is important in understanding a client's life. The author found some main similarities between ACT and the basic foundations of Islam (e.g., acceptance, values, use of metaphors), which may bridge the gap between Muslim clients and non-Muslim counselors. He also explained in more detail how one could tailor ACT to be even more appropriate to Muslims' needs. He suggested using more Islamic metaphors in the counseling sessions (e.g., using Rumi's Guest House poem). He also suggested counselors explore the daily prayers (especially the *salah*) and their effect on the client.

Similarly, Cook-Masaud and Wiggins (2011) explained how a Muslim woman who did not know a lot about counseling benefitted from the counselor's engagement with her religion. The counselor invested time to build a rapport and provide some psychoeducation to help the client to understand counseling and achieve more effective sessions. The counselor found it was important to learn about historic and current political, economic, and religious aspects of Islam and Muslim culture both at domestic and global level. As the Muslim client was a recent Muslim immigrant, the counselor intentionally acknowledged the cultural gap between them. As a Caucasian Christian, the counselor invited the Muslim client to share her experiences and correct the counselor if the counselor said something incorrect about Islam or Muslims.

Cook-Masaud and Wiggins (2011) strongly suggested counselors pay attention to cultural competency. The authors also stressed the importance of paying attention to specific strengths Muslims might have. The counselor took time to understand how the

client's culture and religion facilitated her life and gave her strength at times. In sum, the authors stressed the importance of providing psychoeducation, addressing the role of being a person's sex, taking a strength-based approach, addressing spiritual issues, reviewing how a sacred text (e.g., Qur'an) affects perspectives and the daily life, and collaborating as an advocate.

Kelly et al. (1996) found in their studies with 121 Muslims that the majority of the participants were willing to see a counselor who understands Islam. Therefore, the authors stressed that counselors should have at least basic knowledge about Islam. In a similar study, Khan (2006) in her study with 459 Muslims found that Muslims had positive attitudes toward counseling but had underutilized the resources available to them. Therefore, the researcher strongly suggested both psychoeducation at the community level and collaboration with Muslim leaders to provide counseling to Muslims. The researcher also suggested training voluntary community members so that they can provide help to one another in peer-to-peer training. Similarly, Bektas and others (2009) explained how students from Turkey might not feel comfortable about seeing a counselor in a traditional counseling setting. The authors noted that students would be more likely to attend cultural events or cultural gathering centers to seek help from familiar people and friends. The authors suggested the counselors attend such events to become more familiar with the community and reach out to the students through culturally appropriate interventions. Strack and others (2016) along with a research team including a counselor used a Photovoice technique in order to understand the lived experiences, strengths, and concerns of Muslims at a university in the Southeast of the

U.S. 131 Muslims participated and 112 participants completed the full study, which is a high participation number considering the nature of the Photovoice technique and the fact that the study was conducted totally online. To the knowledge of the authors, this is the first study to utilize Photovoice with Muslims and also the first study to utilize Photovoice completely online. The authors explained that the use of a Photovoice technique is commonly used with minority and disempowered communities. Therefore, they explained how the technique was a culturally appropriate approach for the Muslim participants and empowered the community. The results were used both by the community and the researchers to advocate for the community. The authors also suggested using Photovoice in future studies for specific issues and with more reliable data analysis techniques (e.g., content analysis, Interpretative Phenomenological Analysis).

Aloud and Rathur (2009) found in their study with 360 Muslims that the participants were not willing to use mental health services and were more willing to utilize other cultural resources (e.g., seeing an imam, reciting Qur'an, or seeing a family member) to seek help. Therefore, the authors suggested mental health providers make the services more familiar (psychoeducation) and more culturally appropriate. This includes providing mental health providers information about the clients' ethnicity or providing services in the clients' language. Youssef and Deane (2006) also found very similar results in their study with Arabs (participants included Muslims as well). The participants had negative attitudes toward mental health services. The authors also found a great lack of trust toward mental health providers. Therefore, the authors called for more promotion

of existing mental health services (psychoeducation) and a greater collaboration with religious leaders and families to improve the use of mental health services. The researchers also suggested providing an option to give counseling at home since it might be more convenient and have less stigma than having sessions at a mental health service institution.

Soheilian and Inman (2009) also found Muslims hold negative attitudes toward counseling. The researchers called on counselors to improve culturally appropriate interventions, like paying attention and exploring more indigenous healing strategies (e.g., integrating more culturally and religiously appropriate techniques) for Muslims. Similar to many other researchers, they also suggested public education about mental health and the services. Related to paying attention to indigenous healing strategies, Thomas and others (2015) found traditional healers in the United Arab Emirates wanted to have more collaboration with formal mental health providers and provide more effective referrals. The traditional healers also called for the mental health providers to pay more attention to cultural aspects (e.g., acknowledging that jinns and magic can cause mental issues, or that reciting the Qur'an and some other traditional prayers can be effective) in order to understand and address mental issues.

Ahmed and Amer (2012) in their book also stressed the importance of culturally appropriate interventions while providing mental health services. They have provided a chapter on appropriate interventions for Muslims. In this chapter, Dharamsi and Maynard (2012) stressed the importance of Islamic-based interventions. In order to accomplish this, they introduced their "*Tasawwuf*-based model" (p. 148) that includes concepts from

Quran and Sunnah. The authors focus on the seven levels of self and how the transitions or the interplay among them could aid in addressing issues. In another chapter, Ansary and Salloum (2012) stressed the importance of utilizing community-based prevention and intervention since Muslims come from a more collectivistic culture and have a strong *Ummah* (community) perspective in their life. The authors suggested collaboration with Islamic centers, imams, mosque services, and Islamic schools. They also suggested providing psychoeducation, mental health screenings and outreach services, and panels and conferences. Francisco and Tanhan (2015) and Strack and others (2016) organized their studies on Muslims psychosocial issues around a community-based perspective. In their studies, there was a research team that included Muslim and non-Muslim professors, college students, and some Muslim leaders from the larger community (e.g., imams, chaplain, and presidents of Islamic centers). The authors found it very effective to include more members of the Muslim community in the research team to help design and conduct the studies, disseminate the results, and advocate for the necessary steps to address psychosocial issues. In each of these two studies, at least one of the researchers was a counselor. The counselor found it very effective to work with the Muslim community at the community level, as differentiated from the mainstream individual or group counseling. The researchers also called for more follow-up community and culturally appropriate interventions within the Muslim community.

In sum, Muslims' spiritual/religious beliefs are quite likely to affect how they conceptualize mental illness and healing. There are, however, contradictory research results regarding how much weight Muslims give to cultural and/or biomedical

perspectives both for mental illnesses and their treatments. Nevertheless, the recognition and incorporation of these cultural aspects into the process of providing mental health services are crucial for mental health providers who are in general aligned with biomedical perspectives of mental illness and their treatments.

Research on Muslims' Approach to the Use of Formal Mental Health Services

The preponderance of the literature addressing Muslims and mental health supports the conclusion that mental health services are underutilized by Muslims in the U.S., many of whom face many psychosocial issues and therefore are in need of more attention (Ahmed et al., 2014; Aloud, 2004; Aloud & Rathur, 2009; Amri & Bemak, 2013; Francisco & Tanhan, 2015; Inayat, 2002; Khan, 2006; Martin, 2015; Padela et al., 2012; Strack et al., 2016; Tanhan, 2014). Researchers have identified many reasons for the underutilization of services, and the results are sometimes contradictory. A concept map (see Appendix A) based on a thorough literature review outlines 10 main factors and concepts that appear to impact formal mental health service utilization.

These 10 factors described in the appendix include (a) cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-Cultural Beliefs), (b) knowledge about formal mental health services (KFMHS-Knowledge), (c) perceived social stigma toward seeking formal mental health services (PSTSMHS-Stigma), (d) sex, (e) economic factors, (f) institutional and/or professional factors, (g) use of other informal (cultural) resources, and (h) acculturation. Based on the thorough literature review, the researchers found that these first eight factors affect attitudes toward seeking formal mental health services (ATFMHS-attitudes being the 9th factor). The last

(10th) factor is the use of formal mental health services, which means real behavior/action.

The research reviewed for this chapter typically included one or more of the factors outlined above and found them to be important contributors to the underutilization of mental health services by Muslims. However, to the knowledge of the current researcher, not much research was performed in which the investigators organized their work around a model based on a solid theoretical framework. Therefore, the need exists to investigate this topic utilizing a clear theoretical framework along with a well-grounded rationale as to the salient factors for inclusion in a research model. This would allow for an investigation that could enhance the understanding of Muslims' approach toward utilization of mental health services.

Many researchers have called for well-established research to understand what factors (e.g., CBMHP-Cultural Beliefs) explain Muslims' approach to seeking mental health services so that mental health providers can facilitate Muslims addressing their issues in more effective ways (Ali & Milstein, 2012; Aloud, 2004; Aloud and Rathur, 2009; Amri & Bemak, 2013; Aprahamian et al., 2011; Bagasra, 2010; Bagasra & Mackinem, 2014; Bektas et al., 2009; Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Goforth et al., 2014; Herzig et al., 2013; Kelly et al., 1996; Khan, 2006; Martin, 2015; Soheilian & Inman, 2009; Tanhan, 2014; Thomas et al., 2015; Tummala-Narra & Claudius, 2013; Youssef & Deane, 2006). Based on an extensive literature review, no studies were identified that focused on Muslims in the Southeast of the U.S. Considering past and current sociopolitical and economic conditions in the country both for Muslim

and non-Muslim demographics, the South and the North are likely to be different from one another. For example, based on the current researcher's working with Muslim communities in different settings in the Southeast and Northeast of the U.S., it appears that more Muslims immigrants from Africa settle in the Northeast compared to the Southeast.

It is necessary to understand the existing literature in more depth. Therefore, the current researcher in the following section describes the five main concepts researchers in the Muslim mental health literature found most important.

The five concepts are (a) CBMHP-cultural beliefs, (b) KFMHS-knowledge, (c) ATFMHS-attitudes, (d) PSTSFMHS-stigma, and (e) Perceived Behavioral Control (meaning perceived self-efficacy) toward seeking formal mental health services (PBC). The first four concepts are the most empirically studied and/or clearly mentioned in the Muslim mental health literature. The fifth one (PBC) is only mentioned by a few researchers in the Muslim mental health literature and only indirectly and without clearly being named as self-efficacy, perceived self-efficacy, and/or PBC. However, many researchers who utilized Theory of Planned Behavior (TPB; see Appendix C), Theory of Reasoned Action (TRA; see Appendix D), and/or SEM (see Appendix E) clearly stressed the role of PBC in understanding the behavior/subject of interest. Some researchers clearly stressed that TPB and TRA are similar and recommended to use them in research (Mackenzie et al., 2004; Morrison, Golder, Keller, & Gillmore, 2002; Romano & Netland, 2008). Some other researchers (e.g., Romano & Netland, 2008) utilized *Theory of Planned Behavior/Theory of Reasoned Action* (TPB/TRA, See Appendix B) together

as one theory because these two theories are the same thing with only some subtle differences. In this study, TPB/TRA means only one theory. These researchers also highlighted that PBC is one of the most important concept to understand behavior of interest. Based on all these, the current researcher included the fifth concept (PBC) in this study.

Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments (CBMHP-Cultural Beliefs)

The researchers in the literature on Muslims' mental health made it clear that one of the most important concepts is CBMHP-cultural beliefs (Ali & Milstein, 2012; Bagasra, 2010; Bektas et al., 2009; Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Tanhan, 2014; Thomas et al., 2015; Youssef & Deane, 2006). Although few researchers specifically used scales to empirically study CBMHP-cultural beliefs, they found them to be very important (Aloud, 2004; Aloud & Rathur, 2009; Ansary & Salloum, 2012; Bagasra, 2010; Bagasra & Mackinem, 2014). Almost the rest of the researchers in the literature of Muslim mental health who conducted qualitative studies or provided some literature review constantly and strongly stressed that the CBMHP-cultural beliefs concept was very important and should be considered in research and while providing mental health services to Muslims (Amri & Bemak, 2013; Bektas et al., 2009; Ciftci et al, 2013; Khan, 2006; Tanhan, 2014; Thomas et al., 2015; Youssef & Deane, 2006). The researchers also constantly called for more research to improve the measurements that have good psychometric features or at least utilize the existing scales with different Muslim populations due to a lack of well-established scales examining Muslims' CBMHP-cultural beliefs.

Haslam (2007) stated, “laypeople’s beliefs, not ours [scientific or medical results], decide whether they seek help for” their issues and collaborate with the mental health providers (p. 79). Therefore, CBMHP-cultural beliefs as a concept in this study includes some aspects (e.g., effect of supernatural entities) that do not fit within the scientific biomedical model of mental issues and their treatments. These beliefs might originate from Islam (e.g., jinn, evil eye) or any other cultural elements (e.g., the idea that deceased people can harm or benefit people). Bagasra (2010) explained how some Muslim mental health providers and researchers critiqued contemporary mental health providers for not paying enough attention to CBMHP-cultural beliefs among Muslims and only focused on biomedical aspects. Holmes (2013) also explained in detail in their case studies how medical health providers provided unethical services, both in terms of medical and mental issues, while working with Mexican farm workers in the U.S. This was mainly due to not paying attention to cultural factors and only considering clinical (medical, biological) perspectives while providing the services. The author noted that it is very common for health providers to not consider minority groups’ cultures in understanding their issues and provide appropriate services.

Young and Cashwell (2011) explained how considering spirituality/religiosity in the counseling process is vital and ethical in understanding clients whose life is shaped more by their belief system, which is very accurate for the majority of Muslims. Based on the research, Islam is one of the most vital religions affecting all aspects of life to such an extent that many researchers explained Islam as a way of life for Muslims (Nasr, 2002).

Most of the researchers argued that holding CBMHP-cultural beliefs lead Muslims to have a negative approach toward formal mental health services. This leads to the overuse of cultural resources (e.g., spiritual and/or religious leaders, healers) to address mental health issues. However, there are contradictory findings regarding how much Muslims hold CBMHP-cultural beliefs and/or contemporary biomedical perspective regarding the causes and treatments of mental issues.

Overall, almost all the researchers constantly and strongly reported that Muslims hold CBMHP-cultural beliefs and do not hold contemporary biomedical explanations for mental issues and their treatments; however, some of the researchers (Bagasra, 2010; Bagasra & Mackinem, 2014) found that Muslims hold both cultural and contemporary biomedical explanations for mental issues and their treatments. In the following paragraphs, the current researcher first provided more detailed information about the researchers who developed and/or utilized some scales to study CBMHP-cultural beliefs from a more quantitative perspective. The current researcher then provided more detailed information about other researchers' qualitative studies or literature review.

One of the first studies to develop and utilize scales is Aloud's (2004) study. He developed an 11-item scale to measure the Arab Muslims' CBMHP-cultural beliefs. He had 285 participants from a city in the Midwest U.S. as participants. He found that participants had a moderate level of CBMHP-cultural beliefs. Aloud and Rathur (2009), based on the data Aloud had collected, found that such CBMHP-cultural beliefs are more likely to affect ATFMHS-attitudes in a negative way. The authors in their hierarchical regression analysis found that CBMHP-cultural beliefs as a concept by itself explained

nine percent of ATFMHS-attitudes and this regression was significant ($p < .001$). The correlation between CBMHP-cultural beliefs and ATFMHS-attitudes was negative ($r = -.31$), which is a weak negative correlation between the two variables. However, he did not provide any detailed information (e.g., factor analysis results) about the scale except for mentioning that the scale includes two items (e.g., mental health or psychological issues can be caused by biological factors) to measure environmental reasons cause mental illness. The overall Cronbach's alpha was .73. For content validity, he consulted with many formal mental health professionals and religious leaders.

Focusing just on the Arab Muslims living in one city in the Midwest is another one of the limitations of Aloud's study that the author also mentioned. The number of male participants was greater than the females, with 60.5% of the participants being males and 38.8% being females. The number of males overwhelmingly exceeds the number of females, which is a common statistic in the literature of Muslim mental health. Many researchers extensively recruit participants at mosques where there are generally more men than women. Additionally, 91.5% of the participants were foreign born. These two factors (the exceeding number of males and foreign born) might have affected the results. Similarly, in other studies the number of foreign born also exceeds the U.S. born, but none of the other studies has a ratio as high as this one. The correlation between sex and CBMHP-cultural beliefs was insignificant ($r = .06$). However, Aloud and Rathur (2009) found that the U.S. born participants were more likely to seek mental health ($\chi^2 = 12.06, p < .03$). In terms of the participants' country of origin, 29.5% identified as Somali, 20.6% as Palestinian, and 12.1% as Egyptian. The rest of the participants were

almost equally distributed among many other Arab nationalities. In terms of the education level, the sample was representative of the overall Muslim community (e.g., only 8.2% had less than a high school diploma, 29.2% had or were about to receive a bachelor's degree, and only 9.6% had or were about to receive a PhD).

Though the current researcher found some strengths to Aloud's scale and study, the current researcher also found some weaknesses in it. The lack of a factor analysis to determine possible subscales is an important oversight. The current researcher found a few possible dimensions (subscales) to Aloud's scale. For example, in checking the content of the items, the current researcher identified four possible main dimensions. These four main dimensions are: cultural beliefs about the causes of mental issues (with four items; e.g., mental issues can be caused by evil eye, magic, jinn), scientific/biomedical beliefs about the causes of mental issues (with two items; e.g., mental issues can be caused by biological factors, like genetic factors), cultural treatments for mental issues (with three items; e.g., mental issues can be treated by Quranic recitation and traditional medicines, like black seed), and scientific/biomedical treatments for mental issues (with one item; mental issues can be treated by using professional mental health or counseling services). Another weakness is how the participating Muslims scored on each of the items; for example, their mean scores in understanding the biomedical explanations of mental issues and their treatments. The authors (Aloud, 2004; Aloud & Rathur, 2009) did not provide any information about these basic descriptive statistics. For example, the current researcher would have found it very helpful to know how the participants responded to the following two items: "Mental illness can be caused by biological and

environmental factors” and “Mental illness can be treated by using professional mental health providers” (Aloud, 2004; p. 50). It would also have been helpful to know about the rest of the nine items.

Another critique is that Aloud (2004) used a 4-point Likert-type scale with choices ranging from 1 = *false*, 2 = *probably false*, 3 = *probably true*, and 4 = *true*, but in general some other researchers (e.g., Ajzen, Joyce, Sheikh, & Cote, 2011; Ansary & Salloum, 2012; Bagasra, 2010; Bagasra & Mackinem, 2014; Fishbein & Ajzen, 2010; Mackenzie et al., 2004) used and suggested five Likert-type scales with five choices ranging from strongly agree, agree, neither agree or disagree, disagree, and strongly disagree. The shortcomings constitute an important gap that need to be addressed in future studies to meet the need of more well-established psychometric scales.

The final critique of the Aloud’s (2004) scale and study is about language use. The author exclusively and constantly used the word “problems” to describe the mental (psychological) issues (concerns, illnesses). The exclusive use of the word “problem” for mental issues may present a strong negative connotation and deter Muslims from responding to the items at all or lead them to respond in ways that do not represent their views. Some researchers like Thomas et al. (2015) found many Muslims do not see some illnesses like depression and/or anger control problems as illnesses nor as serious enough to seek mental health services. He explained how Muslims are more likely to just name these kinds of problems (e.g., depression, anger control) as issues. He also added that Muslims do not like the word “problem.” Therefore, the current researcher used the terms mental and psychological as synonymous. He also used issues, concerns, distress,

illnesses, and problems as synonymous whether the issues are mild, moderate, or severe. In addition to that, both the narrative therapy and Acceptance and Commitment Therapy (ACT) strongly stress attending to the use (power) of language. The founders of these approaches recommend using more inclusive language (e.g., issues, concerns, struggles, difficulties) rather than exclusive language (e.g., problem, illness, patient).

Unlike Aloud (2004) and Aloud and Rathur (2009) who found that Muslims have moderate to strong CBMHP-cultural beliefs and do not hold biomedical explanations to mental issues and their treatment, Bagasra (2010) and Bagasra and Mackinem (2014) found that Muslims hold both cultural and biomedical perspectives to explain mental issues and their treatments. To the knowledge of the current researcher, these are the first researchers to use these scales to study Muslims' cultural and biomedical perspectives about mental issues and treatments. Bagasra (2010) conducted a mixed-method study with 255 Muslim participants across the country, with 50.8% being from the Southeast, to explore how Muslims conceptualize mental illness and how they approach mental health services. She developed a scale with three subscales (traditional Islamic conception, Western biomedical conception, and spiritual conception) for her study.

To the knowledge of the current researcher, this study is the only scale that includes subscales in order to understand different etiologies of mental illness measuring how Muslims conceptualize mental issues. Therefore, the researcher provided more information about the scale and its subscales. The first subscale, traditional Islamic conceptions, consists of four items and includes sinful actions, jinn possession, evil eye, and black magic, all of which are mentioned explicitly in the primary resources (Quran

and Sunnah) of Islam. This subscale explained 60% of variance in the items, showing that these traditional conceptions are very important. The second subscale is the Western biomedical conception, and it includes six items accounting for 23% of the variance. The subscale includes items related to environment including stress, lack of will power, drug use, alcohol, tension in family, and bad living conditions. Some other researchers only mentioned this second perspective/aspect but did not measure and name it. The last subscale consisted of two items that are more related to spiritual aspects in Islam, and the items counted for 17% of variance between the items. The items are: “If a person becomes mentally ill, it is often the will of Allah” and “Mental illness is a test from Allah,” (Bagasra, 2010, p. 137).

Based on the same data from Bagasra’s study, Bagasra and Mackinem (2014) reported that Muslim participants primarily adhered to the contemporary dominant Western biomedical perspective of mental illness compared to other authors who found that Muslims hold cultural beliefs instead of biomedical perspectives to conceptualize mental issues. The descriptive statistics from the study showed that the majority of the participants indicated that they believe the etiology of mental issues comes from medical and environmental aspects while giving less weight to the cultural aspect.

In terms of cultural beliefs in Bagasra and Mackinem’s (2014) study, the participants aligned with the following items as follows: 8.3% strongly agreed and 15.4% agreed that “sinful actions are often the cause of mental issues,” 2.8% strongly agreed and 10.7% agreed that “mental issue is often a result of possession by jinn,” 8.8% strongly agreed and 19.5% agreed that “mental issues can be caused by the evil eye,” and

finally 8.4% strongly agreed and 19.2% agreed that “mental illness can be caused by the use of black magic.” As it is clear in this study, unlike most other research results (e.g., Aloud, 2004), Muslim participants did not hold strong cultural beliefs that mental issues originate from such supernatural reasons.

Finally, in the spiritual subscale 35.7% strongly agreed and 23.9% agreed that “mental illness is the will of Allah,” and 27% strongly agreed and 28.9% agreed that “mental illness is a test from Allah” (Bagasra & Mackinem, 2014). These findings are consistent with the results of other studies, although in some studies the authors found that Muslims view having mental issue as resulting from a lack of and/or weak faith rather than seeing it as a test.

In addition to their quantitative findings, Bagasra and Mackinem (2014) reported more complex results in the open-ended section of the study about the conceptualization of mental issues. In the study, the participants were asked to provide a definition of mental illness. The authors used content analysis to identify the themes. They found that the participants had more complex perspectives of conceptualizing mental illness with stressing biological, environmental, and psycho-spiritual aspects.

Bagasra’s scale, compared to Aloud’s scale that consists of 11 items, is longer (17 items) and lacks information about Muslims’ cultural beliefs about treatment of mental issues. Bagasra examined Muslims cultural and biomedical explanations for treatment of mental illness with 18 additional items in the same study, making her scales much longer than Aloud’s. Therefore, Aloud’s scale might be more convenient for researchers wanting

a briefer measure and yet assessing both cultural beliefs about mental issues and their treatments.

Bagasra (2010) found that Muslims had favorable attitudes toward standard Western methods (e.g., counseling, self-help groups) compared to some cultural methods (e.g., religious/spiritual leader, herbs, and Quran). The majority of the participants gave favorable ratings to the contemporary Western methods for treatment of mental issues, including counseling services, self-help groups, and working with a psychologist; however, they had a much less favorable view to taking psychoactive medications. She clearly showed that the participants favored contemporary formal mental health services over cultural options. Yet it is noteworthy that cultural options were still viewed as important components for treating mental concerns.

The results of Bagasra's study should be viewed in context to more fully understand the implications of her findings. She had more women than men and had a much more homogenous sample in terms of race/ethnicity with Arabs constituted only 15.5% of the sample. Another important point, Aloud only had 7.8% while Bagasra had 41.8% U.S. born participants. In addition to that, Bagasra disseminated her research survey at a wedding in the Southeast of the U.S., which may have affected the demographics (e.g., reaching out to people from specific groups and/or families). Another consideration is that she created all the scales in her study, which were tested in a pilot study but were not tested with different Muslim groups. She also used an exclusive term "mental illness" (p. 227) in the study which possibly created discomfort for participants leading them respond with apprehension.

Similar to Aloud's (2004) and Bagasra's (2010) scales, Ansary and Salloum (2012) stressed the importance of CBMHP-cultural beliefs and developed a scale for mental health providers to measure their awareness of Muslims' CBMHP-cultural beliefs. The scale consists of 16 Likert-type items with five choices ranging from strongly agree to strongly disagree. The scale includes three subscales including a) importance of involving a religious leader in the treatment (e.g., Approval of mental health services by religious leader is important), b) community perceptions of mental illness (e.g., Mental issues are thought to be caused by a weakness in faith), and c) beliefs regarding therapy (e.g., Shame can be brought to the family if one utilizes mental health services). Six items are reverse-coded so that higher scores in each subscale reflect a stronger agreement. The authors did not pilot and validated the scale, creating limitations and gaps in its psychometric features. The authors also exclusively used the term "mental illness" (p. 179) in the scale, therefore participants may not view milder forms of mental health distress as relevant when completing the measure. Ansary and Salloum stressed viewing Muslims' CBMHP-cultural beliefs from within the Bronfenbrenner's bioecological model to incorporate contextual factors (e.g., imams, cultural beliefs) in mental health service delivery to increase the effectiveness and use of services.

Due to lack of enough quantitative studies about Muslims' CBMHP-cultural beliefs, in the following section the current researcher provides more detailed information about researchers who studied Muslims' CBMHP-cultural beliefs from a more qualitative perspective.

Thomas and others (2015) conducted a qualitative study in the United Arab Emirates (UAE). The researchers studied traditional healers, called Mutawa, who go through a traditional but regulated/licensed training. The researcher found that the Mutawa paid close attention to cultural beliefs (e.g., jinn possession, evil eyes) when they conceptualized mental issues and their treatments. The traditional healers would use different cultural approaches like communicating with jinns to dissolve jinn possession. The Mutawa also included other psychosocial and physical causes to explain mental illness. The authors noted how these Mutawa complained about unlicensed and unregulated “charlatans or sorcerers” (p. 142) who lacked training. The traditional healers collaborated with medical doctors and mental health providers.

In another similar study, Youssef and Deane (2006) argued that CBMHP-cultural beliefs are very important to understand Muslims’ approach to mental issues and their treatments. The researchers conducted a qualitative study with 35 key Arabic-speaking community members (e.g., mental health workers, religious leaders, teachers, medical doctors) in Sydney, Australia to explore factors affecting Arabs’ approach to mental health services. The 35 Arabic-speaking key people included Muslims and Christians. The researchers included Christians due to their similar cultural beliefs and traditions with Muslims. As a result of the content analysis in their study, the authors identified four main domains, the first one being the perception of mental illness. The authors found that 68% of the participants believed that Satanic powers cause mental illness, and 97% of the participants reported that Arabic-speaking people associate mental illness with the word “*majnoon*,” which means “mad” and which carries a huge stigma in the community.

Fifty-seven percent of the participants said the label “mental health” might push away people; therefore, the authors suggested using more inclusive language. The 35 participants also reported that the lay population of the Arabic-speaking community were not good at differentiating mental illnesses. They reported that the community was more likely to accept anxiety and/or nervousness rather than other mental illnesses because anxiety and/or nervousness are acceptable while other mental illnesses like depression or schizophrenia are not.

Another domain was alternative treatments and strategies for improvement of mental health services. Similar to other studies, the majority of the participants explained that Arab-speaking people strongly rely on their cultural resources (e.g., seeing a religious leader) to address mental issues as opposed to utilizing formal mental health services. Seventy-four percent of the participants reported that people from the community see their spiritual/religious leaders as having healing power. One participant who was also a religious/spiritual leader stated, “people don’t want like to feel that they need to go to a psychiatrist and I am afraid one of the reasons they come to us is that they don’t want to feel that they are going insane” (p. 58). All participants reported that the people feel confidentiality with their spiritual/religious leader when they did not feel the same level of confidentiality with the formal mental health providers. Almost all the spiritual/religious leaders among the participants indicated that they are the initial point of contact for help with mental issues. Ninety-one percent of the participants reported that God gives healing, including for mental issues, and they also believed ritual healing will help them to get closer to God. Therefore, the community members would visit holy

places and read religious scriptures for healing. In addition to that, 86% of the participants stated that seeking help from family members is important and would be effective. In terms of seeing a psychiatrist, 86% explained that Arabic-speaking people refuse to see a psychiatrist because they find them threatening and their community would start to see them as crazy. Eighty-six percent of the participants reported that Arabic-speaking people do not know about the role of mental health providers. The participants also reported that the role of mental health providers is not clear in the community. In regards to counseling, 94% reported that the community does not accept nor understand counseling, oftentimes the community will automatically label a person as crazy if they receive mental health services from a counselor.

One of the main critiques the current researcher found for this study is the fact that it was conducted in Sydney, Australia, and the participants were not from the general public but were key people (e.g., health providers, religious leaders, and teachers) in the Arab-speaking community. Furthermore, not all of them were Muslim, which might have created a discrepancy with what the general Muslim population would have described. Another critique is the recruitment of the participants through snowballing, which might have limited participant diversity and the social desirability.

In their literature review of Muslims and mental health, Amri and Bemak (2013) also stressed how CBMHP-cultural beliefs (e.g., spirit possession) cause Muslims to stay away from mental health services. They explained how strong cultural beliefs about family and family leaders may discourage Muslims from utilizing mental health services. Similarly, in their literature review and suggestions in how to decrease stigma toward

mental health issues, Ciftci and others (2013) noted that CBMHP-cultural beliefs (e.g., seeing mental issues as a result of sins, blaming the women/mother for the issues a child has) keep Muslim families away from using the mental health services. Ackerman and others (2009) in their study on American Muslims and Jews also stressed paying attention to cultural beliefs when providing mental health services. In their case study of a woman with family issues, Cook-Masaud and Wiggins (2011) explained how the counselor paid attention to cultural and spiritual aspects while explaining counseling and mental issues to her and her family. Similarly, Tanhan (2014) in his case study explained how the Muslim woman wanted to stay away from some of her friends because she believed they would gossip and create a bad perception of her, which she called “evil eye.” In these case studies, the counselors addressed the concerns and built a therapeutic relationship by considering clients’ cultural beliefs (e.g., mental issues could be a religious/spiritual test) about mental issues and cultural treatment options (e.g., daily prayers called salah, rituals after the prayers).

In addition to these researchers who clearly reported on the importance of CBMHP-cultural beliefs, the consideration of such beliefs is also very important from a well-established theories/models perspective, including TPB/TRA and SEM. The consideration of this concept is crucial because culture constitutes and affects different aspects of individuals and communities, including effects at micro, meso, and macro levels. The researchers who solely utilized TPB/TRA in general did not pay enough attention to such cultural beliefs since the theory (TPB/TRA) considers such concepts as important background factor yet not significant predictors for the behavior of interest.

However, Ajzen (1991) explained that the importance of inclusion of such factors (e.g., beliefs) increases when an environment and/or action is new to the participants. In this current study, mental issues, formal mental health services, and all related concepts are relatively new to the Muslims. The majority of the researcher in the Muslims and mental health literature clearly stressed that mental health services are new to the Muslims in the U.S.

In sum, all these authors explicitly and constantly reported that the existence of such CBMHP-cultural beliefs; therefore, they concluded that the CBMHP-cultural beliefs need to be considered and examined more carefully when conducting research and providing services to the Muslims.

Knowledge about Formal Mental Health Services (KFMHS-Knowledge)

The majority of Muslims in the U.S. are immigrants. Therefore, they have limited knowledge of mental health services in this country (Ali & Milstein, 2012; Amri & Bemak, 2013; Bektas et al., 2009; Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Tanhan, 2014). Muslim immigrants are less likely to have formal mental health services available in their home countries/cultures. Therefore, they often lack information about the formal mental health services available in the U.S. and especially in their communities. This creates a critical lack of knowledge about the services. In fact, most Muslims seek mental health services only for extreme cases, such as when someone is uncontrollable, violent to others (outside the family), and/or has delusions or hallucinations (Aloud, 2004; Aloud & Rathur, 2009; Thomas et al., 2015; Yousef & Deane, 2006). Muslims in general do not acknowledge other mental issues (e.g.,

depression, anxiety, anger issues) as illnesses. The researchers suggested that lack of knowledge and familiarity about mental health issues and services leads to a negative attitude toward mental health services.

Cottrell and others (2015) explained how different individual/intrapersonal or community theories stress understanding level of knowledge to study a behavior of interest. It is very common to see lack of knowledge about mental health issues; therefore, it is important to understand one's knowledge of mental health services and this is also stressed from TPB/TRA (Ajzen et al., 2011; Fishbein & Ajzen, 2010) and SEM perspectives (Holmes, 2013; Sun, Stowers, Miller, Bachmann, & Rhodes, 2015; Yoo, Butler, Elias, & Goodman, 2009) perspectives.

Understanding this concept in more detail is crucial because most researchers have found that Muslims around the world have a poor KFMHS-knowledge, while a few researchers found that Muslims do have knowledge about the formal mental health services. Particularly in light of the fact that the number of researchers who have studied this issue in empirical studies is severely limited though almost all of the researchers in the literature stressed the importance of this concept.

Aloud (2004) noted that Arab-Muslims in the U.S. believed that a person is psychologically healthy as long as they live normally, which means they interact with others and meeting personal and family needs (especially physical needs). Aloud argued that Muslims will first consider seeking help from cultural resources before seeing a physician, and only as a last resort, if at all, do they seek help from mental health professionals. Seeking help for a mental health issue would occur when one is unable to

meet their duties (e.g., family care, job responsibilities, etc.). Based on Aloud's (2004) data collected from 281 Muslims in the Midwestern U.S., Aloud and Rathur (2009) reported that participants had low levels of knowledge of and familiarity with mental health issues, services, and professional providers. The overall mean was 2.02 over 4 point Likert type scale. The correlation between level of knowledge about mental health services and their attitudes toward the mental health services were positive ($r = .12$) and significant ($p < .05$). Aloud's work suggests the importance of considering knowledge of mental health services in relationship to other concepts (e.g., attitudes, social stigma). He conducted a regression analysis and found that KFMHS-knowledge construct by itself explained an important proportion of ATFMHS-attitudes, and the analysis was significant.

Aloud's study is important because it provided a scale to examine Muslims' KFMHS-knowledge. A limitation to the scale is that while the "role of psychiatrist, psychologist, and social worker" are in separate items (Aloud, 2004, p. 122), he did not include any items about the role of counselors and/or therapists, which is important because many mental health settings have both counselors and therapists among other mental health providers. In addition, Aloud's scale includes an exclusive language such as "mental problems, mental abnormalities, instability, or disorders" (p. 122), which may lead the participants to consider the services only for extreme mental issues but not for mild and/or moderate issues. The inclusion of language that allowed a participant to describe their knowledge of less severe mental health concerns would be useful. Considering mental health services from such a positive and/or wellness perspective in

conjunction with the items in the studies is crucial. Finally, Aloud (2004) and Aloud and Rathur (2009) provided no descriptive statistics for the items included, for example the “availability of mental health services in their community; role of psychiatrist, psychologist, and clinical social worker; classified medical disorders; and mental health services” (Aloud, 2004, p. 122). It is also important to note that the scale was self-reported; therefore, the participants might have had bias against reporting accurately due to social desirability considering the social stigma around mental issues and services.

Related to the critiques (e.g., exclusive language regarding mental issues) mentioned above, the current researcher found it important to stress that mental health services are available both to alleviate suffering and pain but also to enhance well-being. Kaplan, Tarvydas, and Gladding (2014) defined counseling, after working with 29 major counseling organizations, as “a professional relationship that empowers diverse individuals, families, and groups to accomplish mental health, wellness, education, and career goals” (p. 366). Considering mental health services from such a positive, strengthening, and/or wellness perspective in conjunction with the items in the studies is very crucial because each study also might introduce a new concept to the participants. As Ajzen and Fishbein (2004) and Ogden (2003) explained, a scale or an item in a study might create a concept that the participants did not know prior to participating in the study. In this study’s case, this might be true for many Muslims and thereby it might be more ethical and accurate to the spirit of mental health professions to include a more inclusive language (e.g., using issues, concerns, problems as synonymous). The last critique is that the authors (Aloud, 2004; Aloud & Rathur, 2009) did not provide

descriptive statistics for each of the items. For example, it would have been helpful to see how Muslims scored on some items, including availability of mental health services in their community; role of psychiatrist, psychologist, and clinical social worker; classified medical disorders; and mental health services. It is also important to note that the scale was a self-report; therefore, the participants might have had bias against reporting accurately due to different reasons, including social desirability considering the social stigma around mental issues and services. Again, this study is especially important as it is the first one to examine the concept through a scale. Many other researchers cited the Aloud's study, and yet none of them used his scale for their studies. The current researcher considered if any of the critiques mentioned above had played a role in that.

In a study of 67 Arab women who were victims of partner abuse, the authors found that the most important barrier to the utilizations of mental health services was the lack of knowledge about the existing services (Abu-Ras, 2003). About 93% of the participants reported that they had no knowledge of existing services. Ciftci and others (2013) reported in their review that Muslims are more likely not to have adequate KFMHS-knowledge. Bektas and others (2009) studied 124 students from Turkey living in the U.S. and reported that the students were often unfamiliar with counseling centers. The researchers suggested that mental health professional could improve relationships with potential clients by reaching out in culturally appropriate ways (e.g., attending cultural events to introduce the services and collaborate with leaders). Similarly, various researchers have observed that Muslims do not use mental health services simply because they are unfamiliar with the services available. Mental health providers were able to

bridge this gap by organizing activities to empower the Muslims and help them address their issues (Bhattacharyya et al., 2014; Tummala-Narra & Claudius, 2013). In Thomas and others' (2015) study, Mutawas (licensed traditional healers in United Arab Emirates, UAE) reported that general public do not know about formal mental health services and are also against utilizing them when Mutawas refer them to the formal mental health providers.

In summary, many researchers have found that Muslims possess poor knowledge of mental health services, while few researchers found that Muslims have knowledge of the services; therefore, almost all the researchers have suggested examining this issue more systematically both for more accurate research and culturally appropriate interventions.

Bagasra (2010), in her study with 255 Muslims in the U.S. (majority being from the Southeast), found that Muslim participants were familiar with the formal mental health services; however, she did not directly measure it through any qualitative methods. She found that Muslims had a favorable approach toward mental health services. In a similar study with 459 adult Muslims, Khan (2006) found that the participants knew about mental health services. However, it is important to examine Muslims' level of KFMHS-knowledge in more direct ways by using well-established scales or qualitative methods rather than interpreting from other results (e.g., positive ATFMHS-attitudes). Overall, these researchers found that Muslims know something about the mental health services and utilize them.

Some other researchers have studied whether key people (e.g., imams, doctors, spiritual leaders, traditional healers, teachers, nurses) serving the Muslim community had KFMHS-knowledge. The researchers found contradictory results. One of these studies by Youssef and Deane (2006) examined 35 key people in the Arab-speaking community that included both Christians and Muslims in a city in Australia. Eighty percent of participants reported that the community lacked an understanding of mental-health services and ways to reach the services. Sixty-three percent of the participants, themselves as key people, were unaware of the available mental-health facilities in their community. Even half of the general physicians (N=4) who were participants were not aware of the services provided by the local mental health centers. Seventy-one percent of the participants emphasized that the community tends to see mental health institutions and psychiatric hospitals as only for people with severe mental illness and who are uncontrollable. One participant noted that the Arab-speaking population tended to deny mental issues and avoid formal mental health services except for when the issues are severe and unmanageable. The lack of knowledge about mental issues and services lead to underutilization of mental health services and overuse of medical services. The researchers emphasized that the Arabic-speaking population did not have accurate knowledge of counseling and associated counseling with being crazy. For example, one of the participants stated that Arab-speaking people “don’t understand the concept of counselling whatsoever and when you say, go for counseling . . . they say ‘no please, no, I am not sick or . . . crazy’” (p. 56). The use of a snowball method to recruit participants and the fact that not all the participants were Muslims are limitations in need of

consideration. Furthermore, all participants were from one city and only from the Arab-speaking community, thus limiting generalizability of the findings.

Some other studies who examined whether key people in the Muslim community have KFMHS-knowledge found that key people were familiar with the services. For example, Thomas and others (2015) interviewed 10 Mutawas in UAE and found that the traditional healers themselves had knowledge of mental issues and formal mental health services, and Mutawas also collaborated with the mental health providers. A limitation of the Thomas and others' study is that all participants were recruited from two cities that are economically the richest in the area. The participants were recruited through convenience sampling, including personal communication and the internet, which might have led to the inclusion of the traditional healers who are more familiar with the services. In another similar study, Ali and Milstein (2012) studied 62 male imams across the U.S. and found that the imams could recognize the presence of mental illnesses in a vignette the researchers provided. The imams were able to identify the mental issues of the character in the vignette and that the mental issues would not be addressed without interventions that included both cultural and formal mental health services. The participants were willing to refer the character to and collaborate with the mental health providers though there were differences among the imams' responses based on backgrounds. Overall, results indicated that the imams possessed KFMHS-knowledge. An important critique to this study is almost all of the imams had some training (e.g., formal education, psychoeducation, personal use of the services) related to the mental health services, while only 18% of the imams reported that they had not received any

kind of training about mental health services. Another main critique of this study is the lack of women participants. In these studies, the main common theme is the key people had gone through some formal or informal education which should be considered.

Some other researchers have found that Muslims did not have knowledge of formal mental health services before they started receiving mental health services, and yet they gained the knowledge within a short time when they started to receive some type of mental health services (e.g., psychoeducation, individual sessions, community projects; Amri & Bemak, 2013; Chen, Liu, Tsai, & Chen, 2015; Cook-Masaud & Wiggins, 2011; Francisco & Tanhan, 2015; Tanhan, 2014). One of the main criticisms of these studies is that the researchers did not directly study Muslims' KFMHS-knowledge in their studies by using scales or qualitative questions. These studies are important because the researchers showed that Muslims are open to learn knowledge about mental health providers and collaborate with the mental health providers to address their psychosocial issues.

In addition to these research results, the two main lenses for the current study (TPB/TRA and SEM) also stress the importance of people having knowledge about the subject of interest in order to understand their approach toward the subject. Therefore, it is important to utilize well-established theories (e.g., TPB/TRA, SEM) to understand Muslims' KFMHS-knowledge and its relationship with other concepts (e.g., attitudes) because there are some contradictory results about Muslims' knowledge of mental issues and formal mental health services mainly due to the different samples and populations. Overall, the current researcher found that the researchers who studied Muslims KFMHS-

knowledge concept were in two distinct groups. One who primarily focused on the general Muslim public and the second group focusing more on key people (e.g., imams, health providers, traditional healers) in the Muslim communities. These researchers also studied Muslims' KFMHS-knowledge in two main ways, including direct (e.g., using a scale or qualitative methods to measure Muslims KFMHS-knowledge) or indirect (e.g., focusing on Muslims' approach to the services and then interpreting these results to discuss Muslims' KFMHS). The first group of researchers found that overall lay Muslim people had poor KFMHS-knowledge (Abu-Ras, 2003; Aloud, 2004; Aloud & Rathur, 2009; Amri & Bemak, 2013; Bektas et al., 2009; Bhattacharyya et al., 2014; Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Francisco & Tanhan, 2015; Tanhan, 2014; Tummala-Narra & Claudius, 2013). Some of the researchers in this first group studying general public's KFMHS-knowledge found that in their studies lay Muslims had KFMHS-knowledge (Bagasra, 2010; Bagasra & Mackinem, 2014; Strack et al., 2016), yet the researchers did not directly measure the participants KFMHS. Some other researchers found that Muslims from the general public gained KFMHS-knowledge within a short time once they had started to receive some mental health services (Cook-Masaud & Wiggins, 2011; Tanhan, 2014). The second group of researchers studying key people's (e.g., physicians, imams, teachers, traditional healers in the Muslim community) KFMHS-knowledge found them to be very important in influencing Muslims' approach to the services. The researchers found some different results based on different Muslim populations; however, the overall result was that the key people know about and collaborate with mental health services. Some of the researchers found that key people

had KFMHS-knowledge (Ali & Milstein, 2012; Thomas et al., 2015) while other researchers found that even key people did not have KFMHS-knowledge (Youssef & Deane, 2006).

In sum, in spite of the controversial results, almost all the researchers stressed the importance of Muslims having KFMHS-knowledge. The researchers stressed the importance of developing or improving scales that have good psychometric features to measure the concept. In addition to these, they also called for understanding how KFMHS-knowledge concept affects and/or gets affected by some other important concepts (e.g., CBMHP-cultural beliefs). All these constitute some important gaps in the literature of Muslims and mental health. Some of the researchers strongly suggested utilizing well-established theoretical frameworks (model) and/or theories to understand this concept and its relationship with other concepts (e.g., social stigma).

Attitudes toward Seeking Formal Mental Health Services (ATFMHS-Attitudes)

Attitudes toward seeking formal mental health services is the third important concept that researchers most commonly studied in the Muslim mental health literature. It is studied much more than any other concepts, especially in terms of quantitative studies. Researchers, even considering the aforementioned contradictions, overall reported that due to CBMHP-cultural beliefs, lack of KFMHS-knowledge, and PSTSFMHS-stigma Muslims in the U.S. and some other Western cultures (e.g., Australia, Europe) tend to hold negative attitudes toward the services (Ali & Milstein, 2012; Aloud, 2004; Aloud & Rathur, 2010; Amri & Bemak, 2013; Tanhan, 2014; Tummala-Narra & Claudius, 2013; Youssef & Deane, 2006). In the following paragraphs, the current researcher provides

more in depth information about the researchers who studied Muslims' ATFMHS-attitudes.

Aloud (2004) found that Muslim participants had generally less favorable ATFMHS-attitudes ($M = 2.36$ over four). The author used an adapted version of the most commonly used attitude scale, Fischer and Turner's 1970 attitude toward mental health services scale. Aloud revised it to make it more appropriate for Arab Muslim participants, especially in terms of language. In total, he had 20 items. However, neither Aloud (2004) nor Aloud and Rathur (2009), who used the same data for their studies, provided basic descriptive statistics (e.g., mean) for each of the 20 items, which could have been very helpful to understand how Muslims rated on each item. The reliability (Cronbach's alpha) for attitude items was .74, which is in the acceptable range.

The correlation data analysis showed that the correlation between ATFMHS-attitudes and CBMHP-cultural beliefs was negative ($r = -.31$). And this relationship was significant ($p < .01$), which means if the participants had stronger CBMHP-cultural beliefs then they had less favorable ATFMHS-attitudes. The correlation between the ATFMHS-attitudes and knowledge about and familiarity with mental health services was positive ($r = .25$), and it was significant ($p < .01$). The relationship between ATFMHS-attitudes and PSTSFMHS-stigma was significantly negative ($r = -.33, p < .01$), which means the more positive attitudes one had, the less perceived stigma they had. Another significant relationship was between the attitudes and the participants' annual income ($r = .13, p < .05$), which means those with higher income had more positive ATFMHS-attitudes. The relationships between ATFMHS-attitudes and sex, age, and education were

not significant. Length of stay in the U.S. was a significant predictor for attitudes when all other demographic variables were controlled for. Muslims born in the U.S. were more likely than foreign-born participants to seek mental health services ($\chi^2 = 12.06, p < .03$). However, only 9.6% of the participants reported that they had visited a mental health provider at least one time in the past three years. The authors found that the participants overused the cultural treatment options and underutilized the formal mental health services.

The current researcher has some critiques to Aloud (2004) and Aloud and Rathur's (2009) studies. The first critique, the authors reported that they added five additional items to the original Fisher and Turner's (1970) scale to measure perceived societal stigma. However, they did not indicate which five items were added, which could be helpful if someone wants to use his adapted scale version. A second critique is that the authors used convenience sampling and had only Arab Muslims met at Islamic centers in one city in the Midwest of the U.S. as participants. That might have affected the results in terms of having a very homogenous sample. A third critique is that the researchers did not provide factor analysis for the scales (e.g., the scale for CBMHP-cultural beliefs and KFMHS-knowledge concepts) they developed themselves and utilized in their study. In spite of all these critiques, this study meets some important gaps including the authors utilizing a theoretical framework (model) to decide which concepts to study, an important gap that many researchers called to be closed. The authors noted that Arab Muslims first use cultural options to seek help, viewing mental health services as the last option, if at all; therefore, the authors called for more culturally appropriate intervention and

psychoeducation. The researchers also mentioned TPB and suggested to consider it in future studies (Aloud, 2004; Aloud & Rathur, 2009).

In another study with 102 Middle Eastern (63% were Muslim) students across the U.S., Soheilian and Inman (2009) found that the Muslims with greater self-stigma also had negative attitudes toward the use of counseling, which was a significant negative relationship ($\beta = -.66, p < .001$). However, different from most of the other research results, the authors found no significant relationship between perceived public stigma and attitudes toward counseling and similarly no significant relationship between public stigma and self-stigma. The researchers attributed the lack of significant relationship among these concepts to the lack of culturally appropriate scales. The authors used Fisher and Farina's (1995) Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS), which is a revision of the commonly used Fisher and Turner's (1970) ATSPPHS scale. Therefore, though Soheilian and Inman (2009) used a valid and reliable scale they criticized the scale for not being culturally appropriate. A critique of this study is that all the participants were students, with 55% of them being graduate students with 77% of all participants being women. This also might have affected the results.

Similarly, in their qualitative study with 35 key people who provided different services to an Arabic-speaking community which included many Muslims, Youssef and Deane (2006) found that the community underutilized mental health services due to different reasons including negative ATFMHS-attitudes. The researchers identified that both the key people (e.g., spiritual/religious leaders, physicians) and lay people had negative ATFMHS-attitudes. The authors identified that the lay people over-utilized

cultural approaches and medical doctors to address their mental issues while dismissing mental illnesses and formal mental health services.

All these researchers found that Muslims had negative ATFMHS-attitudes; however, there are few researchers who found that Muslims held positive attitudes. For example, Bagasra's (2010) study is one of the recent quantitative studies in which she found that Muslims had positive ATFMHS-attitudes. The majority of the participants strongly agreed or agreed with the effectiveness of contemporary scientific mental health services including counseling, self-help groups, and working with a psychologist or psychiatrist, while the participants strongly disagreed with the idea that medication could be helpful. These results showed that the attitudes toward cultural options to treat mental health issues were not as strong as ATFMHS-attitudes, except for the attitudes toward recitation of Quran and prayer.

Similar to Bagasra's study, Khan (2006) found that 63% of the participants had positive ATFMHS-attitudes. The author, similar to many other researchers, found that Muslim women had more positive ATFMHS-attitudes compared to men. Khan also found that there was an underutilization of the mental health services and unmet needs based on participants' self-reported needs (15.7% indicated the need) and their use of the mental health services (only 11.1% reported that they had used the resources). She also found cultural options (especially daily prayers) to be very important for the participants. Khan's (2006) study has some important points that fill some gaps and considerations in the literature. She conducted the study in 2002 following the September 11 terrorist attack, an attack that traumatized not only those in the U.S. but which also led to the

destruction and exploitation of Muslim-majority countries and lead to millions of people dying and more becoming refugees. Therefore, she paid utmost attention not to disturb the Muslim community and their confidentiality. For example, she did not ask for the origin of their country and conducted paper-based a study with the help of four imams from four mosques after the Friday prayers. Importantly, Khan shared the results of the study with the community.

The current researcher has some critiques of Khan's study. The first critique, Khan changed the word counselor to psychiatrist to make the scale more culturally appropriate, and yet she did not explain how this made the scale more appropriate. Some of researchers found that Muslims had stronger negative response to the words "psychiatrists" and "medicine" than to "counseling" (e.g., Bagasra, 2010). The second critique is that she recruited the participants through only four mosques and only used paper-based questionnaires after the Friday prayers. This might have created a very homogenous sample. Another critique is that the author did not provide and/or utilize any theoretical framework to provide the rationale behind her study for examining ATFMHS-attitudes and its relationship with sociodemographic variables. Similarly, Kelly et al. (1996), in their study with 121 Muslims around Washington, DC, found that the Muslim participants were willing to see a counselor if they had had some mental issues.

In addition to these studies, some other researchers found that Muslims first held negative attitudes toward counseling but developed positive ones once they started to utilize the services (e.g., having individual or family sessions; Cook-Masaud & Wiggins, 2011; Tanhan, 2014). Similarly, Amri and Bemak (2013) explained how Muslims in

general do not have favorable attitudes toward mental health services. Therefore, the authors provided two vignettes and explained how mental health providers can utilize the characters and their mental health issues in the vignettes to improve their skills and knowledge in providing culturally appropriate interventions to help Muslims develop a more positive approach toward utilizing the services.

In some other studies, the researchers studied Muslims' ATFMHS-attitudes from a different perspective, focusing on how the key people in Muslim communities perceive mental health services and their perceptions of Muslims' approach toward the services. For example, Ali and Milstein (2012) in their study with 62 imams in the U.S. found that the imams had a positive ATFMHS-attitudes. In a similar case, Thomas and others (2015) in their study with 10 traditional healers (Mutawa) in UAE found that the traditional healers had positive ATFMHS-attitudes and collaborated with other mental health providers. However, these traditional healers pointed out that lay people in the community had negative ATFMHS-attitudes. In a similar study, Youssef and Deane (2006) conducted a qualitative study with 35 key people (Muslim or Christian) who were serving the Arab speaking community in a city in Australia. The researcher found that lay people and even well-educated key people (e.g., physicians, spiritual/religious leaders) had negative ATFMHS-attitudes. As noted before, another reason for such a negative approach to the use of the services was the PSTSMHS-stigma. Another factor was the sex of the participants. Women's access to mental health services was more restricted, and they were more criticized by their family and others if they utilized the services. Eighty-six percent of the participants expressed that a sign of mental illness and/or use of

mental health services would have detrimental effects on current or future marriage relationships. Fifty-one percent of the participants also reported that isolation of the person with mental illnesses from the community and mental health services is common. The family would keep the person hidden inside the house so that nobody would see them.

In sum, though the researchers in the Muslim mental health literature did not find consistent results, most of them found that general Muslim population hold negative ATFMHS-attitudes. However, the researchers' common conclusion was that the integration of cultural and contextual aspects with the formal mental health services are crucial and necessary to improve more favorable ATFMHS-attitudes. Similarly, Mackenzie et al. (2004) also explained how the understanding of the influence of Muslims' attitudes toward mental health service utilization is not clear because of the differing results found by the researchers. Therefore, they noted the need for well-established theories like TPP and/or TRA for the inclusion of some other necessary constructs (e.g., PBC), not just attitudes.

To recap, understanding ATFMHS-attitudes is very important as noted in the research results mentioned above as well as from both lenses (TPB/TRA and SEM) of this study. From TPB/TRA perspective, studying attitude is especially important at the individual/intrapersonal level. Mackenzie et al. (2004) adopted Fisher and Turner's (1970) ATSPPHS to make it a more compatible scale with TPB/TRA to measure attitudes toward seeking services. Mackenzie and others in multiple studies found that attitudes toward mental health services were a significant predictor in determining

whether participants had used the mental health services. In addition to TPB/TRA, examining ATFMHS-attitudes is also crucial from SEM perspective, as most of the researchers in the Muslim mental health literature stressed understanding the attitudes especially in the larger contextual factors (e.g., culture, religion, and environment). Therefore, understanding ATFMHS-attitudes and its relationship with other important concepts (e.g., CBMHP-cultural beliefs, KFMHS-knowledge, PSTSFMHS-stigma) through a well-established theoretical framework is necessary and will meet an important gap.

Perceived Social Stigma toward Seeking Formal Mental Health Services (PSTSFMHS-Stigma)

The next important concept in the literature of Muslim mental health is perceived social stigma toward seeking formal mental health services. It is also one of the most studied concepts. All the researchers in the Muslims and mental health literature stressed that CBMHP-cultural beliefs, lack of knowledge about mental health issues and services, and the desire to protect the family name/honor lead to perceived social stigma. And similarly, all the researchers strongly suggested collaboration with spiritual/religious leaders and other community key people to provide appropriate psychoeducation and services. In the following paragraphs, the current researcher provided more detailed information about PSTSFMHS-stigma.

Ciftci and others (2013) provided a comprehensive explanation and literature review of the stigma about mental issues and mental health services in the Muslim community in the U.S. Stigma is defined as, “The situation of the individual who is disqualified from full social acceptance” (Goofman, 1963, p. 9, as cited in Ciftci et al.,

2013). Ciftci and others (2013) stated, “Stigma hurts individuals with mental [issues] and their communities, creating injustices and sometimes devastating consequences” (p. 17). They also explained how there are different aspects/types of stigma including label avoidance, self-stigma, perceived public stigma, double stigma, and intersectional stigma, all of which further complicates PSTSFMHS-stigma. They explained how stigma is moderated by six factors (e.g., concealability, course, disruptiveness, aesthetic qualities, origin, and peril) and how the stigma prevents people, including Muslims, from seeking out and utilizing many important mental health services. The authors reported a few main reasons that lead to public stigma. One, Muslims perceive mental issues from a pessimistic faith perspective (fatalism), which means seeing mental issues as a result of a lack of faith or weak faith. The authors stressed how seeing such a belief as the sole reason for mental issues contradicts the essence of Islam. The second reason are confused beliefs (e.g., existence of jinns, the idea that deceased people can affect one) about mental issues originating from cultural or religious sources. The third reason is a lack of knowledge regarding the genetic aspect of mental issues. The last reason contributing to stigma are some demographic differences (e.g., sex, country, class, and level of education).

The authors explained how the first author (Ciftci) witnessed PSTSFMHS-stigma when she was working at a rehabilitation center in Turkey. She witnessed that family and community members would blame mothers for having children with some mental issues, and some of those families would keep the children inside so that other people would not see them. The authors pointed out that Muslims face many issues in social life. However,

because of PSTSMHS-stigma Muslims underutilize mental health services, experience more conversion disorders, visit physicians more often, and segregate the individuals and even their families with mental issues from the community.

The authors clearly stressed how all these harm the society as a whole; therefore, they called the researchers and practitioners who have expertise in stigma to address issues Muslims face by utilizing more local and culturally appropriate anti-stigma interventions. They suggested collaborating with religious/spiritual leaders and other key people (e.g., physicians, nurses, families, and family leaders), providing more psychoeducational activities in the community, paying attention to intersectional stigma that originates from different sources (e.g., race, sex, discrimination, media, and government), paying attention to primary needs (e.g., safety, threats, discrimination, and effect of wars), and utilizing more culturally appropriate interventions while providing the services.

One of the main critiques the current researcher has of the study is that the authors did not conduct an empirical research, only providing a thorough literature review. Another critique is the lack of a theoretical framework to visually show stigma's different aspects and relationships.

Two additional important studies are Aloud's (2004) and Aloud and Rathur's (2009) studies. The authors found that Arab Muslims have perceived social stigma toward mental health issues and services. The participants had a significant amount of shame toward seeking the services ($M = 2.76$ over 4). There was a significant negative correlation ($r = -.33, p < .01$) between PSTSMHS-stigma and ATFMHS-attitudes,

which means the greater the stigma level the participants had, the less favorable attitudes they had toward formal mental health services. The correlation between PSTSFMHS-stigma and KFMHS-knowledge was also significantly negative ($r = -.12, p < .05$), meaning the less KFMHS-knowledge, the greater the stigma toward the services. The relationship between PSTSFMHS-stigma and help-seeking preferences was significantly negative ($r = -.22, p < .01$), which means the more stigma associated with an issue, the more likely they would first seek help from cultural resources (e.g., spiritual/religious leaders, pray, family, friends, and herbs). All the other correlations with other concepts or variables (e.g., age, income, and sex) were not significant.

In terms of regression analysis, PSTSFMHS-stigma along with some other variables (selected demographic variables, CBMHP-cultural beliefs, and KFMHS-knowledge) explained a significant number of ATFMHS-attitudes ($R^2 = .21, p < .000$). PSTSFMHS-stigma concept by itself significantly explained 8% of the variance in the attitude construct. The researchers reported that when one controls for demographic variables, PSTSFMHS-stigma is one of the best constructs explaining ATFMHS-attitudes.

Similar to many other researchers, the authors also emphasized that the protection of family honor is one of the most important values for many Arab Muslims. Individuals with a mental health issues do not want to damage the name of the family. Even if the family accepts the issue, they think of it first as a family concern that should remain and be addressed inside the family. Utilizing outside resources like formal mental health resources would likely lead the family to feel a loss of family name and unity. The

authors found that mental health service utilization is the last option after Arab Muslims pursue all other possible cultural options especially religious/spiritual resources.

This study is important because the authors empirically found what many other researchers stressed (e.g., high level of PSTSMHS-stigma explains negative ATFMHS-attitudes); however, there was no a significant relationship between PSTSMHS-stigma and CBMHP-cultural beliefs. There are some other researchers (e.g., Bagasra, 2010) who also found similar results. In general, the other researchers explicitly stressed that PSTSMHS-stigma will have a strong negative correlation with the CBMHP-cultural beliefs. One of the main critiques here is that the participants were all Arab Muslims and they all came from one city in the Midwest of the U.S., which makes it difficult to generalize their results to other Muslims.

Similarly, in their quantitative study with 102 Middle Eastern American students (63% being Muslim and 55% being graduate students), Soheilian and Inman (2009) found that stigma was one of the most important barriers leading to the underutilization of mental health services. The authors examined whether self-stigma (internalized stigma) acts as a mediator between perceived social stigma and attitudes toward counseling, and they found that neither perceived social stigma nor self-stigma explains attitudes toward counseling. For this population, self-stigma and perceived social stigma were two different constructs. Based on the results of regression analysis, the only significant relationship was between self-stigma and attitudes toward counseling, and that was negative (Beta = $-.66$, $p < .001$). Unlike Aloud (2004) and many other researchers who found a significant negative correlation between perceived social stigma and

attitudes toward mental health services, Soheilian and Inman (2009) did not find the relationship and they attributed the lack of this correlation to the scale they used. They noted that the scale does not represent Muslims' culture, and therefore the authors concluded that individuals with greater self-stigma (internalized stigma) are less likely to utilize mental health services. The researchers interpreted this result as someone with self-stigma "wanting to save face for the family and protecting the family image" (p. 150). This interpretation is very similar to other researchers' interpretation (e.g., Aloud, 2004; Ciftci et al., 2013) who found a negative relationship between perceived social stigma and negative attitudes toward seeking the services. They provided some critiques (e.g., seeking mental health services being not very culturally appropriate) to the Perceived Devaluation-Discrimination Scale (PDDS), which they used to measure PSTSMHS-stigma. The current researcher thought these different and unexpected findings might be primarily a result of having only students as participants, and the majority of them (55%) being graduate students.

In another similar study with 120 American-born Muslim college students, Herzig and others (2013) found that there is a significant negative relationship (Beta = -.22, $p < .001$) between stigma and active coping (active coping scale included items that indicate one makes some plan and does something about it, which is close to perspective of mental health services).

In some other studies, researchers who used more qualitative methods also found that Muslims had negative ATFMHS-attitudes. For example, Bektas and others (2009) mentioned how students from Turkey living in the U.S. might have some stigma about

seeing a counselor for their issues while they adjust to the country. The authors suggested counselors reach out and utilize more culturally familiar techniques, like attending some cultural events with the clients and providing wider social connections. Similarly, Youssef and Deane (2006) also found that the Arab-speaking population in a main city in Australia (participants being Muslims and Christians) had a significant level of PSTSFMHS-stigma. The researchers found that among Arab-speaking people there is a great deal of shame associated with sharing personal issues, except for medical issues, with someone outside of the family. The authors explained that there is a cultural prohibition on exposing personal and family issues to a person outside of the family. They found the level of stigma especially high for women and some key people (e.g., community leaders, family leaders). They also explained how Arab-speaking people feel pride in being healthy, even sometimes to the extreme degree of denying physical illnesses. Women were seen as the foundation of a marriage and a family, and therefore there is a cultural belief that women have to be more isolated from such issues than men. The participants indicated that mentioning the name of a woman with mental issues would interfere not just with her personal current or future marriage but also with all of her family and especially with the all women from her family. Fifty-one percent of the participants reported that the isolation of a person with mental issues is a norm for the Arab-speaking community. The participants also indicated that Arab-speaking people want the fewest follow-up procedures (e.g., counseling, home assistance, and follow-up sessions). Another important finding was how Arab-speaking people stay away from mental health centers because of the names used in the hospitals. For example, "Mental

health [could] be too confronting . . . and this contributed to mental health services being viewed as unapproachable” (p. 57). Therefore, the authors recommended using more inclusive language. Similarly, Ciftci and others (2013) also found similar results and they named this concept as “label avoidance” (p. 18), meaning that people want to avoid places and labels with mental health and/or mental health diagnoses connotations. This is different from and yet related to public stigma. Amri and Bemak (2013) also talked about ways to address PSTSMHS-stigma since they have found in the literature that the stigma is “deep-rooted” (p. 43). They pointed out that the stigma becomes more complex because Muslims living in the U.S. do not have enough culturally appropriate services. They explained in detail how the Multi-Phase Model of Psychotherapy (MPM) could be utilized to address psychosocial issues and the social stigma existing among Muslims toward the services. MPM includes five phases: mental health education; individual, group, and family interventions; cultural empowerment; integration of traditional and western healing practices; and addressing social justice and human rights issues. They also provided two hypothetical case studies in which they explained how to use the model and address social stigma.

These researchers who used quantitative and/or qualitative methods to understand PSTSMHS-stigma and its relationship with other concepts (especially ATFMHS-attitudes) found some different results, and yet majority found that Muslims have a strong PSTSMHS-stigma. These are signs that more empirical and culturally appropriate studies are needed. In the following paragraphs, the current researcher provided some

more detailed information about some other researchers who found that Muslims do not have significant PSTSMHS-stigma.

Compared to other researchers, Bagasra (2010) found that Muslims did not have a significant stigma. The findings were based on how the participants rated their comfortability in seeing a mental health provider. One item contributing to stigma levels was “if a family member is mentally ill, it is better others do not know about it” (p. 142). The results were as follows: only 2.3% strongly agreed, 7% agreed, 22.5% disagreed, 21.1% neither agreed nor disagreed, and 46.9% strongly disagreed. In terms of comfortability in seeking help from mental health providers or cultural resources, the percentages were as follows: 24.1% strongly agreed and 44.8% agreed seeking help from counselors, and 29.4% strongly agreed and 52.1% agreed that they would feel comfortable seeking help from a therapist. These numbers contradict the majority of the research mentioned above since most of the researchers (e.g., Aloud, 2004; Ciftci et al., 2013; Tanhan, 2014) found that Muslims felt more comfortable if they sought help from close family, relatives, and spiritual or traditional leaders like imams rather than mental health providers. One common thing between Bagasra’s and other researchers’ studies was that her participants also indicated the most comfort (30.5% strongly agreed and 50.2% agreed) with doctors if they sought help. However, in addition to these quantitative results showing that the Muslims in this study did not have significant PSTSMHS-stigma, open-ended responses from the participants with experience with mental health providers showed that the stigma was their second most important concern.

This showed how PSTSFMHS-stigma could be a main barrier to utilizing services, even for the ones who sought out the services.

In addition to Bagasra's (2010) study, there are some other researchers who did not focus on perceived social stigma yet mentioned it and found it was not a main barrier for Muslims utilizing the services (Kelly et al., 1996; Khan, 2006). They suggested examining stigma within the context of other concepts (e.g., KFMHS-knowledge) in empirical studies.

Some other researchers specifically focused on key people (e.g., imams, physicians, traditional healers) who serve Muslim communities in order to understand their PSTSFMHS-stigma. For example, Thomas and others (2015) found in their study with 10 certified traditional healers (Mutawa) in UAE that the healers did not have any stigma toward mental health services and wanted more collaboration to provide more effective services and referrals. In another similar study, Ali and Milstein (2012) examined how male imams ($N = 62$) in the U.S. approach mental illnesses and collaborate with mental health providers. They found that the imams were willing to collaborate and did not have a significant level of stigma toward mental issues and mental health services. In these two studies, the key people had some formal or informal training related to mental health issues and services.

Based on all these studies, it is obvious that PSTSFMHS-stigma is an important in preventing Muslims from utilizing services, especially when most of the researchers explained how general Muslims in the U.S. face issues at five levels from the individual to the global level. Based on the studies mentioned above, the results are contradictory

with some researchers' findings that Muslims have significant levels of the stigma and other researchers' findings that Muslims do not. However, the majority of the researchers found a significant level of PSTSFMHS-stigma. All the researchers strongly suggested paying attention to cultural resources to create scales with more reliable psychometric features and also provide more culturally appropriate services. These researchers also mentioned that examining this concept requires well-established studies based on well-grounded theories and theoretical frameworks.

The importance of the PSTSFMHS-stigma concept is also very important from both lenses (TPB/TRA and SEM) of this current study. Perceived social stigma is one of the most important constructs in TPB/TRA (e.g., Morrison et al., 2002). Mackenzie and others (2004) also stressed how perceived social stigma is an important concept while trying to understand the use of mental health services. They developed a subscale specifically from TPB perspective to measure PSTSFMHS-stigma. Perceived social stigma is an important concept in SEM because SEM stress the role of larger community and environment within which individuals live. Therefore, the lack of understanding PSTSFMHS-stigma and its relationship with the other important concepts (e.g., culture, attitudes) and/or variables (e.g., sex, education) are important gaps, as mentioned by many researchers.

Perceived Behavioral Control toward Seeking Formal Mental Health Services (PBC)

The last important concept in the literature of Muslim mental health is perceived behavioral control (means perceived self-efficacy) toward seeking formal mental health services (PBC). The researchers in the literature did not clearly name, state, and study the

PBC concept. This creates a lack of research to study the concept. Perceived behavioral control (PBC) “is most compatible with Bandura’s concept of *perceived* self-efficacy” (Ajzen, 1991, p. 184). To the knowledge of the current researcher, there are not any researchers from the Muslim mental health literature who specifically studied this concept and/or developed an instrument to examine it, yet they have mentioned it indirectly. However, this concept is well studied in many other areas (e.g., sexual health) from TPB/TRA perspective. The researchers who utilized TPB/TRA found PBC (*perceived* self-efficacy) as one of the strongest constructs in their studies, especially with intention (another construct in the TPB/TRA), to predict or explain a behavior of interest. Most of the times, PBC and intention together are the best predictors for a given behavior, which increases the role of PBC as a concept in research and practice (Ajzen, 2006; Ajzen et al., 2011). Therefore, studying and naming this concept in this current study will be a significant and unique contribution to the mental health discipline and especially to Muslim mental health literature.

Ajzen (1991) explained how his theory (TPB) takes PBC in a more general framework with some other constructs (e.g., attitudes, stigma). PBC in this study identifies to what degree a Muslim believes they can take the steps necessary to identify and utilize mental health services. Ajzen (1991) added this construct and stated that “in fact, the theory of planned behavior differs from the [former/first] theory of reasoned action [TRA] in its addition of [PBC]” (p. 183). After Ajzen had found PBC as a strong construct, Fishbein and Ajzen (2010) updated the first version of TRA (see Appendix F) by adding PBC, and now the current TRA also includes the PBC construct as one can see

from the TRA figure. There are some discussions about PBC and how it differs from some other constructs (e.g., self-efficacy, perceived locus of control); therefore, the current researcher provided more definitions and explanations in the following paragraphs to clarify PBC.

PBC means one's perception of (Ajzen, 1991, 2006) and capacity to seek and/or utilize mental health services. From another perspective, it means "people's perception of the ease or difficulty of performing the behavior of interest" (Ajzen, 1991, p. 183), which in this current study means utilizing or seeking the mental health services. Fishbein and Ajzen (2010) stated, "from a theoretical perspective self-efficacy and perceived behavioral control are virtually identical" (p. 161) and "[PBC] is most compatible with Bandura's concept of perceived self-efficacy" (Ajzen, 1991). Fishbein and Ajzen (2010) explained how some researchers found two different concepts (self-efficacy versus perceived behavioral control) in studies where they ran factor analyses for studies in different subjects, including physical exercise (Armitage & Conner, 1999, 2001; as cited in Fishbein and Ajzen, 2010) and academic performance. However, Fishbein and Ajzen (2010) noted that they could not understand what made these researchers come up with two different concepts and name one of them self-efficacy and the other one as *perceived* behavioral control, respectively. However, based on these researches and related to the difference, Fishbein and Ajzen (2010) stated, "to have [high] self-efficacy, people must believe that they can perform the behavior even in the face of difficult obstacles" (p. 160) not just when a task is easy. The authors also explained how this perspective of self-efficacy is identical with Bandura's (1977) conceptualization of the self-efficacy

construct that states person with high self-efficacy may see some tasks/behaviors inherently more difficult, yet the person strongly believes that they can be successful through ingenuity and perseverant effort (as cited in Fishbein & Ajzen, 2010). This definition is a little different from the definition of PBC because as Ajzen explained in almost all his studies (e.g., Ajzen, 1991) the importance of one of the constructs including PBC might change from context to context. This was the reason the researchers identified PBC and self-efficacy as two different concepts. This is even more accurate for PBC because as Ajzen stated, “[PBC] might not be particularly realistic when a person has relatively little information about the behavior” or the person’s environment or resources changed (p. 185). This is very accurate for Muslims in the U.S. including the Muslims in the Southeast because of most of them are recent immigrants and are not very familiar with mental health services. Considering all these, in this current study PBC means a Muslims’ perceived self-efficacy rather than just self-efficacy in seeking formal mental health services as Ajzen has suggested in some of his studies (e.g., Ajzen, 1991).

Another important concept is the *actual control* (the availability of physical/ actual) resources as seen in TPB/TRA figure. Ajzen (1991) stressed the clear importance of actual behavioral control because the resources and opportunities affect people’s behavior. However, he stated, “of greater psychological interest than *actual* control, however, is the *perception* of behavioral control and its impact on intention and behavior” (p. 183). Therefore, in the studies from TPB/TRA perspective the focus of studies in general is not on actual control (actual resources) but more on intrapersonal and interpersonal processes, meaning perceived ability to conduct the behavior in different

contexts or circumstances. Therefore, actual control is a moderator in TPB/TRA model on PBC and intention, and in most cases actual control is not studied empirically by researchers who utilize TPB/TRA as their main models. The importance and accurate measurement of PBC increases to the degree it can substitute or count for actual behavioral control construct (Ajzen, 1991, 2006).

Burke (2002) reported that between 70% and 80% of people with diagnosable mental issues do not receive professional help (as cited in Mackenzie et al., 2004); therefore, Mackenzie and others (2004) stressed the importance of PBC to understand peoples' approach to the formal mental health services from well-grounded theories. They emphasized that TPB/TRA provides a clear framework to empirically study peoples' approach (e.g., PBC) toward the services rather than some other frameworks that are too general (e.g., Anderson and Newman's health service utilization framework). Furthermore, there are few researchers in the literature of Muslims and mental health who utilized theoretical frameworks but none included PBC as a construct. For example, Aloud (2004) used a theoretical framework and yet it is too complex and designed only based on Arab Muslims' approach toward mental health services. Therefore, there are not any scales or guidelines from Muslim mental health literature to measure Muslims' PBC; however, Mackenzie and others (2004) improved a subscale based on TPB perspective to measure one's PBC. The subscale has good validity and reliability, which fills an important gap in the literature. Based on that, Mackenzie and others (2004) also stressed importance of PBC with some other important constructs including attitudes and perceived social stigma toward seeking formal mental health services to predict the use of

mental health services. They emphasized that there is a lack of measurement with good psychometric features to measure one's PBC; therefore, they improved the subscale using eight items to meet the gap.

As mentioned above, Ajzen (1991) added PBC construct to the first version of Theory of Reasoned Action (TRA) and conducted many studies to see how PBC predicted the behavior. He found that PBC was one of the strongest constructs, especially when considering it with the intention (another construct in the model) to best predict the behavior of interest (Ajzen, 1991; Ajzen et al., 2011). Once he found PBC to be one of the strongest predictive constructs, he called the new theory the Theory of Planned Behavior (TPB) rather than TRA. Later, Fishbein and Ajzen (2010) added this new construct (PBC) to the former TRA, and so now the last/current version of TRA also includes PBC as a main construct. In addition, the authors also visually added background variables related to three aspects including individual (e.g., personality, values), social (e.g., education, sex), and informational (e.g., knowledge, media) so that now the last version of TRA is much more comprehensive compared to the previous versions. However, most of the researchers did not stress the background variables as much as the other five main variables (attitude, stigma, PBC, intention, and behavior) in their empirical studies. As the current researcher mentioned above, whether TPB or the current/last version of TRA, they (TPB or TRA) are almost the same thing with some minor differences between them. *Therefore, he utilized both together as one theory/lens and called it Theory of Planned Behavior/Theory of Reasoned Action (TPB/TRA) in this study.*

Self-efficacy or *perceived* self-efficacy, which means PBC, is also a very important concept in SEM and in some other individual and interpersonal theories like Bandura's Social Cognitive Theory (SCT) (Cottrell et al., 2015). Therefore, including PBC and understanding the concept and its relationship with the other concepts (e.g., ATFMHS-attitudes) is very important, as some authors in the Muslim mental health literature have mentioned the concept indirectly. From the SEM perspective, examining PBC in the larger context of the other important concepts (e.g., CBMHP-cultural beliefs) is important because almost all the researchers in the Muslim mental health literature stressed considering factors affecting Muslims and their approach to the services contextually rather than acontextually. That means they call for understanding relationships among the five important concepts: CBMHP-cultural beliefs (1st concept), KFMHS-knowledge (2nd concept), ATFMHS-attitudes (3rd concept), PSTSMHS-stigma (4th concept), and PBC (5th concept).

The current researcher benefited both from the studies in Muslim mental health literature and especially from the studies using TPB/TRA to provide more information about PBC and Muslims' PBC. However, as mentioned above, the authors in the literature of Muslim mental health only mentioned PBC indirectly, and they did not study it well. Therefore, it is important to examine it empirically and provide more information about how some of the researchers in the Muslim mental health literature mentioned PBC indirectly.

Most of the researchers in the Muslim mental health literature underlined that Muslims have strong CBMHP-cultural beliefs, poor KFMHS-knowledge, negative

ATFMHS-attitudes, and strong PSTSFMHS-stigma. And these researchers said such factors lead to Muslims' low PBC, although the researchers did not explicitly use the terms neither self-efficacy nor PBC. For example, Ciftci and others (2013) reported that some Muslims indicated that they could utilize (high PBC) counseling yet due to PSTSFMHS-stigma they were not able to seek the services. Some other researchers also mentioned how Muslims had a lack of trust and had doubts about confidentiality while receiving mental health services, and that led them to doubt whether they could utilize the services (Amri & Bemak, 2013; Tanhan, 2014; Youssef & Deane, 2006). In Youssef and Deane's (2006) study, the key people serving the Arab-speaking community reported that some Arab-speaking people could seek (high PBC) the services but could not go (low PBC) to a building with a name like mental health center where others could see them and cause dishonor for the patient. Amri and Bemak (2013) explained how Muslims had cultural mistrust (e.g., lack of trust for confidentiality) in mental health institutions and professionals; therefore, the Muslims stayed away from utilizing the services when they could use them to address their issues. All these researchers called for understanding Muslims in a more holistic perspective by utilizing well-grounded theories which will help to examine and understand Muslims' PBC. Some of these researchers also specifically mentioned some theories like TPB, TRA, and SEM.

As noted before, Khan (2006) among others (Aloud, 2004; Aloud & Rathur, 2009; Amri & Bemak, 2013) found that Muslim women were more willing to see mental health providers than men, and yet Muslim women found it difficult to seek and use the services. Therefore, the researchers suggested examining this dynamic in a more

contextual perspective by utilizing TPB/TRA, which stresses PBC as well as the other four main concepts (e.g., CBMHP-cultural beliefs, ATFMHS-attitudes). Although the researchers did not mention and clearly name how Muslim women's PBC affect their seeking the services, it is more likely that Muslim women find it much more difficult to get over barriers (e.g., PSTSMHS-stigma) to seek and utilize the services, which could be named as low PBC.

Another aspect related to PBC concept is the availability of transportation, which can be seen in the actual control construct in TPB/TRA model. Cook-Masaud and Wiggins (2011) explained how a Muslim woman was willing to continue the counseling (high PBC) and yet faced some difficulties due to lack of transportation and time (taking care of her children); therefore, the counselor provided sessions at the client's house. In this case, one can see how actual behavioral control (availability of physical resources in the community) construct affects PBC.

In addition to these researchers above who found that some Muslims have low PBC, there are some other researchers (e.g., Ali & Milstein, 2012; Bagasra, 2010; Bagasra & Mackinem, 2014; Kelly et al., 1996; Tanhan, 2014) who found that Muslims utilized mental health services. The fact researchers found that Muslims used the mental health services could be a sign of high PBC. Almost every single researcher at least called attention to some significant barriers, especially PSTSMHS-stigma. Kelly and others (1996) reported that a substantial minority of Muslims were willing to use counseling and yet they indicated a lack of culturally competent counselors who would understand Islam. Bagasra (2010) found Muslims utilized and had very favorable

ATFMHS-attitudes; however, she also found that some of the Muslims who used the services reported PSTSFMHS-stigma and how it was difficult for them to get over the stigma. All these could mean Muslims who overcame the barriers had high PBC though the researchers did not mention the concept.

In some other studies examining the key people (e.g., traditional healers, imams, physicians) authors found different results. For example, Thomas et al. (2015) and Ali and Milstein (2012) studies with the key people (traditional healers in UAE and imams in the U.S., respectively) serving Muslim community found that the key people were willing to collaborate with, refer people to, and utilize the mental health services. These show the key people had a high PBC. However, Youssef and Deane (2006) found that even well-educated key people (e.g., imams, spiritual/religious leaders, physicians) serving Arab speaking community had some doubts about referring (low PBC) people to the formal mental health services because of the strong negative responses (e.g., people telling them they are not crazy) from their communities. In addition to that, some of these key people participating in the study did not even know the mental health resources in the community. Though none of these researchers directly explained or mentioned PBC, they indirectly talked about how some both lay and key people in the community had some low level of PBC due to some factors (e.g., especially social stigma, sex, actual resources). TPB/TRA model also shows how some other important concepts (e.g., social stigma, attitudes) and actual resources (e.g., transportation, availability of services) affect the level of PBC.

Therefore, paying attention to PBC and its relationship with other important concepts becomes even more important when one considers SEM. SEM provides more attention to the contextual circumstances and stresses changes at the environmental level to make it more appropriate and easier for people in order to increase health rather than just focusing on individual/intrapersonal factors (e.g., attitudes, skills; McLeroy et al., 1988).

The authors who purely utilized TPB/TRA for some other studies (e.g., public health, psychology) stressed almost in each study that PBC is one of the most important concepts. However, nobody explicitly studied Muslims' PBC, which creates an important gap. Therefore, the researchers called for understanding Muslims' PBC and its relationship to the other important concepts (e.g., CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes), and few of them strongly suggested utilizing theories (e.g., TPB, TRA) in a contextual framework (e.g., SEM) to understand Muslims' approach to mental health services (e.g., Aloud, 2004; Aloud & Rathur, 2009; Amri & Bemak, 2013). Furthermore, some researchers in the counseling literature also called for counselors as researchers and practitioners to utilize TPB/TRA (e.g., Romano & Netland, 2008) in counseling.

In summary, it is clear that these five important concepts (e.g., CBMHP-cultural beliefs, PBC) are the most important concept in the Muslim and mental health literature, and there are some other concepts (e.g., institutional/professional factors, acculturation, economic factors, use of other cultural resources) affecting Muslims' approach toward seeking formal mental health services as one can see from the concept map. Based on all

these, the current researcher did not elaborate on the other concepts in the concept map. In addition to these concepts, the researchers stressed the importance of understanding the relationship among control/background variables (e.g., sex, education) and the concepts (e.g., PBC and ATFMHS-attitudes). Understanding these relationships by using a contextual theoretical framework built based on well-grounded theories' (e.g., TPB/TRA and SEM) perspectives is especially important; therefore, the current researcher provided more information regarding the relationships among the control variables and the five concepts.

Control Variables and Approach to Mental Health Services

As it has been explained in the previous sections, researchers found some contradictory results between the control variables (e.g., education, sex, past behavior, race/ethnicity) and their relationships with the five concepts. Therefore, it is also important to understand the relationship between these four control variables and the five constructs in this current study. Overall, the majority of the researchers found that such control variables did not have a significant relationship with the concepts. This means such control variables do not significantly affect one's approach toward seeking the services. However, the current researcher provided more information in following sections.

In terms of the four variables including education, sex, past behavior, and race/ethnicity, Bagasra (2010) found very different results from many other researchers. She found that Muslims had more favorable approaches (e.g., positive ATFMHS-attitudes, low level of social stigma, high level of knowledge about the contemporary

scientific explanation of mental issues and their treatments) toward seeking the services. However, she also reported that the majority of the participants, relative to Muslim population in the U.S., had a high degree of education (e.g., 5.6% doctorate degree and only 0.8% less than high school). For example, in Aloud's (2004) study 8.2% had an education level lower than high school. Bagasra had 118 males and 136 females, a little unusual among the related literature because in general the number of male participants is much greater than female participants. However, the author did not report the specific descriptive statistics nor included significance tests for education, sex, past behavior, and race/ethnicity. Ciftci and others (2013) cited some other researchers who found that participants with higher education levels had more positive attitudes and less stigma toward the services, and they noted that Muslim women had more favorable approaches to the mental health services though they could not utilize them as much as they were willing due to the social stigma. Similarly, Kelly and others (1996) found that Muslim participants ($N = 121$; 43 women and 78 men) had a positive approach to counseling, but the authors did not report the statistics for the four control variables. Some other researchers found race/ethnicity to be related to how Muslims seek mental health services but not a significant relationship when accounting for education and sex (Aloud, 2004; Aloud & Rathur, 2009). The authors found length of stay in the U.S. to be a significant variable for having positive approaches toward the services. Youssef and Deane (2006) also underlined that it is more difficult for women to seek the services because of the high PSTSMHS-stigma. The authors also found that the Arab speaking community has an especially negative approach to the mental health services, including high level of

negative attitudes and social stigma toward and very low level of knowledge about the services. Cook-Masaud and Wiggins (2011) explained how it might be more difficult for Muslim women to utilize the services due to some barriers (e.g., lack of transportation, having children). Khan (2006) also found that the majority of Muslim participants had a positive approach toward counseling ($N = 459$), and the women had more positive approach. However, there was not a significant difference between men and women in terms of the actual use of the services, though women were more willing to use them. In this study, the education level did not have a significant relationship on approaches toward the services. In terms of race/ethnicity, South Asian Muslims (72.3%) had the highest favorable approach to the counseling compared to Arab Muslims (57.5%), African American Muslims (50%), and others (75%). Similarly, Soheilian and Inman (2009) also found that Middle Eastern Americans had negative approach toward the services ($N = 102$ with 63% of the participants being Muslim; 77% women, and 55% being graduate students). However, the researchers did not find any significant relationship between these demographic variables and approach toward the services.

Thomas et al. (2015) found that the 10 traditional healers (all men) had a positive approach to the mental health services, and the authors found that overall general Muslims had a negative approach toward the formal mental health services, while Muslim women sought and utilized traditional healers more often than men. The authors, similar to other researchers, reported that it could also be difficult for women to seek traditional options because of social stigma, especially related to effects on marriage and marriageability. Similar to all these researchers, Tanhan (2014) explained how a Muslim

female client had some concerns how her family and others in the community might think of her if they knew that she was receiving counseling. He also explained how an Arab male college student first responded very negatively when he heard that he could benefit from counseling. Amri and Bemak (2013) stressed that it is more difficult for Muslim women to seek help mainly due to high PSTSMHS-stigma, and yet they are less likely to internalize stigma, which makes them to be more open to seek the services compared to Muslim men. In another study with 35 imams (all male) in the U.S., Ali and Milstein (2012) found that the imams had a positive approach to the services, and they all had some kind of higher education or different experiences (e.g., psychoeducation, personal experience) regarding mental health services.

In terms of the last control variable, not many researchers clearly examined the past behavior, which means having the experience of utilizing (collaborating with) the mental health services and providers. Some of the researchers found the Muslims who had utilized the services in the past were more likely to use them again and had more positive approaches toward the services. For example, Tanhan (2014) explained how a Muslim woman had some negative ATFMHS-attitudes and yet still was willing to start the counseling with a new counselor after her previous counselor had left. Strack and others (2016) also found that some participants reported working with a counselor and counseling department at their colleges to address some psychosocial issues. They identified this as one of the most important strengths and resources they had on campus. Some of the participants acknowledged how working with a counselor had benefited

them at individual and community levels that they wanted to keep having the support from the counselor and the counseling department.

Considering all these research results, it is clear that there are some contradictory results in the significant relationships these control variables (e.g., sex, education, race) have with some important concepts (e.g., ATFMHS-attitudes). The most common result among all the studies is that Muslim women had more favorable approach toward utilizing the mental health services, though it was not statistically significant in all studies. And Muslim women were not able to utilize the services as much as they needed mainly due to the PSTSFMHS-stigma from their family and larger community. Having more formal and/or some informal education/training was another common factor for having more positive approach toward mental health services; however, that was also not always true. The researcher also found that the Muslims who utilized (i.e., having the experience of working with a mental health provider) the services in the past were also more likely to have more favorable approaches toward seeking the services (Bagasra, 2010; Tanhan, 2014). The past behavior is also an important concept stressed by many researchers who utilized SEM. The role of the past behavior is also important in TPB/TRA, though this variable is not well examined by the researchers who utilized TPB/TRA. The final variable was the role of race/ethnicity, and one of the most common results was that Arab Muslims had more negative attitudes compared to other ethnicities.

Conceptualization of Mental Health Providers

In addition to all these gaps related to the concepts and control variables, there is another important concept that constitutes an important gap: how Muslims conceptualize

mental health providers (e.g., what a counselor means to them). This concept was indirectly mentioned in most of the studies that many Muslims did not understand what role mental health providers and mental health services perform though some researchers (e.g., Bagasra, 2010; Bagasra & Mackinem, 2014) found that Muslim participants in their studies were very familiar with mental health providers and their services. However, to the knowledge of the current researcher none of the researchers directly examined through an empirical study how Muslims conceptualize professional mental health providers. This constitutes an important gap because understanding how Muslims identify formal mental health providers is important, and this is also related to KFMHS-knowledge.

Based on all these studies and their relationship to Muslims in the Southeast and the larger, country-wide Muslim community, it is important to understand how Muslims in the Southeast approach mental health services. This is important because Muslims in the Southeast of the U.S., similar to the larger Muslim population in the U.S., face issues at all levels including the global (wars, immigration, policies), larger community (jobs, neighborhood, institution), local community (family, mosque), interpersonal (friend, significant other), and individual/intrapersonal (meaning of life, knowing themselves better). It is important to note the lack of research about the Muslims' mental health in the South and especially the Muslims in/around the Southeast and their approach to mental health issues and services. In the next section, the current researcher provides more specific information about a few studies conducted in an effort to understand the Muslims in the Southeast and their psychosocial issues.

Muslims in the Southeastern U.S. and Their Psychosocial Issues

Francisco and Tanhan (2015) conducted a study with 114 (63 males and 51 females) adult Muslims (e.g., students, parents, faculty and staff) who were affiliated with a Southeastern university. The researchers found that the Muslims experienced many psychosocial issues related to the five levels (global, larger community, local community, interpersonal, intrapersonal). Out of 114 participants, only 20.50% were satisfied with “having prayer places/tools/conditions to be able to pray” on their campus, while 94.5% of the participants indicated that praying was the most important issue for them among the other 33 issues/items in the survey (Byrne, 2015; TWC News Staff, 2015). Many participants reported feeling stressed and anxious when they were not able to pray (*salah*) on time.

Similarly, in terms of being satisfied with some other important items/issues, the numbers were as follows: only 39.06% for “I feel safe;” 40.37% for “I am safe;” 45.33% for “You do not experience verbal or physical insults, or abuse;” 36.36% for “You do not have to be concerned about your physical appearance;” 33.80% for “Your belief/religion/spirituality is seen in a positive light/perspective by others;” 44.76% for “You are able to cope with difficult situations and pay attention to your academic studies;” 35.68% for “You feel safe to call police/security when faced with some disturbance (e.g., insults, threats);” 48.66% for “[...] community members prevent misconceptions or stereotypes about Islam;” and 44.10% for “You have the support needed to handle sad news” (Byrne, 2015). Satisfaction rates were very low with these 10 items even though the participants rated them as very important, ranging from 94.52% to

84.63%. The high importance and low satisfaction suggested an unmet need for psychosocial support. For the remaining 23 survey items, the importance was also very high and the satisfaction was low, indicating the Muslim community faces many issues but does not have the resources to address those issues.

In the study the authors also had an open-ended section asking for any other comments or issues that were not addressed in the 33 items. In the open-ended section of the study and in a community dinner and discussion (described below), many attendees expressed that they understood the study and the results. They reported that they felt sad, angry, unhappy, distracted, and unproductive mainly due to not having the supports and resources from the university to practice their obligatory faith practices.

The researchers also held the community dinner and discussion at a university after they had analyzed the results. The main purposes were to share the results with the community and see if they understood the results, and also to start a productive discussion among the ones interested in the topic (e.g., university administration, Muslim organizations, health departments on campuses). The authors with the help of some student organizations (e.g., Muslim Student Association), some other offices, and departments at the university (e.g., counseling department, school of education, office of intercultural engagement) invited the Muslim community at a few local colleges supporting the study to recruit participants, local media, key people at the administration, faculty and key student organization leaders, and some members of larger Muslim community in the Southeast area. About 60 to 70 people attended the community dinner and discussion. More people, both Muslims and non-Muslims, expressed and discussed

thoughts regarding the results, some other related issues, and possible solutions about moving forward. For example, the president of the Muslim Student Association (MSA) at a university in the area expressed that they (as Muslims and MSA) cannot do everything without the support of academic institutions because they are students and cannot afford the demands of the Muslim community both in terms of money and time. Some attendees from different universities around the area indicated that they also have similar issues and asked the authors to conduct a similar study at their universities to address such issues. The researcher showed Muslims in the Southeast face some serious psychosocial issues that could mean that mental health providers also can be part of addressing the issues in addition to the other health professionals and administrators. It might be important to note that the second author was a Muslim and PhD student at a counseling department who worked under the supervision of the first author who was a Christian professor at a public health department at a university in the area.

In a qualitative study, Strack et al. (2016) found similar results by utilizing a Photovoice technique. The researchers had 121 Muslim participants affiliated with a few universities in the Southeast. The participants were asked to take one photo of a concern/issue and one photo of a strength/support that they have experienced on their campuses and give a little more information about each photo through the SHOWED acronym, which is commonly utilized to get the lived perspective/experiences of the participants in Photovoice (Wang & Burris, 1997). The authors specifically encouraged the researchers to utilize Photovoice with minority groups who do not have a voice because of its appropriateness. In addition to that, the use of Photovoice is becoming

more common in mental health profession as it helps researchers understand lived experiences of participants related to specific mental health issues, leading to more effective services (Becker, Reiser, Lambert, & Covello, 2014). Strack et al. (2016) disseminated and collected the data through the Qualtric to respect confidentiality and also reach out to a larger and more diverse group of participants rather than a specific group affiliated with Muslim organizations on campuses. The researchers modified the SHOWED acronym, and in their study it stood for the following explanations:

S: What do you SEE in the picture as representative of a strength/facilitator for you or as part of your life/experience on your campus? H: What is HAPPENING in the picture you have taken (briefly describe the picture)?

O: How does that relate to (Y)OUR life as a person and/or community?

W: WHAT does contribute to/create the strength/facilitator?

E: What did you EXPERIENCE (feelings, thoughts, sensations) in the moment when taking the photo, and what/how do you EXPERIENCE/ (feelings, thoughts, sensations) in the moment when writing the caption and submitting the photo?

D: What can we (as counselors, peers, university, others, and all) DO about it? (Strack et al., 2016, p. 9)

The researchers found nine clusters of issues: 48.2% had issues related to not being able to pray on their campuses, 28.57% had some issues with community/friends/administrators, 12.93% had issues related to health and healthy food, 13.39% had issues related to ignorance/lack of knowledge about Islam and Muslims, 8.93% for global issues (e.g., Palestine, Zionism, terrorism), 8.93% had issues related to a research team and counselors working with their Muslim community, 7.14% had issues related to MSA and Muslim chaplain, 5.36% had issues related to study and success, 2.68% had issues related

to transportation. The sum of the percentage exceeds 100 because some participants' issues were related to more than one cluster. This qualitative study provided a descriptive explanation to understand how Muslims in the Southeast affiliated with the universities have many biopsychosocial issues.

Following the study, the authors organized an exhibition and dinner and invited the participants, key administrators, local media, student organization leaders, and some key people from the larger Muslim community in the area. The exhibition and invitation of key people in the community was an important part of the Photovoice methodology so that the key people could hear about the lived experiences of participants and address the issues more effectively. Strack and others' (2016) main purpose was to create a space to share the results, provide a chance to the Muslim community to reach out to the key people, and as researchers to gain more information about the study from the Muslim community. The exhibition and dinner gave an opportunity to the Muslim community to express and share more about the psychosocial issues they have faced on campuses (McKane, 2016). For example, many non-Muslim counselors and public health educators attended, and they had conversations with the Muslims to get more information about their issues and to learn how they can be helpful. In addition to that, the leaders of the Muslim community, both from the larger community and from MSA also asked the authors for more effective collaboration to address the issues Muslims faced. It is also important to mention that the third author was a PhD student at a counseling department at a university in the area and worked with the first the two authors who were professors at a public health department at the same university.

The authors in these two (Francisco & Tanhan, 2015; Strack et al., 2016) specific studies showed that the Muslim community in the Southeast had many complex and multidimensional issues. Therefore, they suggested further discussions and more professional and collaborative assessments, evaluations, and interventions to address the issues.

In another community advocacy and empowering event, a Muslim community in the Southeast collaborated with a counselor to organize a peace festival after they had received a hate letter that asked Muslims, and especially the Muslims around a college in the area, to disappear (Matthis, 2015). Following receiving the hate letter, an Islamic Center in the area contacted the counselor, who had worked with the community, to collaborate to address the issue. The author described how the counselor created a place to discuss what happened and how to address this hate letter in a more peaceful and effective way in keeping with the spirit of Islam. Therefore, the counselor facilitated a few meetings held at a university and at an Islamic Center in the Southeast. The meetings included many people from different faith backgrounds including Muslim leaders, Muslim community members, and representatives from a few churches, a few cultural centers, MSAs, and a few members of the city council. All parties agreed on organizing a peace festival at a civil rights museum in the city. The author reported that the counselor played a key role in uniting spiritual groups and other important people (e.g., police department) to advocate for Muslims and address the issues in an effective way. More than 200 people, including people from many faith groups and backgrounds, attended the event.

The counselor also collaborated with many partners and organized the second annual peace festival in 2016. He mainly provided space for the festival and facilitated meetings so that the partners build more partnership among themselves as more than 20 partners from all spiritual/religious perspectives. In the process of these two peace festivals, the counselor shared and described how to improve alliances and stand together. Bhattacharyya et al. (2014) as counselors utilized a similar framework to help Muslims in Boston to address their issues with hate attacks. Ally development gave the partners a framework for the peace festivals to more intentionally reach out to other partners and improve relationships both for the peace festivals and for future collaborations in different areas.

In sum, most of the Muslim mental health literature in the U.S. is about Muslims in the Northeast of the country, and there is a great lack of studies about Muslims in the Southeast. However, the authors mentioned above clearly showed that Muslim communities in the Southeast, as part of the larger Muslim community in the Southeast, also had many psychosocial issues that were not addressed. These issues are similar to what many other researchers found related to other Muslim communities across the country facing many issues.

Muslims and Mental Health: Use of Conceptual Framework, Concept Mapping, and Theoretical Framework

In Muslim mental health literature, most of the researchers did not utilize concept maps, conceptual frameworks, and theoretical frameworks. Therefore, in this section the current researcher provides information about these concepts and the importance of organizing one's study around clear theoretical concepts. Ravitch and Riggan (2012)

explained in detail how it is important for researchers and practitioners to have conceptual mapping and conceptual and/or theoretical framework to conduct empirical research and provide effective practice. They also underlined different terminologies that different researchers might use, like conceptual framework, conceptual mapping, and/or theoretical framework that mean similar things with some differences. The main goal in using such concepts is to help the researchers become more organized and well-grounded in theory and literature to move forward in research and practice.

Ravitch and Riggan (2012) defined conceptual framework as a discussion to clarify what makes the topic of a study “. . . significant and why the theoretical and methodological tools for conducting the study are rigorous and appropriate” (p. 136). In other words, conceptual framework is the main umbrella that includes methodology, personal interest, theoretical framework (model), and some other elements of a study like researchers’ philosophy/paradigm (K. Wester, personal communication, September 1, 2015). She also added that researchers in general automatically have a conceptual framework. What is more important is whether they have a theoretical framework to clarify what and how one will study the topic of interest. Therefore, it is important to utilize well-established theories/models (e.g., TPB, TRA, TPB/TRA, SEM) to shape one’s theoretical framework for the study of interest.

Ravitch and Riggan (2012) also suggested researchers do concept mapping for a more effective theoretical framework while reading the related literature. They stated, “. . . concept mapping is a tool for developing the conceptual [theoretical] framework” (p. 151). Therefore, the current researcher provided the concept map of the Muslim mental

health literature to provide the readers, future researchers, and practitioners within the larger picture of the main concepts and their dynamic relationships with one another. He included this because there is a lack of such visual concept mapping and use of it in the Muslim mental health literature.

The researchers in the Muslim mental health literature overall provided all points (purpose, methodology, personal interest, etc.) mentioned above in their studies for their conceptual framework. However, the majority of the researchers failed to provide concept mapping, theories, and/or the theoretical framework for their studies. The current researcher first provided a basic definition of theoretical framework and then more detail information about the theoretical framework of the current study. A well-spelled definition of theoretical framework is as follows:

A theoretical framework consists of [constructs] and, together with their definitions and reference to relevant scholarly literature, existing theory that is used for your particular study. The theoretical framework must demonstrate an understanding of theories and [constructs] that are relevant to the topic of your research paper and that relate to the broader areas of knowledge being considered. The theoretical framework is most often not something readily found within the literature. (University of Southern California, 2016)

Flanagan and Kaufman (2004) explained in depth how the history of intelligence tests including the Wechsler Intelligence Scale for Children-fourth edition (WISC-IV) changed dramatically from previous tests and revisions primarily due to the integration of well-established theory into both scales and practices of interpreting the test scores. Ravitch and Riggan (2012) also explained in detail the rationale and necessity of utilizing theories and theoretical frameworks/models when designing research. They stressed how

lack of theoretical frameworks might lead to confusion and lack of well-grounded research. Therefore, they strongly recommended researchers utilize well-grounded theories and literature regarding one's subject to create one's final theoretical framework to go further in research and practice.

Theoretical Foundations—Individual and Contextual Influences

Based on all mentioned above, there exists a research gap and necessity to understand the Muslims' approach to mental health issues and services through a well-established theoretical framework (model) that is built on well-grounded theories (e.g., TPB/TRA, SEM). There are many researchers in the Muslims mental health literature calling for the use of theories and/or theoretical frameworks to achieve more effective evidence-based research and practice (Ahmed et al., 2014; Aloud, 2004; Aloud & Rathur, 2009; Amri & Bemak, 2013; Nadal et al., 2012). For example, Aloud (2004) and Aloud and Rathur (2009) benefited from TPB in shaping their theoretical framework of mental help-seeking pathways and modifying factors among Arab Muslims to understand Arab Muslims' ATFMHS-attitudes. The researchers called for more use of such theoretical frameworks and suggested using some theories (e.g., TPB, SEM) for future studies.

Most of the researchers only focused on how PSTSFMHS-stigma, CBMHP-cultural beliefs, and KFMHS-knowledge (as independent variables) affect the ATFMHS-attitudes (as dependent variable). As it has been explained above, most of the time the researchers did not organize their studies from a well-grounded theoretical framework and/or theory. The current researcher found some common and contradictive results among the studies in the Muslim mental health literature. Therefore, studying and

understanding Muslims' approach toward mental health issues and services through well-grounded theoretical frameworks might help with more consistent results.

In light of all the discussions above, the current researcher utilized Muslim mental health literature (the concept map), SEM, and TPB/TRA to create the final contextual theoretical framework (see Figure 1 in Chapter I) for this current study. In this way, the theoretical framework (model) is not disconnected from the literature, practice, and theories; therefore, the theoretical framework will meet an important gap in the literature of mental health and more specifically in the Muslim mental health literature. The use of the theories and/or theoretical framework is necessary because without the theoretical framework it will be very difficult, if not impossible, to study all the 10 main concepts in the literature. As the current researcher showed in the concept map, the researchers in the literature focused on 10 main concepts. Without a well-established framework based on the literature and theories, it will be very difficult for a researcher to promise to further research and practice (Flanagan & Kaufman, 2004; Ravitch & Riggan, 2012).

As one can see in Figure 1 in Chapter I, the contextual theoretical framework (model) for this current study includes seven constructs: (a) CBMHP-cultural beliefs, (b) KFMHS-knowledge, (c) ATFMHS-attitudes, (d) PSTSMHS-stigma, (e) PBC, (f) intention toward seeking formal mental health services, and (g) behavior meaning the actual use of formal mental health services. However, the current researcher only focused on the first five constructs and their interactions with one another and with the four control variables (education, sex, past behavior, race-ethnicity). The current researcher did not focus on the other two constructs (intention and behavior) and some other control

variables (e.g., income, job) due to some limitations (e.g., time, available scales with good psychometric features). It is the wish of the current researcher that he and/or some other researchers do some follow-up studies to examine the whole theoretical framework with its seven constructs by meeting the limitations and running a path analysis for the full model.

In the next section, the current researcher provided more information about TPB/TRA and SEM because almost all researchers in the Muslim mental health literature stressed using a comprehensive model (e.g., SEM) while few other researchers suggested using TPB/TRA, TPB, and/or TRA.

Theory of Planned Behavior/Theory of Reasoned Action (TPB/TRA)

TPB and TRA are two similar theories, with some minor differences, that predict or explain a voluntary behavior toward a targeted behavior. *Therefore, the current researcher used them together as one theory in this study and called it Theory of Planned Behavior/Theory of Reasoned Action (TPB/TRA).* There is a gap in the use of TPB/TRA in mental health including counseling and especially in the Muslim mental health areas. For example, in Muslim mental health literature Amri and Bemak (2013) suggested the use of theoretical frameworks and suggested using TRA for more systematical research and evidence-based interventions. Similarly, Aloud (2004) and Aloud and Rathur (2009) mentioned the use of TPB in their studies about Muslims and their ATFMHS-attitudes. From counseling literature, in their study Romano and Netland (2008) emphasized that the use of TPB/TRA is very limited in mental health and especially in counseling; therefore, all these authors called for counselors as practitioners, researchers, and teachers

to utilize TPB/TRA in research, practice, and teaching. To the knowledge of the current researcher, there are no researchers that utilized TPB/TRA as an underlying theory to shape their theoretical framework in mental health in the Muslim mental health literature except for Mackenzie and others (2004).

In addition to the authors mentioned above, there are many other researchers who used TPB/TRA in psychology and health disciplines for different topics (Ajzen, 1991, 2006; Ajzen & Fishbein, 2004; Ajzen et al., 2011; Fishbein & Ajzen, 2010) rather than mental health, and some others recommended the use of TPB/TRA in mental health professions (e.g., Mackenzie et al., 2004). Therefore, there is a gap in the use of TPB/TRA and their integration will meet an important need in the literature of mental health services. This includes counseling, especially for Muslims and mental health research and practice. Therefore, the current researcher elaborated a little more on TPB/TRA in following sections.

Originating from the first version of TRA, TPB is a theory focusing on predicting an individual's voluntary (volitional, not involuntary ones) action regarding possible choices by focusing on four main constructs. These four constructs include one's attitude (1st), perceived social stigma (social norms, 2nd), Perceived Behavioral Control (PBC, meaning *perceived* self-efficacy, 3rd), and intention (one's motivation or readiness, 4th) toward a specific behavior/action (5th construct).

TPB comes from a psychological perspective that values intrapersonal processes rather than other contextual or physical factors because from a psychological interest perspective/point examining what happens at the intrapersonal (individual) level is more

important than studying the actual/physical factors (Ajzen, 1991). Therefore, perception of behavioral control means one's perceived self-efficacy to perform the behavior. The author did not deny the importance of contextual factors (e.g., the role of having knowledge about the topic, having access to resources to execute the behavior). However, he did not include any constructs in the main TPB framework to measure such contextual aspects while predicting the behavior. Therefore, the theory gives utmost attention to individual processes (the first four constructs) in predicting or explaining the targeted behavior (the 5th construct). However, the author also emphasized that if contexts and/or actions are not familiar to a person, then it is important to pay attention to other factors (e.g., knowledge, resources, background).

As it has been mentioned above, TPB emerged from the former TRA model after Ajzen had added PBC (perceived behavioral control, meaning perceived self-efficacy) as a new construct. This was done in addition to including attitude, social norm, and intention to predict or explain behavior. However, Fishbein and Ajzen (2010) later improved the first version of TRA so that now the current TRA conceptually and visually includes the PBC construct, the background factors (e.g., education, culture, knowledge, family, economic situation), and how these factors affect the main constructs (attitudes, social stigma, PBC, and intention) to predict or explain the behavior.

Although researchers use different names like TPB, TRA, or TPB/TRA, they are almost identical things with some minor differences. *Therefore, in this study the current researcher utilized both TPB and TRA and mentioned them together as one theory TPB/TRA.* Although it is a progress to include TPB/TRA in some important contextual

factors in the last recent model, the authors (Fishbein & Ajzen, 2010) still did not address/study the background variables (e.g., culture, cultural beliefs) very well in the many empirical studies they have conducted.

In sum, many researchers utilized TPB/TRA in different studies throughout different disciplines. They found TPB/TRA to be effective and provide a well-established theory for designing frameworks, studies, and interventions. Therefore, the inclusion of TPB/TRA and SEM as two main lenses to create and shape the contextual theoretical framework for the current study will close an important gap. The current researcher provided more information about each of the constructs of TPB/TRA later in this chapter when he elaborates on the constructs of the theoretical framework.

The Social Ecological Model (SEM)

Although TPB/TRA included important contextual factors (e.g., background, knowledge, culture, education, information), the researchers who utilized TPB/TRA like Ajzen and Fishbein paid more attention to individual/intrapersonal dynamics rather than the larger context. Therefore, inclusion of the Bronfenbrenner's Social Ecological Model (SEM) is important because almost all the researchers in the Muslim mental health literature stressed repeatedly the importance of paying attention to the contextual factors even though just few mentioned or explained how to use SEM (e.g., Ahmed, 2012; Martin, 2015). The researcher stressed the necessity of including all aspects (e.g., attitudes, stigma, sex, culture, religion, knowledge, institutional factors, policies, global issues, and community factors) to understand Muslims' approach toward formal mental health issues and services.

In addition to the Muslim mental health literature, the researchers in the public health discipline paid attention to contextual factors and SEM more than any other models or theories to understand and address many different health issues. Therefore, using SEM in this current empirical study will fill an important gap in the Muslim mental health literature.

SEM, also known as human ecological theory or just ecological theory, was proposed by Urie Bronfenbrenner in 1970 as a conceptual model to take the environmental conditions into account rather than just intrapersonal/individual and genetic factors (Bronfenbrenner, 1977). He kept improving the model from 1970 until 2005. The model was a kind of reaction to individual approaches in psychology that focused solely on individuals isolated from their contexts (McLeroy et al., 1988). Therefore, Bronfenbrenner (1977) stressed the importance of seeing the person within their contexts and all the constant dynamic relationships in those contexts. He explained each of the levels (e.g., microsystem, mesosystem) and how to use the model for the experimental studies. SEM consists of four levels including microsystem (including the individual themselves), mesosystem, exosystem, and macrosystem. According to the model, all these levels are interrelated and have dynamic relationships with one another, which means a change in one affects the others as well. A thorough understanding of a person is possible if one sees and understands the individual within these contexts rather than isolated from their circumstances (Bronfenbrenner, 1977).

The model has affected many studies and professions (e.g., psychology, public health, medicine, education, and social work). McLeroy et al. (1988) explained how some

researchers criticize individual approaches from a SEM perspective because the individual approaches neglect the role of other contextual aspects (e.g., social, global) and just focus on personal life-style. Such individual approaches can create victim-blaming situations (Freire, 1972) where the victims are disserved and blamed for the issues they face, creating important ethical dilemmas. Therefore, McLeroy et al. (1988) explained how SEM could be utilized to focus both on individual and environmental factors for health disciplines. They noted that many researchers combined some individual theories with SEM to study their topic of interest.

In summary, many researchers utilized SEM to understand how individuals, groups, and communities function within their contexts at individual, microsystem, mesosystem, exosystem, and macrosystem levels and the constant interactions among these levels for accurate and effective assessment, intervention, and evaluation. In this way, the researchers and practitioners can increase the quality of health for all by improving the conditions at all levels simultaneously.

The researchers stressed the inclusion of SEM or its perspective much more often when they utilized intrapersonal/individual theories (e.g., TPB/TRA, health belief model) in the public health literature (Adelman et al., 2008; Bronfenbrenner, 1977; Cottrell et al., 2015; Freire, 1972; Holmes, 2013; Hovell et al., 1994; Kågesten, Parekh, Tunçalp, Turke, & Blum, 2014; McLeroy et al., 1988; Plant et al., 2010; Prilleltensky, 2003, 2008, 2012; Rhodes et al., 2011; Ybarra, DuBois, Parsons, Prescott, & Mustanski, 2014). One thing that most of these researchers strongly emphasized is how it would be unethical and inappropriate if researchers and/or practitioners do not take a contextual perspective into

consideration. Some authors expressed this concern clearly and repeatedly as unethical (Freire, 1972; Holmes, 2013; Prilleltensky, 2003, 2008, 2012; Prilleltensky & Prilleltensky, 2003). They constantly stressed that an accurate wellness could be achieved only if researchers and/or practitioners think from a contextual perspective. The researchers in the Muslim mental health literature stressed the same perspective. The researchers warned against considering and implementing an intervention without considering the contextual factors. Similarly, Hayes et al. (2012) also constantly stressed how to consider their approach, Acceptance and Commitment Therapy (ACT), in a contextual perspective while providing mental health services. They constantly used the phrase “ACT in context” in their studies and/or presentations to stress the importance of having a contextual perspective, and Tanhan (2014) explained how ACT could be utilized with Muslims from such a contextual perspective.

Similarly, Holmes (2013) explained how not taking contextual factors like cultural factors, social economic situations, and political processes would cause apolitical, acontextual, and a merely clinical/medical gaze that could assign blame to people. In his book, *Pedagogy of the Oppressed*, Freire (1972) also explained how lack of contextual and cultural consideration of a person, group, and nation could cause oppressive victim-blaming. The authors addressed how people, including key people like the ones providing health services, are being manipulated by the system. As a result, even key people forget about the larger systems they live in and just get stuck within their individual life and circumstances, evaluating other people and blaming them from such an individual, narrow, and acontextual perspective. Prilleltensky and Prilleltensky (2003)

stressed, especially regarding minority people, a critical health psychology perspective that calls attention to work with entire communities at the individual, interpersonal, and collective levels from an ecological perspective. They stressed the importance of working at all spheres of the ecological model both from a treatment and a prevention perspective. Similarly, Prilleltensky (2012) underlined that wellness is possible if justice and wellness exist simultaneously in all spheres. He added that if wellness is not available at one level it will negatively affect the others. Adelman et al. (2008) also explained how social ecological factors (e.g., poverty, neighborhood, culture) affected some minority groups' lives, including their health (e.g., life satisfaction, longevity) in the U.S. They also stressed how it is crucial to be aware of these factors rather than just focusing on individual factors, which could lead to blaming the person and/or their community. Holmes (2013) strongly recommended health providers, their educators, educational institutions, and all people to be more mindful of structural competency (being aware of how sociopolitical structures work and affect people and their communities). On one hand, structural competencies can cause biological, psychological, social, and political issues that could simultaneously ruin many lives, and more severely for the unprivileged. On the other hand, the same structural circumstances could increase life quality for all.

Paying attention to the contexts people live within was also mentioned in counseling literature (ACA, 2014; Arredondo, Tovar-Blank, & Parham, 2008), and it seems this perspective is becoming more central to the counseling discipline with multicultural and social justice becoming the fourth and fifth forces in the counseling profession. Almost all researchers in the relevant literature suggested a comprehensive

approach to understanding Muslims and their approaches to mental health services. However, just a few of them (e.g., Ahmed, 2012) talked about and utilized SEM. The use of such a comprehensive perspective also goes well with the spirit of Islam (Hamidullah, 2007). Therefore, it will not be very ethical, appropriate, and effective if the mental health providers as researchers or practitioners do not take into account the larger contexts and their interactions with one another while studying Muslims' approach toward mental health services. Based on all these, the use of SEM as an underlying model for the theoretical framework of the current study is very appropriate and necessary, which will fill an important gap.

Contextual Theoretical Framework (Model) of the Current Study

In the previous sections, it was explained how the use of TPB/TRA and SEM together is appropriate to understand Muslims' approach to mental health services. Almost all researchers in the Muslim mental health literature explained researchers and practitioners better to consider a comprehensive perspective to understand Muslim mental health. Based on all these, the current researcher utilized TPB/TRA and SEM, two well-established and commonly used theories/models, as underlying lenses to create and shape the theoretical framework of the current study. In this way, mental health providers as researchers and practitioners can have more contextual, systematical, empirical, and effective research and interventions.

The use of TPB/TRA and SEM together is also important because TPB/TRA as an individual/intrapersonal theory provides a clearer model that makes empirical studies more possible, while SEM is a more comprehensive model when one considers

TPB/TRA within in it. This combined comprehensive approach may also be culturally relevant as Muslims come from more collectivist cultures and face many psychosocial issues at global, larger and local communities, interpersonal, and intrapersonal/individual levels.

McLeroy et al. (1988) explained and cited many researchers who used SEM with some other individual theories to look at health issues (e.g., child abuse, sexual health). For example, some researchers (Hovell et al., 1994; Plant et al., 2010) used different individual theories with SEM to study sexual health among different groups. In these studies, the researchers utilized SEM in paying attention to the larger contextual factors and used individual theories to provide information/knowledge at individual levels. Similarly, using an individual/intrapersonal theory (e.g., TPB/TRA) with SEM could be another example of integrating individual theories and SEM as mentioned above.

To the knowledge of the current researcher, there are no other researchers who utilized TPB/TRA and SEM together in the mental health literature for empirical studies. However, there are some researchers who used TPB/TRA within a larger context. For example, Morrison and others (2002) explained that TRA and TPB are similar models, and they utilized TRA and some aspects of SEM to test their model on young pregnant mothers (younger than age of 17, $N = 230$ at time one and $N = 235$ at time two) who had used marijuana. They found that the TRA model was a good model to predict the mothers' future use of marijuana. The authors found significant paths among the main constructs of their model (TRA) (e.g., attitude and intention, Beta = .538; intention and use, Beta = .476) as it is hypothesized in TRA. However, the authors did not find a

significant path between social norms and intention, while TRA model hypothesizes such a significant relationship. The researchers did not measure PBC but paid attention to some other contextual factors like prior use and peers' effect as it is suggested in SEM. The researchers found that prior use had a significant relationship with the main constructs including intention (Beta = .400) and actual use (Beta = .315). These results show that as a contextual (coming from SEM perspective) factor, prior use explained an important proportion of the two main constructs of TRA.

Another important factor that requires integrating TPB/TRA and SEM is the role of beliefs and their effect on one's approach toward a behavior. Fishbein and Ajzen (2010) through TPB/TRA visually depicted and stressed the role of beliefs toward the first three main constructs (e.g., attitudes, perceived social stigma) as important. However, beliefs are not counted and studied empirically as main constructs in TPB/TRA. Cultural beliefs toward mental issues and health services are more related to SEM perspective and constitute an important construct in the Muslim mental health literature.

Based on all these, TPB/TRA and SEM are worth considering together in order to more comprehensively understand Muslims' approach to the mental health. Furthermore, some researchers (Aloud, 2004; Aloud & Rathur, 2009; Amri & Bemak, 2013) from the Muslim mental health literature suggested the use of TPB/TRA with SEM to understand Muslims' approach toward mental health issues and services. Similarly, Romano and Netland (2008) called for counselors to utilize TPB/TRA together both for research and practice. All these researchers found the integration of these theories appropriate;

therefore, the current researcher utilized TPB/TRA and SEM to create and shape the contextual theoretical framework of the current study. The framework includes seven constructs and four control variables, but the researcher only focused on part of the framework.

The Figure of the Current Contextual Theoretical Framework (Model)

Based on all the studies mentioned above, in order to draw a well-established contextual theoretical framework, the current researcher utilized a thorough literature review of Muslim mental health (the concept map), TPB/TRA, and SEM as underlying lenses to create the well-grounded contextual theoretical framework (see Figure 1 in Chapter I).

As seen in Figure 1 in Chapter I, the current researcher focused on the first five constructs and the four control variables for this current study. The first five constructs include CBMHP-cultural beliefs (1st construct), KFMHS-knowledge (2nd construct), ATFMHS-attitudes (3rd construct), PSTSFMHS-stigma (4th construct), PBC (5th construct), intention toward seeking formal mental health services (6th construct), and actual use of formal mental health services i.e., behavior (7th construct). However, the current researcher will only focus on the first five constructs and the four control variables. In the following sections, the current researcher provided more detailed information about each construct, and how he utilized TPB/TRA and SEM as lenses for the framework.

Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments (CBMHP-Cultural Beliefs)

This is the first construct in the theoretical framework that the current researcher examined to understand more about Muslims' approach to mental health issues and services. The researcher included this construct because it was mentioned throughout the Muslim mental health literature as one of the most important concepts. In addition to that, beliefs have an important role in TPB/TRA, though the CBMHP-cultural beliefs construct is not stressed and studied in TPB/TRA. In TPB/TRA, some other beliefs (i.e., behavioral, normative, and control beliefs) are stressed because they lead to some main constructs (e.g., attitude, perceived social stigma). However, the researchers in the Muslim mental health literature clearly stressed that the CBMHP-cultural beliefs concept is the one that matters. The researchers solely utilized TPB/TRA in general did not focus on cultural beliefs since they are not significant predictors of behavior based on TPB/TRA. However, Ajzen (1991) stressed that the importance of inclusion of such other contextual factors (e.g., culture, belief) increases when environments and/or actions are new to participants. In this current study, mental health issues, formal mental health services, and all related concepts are relatively new to the most of the Muslims in the U.S., which have been repeated by the majority of the researchers in the Muslim mental health literature. In addition to that, TPB/TRA visually depicts that background factors (e.g., culture) affect the main constructs of TPB/TRA (e.g., attitudes). Therefore, from TPB/TRA perspective the inclusion of the CBMHP-cultural beliefs construct is crucial, and it should be an independent variable/construct.

From SEM aspect, the consideration of the CBMHP-cultural beliefs construct is crucial since culture constitutes and affects the other factors in life's contexts, which includes microsystem (e.g., individual, family, peers), mesosystem, macrosystem, and exosystem levels. From the SEM perspective, CBMHP-cultural beliefs should be included in the framework as an independent variable/construct.

To summarize, understanding Muslims' CBMHP-cultural beliefs (1st construct) will meet an important need in the literature. In addition, understanding the relationship among the nine variables (five constructs and four control variables) will meet some important gaps in the literature. Based on Muslim mental health literature, TPB/TRA, and SEM perspectives the inclusion of this first construct as an independent variable/construct that explains the other constructs (e.g., attitudes) is important. The second construct, explained in the following section, is the second independent variable that is closely related to the first construct.

Knowledge about Formal Mental Health Services (KFMHS-Knowledge)

This is the second construct in the framework. Almost all of the researchers in the literature strongly encouraged that researchers and practitioners to consider Muslims' KFMHS-knowledge. It is also an important background factor in TPB/TRA, and it is even more important in SEM.

From TPB/TRA perspective, knowledge about a subject is a background variable and not a main variable, and yet knowledge about a subject affects the main constructs (e.g., attitudes, stigma). In general, the researchers conducting their studies from TPB/TRA perspective stressed and found knowledge to be a non-significant predictor

(Ajzen, 1991; Ajzen et al., 2011). However, they also highlighted that the weight of such background variables, like knowledge, change from context to context. Ajzen (1991) explained how if someone does not know about the subject of interest, then the inclusion of knowledge as a main construct becomes a necessary and empirical question. In the case of this study, based on a thorough literature review, Muslims are not very familiar with the mental health issues and services; therefore, the inclusion of this construct is necessary from TPB/TRA perspective. From the SEM perspective, having knowledge of the subject of the interest is crucial, which in this case is KFMHS-knowledge. From the SEM perspective, making sure people at the individual, group, and community levels have KFMHS-knowledge is one of the main concerns because having knowledge about actual services and access to them is more important than other individual processes (e.g., attitude, preference). As the current researcher explained in the SEM section, most of the researchers who designed their studies from the SEM perspective focused on increasing people's knowledge and awareness of the subject of interest so that people can act on the targeted behaviors. The researchers from the SEM perspective found the participants' high level of knowledge about the subject of interest to be a good predictor of the actual behavior. Cottrell and others (2015) also explained how the role of knowledge is stressed in many different individual/intrapersonal and community theories. Based on all the Muslim mental health literature, TPB/TRA, and SEM, the current researcher found this second construct also important and included it as the second independent construct/variable.

Attitudes toward Seeking Formal Mental Health Services (ATFMHS-Attitudes)

The third construct in the theoretical framework is attitudes toward seeking formal mental health services (ATFMHS-attitudes). The current researcher included this construct because the researchers in the Muslim mental health literature found the construct to be one of the most important and commonly studied concepts. From TPB/TRA perspective, attitude changes in importance from subject to subject and from context to context. It is very rare to see a study from TPB/TRA finding attitudes as a non-significant predictor toward the behavior of interest. From SEM perspective, understanding attitudes at the individual level is important. What is more important is understanding ATFMHS-attitudes construct within the contexts of other constructs (e.g., CBMHP-cultural beliefs). Based on all these, ATFMHS-attitudes is a dependent construct/variable in the theoretical framework.

Perceived Social Stigma toward Seeking Formal Mental Health Services (PSTSFMHS-Stigma)

Perceived social stigma toward seeking formal mental health services (PSTSFMHS-stigma) is the fourth construct. It is also one of the most commonly studied concepts in the Muslim mental health literature. Most of the researchers stressed that CBMHP-cultural beliefs and lack of knowledge about mental health issues and services lead to PSTSFMHS-stigma, and together they cause underutilization of the mental health services. In TPB/TRA, perceived social stigma is a main construct that most of the times the researchers found it as a significant construct to predict the behavior of interest (Ajzen, 1991, 2006; Ajzen et al., 2011). From SEM perspective, perceived social stigma is also a crucial construct that needs to be examined because it is not just about

individuals but also how the other factors (e.g., peers, family, media, culture) in the community affect the person. Understanding PSTSMHS-stigma and its relationship with the rest of the constructs and control variables will close some important gaps both for research and practice. Based on all these, PSTSMHS-stigma is a dependent variable in the framework.

Perceived Behavioral Control toward Seeking Formal Mental Health Services (PBC)

The fifth construct of the framework is perceived behavioral control toward seeking formal mental health services (PBC). The researchers in the Muslim mental health literature mentioned this construct indirectly without naming the construct as PBC, self-efficacy, or perceived self-efficacy. Therefore, clearly stating and studying this construct as PBC is important. More importantly, this construct has a very important role in TPB/TRA because it is one of the most significant predictive constructs of behavior. In addition, from a SEM perspective PBC is important since it represents how an individual perceives not just their own ability or capacity but also how other contextual factors might affect the person dramatically while they seek the formal mental health services.

Based on all these, including and directly naming this construct as PBC will be a significant contribution to the proposed study of Muslim mental health literature.

Therefore, in the framework, PBC is also a dependent construct. Understanding the level of Muslims' PBC and its relationship with the rest of the four constructs and the four control variables will bridge some important gaps.

In sum, the current researcher only focused on these first five constructs and the control variables of the theoretical framework (see Figure 1 in Chapter I) for this current

study. However, it is the wish of the current researcher that he and/or some other researchers will do some follow-up studies to examine/test the whole framework by meeting limitations such as: getting enough participants, having well-established scales for intention and behavior constructs, and running path analysis to test the full model.

Based on all these studies, the current researcher examined, through the proposed theoretical framework, how the first two constructs explain the other three constructs. That means understanding how CBMHP-cultural beliefs (1st construct) and KFMHS-knowledge (2nd construct) explain ATFMHS-attitudes (3rd construct), PSTSFMHS-stigma (4th construct), and PBC (5th construct) for the adult Muslims in the Southeast. Studying these constructs in this way is the primarily result of utilizing TPB/TRA and SEM as lenses for this current study's theoretical framework. This is quite different from how most of the other researchers in the Muslim mental health literature studied these constructs because most of the researchers primarily focused on ATFMHS-attitudes and taking the attitudes as the only dependent variable.

In addition to all these, the current researcher found it might be helpful to briefly provide some information about the sixth (intention toward seeking formal mental health services) and seventh (behavior meaning actual use of formal mental health services) constructs of the framework though he did not examine them in this current study.

Intention toward Seeking Formal Mental Health Services

Intention is the sixth construct in the current theoretical framework. Intention means one's readiness (Ajzen, 2006) or motivation (Ajzen, 1991) to perform a behavior of interest. Intention is based on the first main three constructs (attitude, perceived social

stigma, and PBC) of TPB/TRA. It means intention is a mediator (Ajzen, 1991) in TPB/TRA. Intention is important because in most of the studies from TPB/TRA perspective the researchers found PBC and intention together most of the times explaining the most variance in the behavior (Ajzen, 1991; Ajzen et al., 2011; Fishbein & Ajzen, 2010).

Behavior (Actual Use of Formal Mental Health Services)

This is the last construct in the framework for the current study, and it is also the last construct in TPB/TRA. Ajzen (2006) explained behavior as an observable response toward a subject of interest. In the next section, the current researcher provided more information about the four control variables in the context of the proposed theoretical framework.

Control Variables

The current researcher provided some in-depth information in the previous sections about how the researchers in the Muslim mental health literature studied different control variables. The researchers encountered many contradictions, finding different control variables to be significant or not related to the constructs of the framework. Therefore, the current researcher focused only on the following control variables including participants' education, sex, past behavior in terms of use of mental health services, and race/ethnicity. Based on Muslim mental health literature, TPB/TRA, and SEM, it is important to examine such control/background variables to understand the relationship between the control variables and the five constructs in the proposed framework.

Chapter II Summary

The Muslim community in the Southeastern U.S., being a small part of the larger Muslim population in the U.S., faces many psychosocial issues and underutilizes mental health services. Underutilization of mental health services to address psychosocial issues affect both Muslims and non-Muslims, because in today's global world the issues of one individual or community are more likely to affect everyone and their quality of life than at any other time in history. However, there is lack of research on Muslims in the Southeast regarding their approach toward mental health services, which makes this current study significant.

Overall, the researchers who examined Muslims and mental issues made it clear that there are unmet needs due to Muslims underutilizing the mental health services. The underutilization is mainly due to the following reasons: strong CBMHP-cultural beliefs, low level of KFMHS-knowledge, strong negative ATFMHS-attitudes, high level of PSTSMHS-stigma, and low level of PBC.

Some researchers studied many other concepts (e.g., level of acculturation, economic factors) yet the current researcher found the five constructs of the current theoretical framework as the most important to focus on, based on a thorough literature review. In addition, there are some contradictory results regarding the five constructs because, on one hand, few of the researchers found that Muslims in their studies overall had positive approaches toward seeking formal mental health services. This means the Muslim participants had high or moderate level of KFMHS-knowledge, low or moderate negative ATFMHS-attitudes, and low or nonsignificant level of PSTSMHS-stigma, and

high level of PBC. On the other hand, the majority of the researchers found Muslims had a negative approach toward seeking mental health services. This means they had poor KFMHS-knowledge, strong negative ATFMHS-attitudes, strong level of PSTSFMHS-stigma, and low level of PBC. The researchers found even more controversial results when they studied how control variables (e.g., education, sex) are related to Muslims' approach toward seeking mental health services. Therefore, the current researcher only focused on four control variables in the framework.

In addition to all these, another crucial gap is a lack of well-established theoretical framework in the Muslim mental health literature. Only a few researchers in the literature utilized theoretical frameworks for their study, though most of them mentioned the importance of using well-grounded theories and/or theoretical frameworks. Therefore, the current researcher created the proposed contextual theoretical framework based on Muslim mental health literature, TPB/TRA, and SEM so that the framework is well grounded in practice, research, and theory.

Based on all these, there is an important gap in understanding how adult Muslims living in the Southeastern U.S. approach mental health issues and use formal mental health services. Therefore, in this study the current researcher examined how CBMHP-cultural beliefs (1st construct) explains ATFMHS-attitudes (3rd construct), PSTSFMHS-stigma (4th construct), and PBC (5th construct). Similarly, he also examined how KFMHS-knowledge (2nd construct) explains the third, fourth, and fifth constructs. Another important thing related to the theoretical framework is examining the

relationship among the four control variables (education, sex, past behavior, race/ethnicity) and the five constructs.

Finally, understanding how Muslims conceptualize mental health providers is another important gap. Therefore, the current researcher included one open-ended question (e.g., What does a counselor mean?) to understand how Muslims conceptualize mental health providers.

This current study is important and bridges many gaps because most of the researchers in the literature of Muslim mental health noted that Muslims all around the world, including the ones in the U.S. and Southeast of the country, have some psychosocial issues. The researchers also noted that the Muslims underutilize the formal mental health services. Most of the researchers strongly suggested understanding Muslims' approach toward seeking formal mental health services by utilizing well-grounded frameworks to go further in research and practice.

Similarly, nearly all researchers in the Muslim mental health literature stressed the importance of paying attention to contextual factors (e.g., CBMHP-cultural beliefs) for more culturally, spiritually, and structurally appropriate interventions and services. Although a few researchers have explained culturally appropriate interventions for Muslims (e.g., Cook-Masaud & Wiggins, 2011; Strack et al., 2016; Tanhan, 2014), more studies and integrations are needed for effective counseling services. Importantly, in their study with 88 counselors in the U.S. Cashwell et al. (2013) found that although participants rated the integration of religious/spiritual aspects into counseling as very important, they integrated these aspects less frequently into their counseling practice than

how ratings of importance would suggest. Young and Cashwell (2011) stressed attending client's spiritual/religious perspective by stating, "meeting the client where [they] are, without judgment and with compassion, is the foundational building block" (p. 22) to address issues in counseling. Based on these findings, it is first necessary to assess and understand how Muslims in the Southeastern U.S. approach mental health issues generally and how they seek out formal mental health services. In this way, mental health providers, as researchers and practitioners providing services to Muslims in the U.S. and especially those in the Southeast, will be more able to understand Muslims within a culturally contextual perspective. As a result, mental health professionals will be able to provide more culturally, spiritually, and structurally appropriate services. Counselors may then more effectively assist Muslims' in addressing their psychosocial issues to enhance their quality of life, thereby improving overall wellness for everyone due to the global context in which we all live.

CHAPTER III

METHODOLOGY

The current study focuses on understanding how adult Muslims who have lived in the Southeastern U.S. approach seeking formal mental health services. In Chapter I, an overview of the study was provided while Chapter II described a detailed literature review of Muslims' approach toward mental issues and seeking mental health services. Based on the previous two chapters and the gaps present in the Muslim mental health literature, a study based on well-established theoretical foundations is clearly needed to understand adult Muslims' approach toward mental issues and mental health services. Therefore, this chapter includes a detailed description of the methodology for the current study and describes the research questions, participants, instruments, procedures, data analysis, pilot study, and changes to the full study based on the pilot study.

Research Questions

The first seven research questions explore the descriptive statistics of the first five constructs of the proposed theoretical framework and the relationships among these constructs. The final research question examines how Muslims conceptualize/define mental health providers (e.g., counselors). The first five constructs of the proposed theoretical framework are as follows: cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-Cultural Beliefs), knowledge about formal mental health services (KFMHS-Knowledge), attitudes toward seeking formal mental

health services (ATFSMHS- Attitudes), perceived social stigma toward seeking formal mental health services (PSTFSMHS-Stigma), and perceived behavioral control toward seeking formal mental health services (PBC).

Research Question 1: What are the descriptive statistics (e.g., mean, standard deviation) for the participants' scores in terms of the five constructs including CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTFSMHS-stigma, and PBC?

Research Question 2: Is the path between participants' scores on a measure of ATFMHS-attitudes and the participants' CBMHP-cultural beliefs scores significant?

Research Question 3: Is the path between participants' scores on a measure of PSTFSMHS-stigma and the participants' CBMHP-cultural beliefs scores significant?

Research Question 4: Is the path between participants' scores on a measure of PBC and the participants' CBMHP-cultural beliefs scores significant?

Research Question 5: Is the path between participants' scores on a measure of ATFMHS-attitudes and the participants' KFMHS-knowledge scores significant?

Research Question 6: Is the path between participants' scores on a measure of PSTFSMHS-stigma and the participants' KFMHS-knowledge scores significant?

Research Question 7: Is the path between participants' scores on a measure of PBC and the participants' KFMHS-knowledge scores significant?

Research Question 8: How do participants conceptualize/define mental health providers (e.g., counselors)?

Participants

The participants in this study were adults aged 18 or older who identify themselves as Muslims and have lived in the Southeastern U.S. for at least two months. In total 209 participants were used for the statistical analyses, and in depth information is provided in Chapter IV. Systematic attempts were made to gain a diverse sample in terms of education, sex, past behavior regarding use of formal mental health services, and

race/ethnicity. The sampling procedure was convenience sampling; therefore, participants were recruited from various organizations, email lists, and social media to reach out to different subgroups of the population. Organizations such as Muslim Student Associations (MSA), Research Association of Muslims (RAM), two large Islamic organizations in the area including Islamic Center of Greensboro (ICG) and Islamic Center of Triad (ICT), and the Office of Intercultural Engagement (OIE) at the University of North Carolina at Greensboro (UNCG) will be approached to solicit participants. Individuals were asked to participate through the consent form and letter to participate if they identify themselves as Muslim and/or entered/accepted Islam and have lived in the Southeastern U.S., at least for two months.

To determine sample size, general guidelines for the use of Structural Equation Modeling (SEM) were considered. According to Kline (2016), sample size should be determined based on the complexity of the model that is empirically examined. However, he explained that many studies from different disciplines that show a median size of 200 is suggested while 200 participants might be too small for a complex model. More complex models, with more parameters, require larger sample sizes, thus, a ratio of observations (meaning cases or participants) per parameter (statistical estimates) is recommended in order to come with a reasonable sample size for the study. The most ideal ratio is having 20:1 meaning 20 participants per estimates (parameter); however, 10:1 is considered acceptable (Kline, 2016).

In this current study the whole proposed model (theoretical framework) is complex; however, only part of the model is empirically examined meaning the

relationships among first five variables and background (control) variables. Therefore, the studied model (part) is less complex compared to the whole model (theoretical framework). Therefore, given that the examined part is not too much complex, the ratio of 10:1 per parameter was utilized to calculate sample size in the current study. In SEM, parameter mean characteristics of the model of interest to researchers (e.g., the variances, regression coefficients, covariance among variables, and errors (B. Henson, personal communication, 2016; Stoelting, 2002).

In this current study, there are nine variables: two main exogenous (independent) variables consist of CBMHP-cultural beliefs and KFMHS-knowledge; three endogenous (dependent) variables consist of ATFMHS-attitudes, PSTSFMHS-stigma, and PBC; four background (control) variables consist of education, sex, past behavior, and race (ethnicity). Based on the examined part of the model, there are 39 parameters that are calculated: 32 path coefficients, four covariance, and three errors. The 32 path coefficients consist of 20 from background (control) variables to the other five exogenous and endogenous variables (e.g., four path coefficients from education to each of the five variables; four path coefficients from sex to the first five variables) and 12 path coefficients from the two exogenous variables (CBMHP-cultural beliefs and KFMHS-knowledge) to the endogenous variables (ATFMHS-attitudes, PSTSFMHS-stigma, and PBC). The four covariance are between CBMHP-cultural beliefs and KFMHS-knowledge; ATFMHS-attitudes and PSTSFMHS-stigma; ATFMHS-attitudes and PBC; and PSTSFMHS-stigma and PBC. The three error parameters are for each of the endogenous variables (ATFMHS-attitudes, PSTSFMHS-stigma, and PBC).

Based on all these, the researcher aimed for minimum of 390 participants; however, this number was not achieved and he considered that the examined part of the model is not very complex, less than 10:1 ratio is also accepted based on experts' view (J. Willse, personal communication, 2016; Kline, 2016). Kline explained that below 10:1 is acceptable especially considering that if the number of participants pass 200 (Kline, 2016) though that the more ratio falls below 10:1 it is more likely to see "trustworthiness falls and greater technical problems in analysis" (Kline, 2016, p.17). He also stated most of the studies use SEM do not meet 20:1 or 10:1 ratio.

The researcher also had a second plan if he had not reached 390 or at least 200 participants considering the current sociopolitical context of the world and especially the U.S. go through at that time; in such a case, the following perspective would have been followed. From a simple regression analysis perspective and based on preliminary/priori G*Power 3.1 (Faul, Erdfelder, Buchner, & Lang, 2009) analysis with given alpha, effect size, and power, a minimum of 118 participants would have been necessary taking F as test of family, linear multiple regression: fixed model, R^2 deviation from zero as statistical test, power of 0.8, alpha level at 0.05, moderate effect size as Cohen's $f^2 = 0.15$, and number of predictors as 10: two independent (CBMHP-cultural beliefs and KFMHS-knowledge) and the four background (demographic) variables with their subcategories.

The current researcher aimed to pass the minimum required number of participants in case there is a need to eliminate participants for any reason, such as incomplete responses. A moderate effect size was considered to be consistent with earlier research in the area (e.g., Aloud & Rathur, 2009).

Procedures

Following approval by UNCG's Institutional Review Board (IRB), the researcher contacted the organizations listed above and shared the link to the survey with individuals in charge of the organizations so that they can distribute it through different ways (e.g., texts, email lists, social media). The researcher also provided iPads and/or computers at some settings (e.g., ICT, ICG) to make it easy for participants to complete the instrumentation. A printed version of the survey also was distributed to organizations to increase participation and the diversity of the sample, as all participants may have not had access to the internet and/or a computer or device to access the internet. The participants who wished to respond later were provided with a stamped envelope and printed version of the survey so that they could send the completed survey to the researcher's office. Additionally, the researcher also collaborated with each organization to identify a specific safe and private place for participants who wish to complete and submit the printed version in the envelope.

The link for the questionnaire or printed version consisted of a cover letter, informed consent, the questionnaires, and a demographic (background) survey. The cover letter included a brief explanation of the study, approximate time required to complete the study, a description of an optional dinner at UNCG that the researcher will organize after the results have been analyzed. In this way, anyone interested in the study can learn the results and have a further dialogue related to the study. The research package included information about counseling services in case of need, instructions related to completion of the informed consent, and an invitation to contact the researcher with questions. The

informed consent included a brief description of the study, approximate time to complete the study, and the potential risks and benefits associated with participation. It specified that participation is voluntary and that agreement to participate can be withdrawn without penalty at any time. To protect privacy, participants were informed not to sign the form. For the printed packages, the participants were provided with two copies of the informed consent and the participants were asked to keep one.

Participants in the study completed the instruments and a demographic questionnaire. The demographic questionnaire and psychometric properties of the instruments are described below. The demographic questionnaire and all the scales used for the pilot study are included in Appendix G. For the original scales (without adaptation; See Appendix H). Completing the survey took about between 20 and 30 minutes. For the final full survey, see Appendix I.

Instruments

Cultural Beliefs about Mental Health Issues/Problems, Their Causes and Treatments (CBMHP-Cultural Beliefs) Scale

The influence of cultural and religious beliefs about the causes and treatments of mental health issues was assessed through the Aloud's (2004) *Cultural Beliefs about Mental Health Problems* (CBMHP) scale. The original CBMHP consists of 11 Likert-type items rated as 1 = *False*, 2 = *Probably False*, 3 = *Probably True*, and 4 = *True*. Examples of items include "Mental health or psychological problems can be caused by 'Ajeen' (evil eye); Mental health or psychological problems can be treated using 'Ruqia' (Quranic Recitation)" (p. 120). Aloud developed the scale to measure Arab Muslims' cultural beliefs about mental health issues/problems and their causes and treatments. A

reliability analysis of all items on the scale provided a Cronbach's alpha of .73 (Aloud, 2004) which is in the acceptable range. The scale is appropriate to use as there are few standardized scales developed to measure Muslims' CBMHP-cultural beliefs as they relate to mental health issues.

For the current research, the scale was edited slightly due to the fact that Aloud (2004) created the scale to examine Arab-Muslims' CBMHP-cultural beliefs. Most researchers who benefited from Aloud's scale or similar measures (e.g., Ansary & Salloum, 2012; Bagasra, 2010; Bagasra & Mackinem, 2014) provided five intervals with options from *strongly disagree (0)* to *strongly agree (4)*. Other researchers have discussed the importance of utilizing at least five intervals and intervals such as strongly agree, agree, neutral/undecided/neither agree or disagree, disagree, strongly agree (Fishbein & Ajzen, 2010; Mackenzie et al., 2004). Therefore, the current researcher edited Aloud's CBMHP scale to use a five point Likert-type scale (disagree, somewhat disagree, undecided, somewhat agree, and agree). That means, for the scale, the lowest achievable score is zero while the highest achievable score is 44.

Some researchers who have discussed CBMHP-cultural beliefs have used Aloud's scale to inform new scales and many other researchers have cited Aloud's work. Interestingly, none of the researchers in the literature directly used Aloud's scale to conduct empirical studies. For example, Al-krenawi, Graham, Al-bedah, Kadri, and Sehwaileh (2009) developed a scale with 11 items to measure cultural beliefs of Arabs cross-culturally among four countries, yet the Cronbach's alpha was only .60. Bagasra (2010) developed a scale with 12 Likert-type items to examine cultural beliefs about

mental issues but did not include any items about cultural treatments for mental issues. Her scale had an overall Cronbach's alpha for 0.78. It is likely that many researchers have drawn from but not directly used Aloud's scale because of measure's four intervals and the type of labels, as explained above. Therefore, the current researcher utilized the scale with minor changes to increase the psychometric features of the scale. In this way, using Aloud's (2004) modified scale was the most appropriate for this study.

For the current study the term *issues* was added next to the word *problems* as a synonym since some authors from the Muslim mental health literature stress that Muslims avoid the term *problem*. Furthermore, the use of the term *issue* is culturally more appropriate and are much more common in Islam. Many researchers have noted that Muslims do not see depression as a mental health problem; therefore, the inclusion of *issues* will help the participants consider a range of unpleasant psychological experiences while responding to the study.

Another important point to consider is how to score items to achieve more consistent scores for participants' CBMHP-cultural beliefs' scores. Aloud (2004) and Aloud and Rathur (2009) reported that two items "Mental health or psychological problems can be caused by biological factors (e.g. genetic illness inherited from parents or grandparents)" and "Mental health or psychological problems can be caused by environmental factors (e.g. social stress, war experience, etc." (p. 120) are reverse-scored to test the consistency of participants' responses. In the current study, the item "Mental health or psychological problems can be treated using professional mental health or psychological counseling services" (Aloud, 2004, p. 120), also was reverse coded so that

participants with high score on this scale mean holding stronger/solely CBMHP-cultural beliefs. That means items one, two, and six in the final modified version of the scale were reverse scored for the analyses. Active language was used for all the items so that the items are shorter and more easily understood. The current researcher shared all these modifications with the author (Aloud, 2004) of the scale and he approved all the editing.

Knowledge about Formal Mental Health Services (KFMHS-Knowledge) Scale

The participants' knowledge about mental issues and services was measured through Aloud's (2004) Knowledge and Familiarity with Formal Mental Health Services Instrument. However, the current researcher slightly edited Aloud's scale and called it Knowledge About Formal Mental Health Services (KFMHS-Knowledge) scale. Aloud improved his scale to examine Arab-Muslim participant's knowledge about various types of mental health issues (e.g., depression, anxiety, schizophrenia) and familiarity with mental health services (e.g., common formal mental health interventions, location and means of contacting local formal mental health providers). The scale consists of 11 Likert-type items that are marked using a 4-point Likert type scale (i.e., 0 = *Not at All*, 1 = *Very Little*, 2 = *Somewhat*, and 3 = *Very Familiar*). Scores in the edited version range from 0 to 33, with the higher scores indicating a greater level of knowledge about formal mental health services. Three sample items include "How much do you know about: The available mental health services/settings in your community (e.g. location, phone number, type of services)?; Counselor/therapist's role in mental health services/settings?; How to get professional mental health services/counseling when needed (procedures and requirements)?). Aloud reported an overall Cronbach's alpha of .88 for the scale.

Minor editing was made to the scale to make it more appropriate and inclusive for the current study (e.g., including the word *issues* as a synonym for the word *problems*; adding “counselor, therapist, and clinical social worker” next to the word “psychologist”; changing “clinical social worker” to “mental health providers.” “The Arab and Muslim professionals who practice mental health or psychological counseling [...]” within your community (Aloud, 2004; p. 122) was adjusted to “Mental health providers in your community who know, respect, and consider Muslims’ faith/religion/spirituality while providing services to Muslims.” Through these modifications, the scale becomes easier to read, comprehend, and respond to. The current researcher shared all these changes with the author of the scale, and he found them appropriate.

Inventory of Attitudes, Perceived Social Stigma, and PBC toward Seeking Formal Mental Health Services (IASMHS)

The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS) (Mackenzie et al., 2004) was used to measure attitudes, perceived social stigma, and PBC toward seeking formal mental health services. The scale consists of 24 Likert-type items with three subscales each of which consists of eight items. Participants are asked to rate each item from 0= Disagree, 1= Somewhat Disagree, 2= Undecided, 3=Somewhat Agree, to 4= Agree. Scores on the IASMHS range from 0 to 96, with subscale scores ranging from 0 to 32, and high scores representing a more favorable/positive approach toward seeking mental health services.

Mackenzie et al. (2004) expanded the original version of the instrument based on Fisher and Turner’s (1970) Attitude Toward Seeking Professional Psychological Help Scale (ATSPPHS) to create IASMHS. In addition, Mackenzie et al. improved the

modified scale (IASMHS) in away so that it includes three subscales; the psychological openness subscale that measures attitudes, the indifference to stigma subscale that measures perceived social stigma, and the help-seeking propensity subscale that measures PBC toward seeking formal mental health services. The reliability (Cronbach's alpha) score for the overall scale is .87; thus, the scale demonstrated good reliability.

Mackenzie et al. (2004) reported that the IASMHS has limited construct validity (convergent and discriminant validity) due to the lack of psychometrically valid and reliable measures. However, the authors explained that the measure has discriminant validity as the instrument allows researchers to "distinguish between those who had and had not used mental health services in the past, and those who would and would not use these services in the future" (p. 2410). The authors examined validity through a community sample and a replication sample to examine the validity more in depth. They included few items to examine criterion validity, which examined participants' "past use [and] intentions to use mental health services" (p. 2425). The results showed the scale has criterion validity (e.g., $r = .33$ for past use of professional help and $r = .38$ for intentions to use professional help and these values were significant at $p < .01$ level for the community sample; $r = .21$ for past use of professional help and $r = .34$ for intentions to use professional help for the replication sample). In addition, the authors noted that the measurement has discriminant validity due to its ability to differentiate between the individuals who intend to use professional or nonprofessional help. The measurement was able to identify the "known-groups validity" (p. 2426), which means women in general hold more positive attitudes for mental health services than men. Known-groups

validity is provided when a scale provides expected differences among two or more groups. The authors explained that in general women hold more positive attitudes toward mental health services, and in their study women participants had significantly more positive attitudes than men in both samples ($p < .01$). The authors did not discuss content validity of the measure; however, they adapted and extended one of the most reliable and most used measurements, Fisher and Turner's (1970) ATSPHHS, which could be a good sign of content validity. Collectively, this suggests that the scale overall has sufficient validity to be used in this study.

The current researcher included some minor editing to make the scale more appropriate for this current study. These include adding some words in parentheses to clarify some vocabulary since many participants might have not had English as their first language. For example, "spot, fault, stigma" were added in parenthesis to clarify the word "blot" in the 17th item. The current researcher received permission from Mackenzie who found the editing appropriate and meaningful.

Attitudes toward Seeking Formal Mental Health Services (ATFMHS-Attitudes) Subscale

The attitude subscale of the IASMHS was used to measure participants' attitudes toward seeking formal mental health services (ATFMHS-attitudes). The original reliability (Cronbach's Alpha) score for the attitude subscale is .82, providing evidence of good reliability. The subscale includes eight items all of which are reverse coded. An example of the items on the subscale is "Psychological problems, like many things, tend to work out by themselves" (Mackenzie et al., 2004, p. 2421). High score for this subscale means more favorable ATFMHS-attitudes. The subscale has criterion validity

(e.g., $r = .34$ for community and $r = .18$ replication samples for past use of professional help, and this was significant at $p < .01$; $r = .24$ for community and $r = .20$ for replications samples for intentions to use professional help, and this was significant at $p < .01$).

Perceived Social Stigma toward Seeking Formal Mental Health Services (PSTSMHS-Stigma) Subscale

The indifference to stigma subscale of the IASMHS was created to measure perceived social stigma toward formal mental health services. The (PSTSMHS-stigma) subscale was used in the current study to examine participant's perceived stigma. The original reliability (Cronbach's Alpha) for the subscale has been reported as 0.79, providing evidence of reliability. The PSTSMHS-stigma subscale consists of eight items, seven of which are reverse coded. An example is, "I would feel uneasy going to a professional because of what some people would think" (Mackenzie et al., 2004, p. 2422). High scores for this subscale mean less PSTSMHS-stigma. The subscale has low criterion validity score in terms of the subscales' strength with the past use of professional help ($r = .10$ for community sample, not significant); however, $r = .14$ and was significant ($p < .05$) for the replication sample for the past use of professional help. The subscale also has criterion validity in terms of intentions to use professional help (e.g., $r = .24$ for community and $r = .18$ for replication samples, and that was significant at $p < .01$). Overall, the scores show that the subscale is valid especially considering the dearth of alternative instruments.

Perceived Behavioral Control toward Seeking Mental Health Services (PBC) Subscale

The help-seeking propensity subscale of the IASMHS was used to measure perceived behavioral control toward seeking formal mental health services (PBC) (Mackenzie et al., 2004). The original Cronbach's alpha (reliability) is 0.76, which is in the acceptable range. The subscale consists of eight items, an example is "If I were to experience psychological problems, I could get professional help if I wanted" (p. 2434). High score on this subscale means a greater level of PBC. The subscale has criterion validity (e.g., $r = .34$ for community and $r = .26$ for replication samples for past use of professional help, and this was significant at $p < .01$; $r = .43$ and $.42$ for community and replication samples, respectively, for intentions to use professional help, and this was significant at $p < .01$).

Demographic Questionnaire

A demographic (background) questionnaire was used to gather some basic demographic and background variables especially the four variables (education, sex, past behavior meaning use of mental health services, race/ethnicity).

Data Analysis

A quantitative methodology was used to examine the descriptive correlational data, and a qualitative methodology (content analysis) was used to analyze the last research question. Alpha coefficients were calculated to determine the reliability for each instrument. IBM SPSS 22 and LISREL statistical packages were used to analyze the study's data.

LISREL was used for the path analyses for analyzing the data because there are two independent (exogenous) variables, four control variables which are also independent, and three dependent (endogenous) variables. The two independent (exogenous) variables affect three other dependent (endogenous) variables directly. Some of the dependent variables also affect the other dependent variables. Therefore, there are many interactions, and it will be too difficult and not very accurate to just use regression since alpha level will increase too much if one tries to analyze the relationships among the variables with regression. Therefore, path analysis was used, which is a straightforward extension of multiple regression. The goal of using path analysis is to provide estimates of the magnitude and significance of hypothesized causal connections between sets of variables, and this is best explained by considering a path diagram (Path Analysis, 1997). Path analysis is appropriate because it also provides looking “at direct and indirect effects of predictor variables” (When to Use a Particular Statistical Test, n.d.). In light of these, path analysis fits the proposed theoretical framework and examined part of the framework. In path analysis, one gets many parameters including paths and their coefficients; based on them, one can decide whether the path from one variable to another one is significant or not. Content analysis was utilized for the last research question to identify themes/patterns about how the participants conceptualize/define mental health providers. In the next paragraphs, the researcher explained analyses for research question one and eight and provided an overall table for all the research questions and their analyses.

For Research Question 1 (What are the descriptive statistics for the participants' scores on the measure of the five constructs including CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSFMHS-stigma, and PBC based on the four background variables: education, sex, past behavior, race/ethnicity?) descriptive statistics including frequency distributions, measure of central tendency, and measure of variability were employed to describe the sample's primary characteristics. For this research question one, the participants' four background variables (education, sex, past behavior, race/ethnicity) were independent variables and the participants' scores on CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSFMHS-stigma, and PBC measurements were dependent variables. The Research Questions 2 through 7 are similar to one another in terms of the variables and analyses, and detailed information about each research question is provided in the following table.

For the eighth research question (How do the participants conceptualize mental health providers; for example, what does a counselor mean to the participants?), the participants' responses were analyzed with content analysis to identify themes and patterns among the participants' responses. See Table 2 for an overview of the analyses that were conducted for each research question.

Pilot Study

A pilot study was conducted to understand whether the data collection process (e.g., cover letter, consent form, instruments, style of the questions) was clear, easy, and appropriate for adult Muslims who may serve as participants in the full study.

Table 2

Description of Research Questions and Data Analyses

| Research Questions, Variables, and Analyses | | | | | |
|--|--|--|--|--|---|
| | Research Questions | Independent (Exogenous) Variable/s | Dependent (Endogenous) Variable/s | Variables Controlled For | Analyses |
| Q 1 | What are the descriptive statistics (e.g., mean, standard deviation) for the participants' scores in terms of the five constructs including CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSFMHS-stigma, and PBC? | Subpopulation were defined based on participants' background (control) variables: education, sex, past behavior, and race/ethnicity. | The participants' scores on CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSFMHS-stigma, and PBC measurements | Not applied | Descriptive statistics analysis |
| Q 2 | Do participants' CBMHP-cultural beliefs scores explain participants' ATFMHS-attitudes scores when controlling for background (control) variables and KFMHS-knowledge? | The participants' scores on CBMHP-cultural beliefs measurement | The participants' scores on ATFMHS-attitudes measurement | Background (control) variables and KFMHS-knowledge | Significance of path from path analysis |

Table 2

Cont.

| Research Questions, Variables, and Analyses | | | | | |
|--|---|--|--|---|---|
| | Research Questions | Independent (Exogenous) Variable/s | Dependent (Endogenous) Variable/s | Variables Controlled For | Analyses |
| Q 3 | Do participants' CBMHP-cultural beliefs scores explain participants' PSTSFMHS-stigma scores when controlling for background (control) variables and KFMHS-knowledge? | The participants' scores on CBMHP-cultural beliefs measurement | The participants' scores on PSTSFMHS-stigma measurement | Background (control) variables and KFMHS-knowledge | Significance of path from path analysis |
| Q 4 | Do participants' CBMHP-cultural beliefs scores explain participants' PBC scores when controlling for background (control) variables and KFMHS-knowledge? | The participants' scores on CBMHP-cultural beliefs measurement | The participants' scores on PBC measurement | Background (control) variables and KFMHS-knowledge | Significance of path from path analysis |
| Q 5 | Do participants' KFMHS-knowledge scores explain participants' ATFMHS-attitudes scores when controlling for background (control) variables and CBMHP-cultural beliefs? | The participants' scores on KFMHS-knowledge measurement | The participants' scores on ATFMHS-attitudes measurement | Background (control) variables and CBMHP-cultural beliefs | Significance of path from path analysis |

Table 2

Cont.

| Research Questions, Variables, and Analyses | | | | | |
|--|---|---|---|---|---|
| | Research Questions | Independent (Exogenous) Variable/s | Dependent (Endogenous) Variable/s | Variables Controlled For | Analyses |
| Q 6 | Do participants' KFMHS-knowledge scores explain participants' PSTSFMHS-stigma scores when controlling for background (control) variables and CBMHP-cultural beliefs? | The participants' scores on KFMHS-knowledge measurement | The participants' scores on PSTSFMHS-stigma measurement | Background (control) variables and CBMHP-cultural beliefs | Significance of path from path analysis |
| Q 7 | Do participants' KFMHS-knowledge scores explain participants' PBC scores when controlling for background (control) variables and CBMHP-cultural beliefs? | The participants' scores on KFMHS-knowledge measurement | The participants' scores on PBC measurement | Background (control) variables and CBMHP-cultural beliefs | Significance of path from path analysis |
| Q 8 | How do the participants conceptualize mental health providers; for example, what does a counselor mean to the participants? Content analysis was utilized to identify themes. | | | | |

Participants

The current researcher shared the link for the pilot study with 20 adult Muslims. Out of 20 participants, 13 submitted some responses and nine fully completed the instrumentation.

Instruments

Participants completed an online survey that was developed utilizing Qualtrics software. The study included the cover letter, consent form, and the following three scales: CBMHP-cultural beliefs (Aloud, 2004); KFMHS-knowledge (Aloud, 2004); and IASMHS (Mackenzie et al., 2004) which includes three subscales to measure attitudes, perceived social stigma, and PBC toward seeking formal mental health services.

The pilot study also included four questions to examine the demographic (background) variables including education, sex, past behavior, race/ethnicity. The participants in the study also responded to an open-ended question regarding how they define mental health providers. The question: How do you define mental health providers; for example, what does a counselor/therapist mean to you? Please describe/define below with a few sentences. (For example, to me a counselor/therapist means . . .). At the end of the study, the participants were asked, through an open-ended question, to provide feedback about anything related to the study that might improve the study, especially in terms of its length, language, clarity, and other suggestions.

Procedures

The current researcher created an online survey using Qualtrics software at UNCG. Support letters, were also submitted to the IRB, from the following organizations

who are able reach out to Muslim participants: MSA, RAM, OIE, ICG and ICT (See Appendix J). The cover letter, consent form, and survey were reviewed and approved by the UNCG IRB. After the obtained approval from the IRB for the study, a recruitment e-mail was sent to 20 Muslims (10 females and 10 males). The participants were from different settings/organizations (e.g., MSA, RAM, ICG, ICT), and they had known the researcher and were willing to complete the survey to provide feedback for the full study. The e-mail included a link to the web-based survey and a few points to appreciate the participants' consideration, remind them to keep notes for feedback (e.g., length, clarity), and not to spread the link to any others.

Brief Results of the Pilot Study

The number of the participants was not enough to run statistical analysis. Out of 20 participants who had the link, 14 looked at the study and nine of them (three females and six males) completed all components. The average time for the participants who completed all the survey was 27 minutes. The five participants who did not complete the pilot study spend from one minute to six minutes on the survey. In terms of the four background variables, the sample for the pilot study was diverse. In terms of race/ethnicity, the participants identified themselves as follows: two Asians; one Black, one African American, one West African; one Middle Eastern (Arab), and three Whites. The average age for the nine participants was 27.7; the ages changed from 20 to 45. In terms of education level, five participants graduated from or were currently enrolled in a bachelor's degree program, two graduated from or were currently enrolled in a master's program, and two graduated from or were currently enrolled in a doctoral program. In

terms of past behavior of utilizing of mental health services, four participants reported that they had not utilized any mental health services, while the other five included that they had utilized mental health services (e.g., individual/group sessions; collaboration with mental health providers for community projects, events, research; psychoeducational trainings).

In regards to the open-ended question to understand how the participants conceptualized/defined mental health providers, all the nine participants shared what mental health providers (e.g., counselor/therapist) mean to them.

In terms of the results based on the scales and variability, the sample in the pilot study described a moderately heterogonous group though no meaningful conclusions can be drawn from a sample of only nine participants. The participants scored very similarly on some of the items in the scales while they scored very differently on other items. For example, eight participants strongly agreed and one participant undecided on the item: “Environmental factors (like social stress, war exposure, migration, environment with lack of resources) can cause mental/psychological issues/problems.” However, for another item “Aieen or nazar” (evil eye) can cause mental/psychological issues/problems,” the participants responded in a very heterogeneous way. The responses were as follows: one disagreed, two somewhat disagreed, two undecided, two somewhat agreed, and two agreed. These two items are part of CBMHP-cultural beliefs scale.

Suggestions by the Participants for the Full Study

The participants overall appreciated the study and its sensitivity to their culture and religion/spirituality. They had some suggestions to improve the full study. Most of

the suggestions were related to language (e.g., clarity, grammar, not using extra words to explain the same concept), culture (e.g., recommending adding *issues* next to *problems*; adding more items related to spiritual/religious aspects), and the length of the consent form. For example, two participants (a nurse and an imam) who had provided some type of mental health services to Muslims suggested to replace the word *problems* with *issues/problems* in the second section (IASMHS) of the survey. They recommended making the section more compatible with the rest of the survey and thereby making it more appropriate for participants. In the original inventory (IASMHS), Mackenzie et al. (2004) only used “problems” in the root of the items. Based on the feedback from the two participants, the current researcher received permission from Mackenzie to edit all the items in the full study to include *issues/problems* rather than just *problems*.

Participants’ feedback was helpful to the current researcher as the pilot study was designed to understand whether the study (e.g., cover letter, consent form, instruments, style of the questions) was clear, easy, and appropriate. Based on feedbacks, the researcher added the following additions for the final study.

Adjustments to the Full Study Based on the Pilot Study

Overall, the field testing was successful and administration of the study ran smoothly. Timing estimates between 20 and 30 minutes were consistent with most participants’ time to complete the pilot survey.

Based on the feedback from the participants, the current researcher has added the following changes for the full study. First and foremost, he has shortened the cover letter and consent form. A second important modification was replacing the word *problems*

with *issues/problems* in the second section of the survey (IASMHS) after getting permission from the author. Utmost attention was given to the clarity of language (e.g., grammar, removing some extra words) for the full study. The final change was to allow participants to choose more than one option for race/ethnicity (e.g., Asian and White; Asian, Black, and Arab). Related to that, few more options (e.g., Western African, Arab) were added as options for the race/ethnicity question. The IRB approved all these changes. The survey for the full study with all modifications based on the pilot study, can be found in Appendix I.

In addition to that, based on the feedback from the professors during the proposal defense of the study, the researcher has added two more questions to understand how much people feel safe and what factors have affected their level of feeling safe. These questions were added specifically from the social ecological model to understand how current sociopolitical (social ecological) factors affect participants' psychological wellbeing and specifically them feeling safe.

CHAPTER IV

RESULTS

In Chapter I, the researcher presented the study by discussing the purpose and significance of the current research. In Chapter II, he described an in-depth literature review of the approach of Muslims, especially Muslims in the U.S., toward mental health issues and formal mental health services. He explained in detail the most important concepts (e.g., CBMHP-cultural beliefs, KFMHS-knowledge, and ATFMHS-attitudes) stressed throughout the Muslim mental health literature. Following that, he described the importance of utilizing well-grounded theories and/or theoretical frameworks to empirically study this current subject. He explained how the use of TPB/TRA and SEM is appropriate to shape the theoretical framework of the current study based on the related literature. In Chapter III, the researcher outlined the methodology for the current study, including research questions, instrumentation utilized, data analysis procedures, and a description of the pilot study. In this chapter, the researcher presents the results of the analyses that were conducted to test the research questions. First, a description of the sample is explained using the background information collected in the study. Second, descriptive statistics for the instruments used in the study are outlined. Finally, a discussion of the outcomes for each research question is presented. The chapter concludes with a summary of the findings.

Description of Participants and Representativeness of the Sample

The researcher contacted the Muslim organizations (ICT, ICG, UNCG MSA, and RAM) to distribute the survey for the study. He asked the organizations to distribute the online link as well as printed versions. The organizations sent the link through many channels (e.g., email, social media, phone text/message) to about 2,000 Muslims in their contact lists. Some of these participants could have been in multiple lists (e.g., being in the email lists of UNCG MSA and RAM). The organizations also distributed about 250 printed versions at different gatherings, especially at one Friday prayer. One hundred two participants returned the printed versions, which were completely filled out, and the researcher entered them in the computer. Two hundred twenty participants submitted the survey online; of those 107 were complete while 113 were not usable at all (the participants completed at most 5% of the survey; therefore, the researcher removed the responses). This resulted in a total sample for the current study of 209. All the analyses for the research questions were conducted with 209 participants. The participants had 15 days to participate and complete the study.

In terms of background (control) variables, the participants reported their education level as follows: less than high school ($n = 2$), high school ($n = 38$), college ($n = 100$), and graduate ($n = 69$). These education level statistics are comparable to existing Muslim mental health literature. A majority of the sample was male ($n = 120$) as opposed to female ($n = 89$). Compared to other studies in the Muslim mental health literature, the ratio in this study is more balanced because it is much more common to see many more men than women mainly because Muslim men are more involved in Islamic centers,

especially at mosques; there are some obligatory prayers, like Friday prayer, that Muslim men must attend, yet those prayers are optional for Muslim women.

In terms of past behavior (utilizing mental health services), 133 participants reported they have never utilized mental health services, while 76 participants reported that they utilized mental health services. Of the participants who indicated that they utilized mental health services, 49 reported that they “have worked/collaborated with a mental health provider (for example a counselor) in individual, group, family, and/or couple sessions to address psychological or social issues”; 47 reported that they “worked/collaborated with a mental health provider (for example a counselor) individually or with a group to organize a project, research, social advocacy action, or some similar other social events;” and 45 reported that they “have received some educational and/or psychoeducational training at individual, group, and/or community level from mental health provider(s).” The sum of the participants exceeds 76 because the participants were allowed to choose more than one option.

For race/ethnicity, the participants were grouped into five categories: Black (e.g., Sudani, Ethiopian; $n = 59$, 28.2%), Arab ($n = 61$, 29.2%), Asian (e.g., Kurdish, Persian, Pakistani/Indian, Turkish; $n = 43$, 20.6%), American (e.g., African American, White American; $n = 28$, 13.4%), and other ($n = 18$, 8.6%).

Assessing Normality and Reliability of the Variables in the Research Sample

Assumptions of normality were assessed using skewness and kurtosis statistics using IBM SPSS 22. Statistics for four instruments (KFMHS-knowledge, ATFMHS-attitudes, PSTSFMHS-stigma, and PBC) were within the acceptable range of $\leq \pm 1$; the

statistics for CBMHP-cultural beliefs scale was also within the acceptable range of $\leq \pm 2$ (see Table 3).

Table 3

Descriptive Statistics for Instruments and Subscales

| Instrument | <i>M</i> | <i>SD</i> | Skewness | Kurtosis | Cronbach α values of the current study | Cronbach α values of the original scales |
|------------------------|----------|-----------|----------|----------|---|--|
| CBMHP-cultural beliefs | 25.19 | 5.64 | -1.03 | 1.34 | .65 | .73 |
| KFMHS-knowledge | 18.67 | 7.77 | -0.36 | -0.32 | .89 | .88 |
| ATFMHS-attitudes | 16.86 | 8.90 | -0.17 | -0.94 | .87 | .82 |
| PSTSFMHS-stigma | 15.36 | 8.65 | 0.14 | -0.96 | .93 | .79 |
| PBC | 20.23 | 9.26 | -0.58 | -0.82 | .93 | .76 |

Note. SD = Standard deviation; CBMHP = Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments; ATFMHS = Attitudes Toward Seeking Formal Mental Health Services; PSTSFMHS = Perceived Social Stigma Toward Seeking Formal Mental Health Services; PBC = Perceived Behavioral Control Toward Seeking Formal Mental Health Services; KFMHS = Knowledge About Formal Mental Health Services; the overall Cronbach's alpha for the last three scales (ATFMHS-attitudes, PSTSFMHS-stigma, and PBC) in this study .83 and the original overall value was .87

An analysis was conducted to evaluate the reliability of the instruments used in the study. The results of the reliability analyses revealed the following Cronbach's alpha scores (see Table 3): 0.65 for the CBMHP-cultural beliefs (low internal reliability), 0.89 for ATFMHS-attitudes (good internal reliability), 0.87 for PSTSFMHS-stigma (good internal reliability), 0.93 for PBC (excellent internal reliability), and 0.93 for KFMHS-knowledge (excellent internal reliability). The overall alpha for three dependent (endogenous) variables (ATFMHS-attitudes, PSTSFMHS-stigma, and PBC) was found to have good internal reliability at 0.83. Reliability for the CBMHP-cultural beliefs in the

utilized sample did not reach adequate levels of reliability ($\alpha = .65$). Although to the knowledge of the current researcher there are no other researchers who utilized the scale, it might be helpful to consider the following influences. The author of the scale improved the scale especially for Arab Muslims and he found the Cronbach's alpha to be .73 (Aloud, 2004), which is in the acceptable range. The scale consists of 11 Likert-type items to measure Muslims' cultural beliefs about mental health issues/problems and their causes and treatments. Compared to Aloud's (2004) study, this current study had more diverse participants in terms of race/ethnicity mainly due to not just recruiting Arabs who lived in Columbus, OH (as in Aloud's study), but any Muslims who live in the Southeastern U.S. Having an internal consistency value of $\alpha = .65$ created an important limitation; however, due to lack of valid and reliable measurements, the current researcher utilized this scale.

Results of Research Questions

The purpose of the following section is to examine the results of the research questions in the study.

Analyses and Results for Research Question 1

Research Question 1 was, "What are the descriptive statistics (e.g., mean, standard deviation) for the participants' scores in terms of the five constructs including CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSFMHS-stigma, and PBC?" In order to get the results for Research Question 1, IBM SPSS 22 was used with the final 209 participants. For the research question, background (control) variables were independent variables and the participants' scores on each scale were the dependent

variables. In this way, subpopulations were defined based on participants' background (control) variables of education, sex, past behavior, and race/ethnicity as one can see in Table 4.

Some of the important results based on basic descriptive statistics in terms of the five main constructs are as follows though the researcher did not conduct any significance tests to see if the differences are statistically significant. The researcher did not conduct significant tests for several different reasons (e.g., not having enough participants in each category, not wanting to have more research questions in this current study). For the first construct (CBMHP-cultural beliefs) scores were close to one another based on education levels (mean scores for the construct changed from 24.77 for the participants with college degree to 26.50 for the participants with high school education degree; the scores for the construct can change from the lowest a score of zero to the highest possible score of 44). The scores were also very similar based on other background (control) variables because the lowest observed mean score for the construct was 23.74 and the highest observed mean scores for the construct was 26.56. The overall mean for the construct was 25.19 over the highest possible score of 44. All these show that regardless of background (control variables), the participants had slightly high scores on this construct. In addition to these, another important aspect related to the scale, there are three reverse-coded items (one, two, and six) that measured participants' beliefs about contemporary scientific/medical aspect of mental health issues and their causes and treatments, and lower scores/means on these items mean the stronger belief in medical/scientific explanation rather than CBMHP-cultural beliefs.

Table 4

Descriptive Statistics for the Participants' Scores in Terms of the Five Constructs

| Variable | CBMHP-cultural beliefs | | KFMHS-knowledge | | ATFMHS-attitudes | | PSTSMHS-stigma | | PBC | |
|---------------------------|------------------------|-----------|-----------------|-----------|------------------|-----------|----------------|-----------|----------|-----------|
| | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> | <i>M</i> | <i>SD</i> |
| <i>Education</i> | | | | | | | | | | |
| Less than high school | 25.00 | 1.41 | 9.00 | 9.90 | 19.50 | 4.95 | 20.50 | 2.12 | 23.50 | 10.61 |
| High school | 26.50 | 4.62 | 16.84 | 6.97 | 17.16 | 8.22 | 13.53 | 7.01 | 16.34 | 8.36 |
| College, Associate degree | 24.77 | 5.61 | 18.83 | 7.64 | 16.68 | 8.55 | 16.55 | 9.18 | 20.71 | 8.92 |
| Graduate school | 25.09 | 6.20 | 19.78 | 8.12 | 16.87 | 9.93 | 14.49 | 8.61 | 21.59 | 9.79 |
| <i>Sex</i> | | | | | | | | | | |
| Female | 24.89 | 5.56 | 18.35 | 8.24 | 20.48 | 8.26 | 16.64 | 9.45 | 17.48 | 9.90 |
| Male | 25.42 | 5.71 | 18.94 | 7.42 | 14.17 | 8.42 | 14.41 | 7.92 | 22.28 | 8.22 |
| <i>Past behavior</i> | | | | | | | | | | |
| Yes | 24.41 | 6.10 | 20.80 | 6.36 | 23.12 | 6.45 | 15.80 | 9.82 | 16.05 | 10.01 |
| No | 25.64 | 5.33 | 17.48 | 8.25 | 13.28 | 8.11 | 15.11 | 7.94 | 22.62 | 7.89 |
| <i>Race/Ethnicity</i> | | | | | | | | | | |
| Black | 26.20 | 4.75 | 17.68 | 8.25 | 19.88 | 7.99 | 15.83 | 8.84 | 16.86 | 9.97 |
| Arab | 23.74 | 6.62 | 18.26 | 7.62 | 13.34 | 9.10 | 15.18 | 8.29 | 23.03 | 7.55 |
| Asian | 25.58 | 4.52 | 21.63 | 6.73 | 18.49 | 9.03 | 13.58 | 9.40 | 18.63 | 9.51 |
| American | 24.75 | 5.83 | 16.04 | 8.41 | 17.25 | 7.61 | 19.00 | 7.54 | 22.25 | 8.40 |
| Other | 26.56 | 6.23 | 20.56 | 6.01 | 14.33 | 8.76 | 13.00 | 7.86 | 22.50 | 9.33 |

Note. CBMHP = Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments; KFMHS = Knowledge About Formal Mental Health Services; ATFMHS = Attitudes Toward Seeking Formal Mental Health Services; PSTSMHS = Perceived Social Stigma Toward Seeking Formal Mental Health Services; PBC = Perceived Behavioral Control Toward Seeking Formal Mental Health Services.

The results showed that the overall means for each of the three reverse-scored items (.58, .48, and .72, respectively, over the possible scores from zero to four) were much lower than the other eight items that were measuring CBMHP-cultural beliefs (the mean scores for the eight items changed from 2.04 to 3.32). In light of these results, the participants appear to have been strongly aligning with explaining mental health issues and their causes and treatments from a scientific/medical perspective while holding CBMHP-cultural beliefs at a moderate level as well.

For the second construct (KFMHS-knowledge), it seems the observed mean scores increase with the level of education increasing. In terms of sex, females had a score of 24.89 and male had a score of 25.42. However, it is important to pay attention that the scores for the construct can range from the lowest a score of zero to the highest possible score of 33. The participants who reported that they had utilized mental health services had an observed mean of 20.8 and the ones who reported that they had not utilized the mental health services had an observed mean of 17.48. Therefore, in future studies it might be worth it to run statistical significance tests. Based on all these, the participants overall have a slightly higher mean score (18.67) over the highest possible score of 32 (see Table 3).

For the third construct (ATFMHS-attitudes), the lowest possible score is zero and the highest possible score is 32 with the higher score indicating more positive/favorable attitude. The participants' overall mean for the construct was 16.86 (see Table 3). Females had much higher scores ($M = 20.48$) than males ($M = 14.17$). The participants who had utilized mental health services had a mean score of 23.12 while the ones had not

utilized had a mean score of 13.28. In terms of race/ethnicity, Black participants had a mean score of 19.88 and the Arabs had a mean score of 13.34.

For PSTSFMHS-stigma construct, the scores change from zero to 32, with the higher score indicating less perceived social stigma. The overall mean was 15.36 indicating a slightly below the midpoint (rather than moderate) level of stigma considering the highest possible score being 32. Based on education level, there is not a clear pattern because participants with education less than high school had a mean score of 20.50 and individuals with high school education level had a mean score of 13.53. The mean score for females was 16.64 and the mean for the males was 14.41. The participants who had utilized mental health services in the past had a mean score of 15.80 and the ones who had not utilized had a mean score of 15.11. In terms of race/ethnicity, Americans had a mean score of 19, while the other participants from other ethnicities/races had more similar mean scores, ranging from $M = 13$ to 15.18.

For the last construct, PBC, the lowest possible score is zero and the highest possible score is 32, with the higher scores indicating higher perceived behavioral control (perceived self-efficacy) toward seeking formal mental health services. The overall mean for the construct was $M = 20.23$. In terms of education level, there is no regular pattern because the observed mean score for the participants with education less than high school was 23.50 and mean score for the participants with high school education was 16.34. Females had a mean of 17.48 and males had a mean of 22.28. The participants who had utilized mental health services in the past had a mean score of 16.05 and the participants who had not utilized before had a mean score of 22.62. In terms of race/ethnicity, Blacks

had a mean score of 16.86 and Arabs had a mean score of 23.03. It is important to highlight that these observed mean scores are based on basic descriptive statistics rather than significance tests. It might meet some important gaps, since there is lack of empirical research about these constructs and the relationship among them, to have more participants and run significance test for all main constructs based on the background variables.

Analyses and Results for Research Question 2

Research Question 2 was, “Do participants’ CBMHP-cultural beliefs scores explain participants’ ATFMHS-attitudes scores when controlling for background (control) variables and KFMHS-knowledge?” In order to get the results, a path analysis was used with the participants’ scores on CBMHP-cultural beliefs measurement being the exogenous (independent) variable and the participants’ scores on ATFMHS-attitudes measurement being the endogenous (dependent) variable while controlling for background (control) variables and the KFMHS-knowledge construct. Based on the path analysis result (see Figure 2), the path is significant, and CBMHP-cultural beliefs explains ATFMHS-attitudes in a negative way ($\beta = -.12, p < .01$). This finding can be interpreted as the more a participant holds strong CBMHP-cultural beliefs, the more likely he or she is to have negative ATFMHS-attitudes towards formal mental health services. In addition to these results, all the independent variables (CBMHP-cultural beliefs, KFMHS-knowledge, and the four background variables) together explained 36% ($R^2 = .36$) of the variance of ATFMHS-attitudes.

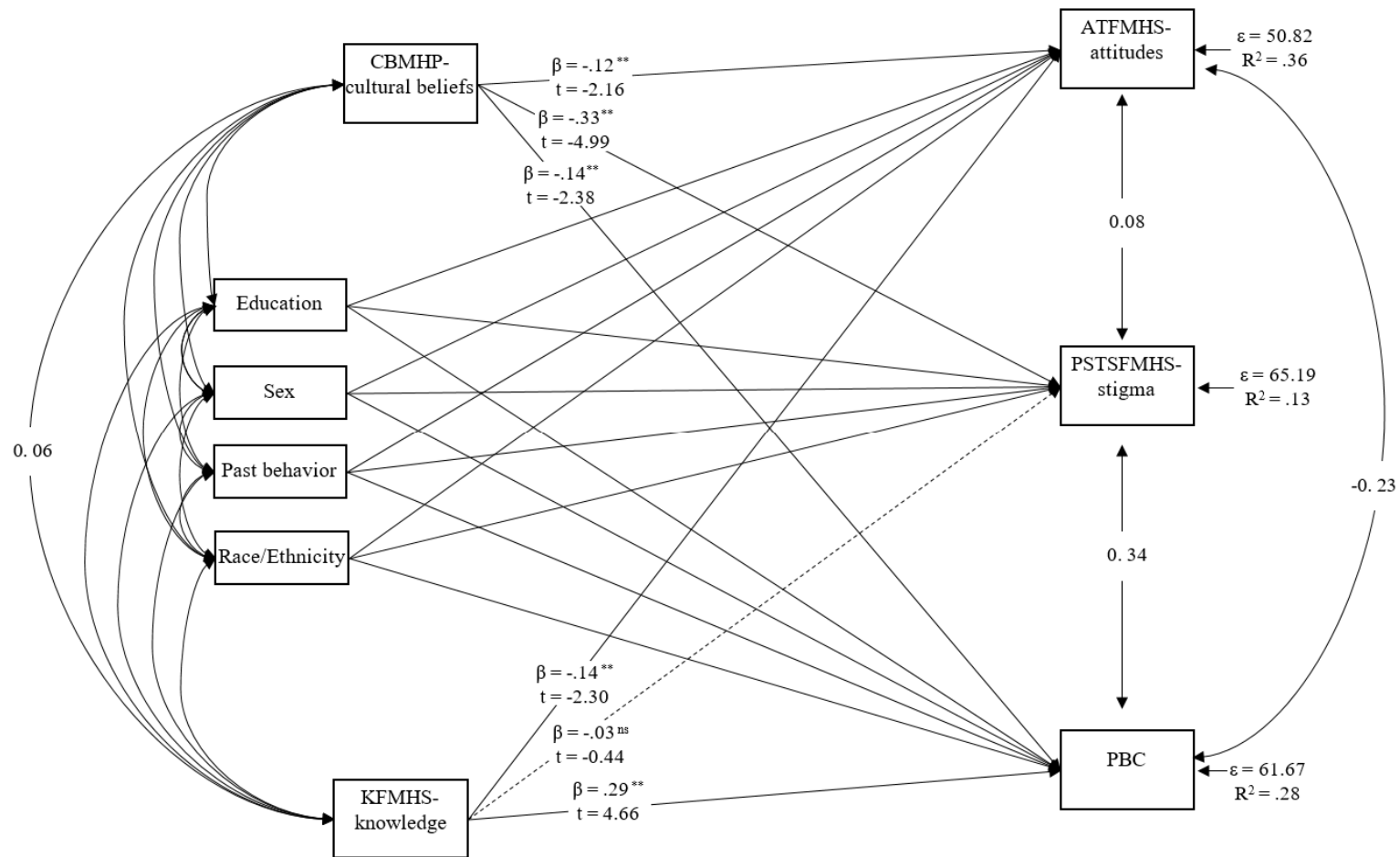


Figure 2. Path Analysis to Understand Muslims' Approach toward Mental Health Issues and Seeking of Formal Mental Health Services. CBMHP=Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments; KFMHS=Knowledge About Formal Mental Health Services ATFMHS=Attitudes Toward Seeking Formal Mental Health Services; PSTSMHS=Perceived Social Stigma Toward Seeking Formal Mental Health Services; PBC=Perceived Behavioral Control Toward Seeking Formal Mental Health Services. Chi-Square=0.00, $df=0$, P -value=1.00000, RMSEA=0.000.

Analyses and Results for Research Question 3

Research Question 3 was, “Do participants’ CBMHP-cultural beliefs scores explain participants’ PSTSFMHS-stigma scores when controlling for background (control) variables and KFMHS-knowledge?” In order to get the results, path analysis was used with the participants’ scores on CBMHP-cultural beliefs measurement being the exogenous (independent) variable and the participants’ scores on PSTSFMHS-stigma measurement being the endogenous (dependent) variable while controlling for background (control) variables and KFMHS-knowledge construct. Based on the path analysis result (see Figure 2), the path is significant, and CBMHP-cultural beliefs explains PSTSFMHS-stigma in a negative way ($\beta = -.33, p < .01$). In other words, the more a participant holds strong about mental health problems (CBMHP-cultural beliefs), the more likely that he or she might have a negative perception of the stigma of seeking mental health services (PSTSFMHS-stigma). In addition to these results, all the independent variables (CBMHP-cultural beliefs, KFMHS-knowledge, and the four background variables) together explained 13% (R-square = .13) of the variance of PSTSFMHS-stigma.

Analyses and Results for Research Question 4

Research Question 4 was, “Do participants’ CBMHP-cultural beliefs scores explain participants’ PBC scores when controlling for background (control) variables and KFMHS-knowledge?” In order to get the results, a path analysis was used with the participants’ scores on CBMHP-cultural beliefs measurement being the exogenous (independent) variable and the participants’ scores on PBC measurement being the

endogenous (dependent) variable while controlling for background (control) variables and KFMHS-knowledge construct. Based on the path analysis result (see Figure 2), the path is significant, and CBMHP-cultural beliefs explains PBC in a negative way ($\beta = -.14, p < .01$). This finding could mean that the more a participant holds strong cultural beliefs about mental health problems (CBMHP-cultural beliefs), the more likely the participant might have low level (score) for PBC. In addition to these results, all the independent variables (CBMHP-cultural beliefs, KFMHS-knowledge, and the four background variables) together explained 28% (R-square = .28) of the variance of PBC.

Analyses and Results for Research Question 5

Research Question 5 was, “Do participants’ KFMHS-knowledge scores explain participants’ ATFMHS-attitudes scores when controlling for background (control) variables and CBMHP-cultural beliefs?” To determine the result, a path analysis was used with the participants’ scores on KFMHS-knowledge measurement being the exogenous (independent) variable and the participants’ scores on ATFMHS-attitudes measurement being the endogenous (dependent) variable while controlling for background (control) variables and CBMHP-cultural beliefs construct. Based on the path analysis result (see Figure 2), the path was significant, and KFMHS-knowledge explains ATFMHS-attitudes in a negative way ($\beta = -.14, p < .01$). This finding could be interpreted to suggest that the more a participant had knowledge of formal mental health services (KFMHS-knowledge), the more likely he or she might have negative attitudes toward formal mental health services (ATFMHS-attitudes), while almost the rest of the Muslim mental health literature stating (although not all of them are based on

empirical research) that the more Muslims have knowledge of formal mental health services the more likely they have positive/favorable attitudes toward seeking formal mental health services. As mentioned above, the independent variables (CBMHP-cultural beliefs, KFMHS-knowledge, and the four background variables) all together explained 36% (R-square = .36) of the variance of ATFMHS-attitudes.

Analyses and Results for Research Question 6

Research Question 6 was, “Do participants’ KFMHS-knowledge scores explain participants’ PSTSFMHS-stigma scores when controlling for background (control) variables and CBMHP-cultural beliefs?” To determine the result, a path analysis was used with the participants’ scores on KFMHS-knowledge measurement being the exogenous (independent) variable and the participants’ scores on PSTSFMHS-stigma measurement being the endogenous (dependent) variable while controlling for background (control) variables and CBMHP-cultural beliefs construct. Based on the path analysis result (see Figure 2), the path is not significant ($\beta = -.03$), indicating there was not a positive or negative relationship between KFMHS-knowledge and PSTSFMHS-stigma for the participants in this study. As mentioned above, all the independent variables (CBMHP-cultural beliefs, KFMHS-knowledge, and the four background variables) together explained 13% (R-square = .13) of the variance in PSTSFMHS-stigma construct.

Analyses and Results for Research Question 7

Research Question 7 was, “Do participants’ KFMHS-knowledge scores explain participants’ PBC scores when controlling for background (control) variables and

CBMHP-cultural beliefs?” To determine the results, a path analysis was used with the participants’ scores on KFMHS-knowledge measurement being the exogenous (independent) variable and the participants’ scores on PBC measurement being the endogenous (dependent) variable while controlling for background (control) variables and CBMHP-cultural beliefs construct. Based on the path analysis result (see Figure 2), the path is significant, and KFMHS-knowledge is explaining PBC in a positive way ($\beta = -.29, p < .01$). This finding indicates that the more a participant held knowledge of formal mental health services (KFMHS-knowledge) the more likely they were to report perceived behavioral control (PBC, meaning perceived self-efficacy) toward seeking formal mental health services if needed. As explained above, the independent variables (CBMHP-cultural beliefs, KFMHS-knowledge, and the four background variables) combined explained 28% ($R^2 = .28$) of the variance of the PBC construct.

Analyses and Results for Research Question 8

Research Question 8 was, “How do you define mental health providers; for example, what does a counselor/therapist mean to you? Please describe/define below with a few sentences (for example, to me a counselor/therapist means . . .).” This research question was qualitative in nature; therefore, the responses were analyzed through content analysis by the researcher. The researcher looked for central themes and/or perspectives based on the responses. Seventy-five participants responded, which is a good ratio compared to other research (e.g., Bagasra, 2010). In earlier research, it was common for Muslims not to respond to open-ended questions. From the content analysis, the responses fell into four categories. Forty-five percent of the participants ($n = 34$ out of

75) identified mental health providers (e.g., counselors/therapists) from a psychopathology perspective (e.g., problem solvers-fixers, fixing a person and their problems), which constituted the first category of responses. In the second category, 11 of 75 participants (14.7%) identified mental health providers (e.g., counselors/therapists) from a wellness (positive psychology) perspective (e.g., increasing the quality of life, addressing issues). For the third category, the participants ($n = 17$ out of 75; 22.7%) identified mental health providers from a more holistic perspective as professionals who address both severe psychological issues/problems (from a psychopathology perspective) and/or professionals who help one to improve the quality/wellness of life (from a positive psychology perspective). The current research labeled the last category as “other” because the participants ($n = 13$ out of 75; 17.3%) held a variety of ideas. For example, few of the participants stated that “mental health providers are important, needed for [Muslim] community, good people, they do good job but for spiritual illness you need Quran, etc.” All responses for each of the categories can be found in Appendix L.

The most common themes identified were that mental health providers are problem solvers/fixers, help with problems, give advice, and listen to people to address problems.

In addition to the results of the research questions, in order to understand how the participants’ larger exosystem (e.g., media, local institutions) and macrosystem (e.g., governments, political atmosphere) affect them, the participants were asked two questions. The first one was “How safe do you feel as a Muslim in the U.S.?” and the participants were given the following options: “not at all, very little, somewhat, and

very.” The second question was “What factors affected your response to the previous question?” and the participants were given space to type their responses. In total 206 people responded to the first question and the responses were as follows: not at all ($n = 7$), very little ($n = 56$), somewhat ($n = 102$), and very ($n = 41$). In terms of the second (open-ended) question, most of the participants who reported that they did not feel safe (whether not at all, very little, or somewhat) stated the following factors as reasons to their responses: current political conditions, elections, media, attack on Muslim in the U.S., attack on Islam, social environment and Muslim attire, unpredictable actions of non-Muslim community members who are manipulated by media and leaders, misconception about Islam and Muslims, being Muslim and negative attitudes from non-Muslims including family members, current president’s attitude and actions, racism, white supremacy, Muslim ban, lack of services to practice my religion, wearing scarf and being obvious, killing Muslims, and stereotypes and stigma about Muslims, to name a few. The other participants who reported that they feel very safe or somewhat safe listed the following factors for feeling safe: Islam, being Muslim, faith in Allah, not facing any difficulty or discrimination, being American citizen, not being identifiable as Muslims from outside in terms of race and attire, and myself, to name a few.

Summary of Results

The purpose of this chapter was to present results from analyses performed to for the eight research questions outlined in Chapters I and III. For the first research question, basic descriptive statistics for the five constructs (CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSFMHS-stigma, and PBC) based on the

four background (control) variables (education, sex, past behavior, race/ethnicity) were provided through using IBM SPSS 22. The statistical analyses were conducted with 209 participants. Overall, the participants, regardless of background (control variables), had a slightly high level of scores ($M=25.19$ over the highest possible score of 44) for holding cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-cultural beliefs). For the second construct (KFMHS-knowledge), the participants overall had slightly high scores ($M=18.67$ over the highest possible score of 33) for knowledge about formal mental health services. For the third construct, the participants had moderate scores ($M=18.86$ over the highest possible score of 32), indicating a slight positive ATFMHS-attitudes. For the fifth construct, PSTSMHS-stigma, the participants overall had slightly low scores ($M=15.36$ over the highest possible score of 32) meaning slightly strong public stigma toward seeking formal mental health services. For the last construct, PBC, the participants had a score of 20.23 over the highest possible score of 32, which could be sign of high PBC. In terms of background (control) variables' descriptive statistics, there were no specific patterns between the background variables and the five main constructs, although the researcher did not conduct any significance tests to examine the relationships. Therefore, it may prove useful to run statistical significance tests for all or for some variables to see if significant differences exist.

For the Research Questions 2–7, path analysis and their coefficients were provided based on using LISREL 18.8. Based on the analysis, all the paths for Research Questions 2–7 were found to be significant except for Research Question 6. The results

for Research Question 8 were also provided based on using content analysis, and based on that four main categories were found. In addition to that, the majority of the participants reported that they do not feel safe (only 41 participants reported they feel very safe) and majority of the participants who did not feel safe reported the factors were related to exosystem (e.g., media, racism and discrimination in social life) and macrosystem (e.g., governments, political atmosphere).

In the final chapter, the results presented in Chapter IV will be discussed as they relate to previous research findings. Limitations of the current study will also be addressed, as will implications for future research and practice.

CHAPTER V

DISCUSSION

The goal of the present study was to explore the approach of adult Muslims who live in the Southeast U.S. (the five constructs: CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, PSTSMHS-stigma, and PBC) toward mental health issues and formal mental health services considering a contextual theoretical framework/lens. The background (control) factors (education, sex, past behavior, race/ethnicity) were also examined in this contextual framework. The current researcher presented the results of the eight research questions in Chapter IV. In the current chapter, the researcher provides a detailed discussion of the reported results. He highlights the implications related to the sample utilized and reliability estimates for the instrumentation. Furthermore, he presents a discussion of the results of each research question to highlight the relationship among the variables, especially the five main constructs. Limitations in the current study also are presented in this chapter. Finally, the researcher provides theoretical and practical implications of the results of the study for future research and practice.

Participants' Approach to Mental Health Issues and Services

The researcher of the current study examined how adult Muslims in the Southeastern U.S. approach mental health issues and formal mental health services using the proposed theoretical framework based on a thorough literature review and two well-

grounded theories/approaches (TPB/TRA and SEM). Based on the extant research it is clear that the Muslim community in the Southeastern U.S., being part of the larger Muslim community in the country and the world, has experienced psychosocial issues (Francisco & Tanhan, 2015; Strack et al., 2016). However, it is also reported by numerous researchers that the Muslim community in the U.S. overall underutilize mental health services to address issues and have a negative approach toward seeking services (Aloud & Rathur, 2009; Francisco & Tanhan, 2015; Tanhan, 2014), while other researchers have found that Muslims have a positive approach (Bagasra & Mackinem, 2014; Strack et al., 2016).

Based on the available literature, more study is needed to understand Muslims' approach to utilizing mental health services. However, one of the issues that most of the researchers in the literature missed is utilizing well-grounded theories or theoretical frameworks to examine Muslims' approaches to utilizing mental health services. Another issue is the lack of studies about Muslims in the Southeastern U.S. Therefore, the current researcher tried to close these two gaps in this current study by grounding the proposed theoretical framework (model) on the Muslim mental health literature and well-grounded TPB/TRA and SEM to answer the research questions. By meeting these gaps, the current study is unique and will expand understanding Muslims' approaches toward mental health issues and services and also how mental health providers as researchers and providers can utilize the results to move forward. More detailed information is provided in the next sections by elaborating on the results of the research questions and how the results fit in the larger literature.

Major Findings

Overall, the results of the study are consistent with the results of the larger literature review while some other results are not. Additionally, some unique research results are not possible to compare to the larger literature because the researchers in the literature of Muslim mental health have not addressed them whatsoever. The first major finding is that the Muslim participants in this current study held moderate levels of holding cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-cultural beliefs). This finding is consistent with the larger Muslim mental health literature (e.g., Aloud & Rathur, 2009; Bagasra, 2010), although some researchers found that Muslims held much stronger CBMHP-cultural beliefs. The negative path coefficients from CBMHP-cultural beliefs to the other three dependent constructs of ATFMHS-attitudes, PSTSFMHS-stigma, and PBC also fit with the majority of the literature. The path coefficients—which were negative, not significant, and positive from KFMHS-knowledge construct to ATFMHS-attitudes, PSTSFMHS-stigma, and PBC, respectively, to the other three dependent constructs are different from larger Muslim mental health literature results. More detailed information is provided below. However, it is important to state that there are not enough empirical research studies that examined the relationship among these constructs in the same way the current researcher examined them. Except for a few researchers, almost none of the researchers examined CBMHP-cultural beliefs and KFMHS-knowledge through quantitative methods. In terms of background (control) variables and the main five constructs, there were no specific regular patterns except that overall participants' KFMHS-knowledge score increased

gradually when their education level increased. However, the current researcher did not test for significant differences based on background variables. In terms of the larger Muslim mental health literature, the studies found different results. More detailed information is provided in the sections that follow.

Another important overall result was considering the reliability (overall Cronbach's alpha) values for the scales. One of the main limitations in this study was the weak Cronbach's alpha (.65) for the CBMHP-cultural beliefs scale, while the original value was .73 in Aloud's (2010) work. The current researcher edited the scale to make it more appropriate for the participants and not just for Arab-Muslims. There is a lack of well-established scales to measure CBMHP-cultural beliefs; therefore, the current researcher decided to use this scale although it had a weak value (0.65). Because of all these modification and low value, the scale should be used with these points in mind, and this might be subject for future research since use of the scale for additional research requires further examination. For the KFMHS-knowledge scale, the Cronbach's value in this current study (.89) slightly increased compared to the original scale (.88); the current researcher also slightly modified the scale to make it more appropriate, and it seems the modified version is appropriate for use with any Muslims, not just with Arab-Muslims. For the third scale (ATFMHS-attitudes), the Cronbach's alpha value (.87) increased compared to the original value (.82). For the next scale (PSTSMHS-stigma), the Cronbach's alpha value (.93) increased compared to the original value (.79). For the last scale (PBC), the overall Cronbach's alpha value (.93) also increased compared to the original scale (.76). However, the overall alpha values for the last three scales

(ATFMHS-attitudes, PSTSFMHS-stigma, and PBC) decreased slightly for the current study (.83) compared to the original value (.87). Overall, the scales could be used because the Cronbach's alphas are within an acceptable range except for the first one, which has a low value (yet can be used with caution due to lack of the scales). This study is also important because Aloud (2010) developed and used the first two scales, but only with Arab-Muslims, and no other researchers utilized the other three scales by themselves or together for Muslims. Therefore, this study is meeting some important needs in the Muslim mental health literature by modifying and utilizing the scales and overall having acceptable and improved Cronbach's alpha values compared to the original values.

In the next sections, the researcher elaborates on each research question in the larger context of the literature to determine if the current results fit or do not fit in the larger body of literature.

Research Question 1 Discussion

The sample of participants utilized in the study consisted of 209 adult Muslims (89 female and 120 male) from the Southeastern U.S. Compared to most other research studies concerning Muslim mental health, this ratio of females to males is not an unexpected result because in many studies the number of males is greater or much greater than females (e.g., Ali & Milstein, 2012; Aloud & Rathur, 2009; Bektas et al., 2009; Francisco & Tanhan, 2015; Khan, 2006; Strack et al., 2016), except for a few studies (e.g., Bagasra, 2010; Bagasra & Mackinem, 2014) in which there were more females than males. Additionally, in some cases, the number of males is greater than the female participants; therefore, the ratio of females to males is more balanced in this current

study. In general, one of the reasons that the number of males is more than females might be that most of the researchers have collaborated with Islamic centers (especially mosques) where males are more present because of some obligatory prayers (e.g., going to Friday prayer every week is an obligation for Muslim man, while it is optional for a Muslim woman). In this current study, the researcher collaborated with the two largest Islamic centers (mosques) in the area to deliver the printed version and also to distribute the online survey. The directors of the centers reported that they have more male attendees and contact information (e.g., email, phone numbers, social media) that they used for distributing the survey. Another reason could be that the main researcher was male, and more male participants from the community felt it was easier to participate due to familiarity with the researcher. These might be some of the main reasons that males outnumbered females. This information is important from a SEM perspective because the contextual factors and resources affect one's availability to reach out for the services.

For the first construct (CBMHP-cultural beliefs), participants' scores were close to one another across all background variables and their subcategories, and the overall mean for the construct was 25.19 with the standard deviation being 5.64 (the highest possible score on the scale is 44). All these could suggest that regardless of background variables and their subcategories, the participants have a slightly high level of holding cultural beliefs about mental health issues/problems and their causes and treatments (CBMHP-cultural beliefs). This construct has been stressed by almost every researcher in the Muslim mental health literature, although to the current researcher's knowledge only a few researchers (Aloud, 2004; Bagasra, 2010) empirically looked at similar constructs

through quantitative studies. For example, researchers Aloud (2004) and Aloud and Rathur (2009) found that CBMHP-cultural beliefs play an important role in Arab-Muslims' approach toward mental health services, and Aloud found that the Arab-Muslim participants in Columbus, OH had a mean of 2.41 (over the highest possible score of 4) for this construct, while they had less belief in contemporary medical perspective of mental health issues and health services. Unlike Aloud, other researchers (Bagasra, 2010; Bagasra & Mackinem, 2014) found that Muslims in the U.S. (a majority being from the Southeast and/or South) held such a cultural perspective and also the medical perspective to explain mental issues and their treatments. The results of this current study align a little more with the later researchers because the participants had a mean of 25.19 (out of a highest possible score of 44 on the scale), which is slightly higher than average. A majority of researchers (e.g., Youssef & Deane, 2006) in the literature stated that Arabs hold such cultural beliefs strongly; however, in this current research, the participants who identified themselves as Arab had the lowest score (23.74) on the construct (CBMHP-cultural beliefs) across the race/ethnicities. This might be an important point to examine in more detail in future research.

In addition to these, another crucial point to consider is that the scale had three reverse-coded items (one, two, and six) that measured one's beliefs about the scientific/medical aspect of mental health issues and their causes and treatments; lower scores/means on these items mean the participants held stronger beliefs in medical/scientific explanation than CBMHP-cultural beliefs. The results showed that the overall means for each of the three reverse-scored items (.58, .48, and .72, respectively,

over the possible scores from zero to four) were much lower than the other eight items that were measured CBMHP-cultural beliefs (the mean scores for the eight items changed from 2.04 to 3.32). Based on these three items and these main descriptive statistics, it seems the participants strongly align with explaining mental health issues and their causes and treatments from a scientific/medical perspective while holding CBMHP-cultural beliefs at a moderate level. In terms of these results, the current research results align more with Bagasra's (2010) study.

All of these results related to CBMHP-cultural beliefs indicate that mental health providers can benefit from paying close attention to understanding how the cultural and scientific/medical beliefs/perspectives related to mental issues and their treatments might create some challenges and uneasiness for Muslims. For example, mental health providers can take time to become more familiar with the cultural beliefs so that they become more culturally competent and create a safer place so that the Muslims can feel comfortable enough to share their perspectives. In this way, the mental health providers can bring awareness to the functional and dysfunctional cultural beliefs for the client(s) and make the process more engaged, meaningful, and productive. It may be very helpful that mental health providers are open to seeing and discussing the cultural beliefs from a curiosity and strengths-based perspective to understand how they function or do not function for the person or community rather than putting those beliefs down and trying to eliminate and dispute them to replace with contemporary scientific findings. The mental health providers also can work toward creating a place to provide and discuss more about scientific explanation of mental issues and their treatments so that the Muslims might

become more familiar with that perspective as well since they held scientific explanations stronger than the cultural beliefs.

Considering CBMHP-cultural beliefs from TPB/TRA is important because from the theory perspective the beliefs indirectly (as background factors) affect one's intention and behavior through one's attitudes, stigma, and PBC. Though from a TPB/TRA perspective cultural beliefs are not empirically examined, their role becomes much more crucial when subjects are not familiar with the behavior of interest. From a SEM perspective, examining CBMHP-cultural beliefs is very crucial because one's culture affects every aspect of one's life, while the person also affect the culture, yet in an individual and limited way. Therefore, CBMHP-cultural beliefs are very important and crucial to be considered by themselves and also how they interact with other constructs, since both TPB/TRA and SEM see cultural beliefs and other constructs (e.g., knowledge, stigma) as interrelated.

For the second construct (KFMHS-knowledge), the participants in this current study overall had a slightly high amount of knowledge about formal mental health services because the overall mean for the construct for all the participants was 18.67 (out of a highest possible score of 33), with the standard deviation being 7.77. The researchers (Aloud, 2004; Aloud & Rathur, 2009) empirically examined this construct for Arab Muslims and found that the participants had a mean score of 2.02 (with the highest possible score being 4 and $SD = .62$). Similarly, other researchers in their qualitative studies reported (especially for key people like imams and health providers in the community) that Muslims have knowledge of mental health services and issues (e.g., Ali

& Milstein, 2012), while others reported otherwise (e.g., Cook-Masaud & Wiggins, 2011; Youssef & Deane, 2006). Therefore, the results of this construct in this study fits the larger picture considering Muslims to have a slightly high level of knowledge; however, further examination will be important to understand this construct more in-depth. One of the observed results is that the mean scores increase gradually with the level of education increasing. The participants who had utilized mental health services had a mean of 20.8 and the participants who had never utilized the services had a mean of 17.48, which can be examined in more details with significance tests. This second construct has been stressed by nearly all researchers, although not examined empirically, and in general they found that Muslims do not have KFMHS-knowledge.

Based on these results, the mental health providers can collaborate at an individual and community level using different avenues (e.g., face-to-face, organizing informative events, events on local and national media, creating groups and pages on social media) to understand more in detail and increase Muslims' level of knowledge and awareness of mental health issues and especially of the services.

KFMHS-knowledge from TPB/TRA perspective is important because from the theory perspective knowledge indirectly (as background factors) affect one's intention and behavior through one's attitudes, stigma, and PBC. Although from the TPB/TRA perspective KFMHS-knowledge is not empirically examined and even in some studies found to be nonsignificant with main constructs (e.g., attitudes, stigma), the role of having knowledge becomes very crucial when the subject of interest is not familiar with the subjects. In this case, Muslims are not very familiar with mental health services based

on this current research, and especially based on Muslim mental health literature. From the SEM perspective, examining and focusing on KFMHS-knowledge is necessary because having or not having knowledge of a subject directly affects one's approach, and SEM stresses how one needs to pay attention to environment and system to provide knowledge and awareness while trying to promote a behavior rather than just focusing on intrapersonal processes. Therefore, KFMHS-knowledge is very important and crucial to be considered by itself and also how it interacts with other constructs since both TPB/TRA and SEM see KFMHS-knowledge and other constructs (e.g., knowledge, stigma) in a contextual perspective that affect one another.

For the third construct (ATFMHS-attitudes), the overall mean for the participants was 16.86 over the highest possible score of 32. This construct is one of the most empirically studied constructs, which makes it more important. The researchers reported contradicting results as the current researcher explained in more details in Chapter II. Aloud (2004) found that Arab-Muslims in his study held negative ATFMHS-attitudes ($M = 2.36$ over four), and similar results were reported by multiple researchers (e.g., Youssef & Deane, 2006). While some researchers found a significant correlation between control variables (e.g., education, sex) and ATFMHS-attitudes (e.g., Khan, 2006; Youssef & Deane, 2006), others did not find such a meaningful correlation (e.g., Aloud & Rathur, 2009). For example, Khan (2006) found Muslim women to hold a more positive approach toward seeking the services. Based on these results, the research results of this current study overall fit in the larger picture with the one reporting that Muslims have scores at a moderate level for ATFMHS-attitudes. In terms of background variables and ATFMHS-

attitudes, the results of this current study contradict some studies (e.g., Aloud, 2004; Bagasra, 2010; Ciftci et al., 2013) because in the current study the higher education level, the lower were observed mean scores for ATFMHS-attitudes. However, the current study results align with many other research results (e.g., Aloud & Rathur, 2009; Ciftci et al., 2013) from some other aspects because similar to other research, in this current study females had much higher observed scores ($M = 20.48$) than males ($M = 14.17$). Similarly, participants who had utilized mental health services had much higher observed scores ($M = 23.12$) than ones who had not utilized mental health services ($M = 13.28$). In terms of race/ethnicity, in this current study Black participants had the highest mean score (19.88) and Arabs had the lowest mean scores (13.34), which contradicts some researchers who found Americans (e.g., Aloud, 2004) had higher scores for ATFMHS-attitudes and fits more with some others (e.g., Khan, 2006) who found Asians had more favorite approaches than Americans.

Mental health providers can share these results with the Muslim community to start a discussion about seeking mental health services and what these average scores of ATFMHS-attitudes mean for Muslims. Starting such a conversation with key people and/or organizations in the community (e.g., imams, spiritual leaders, community leaders, and Muslim organizations like mosques or MSA) might be crucial since Muslims neither have strong favorable or unfavorable ATFMHS-attitudes. Based on the Muslim mental health literature, key people had much stronger favorable ATFMHS-attitudes and they are the gatekeepers to reach out to the community; therefore, they might be the most effective ones to collaborate with to increase favorable ATFMHS-attitudes.

From the two main theoretical lenses (TPB/TRA and SEM) perspective, examining ATFMHS-attitudes is important. It is a main construct in TPB/TRA at the intrapersonal level and the construct has an important role in SEM to consider in a contextual perspective related to other larger systems (e.g., culture, institution, media) rather than just at the intrapersonal level. Therefore, understanding the results and implications based on them is important.

For PSTSFMHS-stigma construct, the overall mean score of the participants was 15.36 (over the highest possible score of 32). This construct is also well examined both through quantitative and qualitative research with overall the researchers finding Muslims having a high or moderate level of perceived social stigma (e.g., Ciftci et al., 2013; Herzig et al., 2013; Soheilian & Inman, 2009; Thomas et al., 2015), except for few researchers (e.g., Bagasra, 2010). From this perspective, this current research fits with most of the research literature because the participants' scores were slightly lower for PSTSFMHS-stigma. In terms of background variables, this current study contradicts other studies because some researchers found (e.g., Bagasra et al., 2013) the higher the education level one achieved the less the PSTSFMHS-stigma. However, in this current study, there was not a pattern because the participants with education lower than high school had the highest observed mean score ($M = 20.50$; meaning the less perceived social stigma) while the participants with higher levels of education had the lowest observed mean score ($M = 13.53$; meaning the most perceived social stigma). In terms of sex, the current study also contradicts some studies because females had a mean score of 16.64 while males had a mean score of 14.41 while many other researchers found females

had more PSTSFMHS-stigma. The participants who had utilized mental health services in the past had a slightly higher mean score ($M = 15.80$) than those who had not ($M = 15.11$). In terms of race/ethnicity, Americans had the highest observed score ($M = 19$, meaning the least perceived social stigma) while the other participants from other ethnicities/races had close observed mean scores, ranging from 13 to around 15.

In order to understand and have less PSTSFMHS-stigma among Muslims in an effective way, mental health providers might benefit from paying attention to the previous constructs based on the Muslim mental health literature, as the current researcher explained in the previous sections (e.g., creating a safe and welcoming place where Muslims can discuss their cultural beliefs, mental health providers collaborating through different avenues to increase Muslims' level and awareness of KFMHS-knowledge, and collaborating with key people/organizations to discuss Muslims' ATFMHS-attitudes).

Perceived social stigma is a main construct in both TPB/TRA and SEM, and it is important to examine and understand it from different perspectives. Therefore, considering PSTSFMHS-stigma in this study at the individual level and how it is related to other larger factors (e.g., cultural beliefs) is important.

For the last construct (PBC), the overall mean for the participants was 20.23 over the highest possible score of 32, meaning the participants had quiet high scores in terms of perceived self-efficacy to be able to seek/utilize mental health services if they needed. This an important construct that some of the researchers mentioned indirectly, and yet to the knowledge of the current researcher none examined it empirically. Therefore, there

are no empirical data to compare to the results of this study. However, some of the researchers consistently indicated that Muslim women had many more barriers (e.g., transportation, facing more stigma/pressure from community if seeking mental health services), and were therefore less likely to have high PBC. The result of this study may support this assumption because female participants had a much lower mean ($M = 17.48$) than males ($M = 17.48$ and 22.28 , respectively). Another important point for PBC and education level is that there was no regular pattern because the participants with education less than high school had the highest observed mean scores ($M = 23.50$) while the participants with high school education had a mean score of 16.34 . The participants who had utilized mental health services in the past had a much lower mean score ($M = 16.05$) than the participants who had not ($M = 22.62$). In terms of race/ethnicity, Blacks had the lowest mean score ($M = 16.86$), while Arabs had the highest mean scores ($M = 23.03$). All these scores require more in-depth study to understand them more fully and especially if there are any statistical significant differences.

PBC is a very new construct in Muslim mental health literature; however, based on the limited literature of Muslim mental health, TPB/TRA, and SEM, mental health providers can pay attention to all points mentioned above to have a holistic and systematic approach to bring awareness to PBC and create a space for discussion and awareness for Muslims at the individual and community level. Therefore, mental health providers—based on limited literature on Muslim mental health, TPB/TRA, and SEM—can first pay attention to see if there are actual (physical) resources like availability of mental health services (e.g., clinic, center, culturally competent providers). Then, the

mental health providers can try to understand if Muslims are aware and have knowledge of those services to systematically approach the Muslim community to increase their PBC.

These results are based on the basic descriptive statistics rather than significance tests, and could be the subject of future research to understand them in greater depth. The different and contradictory results among the research results should be considered from the SEM perspective that stresses the interaction among contextual factors, meaning Muslims in one community, city, or region might have different contextual factors that affect their approach toward mental health issues and services. Overall, the participants in this study compared to most of the other studies have a slightly more positive approach toward seeking mental health services because for the four constructs (CBMHP-cultural beliefs, KFMHS-knowledge, ATFMHS-attitudes, and PBC). The only exception is for PSTSMHS-stigma in which the participants overall mean is 15.36 (over the highest score of 32), which shows that the average score was slightly below the mid-point of 16. some slightly strong stigma. All these overall results are similar to Bagasra's (2010) study who had most of her participants from the southeastern U.S.. From this perspective, the current researcher has been aware that some mental health providers as researchers and providers at universities in this area have been striving to collaborate with the larger population, including the Muslim community, to provide mental health services at different levels (e.g., individual and group counseling, psychoeducation, and/or working with the community through projects to reach more people and address psychosocial issues at more system level). In Chapter II, the current researcher provided more detailed

information about these local and contextual collaboration with the Muslim community in the area to address the psychosocial issues. Another contextual factor/aspect to consider while interpreting the overall results is that one of the two Islamic centers (mosques), where the printed version was delivered and about 50 samples were collected, has collaborated more with a counseling department in the area and also with some other mental health providers to provide some psychoeducational sessions. However, these contextual/local collaborations cannot be seen in a causal-effect relationship and further research and analyses are necessary to make more contextually and statistically accurate interpretations of these results.

Research Question 2 Discussion

The path from CBMHP-cultural beliefs (exogenous variable) to ATFMHS-attitudes (endogenous variable) is significant and explains ATFMHS-attitudes in a negative way ($\beta = -.12, p < .01$) while controlling for background and KFMHS-knowledge variables. This finding indicates that the more a participant holds strong CBMHP-cultural beliefs, the more likely he or she is to have negative ATFMHS-attitudes. This result overall fits with the larger literature on Muslim mental health because a majority of the researchers found such a negative relationship between CBMHP-cultural beliefs and ATFMHS-attitudes (e.g., Aloud, 2004; Aloud & Rathur, 2009). As the current researcher previously explained, the overall Cronbach's alpha for the current study of .87 improved somewhat compared to the original scale of .82; this shows the scale was appropriate to use. However, since the Cronbach's alpha for CBMHP-cultural beliefs scale ($\alpha = .65$) was low, it is important to keep in mind that in

terms of CBMHP-cultural beliefs, the participants held slightly high scores on the construct. Almost all the researchers in the Muslim mental health literature constantly and strongly stressed the importance of considering CBMHP-cultural beliefs while providing mental health services to Muslims (Amri & Bemak, 2013; Bektas et al., 2009; Ciftci et al, 2013; Khan, 2006; Tanhan, 2014; Thomas et al., 2015; Youssef & Deane, 2006). The researchers also consistently called for more research to improve the measurements that have good psychometric features or at least utilize existing scales with different Muslim populations for empirical research due to a lack of well-established scales examining Muslims' CBMHP-cultural beliefs. To the knowledge of the current researcher this is the first study, after Aloud who developed the scale for Arab-Muslims, in which the scale was modified and utilized for empirical research with Muslims. Therefore, this study is meeting an important need in the literature of Muslims and mental health.

From TPB/TRA and SEM (theoretical lenses) perspectives, the significant path relationship is understandable because cultural beliefs are crucial factors affecting one's attitudes. This relationship is even more significant from the SEM perspective since the emphasis in SEM is on the system and how it affects the individual.

Research Question 3 Discussion

The path from CBMHP-cultural beliefs (exogenous variable) to PSTSFMHS-stigma (endogenous variable) is significant and explains PSTSFMHS-stigma in a negative way ($\beta = -.33, p < .01$) while controlling for background and KFMHS-knowledge variables. This finding can be interpreted as the more a participant held strong

CBMHP-cultural beliefs the more likely he or she was to have PSTSMHS-stigma. This result fits with most of the larger literature of Muslim mental health because a majority of the researchers found such a negative relationship between CBMHP-cultural beliefs and PSTSMHS-stigma (e.g., Aloud, 2004; Aloud & Rathur, 2009; Ciftci et al., 2013; Tanhan, 2014). As the current researcher previously explained, he modified the scale and the overall Cronbach's alpha increased for this study ($\alpha = .93$ compared to the original value .79), and this is an indication that the scale was appropriate to use. The results fit with what researchers in the Muslim mental health stated; the stronger Muslims hold CBMHP-cultural beliefs, the less likely they have high PBC and seek mental health services. That means the mental health providers need to consider both of the constructs, especially the CBMHP-cultural beliefs.

As most of the researchers stated (e.g., Ciftci et al., 2013; Tanhan, 2014), which the current researcher explained in detail in Chapter II, the relationship between these two constructs is very crucial because even the researchers who found that Muslims do not hold strong CBMHP-cultural beliefs (e.g., Bagasra, 2010) found that Muslims have an important amount of PSTSMHS-stigma. Another important point is considering that the path is the strongest path coefficient is from CBMHP-cultural beliefs to PSTSMHS-stigma among the six main paths. That might mean the mental health providers could benefit from paying attention to these two constructs much more closely than any other construct based on the current results, which was also strongly suggested by some other researchers (e.g., Amri & Bemak, 2013). The consideration of CBMHP-cultural beliefs and PSTSMHS-stigma is crucial from the SEM perspective because SEM emphasizes

understanding perceived social stigma in the context rather than just at intrapersonal and/or interpersonal levels. PSTSMHS-stigma is one of the main constructs in TPB/TRA and understanding it in a contextual perspective with CBMHP-cultural beliefs is more important since TPB/TRA sees cultural beliefs as factors leading to stigma in an indirect way, and the importance of such beliefs becomes much more important when the topic of interest is new to the participants (Fishbein & Ajzen, 2010).

In terms of TPB/TRA and SEM (theoretical lenses) perspectives, the significant relationship is meaningful because cultural beliefs are crucial factors affecting perceived social stigma. This relationship is much more meaningful from a SEM perspective because individuals are placed in their culture where culture as a larger system has a constant and strong effect on the individual system.

Research Question 4 Discussion

The path from CBMHP-cultural beliefs (exogenous variable) to PBC (endogenous variable) is significant and explains PBC in a negative way ($\beta = -.14, p < .01$) while controlling for background and KFMHS-knowledge variables. These findings indicate that the more a participant holds strong CBMHP-cultural beliefs the less likely he or she is to have high PBC which means perceived self-efficacy toward seeking mental health services if they needed it. None of the researchers in the Muslim mental health literature empirically examined PBC for Muslims and mental health, although few of them indirectly mentioned such a concept. Therefore, there is lack of direct and especially empirical research about this construct. As previously explained, the overall Cronbach's

alpha ($\alpha = .93$ compared to the original value of $.76$) for this study improved, which could be an indication that the scale was appropriate to use.

Understanding PBC in such a contextual perspective is crucial from the SEM perspective because many researchers (e.g., Aloud and Rathur, 2009; Amri & Bemak, 2013) indirectly (without calling it PBC or self-efficacy) mentioned PBC and recommended considering a more contextual (comprehensive) perspective. From the TPB/TRA perspective, PBC is one of the most important constructs in understanding one's approach toward the behavior of interest (Ajzen, 2006; Fishbein & Ajzen, 2010). Romano and Netland (2008) specifically called for counselors to utilize TPB/TRA and to pay attention to PBC. Therefore, this study meets an important gap and call in the literature of mental health, especially in Muslim mental health. The relationship between CBMHP-cultural beliefs and PBC is the third strongest path among the five main variables. It might be important to keep in mind that the CBMHP-cultural beliefs construct is one of the most commonly explained constructs while PBC is the least—if at all—mentioned construct in the Muslim mental health literature; therefore, further empirical research is needed to understand more in depth what this relationship means.

The significant path (relationship) between CBMHP-cultural beliefs and PBC is understandable from TPB/TRA and SEM perspectives. From the SEM perspective, the relationship is more understandable because one's culture is a strong system that directly affects one's approach toward acting on the topic of interest.

Research Question 5 Discussion

The path from KFMHS-knowledge (exogenous variable) to ATFMHS-attitudes (endogenous variable) is significant and explains ATFMHS-attitudes in a negative way ($\beta = -.14, p < .01$) while controlling for background and CBMHP-cultural beliefs variables. This finding indicates that the more a participant has KFMHS-knowledge, the more likely he or she is to have negative ATFMHS-attitudes. This finding is contradictory with the rest of the Muslim mental health literature because the rest of the research on Muslim mental health state that the more Muslims have KFMHS-knowledge, the more likely they have favorable ATFMHS-attitudes (although not all of them are based on empirical research). It might be important to keep in mind that all the survey and data collection was through self-reporting and the current researcher did not check for the accuracy of the participants' KFMHS-knowledge. The participants might have some misinformation and/or misconceptions about formal mental health services. From SEM and TPB/TRA perspectives, this construct is important, especially when the topic or the behavior of interest is new to the participants. In addition to these perspectives, Cottrell and others (2015) explained how different individual/intrapersonal or community theories stress level of knowledge to understand the behavior of interest. Based on all of these and especially that almost all the researchers (e.g., Abu-Ras, 2003; Cook-Masaud & Wiggins, 2011; Tanhan, 2014; Strack et al., 2016) in the Muslim mental health reported that Muslims' lack of KFMHS-knowledge is related to negative approaches toward mental health services, although except for few the researchers none examined Muslims' KFMHS-knowledge through empirical ways, further and more systematical research is

needed. For example, improving this current scale or developing a new scale to examine the accuracy of one's KFMHS-knowledge, misinformation, and/or misconceptions about mental health services and then looking at the relationship between KFMHS-knowledge and ATFMHS-attitudes is warranted.

This result does not fit with the TPB/TRA of the SEM perspective. From the TPB/TRA perspective, knowledge is a background factor that affects one's attitudes in a positive way, yet not at a significant level. There are some empirical studies from the TPB/TRA perspective that found there is a positive (yet not significant) relationship between knowledge and the behavior of interest. From the SEM perspective, the negative relationship between KFMHS-knowledge and ATFMHS-attitudes is not understandable since it is through the main theme of SEM that individuals and communities who have knowledge will be more likely to have a more favorable approach. Based on all these, the results of this research question should be interpreted and used with extreme caution.

Another consideration for interpreting the results is that participants could have had a mental health experience where they were not served effectively (e.g., lack of culturally competent mental health providers) and therefore hold less favorable attitudes toward formal mental health services while having high knowledge about the services. This can be subject of future research.

Research Question 6 Discussion

The path from KFMHS-knowledge (exogenous variable) to PSTSFMHS-stigma (endogenous variable) is not significant and is the only path that is not significant ($\beta = -.03$) while controlling for background and CBMHP-cultural beliefs variables. This

finding indicates that there was no a regular relationship found between the participants' KFMHS-knowledge and their PSTSFMHS-stigma. This result also does not fit with the results in the larger Muslim mental health literature because most of the researchers (e.g., Aloud, 2004; Aloud & Rathur, 2009; Ciftci et al., 2013) indicated that the more Muslims have KFMHS-knowledge the less they have PSTSFMHS-stigma, although not many of them conducted empirical research about Muslims' KFMHS-knowledge and its relationship with PSTSFMHS-stigma. As the current researcher explained in the previous research question discussion, more systematical and comprehensive studies and scales are necessary to examine Muslims' KFMHS-knowledge because the current scale for KFMHS-knowledge is only based on self-reporting and does not measure the accuracy of one's KFMHS-knowledge.

From the TPB/TRA perspective, the lack of significance is acceptable because from the theory perspective, knowledge in general is a not a good/significant predictor. However, the lack of a positive relationship between KFMHS-knowledge PSTSFMHS-stigma in this study (meaning higher scores on knowledge construct will predict higher scores on stigma construct, which means less stigma) is not understandable. From the SEM perspective, the individual and communities with higher knowledge toward a subject are more likely to have less perceived social stigma. Therefore, the result should be interpreted very carefully.

Research Question 7 Discussion

The path from KFMHS-knowledge to PBC is significant and explains PBC in a positive way ($\beta = .29, p < .01$) while controlling for background and CBMHP-cultural

beliefs variables. This is the only path that had a positive coefficient and is the second strongest path among the main variables. This finding indicates that the more a participant held KFMHS-knowledge the higher the PBC (meaning higher perceived self-efficacy) toward seeking formal mental health services if needed. This result fits with the larger body of research on Muslim mental health because almost all of the researchers consistently reported the importance of Muslims having KFMHS-knowledge and how that affects their approach toward mental health services (e.g., Ciftci et al., 2013; Cook-Masaud & Wiggins, 2011; Strack et al., 2016). However, as it has been explained in previous section in detail, none of the researchers empirically measured Muslims' PBC and its relationship with other constructs although they were indirectly mentioned, which makes it difficult to compare and place the current results. The researchers (e.g., Cook-Masaud & Wiggins, 2011; Kelly et al., 1996; Khan, 2006; Tanhan, 2016) in Muslim mental health research explained how some Muslims, especially Muslim women, might have a favorable approach toward seeking the services but could not due to different reasons (e.g., lack of transportation, lack of mental health providers with competency). Therefore, this positive relationship between these two constructs and the overall high mean of the participants for the PBC construct should be interpreted cautiously. Another important point to consider is that the current study is the first empirical and quantitative study examining Muslims PBC; therefore, more studies are needed for further understanding.

The positive relationship between the two constructs fits SEM as most of the researchers in the Muslim mental health stressed this perspective, though not clearly.

From the TPB/TRA perspective, knowledge about a subject (in this case about mental health issues, services, and treatments) in general is not a significant factor; however, its importance is magnified when the topic of interest is new to the participants. From the TPB/TRA perspective, knowledge affects other main factors (e.g., PBC) indirectly as a background through beliefs. Based on the literature and the current results, it is important to know that the KFMHS-knowledge construct in this study is partially measuring the participants' knowledge about available resources (e.g., mental health clinics, providers, services) as well in their environment (as it was explained in previous chapters like Chapter I and III), and such variables are called more directly as *actual control* in TPB/TRA and directly affects PBC level. Therefore, the positive relationship between KFMHS-knowledge and PBC is understandable from the TPB/TRA perspective.

From a theoretical lens perspective, the result is understandable from both the TPB/TRA and SEM perspective. From both theories'/models' perspectives, and especially when the topic of interest is new or unfamiliar to the participants, a high level of knowledge is more likely to have a positive relationship with one's high PBC level.

In addition, as it was mentioned in the previous chapter, it is important to consider that an important amount of variance in the three dependent variables (R-squares= .36, .13, and .28 respectively for attitudes, stigma, and PBC) was explained by the independent variables (cultural beliefs, knowledge, and the four background variables) combined. Therefore, further research and interpretation might worth.

Research Question 8 Discussion

There are no known researchers who have empirically examined how Muslims identify mental health providers. Therefore, this study met an important need in the literature, and it is even more important considering the previous research questions and especially how some constructs are not well structured. Therefore, the answer and analysis of this question provide a more contextual and rich description of how the participants see the mental health providers.

The current researcher used content analysis to see if any main categories existed. The responses fell into four categories. Thirty-four participants out of 75 (45.3%) identified mental health providers from a psychopathology perspective (e.g., problem solvers-fixers), which constituted the first category of responses. In the second category, 11 participants (14.7%) identified mental health providers from a wellness (positive psychology) perspective (e.g., increasing the quality of life, addressing issues). In the third category, 17 participants (22.7%) identified mental health providers from a more holistic perspective as professionals who address both severe psychological problems (from a psychopathology perspective) and/or professionals who help improve their quality/wellness of life (from a positive psychology perspective). In the last category (labeled as *other*), 13 participants (17.3%) held a variety of ideas.

The most common themes identified were that mental health providers are problem solvers/fixers, help with problems, give advice, and listen people to address problems.

From these results, one can see Muslims have a variety of ideas about mental health providers, and a majority identify them more from a psychopathology and also medical perspective, which is not very compatible with the definition of counseling (Kaplan et al., 2014) which comes from a more positive/wellness perspective. This result is important because how Muslims identify mental health providers affects their approach to mental health providers. Based on the participants' responses, they are more likely to seek mental health services and providers when they have some psychosocial issues that prevent them from functioning, as a majority of the researchers from the Muslim mental health have noted (e.g., Aloud & Rathur, 2009; Ciftci et al., 2013; Tanhan, 2014).

Contextual Questions Discussion

From the SEM perspective, human beings are affected by and do affect all the systems within which they live, and the most important part of SEM is to keep such a contextual and comprehensive dynamic in mind while trying to understand people. Therefore, as many other researchers in Muslim mental health have noted about such contextual factors (e.g., safety, attack on Muslims, immigration, wars), the current researcher also strived to pay attention to such factors, especially considering the time frame in which the research was conducted, just after the ban on seven countries (known as *Muslim ban* by many in the mainstream media and general public) in 2017 after president Trump signed an executive order. Based on all of these, in order to understand how the participants' larger exosystem (e.g., media, local institutions) and macrosystem (e.g., governments, political atmosphere) affect them, the participants were asked two questions as they were explained in Chapter IV.

Two hundred six participants responded to the first question, regarding how they feel safe, as follows: not at all ($n = 7$), very little ($n = 56$), somewhat ($n = 102$), and very ($n = 41$). In terms of the second (open-ended) question, most of the participants who reported that they did not feel safe (whether not at all, very little, or somewhat) listed the following reasons for their responses: current political conditions, elections, media, attack on Muslim in the U.S., attack on Islam, social environment and Muslim attire, unpredictable actions of non-Muslim community members who are manipulated by media and leaders, misconception about Islam and Muslims, being Muslim and negative attitudes from non-Muslims including family members, current president's attitude and actions, racism, white supremacy, Muslim ban, lack of services to practice my religion, wearing scarf and being obvious, killing Muslims, and stereotypes and stigma about Muslims, among others. The other participants who reported that they feel very safe or somewhat safe listed the following reasons for their responses for feeling safe: Islam, being Muslim, faith in Allah, not facing any difficulty or discrimination, being American citizen, not being identifiable as Muslims from outside in terms of race and attire, and myself, to name a few.

Based on all of these responses it is important to consider contextual factors and the systems within which Muslim live so that mental health providers do not victim blame, as many researchers consistently stressed and called mental health providers to pay more attention to contextual/system factors and not just intrapersonal factors to meet people where they are (e.g., ACA, 2014; Francisco & Tanhan, 2015; Prilleltensky, 2008; Strack et al., 2016; Young, 2011). In this case, it is so crucial to pay attention to the larger

system levels since they are directly affecting one's most fundamental right, having the right to feel and live safe. These results fit with the larger Muslim mental health literature because a majority of the researchers somewhat addressed this issue, although not all asked such specific questions.

Limitations

There are several limitations regarding the current study. The data for the study were collected from adult Muslims in the Southeastern U.S., and the sampling method was convenience sampling, which restricted the generalization of the result. In addition, a majority of the participants were from only one mid-sized city in the area. In addition, the survey was delivered through Muslim organizations in the area (e.g., mosques, RAM, MSA), which restricts generalizability of the findings to other populations. Furthermore, the length of the survey might have affected some participants' participation and/or completion, as was detailed and explained in Chapter IV; this is very important especially considering that most of the Muslims might not have had English as their first language. Related to that, leader(s) of one Muslim community at one of the mosques asked the participants to complete the survey in the mosque and/or in the garden of the mosque and return it in closed envelope without taking it home to increase the return and completed survey rate, while the leader(s) at the second mosque let the participants take the survey home and return it when it was completed. These approaches might have affected participants in different ways, and the return and completed ratio was much higher for the participants who were not allowed to take the survey home and complete it at a later time.

A second limitation is related to confidentiality and social desirability. The survey was delivered online and paper-based. Despite the assurance, as much as possible and as reported to IRB concerning confidentiality of responses and participants, participants may have acted in some ways (e.g., even though they did not want to participate yet ended up with participating, knowing the researcher was a counselor and so might have responded differently) to satisfy the researcher and Muslim community leaders since most of the community was familiar with the researcher and the leaders. In addition to online survey and printed version, the researcher also checked out about five iPads and/or computers and gave them to the leaders of RAM and MSA at the universities in the area to help with reaching out to participants.

A third limitation is related to time (e.g., historical and contextual time/place, time period to complete). The survey was sent out about when a ban on seven countries, known as *Muslim ban*, was discussed and executed. This might have prevented some Muslims from those specific countries from participating due to them thinking they were being profiled, which is a common threat to Muslims. In addition, the researcher used the responses submitted within the first 14 days for this study. The participants and the city was in the Southeast, which is socio-politically different from some other parts of the U.S., especially compared to the Northeast. Therefore, the study can only be generalized to Muslims living in the Southeastern U.S.

The fourth limitation is that there were more males than females who participated, mainly due to the study being delivered at the mosques (where the Muslim man has the obligation to go and the Muslim woman has the option to go) and the key people (e.g.,

the researcher himself and the Muslim community leaders) who delivered the study were male.

The next limitation is about the psychometric features of the instruments utilized in the current study. First and foremost, the current researcher slightly modified all the five instruments to make them more appropriate for the Muslim participants in this study; however, he did not examine the psychometric features of the scales afterward due to the small number of participants in the pilot study. In following paragraphs, the researcher provides some limitations for each instrument.

Aloud (2010) developed and used the first instrument (CBMHP-cultural beliefs) for Arab-Muslims in Columbus, OH; the current researcher is the first researcher who slightly modified the instrument and used it for any Muslims living in the Southeastern U.S. Therefore, this modified and/or original instrument needs to be used in more empirical research to examine its psychometric features because in this current study the Cronbach's alpha for the instrument was in the low range ($\alpha = .65$). This is one of the main limitations of the current study; therefore, the results should be interpreted with that in mind. It is also the first time that the current researcher slightly modified and utilized the second instrument (KFMHS-knowledge) with any Muslims living in the Southeastern U.S., and the Cronbach's alpha level increased ($\alpha = .89$). It is important to consider that these two scales, in their original version, lacked information about their criterion and/or construct validity. Based on all these, considering the strength and weaknesses of these two instruments, more studies are needed to understand psychometric features of these instruments to improve and utilize them more effectively.

The researcher slightly modified the last three instruments, and this is the first study in which the three scales are being used with Muslims. They were not normed for Muslims. Though the Cronbach's alphas for each of them improved, the overall alpha for the three dropped a few points; therefore, more empirical studies are needed to determine the psychometric features of the instruments with different and larger samples of Muslims.

The next limitation that might be related to the previous limitation is the low number of participants. As explained in Chapter III, it would have been much more effective if the current researcher had 20 participants per parameter or at least 10 participants, and not just going with the acceptable number of 200 participants as Kline (2016) suggested. Having 20 or at least 10 participants per parameter and a more diverse representative of Muslim participants could have helped with higher Cronbach's alpha for all scales and especially for the CBMHP-cultural beliefs scale, which produced a low alpha level. The higher number of participants could also have helped with running significance tests across the background variables for each of the five main constructs for the first research question.

Two more limitations are related to language. The first one is that the survey was only in English and required one to be able to read, which could have prevented some participants from participating, although the researcher had included in the consent form that he and/or any other could help explain the survey. No one asked for such a help to read and explain the survey. The second limitation was related to language was the use of "issues/problems" as one word throughout the survey. The importance of such inclusive

(not just a psychopathology) language is stressed by some researchers and by the participants of the pilot study, which the researcher explained in the previous chapters. However, none of the researchers used the words together in their empirical studies; therefore, it is an important point to consider in future studies to see how it affects the participants' approach and more specifically the psychometric features of the instruments. Additionally, to make the survey more culturally appropriate, some synonymous words were used for the words that may have been more difficult for mainstream Muslims to interpret. However, a few highly educated and Muslim American participants told the researcher that it is not necessary to use extra words because the survey becomes lengthy. This might have affected some participants and the approach to their participation.

Finally, there are various limitations in regards to the findings in the study. The most important limitation is the lack of use of well-grounded theories and/or theoretical frameworks (models) in the literature of Muslim mental health. Such a lack makes it much more difficult and creates many limitations to compare the current findings with the larger body of related research. In following paragraphs, the researcher provides more specific limitations regarding findings of each research question.

For the Research Question 1, Americans (across race/ethnicity) had the lowest KFMHS-knowledge level, which does not fit the larger research body at all. One of the main reason could be that some Americans identified themselves with other races rather than just saying American; however, more in-depth study is needed to understand that. In terms of ATFMHS-attitudes and PSTSFMHS-stigma, the higher the level of education

the less favorable ATFMHS-attitudes and more PSTSFMHS-stigma, which contradicts a majority of the body of research. Therefore, more in-depth understanding beyond basic descriptive statistics is necessary. In terms of PBC level and past behavior of use of mental health services, it is important to understand what caused the participants who had used mental health services in the past to have less PBC, while the literature reports otherwise (e.g., Cook-Masaud & Wiggins, 2011; Strack et al., 2016; Tanhan, 2014). Based on all these, the results of the first research question should be interpreted with caution.

While path coefficients for Research Questions 2-5 and Research Question 7 overall were significant and fit the larger body of Muslim mental health literature, there are a few results that should be interpreted with extra caution, which were discussed in more depth in the discussion section of this chapter. To reiterate this important limitation more specifically, the path from KFMHS-knowledge (exogenous variable) to ATFMHS-attitudes (endogenous variable) is significant and explains ATFMHS-attitudes in a negative way ($\beta = -.14, p < .01$). However, this negative relationship (path) does not fit the larger research body and should be interpreted with caution, as explained in the discussion section. Further systematical research and especially effort toward establishing instruments with good psychometric features are needed. Another path (relationship) that does not fit the larger research body is the nonsignificant relationship (path) from KFMHS-knowledge (exogenous variable) to PSTSFMHS-stigma (endogenous variable) ($\beta = -.03$). This result also should be interpreted with caution since a negative relationship between the two constructs is what a majority of the research body stresses.

For the last research question, the researcher analyzed the responses and that brings personal bias, which constitutes an important limitation.

Implications

The findings from the present study examining adult Muslims' approach toward mental health issues and formal mental health services through a contextual theoretical framework (model) based on TPB/TRA and SEM possess implications for mental health (e.g., counseling) research, practice, and training. In following sections, implications for each area are discussed.

Implications for Future Research

The results of the current study present a variety of directions for future research including testing and improving the constructs, running the whole proposed theoretical framework (model) with larger samples, using well-grounded theories and/or theoretical frameworks based on TPB/TRA and/or SEM, and using concept maps to decide which concepts/variables to study as the main construct. In this way, the research and practice in Muslim mental health literature will be more organized and systematical, which will lead more contextual, effective, and evidence-based practices. The researcher explains in detail a few implications for future research in the following paragraphs.

The first implication is improving the modified scales so that they are more culturally appropriate for all Muslims and also have good psychometric features (e.g., good validity and reliability) because there is a lack of such instruments. The current study meets some important gaps by modifying and empirically using the five instruments. In future research, it will be important to check the factor analysis for the

first two constructs since no one has checked for this one, and that might explain some of the limitations discussed in previous sections.

The second implication is utilizing the well-grounded proposed contextual framework (model) to examine whole or part of the model and/or shape future theoretical frameworks for empirical studies. Related to that, future researchers, especially the ones in Muslim mental health area, also can pay more attention to utilizing well-grounded theories like TPB/TRA and/or SEM to empirically examine Muslims' approach toward mental health issues and formal mental health services, rather than just mentioning and/or suggesting it. The use of TPB/TRA is also lacking in larger mental health disciplines including counseling; therefore, the future researchers also can pay attention to use the theory with different groups, not just Muslims.

The third implication for future research is drawing concept maps based on the literature and/or using the concept map provided in this study to decide which concepts to be studied as main constructs.

Another implication could be designing experimental studies after providing some mental health services such as interventions (e.g., psychoeducation, individual or group counseling/therapy, and/or community projects) to examine how participants' scores change on constructs. For example, providing psychoeducation about the KFMHS-knowledge construct to provide accurate information and then examining the scores for the construct and/or its relationship with other constructs could be done, since in this current study there were two paths that did not fit with the larger body of research.

A final implication is the need to conduct qualitative studies to understand each construct of the proposed theoretical framework, especially the first five constructs, related to how Muslims approach mental health issues and services. For example, a qualitative study with Muslims who have utilized mental health services to explore what made counseling more safe and appropriate for them. Based on the qualitative findings, looking at knowledge, attitudes, and PBC toward mental health services might be a worthwhile empirical study especially in light of the current research, and research findings that contradict with the larger literature. This might be important because as it was explained, participants' knowledge was negatively related with attitudes, and the participants who had utilized mental health services had a mean score of 16.05 for PBC while the ones had not utilized the services had a mean score of 22.62 for PBC. Therefore, understanding these constructs and the relationships among them may meet important needs to further understand this population.

Researchers who wish to conduct some of these future research ideas might benefit greatly from considering the limitations mentioned in this section to generalize the results to different Muslim populations and also run more complex analysis with larger samples.

Implications for Counseling Practice

Mental health providers are key people to address psychosocial issues and/or to increase the quality/wellness of life at all levels of life (e.g., individual including intrapersonal and interpersonal, group, community, exosystem, and macrosystem levels) from a SEM perspective. Therefore, based on the findings of the current research, mental

health providers (e.g., counselors) can provide various services to accompany Muslims while addressing their psychosocial issues.

The first practice can be mental health providers paying attention to considering intrapersonal theories (e.g., TPB/TRA) with larger system theories/models (e.g., SEM) while attending the people to understand and accompany them in addressing their biopsychosocial issues and/or to enhance their quality of life. It is very common to see mental health providers who fail to consider the larger context/systems people, and especially Muslims, live within and just stressing intrapersonal processes/factors. Therefore, as the proposed contextual framework (model) proposes, a broadened perspective that is based on intrapersonal and larger/system level will be crucial for an effective service; otherwise, it is more likely that mental health providers disserve and blame the victims, as the researchers explained. For example, it might be important for mental health providers to not just collaborate and address biopsychosocial issues at the individual level (e.g., individual sessions), but also collaborate with the community for projects (also known as community psychology) to identify, assess, and advocate for the issues on larger levels (e.g., institution, local, and government).

The second implication for mental health providers is paying special attention to understanding the five main constructs examined in this study, meaning what each of them means to Muslims and how they scored on them. Additionally, considering background variables and their interactions is important. For example, many mental health providers are not aware of CBMHP-cultural beliefs at all, when in this current and many other studies Muslims hold these beliefs from a moderate to a strong level.

Understanding these beliefs and incorporating them in the process of providing mental health services is crucial as all the researchers, without exception, stressed this construct and its role in Muslims' lives and the process of getting mental health services.

Therefore, a more accurate and deep understanding of these five constructs (what they mean to Muslims), their interaction/relationship, and then their integration to the process of providing service is another implication.

The next implication, more specifically than others, is paying attention to Muslims' level of PBC (perceived self-efficacy) toward seeking mental health services, because high PBC does not mean that Muslims will eventually utilize the services. Therefore, a more contextual and deep understanding of this construct is crucial.

Another important implication is mental health providers paying attention to a more inclusive language while interacting with Muslims in terms of providing information, practices, and events that introduce mental health services and providers, not just when one has serious issues (psychopathology) that prevents him or her from functioning in life, but also for enhancing the wellness/quality of life. As the researchers and findings in this study show, Muslims are more likely to identify mental health providers from a medical/psychopathology perspective, which leads them to resort to the services as the last option after they have tried other things which have not given them hope and could be a waste of time, money, and most importantly, life.

Another important implication is that other key people/professions (e.g., imams, spiritual leaders) who do not directly fall in line as a mental health provider also could benefit from these results if they integrate them because the participants did not hold very

strong CBMHP-cultural beliefs, as their scores on three items (one, two, and six) in the scale showed that the participants strongly align with explaining mental health issues, their causes, and treatments from a contemporary medical/scientific perspective. Therefore, the professionals and key people who are non-mental health providers might find considering these results helpful while providing services to Muslims.

As a final and comprehensive implication, considering the contextual and complex interaction of main constructs and background variables, more attention could be paid to cultural, spiritual/religious, and structural interventions to provide more effective services and to do so collaborating with other health providers (e.g., physicians, social workers) and key people in the Muslim community (e.g., imam, spiritual leaders).

Implications for Counselor Educators

Mental health educators, as gatekeepers, are crucial to affecting what the counselors-in-training learn, search, improve their perspectives, intervene, and how to approach issues after gaining all the knowledge/content (Borders & Brown, 2005). Many researchers (e.g., Holmes, 2013) invited the key people (professors) in education to be more cautious about their pedagogy while teaching how to address biopsychosocial issues. Therefore, the current findings will be helpful to mental health educators as well. More specific implications are presented in the following paragraphs.

The first implication is embracing the TPB/TRA and SEM perspectives in teaching. Most of the researchers in the Muslim mental health research body called for evidence-based interventions, and they especially called for considering a contextual and comprehensive perspective, which means SEM, while conducting research and providing

services related to Muslims. A few other researches from Muslim mental health and larger counseling literature also stressed and called for utilizing TPB or TRA, as they are called TPB/TRA in this study, in teaching and practice. The researcher provided more in-depth information about these researchers in Chapters I and II. Therefore, mental health providers, in getting more familiar with these models separately or together and integrating the models and its perspective in their teaching, will be important.

The second implication is integrating more information about Muslims' approach toward mental health issues (e.g., vignettes) in the teaching process so that the trainees can be more familiar with the concepts. For example, trainers could bring some speakers (e.g., an imam, key person from community) to share their struggles and issues at any level (intrapersonal, interpersonal, community, or macrosystem) and how they see these issues. In this way, it might be possible to see how they see and conceptualize their biopsychosocial issues. Additionally, the trainers can ask some questions to understand how Muslims cope with their issues and ask them if they can share how their spiritual/religious aspect affects them in this struggle. A second example will be for the trainers to call a scholar of Islam who is familiar with the nine aspects of self (since not all but many Muslims use them, whether consciously or unconsciously) and the journey between and among them might be used to conceptualize mental issues/struggles and healing. Another example would be for trainers to find a passage, video, or again, a guest to understand and discuss what kinds of daily rituals (e.g., daily prayers, remembrance of Allah) Muslims do to manage their stress/mental health issues.

A third implication could be for the trainers to collaborate with key people in the Muslim community and organize tours to the settings (e.g., mosques, Muslim cultural centers, Islamic schools, and/or Muslim events) where Muslims gather so that trainees get more familiar with the contexts of Muslims rather than developing a contextual picture. In addition, the trainers can invite guest speakers or organize some events at their schools/institutions and be intentional to include/invite Muslims so that again, the trainees get a more contextual perspective about Muslims and their approach mental health issues and formal mental health services.

Conclusion

The purpose of this study was to understand how Muslims in the Southeastern U.S. approach mental health issues and seeking formal mental health services. A second purpose was to partially test (examine) the proposed contextual theoretical framework to answer the eight research questions. In total 209 participants' responses were used for statistical analyses. The results indicated that the participants had a slightly high moderate/favorable levels/scores (observed $M= 25.19$ over the highest possible score of 44) on CBMHP-cultural beliefs, KFMHS-knowledge ($M= 18.67$ over the highest possible score of 33) , and PBC (observed $M= 20.23$ over the highest possible score of 32) constructs, a moderate/favorable level/score on ATFMHS-attitudes (observed $M= 16.86$ over the highest possible score of 32) construct, and slightly lower under-moderate level for PSTSFMHS-stigma (observed $M= 15.36$ over the highest possible score of 32) construct, meaning slightly strong stigma. For all these constructs, the higher scores mean the more favorable approach meaning favorable attitudes, less stigma, and higher PBC.

All these results indicate the participants did not strongly/extremely favor or disfavor the five constructs meaning approach toward mental health issues and seeking formal mental health services. In addition to these, the participants strongly aligned with the contemporary medical/scientific explanation of mental health issues and their causes and treatments through their responses to the three items in CBMHP-cultural beliefs construct.

All paths (relationships) for Research Questions 2-7 were significant, except for Research Question 6. Path coefficients from CBMHP-cultural beliefs for the each of the other three endogenous variables (ATFMHS-attitudes, PSTSMHS-stigma, and PBC) were negative and fit with the majority of the larger body of literature on Muslims and mental health. That indicates the stronger a Muslim participant holds CBMHP-cultural beliefs, the less likely they will have a favorable approach toward seeking mental health services. The path coefficient from KFMHS-knowledge to ATFMHS-attitudes was negative, which does not fit with the larger body of research and requires more in-depth study. This can be interpreted as the more a Muslim participant had KFMHS-knowledge, the less favorable ATFMHS-attitudes they had. The path from KFMHS-knowledge to PSTSMHS-stigma was not significant, which means there was not a positive or negative relationship between these constructs. This finding also does not fit the larger body of research because it is expected that the more one has KFMHS-knowledge the less PSTSMHS-stigma they have. The last path from KFMHS-knowledge to PBC was positive, meaning the more one has knowledge about mental health issues and services

the more likely they have a high PBC (perceived self-efficacy) to seek formal mental health services.

For the last research question, the participants' responses fell under four categories with the largest group (45.3%; 34 participants out of 75) identifying mental health providers from a medical/psychopathology perspective.

In addition to these, the researcher provided the limitations and implications of study for research, counselor educators, and practice.

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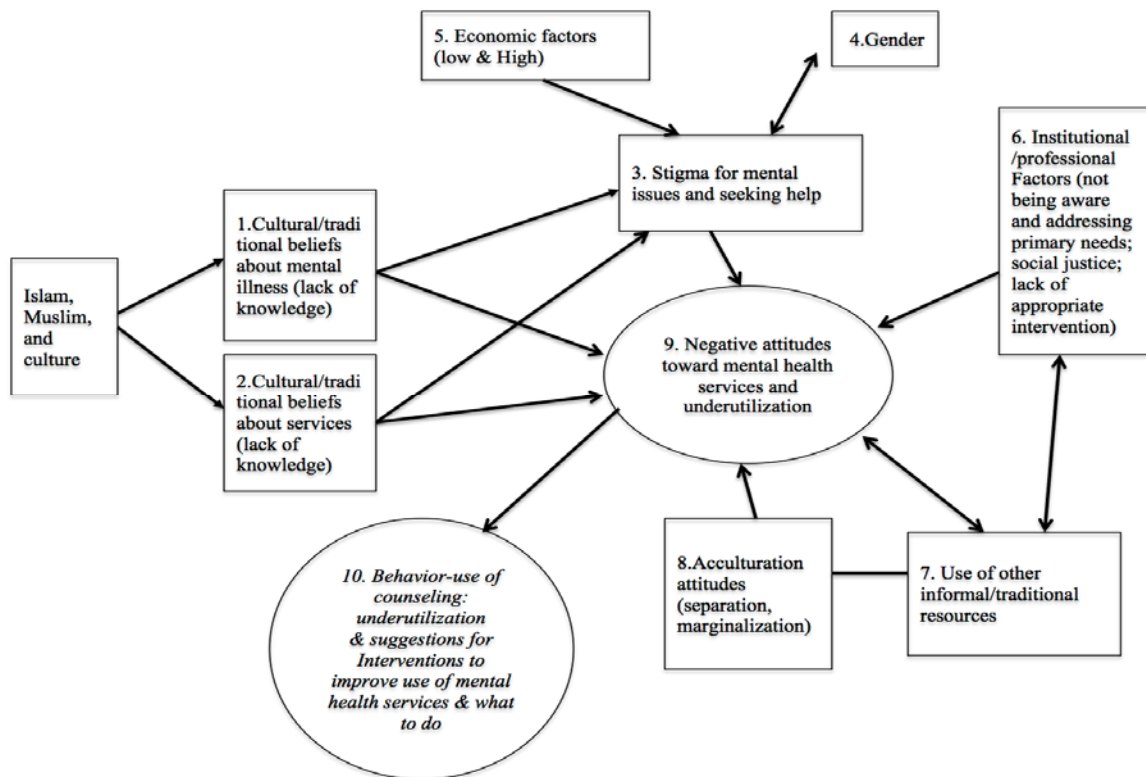
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APPENDIX A

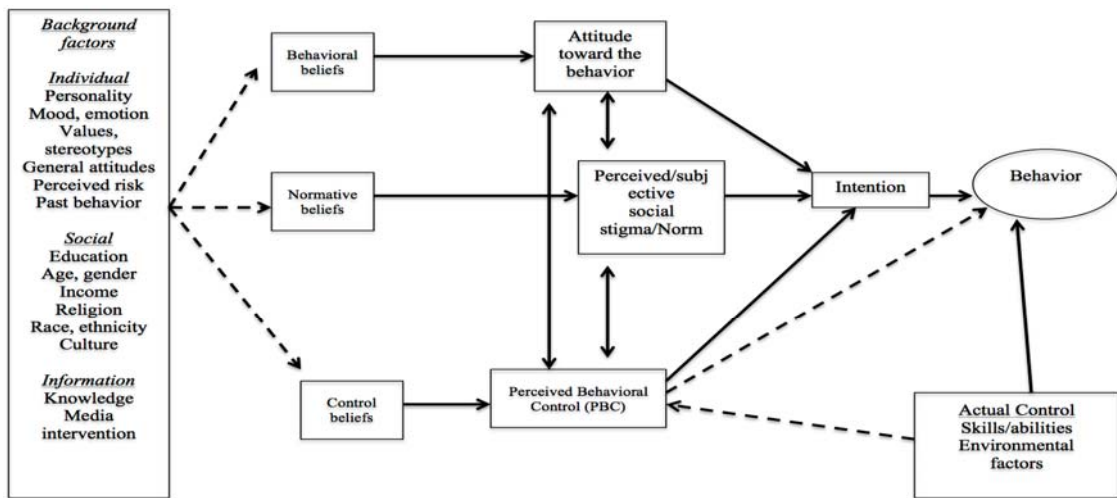
CONCEPT MAP

The current researcher drew this concept map based on a thorough Muslim mental health literature about the factors affecting Muslims' approach toward mental issues and seeking formal mental health services.



APPENDIX B

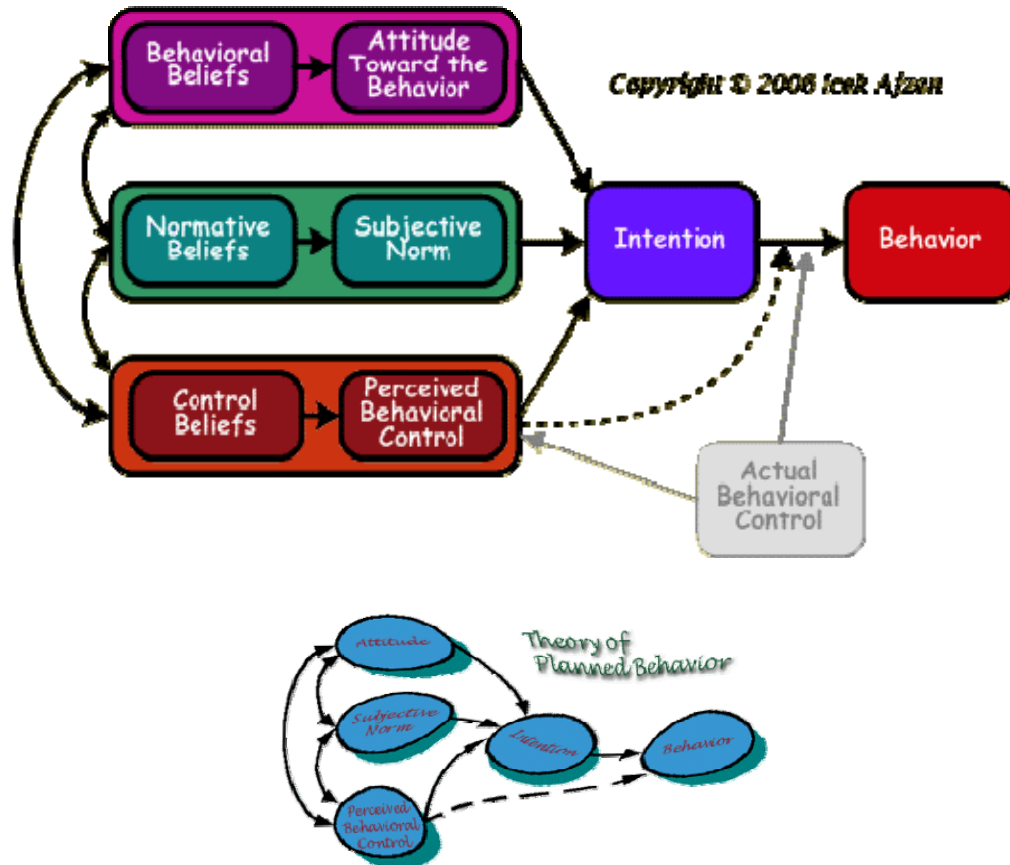
THEORY OF PLANNED BEHAVIOR/THEORY OF REASONED ACTION
(TPB/TRA) AS ONE THEORY



Theory of Planned Behavior (TPB) (Ajzen, 2006) and Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 2010) (TPB/TRA)

APPENDIX C

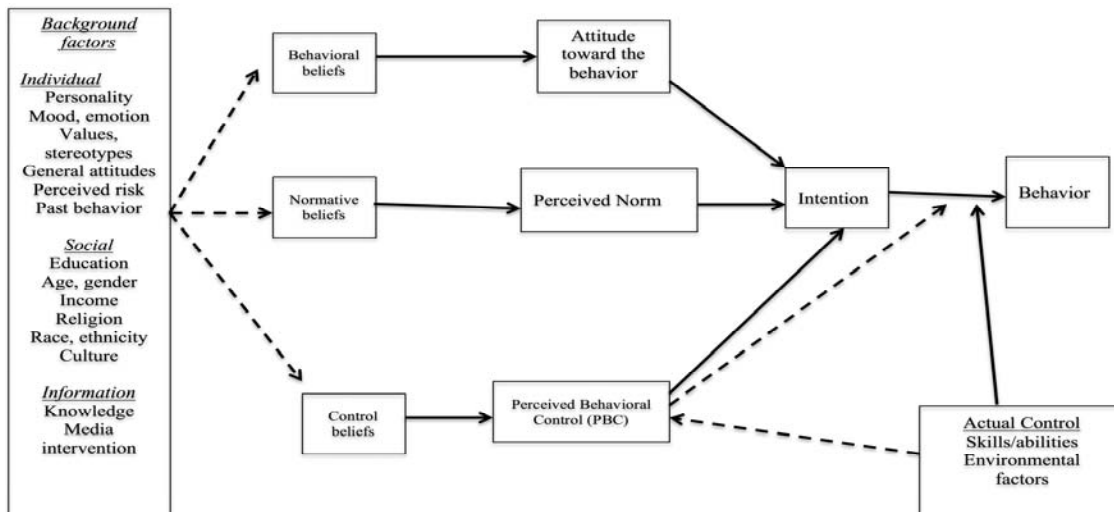
THEORY OF PLANNED BEHAVIOR (TPB)



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APPENDIX D

THEORY OF REASONED ACTION (TRA)



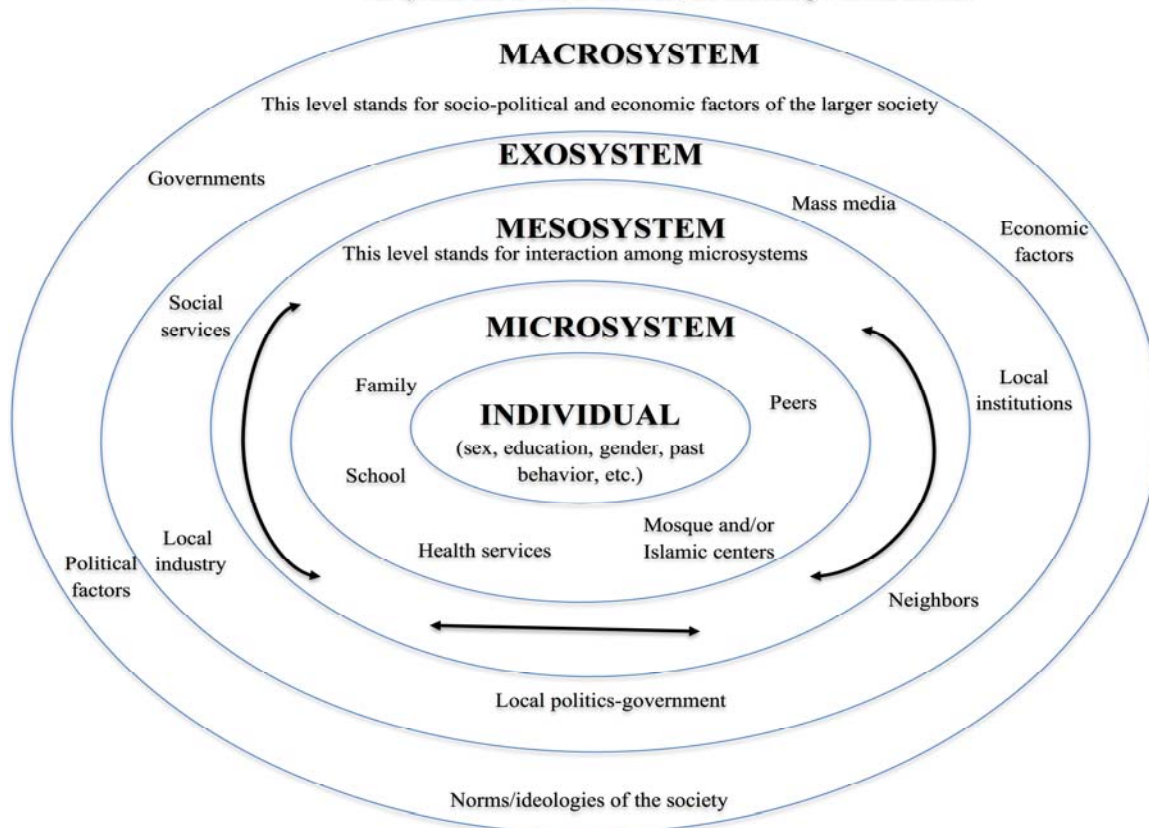
Theory of Reasoned Action (TRA) (Fishbein & Ajzen, 2010)

APPENDIX E

BRONFENBRENNER'S SOCIAL ECOLOGICAL MODEL (SEM)

Bronfenbrenner's Social Ecological Model (SEM)

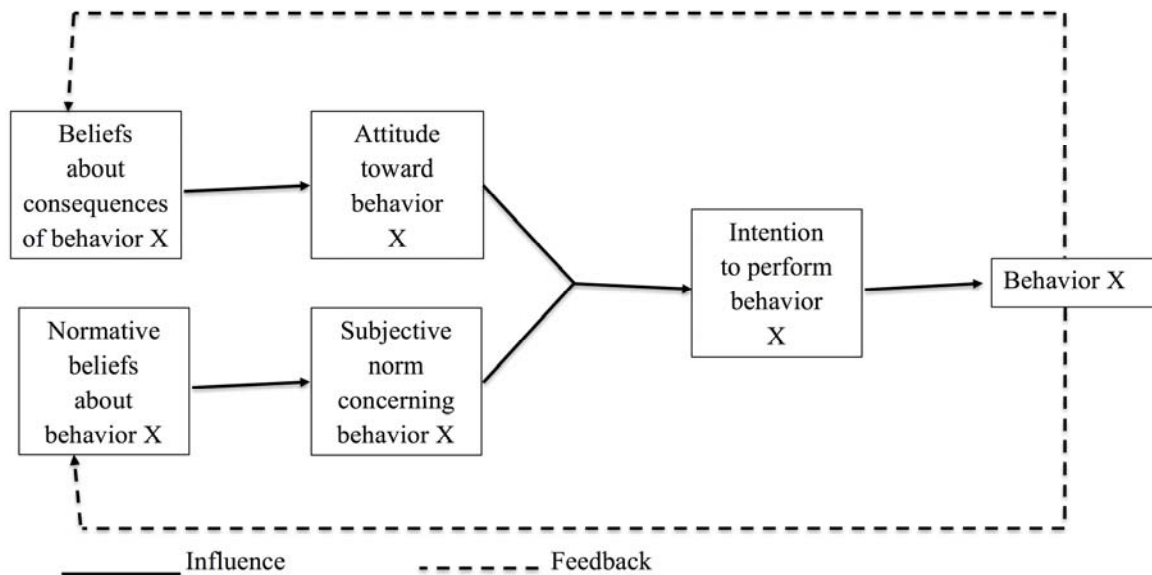
All systems and levels, in the model, are interacting with one another.



APPENDIX F

FIRST VERSION OF THEORY OF REASONED ACTION (TRA)

A conceptual framework that Fishbein and Ajzen (1975) used, which represents an *earlier/first* version of Theory of Reasoned Action (TRA), much before TPB (Ajzen, 2006) and the last version of TRA (Fishbein & Ajzen, 2010). The current researcher took the following figure from Fishbein and Ajzen (1975; p. 16).



APPENDIX G

PILOT STUDY: COVER LETTER, CONSENT FORM, SURVEY, IRB APPROVAL

Cover Letter for the Pilot Study

1

The Letter about this Study at the Counseling Department at UNCG

Assalamualaikum (peace be on you) sister/brother,

I, Ahmet Tanhan, am a Ph.D. student at the counseling department at UNCG. I will feel very happy if you can help me with participating to this study/survey about understanding adult Muslims in Greensboro and their approach to the use of mental health services. This study is need because our Muslim community needs to be heard and understood by mental health providers so that all together as community people, mental health providers, and researchers we can collaborate to increase the quality of life for all people including our Muslim community. Without you and your voice we as mental health providers and researchers cannot understand and work toward increasing the quality of life for our Muslim community, and we hope you see this study as a project of our community. Therefore, I hope you will agree to participate to this study and share your perspective with us so that we all together can work/strive toward a more meaningful and higher quality conditions for our community.

We guarantee you, insha'Allah/God willing, the participation is totally anonymous, volunteer, and confidential. We are not asking your name, address, or any other identification information. We are asking your and other adult Muslims' approach to the use of mental health services. **If you identify yourself Muslim, 18 years old or older, and have lived in Greensboro at least for two months then you can participate. Again, without your and other adult Muslims' participation and voice, this study will not be possible.**

The Institutional Review Board (IRB, an institution that pays utmost attention to protect people and communities during research studies) at the University of North Carolina Greensboro (UNCG) has reviewed and approved it.

The survey you will have **6 sections** and in total 82 questions with multiple choices and one question at the end asking you to share/write your idea with a few sentences. It might take 20-30 minutes based on your reading and wanting to take time. If you cannot understand some questions, you can get help from any other people and/or contact me so that I can meet you at an appropriate place like at UNCG, a library, a cultural center, a mosque, and/or any other appropriate (not private home or business place) places to clarify the survey/and questions. If you and/or any other adult Muslims want a paper/printed version of the questionnaire I can provide that as well.

There are no any personal gifts for your participation except for Allah/God's rewards for contributing to ilm/knowledge to increase the quality of life conditions of Muslim community. In addition to that, in April 2017, we will provide a **free dinner** at UNCG to share the results of the study with you, rest of the Muslim community, important key people in the city, and any others interested in Muslims and mental health. Attending the dinner is totally volunteer and all people whether they participated to the study or not will be invited, and we will announce the details (place, time, plan) about the dinner through Muslim organizations, and we hope you can join if you wish so that we can discuss the results and collaborate more to increase the quality of life conditions for our Muslim community. I will feel happy if you can spread this survey to other Muslims around you.

May Allah/God be pleased with you for your time, participation, and honest responses regarding this study. I ask Allah to reward all of you, others, and all of us for our efforts to contribute for Muslims and all people. **I will feel very happy to be contacted if you have any other questions, my phone numbers and emails: 336-265-5618, 585-360-5900; and/or 724-888-3990; tanhanahmet3@gmail.com and/or a_tanhan@uncg.edu or can contact the counseling department at UNCG: 1300 Spring Garden Street Greensboro, NC 27412 and phone number 336-334-5000.** Thanks a lot and may Allah/God be please with all of us for our effort,

Ahmet Tanhan, MS
Ph.D. Student
Counseling department at UNCG

Dr. Young, J. Scott
Chair and professor at the counseling department
Chairperson/advisor for the study/dissertation

Approved IRB
10/13/16

Consent Form for the Pilot Study

UNCG CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Understanding approach of adult Muslims' (who have lived in/around Greensboro, NC) toward seeking/using mental health services: a model (theoretical framework) based on the theory of planned behavior and theory of reasoned action (TPB/TRA) and the social ecological model (SEM)

Principal Investigator: Ahmet Tanhan, MS, PhD student; **Advisor:** J. Scott Young, PhD, Professor and chair (counseling department at UNCG)

What are some general things you should know about research studies? You are being asked to take part in a research study that focuses on understanding how adult Muslims in/around Greensboro approach/perceive/see mental health services like counseling/therapy. Your participation in the study is voluntary. You may choose not to join, or you may withdraw your consent to be in the study, for any reason, without penalty.

Research studies are designed to obtain new knowledge. This new information may help people in the future. There may not be any direct benefit to you for being in the research study. Getting/feeling some emotional disturbance because of the questions in this study is possible. If you choose not to be in the study or leave the study before it is done, it will not affect your relationship with anyone including the researcher or the University of North Carolina at Greensboro. Details about this study are discussed in this consent form. It is important that you understand this information so that you can make an informed choice about being in this research study. You can, and we recommend that, keep a copy of this consent form. If you have any questions about this study at any time, you can contact the researchers named in this consent form. Their contact information is below.

What is the study about? This is a PhD dissertation research project. Your participation is voluntary. The purpose of this study is to understand how adult Muslims in/around Greensboro approach mental health services (counseling, therapy). More specifically, the researcher is interested in understanding how the Muslims approach to the mental health services so that we can provide more effective services to Muslims and their communities who might want to utilize the services. To do this, I am asking you to share your perspective through participating in this survey.

What made me to ask you to participate? I am looking for adult Muslims (age 18 or older) who currently live or have lived in/around Greensboro at least for two months.

What will you ask me to do if I agree to be in the study? If you agree to participate in this study, you will be asked to complete the questions in the survey about your approach (cultural belief, knowledge, attitudes, and intention) toward mental health services. Participation is completely anonymous. Your participation to complete the survey might take about 20-25 minutes. You can complete it online. If you are willing to complete online and need a computer, you can contact the principal researcher. Some other options to complete are you can print or you can get a printed version from the principal researcher (Ahmet Tanhan), UNCG Muslim Student Association (MSA), UNCG Research Association of Muslims (RAM), UNCG office of intercultural engagement office, and Islamic centers (ICT, ICG) in Greensboro. If you choose to complete the study in person, your responses will not be linked to your name. Once you complete you can submit it online, give it to your community leaders at your mosque or UNCG MSA or RAM board members at UNCG, mail it to counseling department at UNCG, and get in touch with me to meet at a mosque or at UNCG to give it to me.

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Valid from:

10/13/16

10/12/17

For any reasons to complete and submit the survey you can get in touch with me personally or through my emails a_tanhan@uncg.edu and/or tanhanahmet3@gmail.com and/or my phone

(336-265-5618; 724-888-3990; 585-360-5900). Once I got enough data and analyzed them I will announce, through email lists from the Islamic organizations, specific plan for a free dinner at UNCG so that you and any others who are interested in the study can join the dinner to hear about the results. Everybody, whether they completed the survey or not, can attend to the dinner.

What are the risks to me? The Institutional Review Boards (IRB) at the University of North Carolina at Greensboro (UNCG) has determined that this study may involve minimal risks. Participation in this study may lead some unpleasant feelings/thoughts because of the questions. UNCG IRB also has determined that this study may potentially be beneficial to your community. The Islamic centers and organizations (ICT, ICG, UNCG MSA and RAM) also checked the whole study and found the study very beneficial to the community. If you have any questions, want more information, or have suggestions, I will feel more than happy to hear from you. You can contact me through my emails a_tanhan@uncg.edu and/or tanhanahmet3@gmail.com or through my phone number 336-265-5618 or you can contact my advisor Dr. Young, Scott (professor and chair at the counseling department at UNCG) and his email is jsyoung3@uncg.edu and his phone number at the department is 336-334-3433. We will feel happy to clarify any questions you have and make your participation is easy.

If you have any concerns about your rights, how you are being treated, concerns or complaints about this study or benefits or risks associated with being in this study, please contact the UNCG Office of Research Integrity toll-free at (855)-251-2351.

If you are willing to see and/or need a mental health provider like a counselor you can directly contact the primary researcher through his emails (a_tanhan@uncg.edu and/or tanhanahmet3@gmail.com) and/or phone numbers (336-265-5618; 724-888-3990; 585-360-5900). If you are a student at UNCG you can also contact UNCG counseling center on their website <https://shs.uncg.edu/cc> and/or by the phone 336.334.5874. If you are or are not a student, you can contact Vacc counseling clinic at the counseling department at UNCG: <http://soe.uncg.edu/academics/departments/ced/vacc-clinic/> and/or 336-334-5112. The clinic provides different services (for example individual, group, and family counseling) to students and Greensboro community as well. If you are student and or staff at some other specific settings (like NC Agricultural and Technical State University) you can contact their counseling centers as well, and the primary researcher can provide more information about that. The primary researcher will feel more than happy to answer any other questions you have.

Are there any benefits to society as a result of me taking part in this research? Mental health providers/researchers (e.g., counselors), friends, family members, administrators, and in general Muslim community may gain knowledge about how Muslims in/around Greensboro approach mental health services. In this way, the mental health providers/researchers can work more effectively with Muslim communities in/around Greensboro and other Muslim communities across the country to increase the quality/wellness of life for the Muslims and all other people.

Are there any benefits to me for taking part in this research study? There are no direct benefits to you for participating in this study. However, you will be contributing knowledge of understanding how Muslims approach mental health services so that mental health providers as

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researchers and practitioners work with Muslim communities to increase the quality/wellness of their life, and this may benefit you and all in the larger picture. If you decide to attend the dinner after the data/responses are analyzed, you may learn more about how Muslims approach mental health services.

Will I get paid for being in the study? Will it cost me anything? There are no payment or costs to you for participating to this study. However, everybody who is willing to whether they participated or not will be invited to the dinner after the data is analyzed. You will have a chance to learn more about the results and have a chance to contact the researchers and ask them any questions you have related to the study and/or mental health services.

How will you keep my information confidential? Your responses will be stored in the principal researcher's password protected computer and the paper survey will be protected in a locked place in the counseling department at UNCG. Please note that participation and responding to the survey is totally anonymous if you complete it online. However, absolute confidentiality of data provided through the internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. If you complete printed/paper based survey, I and/or the others around you who see you completing will know that you participated but again your name will not be asked and your responses will NOT be linked to you in any ways. That means I will not be able to understand which survey belongs to whom once I collected all the surveys. The responses will not be linked to you and any aspect of you. All information obtained in this study is strictly confidential unless disclosure is required by law. If you decide to go with paper/printed version of this survey you have FEW options to complete the survey and give it to the researcher (Ahmet Tanhan): completing the survey at the setting when you receive it and giving it to the researcher, completing the survey and giving it to one of the board members (community leaders) at your mosque or center and the community leader will save it in a safe box in their rooms so that the researcher can get it, calling the researcher to meet at a mosque or at UNCG to give your responses, giving your responses to board members of UNCG Muslim Student Association (MSA) or Research Association of Muslims (RAM), in all these printed/paper based options you will be offered a survey and an envelope so that you can return them to the researcher by yourself and/or through other partners mentioned above in a confidential way, and lastly asking the researcher to provide an already STAMPED ENVELOPE so that you can mail it to the counseling department at UNCG, in this last option you do NOT PAY AND PUT YOUR ADDRESS for mailing so that it is confidential.

What if I want to leave the study? You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of the data that has been collected to be destroyed unless it is not identifiable.

What about new information/changes in the study? If the current researcher change some significant amount of questions/information relating to the study, this information will be provided to you.

Voluntary consent by participant: By participating and completing the survey, you agree that you read and you fully understand the content of this document and freely consent to participate in this study. All of your questions about this study have been answered. By completing the survey, you agree that you are 18 years or older and agree to participate in this study described to you by Ahmet Tanhan who is a Ph.D. student at the counseling department at UNCG under his advisor Dr. Young's guidance.

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If you want, please keep a copy of this informed consent document for yourself. Institutional Review Board (IRB) at UNCG does NOT require a signature, so please do NOT sign.

If you have all the conditions mentioned above and are willing to participate, please start the next section of the survey/questions.

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Full Survey for the Pilot Study

All the materials that the participants read and responded for the pilot study are included in this appendix. The appendix includes the following sections: cover letter; consent form, demographic/background section, and the scales. The scales include Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments (CBMHP-cultural beliefs; item 1,2, and 6 are reverse coded) scale; Knowledge About Formal Mental Health Services (KFMHS-knowledge); and Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS). IASMHS **includes the three subscales that the current researcher used to measure** Attitudes Toward Seeking formal mental health services (ATFMHS), Perceived Social Stigma Toward Seeking Formal Mental Health Services (PSTSMHS), and Perceived Behavioral Control Toward Seeking Formal Mental Health Services (PBC). Each subscale has eight items: ATFMHS-attitudes subscale consists of items numbered 1, 4, 7, 9, 12, 14, 18, 21 (all reverse coded); PSTSMHS-stigma subscale consists of items numbered 3, 6, 11, 16, 17, 20, 23, 24 (all seven reverse coded except for item 23); and PBC subscale consists of items numbered 2, 5, 8, 10, 13, 15, 19, 22.

Important note for the next 5 sections

In this survey, **mental** and **psychological** are two words meaning the same thing. Similarly, the following a few words (**issues, problems, concerns, illnesses, and disorders**) also mean the same thing in this study.

Mental (psychological) issues/problems refer to any disturbance, pain, dissatisfaction, and/or unpleasantness (at mild, moderate, or severe levels) **that a person** feels/experiences because of different life conditions (for example forced or volunteer migration, searching for meaning of life, difficulties at job or school, difficulties with relationships with parents or others, unpleasant emotions, exposing to violence/war) **so that** the issues are decreasing the quality/wellness/functionality of life for the person and/or other people around. The term **professional mental health provider** refers to individuals who have been trained to deal with mental health issues/problems from a scientific/biomedical perspective; for example, counselors, therapists, psychologists, psychiatrists, and clinical social workers.

Cultural Beliefs about Mental Health Issues/Problems and their Causes and Treatments
(Section 1: 11 questions) (For the Pilot Study)

The following 20 items/sentences are about what you believe for each sentence. Please carefully read each item/sentence and select the response that best describes how you personally believe in each. It is important that you provide a response to each item. Please select only one response for each statement/sentence.

For each item, please indicate whether you

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

1. Biological factors (for example; genetic illness inherited/received from parents/grandparents) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

2. Environmental factors (like social stress, war exposure, migration, environment with lack of resources) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

3. “Aieen or nazar” (evil eye) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

4. “Seher” (magic or black magic) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

5. “Jinn” (spirits) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

6. Using professional mental health services (for example counseling/therapy) can treat mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

7. Using traditional prescribed medicines (for example black seed/cumin, za’atar, dates, honey) can treat mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

8. Using “Ruqia” (Quranic Recitation) can treat mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

9. There are certain mental health or psychological issues/problems that might NOT be treated using professional mental health or psychological treatment/services; rather they require “Ruqia” (Quranic Recitation).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

10. Many physical illnesses are likely to be a result of experiencing psychological distress/stress.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

11. Mental health professionals often experience more mental/psychological issues/problems than their clients (people who see mental health providers).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)
(Section 2: 24 questions) (For the Pilot Study)

For this section please choose just one and if possible answer each item, indicate whether you

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

1. There are certain problems which should NOT be discussed outside of one's immediate family.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

3. I would NOT want my significant other (spouse, fiancé) to know if I were suffering from psychological problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

6. having been mentally ill carries with it a burden of shame.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

7. It is probably best NOT to know everything about oneself.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief/help in psychotherapy (counseling).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

9. People should work out (solve, address) their own problems; getting professional help should be a last resort (option, solution).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

10. If I were to experience psychological problems, I could get professional help if I wanted to.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

11. Important people in my life would think less of (think negative) me if they were to find out that I was experiencing psychological problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

12. Psychological problems, like many things, tend to work out by themselves (without professional services).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

13. It would be relatively easy for me to find the time to see a professional for psychological problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

14. There are experiences in my life I would NOT discuss with anyone.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

15. I would want to get professional help if I were worried or upset for a long period of time.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out (hear, know) about it.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

17. Having been diagnosed with a mental disorder/illness is a blot (spot, fault, stigma) on a person's life.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to (using, seeking) professional help.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

19. If I believed I were having a mental breakdown (difficulty), my first inclination would be to get professional attention (services, help).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

20. I would feel uneasy (worried) going to a professional because of what some people would think.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

21. People with strong characters can get over psychological problems by themselves and would have little need for professional help.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

22. I would willingly (voluntarily, freely) confide (share) intimate matters to an appropriate person if I thought it might help me or a member of my family.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

23. If I had received treatment for psychological problems, I would have NOT feel that it should be hidden.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with (address) psychological problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

Knowledge about Formal Mental Health Services
(Section 3: 11 questions) (For the Pilot Study)

Below are sentences about ***your*** knowledge about mental health (psychological) issues/problems, services and professional mental health providers. Please carefully read each sentence and select the response that best describes how much you know about each sentence. It is important that you provide a response to each item.

For this section, please select only one response for each statement/sentence

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar for each

Each of the following sentence is a continuation of **“How much do you know about...”**

1. Mental/psychological issues/problems (for example; mental instability, an abnormal fear or feeling, anxiety, depression) that might require professional mental health services?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

2. The available mental health services/settings in your community (e.g. location, phone number, type of services)?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

3. The psychiatrist’s role in mental health services/settings?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

4. Counselor/therapist’s role in mental health services/settings?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

5. The other mental health providers’ (clinical social worker, psychologist) roles in mental health services/settings?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

6. Classified medical/behavioral or mental/psychological health issues/problems (for example depression, anxiety, schizophrenia, bipolar)?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

7. The type of treatment models/clinical interventions (for example individual, group, family counseling/therapy) used in professional mental health settings/clinics?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

8. How to get professional mental health services/counseling when needed (procedures and requirements)?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

9. Common medical/drug treatments prescribed to individuals with mental/psychological issues/problems?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

10. Mental health providers in your community who know, respect, and consider Muslims' faith/religion/spirituality while providing services to Muslims?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

11. Your eligibility for mental health care under your current health insurance plan?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

Demographic (Background) Section of the Survey for the Pilot Study
(Section 4: 3 questions)

In this section, you are asked to provide some general information; for example, your age, education level.

1. What is your sex?

Female (1)

Male (2)

2. How do you describe your race/ethnicity/origin?

Asian, Black, White, Hispanic/Mexican, Mixed, Not sure, Other-please indicate_____

3. What is the highest level of education you have achieved or currently registered/enrolled, at this point?

| | | | | | | | |
|-----------|--------|------------|---------|-----------|----------|-----------|---------------|
| Less than | | | J.D. | B.A. or | | MD | |
| high | High | Associates | (Law | B.S. | Master's | (Medical | |
| school | School | Degree | Degree) | (College) | Degree | Doctorate | Degree) Other |

The Use of Mental Health Services and Definition of Mental Health Providers
(Section 5: The last section and the last 3 questions) (For the Pilot Study)

1. Have you ever used mental health services and/or collaborated with any mental health providers (for example counselors/therapists) to talk about (get help) mental/psychological and/or social issues at individual, group, and/or community levels?

- **No**
- If yes, which one(s) below, please select all correct options for you
 - I have worked/collaborated with a mental health provider (for example a counselor) in individual, group, family, and/or couple sessions/meetings to address psychological or social issues
 - I worked/collaborated with a mental health provider (for example a counselor) individually or with a group to organize/prepare a project, research, social advocacy action, or some similar other social events.
 - I have received some educational and/or psychoeducational training at individual, group, and/or community level from mental health provider(s).

2. How do you define/describe mental health providers; for example, what does a counselor/therapist mean to you? Please describe/define below with a few sentences. (For example, to me a counselor/therapist means....)

3. If you have any recommendation to improve this survey/study, we will feel happy to hear about them, and you can type them in the following box. If you do not have any, please leave the box empty and read the last note to finish/submit your participation.

The end of the survey: please submit the survey to the researcher to submit your participation. May Allah be pleased with you for your support and consideration. Thanks a lot for all your time and consideration. Assalamualaikum/Peace be on you

APPENDIX H

THE ORIGINAL SCALES WITHOUT ANY EDITING

In this appendix, the current researcher provided an original sample of the scales he has edited and used in this current study so that the readers can see the original ones and editing more clearly if they wish to do so. The appendix includes Aloud's (2004) Cultural Beliefs about Mental Health Problems, their Causes and Treatments (CBMHP) scale (item 1 and 2 are reverse coded) and Knowledge and Familiarity with Formal Mental Health Services Instrument (KFFMHS). The appendix also includes Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS; Mackenzie et., 2004). **IASMHS includes three subscales that the current researcher used to measure** Attitudes Toward Seeking formal mental health services (ATFMHS), Perceived Social Stigma Toward Seeking Formal Mental Health Services (PSTSMHS), and Perceived Behavioral Control Toward Seeking Formal Mental Health Services (PBC). Each subscale has eight items: ATFMHS subscale consists of items numbered 1, 4, 7, 9, 12, 14, 18, 21 (all items are reverse coded); PSTSMHS subscale consists of items numbered 3, 6, 11, 16, 17, 20, 23, 24 (all items are reverse coded except for the item 23); and PBC subscale consists of items numbered 2, 5, 8, 10, 13, 15, 19, 22.

**Cultural Beliefs about Mental Health Problems, their Causes and Treatments
(CBMHP) Scale (Original Scale without any Editing)**

Below are statements regarding your belief about mental illness or psychological problems, their causative factors and treatments. Please carefully read each statement and select the response that best describes **how true each statement is for you**. It is important that you provide a response to each item.

Please select only one response for each statement.

For Example: if you tend to believe that such statement may be true, mark your answer as:

1. False 2. Probably false 3. Probably true 4. True

1. Mental health or psychological problems can be caused by biological factors (e.g. genetic illness inherited from parents or grandparents).

1. False 2. Probably false 3. Probably true 4. True

2. Mental health or psychological problems can be caused by environmental factors (e.g. social stress, war experience, etc).

1. False 2. Probably false 3. Probably true 4. True

3. Mental health or psychological problems can be caused by “Aieen” (evil eye).

1. False 2. Probably false 3. Probably true 4. True

4. Mental health or psychological problems can be caused by “Seher” (magic).

1. False 2. Probably false 3. Probably true 4. True

5. Mental health or psychological problems can be caused by “Jinn” (spirits).

1. False 2. Probably false 3. Probably true 4. True

6. Mental health or psychological problems can be treated using professional mental health or psychological counseling services.

1. False 2. Probably false 3. Probably true 4. True

7. Mental health or psychological problems can be treated using traditional prescribed medicines (e.g. black seed)

1. False 2. Probably false 3. Probably true 4. True

8. Mental health or psychological problems can be treated using “Ruqia” (Quranic Recitation).

1. False 2. Probably false 3. Probably true 4. True

9. There are certain mental health or psychological problems that might NOT be treated using mental health or psychological treatment; rather they require “Ruqia” (Quranic Recitation).

1. False 2. Probably false 3. Probably true 4. True

10. Many physical illnesses are likely to be a result of experiencing psychological distress.

1. False 2. Probably false 3. Probably true 4. True

11. Mental health professionals often experience more psychological problems than their patients.

1. False 2. Probably false 3. Probably true 4. True

**Knowledge and Familiarity with Formal Mental Health Services Instrument
(KFFMHS)
(Original Scale without any Edit)**

Below are statements pertaining to your knowledge and familiarity with mental health and psychological disorders, types of formal services, as well as mental health professional providers.

How much *familiar* are you with:

1. The type of problems that might require professional mental health or psychological intervention (e.g. mental instability, an abnormal fear or feeling, a depressed mood, etc)?

1. Not at all 2. Very little 3. Somewhat 4. Very familiar

2. The availability of mental health and psychological services in your community (e.g. location, phone #, type of care)?

1. Not at all 2. Very little 3. Somewhat 4. Very familiar

3. The psychiatrist's role in mental health and psychological counseling settings?

1. Not at all 2. Very little 3. Somewhat 4. Very familiar

4. The psychologist's role in mental health and psychological counseling settings?

1. Not at all 2. Very little 3. Somewhat 4. Very familiar

5. The clinical social worker's role in mental health and psychological counseling settings?

1. Not at all 2. Very little 3. Somewhat 4. Very familiar

How much do you *know* about:

6. Classified medical/behavioral mental health or psychological disorders (e.g. depression, anxiety, schizophrenia, etc.)?

1. Nothing 2. Very little 3. Some 4. A great deal

7. The type of treatment models/clinical interventions (e.g. psychotherapy) used in professional mental health clinics?

1. Nothing 2. Very little 3. Some 4. A great deal

8. How to get professional mental health or psychological counseling services when needed (e.g. procedures and requirements)?

1. Nothing 2. Very little 3. Some 4. A great deal

9. Common drug treatments prescribed to individuals with mental health or psychological problem?

1. Nothing 2. Very little 3. Some 4. A great deal

10. The Arab and Muslim professionals who practice mental health or psychological counseling within your local community (Columbus, OH)?

1. Nothing 2. Very little 3. Some 4. A great deal

11. Your eligibility for mental health care under your current health insurance plan?

1. Nothing 2. Very little 3. Some 4. A great deal

**Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)
(Original Scale without any Edit)**

The term *professional* refers to individuals who have been trained to deal with mental health problems (e.g., psychologists, psychiatrists, social workers, and family physicians). The term *psychological problems* refers to reasons one might visit a professional. Similar terms include *mental health concerns*, *emotional problems*, *mental troubles*, and *personal difficulties*.

For each item, indicate whether you *disagree* (0), *somewhat disagree* (1), *are undecided* (2), *somewhat agree* (3), or *agree* (4):

1. There are certain problems which should not be discussed outside of one's immediate family
2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological problems
3. I would not want my significant other (spouse, partner, etc.) to know if I were suffering from psychological problems
4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns
5. If good friends asked my advice about a psychological problem, I might recommend that they see a professional.
6. Having been mentally ill carries with it a burden of shame.
7. It is probably best not to know *everything* about oneself
8. If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief in psychotherapy
9. People should work out their own problems; getting professional help should be a last resort
10. If I were to experience psychological problems, I could get professional help if I wanted to
11. Important people in my life would think less of me if they were to find out that I was experiencing psychological problems
12. Psychological problems, like many things, tend to work out by themselves
13. it would be relatively easy for me to find the time to see a professional for psychological problems
14. There are experiences in my life I would not discuss with anyone
15. I would want to get professional help if I were worried or upset for a long period of time
16. I would be uncomfortable seeking professional help for psychological problems because people in my social or business circles might find out about it
17. Having been diagnosed with a mental disorder is a blot on a person's life.
18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears *without* resorting to professional help

19. If I believed I were having a mental breakdown, my first inclination would be to get professional attention
20. I would feel uneasy going to a professional because of what some people would think
21. People with strong characters can get over psychological problems by themselves and would have little need for professional help
22. I would willingly confide intimate matters to an appropriate person if I thought it might help me or a member of my family
23. Had I received treatment for psychological problems, I would not feel that it ought to be “covered up.”
24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with psychological problems

Note. No permission is required to use this inventory.

APPENDIX I

FULL STUDY: COVER LETTER AND CONSENT FORM, FULL SURVEY AS APPROVED BY IRB

All the materials that the participants read and respond for the full (final) study are included in this appendix. The appendix includes the following sections: cover letter and consent form approved by IRB, the scales, and demographic/background section. The scales include Cultural Beliefs about Mental Health Issues/Problems and Their Causes and Treatments (CBMHP-cultural beliefs; item 1,2, and 6 are reverse coded) scale; Knowledge About Formal Mental Health Services (KFMHS-knowledge); and Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS). IASMHS **includes the three subscales that the current researcher used to measure** Attitudes Toward Seeking formal mental health services (ATFMHS-attitudes), Perceived Social Stigma Toward Seeking Formal Mental Health Services (PSTSFMHS-stigma), and Perceived Behavioral Control Toward Seeking Formal Mental Health Services (PBC). Each subscale has eight items: ATFMHS subscale consists of items numbered 1, 4, 7, 9, 12, 14, 18, 21 (all eight items are reverse coded); PSTSFMHS subscale consists of items numbered 3, 6, 11, 16, 17, 20, 23, 24 (all eight items are reverse coded except for item 23); and PBC subscale consists of items numbered 2, 5, 8, 10, 13, 15, 19, 22.

Cover Letter and Consent Form for the Full Study Approved by IRB

1

A Humble Letter about the Study: Approach of Muslims Toward Seeking Mental Health Services

Assalamualaikum (peace be on you) sister/brother,

I (Ahmet Tanhan) am a Ph.D. student at the counseling department at UNCG. I will feel very happy if you can help me with participating to this study. I am looking for adult (18 years old or older) Muslims who have lived in the Southeast of the U.S., and especially the one lived in/around Greensboro, NC. This study is need because our Muslim community needs to be heard and understood by mental health providers so that all together as community people, mental health providers, and researchers we can collaborate to increase the quality of life for all people including our Muslim community. I hope you will agree to participate to this study and share your perspective with us so that we all together can strive toward a more livable and meaningful life conditions for our community.

We guarantee you, insha'Allah, the participation is anonymous, volunteer, and confidential. We are not asking your name, address, or any other identification information. **The Institutional Review Board (IRB, an institution that pays utmost attention to protect people and communities during research) at the University of North Carolina Greensboro (UNCG) has reviewed and approved the study.**

The survey includes **six sections**. Completing the survey might take 20-30 minutes. If you cannot understand some questions, you can get help from any other people and/or contact me. I also can provide a printed version of the questionnaire if you want. There are no any personal gifts for your participation except for Allah's rewards for contributing to ilm/knowledge to increase the quality of life conditions for Muslim community. In addition to that, in April 2017, we will provide a **free dinner** at UNCG to share the results of the study with you, rest of the Muslim community, important key people in the city, and any others interested in Muslim mental health. Attending the dinner is totally volunteer and will be open to all. We will announce the details about the dinner through Muslim organizations. I will feel happy if you can spread this survey to other Muslims around you.

May Allah be pleased with you for your time, participation, and honest responses regarding this study. I ask Allah to reward all who contribute to humanity including our Muslim community. **I will feel very happy to be contacted if you have any other questions.**

UNCG CONSENT TO ACT AS A HUMAN PARTICIPANT

Project Title: Understanding approach of adult Muslims toward seeking mental health services **Principal Investigator:** Ahmet Tanhan, MS, PhD student; 336-265-5618; 724-888-3990; tanhanahmet3@gmail.com or a_tanhan@uncg.edu ; Ferguson building, office 244; counseling department at UNCG; 1300 Spring Garden Street Greensboro, NC 27412 and phone number 336-334-5000. **Advisor:** J. Scott Young, PhD, Professor and chair (counseling department at UNCG); jsyoung3@uncg.edu ; 336-334-3433.

What are some general things you should know about research studies? You are being asked to take part in this research study that focuses on understanding how adult Muslims in the Southeast of the U.S. approach mental health services. Your participation in the study is voluntary. Research studies are designed to obtain new knowledge. This new information may help people in the future. You must be 18 or older to participate.

What is the study about? This is a PhD dissertation research project. The purpose of this study is to understand adult Muslims' (who live in the Southeast of the U.S.) approach to mental health services. If you agree to participate, you will answer some questions about your approach to mental health services. It might take 20 to 30 minutes to complete the study. You have the right to refuse to participate or to withdraw at any time, without penalty. If you do withdraw, it will not affect you in any way. If you choose to withdraw, you may request that any of the data that has been collected to be destroyed unless it is not identifiable. You can complete it online or printed version, and I (Ahmet) can provide the necessary tools (e.g., computer, paper based survey) to complete the study. If you choose to complete the study in person, your responses will not be linked to your name. Once you complete you can submit it online, give it to your community leaders at your mosque, UNCG MSA or RAM board members at UNCG, mail it to my office at UNCG, or get in touch with me to meet at a mosque or at UNCG to give it to me. **For questions about the study or to complete and submit the survey you can get in touch with me or my advisor personally or through our contact information.**

What are the potential risks and benefits? The IRB at UNCG has determined that participation may involve minimal risks. Potential risks may include unpleasant feelings/thoughts because of the questions. This study may potentially be beneficial to your community. Some Islamic organization in the area (ICT, ICG, MSA,

UNCG IRB
Approved Consent Form
Valid from:

1/5/17 to 10/12/17

RAM) also checked the whole study and found the study potentially beneficial to the community. If you have any concerns about your rights, how you are being treated, concerns or complaints about this study or benefits or risks associated with being in this study, please contact the UNCG Office of Research Integrity toll-free at (855)-251-2351. If you are willing to see and/or need a mental health provider like a counselor you can directly contact the primary researcher through his emails and/or phone numbers. If you are a student at UNCG you can also contact UNCG counseling center on their website <https://shs.uncg.edu/cc> and/or by the phone 336.334.5874. If you are student and or staff at some other specific settings (like NC Agricultural and Technical State University) you can contact their counseling centers.

Are there any benefits to society and me as a result of me taking part in this research? Mental health providers (e.g., counselors), friends, family members, administrators, and in general Muslim community may gain knowledge about how Muslims approach mental health services. In this way, the mental health providers/researchers can work more effectively with Muslim communities to increase the quality of life for the Muslims and all. There are no direct benefits to you for participating in this study. You will be contributing knowledge of understanding how Muslims approach mental health services. If you decide to attend the dinner after the responses are analyzed, you may learn more about how Muslims approach mental health services.

Will I be paid for participating in the study? There is no payment or costs to you for the study. You will have a chance to learn and contact the researchers more about the results at the free dinner in April.

How will you keep my information confidential? The principal researcher will store all data in a password protected computer, and he will protect the paper survey in a locked place at his department. Please note that participation and responding to the survey is totally anonymous if you complete it online. However, absolute confidentiality of data provided through the internet cannot be guaranteed due to the limited protections of Internet access. Please be sure to close your browser when finished so no one will be able to see what you have been doing. If you complete printed based survey, I and/or the others around you who see you completing will know that you participated but again your name will not be asked and your responses will NOT be linked to you in any ways. That means I will not be able to understand which survey belongs to whom once I collected all the surveys. The responses will not be linked to you and any aspect of you. All information obtained in this study is strictly confidential unless disclosure is required by law. If you decide to go with printed version of this survey you have FEW options to complete the survey and give it to the researcher: completing the survey at the setting when you receive it and giving it to the researcher, completing the survey and giving it to one of the board members (community leaders) at your mosque or center, and the community leader(s) will save it in a safe box in their rooms so that the researcher can get it, calling the researcher to meet at a mosque or at UNCG to give your responses, giving your responses to board members of UNCG MSA or RAM, in all these paper based options you will be offered a survey and an envelope so that you can return them to the researcher by yourself and/or through other partners mentioned above in a confidential way, and lastly asking the researcher to provide an already STAMPED ENVELOPE so that you can mail it to his office WITHOUT PAYING and WITHOUT PUTTING YOUR ADDRESS.

What about new information/changes in the study? If the current researcher change some significant amount of information relating to the study, this information will be provided to you.

Voluntary consent by participant: By participating and completing the survey, you agree that you read and you fully understand the content of this document and freely consent to participate in this study. All of your questions about this study have been answered. By completing the survey, you agree that you are 18 years or older and agree to participate in this study described to you by Ahmet Tanhan under his advisor Dr. Young's guidance. If you want, please keep a copy of this informed consent document for yourself. This study qualifies for a waiver of a signature, so please do NOT sign.

If you have all the conditions mentioned above and are willing to participate, please start the next section of the survey.

UNCG IRB
Approved Consent Form
Valid from:

1/5/17 to 10/12/17

Full Survey for the Full Study Approved by IRB

Important note for all the following sections:

In this survey, **mental** and **psychological** are two words meaning the same thing. Similarly, the following a few words (**issues, problems, concerns, illnesses, and disorders**) also mean the same thing in this study.

Mental (psychological) issues refer to any disturbance, pain, dissatisfaction, and/or unpleasantness (at mild, moderate, or severe levels) **that a person** feels/experiences because of different life conditions (for example forced or volunteer migration, searching for meaning of life, difficulties at job or school, difficulties with relationships with parents or others, unpleasant emotions, exposing to violence/war) **so that** the issues are decreasing the quality of life for the person and/or other people around. The term **professional mental health provider** refers to individuals who have been trained to deal with mental health issues from a scientific perspective; for example, counselors, therapists, psychologists, psychiatrists, and clinical social workers.

In the following items, the current researcher used few words together that mean the same thing to make it easier for our Muslim community members who have English as their second, third, or fourth language. Therefore, it might be a little more difficult for some of us to read, and thanks a lot to all for your patient, understanding, and investing your time.

**Cultural Beliefs about Mental Health Issues/Problems and their Causes and
Treatments (CBMHP) Scale
(Section 1: 11 items) (For the Full Study)**

The following 21 items are about **what you believe** for each sentence. Please carefully read each item and select the response that best describes how **you personally believe** in each. It is important that you provide a response to each item. Please select only one response for each statement.

For each item, please indicate whether you

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

1. Biological factors (for example; genetic illness inherited/received from parents/grandparents) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

2. Environmental factors (like social stress, war exposure, migration, environment with lack of resources) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

3. “Aieen or nazar” (evil eye) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

4. “Seher” (magic or black magic) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

5. “Jinn” (spirits) can cause mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

6. Using professional mental health services (for example counseling/therapy) can treat mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

7. Using traditional prescribed medicines (for example black seed/cumin, za’atar, dates, honey) can treat mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

8. Using “Ruqia” (Quranic Recitation) can treat mental/psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

9. There are certain mental health or psychological issues/problems that might NOT be treated using professional mental health or psychological treatment/services; rather they require “Ruqia” (Quranic Recitation).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

10. Many physical issues/illnesses are likely to be a result of experiencing psychological distress/stress.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

11. Mental health professionals often experience more mental/psychological issues/problems than their clients (people who see mental health providers).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

**Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS)
(For the Full Study)**

Note: The current researcher used this inventory with its three subscales to measure attitudes toward seeking formal mental health services (ATFMHS); perceived social stigma toward seeking formal mental health services (PSTSMHS-Stigma); and Perceived Behavioral Control toward seeking formal mental health services (PBC).

(Section 2: 24 questions)

For this section please choose just one and if possible answer each item, indicate whether you

0. __ Disagree 1. __ Somewhat disagree 2. __ Undecided 3. __ Somewhat agree 4. __ Agree

1. There are certain issues/problems which should NOT be discussed outside of one's immediate family.

0. __ Disagree 1. __ Somewhat disagree 2. __ Undecided 3. __ Somewhat agree 4. __ Agree

2. I would have a very good idea of what to do and who to talk to if I decided to seek professional help for psychological issues/problems.

0. __ Disagree 1. __ Somewhat disagree 2. __ Undecided 3. __ Somewhat agree 4. __ Agree

3. I would NOT want my significant other (for example, spouse, fiancé, partner) to know if I were suffering from psychological issues/problems.

0. __ Disagree 1. __ Somewhat disagree 2. __ Undecided 3. __ Somewhat agree 4. __ Agree

4. Keeping one's mind on a job is a good solution for avoiding personal worries and concerns.

0. __ Disagree 1. __ Somewhat disagree 2. __ Undecided 3. __ Somewhat agree 4. __ Agree

5. If good friends asked my advice about a psychological issue/problem, I might recommend that they see a professional.

0. __ Disagree 1. __ Somewhat disagree 2. __ Undecided 3. __ Somewhat agree 4. __ Agree

6. Having mental issues/illnesses carries a burden (load) of shame.

0. __ Disagree 1. __ Somewhat disagree 2. __ Undecided 3. __ Somewhat agree 4. __ Agree

7. It is probably best **NOT to know everything** about oneself.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

8. If I were experiencing a serious psychological issues/problem at this point in my life, I would be **confident that I could find relief/help** in psychotherapy (counseling).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

9. People should work out (solve, address) their own issues/problems; getting professional help should be a **last resort (option, solution)**.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

10. **If I were to experience psychological issues/problems, I could get professional help** if I wanted to.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

11. Important people in my life **would think less (think negative) of me if they were to find out** that I was experiencing psychological issues/problems.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

12. Psychological issues/problems, like many things, tend to work out **by themselves (without professional services)**.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

13. It would be relatively **easy for me** to find the time to see a professional **for psychological issues/problems**.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

14. There are experiences in my life **I would NOT discuss with anyone**.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

15. I would **want to get professional help** (for example, counseling, therapy) if I were worried or upset **for a long period of time**.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

16. I would be uncomfortable seeking professional help for psychological issues/problems because people in my social or business circles might find out (hear, learn) about it.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

17. Having been diagnosed with a mental disorder/illness is a blot (spot, fault, stigma) on a person's life.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

18. There is something admirable in the attitude of people who are willing to cope with their conflicts and fears without resorting (using, seeking) professional help.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

19. If I believed I were having a mental breakdown (difficulty, issues, problems), my first inclination would be to get professional attention (services, help).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

20. I would feel uneasy (worried) going to a professional because of what some people would think.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

21. People with strong characters can get over psychological issues/problems by themselves and would have little need for professional help.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

22. I would willingly (voluntarily, freely) confide (share) intimate matters to an appropriate person if I thought it might help me or a member of my family.

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

23. If I had received treatment for psychological issues/problems, I would NOT feel that it ought to (should) covered up (be hidden).

0. Disagree 1. Somewhat disagree 2. Undecided 3. Somewhat agree 4. Agree

24. I would be embarrassed if my neighbor saw me going into the office of a professional who deals with (address) psychological issues/problems.
0. __Disagree 1. __Somewhat disagree 2. __Undecided 3. __Somewhat agree 4. __Agree

**Knowledge About Formal Mental Health Services
(Section 3: 11 questions) (For the Full Study)**

Below are sentences about **your** knowledge about mental health (psychological) issues/problems and services and professional mental health providers. Please carefully read each sentence and select the response that best describes how much you know about each sentence. It is important that you provide a response to each item. **For this section, please select only one response from 0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar for each statement/sentence.**

Each of the following sentence is a continuation of **How much do you know about**

1. Mental/psychological issues/problems (for example; mental instability, an abnormal fear or feeling, anxiety, depression) that might require professional mental health services?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

2. The available mental health services/settings in your community (e.g. location, phone number, type of services)?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

3. The psychiatrist's role in mental health services/settings?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

4. Counselor/therapist's role in mental health services/settings?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

5. The other mental health providers' (clinical social worker, psychologist) roles in mental health services/settings?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

6. Classified medical/behavioral or mental/psychological health issues/problems (for example depression, anxiety, schizophrenia, bipolar)?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

7. The type of treatment models/clinical interventions (for example individual, group, family counseling/therapy) used in professional mental health settings/clinics?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

8. How to get professional mental health services/counseling when needed (procedures and requirements)?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

9. Common medical/drug treatments prescribed to individuals with mental/psychological issues/problems?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

10. Mental health providers in your community who know, respect, and consider Muslims' faith/religion/spirituality while providing services to Muslims?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

11. Your eligibility for mental health care under your current health insurance plan?

0. Not at all, 1. Very little, 2. Somewhat, and 3. Very familiar

Demographic (Background) Section of the Survey for the Full Study

(Section 5: 7 Questions)

In this section, you are asked to provide some general information; for example, education level, sex.

1. What is the highest level of education you have achieved or currently registered/enrolled, at this point? (circle one)

| | | | |
|-----------------------|-------------|---------------------------|--|
| Less than high school | High School | College, Associate degree | Graduate school (for example: master's, doctorate, medical degree) |
|-----------------------|-------------|---------------------------|--|

2. What is your sex?

1. Female

2. Male

3. How do you describe your race/ethnicity? (Please circle/choose ALL applied to you.)

- African American
- Arab
- Asian
- Ethiopian
- Sudani
- Hispanic/Latino
- Kurdish
- Pakistani and/or Indian
- Somalian
- Turkish
- Persian
- West African
- White (for example: Caucasian, European)
- American (USA citizen)
- Other-please type _____

4. How do you describe country of origin for your family (if you are Native American then indicate it as USA; otherwise, please indicate where your family came from if you know; for example, France, Sudan, Palestine; if not sure you can say Europe, Asia, Africa, or unknown)? Please type in the box, and if your family/parents were from different countries please type both.

Country or countries: _____

5. Which part of the U.S. have you lived in? (Circle one)

- I currently live in/around Greensboro, NC
- I currently live in the Southeast of the U.S.
- I have lived in Greensboro, NC
- I have lived in the Southeast of the U.S.
- I have lived in the other areas of the U.S.

6. How safe do you feel as a Muslim in the U.S.?

- Not at all
- Very little
- Somewhat
- Very

7. What factors affected your response to the previous question?

The Use of Mental Health Services and Definition of Mental Health Providers

(Section 6: The last section and the last 3 questions) (For the Full Study)

1. Have you ever used mental health services and/or collaborated with any mental health providers (for example counselors/therapists) to talk about (get help) mental/psychological and/or social issues at individual, group, and/or community levels?

- No
- Yes

2. If you have answered as "yes" to the previous question, please choose all correct options for you.

- I have worked/collaborated with a mental health provider (for example a counselor) in individual, group, family, and/or couple sessions to address psychological or social issues
- I worked/collaborated with a mental health provider (for example a counselor) individually or with a group to organize a project, research, social advocacy action, or some similar other social events.
- I have received some educational and/or psychoeducational training at individual, group, and/or community level from mental health provider(s).

3. How do you define mental health providers; for example, what does a counselor/therapist mean to you? Please describe/define below with a few sentences. (For example, to me a counselor/therapist means....) (Please type below)

The end of the survey: please click on the arrow to submit your participation. May Allah be pleased with you for your support and consideration. Thanks a lot for all your time and consideration. Assalamualaikum/Peace be on you

APPENDIX J

LETTERS OF SUPPORT

Support Letter from Research Association of Muslims (RAM) at UNCG

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

(In the name of Allah/God, the Entirely Merciful, the Especially Merciful)

Research Association
of Muslims @ UNCG



October 25, 2016; The Office of Research Integrity
The University of North Carolina at Greensboro, 2714 MHRA Building, 1111 Spring
Garden Street, Greensboro, NC 27412, phone: 336.256.1482)

**Subject: Letter of Support for (Ahmet Tanhan, MS) dissertation study to the
Institutional Review Board (IRB) at UNCG**

Assalamualaikum (peace be on you),

This is a letter of support for Ph.D. student (Ahmet Tanhan) at the counseling department at UNCG to conduct his study titled "Understanding approach of Greensboro (NC, USA) adult Muslims toward seeking/using mental health services: a model (theoretical framework) based on the theory of planned behavior and theory of reasoned action (TPB/TRA) and the social ecological model (SEM)." As Research Association of Muslims (RAM) at UNCG, we feel happy to support brother Ahmet's work to benefit our Muslim community and all others in/around Greensboro. We understand that the researcher will use the collected data for research purpose to increase the quality of life condition for all including Muslims in/around Greensboro. We understand that he will inform and share the data with us after he analyzed and got the results. We, as RAM@UNCG, will provide adequate support to spread the study through all our resources (e.g., emails, social media, social events). As RAM@UNCG, we appreciate UNCG counseling department's and brother Ahmet's collaboration with our community to enhance the quality of life. We are looking forward for further cooperation both in this current study and following studies to improve the quality of life for all including Muslim community in Greensboro. If you have any questions, we will feel happy to be contacted through our email (RAMUNCG16@gmail.com) and/or our personal emails.

May Allah/God make this study beneficial to all,

Thanks a lot,

Co-presidents of RAM@UNCG (names, emails, signatures)

Sara Alagha
S_alagha@uncg.edu
Sara Alagha

Youssef Alshemmani
Y_alshem@uncg.edu

Support Letter from Muslim Student Association (MSA) at UNCG

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

(In the name of Allah/God, the Entirely Merciful, the Especially Merciful)



October 10, 2016

The Office of Research Integrity

The University of North Carolina at Greensboro, 2714 MHRA Building, 1111 Spring Garden Street, Greensboro, NC 27412, phone: 336.256.1482)

Subject: Letter of Support for (Ahmet Tanhan, MS) dissertation study to the Institutional Review Board (IRB) at UNCG

Assalamualaikum (peace be on you),

This is a letter of support for Ph.D. student (Ahmet Tanhan) at the counseling department at UNCG to conduct his study titled "Understanding approach of Greensboro (NC, USA) adult Muslims toward seeking/using mental health services: a model (theoretical framework) based on the theory of planned behavior and theory of reasoned action (TPB/TRA) and the social ecological model (SEM)." As Muslim Student Association (MSA) at UNCG, we feel happy to support brother Ahmet's work to benefit our Muslim community and all others in/around Greensboro. We understand that the researcher will use the collected data for research purpose to increase the quality of life conditions for all including Muslims in/around Greensboro. We understand that he will inform and share the data with us once he analyzes the results. We will provide adequate support to spread the study through all our resources (e.g., emails, social media, social events) so that Muslims can participate. We appreciate UNCG counseling department's and brother Ahmet's collaboration with our community. We are looking forward for further cooperation both in this current study and future studies to improve the quality of life for all including the Muslim community. If you have any questions, we will feel happy to be contacted through our email (uncgmsa@gmail.com) and/or our personal emails.

May Allah/God make this study beneficial to all, and thanks a lot

(Signatures, emails, names, and positions in UNCG MSA)

Lena Ragab (president)
lhragab@uncg.edu

Asiya Khan (Vice Pres)
afkhan@uncg.edu

Support Letter from the Office of Intercultural Engagement (OIE) at UNCG



062 Elliott University Center
PO Box 26170, Greensboro, NC 27402-6170
336.334.5090 Phone 336.256.2433 Fax

October 11, 2016

The Office of Research Integrity

The University of North Carolina at Greensboro, 2714 MHRA Building, 1111 Spring Garden Street, Greensboro, NC 27412, phone: 336.256.1482)

Subject: Letter of Support for (Ahmet Tanhan, MS) dissertation study to the Institutional Review Board (IRB) at UNCG

To Whom It May Concern,

This is a letter of support for Ahmet Tanhan, a Ph.D. student at the counseling department at UNC Greensboro to conduct his study titled "Understanding approach of Greensboro (NC, USA) adult Muslims toward seeking/using mental health services: a model (theoretical framework) based on the theory of planned behavior and theory of reasoned action (TPB/TRA) and the social ecological model (SEM)." As the Office of the Intercultural Engagement (OIE) at UNCG, we have collaborated with Ahmet Tanhan and the counseling department, to benefit the Muslim community and larger UNCG Student body. Moving forward, the OIE will continue to support Ahmet's outreach to the Muslim community at UNCG through our office (e.g., email lists, social media) and offer meeting space if any Muslim participants have any further questions regarding participation in the study.

We understand that the researcher will use the collected data for research purposes with the end goal of increasing the quality of life for all including Muslims in and around Greensboro. We understand that he will inform and share the results of data with us. As the office, we will provide all appropriate support for the researcher so that he can collect a more accurate representation of Muslim community at UNCG and Greensboro not just the ones affiliated with some specific Muslim organizations (e.g., MSA, RAM).

As the office, we appreciate the collaboration with the counseling department. We are looking forward for further cooperation both in this study and following studies to improve the quality of life for all including the Muslim community in Greensboro.

Best wishes,

Augusto Peña
Director, Office of Intercultural Engagement

Support Letter from Islamic Center of Triad (ICT)

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

(In the name of Allah/God, the Entirely Merciful, the Especially Merciful)



September 25, 2016

The Office of Research Integrity, The University of North Carolina at Greensboro, 2714
MHRA Building, 1111 Spring Garden Street, Greensboro, NC 27412, 336.256.1482

Subject: Letter of Support for (Ahmet Tanhan, MS) dissertation study to the Institutional Review Board (IRB) at UNCG

Assalamualaikum (peace be on you),

This is a letter of support for Ph.D. student (Ahmet Tanhan, MS) at the counseling department at UNCG to conduct his study titled "Understanding approach of Greensboro (NC, USA) adult Muslims toward seeking/using mental health services: a model (theoretical framework) based on the theory of planned behavior and theory of reasoned action (TPB/TRA) and the social ecological model (SEM)" within the Islamic Center of Triad (ICT) facilities. We understand that the researcher will use the collected data for research purpose to increase the quality of life condition for all including Muslims in Greensboro. We understand that he will inform and share the data with ICT. As ICT, we will provide adequate support for the researcher, giving full access to all ICT facilities and events so that he can collect a more accurate representation of Muslim community in Greensboro.

As ICT, we appreciate UNCG and especially counseling department's collaboration with our Muslim community. We are looking forward for further cooperation both in this study and following studies to improve the quality of life for all people including Muslim community in Greensboro. If you have any questions, we will feel happy to be contacted.

Thanks a lot, and may Allah/God make this study beneficial to all,

Signature

Badi Ali (336-988-0818 and badi323@aol.com)

President of the Islamic Center of Triad (ICT)

4930 Mary St, Greensboro, NC 27409

(336) 856-2870 | badi323@aol.com | <http://www.islamiccenterofthetriad.com>

Support Letter from Islamic Center of Greensboro (ICG)

بِسْمِ اللَّهِ الرَّحْمَنِ الرَّحِيمِ

(In the name of Allah/God, the Entirely Merciful, the Especially Merciful)

Islamic Center



of Greensboro

September 25, 2016

The Office of Research Integrity

The University of North Carolina at Greensboro, 2714 MHRA Building, 1111 Spring Garden Street, Greensboro, NC 27412, phone: 336.256.1482)

Subject: Letter of Support for (Ahmet Tanhan, MS) dissertation study to the Institutional Review Board (IRB) at UNCG

Assalamualaikum (peace be on you),

This is a letter of support for Ph.D. student (Ahmet Tanhan) at the counseling department at UNCG to conduct his study titled “Understanding approach of Greensboro (NC, USA) adult Muslims toward seeking/using mental health services: a model (theoretical framework) based on the theory of planned behavior and theory of reasoned action (TPB/TRA) and the social ecological model (SEM)” within the Islamic Center of Greensboro (ICG) facilities/resources. We understand that the researcher will use the collected data for research purpose to increase the quality of life condition for all including Muslims in Greensboro. We understand that he will inform and share the data with ICG. As ICG, we will provide adequate support for the researcher, giving full access to all ICG facilities and events so that he can collect a more accurate representation of Muslim community in Greensboro.

As ICG, we appreciate UNCG and especially counseling department’s collaboration with our community. We are looking forward for further cooperation both in these study and following studies to improve the quality of life for all including Muslim community in Greensboro. If you have any questions, we will feel happy to be contacted.

May Allah/God make this study beneficial to all,
Thanks a lot,

(Signature)

Ahmed Tejan-Sie, MD (216-392-2508)

President of the Islamic Center of Greensboro (ICG)

2023 16th St. Greensboro, NC 27405 | 336-375-4907 | Fax: 703.935.0857 |

<http://icgnc.com/>

APPENDIX K

COPYRIGHT PERMISSIONS

Copyright Permission for CBMHP-cultural beliefs and KFMHS-knowledge Scales

The researcher got the permission to use the scales and slightly edit them; the researcher checked the editing with the author and the author approved it. The researcher got I touch with the author of the scales through email, as one can see below from the chain of emails.

1. "Assalamualaykum Dr. Aloud,
It is Ahmet Tanhan. I am from Turkey and am doctorate student at the department of counseling at the University of North Carolina at Greensboro (UNCG) in the USA. I am interested in the perception of counseling/mental health in the Muslim community and how to improve it. I have been working with Muslim communities since my master. I have used your article with Dr. Rathur titled "Factors Affecting Attitudes Toward Seeking and Using Formal Mental Health and Psychological Services Among Arab Muslim Population," in my master thesis and the ACA presentation last year in Hawaii. And now I have read again and planning to look at the three measures that you have used including, ATSPPH and ATSFMHS, cultural beliefs about mental health problems, and knowledge about and familiarity with formal mental health services. I am interested in them because I am planning to first check them and use for my classes and then for my dissertation. Therefore, I will be very happy to get the measurements and also demographic questions as well if that is okay, or if there is another way to get them. My school (UNCG) email is a_tanhan@uncg.edu incase you want it. Thanks a lot for your work for the study and article and I will be happy to be more in touch and see if we even can further collaboration now or in the future.

I have been working with the Muslim community on our campus from a counselor perspective and have been doing some productive activity. I am planning keep doing such series of advocacy/studies and then conduct an explanatory study for my dissertation two years from now. And I recently conducted a survey on our campus about "common concerns of the Muslim community on campus" if you want to use the whole report and following activities the link:

<https://www.facebook.com/groups/1630401400505244/>

I first tried to send you an email to your naloud@imamu.esu.sa but the email did not go through and failed permanently. Then I tried to send you through Facebook as well in case you see it through it. Then now I found your hotmail on your twitter account. Having the measurements you have adapted and developed will be helpful to me to serve the Muslim community and mental health profession.

Again thanks a lot for your study and I will be happy to hear back,

Salaam,"

2. "Alaykumsalam Dr. Aloud,

Thanks a lot for your consideration. I found in the database as well. I have not read the whole dissertation and have one more question if you remember which 5 questions you have added to the first scale (ATFSMHS: Attitudes Toward Seeking Formal Mental Health Services) to address perceived societal stigma. I have attached ATFSMHS in case you have time to look at it."

3. "alaykumsalam brother/Dr. Nasser,

Thanks a lot for allowing me to use and modify to make it more appropriate for my study and sample. I will soon share the adapting/editing points once I described it in my dissertation, today I should be done with explaining the editing/adapting. I first want to spell it well in my dissertation so that it becomes easier for you, my professors, and I to be on the same page.

Beyond my dissertation, I have another idea to add some other items that I want use from another research (Bagasra, 2010; Bagasra and Mackinem, 2014) to add to your scale to see if we can create some subscales by running factor analysis. I discussed this with my professors and they liked the idea but this is not going to be in my dissertation since this will require much more work and has some risk if I do not find subscales as a result of the factor analysis. Therefore, this is a second/future step/study that we can talk about once I am done with my research. And this second step will meet a huge gap in the literature review and also in the practice of mental health services to the Muslims.

I will soon share the editing and we can be in touch insaAllah, eid muabarak in advance again brother/Dr. Nasser."

Emails from Dr. Aloud

1. "Sallam

Thank y for the email.. Ofcourse you can use it.. You can find it in my Dissertation that can be accessed via googel. Just type my name and will get it for free."

2. "Sallm Brother, Can please send me the suggestion and we can look at it and see how to improve the Scale You can do. What you want to get your research do. The Scale is not limited and we can change it"

3. "Eid Mubark

"It sounds ok. Just need to ask....."

Copyright Permission for ATFMHS-attitudes, PSTFSMHS-stigma, and PBC Scales

Though taking permission is not required to use the scale, the researcher got the permission to use and slightly edit the scales; the researcher checked the editing with the author and the author approved it. The following emails show the correspondence:

1. "Dr. Mackenzie,

It is Ahmet Tanhan second year PhD student in Counseling and Educational Department (CED) at the University of North Carolina at Greensboro (UNCG) in the USA and my UNCG email is [a_tanhan@uncg.edu](mailto:atanhan@uncg.edu) and it is linked to my gmail/this account.

I want to get your feedback and permission about if it is going to be an appropriate use of the scale(s).

Thanks a lot for your time and consideration,

Sincerely, Ahmet Tanhan"

2. "Dr. Mackenzie,

I have utilized your scale for my pilot study and have few questions to take your permission.

1. I have gotten some feedback from the Muslim participants to add "issues" next to the "problems" in each item to make it more appropriate for Muslims, which I have done for the other items in the other two scales I have used. Therefore, can I edit by using "problems/issues" or "issues/problems" in for the items rather than just "problems."

2. There are a few words that I want to add extra explanation to clarify for and respect Muslims. For example, putting "solve, address" in parenthesis next to "work out" for item 9. And another example is to add "fiancé" to the item 3 in parenthesis.

I am aware this are not very big editing and yet just wanted to be sure to get your permission. I can share the full edited one if you approve and can get your feedback again.

I will feel very happy to hear back and get your permission because I really want to utilize your scale and also make it more convenient for the Muslim participants. Appreciate your time and consideration Dr. Mackenzie."

Dr. Mackenzie's responses: "Hi Ahmet,

The changes you're suggesting make sense to me – you certainly have my permission to make them. They may affect the psychometric properties of the scale, but so long as you report them you should be fine. I wish you luck with your research and please do let me know how your study works out.

Take care, Corey"

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Mar 08, 2017

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| Number of charts/graphs/tables/figures | 1 |
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APPENDIX L

RESPONSES AND CONTENT ANALYSIS OF RESEARCH QUESTION EIGHT

A. Mental health providers (e.g., Counselors/therapists) from a psychopathology perspective (problem solvers-fixers)

1. They are out there to fix problems mainly psychological problems.
2. A professional social problem solver.
3. Someone who can assist a person with decision problem to make the right decision through counseling.
4. To me, a therapist is just like any other doctor, so I can visit him/her whenever necessary.
5. Counselor is someone who I would go to if I'm having personal issues like depression, family issues, loneliness etc. I would open myself up and clearly talk about the problems that I'm dealing with instead of dealing with it by myself. I would go as needed though not for issues that I could handle myself.
6. Someone who treats an illness of the brain and emotion to help bring about healing and how to cope with problems in life
7. I think counselor/ therapist are trained to deal with people who went beyond reality and reach to a point where they can't help themselves
8. counselor/therapist means to me a person specializing in troubleshoot problems related to physiological behavior of a person and trained to treat them
9. A counselor to me is someone who provides a third-person perspective of what you are going through and how those problems can be solved. I don't believe that

most of the solutions are 100% sincere since the counselor/therapist does not go through it. I believe that counselors/therapists are a way for individuals to vent and seek clarity through venting.

10. Help assist clients that have anxiety and depression issues. They also help to their clients to discover the reason and source of their stress, frustration, pain etc. and how best to overcome them.
11. psychiatrist means a doctor who prescribes bills to patients. A therapist provides counseling visits trying to cure the patients of any mental problems in his capability.
12. Someone trained to give guidance on personal, social, or psychological problems
13. It's a great tool to help a lot people who can't solve their own problems
14. They are people that you can express your problems too or also people who have professional training to accurately diagnose and assist your condition.
15. A person who helps the other to deal with their problems.
16. Someone whose job is to assist in overcoming mental health issues & obstacles.
17. Someone who is a professional & has the knowledge to help someone suffering psychological from a disease or illness.
18. They understand mental issues better than anyone but they are also quick to use unnecessary drugs that have lot of side effects.
19. To me the counselor means the right person who will help
20. The counselor/therapist is a doctor. He can help you for mental problems.
21. The counselor/therapist is a doctor. He can help you for mental problems.

22. For me a counselor/therapist means someone you can go to when you're having problems and have the assurance that they will keep it confidential.
23. A counselor/therapist to me means one who is able to provide help and or alleviation from severe problems one may be experiencing at any point in time. they're there to provide relief and prioritize how you feel. it's about the individual, how one feels can be poured out without any judgment or hesitation.
24. He is the guy I go to for my semi-annual medicine refill
25. I feel as if you need a counselor if you're at rock bottom or desperate.
26. People who help you overcome difficulties in your life.
27. Someone who helps another with psychological/mental illness
28. Person help others in need of mental health, someone to talk with.
29. someone who can help you find the source of the problem & try to combat it.
30. A counselor to me is a person that will learn about your life and how you feel about what you're going through. Once they're familiar with the details, they use their training and skills to help you through your problems.
31. professionals that help you cope and work with illness because they truly never go away.
32. To me a therapist or counselor is someone that you can talk to about problems and ask for advice while they keep confidentiality about what is discussed.
33. Someone who can offer insight, non-biased answers to problems I face. Someone who can professional offer solutions to my psychological issues.
34. A person who wants to help others to become in their normal conditions.

B. Mental health providers (e.g., Counselors/therapists) from a wellness positive psychology perspective (increasing the quality of life, addressing issues)

1. I believe they listen you to show your weaknesses and strengths.
2. The counselor is someone who I can tell him everything about me
3. A lot of people are not aware of available resources and lack such help. These counselors/therapists are great resource to help people find some professional help.
4. A person who would listen to you with patience and provide help.
5. somebody has good listening ability and provides advice related Psychological issues.
6. Professional support and space without judgment.
7. To me a counselor means somebody who is trained and knowledgeable in the field of psychology. He or she knows different methods or helpful advice to help a client gain different perspective of a situation that may be affecting their life.
8. A counselor is a great way to express my feelings to him/her.
9. to make sure that your mental is functioning the way it should be.
10. The service guides you to livid a good live, he is acting like a couch train you and guide you to solve the mental issues you have.
11. Someone that can help me express my feelings in a safe zone. They can help explain worries you feel when sometimes you lack words and expression.

C. Mental health providers (e.g., Counselors/therapists) address both psychological issues (from a psychopathology perspective) and also help one to improve the quality/wellness of life (from a positive psychology perspective): a more holistic perspective

1. I defined the counselor as person who can deal with people are suffering from mantel problems in different ways to help patients relieve pain by medication, treatment spiritual, and religious.
2. someone who helps a patient or person with these things in confidentiality
3. A counselor/therapist is someone who I may disclose my life happenings, feelings and emotions with in order to pursue treatment options, medically, physically, spiritually or psychologically.
4. Counselor/therapist are people who can help cope with personal issues and mental health issues such as depression, anxiety, and stress.
5. help to be better
6. They help with Understand life both good and bad
7. Someone to go for help
8. People who help others cope with daily to severe psychological struggles.
9. The therapist hears the details. The psychiatrist treats symptoms, a therapist helps provide ways for self-coping and identifying behavior & thought patterns.
10. A person that gives advice
11. They listen and attend to help you understand yourself to handle problems
12. They are doctors to understand one's soul
13. To help people emotional

14. To me, a counselor/therapist means someone who is available to assist you with your psychological issues.
15. To me a counselor is someone who is willing to give you advice when you ask for it. It's someone who will listen to you.
16. help you understand your life and solve your problems.
17. Counselor/therapist means professional people that gives professional advise/work.

D. Other responses

1. My experience varies because my oldest son is a licensed therapist. A mother will say all is good with her child. Thanks for asking. Outside of that I have sat down and talk with counselor of different types background and religion and I enjoyed it. Thanks for the survey and thanks for asking.
2. They do good job but for spiritual illness you need the Quran.
3. I am not sure I have never been to mental health
4. Nothing
5. None
6. This service is needed, and our community need to be educated about it
7. I do not know.
8. They are good people.
9. They have deep understanding of humanity
10. I don't trust them
11. UNCG counseling

12. Mental health is very important in today live because of the factors of confusion and anxiety.

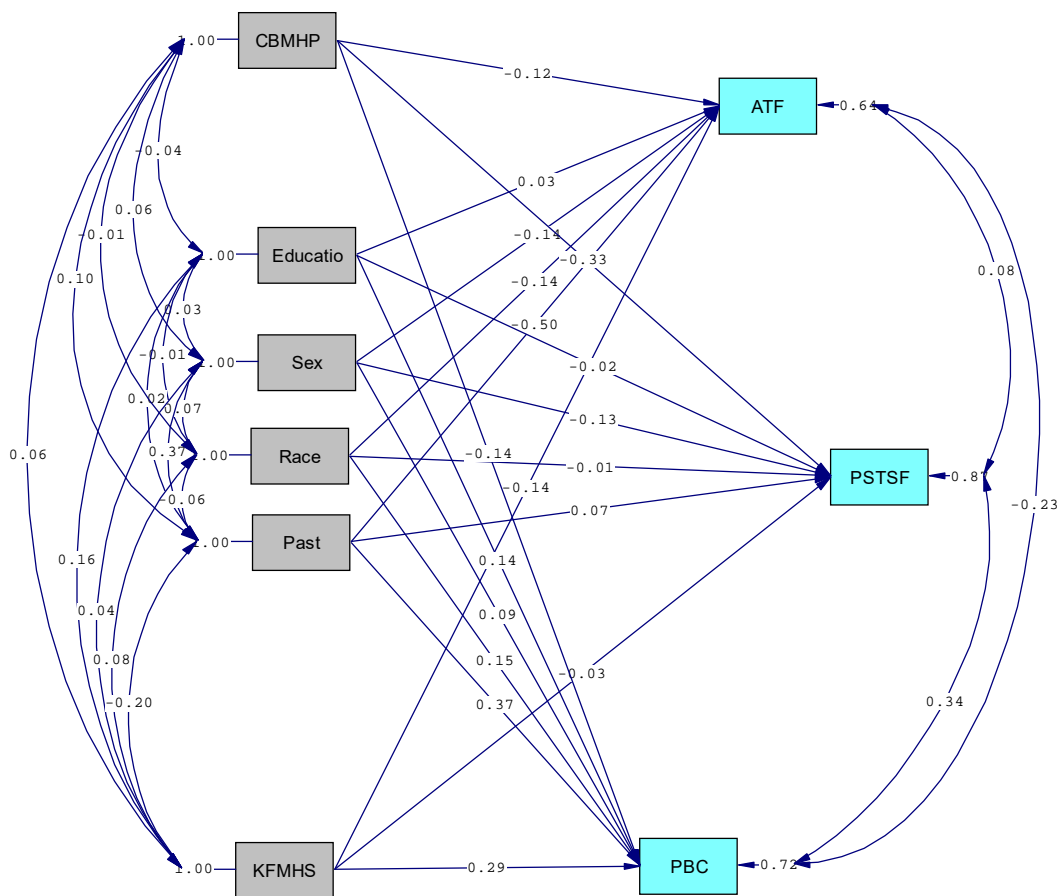
13. Objective view point

Most common words among the responses were: problem solver, fix problem, give advice, listen, help, understand

APPENDIX M

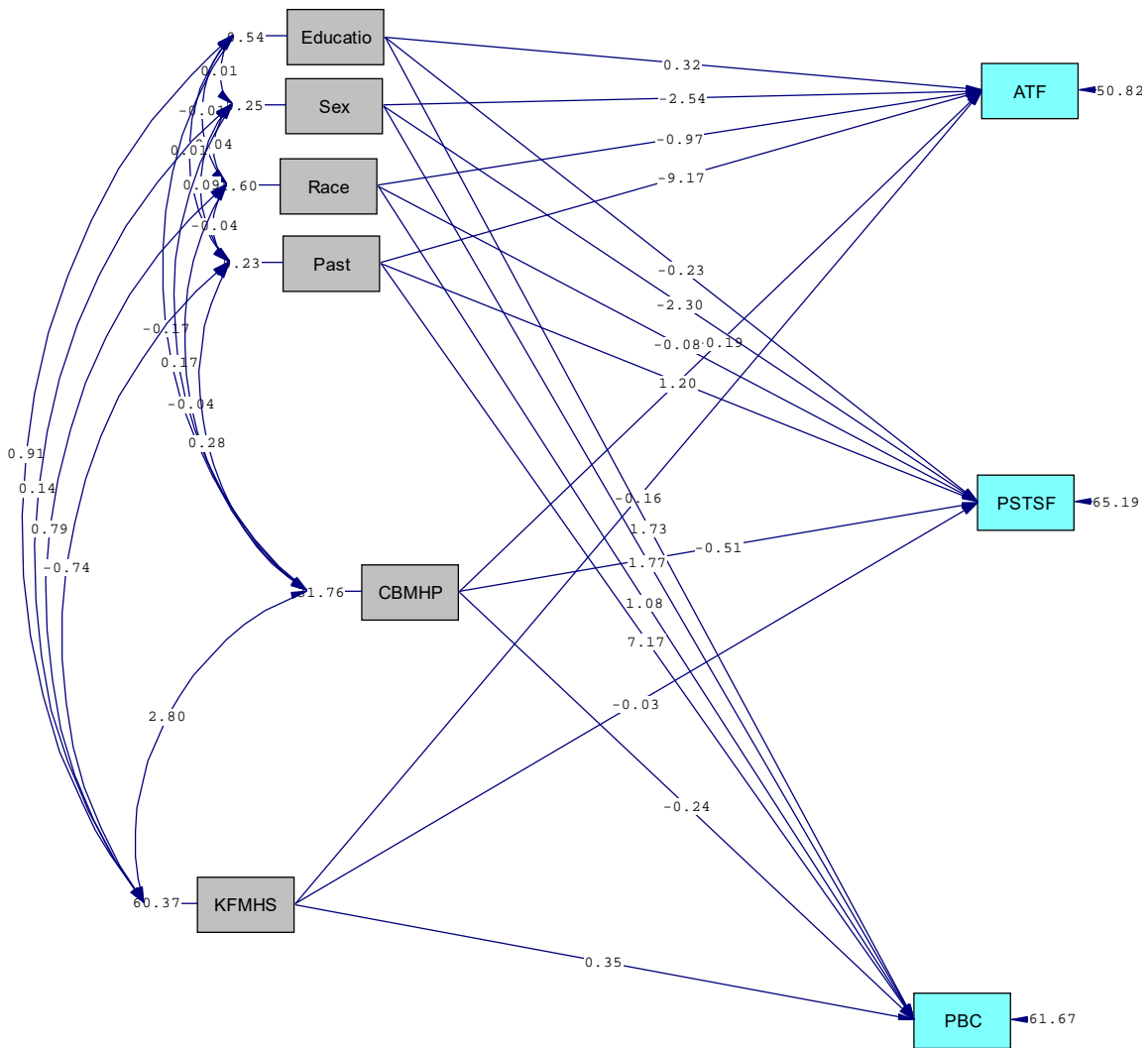
STATISTICAL ANALYSES RESULTS

LISREL Outputs: Standardized Coefficient Paths



Chi-Square=0.00, df=0, P-value=1.00000, RMSEA=0.000

LISREL Output: Estimates



Chi-Square=63.69, df=3, P-value=0.00000, RMSEA=0.316