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An Examination of American-born Muslim College Students' Attitudes toward Mental Health

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by

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DISSERTATION

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Dedication

For my wife, Aminah.

I cannot imagine a better wife, mother, or friend.

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All praise is due to God, the Most-Beneficent, the Most-Merciful. It is He who is the giver of all that is good, and it is through His permission alone that any worthwhile endeavor can be undertaken and completed.

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Abstract

Despite American Muslims' growing numbers in the United States, their frequent encounters with prejudice, and their increased self-reports of emotional stress, little research has been geared toward understanding American Muslims' attitudes toward mental health, specifically those born and raised in the United States. On the basis of current demographic trends, it is reasonable to suggest that American-born Muslims represent the future of Islam in the United States. This study examined the mental health attitudes of American-born Muslim college students ($N = 184$). A primarily quantitative survey approach was employed to address several research hypotheses and questions on the topic of young adult American Muslims' attitudes toward mental health. Additional comments by participants to an open-ended survey question richly described how some of the study's foci manifest themselves in real life situations. Participants indicated the presence in their community of concerning levels of depression, anxiety, social pressures, stress, and family conflict. Participants reported flexible general coping strategies and positive reactions to seeking professional mental health treatment. While religiousness was strongly associated with religious coping, neither was correlated with help-seeking attitudes; perhaps the process of seeking external help is different from seeking guidance from within the meanings of one's faith. Therefore, even highly religious Muslims in the survey who were apt to utilize religious coping strategies were just as willing to seek professional help as young adult American Muslims who were less religious, and this finding held true for both men and women. A preference was expressed for individual therapy above all other treatment modalities. The professional characteristics most desired in treatment providers were multicultural competence and an understanding of developmental issues associated with young adulthood. Participants expressed concerns about the perceived lack of multicultural competence in the mental health

field and the lack of Muslim treatment providers. It is hoped that this study's results will provide mental health practitioners and other stakeholders, such as community leaders and policy makers, with a strong understanding of the beliefs and needs of American-born Muslims with regard to mental health care.

Keywords: Muslims, help-seeking, religiousness, religious coping, college students

An Examination of American-born Muslim College Students' Attitudes toward Mental Health

Chapter 1

Islam is the fastest growing religion in North America, with its adherents in this country numbering about seven million, or over 2% of the current U.S. population (Obama, 2009a). These statistics suggest that Islam may already be the second most practiced religion in the United States (behind Christianity). American Muslims are ethnically diverse, with the most represented groups by far being of Arab, South Asian, and African-American backgrounds (Roysircar, 2003). While cultural differences create a fair amount of variability in terms of the family values and social customs of American Muslims, the religion of Islam remains the central guiding force for the way that most Muslims of all backgrounds live their lives (Daneshpour, 1998).

There are many Muslims on college campuses (Cornell University, 2002). While no exact figures could be obtained for the purposes of the present study, it appears that most large colleges and many smaller ones have active Muslim student groups. On Facebook, the popular social networking website that is especially frequented by college students, one can find thousands of social groups geared toward Muslims (www.facebook.com may be accessed by website members for specific examples of these online groups). Many major American universities have Muslim chaplains or student advisors on staff.

Muslims who live in the United States are increasingly American-born (Sirin & Fine, 2008). This fact has two important implications for researchers. First, it can be said that these American-born Muslims reflect the changing face of Islam in America, and to study these individuals "ahead of the curve" is to learn about the future of American Muslims. Second, this group has undoubtedly had significantly different life experiences than the previous generation,

many of whom were foreign-born immigrants, and it stands to reason that experiences unique to the United States have had an important influence on the identity, attitudes, and worldview of this emerging population. Over the past 45 years, millions of Muslims have come to the United States due to changes in immigration policy, an increasingly globalized economy, and advances in travel and communication (Roysircar & Pimpinella, 2008 a, b). Many Muslim immigrants, the vast majority of whom were originally from the Arabic speaking world (i.e., the Middle East and North Africa) or the Indian subcontinent (i.e., Pakistan, India, and Bangladesh) now have children who were born and raised in the United States and who are attending college; they represent an American Muslim baby boom (Philips, 2006). Another group of young adult Muslims, African-Americans, also have had different life experiences than their generational predecessors, in that these younger Muslims typically have been raised within the fold of traditional Islam, due to their parental cohort's transition from its religious origins in the Nation of Islam.

By some accounts, this new generation of American Muslims, particularly children of immigrants, is in many ways more religious than their parents (Philips, 2006). For instance, many young Muslim women have adopted the traditional religious practice of covering their hair in public, known as "hijab," whereas their mothers might not hold themselves to the same standard of modesty. It has been proposed that these second-generation Muslims, having been raised in the United States and spared the first-generation acculturation process that is typically associated with immigration, have felt less pressure to hold any one aspect of their identity at a distance, and are comfortably developing their own understanding of what it means to be both an American and a Muslim (Philips, 2006). It is pinning down how these attitudes translate into the arena of mental health that is at the heart of this study.

Stakeholders

Particular segments of society who might potentially be invested in this project were broadly categorized as falling into any one of five groups. The first group was the population that the researcher is most interested in studying, American-born Muslim college students. The attitudes of this population with regard to mental health have not been well-explored, and a better understanding of these views would likely inform outreach to and mental health treatment of American Muslim youth, especially through decreasing stigmatization of mental health issues and promoting help-seeking attitudes and behavior. Second, mental health care providers were also considered stakeholders in the study. Understanding the issues that American Muslims struggle with and the types of treatment they gravitate toward will facilitate the jobs of therapists charged with providing treatment. Third, colleges and universities were considered to be a group that might be interested in this topic because examining the attitudes of Muslim college students might lead to specific interventions that will allow this population to feel more comfortable at school and to contribute to a greater degree to the academic and social life of their educational institutions.

Fourth, American Muslims in general were considered to be invested in the study, as its findings may lead to a better understanding of how to help the youth of this community and, thus, promote the interest of the community at large. Further, it may be discovered that the findings gathered from the present study extend to the larger American Muslim community. Fifth and finally, policy makers and government institutions were viewed as interested parties. These stakeholders likely wish to improve their understanding of America's Muslim youth so that a greater emphasis can be placed on identifying and helping individuals who might be at risk to gravitate toward some of the more violent and extreme behaviors and attitudes that are

sometimes justified in the name of Islam, particularly in terms of animosity and aggression toward the West. Indeed, it has been suggested that understanding and supporting America's Muslim community as it continues to emerge and find its voice are critical to global stability (Lustick, 2006).

Conceptual Framework

There are several broad concepts that informed the study, the most pertinent of which might be generally identified as multiculturalism, specifically within the context of multicultural competence in psychology. The American Psychological Association (APA, 2003) has issued a set of guidelines emphasizing the importance of multicultural knowledge and awareness in the training of psychologists, which highlights the broad idea that cultural variables, such as race, religion, and ethnicity are important to consider when conceptualizing individuals' identity and psychological functioning and when designing outreach, intervention, research, and organizational change. In this respect, the concept of multicultural competence of mental health treatment providers (e.g., D.W. Sue, 2001; S. Sue, 1998) especially contributed to an understanding of the present study. This multicultural lens took into account not only the religious perspectives of the Muslim participants studied but also the fact that many of them are identified as racial and/or ethnic minorities with specific identity attitudes.

Additionally, developmental psychology provided a frame for understanding the attitudes of American Muslim college students, as their beliefs may not only be shaped by the religion that they share but also by where they are in their personal development, namely, as emerging adults. This phase of one's life is often marked by a critical period in the development of one's personal identity (Berk, 2006). Finally, an ecological perspective (Bronfenbrenner, 1979) that takes into account the systems and environments that characterize the college experience, particularly for

the group of interest, provided an important systemic framework through which to view the present study.

Relevant Constructs

Help-seeking. As might be expected, individuals in psychological distress may seek assistance in a variety of ways. The specific act of seeking help, whether from mental health professionals or elsewhere, is highly correlated with one's attitudes about the value of using others for support, and this finding is generally universal, including for various minority groups (Leong, Wagner, & Tata, 1995). Despite the link between help-seeking attitudes and help-seeking behavior, there are significant differences in how ethnic and racial minorities choose to seek help, particularly regarding the use of formal mental health services (Frey & Roysircar, 2006). Among college students, for example, Gloria, Hird, and Navarro (2001) found that Whites were much more likely to make use of traditional psychological services than were students from racial and ethnic minority groups. Aloud (2004) found that Arab Muslim adults in the United States would be more likely to seek help from a family doctor or religious leader than they would from a mental health professional.

In general, individuals who belong to racial and ethnic minority groups in the United States are more likely to seek formal mental health services if they have experienced greater acculturation to American society (Frey & Roysircar, 2006; Zhang & Dixon, 2003), which might suggest that Muslims born in the United States would be more open than American Muslim immigrants to seek these types of services. Members of cultural minorities in the United States may be less likely to seek formal mental health services if they have a strong network of family and friends to draw upon (Heaney & Israel, 2002). Given the fact that a strong sense of alliance with a mental health provider can be crucial to positive therapeutic outcomes (Horvath &

Symonds, 1991), minorities in the United States may be reluctant to seek counseling from providers with whom they have difficulty personally identifying.

Stigma about mental health problems. Individuals who encounter psychological difficulties may feel a sense of shame, embarrassment, or disgrace about these experiences because of perceived weak inner strength and/or loss of face, which can lead to negative self-judgments and anxiety about the judgments of the judgments of others (Hayward & Bright, 1997). These negative perceptions have persisted in American society despite increased efforts to dispel stigma and create greater awareness of mental illness (Corrigan & Wassel, 2008). This is especially concerning given the fact that the presence of stigma about mental health problems is generally detrimental to wellbeing (Link, Phelan, Bresnahan, Stueve, & Pescosolido, 1999), further complicating the process of treatment and recovery.

Arabs and Muslims may hold a stigma regarding mental illness that inhibits help-seeking behavior (Al-Krenawi & Graham, 2000). For example, in a study of Arab immigrant women who were victims of abuse, Abu-Ras (2003) found that a majority of participants felt shame in seeking formal mental health services. Some American Muslims may fear that mental health professionals will fail to understand the experiences of shame and vulnerability that often accompany disclosing emotional difficulties (Nassar-McMillan & Hakim-Larson, 2003).

Religiousness. Religion has long been viewed by social scientists as an integral component of one's identity (Francis, 2009). The influence of religiousness on mental health has historically been a subject of debate. Sigmund Freud (1950) posited that religiousness may pose a risk to the maturation of the psyche, while his contemporary, Carl Jung (1938), saw religion as potentially promoting healthy psychological development. Some studies suggest that religiousness is generally associated with positive mental health outcomes, whereas other studies

have found it to be non-contributory or even detrimental in this respect (Koenig, McCullough, & Larson, 2001). Among college students, it has been suggested that religiousness may not be related to attitudes about mental health services (Brody, 1994). Further, with regard to improving wellbeing in formal treatment settings, there may be little distinction between being adherent to a particular faith versus possessing a more general sense of spirituality (Corrigan, McCorkle, Schell, & Kidder, 2003).

A distinction is made in the present study between religiosity, which is sometimes used to describe conservative social and political attitudes, and the influence of religion, which is being called here religiousness. Studies on the effect of religion on psychology have yielded several important findings. Religious involvement is a factor of increased longevity and improved health outcomes (Çoruh, Ayele, Pugh, & Mulligan, 2005). Religious involvement has some stress-buffering effects in instances where people are experiencing multiple negative life events (Schnittker, 2001). Religion may also benefit individuals' mental health through increased social support and a healthier lifestyle due to religious prohibitions (Çoruh et al., 2005). Religious coping with depression has been perceived as being relatively effective; however, if people do not believe that religion helps them to cope then it may have less of an effect (Loewenthal, Cinnirella, Evdoka, & Murphy, 2001).

Religious involvement is an attempt for people to understand reality, and religion is seen as a means of making sense of the world (Hierich, 1977). In elderly African-Americans, active public participation in a religion was viewed positively as associated with higher feelings of mastery over one's environment, personal growth, good interpersonal relations, a purpose in life, and self-acceptance (Frazier, Mintz, & Mobley, 2005). For African-American women who had experienced domestic violence, religious involvement (independent from social support) was

associated with fewer depressive and posttraumatic stress disorder symptoms. On the other hand, feeling alienated from God and experiencing a religious rift in which the person disagrees with a religious institution can contribute to greater depression and suicidality (Watlington & Murphy, 2006).

Mental health service providers may be disconnected from religion because of the "Western propensity to medicalize human suffering" (Goździak, 2004, p. 206). Suffering has been pathologized as a mental illness that must be cured, a view that may be largely discrepant from the view of the client (Goździak, 2004). If a client thinks that suffering is part of the growth process, this person may not feel understood if a provider aimed to immediately reduce the client's suffering, perhaps with medications, without examining the meaning of suffering for the client.

Hathaway (2003) has suggested that religious impairment be viewed as a clinically significant aspect in formulating and treating individuals in mental health settings. Interventions that meld psychological services with a positive integration of religion and spirituality have shown some promise in group settings (Phillips, Lakin, & Pargament, 2002) and through the utilization of community religious organizations (Koenig, 2005). One consistent research finding has been that high levels of religiosity are associated with low levels of substance abuse (Kendler et al., 2003).

Coping. Broadly speaking, the concept of coping refers to the utilization of thoughts and behaviors in attempting to manage psychological stressors (Lazarus & Folkman, 1984). This often involves seeking formal mental health services, but it is also not uncommon for individuals to turn to their religion for solace. Religious coping, which might be thought of as the integration

of one's religious identity, practices, and faith group in managing emotional discomfort, has been shown to be a generally helpful strategy for people of faith (Pargament, 1997). Just as with help-seeking behavior, culture plays a major role in determining how different people choose to cope (Khawaja, 2008).

Amer (2005) studied Muslim and Christian Arabs in the United States and found that Muslims reported greater use of religious coping than did Christians. However, contrary to studies of many other religious subgroups, the use of religious coping methods in this population did not appear to have an overall effect on the presence of psychological stress. It was hypothesized that, for American Muslims, this finding might reflect the fact that coping by outwardly practicing Islam in a post-9/11 environment may have been stressful in and of itself (Amer, 2005).

Availability of Literature on the Present Topic

Pew (2007) reports that little quantitative research exists related to the attitudes of American Muslims in general. Thus far, what professional literature there is has typically focused on examining the beliefs of adult Muslims in the United States, many of whom are immigrants. With regard to the field of mental health, there is a paucity of research on these foreign-born American Muslims, let alone their American-born children (Nassar-McMillan & Hakim-Larson, 2003). Similar research has focused solely on Arab Americans, some of whom are not from Muslim backgrounds.

Prior to the events of September 11, 2001, research on American Muslims and mental health was virtually non-existent (Elias, 2006). In the years immediately following 9/11, psychological research on Muslims and Arabs in the United States became somewhat more prevalent. For instance, Khan (2003) found that about ten percent of Arab Muslims in the

greater Toledo, Ohio area had sought some type of psychological services since 9/11. Aloud (2004) found similar results in a study of Arab Muslims in the greater Columbus, Ohio area. Nonetheless, the field of psychology has lagged behind the fields of nursing and anthropology in amassing data on the mental health experiences of these populations (Amer, 2005). Research on Muslims and mental health has become somewhat more prolific over the past few years, particularly with the ascension of the *Journal of Muslim Mental Health*.

As stated previously, much of the research on American Muslims and mental health has thus far examined the attitudes of immigrant populations (e.g., Al-Krenawi & Graham, 2000; Amer, 2005), and has understandably made note of acculturative stress and how differences in customs affect treatment-seeking behavior. In general, this research has found that American Muslims are reluctant to seek mental health care for a variety of reasons, including having stigmatized beliefs about mental illness and mistrusting the field and those who work in it (Abudabbeh, 1997; Aloud, 2004; Nassar-McMillan & Hakim-Larson, 2003). For instance, Al-Krenawi and Graham (2000) found that some Muslims felt that negative public perception of Islam would translate into ignorant clinical practice by Western treatment providers. It is certainly possible that since 9/11 these doubts have grown, and American Muslims may not have developed an increased willingness to reach beyond their own community for support. Indeed, among Arab Americans, Muslims tend to self-isolate within their community significantly more than their Christian counterparts (Amer, 2005).

Despite some distrust of mainstream psychological services, it has been clear that since 9/11, demand for emotional support has risen among American Muslims (Ali, Milstein, & Marzouk, 2005; Khan, 2003). Often, Muslims have turned to religious leaders for counsel (Ali et al., 2005). In fact, coping with stress using religiously based methods such as prayer and

interacting with one's faith community has been found to be common for Muslims (Amer, 2005; Kelly, Aridi, & Bakhtiar, 1996; Roysircar, 2003).

Only one study could be found that sought to explicitly measure the mental health values of American Muslims without ethnic exclusions (i.e., Kelly et al., 1996). Again, most of the participants in this study were not born in the United States. Kelly and colleagues (1996) found that a majority of participants would prefer to seek counseling with a Muslim provider. Of the minority of participants that did not indicate a strong preference between seeing a Muslim or non-Muslim counselor, most indicated that they would want their counselor to have an understanding of Islam and to possess similar personal values.

Research Areas

This study asked, broadly, what are the attitudes of American-born Muslim college students toward mental health and mental health care? It is hoped that the exploration of these issues yielded insight into the beliefs of this cohort, which is believed to represent the future of Islam in the United States, toward mental illness and mental health care. Related questions included the following:

- What mental illnesses or emotional difficulties are perceived by this group as most common among young adult American-born Muslims?
- What kinds of mental health treatment would this group be willing to seek, and what role might stigma play?
- What are the ideal personal characteristics of a mental health treatment provider for this group?
- What coping strategies, including religious coping, do American-born Muslim young adults utilize?

- What is the effect of personal religiousness on this group's attitudes toward mental health?
- What demographic correlates might contribute to understanding the answers to these questions?

This study attempted to seek meaningful answers to these research questions. American-born Muslim college students were asked to fill out surveys composed largely of psychological measures that have been used in previous studies with Muslims. Questions were asked on a variety of topics, including perceptions mental health concerns and experiences of young adult Muslims, religious coping, religiousness, perceptions of how religion relates to mental health, beliefs about environmental stressors and resources, help-seeking attitudes, and treatment preferences. Participants were also given the option to provide additional comments about their feelings and experiences in an open field in the survey.

Conclusion

The presence of Islam in the United States is significant and growing, and although the American Muslim community is diverse in many respects, the religion of Islam provides both a sense of unity and a light of guidance for its adherents. Muslims in the United States are increasingly American-born and many are currently attending college. While there does exist a small but growing body of research on American Muslims and mental health, much of it has understandably focused on acculturation and has looked at predominantly immigrant populations.

It stands to reason that American-born Muslims may differ significantly from their immigrant counterparts in terms of their attitudes and experiences. This study sought to examine the attitudes and experiences of American-born Muslims in relation to the topic of mental health.

In so doing, the issues of coping, religiousness, stigma, help-seeking, and treatment preferences were explored. It is hoped that the findings of this research will greatly inform mental health practitioners, researchers, and other stakeholders as to the needs, treatment preferences, and beliefs about mental illness, as well as approaches to coping, for this important and emerging group of individuals. The chapter that follows will elaborate further on the predominant characteristics of the Muslim population and lay the groundwork for exploring how religion and mental health might intersect in their lives.

Chapter 2

A Review of the Literature

Islam

History of Islam

The religion of Islam emerged in Arabia in the Seventh Century AD, about 1,400 years ago. Arab society at that time was dominated by tribal power struggles. While some Arabs during this period practiced Judaism or Christianity (Hourani, 1991), most were polytheistic. This was particularly the case for those who lived in Mecca (Makkah), a relatively isolated town that had become a frequent stop along a major trading route in what is now western Saudi Arabia.

In Makkah, a merchant named Muhammad claimed that he was being revealed a holy scripture (Qur'an) from God (Allah). Its message called for a return to monotheism in the tradition of Judaism and Christianity, as well as a more egalitarian social order (Sells, 1999). While this calling struck a chord with many residents of Makkah, there was an understandable amount of resistance from tribal leaders who saw it as a threat to the established societal structure. Those who joined Muhammad and accepted his message were called Muslims, meaning "those who submit." The name of their religion, Islam, is derived from the root Semitic consonants s-l-m, meaning "peace." Islam most literally translates to "submission," as those who practice Islam view themselves as submitting to Allah (Esposito, 1998).

An ensuing conflict with the non-Muslim establishment in Makkah forced the early Muslims to temporarily flee the city. During their exile, the number of Muslims grew exponentially, reaching the point when they were able to retake the city of Makkah toward the end of Muhammad's life. Around this time, the Qur'an had been fully revealed, and its

completed message called for Muslims to practice strict monotheism (Tawheed) and to accept Muhammad as Allah's final prophet (Sells, 1999).

Following Muhammad's death, Muslims continued to be a growing religious group and political force. Over the next hundred years, Islam would expand as far north as modern-day Turkey, as far east as modern-day Iran, as far south as modern-day Ethiopia, and as far west as modern-day Spain. By the end of the First Millennium AD, the Muslim World stretched as far to the east as modern-day Indonesia and had entered a "Golden Age" (Hourani, 1991). Muslims continued to grow in numbers throughout the Second Millennium AD.

Faith and Practice

For Muslims, the Qur'an is viewed as the central source of religious knowledge. The Qur'an is considered inimitable and unaltered—the true Word of Allah as revealed to the Prophet Muhammad (Esposito, 1998). The guidance of the Qur'an is complemented by the historical record of Muhammad's words and actions (Hadith) and what is known of his personal attributes and way of life (Sunnah).

From this base of knowledge stem the main articles of faith and practice in Islam. Most Muslims consider six principles to be integral to their faith (Iman). The first of these is Tawheed, which is essentially a belief in the oneness of Allah. Second, Muslims believe in prophets and messengers, who are seen as unique individuals throughout history that have been tasked by Allah to deliver His Message. This group includes Abraham, Moses, and Jesus, as well as many others. Third, Muslims believe in scripture. This is particularly the case with regard to the Qur'an. Muslims also believe in the scriptures of Jews and Christians, but regard the contents and meanings of these books as having been altered, misconstrued, or lost since their original revelation, rendering them unreliable (Esposito, 1998). Fourth, Muslims believe in

angels, who are seen as intermediaries between Allah and human beings. Fifth, Muslims believe in a Day of Judgment, following which all people will be rewarded or punished in the afterlife for the lives they have led. Sixth and finally, Muslims are to believe in the idea of Allah's Will, which is sometimes seen as a belief in predestination. In other words, there is a belief that the future is known only to Allah.

The required religious practices for Muslims are commonly referred to as the Five Pillars. First, Muslims must openly declare their belief in the oneness of God and the prophethood of Muhammad. The second pillar of Islam is prayer. Muslims are required to pray five times each day at specified times. Prayer is not understood solely as the practice of supplication; it is seen as an act of worship (Esposito, 1998). Third, almsgiving is required for all Muslims who are financially able. This involves paying a fixed percentage on one's liquid assets once a year, which goes to the needy. The fourth pillar of Islam is to fast during the Islamic month of Ramadan. During this month, Muslims abstain from food, water, and sexual relations from dawn to sunset. Last, Muslims who are financially and physically able to do so are required to make a pilgrimage, called the Hajj, to Makkah at least once in their life.

Islam Today

At present, there are an estimated 1.3 billion Muslims in the world, with the most populous Muslim countries being Indonesia, Pakistan, India, and Bangladesh, all of which are non-Arab countries that are each home to at least 100 million Muslims (World Almanac, 2007). Muslim-majority countries span from as far east as the Atlantic coast of Africa, such as Nigeria, to as far west as the Pacific islands, such as Brunei.

The vast majority (around 90%) of Muslims identify as Sunni, with the rest mostly considering themselves Shi'a (Esposito, 1998). The split between these two branches of Islam

occurred following the death of Muhammad over a disagreement about who should succeed him as the leader of the Muslims. Despite these historical roots, differences between Sunni and Shi'a Muslims nowadays are often focused on competing political ideologies and religious traditions. The Shi'a Muslim population at the present time is mostly limited to Iran and many areas of Iraq, and there are significant Shi'a minorities in Lebanon and Pakistan (World Almanac, 2007).

There exists a great amount of diversity with regard to the political and social beliefs of Muslims today (Esposito, 1998). Some Muslims see faith as a personal matter, others think of their religion more in terms of family and community, while others see Islam as a system of governance. In certain countries, (e.g., Saudi Arabia), Islam is seen as a political model on which Muslim-majority countries should be governed, while other Muslim countries (e.g., Turkey) take a more secular approach. Some Muslim countries (e.g., Libya) might be seen as dictatorial regimes. Additionally, the world has recently witnessed the increasing presence of Islamic extremism, most notably illustrated by terrorist attacks such as those which occurred in the United States on September 11, 2001.

Muslims today, just as their predecessors throughout Islamic history, abide by a code of conduct as instructed by the Qur'an and Hadith and as exemplified by the Sunnah. As one might expect, some Muslims are more conservative than others in keeping with these behaviors. Traditionally, Muslims have adopted a restrained approach to gender relations. Men and women are both required to uphold a standard of modesty in their dress, and are not to be physically intimate prior to marriage. Additionally, Muslims are forbidden from drinking alcohol and abusing substances (Esposito, 1998). These rules concerning a Muslim's personal behavior can be observed throughout the world's Muslim population, including those who live in the United States.

Islam in the United States

History of Islam in the United States

The slave trade. Approximately three million Muslims from Africa were brought to the United States during the Atlantic slave trade (United States Department of State, 2009), which began in the Seventeenth Century AD. This marked the beginning of Muslim migration to the United States (Sirin & Fine, 2008). Of course, this migration was forced, and cultural and religious traditions were difficult to preserve for American slaves. While many of these slaves retained a proud sense of Islamic identity, they were unable to leave an enduring religious footprint in this country (Nyang, 1999).

Arab immigration begins. The first wave of Muslim immigration to the United States was a small one, beginning in the late Nineteenth Century AD, when thousands of Arabs came to the United States. The majority of these Arab immigrants were not Muslim, but Christian (Sirin & Fine, 2008). Many of them ultimately settled in the Midwest and joined the manufacturing labor force, eventually helping to meet the demand for workers as the auto industry emerged in the early Twentieth Century AD. However, the selectively strict limits on immigration imposed by the Johnson-Reed Act of 1924 effectively ended this period of Arab migration to the United States.

The Nation of Islam. In 1930, during the ascent of the separatist Pan-African movement in Black America, a mysterious preacher calling himself Wallace Fard Muhammad claimed he was the incarnation of God. He attracted in audience in Elijah Poole, an African-American who would later become known as Elijah Muhammad. Following the disappearance of Wallace Fard Muhammad in 1934, Elijah Muhammad assumed leadership of Wallace Fard Muhammad's nascent religious organization, the Nation of Islam, which integrated certain themes of Islamic

theology with the doctrine of Black Nationalism (Myers, 1993). In the decades that followed, The Nation of Islam and its resonant message attracted many thousands of African-American adherents in the major urban centers of the Midwest and East Coast, reaching the height of its membership and activity as the American Civil Rights Movement blossomed. By this time, the public face of the organization was Malcolm X.

Following his Hajj in 1964, during which he met Muslims from all over the world, Malcolm X began to move away from the Nation of Islam's Black supremacist teachings and exclusive approach to the Civil Rights Movement. This opened a major rift between him and Elijah Muhammad, and Malcolm X left the Nation of Islam shortly thereafter to move his own agenda forward. Later that year, he changed his name to el-Hajj Malik el-Shabazz and embraced traditional Islam, leading many members of the Nation of Islam to splinter off from the organization (Myers, 1993). Malcolm X was assassinated in February of 1965, less than one year after his public split with Elijah Muhammad and the Nation of Islam. While it has never been proven that the Nation of Islam had a direct role in the assassination, this nonetheless marked a seminal event in the organization's history, as allegiances to Elijah Muhammad were tested and the Nation of Islam's differences with traditional Islam were brought more plainly into view.

After the death of Elijah Muhammad in 1975, his son, Warith Deen, became the head of the Nation of Islam. Almost immediately, Warith Deen Muhammad directed that the Nation of Islam's approach toward race relations become more conciliatory. He disavowed some of the organization's most prominent foundational beliefs, such as the infallibility of his father, Elijah Muhammad, and the divinity of Wallace Fard Muhammad. He later changed the name of his ministry to the American Society of Muslims, although a small number of former Nation of

Islam members joined Louis Farrakhan's effort to revive the name and past beliefs of the organization. Beginning in the late 1970s, Warith Deen Muhammad led the Black Muslim community in the United States toward traditional Islam (Lincoln, 1994). As a consequence, most African-American Muslims who have been born since that time have experienced fairly conventional Islamic upbringings that have been unsaturated with the politics, controversies, and non-traditional beliefs of their parents' generation. In 1992, Warith Deen Muhammad became the first American Muslim to deliver the United States Senate's invocation. He died in 2008.

Muslim immigration resumes. The Immigration and Nationality Act of 1965 removed most of the critical provisions of the Johnson-Reed Act. It is estimated that since that time, four million Muslims have come to the United States (Philips, 2006). This wave of immigration grew dramatically in the 1970s. Many of these immigrants were skilled workers from South Asia and the Middle East (U.S. Department of State, 2009). According to Sirin and Fine (2008), a great number of these first-generation American Muslims, in addition to being well-educated, were quite religious. In the 1990s alone, Muslim immigration to the United States more than doubled (Kosmin, Meyer, & Keysar, 2001). Following the 9/11 attacks, however, the American government moved to limit visas from the Muslim World (Paden & Singer, 2003). As a consequence of this and other factors, Muslim migration to the United States has slowed, contributing to a sharp and ongoing decline in the percentage of American Muslims who are of first-generation status.

American Muslims Today

Religiousness. The polling organization Gallup (2009) conducted a major survey, which, pared down from a large original sample size (N = 319,751), examined the attitudes and behaviors of many American religious groups throughout the 2008 calendar year. Findings

specific to the selected adult American Muslim subsample (n = 946) were compared with data gathered from other religious communities in the United States and, in some cases, with recent Gallup surveys of Muslims around the world.

According to Gallup (2009), American Muslims tend to be religious; 80% stated that religion is an important part of their lives. Only Mormons (85%) reported higher levels of religiousness, while 65% of the overall sample of adult Americans endorsed that statement. Muslims in Muslim majority countries tend to report higher levels of religiousness than American Muslims (e.g., 100% in Egypt, 99% in Indonesia, 94% in Pakistan, and 89% in Turkey), while Muslims in other Western countries such as Great Britain (70%) and France (69%) appear to be less religious, on average, than Muslims in the United States.

The Gallup survey (2009) also found that 41% percent of American Muslims attend religious services at least weekly, despite the fact that weekly communal prayers for Muslims are held midday on Fridays, when many adults are working, and the fact that attendance at these services is not mandatory for Muslim women. For American adults as a whole, this number is somewhat lower (34%). Interestingly, Muslims are the only religious group in the United States whose male adherents report roughly equal levels of religiousness as their female counterparts; for every other religion in the United States, women report being significantly more religious than men. Still, Muslim women in the United States are more likely to attend religious services than other Muslim women worldwide. In fact, the United States is the lone country in which the number of Muslim women attending religious services rivals that of Muslim men, with only Bangladesh appearing comparable in that respect. Consistent with Islam's prohibition of consuming alcohol, 86% of American Muslims report that they usually abstain from drinking—a number which is only rivaled by American Mormons (92%).

Education and employment. Muslims are among the most educated groups in the United States (Zogby, 2004). Gallup (2009) reports that 63% of American Muslim adults have a college degree, despite the fact that 36% of the adult Muslim population in the United States is between the ages of 18 and 29, which would suggest that a significant percentage of this group may not have yet finished college. Of all other religious groups, only American Jews (83%) have a higher rate of holding college degrees. Muslims are also the only American religious group in which females' college graduation rates have reached that of males.

American Muslims also boast high levels of employment (Obama, 2009a). Adult Muslims in the United States are more likely to be employed than any other religious group (Gallup, 2009), which might also reflect that the American Muslim population tends to be younger and therefore likely has fewer retirees. Muslims in the United States are more likely than Muslims in any other country to be employed.

General wellbeing. Although American Muslims have relatively high rates of education and employment, they are far less likely than other religious groups in the United States to report being satisfied with their "standard of living" (Gallup, 2009). Sixty-five percent of Muslims report such satisfaction; the next highest group is Catholics (75%). Further, American Muslims are least likely to report they are "thriving" (41%) and most likely to report that they are "struggling" (56%). Muslims are also less likely to report having strong social supports (75%) than the general population (85%).

It is especially concerning that American Muslims report surprisingly high levels of negative emotions. According to a Pew Research Center Report (2007) of a study of over 1,000 American Muslims, only 24% described themselves as "very happy," while the general American population's happiness rate was twice as great as that. Gallup (2009) found that,

compared to other major religious groups in the United States, Muslims were least likely to report feeling respected, well rested, or happy. Only 79% of Muslims report that they smile or laugh regularly, which is a much lower percentage than that of any other religious group. Also, Muslims are the least likely of any religious group in the United States to report experiencing enjoyment and learning in their lives. Finally, Muslims report the highest levels of anger, sadness, and worry.

Discrimination. The role of discrimination may be a major factor in Muslims' emotional struggles. Despite the fact that American Muslims are likely to share the same general values and aspirations as their fellow countrymen (Ravitz, 2009), there remains a strong anti-Muslim sentiment in the United States (Elias, 2006). Gallup (2009) reports that American Muslims are the least likely of any American religious group to report feeling safe. According to Pew (2007), 25% of American Muslim adults report experiencing acts of discrimination after 9/11, 53% state that it has been more difficult to be a Muslim in the United States since 9/11, and only 63% feel no conflict in being both American and Muslim. A recent Pew study (2009) found that 58% of Americans see Muslims as facing "a lot of discrimination." The next highest religious group in terms of perceived discrimination was American Jews, at 35%. Over the past year, a dramatic rise in Islamophobia and hate crimes toward Muslims has been observed, which has manifested itself in terms of community opposition to several proposed Islamic centers across the country, vandalism of mosques, anti-Muslim rhetoric in the media, and violence toward American Muslims (Esposito & Lalwani, 2010).

Present demographics. In his inaugural address, President Barack Obama declared, "We are a nation of Christians and Muslims, Jews and Hindus, and non-believers." (Obama, 2009b, paragraph 22). There are now approximately 1,900 mosques in the United States (Ghosh, 2010).

Numbering about seven million, Muslims make up a significant minority of the United States' population. American Muslims are the most racially diverse religious group in the United States (Gallup, 2009). About a third of American Muslims are African-American, with the rest being mostly of Arab or South Asian descent, along with smaller numbers of Southeast Asian, Caucasian, Persian, Turkish, and Hispanic Muslims. Sirin and Fine (2008) report that Muslims in the United States are more ethnically diverse than Muslims in any other country. Due to some of the common challenges that they have faced in the United States since 9/11, American Muslims have become further united across lines of race, class, and culture (Elliott, 2007).

Demographic trends. Given the historical progression of Islam in the United States, it is not surprising that the American Muslim population is much younger than the American population as a whole (Pew, 2007). This trend is evident in looking at the number of Muslims that fall into the age 18 and under and age 18–29 categories. Gallup (2009) reports that the average number of children under the age of 18 who are living in American Muslim households is 1.33—the national average is 0.75. The same national survey found that 36% of adult American Muslims are between the ages of 18 and 29, which is twice the national average. According to a study by Cornell University (2002), the average annual population growth rate of Muslims in the United States is more than 6 times greater than that of the American population as a whole.

There are also a growing number of Muslim students attending America's institutes of higher education (U.S. Department of State, 2009). According to Gallup (2009), non-working American Muslim adults are more than 3 times as likely to be fulltime students than their counterparts in the general American population. This number may be somewhat inflated by Muslim international students attending school on student visas. However, it is very likely that

most of these students are American-born; Pew (2007) found that 20% of American-born Muslims are currently attending college.

Young Adult American Muslims

Characteristics

Religiousness. Research suggests that Muslims in the United States who are young adults are likely more religious than are their elders. According to Pew (2007), adult Muslims under the age of 30 are more likely than older Muslims to attend religious services, and younger adult American Muslims are also more likely to express a strong Islamic identity. The Pew study also found that of all adult Muslims in the United States, only 17% report that they believe Muslims in the United States are becoming "less religious." According to Gallup (2009), 77% of American Muslims ages 18-29 report that they are religious, which is much higher than the general American population (54%). In a study of 18-to-25-year-old American Muslims, Ahmed (2009) found that they were more committed on average to their religion than were their non-Muslim counterparts. Given that young adult Muslims are increasingly American-born, it is perhaps unsurprising that Muslims born in the United States report attending religious services more frequently than those born elsewhere (Pew, 2007).

General wellbeing. The Gallup (2009) survey, which found that the American Muslim population as a whole is struggling to thrive in the United States, also produced concerning findings in looking specifically at young adult American Muslims. Only 40% of American Muslims ages 18 to 29 described themselves as "thriving," which is significantly less than any other religious group in the same age range; 18-to-29-year-old Catholics reported the next lowest levels of feeling they are "thriving," at 54%. Further, 18-to-29-year-old Muslims in the United States were at the bottom for their age group compared to their peers in reporting feeling

respected by others and experiencing regular enjoyment. They reported the lowest levels of happiness and were the least likely to report smiling and laughing. They were by far the most likely of any group to report anger, and also reported the highest levels of worry. Surprisingly, despite the fact that so many American Muslims ages 18–29 are students, they were the least likely of any religious group to report feeling that they experience learning in their lives or that they are involved in interesting activities. Muslims in the United States ages 18 to 29 were the least likely of any major religious group to report having a strong social network, although they were more likely than American Muslims over the age of 29, many of whom are immigrants, to report having these social supports in place.

Discrimination. Like their elders, American Muslim youth and young adults report experiencing a great amount of discrimination. According to Patel (2010), Muslim adolescents are especially likely to be teased on account of their religion, and this may lead to them feeling uncomfortable at school. Of all American Muslims, the 18–29 age group reports the greatest post-9/11 difficulty being a Muslim in the United States (Pew, 2007). A 2005 study by the Muslim Public Affairs Council found that 70% of American Muslim youth have experienced negative reactions from others due to their religion. Qualitative research by Sirin and Fine (2008) suggests that as many as 84% of American Muslims ages 12–18 and 88% in the 18–25 age group have encountered hardships in the United States due to being Muslim. Gallup (2009) found that only 59% of young adult American Muslims feel safe at night walking in their local communities, which is significantly below average for their age group.

Identity. While research on American Muslim identity development remains lacking (Britto, 2008), available scholarship and cultural observations suggest that adolescent, young adult, and native-born American Muslims are actively engaged in developing more cohesive

identities that embrace aspects of both Islamic and American culture (Sirin & Fine, 2007). More Muslim female high school students are taking part in interscholastic sports while wearing hijab (Karoub, 2007), and 89% of American Muslim adolescents still celebrate the holidays of the countries of their heritage (Sirin & Fine, 2008). It has been generally true that American Muslims are more recently asserting themselves in the public square (Findley, 2001). According to Pew (2007), American-born Muslims are more than twice as likely as their foreign-born counterparts to support greater political involvement from their mosques. The same Pew study also found that native-born Muslims are more likely than foreign-born Muslims to believe that American Muslims should adopt American customs. While a recent study by Anisah Bagasra (Munsey, 2010), a doctoral student at Claflin University, suggests that American-born Muslims experience similar difficulties as their foreign-born counterparts with integrating their religious and American identities, Sirin and Fine (2008) found that young adult American Muslims are generally reporting less conflict in feeling both American and Muslim.

These identities, however, do not evolve seamlessly and cannot integrate all aspects of both tradition and modernity. Sirin and Fine (2008) report that significant generational differences in cultural values persist, and a study by Ahmed (2009) of American Muslims between the ages of 18 and 25 years found that many members of this group may feel that their parents' generation is out of touch with the cultural and social influences acting on American young adults. Young American Muslims may be unlikely to engage in certain types of behavior that are commonplace for many American teens. Hafiz, Hafiz, and Hafiz (2007) received about 150 responses to surveys mailed to Islamic day schools nationwide. All teen respondents reported avoiding drugs and drinking, and 80% expressed unfavorable views toward dating.

Still, a study of North American Muslim college students suggested that these types of cultural disconnects can produce significant intrapersonal discomfort (Asvat & Malcarne, 2008).

Islam on Campus

Muslim students. According to Gallup (2009), 59% of American Muslims ages 18 to 29 report being full-time students. This is significantly above the national average of 48% for this age group. In interviews with young adult American Muslims, Sirin and Fine (2008) found that college education is especially stressed by parents. The authors report that many of these young adults, particularly those who are not African-American, grow up in financially stable families, are the children of professionals, and are expected to attend college and develop professional careers for themselves. While African-American Muslim parents may not place as much emphasis on college, there is nonetheless great diversity within the Muslim college population (MacFarquhar, 2008).

Campus life. Prior to the resumption of Muslim immigration to the United States about a half-century ago, there was very little in terms of communal presence of Islam on American campuses (El Horr & Saeed, 2008). With the creation of the first campus chapters of the Muslim Students Association (MSA) in the 1960s, student life for Muslims became more vibrant and organized. At present, most colleges have MSAs or similar organizations for Muslim students (Sirin & Fine, 2008). Post-9/11, these organizations have become increasingly active (Gallup, 2009), and even less religious Muslim students are becoming integrated into these campus communities (MacFarquhar, 2008). At this time, several major universities and colleges, including all eight Ivy League schools, along with Georgetown University, New York University, Duke University, Tufts University, Northwestern University, Wellesley College, Wesleyan University, and Simmons College employ Muslim chaplains or student advisors. The

United States Department of State (2009) has reported an increasing need for Muslim college chaplains in the United States.

Outreach by college administrators to Muslim students appears to be on the rise. The University of Michigan installed footbaths for Muslim students to more easily complete the ritual ablution needed before offering prayers, and Harvard University has arranged for women's only gym hours so that Muslim women and other likeminded female students might use campus facilities to exercise with the comfort of not being observed by men (El Horr & Saeed, 2008). The first Muslim sorority was established in 2005 (U.S. Department of State, 2009). However, at many colleges, Muslim students feel that their needs are not being met (Nasir & Al-Amin, 2006). Ali and Bagheri (2009) recommend that colleges make greater strides to accommodate Muslim students, such as offering designated space for prayers and arranging for food that is prepared according to Islamic customs to be served in dining halls. Over the past decade, there has been increasing demand for the establishment of colleges dedicated solely for Muslim students in the United States that cater to Islamic academic and religious customs (Zoll, 2009). The first of these, Zaytuna College, opened in California in 2010 (Ghosh, 2010).

Difficulties. American Muslim college students continue to feel uneasy about discriminatory post-9/11 government policies and negative media messages about Muslims (Muedini, 2009), and are frustrated about the perceived lack of concern from political leaders on these issues (Davey, 2009). While Muslim students have become more active in university life, they continue to face challenges. Many Muslim students may feel uncomfortable being visibly Muslim on campus, such as by adhering to Islamic codes of dress or refraining from social behavior prohibited in Islam (Nasir & Al-Amin, 2006). Post-9/11, some female Muslim students stopped wearing hijab due to fear of becoming targets for harassment (Cole & Ahmadi, 2003).

Muslim students who experience discrimination at their colleges are less likely to spend time with peers outside of their faith (Shammas, 2009), while Muslim groups on campus have themselves been targets for discrimination (Woods, 2010). With mental health issues among college students reaching unprecedented levels (Guthman, Iocin, & Konstas, 2010), the many added stressors that Muslim students face raise significant concerns about the onset or exacerbation of emotional difficulties for this population.

Islam and Mental Health

Background

The verses of the Qur'an and the sayings of Muhammad provided the initial Islamic perspective on issues pertaining to wellbeing and mental illness. The Qur'an extols the virtues of patience and prayer and stresses the importance of both romantic and fraternal companionship in promoting comfort and security (Ali, 1998). It instructs Muslims to turn to Allah in times of trouble for hope and solace, and, in a well-known Hadith, Muhammad is quoted as saying that Allah has put on Earth treatments for all afflictions, with the exception of old age. This sense of optimism is accompanied by an emphasis on compassion; the Qur'an implores Muslims to feed, clothe, and speak graciously to the insane.

In some early verses of the Qur'an, the word majnun, meaning possessed by evil spirits (jinn), is used in reference to accusations made against Muhammad by his opponents who sought to discredit him (Ali, 1998). In fact, Muhammad himself questioned his own sanity upon receiving the first revelations of the Qur'an, and famously ran to his wife, Khadijah, crying, "Cover me! Cover me!" When he had calmed down he received assurance from her that he was not insane and that she believed in him (Esposito, 1998). Based on both the Qur'an and, in particular, the Hadith literature, classical Islamic jurists established the consensus that insane

individuals are not responsible before society for their behavior, nor will Allah negatively judge them for actions committed while insane. Individuals deemed to have no control of their behavior were thus classified as similar to children in terms of their accountability for their conduct (Dols, 2006).

Moran (2007) reports that perspectives toward mental illness have varied significantly over time in the Muslim World. In the Seventh Century AD, insanity was often attributed to possession by demons. By the Eighth Century AD, however, the first major psychiatric hospitals, treating a variety of psychotic and affective conditions, had been established in Baghdad, Cairo, and Damascus. In the Tenth Century AD, Muslim physicians had begun writing about eating disorders. These approaches were certainly progressive for their era, and addressed many issues that are the focus of contemporary psychology.

However, with the imposition of colonialism in the Nineteenth Century AD, Muslims around the world may have developed a tendency to instinctively recoil at any Western notions that did not fully take into account or understand the role that religion and culture played in their lives. As a result, those strides made over many centuries by the Muslim World in understanding mental illness may have become devalued to the extent that such views became valued in Western psychiatry, leading to a gradual reversion in terms of Islamic views toward mental illness, back to a time when stigma was prevalent and emotional suffering was seen as reflective of spiritual defectiveness (Moran, 2007).

American Muslims and Mental Health

Depression and anxiety are likely two of the more common mental health issues faced by Muslims in the United States. Particularly since 9/11, American Muslim religious leaders, often referred to as imams, have noticed a spike in depression and anxiety among their congregants

(Elias, 2006). Rippy and Newman (2006) report that American Muslims' perceptions of being discriminated against in the post-9/11 United States may contribute to a rise in anxiety and vigilance. Ali, Liu, and Humedian (2004) suggest that post-9/11 stress and family issues might be among the most common emotional struggles faced by American Muslims. Given Islam's prohibition of substance abuse, this affliction might be less common for Muslims than for other groups (Amer, 2005). Somatization of emotional difficulties has been observed in Arab clients—the majority of whom are Muslims—in greater numbers than would expected to be found in the general American population (Al-Krenawi & Graham, 2000).

Attitudes toward treatment. Moran (2007) reports that some American Muslims may be more open simply to receiving psychopharmacological services rather than participating in psychotherapy. It has been suggested by Jafari (1993) that Muslims might fear that their counselors are likely to project Western values in the course of therapy and will lack familiarity with Islam. Despite the fact that conventional approaches to counseling may fail to accommodate their spiritual needs (Sayed, 2003), American Muslims have been increasingly seeking therapy (Elias, 2006). Khan (2006) surveyed mosque-attending Muslims in the United States about their attitudes toward counseling. She found that males were about twice as likely as females to have negative attitudes toward counseling, but that females were somewhat more likely to indicate the need for counseling. These attitudes were strongly correlated with actual utilization of psychological services.

Treatment considerations. Ahmed and Reddy (2007) report that there is no current research on effective treatments for American Muslims. In working with Muslims, therapists must recognize that attitudes about mental health can vary greatly depending on the client's cultural background (Sayed, 2003). Laird, de Marrais, and Barnes (2007) found that articles that

discuss Muslims in health care journals often have concerning undertones that may lead their professional audiences to believe that Islam does not generally promote healthy living. However, it is imperative that health care providers who treat Muslim minorities in the West try to understand and value their patients' religious commitments (Laird, Amer, Barnett, & Barnes, 2007).

Toward that end, Hedayat-Diba (2000) stresses that it is important for counselors who work with Muslims to attempt to understand what their Islamic identity means for them. Indeed, a survey by Khan (2003) of Muslims in Ohio found that over two-thirds of the participants would always turn to prayer in times of discomfort, and Khawaja (2008) found that Muslims in Australia were likely to turn to their religion in coping with stress. Jafari (1993) states that it is important for Muslims who meet with therapists to have a sense that they are working with someone who possesses similar values as they do. For Muslim therapists, it might be worthwhile to attempt to integrate religious practices into treatment for their more religious Muslim clients (Hamdan, 2007). Finally, because Islam proscribes immodesty between unrelated members of the opposite sex (Esposito, 1998), Muslims may be more comfortable to meet with practitioners of the same sex (Winerman, 2006). Some Muslim women may even prefer to have the door open if meeting with a male provider (Moran, 2007).

Treatment resources. Winerman (2006) reports that reaching out to American Muslims who would benefit from psychological services should be a priority, as it may be unlikely that this population will be able or motivated to identify and make use of available treatment resources. This is complicated by the fact that there are relatively few mental health care providers in the United States who are Muslim. Dr. Ingrid Mattison, the President of the Islamic

Society of North America, was asked by Gallup (2009), "What is the most important thing Muslim Americans must do in the next 5 to 10 years?" She replied as follows:

> Muslim Americans must focus on developing and supporting a professional class of Islamic 'practitioners,' working in well-functioning institutions. We must accelerate the training and placement in our community of Muslim counselors, chaplains, imams, youth leaders, Sunday School teachers, social workers, and others who understand basic Islamic ethics (p. 40).

Since 9/11, some American Muslims have turned to their religious leaders for counsel. A study by Abu-Ras, Gheith, and Cournos (2008) of 22 imams and 102 worshippers at New York City mosques found that imams were often able to provide helpful counseling despite a lack of formal mental health care training. Ali, Milstein, and Marzouk (2005) also report that imams can play a useful role in providing counsel for their congregants. However, Khan (2003) found that even mosque-going Muslims would be hesitant to seek help from an imam who was foreign-born.

Young adult and native-born American Muslims. Research on the intersection between religion and mental health for Muslims born in America and/or young adult Muslims is in its nascence. A study by Sirin and Fine (2008) found that Muslim adolescents in the United States are inclined to use their religion to help them cope with stress in their lives. Khan (2006) found that young adult American Muslims may have more negative attitudes toward counseling than middle-age and older American Muslims. Her study did not query participants' country of birth, but she did find that African-American Muslims, who would be more likely than other Muslims in an adult sample to have been born in the United States, expressed the greatest reluctance to seeking formal mental health services. Participants' level of education was not found to be

correlated with attitudes toward mental health. Aloud (2004) found that American-born Muslims may be more likely than those born in other countries to seek formal mental health services, but this conclusion might be viewed with caution given that only 22 of his 281 participants were born in the United States.

Research on Muslim college students in Kuwait has suggested a strong link between religiousness and happiness (Abdel-Khalek & Lester, 2010), and a recent study by Ahmed (2009) of American Muslims between the ages of 18 and 25 showed that religiousness was significantly correlated with character strengths, such as hope, kindness, and gratitude. Further, results from Gallup's survey (2009) suggest that young adult American Muslims are much less likely to binge drink than their peers. Still, Muslim college students in America likely face more cultural stress than their classmates (Sirin & Fine, 2008). Female college students have reported discomfort in outwardly practicing Islam, such as by wearing hijab, but they also share concerns common to other young women, such as struggling with body image and anticipating difficulties balancing a career and family. Ribeiro and Saleem (2010) found that support groups for young Muslim women can be helpful in managing these stressors.

Brief interviews conducted by Herzig (2008), the present author, with American-born Muslim college students revealed that this population may be inclined to believe that emotional stress is a test from Allah and that it is not necessarily reflective of a lack of faith. Participants also expressed openness to use their religion to help them cope with psychological difficulties. However, it could not be concluded from the results of these interviews the extent to which American-born Muslim college students might be open to receiving formal mental health services. Regardless, it is likely that country of birth plays a role in the answer to that question,

as Brody (1994) found that, for college students, the foremost demographic correlate of attitude toward and use of psychotherapy was whether or not the students were born in the United States.

Summary

Islam is a way of life for over a billion people around the globe, including millions in the United States. At present, a number of demographic signs point to a significant and ongoing shift in the characteristics of American Muslims. They tend to be young, religious, and American-born, and they have been the topic of scant research (Ahmed, 2009). Many of these young adult Muslims attend college; a remarkable 20% of all American-born Muslim adults are college students. In general, American Muslims report relatively high levels of negative emotions and difficulty functioning, and this is especially the case for young Muslim adults. Researchers (e.g., Amer & Hovey, 2005; Khan, 2006) have suggested that future studies of American Muslims and mental health take into consideration country of birth and generational status.

This study aimed to develop a more complete picture of the views of young adult American-born Muslims with regard to the topic of mental health. To accomplish this, Muslim college students who were born in the United States were recruited to complete a survey largely composed of psychological measures that have been previously used with Muslim samples, which address topics such as religiousness, coping, and help-seeking. Through statistical analysis, several relevant findings were brought forth that may yield much greater knowledge than currently exists about young adult American Muslims who are native-born. The next chapter outlines the specific methodological approach used to obtain the data needed to inform those findings.

Chapter 3

Method

This study attempted to use a series of objective inventories in a survey to examine the mental health attitudes of young adult American-born Muslims, who were recruited through United States colleges and asked to complete an online survey (see Appendix A) that touched on a variety of topics, including religiousness, coping, treatment preferences, stigma, and perceptions of the presence of mental health issues in their community.

The order of the individual inventories was determined by the author's perception of questions that would be the least unpleasant to answer, and these were placed first so that rapport could be built with participants. Additionally, questions about religiousness were not placed toward the beginning of the survey so that participants would not be primed to view the rest of the survey through a principally religious perspective. The Measures section presents the inventories in the order in which they appeared in the survey.

Participants

Participants were 184 American-born Muslims who at the time of data collection were undergraduates at colleges in the United States. Participants were asked to verify the following five criteria: (a) that they identified as a Muslim, (b) that they were born in the United States, (c) that they lived in the United States, (d) that they were currently an undergraduate college student, and (e) that they were at least 18 years of age.

Participants were 50 males and 134 females. Their average age was 20.32 years, with a standard deviation of 2.27 and an age range of 18 to 33. The sample consisted of 39 freshmen, 43 sophomores, 48 juniors, and 54 seniors. The most represented ethnic, and/or cultural background was South Asian (n = 90), followed by Arabs (n = 44), and White Americans (n =

15). There were 13 participants who identified as African-American or Americans from African nations. Participants also came from the following backgrounds: mixed race (n = 9), Iranian (n = 5), Afghani (n = 4), Caribbean (n = 2), and East Asian (n = 2).

There were 21 participants who reported being converts to Islam. This group was composed of 18 females and three males. The majority of this subgroup identified as White (n = 15). Additionally, there were two African-American converts, one South Asian convert, one convert from an Iranian background, one convert from an East Asian background, and one convert who reported being of mixed race. The majority of participants (79%) reported being second-generation American Muslims. Of the 184 participants, 119 provided answers to all required questions.

Measures

Demographics and college experience. Participants read an informed consent form (see Appendix B) and verified that they met the aforementioned criteria for taking part in the study, and were then administered ten items that gathered demographic information, along with basic information about the experience of being a Muslim at college. Participants were asked their gender, age, and year at college. They were also asked to select one of thirteen designations that they felt best described their ethnic and/or cultural background. For participants who thought that none of the provided designations were accurate for them, they were provided with a field on the survey where they could type their self-assigned cultural grouping.

Participants were then asked if they have converted to Islam and were also asked if they were second-generation American Muslims (at least one Muslim parent not born in the United States). Participants were asked if there is a Muslim student organization at their college and if they have access to a Muslim chaplain or student advisor. Finally, participants were asked how

often they interact with their fellow Muslim students (*often*, *sometimes*, or *rarely*) and if they felt it was difficult for them to be a Muslim at college (*not difficult*, *slightly difficult*, *somewhat difficult*, or *very difficult*).

Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Aloud, 2004; Fischer & Farina, 1995; Fischer & Turner, 1970). Next, participants were asked to complete a 20-item adaptation of Fischer and Turner's (1970) ATSPPHS, which originally consisted of 29 items. Fischer and Turner established their final version of this scale using a sample of 406 participants, many of whom were college students. Reliability analysis indicated sufficient internal consistency ($\alpha = .83$) using Tyron's (1957) method (a precursor to Cronbach's alpha). Test-retest reliability was established for re-administrations of the scale after five days ($r = .86$), four weeks ($r = .82$), and two months ($r = .84$). Fischer and Turner identified four well-defined factors: Recognition (of personal need for psychological help), Tolerance (of the stigma associated with psychiatric help), Interpersonal Openness (regarding one's problems), and Confidence (in the mental health professional). These factors evidenced internal consistency at the levels of .67, .70, .62, and .74, respectively. Examples of items included "If I thought I needed psychiatric help, I would get it no matter who knew about it" and "If I believed I was having a mental breakdown, my first inclination would be to get professional attention." Response to the ATSPPHS options were *strongly disagree* (Likert score = 0), *disagree* (Likert score = 1), *agree* (Likert score = 2), and *strongly agree* (Likert score = 3); total scores can range from a minimum of zero to a maximum of 87. Major findings of Fischer and Turner's (1970) study showed that a significant relationship existed between treatment-seeking and actual utilization of services and that women held much more favorable attitudes toward help-seeking

than did men. Thus, those who have utilized therapy would have more favorable help-seeking attitudes.

Fischer and Farina (1995) developed an abbreviated version of Turner and Fischer's original scale. The scoring format was adjusted such that the scored response options were *strongly disagree* (Likert score = 1), *disagree* (Likert score = 2), *agree* (Likert score = 3), and *strongly agree* (Likert score = 4). This updated instrument, which lacked the factor structure of its predecessor, consisted of ten items, meaning that total scores could conceivably range from ten to 40. It was strongly correlated with the original scale (r = .87), had a Cronbach's alpha of .84, and demonstrated adequate test-retest reliability (r = .80).

Building on this revised scale, Aloud (2004) adapted the ATSPPHS for study with the Arab-Muslim population in the United States, specifically including five items pertaining to stigma toward mental health. His revised inventory consisted of 20 total items (15 of which feed into the ATSPPHS and five of which load into a separate stigma scale). Its scoring format mirrored that of Fischer and Farina's (1995) shortened form, such that the maximum total ATSPPHS score would be 60 and the minimum would be 15. The scale evidenced fair internal consistency (α = .74), and a factor analysis of the five stigma-related items yielded a Cronbach's alpha of .72 for that five-item scale.

Aloud (2004) made slight changes to the wording of some of the items of Farina and Fischer's (1995) ATSPPHS inventory to accommodate participants' familiarity with religious content. For example, the item "A person with a strong character can get over mental conflicts by himself, and would have little need of a therapist" was changed to "A person with strong IMAN (faith) can get rid of a mental health or psychological problem without the need of professional help." Perhaps Aloud's most notable finding was that, contrary to Fischer and

Turner's (1970) results with the original ATSPPHS, there did not appear to be a significant difference in terms of the overall likelihood for men and women to seek treatment; males' mean ATSPPHS score on the Aloud scale was 35.51, compared to 35.55 for females.

Treatment-seeking. Additional questions, which were relevant to the previous 20 items that composed Aloud's (2004) ATSPPHS adaptation, were administered in the Likert-type format of the ATSPPHS to maintain consistency in the responding format. The present author developed these treatment-seeking items, which made up the next 25 items. Participants were asked to read statements regarding seeking formal mental health services and the response options were again *strongly disagree* (Likert score = 1), *disagree* (Likert score = 2), *agree* (Likert score = 3), and *strongly agree* (Likert score = 4).

These treatment-seeking items were designed to specifically address attitudes toward psychotherapy, ideal characteristics of a treatment provider (e.g., gender, religion, and multicultural competence), preferred treatment modalities, and stigma. Examples of items were "If I sought professional mental health treatment, I worry about what my family would think if they knew," and "I would rather try psychiatric medications before trying therapy."

Brief Arab Religious Coping Scale (BARCS; Amer, 2005; Amer, Hovey, Fox, & Rezcallah, 2008). The following section in the survey consisted of a 15-item questionnaire, the Brief Arab Religious Coping Scale (BARCS). This survey has been used to measure religious coping for Arab Americans. It was developed by Amer (2005), who consented to the use of this scale in the present study and who was consulted on very minor revisions concerning the wording of certain items. This measure contains questions about how Arab Americans, many of whom are Muslims, might utilize religious coping strategies.

The BARCS asks participants to read each item and select how often they engaged in specified behaviors when they have experienced a stressful situation or problem. These statements exhibit strong face validity regarding religious coping. Examples of items include "I prayed for strength," and "I got help from religious leader/s." Participants are asked to select responses of *not used at all or does not apply* (Likert score = 0), *used sometimes* (Likert score = 1), *used often* (Likert score = 2), or *used always* (Likert score = 3). Therefore, the lowest total score would be zero, while the highest total score would be 45. This inventory does not yield subscales as it claims to measure a one-dimensional construct. The most frequently endorsed coping strategies were those that involved minimal time and energy (e.g., asking God for a blessing), while participants who reported the greatest utilization of religious coping were also likely to endorse strategies that required more effort, such as going to a house of worship or donating money (Amer et al., 2008).

Amer's (2005) pilot study on the 15-item BARCS yielded a Cronbach's alpha of .94. A subsequent online study with a much larger sample size similarly yielded an alpha of .94. In sum, the BARCS has proven to have strong internal consistency reliability in measuring the construct of religious coping in Arab and Muslim populations, and has been successfully applied in an online format.

COPE (Carver, Scheier, & Weintraub, 1989; Khawaja, 2008). The COPE is a well-known measure of coping styles (Litman, 2006). It was developed by Carver and colleagues (1989), who stated that the title of the scale is not an acronym but rather is meant to be reflective of the specific construct it claims to measure, namely, coping. The original COPE consisted of 53 items that fed into 14 factor scales, one of which measured religious coping. Exploratory factor analysis discovered that this *turning to religion* subscale exhibited the highest

Cronbach's alpha (.92) of all 14 scales. Only one of the other factor scales yielded a Cronbach's alpha of greater than .80 (Carver et al., 1989). Researchers, such as Litman (2006), have criticized the COPE for attempting to glean information about too many factors (14) given its relatively few items (53).

The COPE asks participants what they generally feel and do when they experience stressful events. Participants are asked to select responses of *I usually don't do this at all* (Likert score = 1), *I usually do this a little bit* (Likert score = 2), *I usually do this a medium amount* (Likert score = 3), or *I usually do this a lot* (Likert score = 4). Examples of items are "I discuss my feelings with someone" and "I use alcohol or drugs to make myself feel better." Items that feed into the "turning to religion" subscale include "I put my trust in God" and "I try to find comfort in my religion."

Khawaja (2008) set out to investigate the factor structure of the COPE on a sample of 319 Australian Muslims so that a more culturally sensitive assessment tool, such as an amended version of the COPE, could be developed for future use with Muslim and/or immigrant populations. Forty-seven of her participants opted to fill out this survey in Arabic, which had been translated from English to Arabic by a certified interpreter. Her analysis resulted in an amended version of the COPE that consisted of 34 items and four subscales, including a scale focused on religious coping. Total scores in her study ranged from 35 to 105, and can theoretically range from 34 to 136. Khawaja's factor scales were labeled *Avoidance Coping*, *Active Coping*, *Emotion and Social Focused Coping*, and *Turning to Religion*. Their respective Cronbach's alphas were .86, .85, .85, and .74. Of the 34 items, only four composed the "turning to religion" subscale ($\alpha = .74$). The Cronbach's alpha for the entire 34-item amended COPE was

.84. Khawaja consented to the use of her version of the COPE in this study. These 34 items followed the BARCS in the survey.

Sahin-Francis Scale of Attitude toward Islam (Sahin-Francis Scale; Sahin & Francis, 2002). The next 23 items in the present survey were composed of the Sahin-Francis Scale, which the authors consented to be included in the present study. This scale measures religiousness in Muslim individuals. Religious attitude measures have demonstrated strong validity across a variety of religions, and those religious scales developed by Francis and his colleagues have been utilized successfully in studies of mental health (Francis, 2009). Such is the case with the Sahin-Francis Scale, which has been effectively used to measure religiousness among Muslims in several different countries (Francis, Sahin, & Al-Failakawi, 2008).

The Sahin-Francis Scale asks participants to simply select the most personally appropriate response for 23 statements regarding their religiousness. The response options are *disagree strongly* (Likert score = 1), *disagree* (Likert score = 2), *not certain* (Likert score = 3), *agree* (Likert score = 4), and *agree strongly* (Likert score = 5). Examples of items are "I find it inspiring to listen to the Qur'an" and "Attending the mosque is very important to me." Four of the 23 items, such as "I think going to the Mosque is a waste of my time," are scored in the reverse direction. The maximum possible score can be 115 while the minimum possible score is 23.

The Sahin-Francis Scale was originally studied on 381 Muslim adolescents in the United Kingdom and yielded a Cronbach's alpha of .90 (Sahin & Francis, 2002). The inventory was most recently used on a large sample of college students in Kuwait (Francis et al., 2008). The Cronbach's alpha for this study was .85. Some items were strongly correlated with the overall scale, such as "Prayer/*Salat* helps me a lot" (r = .60) and "I love to follow the life/*sunnah* of the

Prophet" (r = .58). The lowest item-to-total scale correlation in this respect was the item "I think going to the Mosque is a waste of my time" (r = .18), which is also the first reversed scored item presented in the survey. In general, items pertaining to prayer and closeness to God were especially associated with high levels of religiousness. The Sahin-Francis Scale shows signs of generalizability and external validity because it has been used with Muslim samples in both Western and Arab countries with meaningful results about commonalities and differences in participants.

Symptoms and services. The next 25 questions focused on perceptions of the presence of mental health issues, environmental stress, and substance abuse in present study's sample, along with participants' perceptions of whether members of their Muslim respective communities have received professional treatment for the endorsed mental health difficulties. These 25 items were developed by the author of the study. Participants were specifically asked if they had friends and/or family who were young adult American-born Muslims who had suffered from particular conditions or stressors over the past year and whether those individuals received professional treatment over the past year. Due to concerns about the author's responsibility and ability to intervene for subjects who disclosed severe distress on an anonymous internet-based survey, participants were not asked directly if they were suffering from specific disorders.

While there are several different types of mental illness and environmental stressors that have been identified in the general American population, (see the Diagnostic and Statistical Manual of Mental Disorders-IV Text Revision [DSM-IV-TR], American Psychiatric Association, 2000) this section of the survey focused on eight areas of concern for young Muslim adults: (a) stress, (b) social pressures, (c) family conflict, (d) anxiety, (e) depression, (f) substance abuse, (g) eating disorders, and (h) psychosis.

The DSM-IV-TR (American Psychiatric Association, 2000) has stated that many of these categories of distress may be especially prevalent in the young adult American population. Depression and anxiety are two of the more common conditions present in the general population; similarly, concerning levels of sadness and worry have been reported in the young adult American Muslim population (Gallup, 2009). The DSM-IV-TR also reports that the onset of psychotic symptoms is especially likely to take place in young adulthood, and that adolescence and young adulthood are times of increased likelihood for developing an eating disorder. Additionally, substance abuse has become a serious issue for many college students (Leinwand, 2007). The issue of family stress will be examined, as American-born college students of foreign-born parents may be especially likely to experience intergenerational conflict (Lee & Liu, 2001). Finally, difficulties with stress and social pressure may be of particular concern for college students (Crocker & Luhtanen, 2003).

With regard to the eight previously outlined areas of mental distress, participants were asked three questions for each disorder or category of stress. First, they were asked if they had young adult American-born Muslim friends and/or family who had suffered from that particular condition or stressor in the past year. Second, they were asked if they had young adult American-born Muslim friends and/or family who had received professional treatment for that particular condition or stressor in the past year. Finally, they were asked how common they believed each of those issues to be in the young adult American-born Muslim community relative to other communities (*less common*, *about as common*, or *more common*). Participants were also asked to type in any other conditions not previously mentioned that they felt may be affecting the young adult American-born Muslim population. Additionally, participants were asked whether they had ever received mental health treatment themselves—and if so, from

whom—so that the relationship between help-seeking attitudes and actual use of services could be analyzed. Last, participants were offered the opportunity to type into an open field in the survey any additional thoughts they had regarding any of the issues addressed in the survey they completed.

Choice of Reward for Participation

After participants completed the entire survey, they could select one of two incentives or could choose no incentive at all. They could have money donated on their behalf to an Islamic humanitarian agency or they could enter into a drawing to win an Amazon.com gift card.

Procedures

Participants were primarily recruited through the email listservs of Muslim student organizations. This author used the internet to locate representatives of Muslim student organizations who forwarded information written by this author about the study to potential participants that were members of these email groups. When a contact for a Muslim student organization could not be identified, another individual or office that might have been able to distribute the message, such as a college chaplain, office of diversity, student affairs representative, or student group composed of ethnic minorities that may include Muslims, was contacted. A wide geographic sampling that included 150 colleges in all 50 states and the District of Columbia was sought (see Appendix C). A recruitment message explained the study's goals, potential benefits, and participant requirements, and also informed readers that the study was funded by the Institute for Social Policy and Understanding (see Appendix D).

Amer and Hovey (2007) suggested that internet-based studies may help in gathering valid information about Arab Americans, many of whom are Muslim; the relative anonymity of this medium might reduce the role of stigma with regard to mental health disorders. Participants'

confidentiality was maintained in this study. The website psychdata.com hosted the internet survey. This website had the capacity to securely store data and exclude IP addresses of participants. Most importantly, the website had the ability to have participants taken to a separate survey at the end of the study where email addresses could be entered by participants wishing to enter the drawing for the gift card. The website was thus able to automatically download the email addresses into a separate database to ensure the confidentiality of responses. As such, there was no way to definitively link participants' email addresses to their responses. Those participants who won the gift card were sent the card electronically, over email. Participants who chose to have five dollars donated on their behalf to charity did not need to provide any identifying information.

Research Hypotheses and Questions

Five research hypotheses were tested, and these were as follows:

1) At least 60% of participants will report in the measure, Symptoms and Services, the presence of some type of psychiatric condition or stressor that causes significant impairment among their young adult American-born Muslim friends and/or family in the past year. This assumption was based in part on the findings of the Gallup (2009) study, which documented high levels of self-reported deficits in wellbeing among American Muslims ages 18-29.

2) Of the eight categories of emotional difficulties measured by Symptoms and Services, Depression, Anxiety, and Stress will be perceived by participants to be the three most present concerns in the young adult American-born Muslim population. This assumption was based in part on a report by Elias (2006), in which imams reported concerns about depression and anxiety among their congregants, and the results of the Gallup (2009) study, which found high levels of self-reported unhappiness and stress in the Muslim community.

3) Religiousness will be associated with Religious Coping. The relationship between religious values and religious behavior for Muslims appears to be established by the research of Francis and Sahin (2002), and this author's assumption was that it is not unusual for Muslims in the United States to utilize religious coping strategies (Amer, 2005).

4) Participants will report a significant preference for Treatment-seeking from providers who are Muslim or who are multiculturally competent. Kelly and colleagues (1996) found a strong preference among American Muslims for treatment with Muslim or multiculturally competent providers, but without a major difference in preference between these two (Muslim; multiculturally competent) characteristics of mental health professionals. It was thus hypothesized that there will not be a significant difference among participants in the present study in their preference for Muslim providers or for non-Muslim providers who are multiculturally competent (a null hypothesis). However, it was hypothesized that both types of providers will be preferred significantly over providers who share participants' ethnicity.

5) Religiousness and Formal Help Seeking (i.e., Aloud's amended ATSPPHS) will be negatively correlated with Religiousness, but this correlation will be moderate. It does stand to reason that religious individuals' propensity to utilize religious coping strategies will offset some of their interest in receiving formal mental health services. However, interviews with a small sample of American-born Muslim college students conducted by the present author (Herzig, 2008) suggested that the interviewees were open to viewing mental health difficulties using a religious perspective, but they also acknowledged that religion itself may not solely account for mental health issues. Additionally, Brody (1994) found that there may not be a correlation between religiousness and attitudes toward mental health for college students. As such, it was hypothesized that even highly religious Muslims, despite an increased likelihood of using

religious coping strategies that will lessen their likelihood of seeking formal mental health services, will express at least some openness toward seeking such services, if needed.

Additionally, some specific research questions examined included the following:

● Does the sample perceive the presence of substance abuse in their community to be comparable to that of other young adult populations in the United States?

● Do Muslims who are more religious than other Muslims in the present study feel relatively comfortable on college campuses?

● What are some general coping strategies that tend to be utilized by individuals in the sample?

● Do gender, ethnicity, or generational status influence participants' Formal Help Seeking?

● Do young adult American-born Muslims feel there is a need for more Muslim mental health professionals?

Data Analyses

There were five hypotheses for the present study. For the purpose of running t-tests, bivariate correlations, analyses of variance (ANOVAs and MANOVAs), and multiple regressions with select predictor variables predicting one criterion variable, a sample size of 100 was desired so that these statistical tests could have a power of .80 and achieve a medium effect size (i.e., contributing 8% to 10% of the variance) at alpha = .05 (Cohen, 1988). Relevant descriptive statistics were analyzed (e.g., frequency distributions, means, and standard deviations). The internal consistency reliability of each scale was measured using Cronbach's alpha, and bivariate Pearson correlations showed the relationships among all major scales: the ATTPPHS, the BARCS, the COPE, and the Sahin-Francis Scale.

Hypothesis 1. To test the first hypothesis, survey responders that endorsed the presence of mental illness or significant stressors among their friends and/or family in the past year (Symptoms and Services measure) were tallied and simply divided by the total number of survey responders, and a percentage was calculated. A listwise analysis was performed (i.e., incomplete surveys were not included). A two-tailed t-test was performed to verify greater endorsement of the presence of mental disorders or stressors than the threshold set by the hypothesis.

Hypothesis 2. Two-tailed t-tests were performed to compare reports of Depression, Anxiety, and Stress against reports of the presence of other categories of mental illness or major stressors. Between-item Pearson correlations were devised and the specific mental illness that was shown to be the most salient dependent variable was identified, which was then run as an independent variable in a MANOVA with the correlated dependent variables previously identified. This elucidated relationships between perceived mental health concerns, and post-hoc ANOVAs provided additional data to further conceptualize how participants might categorize different psychological conditions and stressors.

Hypothesis 3. The third hypothesis was tested by running a bivariate Pearson correlation to determine the strength and directionality of the relationship between Religiousness and Religious Coping. The significance level was set at $p < .05$.

Hypothesis 4. Differences in participants' Treatment-seeking preferences between Muslim providers and multiculturally competent providers were assessed with a two-tailed t-test. The comparisons between these variables and the variable of preference for providers of the same ethnicity were also assessed with a two-tailed t-test. Significance levels were set at $p < .05$.

Hypothesis 5. The fifth hypothesis, which pertains to the relationship between religiousness and help seeking, was assessed in a hierarchical multiple regression that entered

Religiousness and Religious Coping, in that order, as predictor variables contributing to the variance of Treatment-seeking, the criterion variable.

Conclusion

This largely exploratory study aimed to utilize a survey method composed of some established inventories supplemented with a pilot measures constructed by the present author and optional fields for qualitative data. Given the relatively little research that has been gathered on the young American-born American Muslim population, the research hypotheses outlined above should be considered tentative. Also, given the exploratory nature of the study, several analyses were performed so that future studies might have the opportunity to focus on the more meaningful results. There is an established body of literature in American psychology on help-seeking among minority groups (e.g., Frey & Roysircar, 2006; Gloria, Hird, & Navarro, 2001), religiousness (e.g., Koenig, McCullough, & Larson, 2001; Schnittker, 2001), and religious coping (Amer, 2005; Pargament, 1997). This literature is complemented with the recent major national polls on American Muslims' experiences and a small but growing research interest in American Muslims and mental health (e.g., Ahmed, 2009; Ribeiro and Saleem, 2010). This author attempted to find a solid framework within which to develop premises related to the important topic of examining American-born Muslim college students' attitudes toward mental health.

Chapter 4

Results

The results outlined herein primarily report on the analysis of survey data collected from quantitative measures. First, the internal consistency reliability of the study's scales are reported, including significant item-specific reliability coefficients. Second, descriptive statistics are reported for all scales, supplemental survey questions, certain individual items related to specific foci of the present study, and relevant independent variables. Third, the five hypotheses are addressed using tests of differences, Pearson correlations, analyses of variance, and multiple regressions. Fourth, supplemental research questions are revisited, additional questions of interest are addressed, and the associated findings are reported. Finally, an additional section reports on a content analysis of qualitative data from participants who elected to contribute comments regarding stressors that may negatively impact the emotional wellbeing of young adult American-born Muslims.

Quantitative Data

Internal Consistency Reliability

Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Aloud, 2004; Fischer & Farina, 1995; Fischer & Turner, 1970). The Cronbach's alpha for the 15-item ATSPPHS was $\alpha = .75$. This is similar to the Cronbach's alpha of .74 reported by Aloud (2004) in his study of Arab Muslims in the United States. However, it is less than the Cronbach's alpha of .84 reported by Fischer and Farina (1995) on their ten-item scale, on which the Aloud ATSPPHS was modeled. An examination of item-to-full scale correlations suggested that the internal consistency reliability of the ATSPPHS might be improved ($\alpha = .79$) if certain questions were deleted, especially item 14. An inter-item correlation matrix found the most

significant correlation between two items to be r =.45, which was between the item 4 on the ATSPPHS ("If I believed I needed professional mental health or psychological counseling, I would get it no matter what people say or think.") and item 6 ("If I decide to seek psychological or mental health services, I am confident they would be helpful.").

Aloud (2004) also developed five additional items, situated within the ATSPPHS, which were designed to measure the level of stigma that Muslims associate with seeking formal mental health services. The Cronbach's alpha for these five items in the present study was $\alpha = .70$. This alpha is similar to the alpha of .72 found in Aloud's study. An analysis of item-total specifics of the five stigma items suggested that internal consistency reliability might be improved if the first item was deleted, resulting $\alpha = .72$ for stigma. An inter-item analysis of these five items showed a strong correlation of $r = .69$ between the second and fourth of these items: "I would feel embarrassed to tell others that I used psychological or mental health services." and "I would be concerned about what others might think or say if I used professional mental health services."

Brief Arab Religious Coping Scale (BARCS; Amer, 2005; Amer, Hovey, Fox, & Rezcallah, 2008). The 15-item BARCS measures religious coping. Its Cronbach's alpha for the present study was $\alpha = .90$; a Cronbach's alpha of .94 was found by Amer in her pilot study. An analysis of item-to-total scale correlations found that the Cronbach's alpha for the present study would not have been improved had any of the items been removed. An inter-item analysis of the BARCS data found that the strongest correlation existed between item 1 and item 15 ($r = .71$). These items stated, respectively, "I prayed for strength." and "I prayed to get my mind off my problem/s."

COPE (Carver, Scheier, & Weintraub, 1989; Khawaja, 2008). A 34-item version of the COPE (Carver, Scheier, & Weintraub, 1989) as adapted by Khawaja (2008) was utilized and its

Cronbach's alpha was α = .84, which was the same as reported by Khawaja. The adapted factor scales were labeled by Khawaja as *Avoidance Coping* (AV), *Active Coping* (AC), *Emotion and Social Focused Coping* (ESF), and *Turning to Religion (*TTR). The Cronbach's alphas were .80, .90, .88, and .93, which were similar to the alphas reported by Khawaja, α = 86, .85, .85, and .74. An analysis of correlations between scales (see Table 1) found that all factor scales were significantly correlated with the overall scale. Additionally, significant negative correlations existed between AV and AC, as well as AV and TTR, while AC was positively correlated with both ESF and TTR.

Table 1

COPE Inter-Scale Pearson Correlations and Subscale Alpha Coefficients

Scale	α		AV	AC	ESF	TTR	COPE
AV	.80	Pearson correlation	1.00	-.19*	.02	-.27**	.23*
		Significance		.04	.86	.00	.01
AC	.90	Pearson correlation		1.00	.30**	.39**	.74**
		Significance			.00	.00	.00
ESF	.88	Pearson correlation			1.00	.14	.72**
		Significance				.12	.00
TTR	.93	Pearson correlation				1.00	.48**
		Significance					.00
COPE	.84	Pearson correlation					1.00
		Significance					

Notes.

AV = Avoidance Coping
AC = Active Coping
ESF = Emotion and Social Focused Coping
TTR = Turning to Religion

* Significant at the .05 level (two-tailed)
** Significant at the .01 level (two-tailed)

Sahin-Francis Scale of Attitude toward Islam (Sahin-Francis Scale; Sahin & Francis, 2002). The Cronbach's alpha for the Sahin-Francis Scale was .95, while in its pilot study (Sahin & Francis, 2002) the alpha was .90. An item analysis did not suggest that the scale would be significantly improved if any of its 23 items were deleted. The highest correlation between individual items was $r = .80$, which was found between items reading, "I know that Allah/God helps me." and "I believe that Allah/God listens to my prayers/*du'a'*."

Descriptive Statistics

College experience. In the sample, 177 of 184 participants (96%) reported the presence of some type of Muslim student group at their college. Also, 79 of 184 participants (43%) reported that their college employed either a Muslim chaplain or a student advisor who served specifically as a resource for Muslim students. When asked how often participants interacted with other Muslim students on campus, 19 replied *rarely* (10%), 51 replied *sometimes* (28%), and 114 replied *often* (62%). Participants were also asked how difficult it was for them to be a Muslim at their college and were given a Likert scale of one through four with responses ranging from *not difficult* (1) to *very difficult* (4). The mean score was 1.61 and 54% of participants selected *not difficult*.

Attitudes toward Seeking Professional Psychological Help Scale (ATSPPHS; Aloud, 2004; Fischer & Farina, 1995; Fischer & Turner, 1970). Of the 184 participants, 130 completed the ATSPPHS. These 15 items, several of which are reverse-scored, present participants with a Likert scale of 1 to 4 for their responses, with the maximum possible score being 60 and the minimum possible score being 15. Higher scores indicate greater receptiveness toward seeking formal mental health services. The mean total score in the present study was 40.72, with a standard deviation of 5.53 and range of 25 to 54. The item that drew the strongest disagreement was "Family members should have the final say whether or not an individual seeks professional help for a psychological or mental health problem." Of the 130 respondents, 120 (92%) either disagreed or strongly disagreed with this statement. Aloud's (2004) inversely related stigma scale, which consists of five items scored in the same Likert scale format as the ATSPPHS, with higher scores indicating higher levels of stigma, yielded a mean of 13.37, with a standard deviation of 2.63 and a range of 7 to 19. This scale had a theoretical range of 4 to 20.

Treatment-seeking. Questions in this section pertained to participants' views of different types of treatment modalities and treatment providers, along with more general attitudes toward treatment-seeking and providers. These questions were answered by 130 participants. The answer format was identical to those used in the ATSPPHS. Results of attitudes toward treatment providers are listed in Table 2 and results of attitudes toward treatment modalities are listed in Table 3. Among the most salient findings were that a preference was expressed for individual therapy and that participants would prefer therapists who are multiculturally competent and/or who understand issues concerning young adults. There was no significant difference between freshmen (n = 29, m = 3.52), sophomores, (n = 24, m = 3.71), juniors (n = 34, m = 3.56), and seniors (n = 43, m = 3.56) in terms of their expressed preference for therapists who are in tune with the developmental issues faced by young adults.

Participants reported a preference for utilizing therapy before trying psychiatric medication (see Table 4). With regard to others knowing about them seeking formal mental health services, participants were somewhat more concerned about the judgments of their Muslim friends and family than the perceptions of their non-Muslim friends (see Table 5). Participants also voiced a desire for more Muslim mental health professionals and were concerned about the lack of familiarity with Islam within the field of mental health care (see Table 6). Finally, while participants were apt to use religious coping strategies, they saw little conflict between utilizing both religious coping and formal mental health services (see Table 7).

Table 2

Treatment Provider Preferences

Item	Mean	SD
If I were to see a therapist, it would be important that he or she be multiculturally competent, that is, who would have an orientation to treatment that involved interest in, respect for, and knowledge of different religions, cultures, and their values and practices, including my own.	3.61	0.60
If I were to see a therapist, it would be important that he or she have a good understanding of the issues that people of my age would be concerned with.	3.58	0.53
If I were to see a therapist, it would be important that he or she take an interest in my identity as a Muslim.	3.28	0.79
If I were to see a therapist, it would be important that he or she would be American-born or be someone who is clearly in touch with current American culture.	3.08	0.79
If I were to see a therapist, it would be important that he or she were to integrate my religious beliefs into treatment, such as helping or encouraging me to use the teachings and practices of my religion to improve my wellbeing.	3.04	0.90
If I were to see a therapist, it would be important that he or she would be the same gender as me.	2.89	0.97
If I decided to seek mental health or psychological help, I would rather contact Muslim professionals than professionals from other groups.	2.88	1.08
If I were to see a therapist, it would be important that he or she would be of the same ethnic background as me.	1.91	0.73
If I were to see a therapist, it would be important that he or she would be someone who is a friend or acquaintance of mine or my family.	1.58	0.66

Note. The Likert scoring scale was:

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

Table 3

Treatment Modality Preferences

Item	Mean	SD
I would be open to receiving individual (one-on-one) psychotherapy (e.g., "talk therapy," counseling) from a professional therapist if I felt that I needed it.	3.32	0.61
I would be open to participating in family therapy if I felt that there was significant conflict within my family.	2.71	0.92
I would be open to seeing a psychiatrist who could prescribe appropriate psychiatric medications (e.g., anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents) if I felt that I needed it.	2.70	0.78
I would be open to seeing a general medical practitioner who could prescribe appropriate psychiatric medications (e.g., anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents) if I felt that I needed it.	2.56	0.84
I would be open to participating in group therapy (e.g., "talk therapy" in a group setting guided by a group therapist) if I felt that I needed it.	2.56	0.88

Note. The Likert scoring scale was:

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

Table 4

Medication versus Therapy

Item	Mean	SD
I would rather try therapy before trying psychiatric medications.	3.48	0.70
I would rather try psychiatric medications before trying therapy.	1.50	0.66

Note. The Likert scoring scale was:

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

Table 5

Worry about Others' Perceptions

Item	Mean	SD
If I sought professional mental health treatment, I worry about what my Muslim friends or acquaintances would think if they knew.	2.52	0.88
If I sought professional mental health treatment, I worry about what my family would think if they knew.	2.48	0.88
If I sought professional mental health treatment, I worry about what my non-Muslim friends or acquaintances would think if they knew.	2.14	0.87

Note. The Likert scoring scale was:

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

Table 6

Islam and Treatment Providers

Item	Mean	SD
I believe that there is a need for more Muslim mental health professionals.	3.45	0.74
I believe that most mental health professionals have a good enough understanding of Islam.	1.78	0.56

Note. The Likert scoring scale was:

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

Table 7

Religious Coping and Formal Mental Health Services

Item	Mean	SD
I see no conflict between using religious coping and using professional mental health services.	3.23	0.75
If I had a mental health problem, I would use my religion to help solve it before seeking professional services.	3.01	0.83

Note. The Likert scoring scale was:

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

Brief Arab Religious Coping Scale (BARCS; Amer, 2005; Amer, Hovey, Fox, & Rezcallah, 2008). The BARCS was completed by 130 participants. Its 15 items are scored in a zero through 3 Likert format, with a minimum possible score of 0 and a maximum possible score of 45. For the present study, the mean for the BARCS was 23.92, with a standard deviation of 9.04 and a range of 2 to 45. There was considerable within-group difference in the distribution of scores. Its most strongly endorsed item was "I asked God/Allah for a blessing" ($M = 2.34$). The least endorsed item was "I got help from religious leaders," which had a mean of 0.71.

COPE (Carver, Scheier, & Weintraub, 1989; Khawaja, 2008). The adapted version of the COPE used in the present study, which has a 1 through 4 Likert format, was completed by 123 participants. The highest possible total score on this version of the COPE is 136 and the lowest possible total score is 34. In the present study, the COPE yielded a total scale mean of 83.84, with a standard deviation of 10.95 and a range of 53 to 105. The most endorsed item was

"I learn something from the experience." (3.37), and the least endorsed items were "I try to lose myself for a while by drinking alcohol or taking drugs." and "I drink alcohol or take drugs, in order to think about it less."; both items had means of 1.09. The COPE contains four subscales: *Avoidance Coping* (AV), *Active Coping* (AC), *Emotion and Social Focused Coping* (ESF), and *Turning to Religion* (TTR). Descriptive statistics pertaining to these scales are presented in Table 8.

Table 8

Descriptive Statistics for COPE Subscales

Scale	Number of items	Mean per item	Overall mean	SD	Highest score	Lowest score
AV	12	1.49	17.90	4.44	37	12
AC	10	3.02	30.24	5.98	40	15
ESF	8	2.85	22.81	5.84	32	11
TTR	4	3.32	12.89	3.30	16	4
COPE Totals	34	2.47	83.84	10.95	105	53

Notes.

AV = Avoidance Coping
AC = Active Coping
ESF = Emotion and Social Focused Coping
TTR = Turning to Religion

The Likert scoring scale was:

1 = I usually don't do this at all
2 = I usually do this a little bit
3 = I usually do this a medium amount
4 = I usually do this a lot

Sahin-Francis Scale of Attitude toward Islam (Sahin-Francis Scale; Sahin & Francis, 2002). The Sahin-Francis Scale was completed by 120 participants. Its 23 items are scored in a 1 through 5 Likert format, with a minimum possible score of 23 and a maximum possible score of 115. For the present study, the mean for the Sahin-Francis Scale was 100.87, with a standard deviation of 13.27 and a range of 38 to 115. Its most strongly endorsed item, with a mean of 4.79, was "I believe that Allah/God helps people." Its least endorsed item was "I feel that I am

very close to Allah/God," with a mean of 3.55, which, however, fell above the mid-point of the Likert scale.

Symptoms and services. Participants were asked about their perceptions of mental illness and major stressors in the young adult American-born Muslim community. These participants (*n* = 119) were asked about eight specific challenges, namely, (a) stress, (b) social pressures, (c) family conflict, (d) anxiety, (e) depression, (f) substance abuse, (g) eating disorders, and (h) psychosis. Descriptions of each of these issues were provided on the survey and each item was worded such that the condition or stressor described was of clinical significance. Participants were asked if they had young adult American-born Muslims friends and/or family who suffered from these particular conditions or stressors over the past year and whether those individuals received professional treatment over the past year. They were also asked how common they believed those conditions or stressors to be among their community relative to the general population, with response options being *Less common* (Likert score 1), *About as common* (Likert score 2), and *More common* (Likert score 3). Table 9 lists the results of this series of questions.

Table 9

Presence of Mental Illness and Major Stressors Perceived among Young Adult American-born Muslims

Item	Perceived presence in peers: percentage of "Yes" responses	Knowledge of peers' treatment: percentage of "Yes" responses	How common relative to other communities?
Social pressures	89.92%	12.61%	2.55
Stress	84.87%	23.53%	2.25
Family conflict	83.19%	10.08%	2.11
Anxiety	63.87%	20.17%	1.99
Depression	57.98%	31.09%	1.87
Substance abuse	36.97%	5.88%	1.35
Eating disorders	15.13%	3.36%	1.38
Psychosis	10.92%	8.40%	1.50
Total	99.16%	50.42%	1.87

Note. The Likert scoring scale for the "How common relative to other communities" question was:

1 = Less common
2 = About as common
3 = More common

Participants were then asked if there were any conditions of concern facing their community other than the eight listed, and were given the option to write brief responses. Answers were provided by 15 participants, some of whom identified more than one issue of concern. This author performed a brief content analysis to simplify these responses into eight

categories. The most represented were "Pressure from Family," which was mentioned by five participants, "Sense of Disempowerment," which was mentioned by four participants, and "Community Stigma toward Mental Health and/or Lack of Understanding within Community," which was mentioned by three participants. Additionally, the following categories were each mentioned by at least two participants: "Gender Relations," "Pornography and/or Masturbation," "Identity Formation," and "Physical and/or Sexual Abuse." Finally, one participant mentioned concerns that were categorized by this author as "Discrimination."

Participants were then asked if they had ever received formal mental health services. Of those 119 participants, 23 reported having received formal mental health services at any time in the past (20 females; 3 males). They were then asked to select the type of provider from whom they received services. Participants were given the option of selecting more than one type of provider. They were also allowed to write in additional past treatment providers who were not listed as options on the survey, which two participants chose to do. Seventeen participants reported having received individual psychotherapy. Eight reported receiving individual treatment from a psychiatrist and seven reported having received psychological care from their general medical practitioner. Two participants reported having been in group therapy and two participants reported having participated in family therapy. Finally, one participant reported receiving counseling from an academic advisor and one participant reported participation in meditation classes as a means of receiving professional care.

Research Hypotheses

Hypothesis 1. The first hypothesis predicted that at least 60% of participants would report in the measure, Symptoms and Services, the presence of some type of psychiatric condition or significantly impairing stressor among their young adult American-born Muslim

friends and/or family in the past year. This hypothesis was confirmed. Of the 119 participants who completed that series of questions, 118 (99%) perceived the presence of such issues, whereas only 71 of 119 participants would have been needed to meet the 60% threshold set by the hypothesis. A two-tailed t-test was performed and verified that this difference was statistically significant, with $t(236) = 8.60$, $p < .001$. Because the categories of Social Pressures, Stress, and Family Conflict are not considered as clinical disorders according to the DSM-IV-TR (American Psychiatric Association, 2000), a separate analysis was performed that focused only on the five other psychiatric conditions that were queried—Anxiety, Depression, Substance Abuse, Eating Disorders, and Psychosis. Still, 116 (97%) of participants reported their perception that a young adult American-born Muslim peer of theirs had suffered from at least one of these conditions over the past year.

Hypothesis 2. It was hypothesized that of the eight categories of emotional difficulties measured, Depression, Anxiety, and Stress would be the most perceived in this community. This hypothesis was rejected, as Social Pressures, Stress, and Family Conflict were all perceived at higher levels than either Depression or Anxiety (see Table 9).

In order to better elucidate the relationships between and among the emotional difficulties variables measured, bivariate Pearson correlations were calculated. Of all of the variables measured, only Depression was correlated with five of the other variables at a significance of $p < .05$. Statistics outlining the correlations of Depression to these five other variables (Family Conflict, Anxiety, Substance Abuse, Eating Disorders, and Stress) are presented in Table 10.

Table 10

Correlations of Depression

	Family conflict	Anxiety	Substance abuse	Eating disorders	Stress
Correlation with depression	.21*	.39**	.19*	.31**	.35**

Note.

* Significant at the .05 level (two-tailed)
** Significant at the .01 level (two-tailed)

Based on these strong correlations, a MANOVA was performed in which Depression was the independent variable (Yes/No), while Family Conflict, Anxiety, Substance Abuse, Eating Disorders, and Stress were dependent variables. This test was intended to shed light on whether participants' perception of whether depression was present or not present may have led them to perceive the presence of other conditions or stressors with which depression was correlated in the sample. The MANOVA was significant; $F(5, 113) = 10.06$, $p < .001$. Post-hoc ANOVAs (see Table 11), devised to further elucidate differences between the five previously identified dependent variables, found that participants who reported knowing someone with Depression were also especially likely to report knowing someone with Anxiety and/or Stress ($p < .001$; medium effect size), suggesting that they may be apt to view Depression, Anxiety, and Stress as a broad construct.

Table 11

Post-hoc ANOVAs with Perceived Depression as the Independent Variable

Dependent variable	*df*	Mean square	*F*	*p*	ω^2
Family conflict	1	.73	5.36	.02*	.04
Anxiety	1	4.12	20.67	.00***	.15
Substance abuse	1	1.04	4.55	.04*	.04
Eating disorders	1	1.49	12.60	.00**	.10
Stress	1	1.91	16.70	.00***	.13

Note.

* Significant at the .05 level
** Significant at the .01 level
*** Significant at the .001 level

This result lent some credence to the original Hypothesis 2, which claimed that Depression, Anxiety, and Stress would be endorsed at the greatest levels. Indeed, there were 108 participants who endorsed the presence of Depression and/or Anxiety and/or Stress, which was greater than any other single issue.

Hypothesis 3. Third, it was hypothesized that Religiousness and Religious Coping would be correlated. This was measured by running a bivariate Pearson correlation, with the variables being the BARCS and the Sahin-Francis Scale. These scales were correlated at $r = .63$, which was significant at the .01 level, confirming the hypothesis.

Hypothesis 4. This hypothesis stated there would be no difference between participants' inclination to seek treatment from Muslim providers or, alternatively, multiculturally competent providers. However, a significant difference ($p < .01$) was indeed found between participants'

preference for multicultural providers ($M = 3.61$) and Muslim providers ($M = 2.88$). The second part of this hypothesis was confirmed, as a preference for both multicultural and Muslim providers was endorsed at a .01 level over a preference for a provider being of the same ethnicity ($M = 1.91$). Therefore, participants reported that multicultural competence for a provider was more important than a provider being Muslim, but participants favored both of these characteristics over the treatment provider being of the same ethnicity.

Hypothesis 5. The final hypothesis posited a negative correlation between religiousness (as measured by the Sahin-Francis Scale) and help-seeking attitudes (as measured by the ATSPPHS). This hypothesis was rejected, as no correlation was found ($r = .03$).

In order to better understand the role of religious coping (as measured by the BARCS) in analyzing the relationship between religiousness and help-seeking attitudes, a hierarchical multiple regression was performed, with religious coping and religiousness as the predictor variables and help-seeking as the criterion variable. Results of this analysis did not suggest that either religious coping or religiousness contributed to a valid model for help-seeking attitudes; $F(2, 117) = .22$, $p > .05$, $R^2 = .00$. However, a multiple regression analysis with religiousness, help-seeking attitudes, and general coping orientation as predictor variables proved to be a robust model for understanding religious coping ($F(3, 116) = 32.93$, $p < .001$, $R^2 = .46$, a large effect size). Table 12 lists the respective contributions for help-seeking attitudes (ATSPPHS), general coping orientation (COPE), and religiousness (Sahin-Francis Scale) for this model of religious coping, as measured by the BARCS.

Table 12

Multiple Regression of Attitudes toward Help-seeking, General Coping, and Religiousness as Predictors with Religious Coping as the Criterion Variable

Factor	*B*	*SE B*	*β*	*t*	*p*
ATSPPHS	-.03	.11	-.02	-.23	.82
COPE	.22	.06	.27	3.57***	.00
Sahin-Francis	.36	.05	.54	7.39***	.00

Notes.

ATSPPHS = Attitudes toward Seeking Professional Psychological Help Scale

*** Significant at the .001 level

Finally, inter-scale correlations (see Table 13) were devised in order to understand the relationships between and among the four major constructs studied, namely, religious coping (BARCS), help-seeking attitudes (ATSPPHS), general coping orientation (COPE), and religiousness (Sahin-Francis Scale). The help-seeking attitudes variable (ATSPPHS) was found to be significantly correlated with general coping (COPE) but was not associated with variables concerning religion. Strong correlations were found between religiousness (Sahin-Francis Scale) and religious coping (BARCS); general coping orientation (COPE) and religious coping (BARCS); and religiousness (Sahin-Francis Scale) and general coping orientation (COPE).

Table 13

Correlations among Standardized Measures of the Study

Scale		BARCS	ATSPPHS	COPE	Sahin-Francis
BARCS	Pearson Correlation	1.00	.06	.45**	.63**
	Significance		.26	.00	.00
ATSPPHS	Pearson Correlation		1.00	.22**	.03
	Significance			.01	.37
COPE	Pearson Correlation			1.00	.35**
	Significance				.00
Sahin-Francis	Pearson Correlation				1.00
	Significance				

Notes.

BARCS = Brief Arab Religious Coping Scale
ATSPPHS = Attitudes toward Seeking Professional Psychological Help Scale

** Correlation is significant at the .01 level (two-tailed)

Additional Analyses

Specific research questions. Five additional research questions were the subject of data analysis as well. The findings for these five questions were as follows:

1) A two-tailed t-test assuming equal variances determined that participants did indeed view substance abuse to be less common in their communities than in others; $t(236) = 9.83$ and $p < .001$.

2) Also analyzed was the relationship between participants' religiousness and their level of comfort being a Muslim at their college. There was no correlation between these variables ($r = .01$).

3) Participants were likely to engage in coping in the following ways (a) using religion, (b) taking a proactive approach, and (c) reaching out to others. These inferences are based on the mean-per-item subscale results of the COPE, in which Turning to Religion (M = 3.32), Active Coping (M = 3.02), and Emotion and Social Focused Coping (M = 2.85) far exceeded Avoidance Coping (M =1.49).

4) A two-tailed t-test examining help-seeking attitudes found that second-generation Muslims (n =100, m = 40.52) were not different than Muslims that were not second-generation (n = 30, m = 41.37) with regard to positive help-seeking attitudes. This t-test was also run using gender as an independent variable. Males (n = 31, m = 39.13) were not found to have significantly different levels of positive help-seeking attitudes than did females (n = 101, m = 41.21). Participants' ethnic background was also utilized as an independent variable in studying help-seeking attitudes. A one-way ANOVA was performed, which did not show significant between groups differences; $F(9, 120) = .86$, $p > .05$. Because there were small sample sizes of certain ethnic groups, a one-way ANOVA with regard to help-seeking attitudes was performed for participants from South Asian backgrounds (n = 64), Arab backgrounds (n = 30), and a third group consisting of White Americans and African-Americans (n = 27). Between groups differences were not significant; $F(2, 118) = 1.07$, $p > .05$.

5) Participants were asked if they felt there was a need for more Muslim mental health providers. Out of the 130 participants who answered this question, 119 (92%) either agreed (n = 45) or strongly agreed (n = 74) with this statement.

Male/female differences. The role of male/female differences was analyzed as an independent variable using two-tailed t-tests to discern its relationship with the ATSPPHS, Stigma scale, BARCS, COPE and its four subscales, and the Sahin-Francis Scale. For all of

these separate dependent variables, male/female differences were non-significant. However, a male/female difference was found to be significant in participants' preferences for certain qualities of treatment providers. Female participants were more likely ($p < .01$) to prefer providers of the same sex (Female $M = 3.02$; Male $M = 2.48$) and of the same ethnic background (Female $M = 1.98$; Male $M = 1.68$). In terms of preferences for certain treatment modalities, males were more open to participating in group therapy than were females (Male $M = 2.84$; Female $M = 2.47$, $p < .05$).

Given the low endorsement of the question on the BARCS that asks participants if they turn to religious leaders as a means of coping, this item was investigated further. Because most Muslim religious leaders are male and because female participants had expressed a preference for providers of the same sex, it was thought that perhaps females would have especially contributed to this item being poorly endorsed. However, a two-tailed t-test did not reveal significant differences by sex for this item on the BARCS (Male $M = 0.65$; Female $M = 0.73$).

Being Muslim at college. A significant negative correlation ($r = -.22$, $p < .01$) was found between the variables of frequency of interaction with other Muslims at college and difficulty being Muslim at college, suggesting a strong relationship between religious satisfaction and time spent with members of one's religious group. Participants were divided into one of two levels of religiousness and a subsequent two-tailed unpaired t-test found that more religious Muslims spent a greater amount of time with other Muslims at college than did less religious Muslims; $t(118) = 2.76$, $p < .01$. A significant correlation ($r = .16$, $p < .05$) was found between the variables of having a Muslim chaplain on campus and ease of being Muslim at college.

Help-seeking. A two-tailed t-test was performed to gauge differences in attitudes toward help-seeking between participants who had and who had not received previous formal mental

health services. A random sampling of the help-seeking attitudes of 23 participants who had no history of treatment was compared to those of the 23 participants who had reported past treatment. A significant difference was found, $t(44) = 2.65$, $p < .05$, with participants with a past history of treatment ($m = 43.96$), reporting greater openness to seek formal mental health services than did participants with no history of treatment ($m = 39.91$).

Help-seeking results for the present study were compared to those of Aloud (2004), who also utilized the ATSPPHS in studying an American Muslim sample. However, most of Aloud's participants were foreign-born and all were Arab. A two-tailed unpaired t-test found that the mean ATSPPHS total for the present study ($M = 40.72$) was greater than the mean of 35.52 found by Aloud in his study, $t(405) = 8.64$, $p < .001$, indicating more favorable help-seeking attitudes in the sample of the present study. The ATSPPHS totals for the Arab subsample in the present study ($M = 39.67$) were also greater than those in Aloud's study; $t(305) = 3.83$ and $p < .001$.

Religiousness. There was no significant difference found in level of religiousness (Sahin-Francis Scale) and whether or not participants were converts to Islam. Further, second-generation Muslims were no more or less likely than other Muslim participants to have high levels of religiousness or religious coping. Strong correlations were found between religious coping (BARCS) and preference for a Muslim treatment provider ($r = .40$; $p < .01$) and between religiousness and preference for a Muslim treatment provider ($r = .43$; $p < .01$). Religiousness was not found to be significantly correlated with mental health stigma as measured by Aloud's (2004) stigma scale.

Choice of Reward for Participation. Of the original 184 participants, 121 completed the entire survey and were given the option of selecting a reward (two of these participants were

later removed from the data set for being ineligible). Seventy-seven participants opted to have five dollars donated on their behalf to charity, which raised 385 dollars for Islamic Relief USA. Thirty-seven participants chose to be entered into a one-in-twenty drawing to win a gift card worth a hundred dollars; two participants received this prize. Finally, seven participants chose to select no reward for participation.

Qualitative Data

In order to better understand challenges facing the young adult American-born Muslim community, participants were given the option of providing additional written comments about the difficulties they have encountered and how they have been personally affected. Responses were provided by 70 of the 184 participants (38%) to the following question:

> "Some American-born Muslims have reported difficulty with completely embracing their religious and/or cultural identities in modern Western society. These types of issues cover many topics, including social pressures, relationships with family, being in mixed-gender environments, feeling misunderstood by others, experiencing discrimination, feeling uncomfortable being outwardly Muslim (e.g., wearing hijab, praying in public, etc.), issues related to dating and marriage, educational and career decisions, and many other topics. If you wish to do so, please use this space to state whether or not these issues have impacted you personally and, if so, which particular issues have affected you and how your emotional wellbeing has been impacted:"

This author conducted a content analysis of these responses and found that they typically fell into one of five categories: gender relations, balancing different identities, discrimination, intergenerational conflict, and feeling misunderstood. Some participants' responses touched on many different subjects, including more than one of the categories discussed below.

Gender Relations

Difficulties with issues relating to gender relations were reported by both males and females and tended to be expressed in terms of the struggle to reconcile Islam's emphasis on modest behavior between men and women with the American societal norm of dating. These concerns were raised by 43% of respondents. Some respondents wrote about how Islamic norms can complicate the process of finding someone to marry in American society, whereas others focused on the trials of navigating mixed-gender social situations. A second-generation female from a South Asian background who is a junior in college wrote:

> "The biggest social pressure for me has been dating. I've never had a problem with turning down drugs and alcohol, but my weakness has been staying strong in the romantic aspect of life. I have made mistakes when I was younger that still impact me today, in the sense that I regret some decisions, and have gone through periods of minor depression. It has taken a lot to come to terms with the past, learn from mistakes, and pray for forgiveness. Allah is the Most-Merciful, after all."

Another second-generation female from a South Asian background, who is a senior in college, expressed concern about the lack of community support and understanding related to these issues:

> "Romantic relationships are very difficult for my American-born Muslim friends because it is unchartered territory. We have no advice, no good role models and very few people to receive advice from because it is such a taboo topic. Many of my friends have undergone a lot of depression due to romantic feelings/relationships. I believe that because Muslim communities and families are less likely to accept and talk about

> romance, American-born Muslims often feel like they have to carry the burden of how they feel by themselves. We are not wise enough to handle this burden by ourselves."

For some young adult American-born Muslims, struggling with the issue of gender relations has had emotional consequences. A second-generation South Asian female who is a freshman recounted:

> "I ended up kind of dating a boy in my junior year of high school without telling my parents but that led to a lot of identity crises and hiding from myself and lying and I think I was very very depressed. I hated my life, I used to think about death a lot and cry all the time and just always be fighting something. But now I don't really worry about it and I just focus on the things that I am meant to do, following my passions and helping people and I guess I've got bigger goals now."

Balancing Different Identities

Another theme that appeared in some of the responses was a sense of unease in balancing American and Muslim identities. These concerns were raised by 21% of respondents. One participant wrote about the difficulty of reconciling his identity as an American with his discomfort with an American foreign policy that sometimes leads to the disenfranchisement of Muslims in other countries. Participants most notably indicated that it was difficult for them to balance their different identities in the social sphere, such as this second-generation South Asian female who is a college sophomore:

> "I feel like how Muslim I am is dictated by who I hang around with, and it is really frustrating that I can't explore what being Muslim means to me because I have to find a balance between being around my friends from my MSA [Muslim Students Association] and my best friends that are not Muslim. Sometimes I feel like my friends who are not

> Muslim can be unsupportive of my actions because it will limit what they can try. We can't go into a bar together or go dancing. I can't wear shorts to the beach or date guys. However, they are respecting of my decision and understand that it is what I want to do, so even though they might resent it somewhat, they realize that it is my personal choice. However, around Muslims it's a whole other story. They might not pressure me into going to bars and to go crazy on spring break, but when they want to do something that I don't feel comfortable with due to the values I have, I cannot tell them that I don't want to do it with them because it hurts for someone to call you out on not being a good enough Muslim."

Discrimination

Some respondents (20%) reported feeling that others had discriminated against them or that they might be judged negatively because of their faith. Many participants spoke of subtle discrimination, such as a respondent who wrote that other people view him suspiciously and ask him incredulously where he is from, to which he replies, "Michigan." However, some experiences of discrimination have been more overt. A second-generation South Asian female who is a college senior provided this particular story:

> "When 9/11 happened, I was living in central Texas, and my family was the only Muslim family within a one-hour radius along with being one of the very few minority families in that same radius. Before 9/11, no one cared where I was from or what religion I followed. But after 9/11, I was asked the stupidest questions by classmates that I had known for years. They would ask if I knew where Saddam Hussein or Osama [bin Laden] were hiding, if I was related to them, and I heard other students say that they wish they could take a machine gun and shoot all the Muslims. The mother of my best friend at the time

> also told her daughter not to accept any food/sweets from me (this was right after the anthrax scare). Also some men came by my house and threatened my father with a gun and said that we needed to leave the town. So all this made a huge impact. I was already shy; this just made me even more shy and also embarrassed of who I was. I was scared to speak anything besides English outside and to admit my religion. If my relatives came to visit, I was much more hesitant to go outside with them since some of them wore scarves and some of the men had beards. However we moved after a year. Even today, if I am outside with anyone who is outwardly Muslim in their appearance, I know other people are looking at us and I wonder what they think of us. However I am not embarrassed or afraid anymore. Especially in this diverse area [college], I am much more comfortable and proud of who I am."

Some participants mentioned fears of being viewed negatively by others because they dress according to religious customs. For example, an African-American female who is a junior in college voiced concerns about others' judgments of her as a female Muslim:

> "I can sense when people are discomforted by my appearance, being a hijabi [hijab-wearing Muslim] and all, and this causes me great concern and worry. I'm not sure where this weight on my shoulders comes from but it affects my emotional well-being at times. It's hard being a Muslimah [female Muslim] in this society, especially when since childhood it's been engraved in my mind that I'm equal to my [non-Muslim] counterparts when in reality I'm not. I'm anything but."

Intergenerational Conflict

Some participants noted that it can be disconcerting when parents are not understanding of the attitudes and behaviors of their young adult sons and daughters. This concern was raised

by 27% of respondents. One respondent wrote about the distress she felt when her parents did not want her to begin wearing the hijab. In discussing various social pressures, another second-generation participant lamented, "Parents don't know that things are different [here] than where they were born." A male college sophomore who is a second-generation American from a South Asian background responded:

> "I have adopted a more conservative interpretation of Islam than my family. While they are supportive, occasionally we get into arguments about some stuff, like when I don't want to buy a silk tie [In Islam, as a matter of modesty, men are not allowed to wear silk]. In addition, my mother is somewhat scared/paranoid about discrimination against Muslims, so she doesn't like when I do overtly Muslim things."

A female college senior from an Arab background who is a second-generation American noted that these differences can extend into the realm of attitudes toward mental health:

> "I feel like many of our issues are overlooked by our parents who grew up in a different background. Their culture is different than ours and this causes problems for the youth. Also, many youth are confused because the way they learn about their religion is incorrect causing them to dislike it or find it too difficult to follow. Also, as far as I am concerned, it is taboo to be speaking about mental/psychological issues in the Arab/Muslim community and only recently, with the new generations, are we starting to change and progress, and accepting the fact that ALL people have the same issues regardless of religion or race. Still, some people stay more conservative to their cultural beliefs and avoid seeing professional help or taking their family members to professionals."

Feeling Misunderstood

Finally, respondents' comments indicated that many of them feel that others do not understand or appreciate the role that being a Muslim plays in their lives. These concerns were reported by 17% of participants. A female college senior who is a White convert to Islam wrote:

> "Some people cannot understand why I would want to be Muslim because it supposedly gives me second class status as a woman. The reality is I actually feel more empowered as a Muslim woman than I did before I became Muslim. Also, people of course make ignorant impassioned comments about Arabs in general. I'm not Arab, but most people don't distinguish Arabs from Muslims. For the most part, the public is fine with me being Muslim but many people do take issue with it."

Similar concerns were mentioned by another White female who is a convert to Islam. This college junior added:

> "I have found that many Americans have difficulty understanding Islam, or have been exposed to biased/incorrect information about the religion. This is very disheartening to me. I try to be patient and explain each point that the other person does not understand. It's upsetting that the American media promotes such a distorted picture of a peaceful religion, and I very much try to correct misinformation when I'm exposed to it."

A male junior who is a second-generation American from a South Asian background stated that his fears about others' judgments have influenced his behavior and sense of self-worth:

> "I am shy to pray in public because I do not want to feel like an outsider. It makes me feel bad about myself and makes me think I am a bad Muslim. I do feel that a lot of the time people don't quite understand my religion."

A freshman female who is a second-generation American of a mixed race background (White, Black, Native American, and Arab) suggests that this lack of understanding from outsiders should lead young adult Muslim women to seek understanding and support from each other:

> "I feel like there is a lot of pressure for young Muslim women to be 'perfect' and when those levels of perfection are not met (regarding social behavior, academic achievement, religiosity, etc.) there is a huge let down. She may feel isolated and it can be difficult to find a good group of women to talk to. I think halaqas [groups where Muslims gather to discuss and learn about Islam] that have connections to professional help led by Muslims is extremely important. This way we have safe environments to discuss our problems and we can solve them with our deen [religion] but also have any necessary help."

Summary

This chapter presented the results from both quantitative and qualitative data. The scales used in the study evidenced sufficient internal consistency reliability. Descriptive statistics were provided on the constructs addressed by the study, such as help-seeking attitudes, coping styles, treatment preferences, and religiousness. Five hypotheses were tested. Additional research questions and topics of interest were addressed through an examination of associated data. Finally, supplemental qualitative data provided a glimpse into some of the concerns of the sample being studied, lending an important context for understanding the American Muslim participants' wellbeing.

Participants indicated an openness to receive formal mental health services, particularly individual therapy. They strongly preferred treatment providers who show multicultural competence in valuing and understanding their clients' religious and cultural backgrounds, and

who are also familiar with issues that are pertinent to the lives of young adults. While religiousness was strongly associated with religious coping, participants' level of religiousness and religious coping did not affect their willingness to seek professional help. Participants were likely to take proactive approaches to coping, use their faith to help, and reach out to others, but this sample did not appear apt to utilize religious leaders for support. Social pressures were found to be a major concern for this population, as was the type of general distress associated with depression, anxiety, and stress. Participants' emotional wellbeing was sometimes impaired by experiences of discrimination, intergenerational conflict, and difficulties associated with gender relations, balancing different identities, and feeling misunderstood. Chapter 5 will provide a more in-depth interpretation of these results. Salient findings are discussed and suggestions for interventions, trainings, and future research are offered. Additionally, the limitations of the present study are addressed.

Chapter 5

Discussion

The author conducted a study of American-born Muslim college students' attitudes toward mental health. Several quantitative measures were employed as part of a survey method, and qualitative data supplemented the survey findings. The measures used were found to have strong levels of internal consistency, and additional comments by participants richly described how some of the study's foci manifest themselves in real life situations. This chapter focuses on presenting and discussing the significant findings of the study and frames these in the context of available literature. Findings are organized into three sections: Emotional Wellbeing, Attitudes toward Treatment, and Attitudes toward Coping. Limitations of the study are noted, and recommendations for future research and interventions are offered. Finally, the author will add a brief personal reflection on the meanings of the study for him.

Significant Findings

Emotional Wellbeing

Presence of mental illness and major stressors. This study affirmed concerns raised by Gallup's (2009) survey, which found that young adult American Muslims may be especially prone to difficulties in their emotional wellbeing. In the present study, participants were asked about their perceptions of the presence of different categories of mental illness and related concerns in their community. These specific emotional conditions and stressors were described with wording that clearly identified them as meeting criteria for clinical impairment. Further, to control against over-endorsement, participants were asked to only report knowledge of these issues for their young adult American-born Muslim friends and/or family, and only for the presence of these afflictions in the past year. Despite these specifications, all but one of the 119

participants who completed this set of questions endorsed the presence of some type of mental illness or major stressor in their community, which confirmed the study's first hypothesis.

With the presence of mental illness and significant stressors in the study sample's community established, it becomes important to understand the extent to which different conditions and stressors were represented. Social pressures, stress, and family conflict were all perceived at high levels in the sample. However, an investigation of Hypothesis 2 revealed high correlations between perceived stress, anxiety, and depression, which suggested that participants may have viewed these issues as a broad constellation of symptoms belonging to a more wide-ranging construct, such as general distress. Despite the fact that family conflict was reported in the study sample's Muslim communities, participants seemed lukewarm to the idea of family therapy. Consistent with the Islamic prohibition on drug and alcohol use, participants perceived that substance abuse was much less common in their community than in others.

Psychosocial stressors. Given the perceived stress, family conflict, and social pressures among the young adult American-born Muslim community, it was helpful that participants were able to contribute personal stories of these experiences. Some respondents felt that many people outside of the young adult American-born Muslim community, ranging from members of the dominant culture to their own parents, struggle to understand them. A study by Ahmed (2009) suggested that young adult American Muslims may be frustrated by their parents' lack of understanding of the cultural influences and stressors that go along with being an American-born Muslim, and the present study echoed those concerns.

In their comments, participants also expressed concern that non-Muslims might be judgmental toward them or, even worse, might discriminate against them. This is consistent with research by Sirin and Fine (2008), which found that 88% of young adult American Muslims have

encountered some type of hardship due to their religious background. While discrimination toward Muslims in the United States is sometimes blatant, it was not unusual for participants to report more subtle forms of insensitivity, such as when they are suspiciously asked, "Where are you from?" Sue (2007), who refers to these occasions as microaggressions, notes that these experiences have become commonplace for many minority groups, invalidating their presence and identity in the United States, and that an accumulation of microagressions is detrimental to one's emotional wellbeing.

Being Muslim at college. Although Nasir and Al-Amin (2006) suggest that being outwardly Muslim on campus might be disconcerting for more religious Muslims, the present study found no correlation between religiousness and difficulty being Muslim at college. It was the case, however, that more religious Muslims were more likely to interact frequently with fellow Muslims students, and participants who reported frequent interaction with other Muslims on campus also tended to report higher levels of comfort with being a Muslim at college. As such, it may be that the key for religious Muslims to feel comfortable on campus is not to self-isolate. There was no relationship found between religiousness and gender, generational status, and whether or not participants were converts to Islam. The Muslim faith seems to override discrete characteristics, including demographic categories.

Despite post-9/11 reports by Cole and Ahmadi (2003) that female Muslim students were removing their head coverings in public for fear of discrimination on campus, the present study's finding suggested that gender and difficulty being Muslim at college are unrelated; it may be that these concerns were only especially heightened in the immediate post-9/11 period. Finally, one of the more notable findings was that there was a significant positive relationship between comfort being a Muslim at college and the presence of a Muslim college chaplain.

Attitudes toward Treatment

Help-seeking. The 19% of participants who had received formal mental health services expressed more positive help-seeking attitudes than those who had not. Also, participants who expressed a greater openness to utilizing different coping methods expressed a greater willingness to seek professional help. However, general openness to help-seeking was not associated with any of the other major variables to which it was related. Religiousness, gender, ethnic background, generational status, and openness to religious coping all evidenced no connection to help-seeking attitudes. As proposed by Hypothesis 3, there was a strong positive correlation between religiousness and religious coping, but the lack of any correlation found between religiousness and help-seeking was a clear rejection of this study's fifth hypothesis. Therefore, even highly religious Muslims in this community who are apt to utilize religious coping strategies were just as willing to seek professional help as young adult American Muslims who are less religious.

The lack of association between gender and help-seeking attitudes for the present study is in direct contrast to the results of Khan's (2006) study of mosque-going American Muslims, in which females expressed a much greater willingness to seek formal mental health services than did males. Further, for the present study, both the overall sample and the Arab subsample indicated a greater willingness to seek professional help than did the participants in Aloud's (2004) study of Arab Muslims in the United States. One major difference between the present study and those by Khan and Aloud is that all of the participants in the present study were American-born. Thus, it may be that being born and raised in America is the principal driver of this sample's willingness to seek mental health services. Indeed, minority groups who have

experienced more acculturation in American society are more likely to seek professional mental health services (Frey & Roysircar, 2006; Zhang & Dixon, 2003).

This finding would be consistent with the results of Brody's (1994) study of college students, which found that while religiousness was not associated with help-seeking attitudes, the foremost predictor of openness to seeking professional help was whether participants were born in the United States. The present study appears to suggest also that, for young adult American-born Muslims, openness to seeking help is not generally hindered by personal background, orientation to religion, or proclivity to utilize religious coping strategies. Therefore, in order to best understand how to meet the needs of this community, it is necessary to focus on participants' preferences for specific qualities in providers and for treatment modalities.

Treatment providers. Participants expressed a strong preference for multiculturally competent providers. In the survey, multiculturally competent providers were defined as individuals "who would have an orientation to treatment that involved interest in, respect for, and knowledge of different religions, cultures, and their values and practices, including my [the participant's] own." Participants also expressed a strong preference for providers who were in touch with American culture and who were attuned to issues faced by young adults. Most participants—particularly those who were more religious and more likely to utilize religious coping strategies—preferred providers who would take an interest in their Muslim identity and who could integrate their religious beliefs into treatment. As proposed by Hypothesis 4, the sample as a whole did not express a preference for providers of the same ethnic background; this result was also found in a meta-analysis on multicultural treatment effectiveness except in the case of elderly, less acculturated Hispanics, for whom therapist identity and Spanish language use had a high effect size (Griner & Smith, 2006). The participants in the present sample were

not especially interested in meeting with providers who were friends or acquaintances of their families.

Participants did, however, express a significant preference for seeking care from a Muslim provider. Still, it is unclear whether those providers are present or accessible; 92% of participants stated that there is a need for more Muslim mental health professionals. Participants were also generally in agreement that most mental health professionals lacked a solid understanding of Islam. This is a critical deficit, as a therapeutic alliance is strongly correlated with positive treatment outcomes (Horvath & Symonds, 1991), and minority populations may feel the need to develop bonds, goals, and treatment processes with providers to whom they feel they can personally relate. Females were more likely than males to prefer treatment providers of the same gender. Given the observance of gender roles in Muslim societies and the proscription of heterosexual closeness outside of marriage, this finding might be consistent with Muslim customs. Although females were more likely than males to express a preference for providers of the same ethnicity, only 17% of them suggested that this would be important.

In sum, these young adult American-born Muslim participants wished that there were more Muslim mental health professionals, but in the absence of this they might remain open to seeking help and are looking for specific personal attributes in treatment providers. A point to keep in mind is that given the participants' belief that most mental health providers lack a good understanding of Islam, it might be difficult for them to receive treatment from a provider possessing the one proficiency that this population values most—multicultural competence, which includes knowledge and understanding of client cultures/worldview and intersecting identities, in addition to cultural awareness/sensitivity, and skills (Roysircar, Dobbins, & Malloy, 2009). Nonetheless, the present study has evidenced that Muslim youth would be interested in

receiving care from providers who can at least appreciate their identity as a Muslim and who are familiar with American culture and with issues of young adults in their developmental interface with the dominant culture.

Treatment modalities. Participants reported a strong preference for individual therapy. This option was endorsed at much higher levels than group therapy, family therapy, or medication management from a psychiatrist or primary care physician. This finding again counters the results of Aloud's (2004) study of a predominantly foreign-born sample of American Muslims, which found that the greatest preference for a provider of formal mental health services was for a general medical practitioner. In the present study, 92% of participants stated that they would prefer to try therapy before taking psychiatric medication. Nonetheless, 72% of participants in the present study were open to taking psychiatric medication if they felt it was needed.

Attitudes toward Coping

Coping style. Results from the present study indicated that young adult American-born Muslims are likely to possess flexible coping styles. In addition to utilizing intrinsic religious coping strategies, participants were likely to use other people as resources and to proactively address the stressors in their lives. Participants were generally unlikely to report an avoidant coping style, such as trying to numb themselves with drugs and alcohol or resigning themselves to the situation at hand. As would be expected, these more avoidant coping strategies were negatively correlated with those that were more proactive, and different types of proactive coping strategies were highly correlated with each other.

In the present study, the sample's most represented ethnic group was South Asians. Additionally, females far outnumbered males, and the majority of participants were

second-generation Americans. It is therefore instructive to examine some of the literature on South Asian females and their coping styles. Frey and Roysircar (2006) report that traditional Asian values tend to produce more avoidant coping styles, and this may especially be the case for women. However, it is not unusual for coping strategies of Asian Indian women to vary based on generational status (Roysircar, 2009), and it has been suggested by Inman, Constantine, and Ladany (1999) that second-generation Asian Indian women may be likely to utilize more active coping strategies than their parents. The present study appears to confirm previous hypotheses and findings about Indian women, and this represents another instance in which generational status and being American-born may have a significant effect on the attitudes of young adult American-born Muslims. Further, gender and ethnic background in the present study did not appear to predict participants' coping styles.

Religious coping. Participants were likely to report utilizing intrinsic religious coping strategies, such as turning to prayer. Certain extrinsic strategies, such as spending time with one's faith group, were reported to be sometimes utilized but much less so than intrinsic strategies. While religiousness and religious coping were highly correlated, it was also the case that religious coping was strongly correlated with a general openness to utilize many different types of coping strategies. Results suggested that participants who possessed a combination of positive help-seeking attitudes, flexible and general coping styles, and religiousness were likely to engage in religious coping. Although participants generally reported a preference for utilizing religious coping strategies prior to seeking formal mental health services, 87% of them reported that they saw no conflict between using religious coping strategies and professional mental health services. This finding concurs with results from interviews conducted by the present author (Herzig, 2008) with American-born Muslim college students, who reported that they did

not see mental illness from a solely religious perspective. There was no relationship found in the present study between the variables of gender and religious coping.

Limitations

Indirect Epidemiological Data

A major limitation of the present study was that it utilized an indirect approach to gathering data about the presence of mental illness and significant stressors in the young adult American-born Muslim community. Instead of asking participants to report on their own mental health issues, they were asked about their knowledge of the experiences of similar individuals and about their perceptions of their community as a whole. Because of this, epidemiological data were not truly collected, as participants' perceptions are not as valuable as reports of what they know to be true for themselves.

Further, because the American Muslim community is tight-knit, it may have been the case that participants' knowledge of the struggles of their friends and family led to an over-endorsement of mental illness and psychosocial stressors in their community. Without a non-Muslim control group it was difficult to place in relative terms the overall presence of mental health issues in the American Muslim community. However, data from past surveys (e.g., Gallup, 2009; Pew, 2007) suggest that emotional troubles are a concern for this population. Additionally, participants' perceptions of the presence of mental illness and major stressors in their community relative to that in other communities indicates that these afflictions are at least as prevalent among American Muslims as they are in other populations.

Attrition

Of the 184 participants who began the survey, there were 119 who completed every item. An advantage of a 156-item survey is that a great amount of data can be collected, but a

downside is the inevitable effect of attrition. For some series of questions, such as those concerning the experience of being Muslim at college, all 184 participants provided responses. However, as participants progressed through the survey, some dropped out, as was their right. The survey was set up so that each scale was on the same page, and participants could only move to the next page when all of the items in a scale were answered. This meant that there was no missing data within any of the scales, which was an advantage of this arrangement.

One interesting feature of the website that hosted the survey was that it could list the amount of time each participant spent on the survey. Because some participants may have been multitasking when completing the survey or taking breaks from it to attend to other matters, it is probably not instructive to calculate the mean amount of time spent on its completion. However, for the participants who filled out every item, the median completion time was just under 26 minutes (this author informed participants that the survey may take approximately 30 minutes to complete). As such, it is understandable that so many participants elected not to complete the entire survey, which was a relatively long pilot questionnaire.

Participant Demographics

Despite the fact that about 25% of Muslims in the United States identify as African-American (U.S. Department of State, 2009), only 9% of participants in the present study reported being fully or partially of African descent. This discrepancy was surprising. Although the parents of African-American Muslims may not place as much emphasis on college as Muslim parents from other backgrounds (Sirin & Fine, 2008), it was expected that African-Americans would be better represented in the sample than they were. Khan (2006) found that level of education for American Muslims was not significantly correlated with attitudes toward mental health, so it is possible that the findings of the present study can be tentatively extended toward

young adult African-American Muslims who are not presently enrolled in college. Additionally, the ethnic background of participants was not significantly correlated with any of the major dependent variables studied.

Another concern for the present study was that female participants (73%) were disproportionately represented in the sample. It is possible that analyses of gender differences might have been more robust if there were more male participants. It is not clear why there was such a difference between the number of male and female participants. One possible explanation is that females may be generally more interested in participating in studies on mental health than males. Indeed, an internet-based study by Amer (2005) of Arab Muslim adults using the BARCS also yielded a high number of female respondents (60%).

Recommendations

Training and Intervention

Participants in the present study indicated that potential supports, such as treatment providers and family members, may not have a good understanding of their identities as young adult American-born Muslims and the associated stressors and challenges. While the participants were open to mental health treatment and valued multicultural competence, they may harbor doubts about treatment providers' familiarity with Islam (see also Roysircar, 2004). It is thus imperative, as is stressed by the American Psychological Association (APA, 2003), that providers work to develop greater multicultural competence. Training workshops may be held for providers to learn multicultural competencies for mental health work with young Muslim clients. Further, participants may feel that their parents do not understand them and may be likely to experience family conflict, so a special prevention emphasis should be placed in both

the field of mental health services and within the American Muslim community on developing approaches to improve family functioning.

Colleges might also play a role in alleviating difficulties faced by their Muslim students. An interesting association was found between participants' level of comfort being a Muslim at college and the presence of a college chaplain who ministers specifically to Muslim students. Muslim college chaplains who develop pastoral counseling skills might become effective supports for students in need. Program development around the cross-training of Muslim chaplains and campus psychological service providers might greatly aid in this process. Colleges that do not yet have Muslim chaplains might at least reach out to their Muslim students to affirm the importance of their wellbeing and to work with them to develop helpful campus resources, such as facilitating the development of support groups, which Ribeiro and Saleem (2010) also encourage.

Although imams have been reported to provide effective counseling services (Abu-Ras, Gheith, & Cournos, 2008; Ali, Milstein, & Marzouk, 2005), a study of mosque-going American Muslims by Khan (2003) found that participants would be unlikely to seek counsel from a foreign-born imam. Despite the fact the participants in the present study were interested in utilizing religious coping strategies, felt there was a need for more Muslim providers, had generally flexible coping styles, and had positive help-seeking attitudes, they expressed a great deal of reluctance to turn to religious leaders for help. However, participants did express a strong desire for assistance from individuals who had a good understanding of American culture and young adulthood and who respected the participants' Muslim faith.

This raises the question of whether young adult American-born Muslims feel that the imams in their communities, many of whom are foreign-born, lack the proficiencies that young

adult Muslims prefer in mental health providers. After all, despite participants' preference for providers who had a good understanding of Islam or who were Muslim, who could appreciate the role of Islamic identity, and who could integrate religious practices into treatment, religious leaders were not seen as valuable resources. Participants also indicated that their conceptions of mental illness were not from a strictly religious perspective, and they might have felt that imams in their community lack that appreciation.

It is thus strongly recommended that American Muslim communities invest in identifying and training community members, imams or otherwise, with the necessary skills to provide support and counsel to young adult American-born Muslims. Trained imams could work collaboratively with psychologists and mental health providers. Given the young Muslim population's possible openness to both professional help-seeking as well as religious coping, it would seem that trained community individuals would be an effective resource.

Imams could devote time in their weekly sermons to recognizing mental illness in an effort to remove stigma, publicize community resources, and encourage professional help-seeking behaviors while also educating congregants about the role that religious coping can play in dealing with stress. Because there appears to be a lack of Muslim mental health professionals, it may be that further validation within the Muslim community of the importance of mental health care might lead more young adult American Muslims to consider psychology as a field of study or a line of work.

Future Research

Because the present study took an indirect approach to gathering epidemiological data, it is strongly recommended that future research focus on gathering interview/screening/assessment base rate data on mental illness in young adult American-born Muslim communities.

Additionally, future research might seek to delineate how this population understands the relationship between depression, stress, and anxiety, as the present study indicated that these may be viewed as a mixed construct.

Perhaps the most pressing need for future research on American Muslims and mental health involves developing a greater understanding of the dimensions of multicultural competence in working with this group. Participants in the present study reported that they valued multicultural competence above all other qualities that providers might possess, yet they felt that treatment providers lacked a solid understanding of Islam. Qualitative research involving interviews with young adult American-born Muslims and community stakeholders might provide more thorough information on what their understanding is of multicultural competence. Additionally, it may be worth investigating further the strong relationship found in the present study between the presence of a Muslim chaplain on campus and the ease of being a Muslim student. It may be that these chaplains themselves could have helpful insights to offer about what multicultural competence might entail in working with young adult American-born Muslims. Finally, given that Muslim immigrants in America have reported somatic symptoms of mental illness (Al-Krenawi & Graham, 2000), it might be worth investigating whether similar symptoms are expressed by American-born Muslims.

The Author's Personal Reflection

The impetus for this study came from the author's experience providing guidance counseling and college counseling services at Islamic primary and secondary schools in Massachusetts from 2003 to 2005. These counseling positions were non-existent before this author proposed them, and their establishment marked a successful initiative for these schools, as principals, teachers, and parents expressed a great deal of appreciation for this resource. During

that experience, it became clear that these Muslim students, who were mostly American-born, were generally open to reaching out for help and embracing active and flexible coping styles, but they felt that their parents' generation lacked this appreciation. While religious, these students appeared to value multiple perspectives in understanding their identities, goals, and challenges.

With that in mind, it is hoped that this study can contribute to a broader effort to better recognize how to empower the young adult American-born Muslim community so that their many strengths, such as positive help-seeking attitudes, religiousness, and proactive coping inclinations, can be affirmed and supported. This new generation of American Muslims faces several stressors, some of which are unique to their American Muslim identity while others of which can be observed in young adults throughout this country. There is room for growth within the American Muslim community and within the field of mental health to accommodate the needs and aspirations of this population. This author feels a great amount of gratitude with the knowledge that perhaps the present study can aid in this process in even a small way.

Summary

The young adult American-born Muslim population is diverse, vibrant, and resourceful, yet they have encountered notable stressors in different spheres of their lives. Results of the present study indicate that mental illness and psychosocial stressors are present in this community at concerning levels. Participants expressed openness to seeking formal mental health services, particularly individual therapy, and indicated a strong desire for providers who possessed multicultural competence. However, doubts were expressed about the extent to which those providers existed or were accessible. Participants also evidenced a multifaceted approach to coping, which included religious methods, proactive cognitive strategies, and utilizing others for support. Individuals who expressed high levels of religiousness or religious coping were no

less likely than other participants to express a willingness to seek formal mental health services. Colleges, mosques, and the field of mental health in general might be involved in developing effective resources and strategies for supporting American Muslim communities. Finally, it will be especially important for future research to gather more complete and accurate epidemiological data and to focus on developing specific guidelines for multicultural competence in working with this important and emerging population.

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Appendix A

A Survey for Muslim College Students

Participants who complete this survey will have the option of entering themselves in a drawing to win a $100 gift card from Amazon.com (odds of winning are 1 in 20) or to have $5 donated to charity on their behalf, or the option of not receiving an award. This study has been funded by the Institute for Social Policy and Understanding (www.ispu.org).

Please answer the following questions:

1. Are you a Muslim undergraduate college student who was born in the United States, lives in the United States, and who is at least 18 years old?

If so, please continue with this survey. If not, you are not eligible to take this survey.

2. What is your gender?

Male Female Other: please write

3. What is your age?

18 19 20 21 22 23 24 25 Other: please write

4. Which best describes your current year in your undergraduate program? (If you are in between years, please select the year that you are *going into*).

Freshman Sophomore Junior Senior Other: please explain

5. Which BEST describes your ethnic, racial, and/or cultural background? (Please select one)

East Asian American (family originally from East Asia, e.g., China, Japan, etc.)

Latin American (family originally from Spanish or Portuguese speaking nations)

Kurdish American (ethnic Kurdish origin)

Non-Kurdish Turkish American (family originally from Turkey)

Non-Hispanic Caribbean American (e.g., family originally from Trinidad, Haiti, Jamaica, etc.)

Non-Hispanic European American (i.e. White, Caucasian, family originally from Europe)

Native American (descended from the Indian tribes of the Americas)

Southeast Asian American (family originally from Southeast Asia, e.g., Indonesia, Malaysia, the Philippines, etc.)

Iranian American (family originally from Iran)

African-American (i.e., descended from Black Americans, some of whose ancestors were likely slaves)

African (i.e., indentifying primarily with a family background in specific countries of West Africa, Central Africa, East Africa, or Sub-Saharan Africa, e.g., Nigerian-American, Kenyan-American, Somali-American, etc.)

Arab American (family originally from the Arabic speaking world, e.g., the Middle East and North Africa)

South Asian American (family originally from South Asia, e.g., Pakistan, India, Bangladesh, etc.)

Other: please write

6. Are you a convert to Islam?

Yes No

7. Are you a second-generation American Muslim? (i.e., do you have at least one Muslim parent who was born outside of the United States)?

Yes No

8. Is there an organization for Muslim students at your college, such as an MSA?

Yes No

9. How often do you interact with fellow Muslim students at your college?

Rarely Sometimes Often

10. Does your college have a chaplain or student advisor specifically for Muslims?

Yes No

11. Would you say that it is difficult for you to be a Muslim at your college?

Not Difficult Slightly Difficult Somewhat Difficult Very Difficult

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Below are some statements concerning your perceptions about seeking formal mental health or psychological services. Please carefully read each statement and indicate whether you strongly disagree, disagree, agree, or strongly agree with each one.

1 = strongly disagree
2 = disagree
3 = agree
4 = strongly agree

12. If I believed I was having a psychological or mental health problem, the first thing I would do would be to seek psychological or mental health counseling.

1 2 3 4

13. A person with strong *iman* (faith) can get rid of a mental health or psychological problem without the need of professional help.

1 2 3 4

14. A person would feel uncomfortable seeking mental health or psychological services because of others' negative opinions.

1 2 3 4

15. Discussing mental health or psychological concerns with a mental health professional is a poor way to solve mental health or psychological difficulties.

1 2 3 4

16. If I believed I needed professional mental health or psychological counseling, I would get it no matter what people say or think.

1 2 3 4

17. I would feel embarrassed to tell others that I used psychological or mental health services.

1 2 3 4

18. I would seek professional counseling services only if I experienced a psychological problem for a long period of time.

1 2 3 4

19. If I decide to seek psychological or mental health services, I am confident they would be helpful.

1 2 3 4

20. I might need to contact professional mental health or psychological services in the future.

1 2 3 4

21. Most mental health and psychological problems can be solved by an individual himself/herself without the assistance of professionals.

1 2 3 4

22. Using mental health or psychological services is more difficult than using general medical services because of the shame involved.

1 2 3 4

23. Considering the high cost of services, I would NOT seek professional help even if I needed it.

1 2 3 4

24. Seeking psychological and mental health services should be the last choice to use after trying all other options (e.g., self-help, counseling from family or friends).

1 2 3 4

25. I would be concerned about what others might think or say if I used professional mental health services.

1 2 3 4

26. I would rather be advised by a close relative or friend than by a mental health professional, even for serious psychological problems.

1 2 3 4

27. I would rather live with certain mental health or psychological problems than go through the process of seeking professional help.

1 2 3 4

28. Mental health and psychological difficulties, like many things, tend to go away over time.

1 2 3 4

29. People would think negatively about an individual who uses mental health or psychological services.

1 2 3 4

30. If I decided to seek mental health or psychological help, I would rather contact Muslim professionals than professionals from other groups.

1 2 3 4

31. Family members should have the final say whether or not an individual seeks professional help for a psychological or mental health problem.

1 2 3 4

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32. I would be open to receiving individual (one-on-one) psychotherapy (e.g., "talk therapy," counseling) from a professional therapist if I felt that I needed it.

1 2 3 4

33. If I were to see a therapist, it would be important that he or she would be the same gender as me.

1 2 3 4

34. If I were to see a therapist, it would be important that he or she be multiculturally competent, that is, who would have an orientation to treatment that involved interest in, respect for, and knowledge of different religions, cultures, and their values and practices, including my own.

1 2 3 4

35. If I were to see a therapist, it would be important that he or she take an interest in my identity as a Muslim.

1 2 3 4

36. If I were to see a therapist, it would be important that he or she have a good understanding of the issues that people of my age would be concerned with.

1 2 3 4

37. If I were to see a therapist, it would be important that he or she would be someone who is a friend or acquaintance of mine or my family.

1 2 3 4

38. If I were to see a therapist, it would be important that he or she would be American-born or be someone who is clearly in touch with current American culture.

1 2 3 4

39. If I were to see a therapist, it would be important that he or she would be of the same ethnic background as me.

1 2 3 4

40. If I were to see a therapist, it would be important that he or she were to integrate my religious beliefs into treatment, such as helping or encouraging me to use the teachings and practices of my religion to improve my wellbeing.

1 2 3 4

41. I would be open to participating in group therapy (e.g., "talk therapy" in a group setting guided by a group therapist) if I felt that I needed it.

1 2 3 4

42. If I were to attend group therapy, it would be important that the other participants would be the same gender as me.

1 2 3 4

43. If I were to attend group therapy, it would be important that the other participants would also be Muslim.

1 2 3 4

44. I believe that there is a need for more Muslim mental health professionals.

1 2 3 4

45. I believe that most mental health professionals have a good enough understanding of Islam.

1 2 3 4

46. I would be open to seeing a general medical practitioner who could prescribe appropriate psychiatric medications (e.g., anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents) if I felt that I needed it.

1 2 3 4

47. I would be open to seeing a psychiatrist who could prescribe appropriate psychiatric medications (e.g., anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents) if I felt that I needed it.

1 2 3 4

48. I would rather try psychiatric medications before trying therapy.

1 2 3 4

49. I would rather try therapy before trying psychiatric medications.

1 2 3 4

50. If I sought professional mental health treatment, I worry about what my family would think if they knew.

1 2 3 4

51. I would be open to participating in family therapy if I felt that there was significant conflict within my family.

1 2 3 4

52. If I sought professional mental health treatment, I worry about what my non-Muslim friends or acquaintances would think if they knew.

1 2 3 4

53. If I sought professional mental health treatment, I worry about what my Muslim friends or acquaintances would think if they knew.

1 2 3 4

54. If I had a mental health problem, I would use my religion to help solve it before seeking professional services.

1 2 3 4

55. I see no conflict between using religious coping and using professional mental health services.

1 2 3 4

56. I could absolutely never see myself using professional mental health services.

1 2 3 4

Please read each statement carefully and select how often you engaged in the following behaviors when you have experienced a STRESSFUL SITUATION OR PROBLEM.

0 = not used at all or does not apply
1 = used sometimes
2 = used often

3 = used always

57. I prayed for strength.

0 1 2 3

58. I looked for a lesson from Allah/God in the situation.

0 1 2 3

59. I got help from religious leader/s.

0 1 2 3

60. I recalled a passage from a religious text (e.g., Qur'an, *Hadith*).

0 1 2 3

61. I attended events at the masjid/mosque or my Muslim student organization.

0 1 2 3

62. I put my problem in Allah/God's hands.

0 1 2 3

63. I increased my prayers to Allah/God.

0 1 2 3

64. I attended religious classes (e.g., *Halaqa*, *Ta'alim*, *Dars*).

0 1 2 3

65. I tried to make up for my mistakes.

0 1 2 3

66. I asked God/Allah for a blessing.

0 1 2 3

67. I used a religious story to help solve the problem.

0 1 2 3

68. I shared my religious beliefs with others.

0 1 2 3

69. I donated time to a religious cause or activity.

0 1 2 3

70. I looked for love and concern from the members of my Masjid/Mosque or my Muslim student organization.

0 1 2 3

71. I prayed to get my mind off my problem/s.

0 1 2 3

There are a lot of ways to deal with stress. The following questions ask you to indicate what you generally do when you experience stressful events. Obviously, different events bring out somewhat different responses, but think about what you usually do when you are under a lot of stress.

Make your answers as true FOR YOU as you can. There are no "right" or "wrong" answers, so choose the most accurate answer for YOU – not what you think "most people" would say or do. Please answer every item.

The scale is as follows:

1 = I usually don't do this at all
2 = I usually do this a little bit
3 = I usually do this a medium amount
4 = I usually do this a lot

72. I try to get advice from someone about what to do.

1 2 3 4

73. I concentrate my efforts on doing something about it.

1 2 3 4

74. I put my trust in God.

1 2 3 4

75. I admit to myself that I can't deal with it, and quit trying.

1 2 3 4

76. I discuss my feelings with someone.

1 2 3 4

77. I use alcohol or drugs to make myself feel better.

1 2 3 4

78. I talk to someone to find out more about the situation.

1 2 3 4

79. I seek God's help.

1 2 3 4

80. I make a plan of action.

1 2 3 4

81. I try to get emotional support from friends and relatives.

1 2 3 4

82. I just give up trying to reach my goal.

1 2 3 4

83. I take additional action to try and get rid of the problem.

1 2 3 4

84. I try to lose myself for a while by drinking alcohol or taking drugs.

1 2 3 4

85. I refuse to believe that it has happened.

1 2 3 4

86. I talk to someone who could do something concrete about the problem.

1 2 3 4

87. I try to come up with a strategy about what to do.

1 2 3 4

88. I focus on dealing with this problem, and if necessary let other things slide.

1 2 3 4

89. I get sympathy and understanding from someone.

1 2 3 4

90. I drink alcohol or take drugs, in order to think about it less.

1 2 3 4

91. I kid around about it.

1 2 3 4

92. I think about how I might best handle the problem

1 2 3 4

93. I pretend that it hasn't really happened.

1 2 3 4

94. I accept the reality of the fact that it happened.

1 2 3 4

95. I feel emotional distress and I find myself expressing those feelings a lot.

1 2 3 4

96. I take direct action to get around the problem.

1 2 3 4

97. I try to find comfort in my religion.

1 2 3 4

98. I make fun of the situation.

1 2 3 4

99. I reduce the amount of effort I'm putting into solving the problem.

1 2 3 4

100. I talk to someone about how I feel.

1 2 3 4

101. I use alcohol or drugs to help me get through it.

1 2 3 4

102. I think hard about what steps to take.

1 2 3 4

103. I act as though it hasn't ever happened.

1 2 3 4

104. I do what has to be done, one step at a time.

1 2 3 4

105. I learn something from the experience.

1 2 3 4

Please read each statement carefully and select the most appropriate response for you.

1 = disagree strongly
2 = disagree
3 = not certain
4 = agree
5 = agree strongly

106. I find it inspiring to listen to the Qur'an.

1 2 3 4 5

107. I know that Allah/God helps me.

1 2 3 4 5

108. Saying my prayers/*du'a'* helps me a lot.

1 2 3 4 5

109. Attending the mosque is very important to me.

1 2 3 4 5

110. I think going to the Mosque is a waste of my time.

1 2 3 4 5

111. I want to obey Allah/God's law/*shari'ah* in my life.

1 2 3 4 5

112. I think Mosque sermons/*khutbah* are boring.

1 2 3 4 5

113. Allah/God helps me to lead a better life.

1 2 3 4 5

114. I like to learn about Allah/God very much.

1 2 3 4 5

115. Islam means a lot to me.

1 2 3 4 5

116. I believe that Allah/God helps people.

1 2 3 4 5

117. Prayer/*Salat* helps me a lot.

1 2 3 4 5

118. I feel that I am very close to Allah/God.

1 2 3 4 5

119. I think prayer/*salat* is a good thing.

1 2 3 4 5

120. I think the Qur'an is out of date.

1 2 3 4 5

121. I believe that Allah/God listens to my prayers/*du'a'*.

1 2 3 4 5

122. Allah/God means everything to me.

1 2 3 4 5

123. Allah/God is very real to me.

1 2 3 4 5

124. I think praying/*du'a'* does no good.

1 2 3 4 5

125. Belief in Allah/God means much to me.

1 2 3 4 5

126. I do not find it hard to believe in Allah/God.

1 2 3 4 5

127. I am happy to be a Muslim.

1 2 3 4 5

128. I love to follow the life/*sunnah* of the Prophet.

1 2 3 4 5

The following questions involve your perceptions of the presence of various psychiatric issues in the young adult American-born Muslim community, including your young adult American-born Muslim friends and members of your family who are young adult American-born Muslims. These questions require an answer that is either YES or NO.

Regarding STRESS (i.e. emotional exhaustion that greatly impairs one's psychological or physical wellbeing)

129. I have young adult American-born Muslim friends and/or family who have suffered from this condition in the past year

Yes No

130. I have young adult American-born Muslim friends and/or family who have received professional treatment for this condition in the past year

Yes No

131. Relative to other communities, how common do you believe this condition to be among young adult American-born Muslims?

Less common About as common More common

Regarding SOCIAL PRESSURES (i.e. conflict with others about how to pursue dating and romantic relationships, peer pressure, difficulty "fitting in" due to cultural or religious differences, being bullied/cyber-bullied by others, etc.)

132. I have young adult American-born Muslim friends and/or family who have experienced this in the past year

Yes No

133. I have young adult American-born Muslim friends and/or family who have received professional treatment for this in the past year

Yes No

134. Relative to other communities, how common do you believe this to be among young adult American-born Muslims?

Less common About as common More common

Regarding FAMILY CONFLICT (i.e. significant discord among immediate family members that greatly impairs the family's ability to function as a whole)

135. I have young adult American-born Muslim friends and/or family who have experienced this in the past year

Yes No

136. I have young adult American-born Muslim friends and/or family whose families have received professional treatment for this in the past year

Yes No

137. Relative to other communities, how common do you believe family conflict to be among young adult American-born Muslims?

Less common About as common More common

Regarding ANXIETY (i.e., worry, panic attacks, phobias, obsessive thoughts or compulsive behaviors, feeling easily overwhelmed, fearful, or overly nervous, etc.)

138. I have young adult American-born Muslim friends and/or family who have suffered from this condition in the past year

Yes No

139. I have young adult American-born Muslim friends and/or family who have received professional treatment for this condition in the past year

Yes No

140. Relative to other communities, how common do you believe this condition to be among young adult American-born Muslims?

Less common About as common More common

Regarding DEPRESSION (i.e. significant sadness that impairs one's daily functioning)

141. I have young adult American-born Muslim friends and/or family who have suffered from this condition in the past year

Yes No

142. I have young adult American-born Muslim friends and/or family who have received professional treatment for this condition in the past year

Yes No

143. Relative to other communities, how common do you believe this condition to be among young adult American-born Muslims?

Less common About as common More common

Regarding SUBSTANCE ABUSE (e.g., abuse of alcohol, marijuana, heroin, abuse of prescription medication, etc.)

144. I have young adult American-born Muslim friends and/or family who have suffered from this condition in the past year

Yes No

145. I have young adult American-born Muslim friends and/or family who have received professional treatment for this condition in the past year

Yes No

146. Relative to other communities, how common do you believe this condition to be among young adult American-born Muslims?

Less common About as common More common

Regarding EATING DISORDERS (e.g., conditions like anorexia or bulimia in which abnormal eating habits, such as excessive or insufficient food intake, become detrimental to one's physical and emotional health)

147. I have young adult American-born Muslim friends and/or family who have suffered from this condition in the past year

Yes No

148. I have young adult American-born Muslim friends and/or family who have received professional treatment for this condition in the past year

Yes No

149. Relative to other communities, how common do you believe this condition to be among young adult American-born Muslims?

Less common About as common More common

Regarding PSYCHOTIC SYMPTOMS (e.g., delusions, paranoia, hallucinations, etc.)

150. I have young adult American-born Muslim friends and/or family who have suffered from this condition in the past year

Yes No

151. I have young adult American-born Muslim friends and/or family who have received professional treatment for this condition in the past year

Yes No

152. Relative to other communities, how common do you believe this condition to be among young adult American-born Muslims?

Less common About as common More common

153. Please use this space to type in any other conditions not mentioned above that you feel may be affecting the young adult American-born Muslim population:

154. For the concerns listed above, or for others, have you received formal mental health treatment from a professional mental health practitioner?

Yes No

155. If so, please select the type of provider you sought treatment from (select as many as apply)

A primary care physician (i.e. a general practitioner, pediatrician, "regular medical doctor," etc.)

A psychiatrist

A family therapist/counselor/psychologist

An individual therapist/counselor/psychologist

A group therapist/counselor/psychologist

Other: Please write

156. Some American-born Muslims have reported difficulty with completely embracing their religious and/or cultural identities in modern Western society. These types of issues cover many topics, including social pressures, relationships with family, being in mixed-gender

environments, feeling misunderstood by others, experiencing discrimination, feeling uncomfortable being outwardly Muslim (e.g., wearing hijab, praying in public, etc.), issues related to dating and marriage, educational and career decisions, and many other topics. If you wish to do so, please use this space to state whether or not these issues have impacted you personally and, if so, which particular issues have affected you and how your emotional wellbeing has been impacted:

Thank you for completing this survey. Please check one of the following boxes:

□ I would like for the author of this study to donate five dollars on my behalf to Islamic Relief USA (www.islamicreliefusa.org). You do not need to provide any identifying information; your $5 will be donated by the author by virtue of your intention.

□ I would like to be entered for the chance to win a $100 Amazon.com gift card (one out of every twenty participants entered will win this prize).

□ I do not want the author to donate money on my behalf or to enter me into a drawing for a gift card.

Appendix B

Project Title:

An Examination of American-born Muslim College Students' Attitudes toward Mental Health

Principal Investigator:

Benjamin A. Herzig, M.S., Psy.D. Candidate

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603-283-2182/2183

Email:

bherzig@antioch.edu

Faculty Advisor:

Gargi Roysircar, Ph.D.

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Same as above

Phone:

Same as above

Email:

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A Survey for Muslim College Students

My name is Ben Herzig and I am a doctoral candidate in the Department of Clinical Psychology at Antioch University New England. As an American-born Muslim who is interested in providing psychological services to fellow Muslims in the United States, my research interests are focused

on developing a better understanding of the mental health attitudes and needs of American Muslim communities. Thank you for agreeing to participate in this survey. Please read this document carefully as it concerns your rights as a participant.

Purpose of this study.
The purpose of this study is to better understand the attitudes toward mental health held by young adult American-born Muslims.

What I'm asking you to do.
You will be asked to answer questions (online survey) about mental health issues in Muslim communities, methods with which you cope with stress, your sense of identity as a Muslim, the role of Islam in understanding and treating mental illness, and your attitudes toward American mental health treatment. We estimate that the survey will take approximately 30 minutes to complete, although some participants might find that this survey can be completed in less time while others may need more than 30 minutes.

Benefits of participation in this study.
Participating in this study has potential benefits. You have the opportunity to inform about mental health attitudes and concerns of American Muslims, about which very little is known in the psychology literature. In addition, funding from the Institute for Social Policy and Understanding (www.ispu.org) has been secured so that participants can be offered financial incentives to complete this survey. Specifically, participants may enter themselves in a drawing for a gift card worth one hundred dollars for Amazon.com, with one in twenty odds of winning. Participants will be taken to a separate and unlinked webpage at the end of the study where identifying information can be entered for this purpose, which will be automatically downloaded separately to ensure the confidentiality of your responses. Alternatively, participants may elect to have five dollars donated on their behalf to charity. The findings from this study will be publicized with the goal of developing a better understanding of how to support the American Muslim community in the future, particularly within the realm of mental health care.

Risks of participation in this study.
Your participation in this study involves minimal risk to you. Your privacy will be completely respected; you will not be asked to provide your name or contact information on the survey and your IP address will not be collected. Your participation in this study is completely voluntary and you may stop at any time you like. However, you're encouraged to complete the survey.

It is not anticipated that participating in this survey will cause any stress. If you have concerns about your rights as a participant, you may contact Dr. Kevin P. Lyness, Chair of the Human Research Committee at 603-283-2149, or Dr. Katherine Clarke, Vice President of Academic Affairs, 603-283-2416. If you have any questions about this survey please contact me at bherzig@antioch.edu.

Thank you again for your participation.

Ben Herzig

Appendix C

List of Colleges and Universities for Participant Recruitment (150)

Alabama (2):

Auburn University
University of Alabama (at Tuscaloosa)

Alaska (1):

University of Alaska (at Anchorage)

Arizona (2):

Arizona State University
University of Arizona

Arkansas (1):

University of Arkansas (at Fayetteville)

California (10):

California Institute of Technology
Fresno State University
Pepperdine University
San Diego State University
San Francisco State University
Stanford University
University of California (at Berkeley)
University of California (at Los Angeles)
University of California (at San Diego)
University of Southern California

Colorado (3):

Colorado State University (at Fort Collins)
University of Colorado (at Boulder)
University of Denver

Connecticut (4):

Connecticut College
University of Connecticut
Wesleyan University

Yale University

Delaware (1):

University of Delaware

District of Columbia (4):

American University
George Washington University
Georgetown University
Howard University

Florida (7):

Florida State University
Nova Southeastern University
University of Central Florida
University of Florida
University of Miami
University of South Florida
University of Tampa

Georgia (3):

Emory University
Georgia Institute of Technology
University of Georgia

Hawaii (1):

University of Hawaii (at Manoa)

Idaho (1):

Boise State University

Indiana (3):

Indiana University (at Bloomington)
Purdue University
University of Notre Dame

Illinois (4):

DePaul University

Northwestern University
University of Chicago
University of Illinois (at Urbana-Champaign)

Iowa (2):

Iowa State University
University of Iowa

Kansas (3):

Kansas State University
Kansas University
Wichita State University

Kentucky (2):

University of Kentucky
University of Louisville

Louisiana (2):

Louisiana State University (at Baton Rouge)
Tulane University

Maine (2):

Bates College
University of Maine (at Orono)

Maryland (2):

Johns Hopkins University
University of Maryland (at College Park)

Massachusetts (11):

Boston College
Boston University
Brandeis University
Harvard University
Massachusetts Institute of Technology
Northeastern University
Simmons College
Tufts University
University of Massachusetts (at Amherst)

University of Massachusetts (at Boston)
Wellesley College

Michigan (3):

Michigan State University
University of Michigan (at Ann Arbor)
University of Michigan (at Dearborn)

Minnesota (2):

Carleton College
University of Minnesota (at Twin Cities)

Mississippi (2):

Mississippi State University
University of Mississippi

Missouri (3):

Saint Louis University
University of Missouri (at Columbia)
Washington University in Saint Louis

Montana (1):

University of Montana (at Missoula)

Nebraska (1):

University of Nebraska (at Lincoln)

Nevada (1):

University of Nevada (at Las Vegas)

New Hampshire (2):

Dartmouth College
University of New Hampshire

New Jersey (3):

Princeton University
Rutgers University (at New Brunswick)

Seton Hall University

New Mexico (1):

University of New Mexico

New York (11):

Bard College
Columbia University
Cornell University
Fordham University
New York University
Long Island University (at Brooklyn)
Pace University
Saint John's University
State University of New York (at Binghamton)
State University of New York (at Stony Brook)
Syracuse University

North Carolina (5):

Davidson College
Duke University
North Carolina State University
University of North Carolina (at Chapel Hill)
Wake Forest University

North Dakota (1):

University of North Dakota

Ohio (5):

The Ohio State University (at Columbus)
University of Cincinnati
University of Dayton
University of Toledo
Xavier University

Oklahoma (2):

University of Oklahoma
Oklahoma State University (at Stillwater)

Oregon (2):

Oregon State University
University of Oregon

Pennsylvania (6):

Carnegie Mellon University
Drexel University
Pennsylvania State University (at University Park)
Temple University
University of Pennsylvania
Villanova University

Rhode Island (2):

Brown University
University of Rhode Island

South Carolina (2):

Clemson University
University of South Carolina (at Columbia)

South Dakota (1):

University of South Dakota

Tennessee (3):

University of Memphis
University of Tennessee (at Knoxville)
Vanderbilt University

Texas (6):

Baylor University
Rice University
Texas A&M University (at College Station)
Texas Tech University
University of Houston (at Houston, Main Campus)
University of Texas (at Austin)

Utah (2):

Brigham Young University
University of Utah

Vermont (1):

University of Vermont

Virginia (5):

George Mason University
University of Richmond
University of Virginia
Virginia Commonwealth University
Virginia Polytechnic Institute and State University

Washington (2):

University of Washington (at Seattle)
Washington State University (at Pullman)

West Virginia (1):

West Virginia University

Wisconsin (2):

Marquette University
University of Wisconsin (at Madison)

Wyoming (1):

University of Wyoming

Appendix D

Recruitment Message

As-Salaamu‘Alaikum. I hope this message finds you well, insha’Allah. My name is Ben Herzig and I am a doctoral candidate in the Department of Clinical Psychology at Antioch University New England. As an American-born Muslim who is interested in providing psychological services to fellow Muslims in the United States, my research interests are focused on developing a better understanding of the mental health attitudes and needs of the American Muslim community.

I am recruiting American-born Muslim college students to participate in a study on attitudes toward mental health. As you may be aware, young adult American-born Muslims are an emerging group in American society whose perspectives on a variety of issues need to be studied. It is my hope that the field of psychology – and the American Muslim community as well – will greatly benefit from a better understanding of the views of mental health held by this important population, as you represent the changing face of Islam in America.

Given the importance of this research, the Institute for Social Policy and Understanding (www.ispu.org) has agreed to fund this study. This funding will allow for one in every twenty participants to win a $100 gift card from Amazon.com! Alternatively, you may choose to have five dollars donated on your behalf to Islamic Relief USA (www.islamicreliefusa.com). Or, you may choose not to receive a reward.

Your participation will consist of taking an online survey that may take about 30 minutes. Some participants might find that this survey can be completed in significantly less time while others may need more than 30 minutes. In order to participate, you must meet the following requirements:

1) You identify as a Muslim.

2) You were born in the United States.

3) You live in the United States.

4) You are an undergraduate college student.

5) You are at least 18 years old.

Your privacy will be completely respected. You will not be asked to provide your name or contact information on the survey and your IP address will not be collected.

Please click the link below to get started!

https://www.psychdata.com/s.asp?SID=139498

Jazakum Allahu‘Khairan,

Ben Herzig, M.S., Psy.D. Candidate

bherzig@antioch.edu