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# Arab American Muslims' Attitudes Toward Seeking Mental Health Services: The Roles of Acculturation, Religion, and Cultural Beliefs

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# ARAB AMERICAN MUSLIMS' ATTITUDES TOWARD SEEKING MENTAL HEALTH SERVICES: THE ROLES OF ACCULTURATION, RELIGION, AND CULTURAL BELIEFS

A Dissertation

by

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# ABSTRACT

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The purpose of this study was to identify the relationship between acculturation, religion, cultural beliefs, and attitudes toward seeking mental health services among Arab American Muslims. A total of 280 participants were surveyed for this study. Regression analysis was conducted to explore relationships among the variables; the alpha level was set at .05. The first research hypothesis was accepted as it showed statistical significance in the relationship between attitudes toward seeking mental health services and demographic variables. The standardized regression coefficients, or beta coefficients ranged from -.008 for gender to .24 for marital status, R=.31 (P<.05). Two variables were significant at the .05 level (marital status, and health insurance). The second hypothesis was also accepted as it showed relationship between attitudes toward mental health services and acculturation, religion and cultural beliefs; the standardized regression coefficients, or beta coefficients ranged from .05 for cultural beliefs to a -.25 for religion, R=.44 (P<.05). The variables of acculturation and religion were significant at the .01 level. Cultural beliefs were not significant at .05 level.

# DEDICATION

The complication of my doctoral studies would not have been possible without the unconditional love of my family and of my beloved mother, who spent, and is still spending, nights praying for my safety and success. To my handsome sons Mahmood, Mohanad and Karim, who forever my inspiration and motivation. My sister Feda who loved, supported, and encouraged me to never give up no matter how hard the obstacles are. To my brother Mohammad and his beautiful wife and daughters. Finally, to Sergio Gonzales for his unconditional love and encouragement, I appreciate everything you did to me and still do. I love you all my support, my strength, my family.

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# CHAPTER I

# INTRODUCTION

Muslim Americans are considered a large diverse and essential part of the greater American society. Approximately 3.45 million Muslims live in the U.S. (Mohamed, 2018), however this estimate may be closer to 3.7 million (Pennock, 2017). Muslims immigrated to the United States for numerous reasons such as, education, progression in career prospects, improved living conditions, fleeing political conflict, etc. (Cook-Masaud & Wiggins, 2011; Diller, 2011).

Islam is considered the second major religion around the world with 1.6 billion followers (Pew Research Center, 2013). Islam is considered the fastest growing religion and Muslim population is expected to grow more than twice as fast as the overall world population between 2010 and 2050 (Hackett & Lipka, 2018). While the world's population is expected to increase by 32% in the approaching years, the number of Muslims is likely to surge by 70%, from 1.8 billion in 2015 to approximately 3 billion in 2060. In 2015, Muslims made up 24.1% of the worldwide population; 45 years later, they are likely to make up more than three-in-ten of the world's citizens (Hackett & Lipka, 2018).

Muslim Americans are a growing minority group and a distinctive subgroup of the United States population with inadequate studies of their wellbeing and health (Sheridan & North, 2004; Maslim & Bjorck, 2009). The Muslim population continues to grow through

immigration, birth rates, and conversion in the United States. The mixture and distinctiveness of the Muslim Americans' population is considered a great challenge to researchers who study how Muslims embrace the American norms and values (Bagasra & Mackinem, 2019). Despite the fact that Muslim Americans are considered a significant minority in the United States (Esposito, 2011), their utilization of mental health services continues to be empirically anonymous; significant gaps are identified in the litreture when it comes to understanding subgroups within the Muslim American group (Sauerherber et al., 2013; Springer et al., 2009). This is unfortunate considering the augmented attention Muslims are receiving in the media (Mohamed, 2016).

Muslims Americans' attitudes toward seeking mental health services in the United States has been associated with numerous factors including cultural beliefs about mental illness (Park et al., 2013), the utilization of other resources, societal stigma accompanying mental illness (Mantovani et al., 2017), prejudice and discrimination in healthcare settings (Cho et al., 2014), and negative attitudes toward mental health services (Villatoro et al., 2014). Furthermore, Arab American Muslims represent the largest population of refugees and asylum-seekers arriving to the United States, therefore, the barriers that alienate them from acculturation and integration into the social framework of the host country puts Arab American Muslims at great risk (Khawaja, 2016).

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), adults who seek mental health services are comprised of 16.0% Caucasian American, 6.8% African American, 7.3% Hispanic American, and 3.9% Asian American

(SAMHSA, 2014). Similarly, Park and colleagues (2013) reported that even though 23% of Korean American participants stated having at least mild symptoms of depression, only 8.5% seek mental health services. Most individuals with mental illnesses refuse to seek mental health services and remain untreated (Nordberg et al., 2013). Nordberg and colleagues reported that 70% of adults who were diagnosed with mental health problems refused to seek any type of service, and only 13% pursued formal mental health services (Nordberg et al., 2013). Henshaw and Freedman (2009) stated that individuals who seek formal mental health services usually are referred by primary care professionals, family members, schools, friends, or court. In other words, these individuals who have metal health disorders do not seek mental health services until the problem has become a catastrophe.

In addition to a lack of help seeking, there is a significant overlap in the literature and lack of understanding with respect to Arab and Muslim Americans (Zidan & Cahn, 2019). Muslim and Arab Americans are two different groups, even though they are repeatedly combined as one (Zidan & Chan, 2019). For example, Arab Americans are acknowledged by their ethnic origin while Muslim Americans are acknowledged by their religious affiliation. Yet, Islam is considered the primary religion within all the Arab countries (Hammoud et al., 2005). The mainstream of Arab Americans is 77% Christian, and only 23% of Arab American are Muslim (Abu-Ras & Abu-Bader, 2008). Therefore, it is critical to mention that not all Arabs are Muslim and not all Muslims are Arab (Zogby, 2001). For instance, most of the Iranian Americans are Muslim but they do not speak Arabic and they do not have Arab ancestry (Amer, 2005).

To prevent mislabeling these two groups, a brief background will be discussed in detail, so as to accurately distinguish between Arabs and Muslims (Zidan & Chan, 2019). Next, the problem statement and purpose of the study will be discussed. The research questions and hypotheses will be stated, followed by the proposed methodology, and finally the definitions of key terms.

## Arab Cultural Background

Arab Americans who identify themselves as being of "Arab" descendent are among the fastest growing of minority groups in the United States (Zidan & Chan, 2019). According to the American Arab Anti-Discrimination Committee (2009), Arab Americans are individuals who have heritage in any of the following 22 Arab countries: Lebanon, Syria, Egypt, Palestine, Iraq, Algeria, Bahrain, the Comoros Islands, Djibouti, Jordan, Kuwait, Libya, Morocco, Mauritania, Oman, Qatar, Saudi Arabia, Somalia, Sudan, Tunisia, the United Arab Emirates, and Yemen. Consequently, this population represents many different cultures and socio-demographic characteristics as reflected in their multiethnic and multinational migration history (Arab American Institute Foundation, 2014). For example, although most Arabs are Muslim; 10% are Christians living in Syria, Egypt, Iraq, Jordan, and Palestine. Similarly, most Arabs speak Arabic with different dialects (Abraham, 1994). In North Africa, some Arabs speak more French and Spanish than they do Arabic (e.g., Tunisians, Moroccans, and Algerians).

In contrast, Arab Americans are recognized as those individuals who identify themselves as Arab, have heritage with any country whose primary language is Arabic and is likewise

located in the Middle East and/or North African regions (Nassar-McMillan et al., 2011). Arab Americans are highly heterogeneous in their ethnic heritage, religious beliefs, country of origin, pre-migration factors, and post-migration circumstances which is reflected in differences in educational background and labor participation for this population (Zidan & Chan, 2019).

In general, the Arab population identifies themselves as "al-Umah al Arabiya" or "the Arab Nation." This Arab Nation speaks Arabic and shares the same values, culture, and traditions as those from the Arabian Peninsula's travelling populations (Amer, 2005). Furthermore, this population distinguishes between "Arabs" and "Arab Americans." "Arabs" are those individuals who are residing in one of the Arab countries, while "Arab Americans" denote individuals who immigrated to the United Sates, or who were born in the United States (Zidan & Chan, 2019). Additionally, there is another population of immigrants who speak Arabic and migrated from Arab countries, but culturally are not considered Arabs, as in the case of Kurds in Iraq and Syria (Majaj, 2000; Samhan, 1997). Similarly, Arab Americans reside in almost all United States, and especially in large metropolitan cities (e.g., Detroit, Houston, Los Angeles, San Francisco, Chicago, Washington, DC, and New York City).

Likewise, despite their mutual languages, religious affiliations, cultural beliefs and traditions, Arabs, in general, are very diverse and heterogenous within their own sub-groups (El-Sayed & Galea, 2009). For example, Arab Americans vary in the way they dress and cook food (Amer, 2005), and religious affiliation based on country and region of origin. In addition, Arabs may have migrated to the United States through Europe and other countries, specifically to the

Detroit-Dearborn area (Wayne County) in Michigan, which has the largest and most diverse Arab American population (Zogby, 2010).

According to Zidan and Chan (2019), Arab American immigrants may have arrived in the United States through numerous immigration waves as part of the slave trade from 1700 to 1890. Arabs started to immigrate into the United States in three main waves over the last 135 years (Diller, 2011; Nassar-McMillan & Hakim-Larson, 2003). The first wave of Arab immigrants landed around 1890 and 1920 to the U.S., the majority were Christian individuals from Syria and Lebanon with poor socioeconomic status searching for job opportunities (Diller, 2015; Nassar-McMillan & Hakim-Larson, 2003). The second wave was between 1948-1966 after World War II, immigrants came from other Arab countries such as Iraq, Egypt, and Palestine and they were mostly well-educated Muslims, due to civil war and political instability in the region (Diller, 2011; Erickson & Al-Timimi, 2001; Nassar-McMillan & Hakim-Larson, 2003). The third wave of Arab immigration occurred after 1966 and consisted of well-educated Muslims with professional careers such as engineers and doctors (Diller, 2011; Erickson & Al-Timimi, 2001; Nassar- McMillan & Hakim-Larson, 2003).

The third wave of Arab Americans faced more struggles to assimilate into American society because of political conflicts, such as the 1967 Arab Israeli war and the catastrophic incidents of September 11, 2001. Arab Americans demonstrated a high level of isolation post 9/11 counterattack (Zidan & Chan, 2019). This geopolitical rift between the Arab world and the United States affected Arab immigrants in all waves of arrival. Thus, the history of Arab

Americans is very complex and multifaceted due to the economic and political relationships between the U.S. and the Arab community (Abu-Raiya et al., 2008).

## Muslim Religious Background

Islam is considered the second major religion in the world. With approximately 23% of the world's population (1.6 billion), Islam is one of the fastest growing emergent religions (Pew Research Center, 2013). Roughly, 62% of Muslims are from the Asian-Pacific region, with the largest number of Muslims living in Indonesia. The North African region and Middle East contribute to the highest intensity of Muslims, but it contributes only 20% of the Muslim population worldwide. In 2010, the number of Muslims in the United States was 2.6 million, a figure which is projected to double over the next 20 years. In addition, Muslims who live in the United States are racially and ethnically diverse. 63% is first-generation immigrants from different countries in the Middle East, South Asia, North Africa, Europe, and Sub-Saharan Africa (Gallup, 2009).

The word *Islam* is originated from an Arabic word 'peace' (*salam*) and the word *Muslim* means 'one who submits to God' or 'one who attains peace through God' (Cook-Masaud & Wiggins, 2011; Hamdan, 2007). Islam is considered an Abrahamic religion, the same as Judaism and Christianity (Kelly et al., 1996). Two main streams of Islam were created after the death of Prophet Muhammad, namely Sunni and Shia. Approximately 80-90% of the Muslim population classifies as Sunni, and approximately 10-15% are Shia (Koenig & Al Shohaib, 2014). Muslims come from different ethnic and racial cultural backgrounds and there are different cross-cultural

variances among Muslim groups. However, there is a lack of research on certain subgroups of Muslims, and oftentimes studies do not stipulate ethnic or racial backgrounds of the Muslim participants (Koenig & Al Shohaib, 2014). Further research is needed to understand the needs of different subgroups of Muslims. Therefore, the focus population of this study is Arab Muslims living in the United States.

## Problem Statement

While racial and ethnic minorities are less likely to seek formal mental health services, detailed research on the Arab American Muslims' population is missing. There is a complicated interaction of psychological, social, and demographic factors that impact attitudes toward seeking mental health services (Henshaw & Freedman-Doan, 2009). There are numerous obstacles and barriers that impede the utilization of mental health services (e.g., absence of access, stigmatization) (Henshaw & Freedman-Doan, 2009; Hussain, 2009; Park et al., 2013). Nonetheless, the level to which each of these factors influences the decision of Muslim Arab Americans to seek help from mental health professionals is vague (Park et al., 2013). The insufficient studies that have been done with the Arab American population showed that mental health services are underutilized (Al-Krenawi & Graham, 2000; Aloud & Rathur, 2009; Erickson & Al-Timimi, 2001; Hamid & Furnham, 2013)

Several barriers hinder the utilization of mental health services among the Arab Muslim population, like negative attitudes toward mental health, religious beliefs, and acculturation (Al-Krenawi & Graham, 2000; Aloud & Rathur, 2009; Erickson & Al-Timimi, 2001; Hamid &

Furnham, 2013). Throughout times of psychological distress, individuals may seek help through informal resources, such as family, friends, and religious figures. By seeking informal help, Arab Muslim Americans may experience less stigma, shame, and taboo (Al-Krenawi, 2005; Aloud, 2004). There is a negative association between the behavior of seeking help and an individual's attitudes toward seeking help from others (Aloud & Rathur, 2009; Herzig, 2011). Individuals who have negative attitudes toward help-seeking will be less likely to use formal services (Aloud & Rathur, 2009; Herzig, 2011).

Consequently, Arab Muslim Americans' attitudes toward mental health may have an adverse influence on help-seeking behaviors. Additionally, the stigma attached to mental illness may negatively influence Arab Muslim's utilization of mental health services (Al-Krenawi, 2005). Thus, Arab Muslims are more likely to seek help from other sources, such as religious leaders or family (Aloud, 2004). Additionally, religious leaders who are not qualified to treat mental illness may feel burdened and overwhelmed by the obligation and commitment to help others. An additional barrier that may affect the utilization of mental health services is acculturation among Arab Muslim Americans to the host culture. Cultural adaptation is a course that happens when two ethnocultural groups come into interaction with each other (Berry, 2003; Fassaert et al., 2011). This cultural contact is usually constant between the two ethnocultural groups for there to be an acculturative process. Berry's (1997, 2003) model of acculturation explains four main consequences that result from the degree of interaction and level of contribution within the greater society and the maintenance of heritage cultural traditions and

identity (Fassaert et al., 2011). Individuals who undergo and endure acculturation are expected to face acculturative stress (Berry, 2003). Among Berry's four outcomes, marginalization from the host culture is correlated to the highest levels of acculturative stress; integration into the dominant culture is correlated with the least (Berry, 1997, 2003). These two consequences have also been associated with mental health. Marginalization was found to have a positive relationship with mental illness, whereas integration had a negative relationship with mental health problems (Fassaert et al., 2011; Hovey & Magana, 2000; Thapa & Hauff, 2005).

Religious beliefs can also be an obstacle to seeking mental health services among Arab American Muslims. Certain beliefs about the cause of mental illness may have originated from religious philosophies, which can influence the choice to utilize formal mental health services (Weatherhead & Daiches, 2010). Religious identity has been found to influence acculturation in some studies (Awad, 2010). Individuals who were identified as Muslims were less acculturated to the host society than those who identified as Christians among Arab Americans (Awad, 2010). However, research on religiosity as a factor that may impact the relationship between acculturation and help-seeking attitudes is missing. Religiosity is unlike religious identification since it indicates the level to which religious beliefs influence the individual's worldview.

Therefore, if religious identification influences acculturation, it seems as though religion can also impact the relationship between acculturation and help-seeking attitudes toward mental health (Aloud, 2004). Research is required to understand how acculturation, religion, and cultural beliefs influence help-seeking attitudes toward mental health. In order to deliver effective

services and increase cultural competence, mental health professionals need to be able to recognize and understand factors, such as acculturation and religiosity that influence help-seeking attitudes among the Arab American Muslim's population. By achieving additional knowledge on this topic, mental health professionals will be able to offer more services, such as educational outreach programs that target to reduce stigma toward mental health (Aloud, 2004).

## Purpose of the Study

The purpose of this survey research is to examine the association between personal characteristics/demographic information, acculturation, religion, and cultural beliefs, on attitudes to seeking mental health services among Arab American Muslims in Midwestern States of U.SA. It is proposed that acculturation, religion, and cultural beliefs has an effect on whether an individual exhibites positive or negative attitudes toward mental health services. Arab Muslim Americans who highly validate Western values are predicted to have more positive attitudes toward mental health than Arab American Muslims who do not. Religion is proposed as an important factor in influencing the attitudes toward seeking mental health services since Islam plays a major role in daily life among Arab American Muslims. Arab Americans Muslims who do not firmly follow Islamic rules and values are predicted to have more positive attitudes than Arab Muslim Americans who are firm followers of Islamic rules and practices. It is important to understand the impact of acculturation, religion, and cultural beliefs on Arab American Muslims attitudes toward mental health services.

## The Significance of the Study

This study highlights the importance of understanding the attitudes of Arab American Muslims towards seeking mental health services. Furthermore, this study examines how the acculturation process can affect attitudes towards mental health services. Mental health practitioners must be culturally sensitive to the distinct aspects of Arab culture and their acculturation process, Arab Americans cultivate high levels of respect towards Western medicine and health practitioners, often leading to a submissiveness of judgment to the practitioner who is expected to adopt an "expert role" (Gorkin, 1986). This clashes with modern recommendations of more humanistic-influenced therapies, which have a stronger client-focused approach. Therefore, mental health practitioners must enhance their skills in the delivery of services to individuals of Arab descents.

## Research Questions (RQ) and Hypotheses (H0)

RQ1. What demographic variables predict attitude toward seeking mental health services among Arab American Muslims?

H01. There is no relationship between demographic variables and attitude toward s seeking mental health services among Arab American Muslims.

RQ2. Is there a relationship between acculturation and attitudes toward seeking mental health services in Arab American Muslims?

RQ3. Is there a relationship between religiosity and attitudes toward seeking mental health services in Arab American Muslims?

RQ4. Is there a relationship between cultural beliefs and attitudes toward seeking mental health services in Arab American Muslims?

H02. There is no relationship between acculturation, religion, cultural beliefs, and attitudes toward seeking mental health services among Arab American Muslims.

## Methodology/ Research design

This study will employ a quantitative methodology of a non-experimental survey design. Data will be collected through convenience and snowball sampling from 280 participants who self-identify as Arab American Muslims. Participants will be recruited via 1) recruitment messages delivered to mosques in the USA, 2) recruitment messages delivered to Arab and Muslim community service agencies in the USA, and 3) snowball sampling. Participants will complete a survey assessing: (a) demographic information, (b) level of acculturation, (c) religion, (d) cultural beliefs (e) and attitudes toward seeking mental health. All variables will measured using valid and reliable instruments. The survey will administered using both online and paper formats. It is hypothesized that acculturation, religion, and cultural beliefs would have no effect on whether an individual exhibited positive or negative attitudes toward mental health services. The hypotheses will be tested using multiple linear regression analyses. A detailed description of the hypotheses can be found in Chapter Three.

## Definition of Key Terms

*Acculturation*: Acculturation is the level of cultural adjustment (Fassaert et al., 2011). High acculturation denotes to an individual who has a higher endorsement of cultural values and practices from the host culture. Low acculturation denotes an individual who has a lower endorsement of cultural values and practices from the dominant or host culture

*American*: For the purpose of this study, American is stated as an individual who meets at least one of the following criteria: self-identifies as an American.; was born in the U.S., has U.S. citizenship.; and has permanent residence in the U.S.

*Arab*: The phrase 'Arab' refers to individuals who have heritage in any of the 22 Arab countries, which include: Egypt, Jordan, Lebanon, Syria, Palestine, Iraq, Kuwait, Qatar, Saudi Arabia, Tunisia, the United Arab Emirates, Oma, Algeria, Bahrain, the Comoros Islands, Djibouti, Libya, Somalia, Sudan, Morocco, Mauritania, and Yemen (Aloud, 2004).

*Formal Mental Health Services*: Formal mental health services are described as professional agencies and therapists that provide therapeutic and psychiatric help for individuals experiencing psychological distress and/or symptoms of mental illness, such as, psychologists, licensed counselors, social workers, therapists, and psychiatrists that may work in a clinical or setting. Licensed professionals who offer mental health services have a master's, doctoral, or medical degree. Licensed professionals who provide mental health services often have a master's

or doctoral degree in their specialized area of work. Formal mental health services can be stigmatizing, especially among racial and ethnic minority groups (Al-Krenawi & Graham, 2000).

*Attitude toward seeing mental health services*: attitudes indicate the attitude's individuals embrace toward seeking help from a mental health professional. These attitudes include four major factors, acknowledgement of personal need for mental and psychological help, acceptance of the stigma that may be associated with seeking mental help, interpersonal sincerity regarding one's problems, and the self-assurance in the mental health professional to be helpful (Aloud, 2004; Fischer & Turner, 1970; Herzig, 2011).

*Muslim:* Muslim denotes an individual who respects and follows the religion of Islam. There are many religious obligations that Muslims have to follow; however, the level of religiosity or degree of rehearsal does not endorse whether an individual is a Muslim (Aloud, 2004).

*Psychological or mental health problems:* Psychological or mental health problems are terms that are used to define short-term or long-term responses to several painful events (e.g., loss in family), stress, or psychiatric disorders (e.g., depression, anxiety) (Aloud, 2004).

*Religion:* The word religion denotes the influence of religion on an individual's life or the degree of religiousness. Religion is the elaboration of three factors: cognitive, behavioral, and affective (Francis et al., 2008).

# CHAPTER II

# REVIEW OF RELATED LITERATURE

## Theoretical Framework of Acculturation

Berry (2005) defined acculturation as "the dual process of cultural and psychological change that takes place as a result of contact between two or more cultural groups and their individuals' members" (p. 698). Acculturation can also be defined as a course of changes that individuals experience in their values, behaviors, and beliefs that occur because of being exposed to a different influential culture (Berry, 1994; Phinney et al., 2001). Acculturation has advanced from a unidimensional model to a bidimensional model. The unidimensional model captures the "assimilationist" approach, "From this point-of-view, it is assumed that individuals from non-dominant cultures will adapt values and customs of the dominant culture (i.e., the host culture) over time" (Ha, 2012, p. 46).

The unidimensional model proclaims that the acculturated individual has lost bonds to their original culture. Berry (1997) defined the unidimensional model as a specific continuum, which shows how individuals change from one point where they still have customs and values of their original culture (not acculturated), to the other point where they have embraced the customs and values of the dominant culture (acculturated to the host) (Berry, 1997). The intermediate point of this continuum exemplifies "biculturalism" where the individual recollects characteristics of both their original culture and the dominant culture (Keefe & Padilla, 1987).

For the purposes of this study, the dominant culture is the American culture. Ha (2012) explored a new model that incorporated both cultural awareness and ethnic loyalty based on the understanding of both the dominant culture and original culture, including the ability of speaking the languages of each culture, familiarity of significant historical events of each culture, and understanding of the musical rituals of each culture; and the ethnic faithfulness which is composed of self-ascribed ethnicity. Additionally, this model recommends that cultural awareness and ethnic faithfulness are manipulated by the individuals' lifestyles, clothing styles, social activities, and food selections (Ha, 2012).

Acculturation has been used to assess the modification of immigrants to the new culture (Phinney et al., 2001). The progress of acculturation undergoes cultural and psychological modifications over an extended period (Berry, 1994; 2005). These modifications can include alterations in sociocultural values, norms, learning the language of that domain culture, eating their food, and dressing like them (Berry, 2005). People can have high to low levels of acculturation to the host or dominant culture. Berry described four different acculturation strategies that the individual may use. Subsequently, he identifies two main factors of acculturation within those four styles to maintain the original cultural identity and the relationship within the host culture (Berry, 1994). The first one is immersion or adoption of the host society and the second is retention or immersion in the heritage society. According to Awad (2010):

> Dominant society immersion refers to the extent to which individuals adopt or adhere to dominant society values, beliefs, and behaviors, whereas ethnic society immersion refers to the extent to which individuals hold onto or adopt beliefs, values, and behaviors believed to be a part of their ethnic heritage. (p. 60)

Berry (1994; 2005) classified four acculturative styles individual's practice in the domain culture: integration, assimilation, separation, and marginalization. Integration is the acceptance and implementation of the cultural values of the domain culture, while also recollecting cultural values from the original culture. Integration is when the individual has a strong preference for saving their original culture and also pursuing relationships with other groups. During this stage individuals have a high acculturation level with a resilient awareness of their ethnic identity (Berry, 2008).

In assimilation, the individual implements the domain cultural values, and ignores his original cultural values. In this stage, the individual does not want to acquaintance with their original culture and may even reject their tradition as part of their identity (Berry, 2008). The stress in this strategy is to accept the host values and norms and discard their traditional values so as to be accepted within the dominant culture. In the separation strategy, the individual rejects the dominant cultural values and maintains their original cultural values. In this stage, the acculturation level is low since the individual refuses to adjust or acknowledge any of the dominant cultural values. The difference between separation and assimilation is that the preserved values are from the original culture rather than the dominant culture (Berry, 2008).

The last strategy is the marginalization. In this stage the individual declines their original culture and the dominant culture (Berry, 2008). While this strategy is uncommon, the individual does not desire to maintain their cultural values and does not pursue any associations among other groups. In conformity with the two main factors of Berry's model, individuals who maintain their original cultural values and refuse any relationships with the dominant culture are believed to have low acculturation. Conversely, individuals who are highly acculturated pursue other relationships and are more exposed to the dominant sociocultural norms and values (Berry, 2008).

Berry (2003) proposed four other strategies from the standpoints of the non-dominant group: multiculturalism, melting pot, segregation, and exclusion (ethnocide). Multiculturalism happens when the dominant group is vulnerable to cultural diversity. The melting pot arises when an individual of the dominant culture chooses to assimilate. Segregation arises when the dominant group forces the non-dominant group to practice the separation strategy.

Consistant with this, the aim of the study is to examine acculturative status or level (i.e., high, or low) of Arab Muslim Americans. This study will use the Psychological Acculturation Scale (PAS; Tropp et al., 1999; Ghorpade et al., 2004) to measure the acculturation level between the participants. The PAS is grounded in Berry's conceptualization and definition of acculturation. Tropp and collogues suggest that psychological acculturation involves changes in the individual's cultural orientation that advance through interaction and contribution within new cultural groups (Tropp et al., 1999). The PAS assesses the psychological connection and

belonging within the White/Anglo-American culture and the individuals' heritage culture (Tropp et al., 1999; Ghorpade et al., 2004). Hence, the assessment emphases the two major factors of Berry's acculturation model, rather than the four strategies.

## Acculturative Stress

Acculturative stress can be identified as the tension associated with two cultures and demanding to encounter the stressors of both cultures (Rudmin, 2010; Williams & Berry, 1991). These stressors can embrace language barriers, employment, housing, transportation, and different customs (Wrobel & Paterson, 2013). Acculturative stress can include physical, psychological, and social aspects (Berry et al., 1987). Ethnic groups that have similar cultural standards to the domain culture are expected to adapt better and experience little acculturative stress (Berry, 2006). Likewise, individuals from ethnic groups who have more cultural variances will cultivate greater levels of acculturative stress. Furthermore, Berry explained that integration is correlated with the lowest level of stress since individuals are able to maintain a healthy balance between their own cultural tradition and the host culture (Berry, 1994; Berry, 2008). On the other hand, Berry argues that people experience the most acculturative stress during marginalization since there is a denial of forming relationships with members of the of their original culture and host culture at the same time (Berry, 2005).

Toward this end, Haque-Khan (1997) conducted a study to examine acculturation levels among Muslim women and reported that women with lower acculturation levels were less likely to seek mental health services. In another study, Amer and Hovey (2007) found that Arab

Christian Americans had a higher level of integration and assimilation compared to Arab American Muslims. However, Muslims reported higher levels of ethnic identity related to their religious beliefs in addition to retaining their Arabic language, traditions, food, music intrinsic and their religious practices (Amer & Hovey, 2007; Wrobel & Paterson, 2013).

Another study on Arab Americans reported that the language barrier was a major problem for this minority group and a cause of depression (Wrobel et al., 2009). Wrobel and Paterson (2013) reported that the difference of the Arabic alphabet from the English alphabet makes it very hard to adopt to the host culture. Arab immigrants find reading traffic signs or passing a citizenship test more challenging than other immigrants of Western origin. Furthermore, another study reported that acculturation is not exclusively based on individual integration but is also highly influenced by family environment. Thus, individuals who watch more Arabic TV and speak the Arabic language at home are more likely to have a higher level of cultural identity than then those that don't (Britto & Amer, 2007).

However, media may play a great role on acculturative stress for Arab Muslim Americans. In some studies, numerous Arab Muslim Americans were found to encounter an increased level of prejudice and discrimination based on their religion and culture, which in turn caused a higher level of acculturative stress (Goforth et al., 2016; Ibish, 2003; Patel et al., 2015). Alleged discrimination has been found to be a strong predictor of increased psychological symptoms such as depression, anxiety, and somatic conditions (Liebkind & Jasinskaja-Lahti, 2000; Patel et al., 2015). Awad (2010) studied the role of acculturation, religion, and ethnic

identity on the alleged discrimination of Arab Americans. Awad reported that 77% of Arab American participants testified facing offensive comments regarding their ethnic community. Likewise, an individual's life can be disturbed by acculturation stressors alongside family and media. Kumar and colleagues (2014) reported that immigrants tend to stay in regions that are similar to their own ethnic groups. Kumar et al. (2014) interviewed 45 middle-school aged, immigrant Arabs living in areas with their ethnic groups. Participants stated that living in an ethnic enclave made them feel safer, protected from discrimination, and perceive greater community support. The acculturation process is an enduring experience; thus, the level of acculturative stress can be different too. While the stress involved in the acculturation process can have an influence on an individual's psychological status, it is critical to understand how this process may influence help-seeking attitudes toward mental health.

## Acculturation and Mental Health Services

Several researchers studied the impact of acculturation on help seeking attitudes toward mental health services (Cachelin et al., 2001; Kim & Omizo, 2003; Kouyoumdjian et al., 2003; Zhang & Dixon, 2003). For example, Zhang and Dixon (2003) explored attitudes toward seeking mental health services and acculturation level among 170 Asian international students in the United States. Participants completed a demographic questionnaire, Attitudes Toward Seeking Professional Help Scale, and a modified version of the Suinn-Lew Asian Self- Identity Acculturation Scale. Results disclosed a positive relationship between the Asian international students' levels of acculturation and their attitudes toward seeking professional psychological

help (Zhang & Dixon, 2003). This suggested that students with greater levels of acculturation had more positive attitudes toward seeking help.

Cachelin et al. (2001) studied the obstacles to treatment for 61 women with eating disorders from an ethnically diverse population (22 Hispanics, 8 Asians, 12 Blacks, 19 Whites). The participants completed a demographic questionnaire, Multigroup Ethnic Identity Measure, Eating Disorder Examination, and were asked questions to assess their treatment history and their acculturation levels. Results showed no significant disparities between ethnic groups toward seeking treatment health services and level of acculturation (Cachelin et al., 2001). In another study, Amer and Hovey (2007) found that Christian Arab Americans endorsed having more assimilation and integration when compared to Muslim Americans. Nevertheless, Muslims reported an increased level of ethnic identity when it comes to religious and cultural practices, as well as the ability to maintain their Arabic language, tradition, music and food (Amer & Hovey, 2007; Wrobel & Paterson, 2013).

Kim and Omizo (2003) studied the adherence of Asian Americans to their cultural values, and their attitudes towards seeking mental health services. Asian American college students (n=242) completed the Asian Values Scale, Suinn-Lew Asian Self-Identity Acculturation Scale, and the Attitudes Toward Seeking Professional Help Scale (Kim & Omizo, 2003). The results revealed an inverse relationship between adherence to Asian cultural values and attitudes toward seeking professional help (Kim & Omizo, 2003). Other studies displayed a relationship between low levels of acculturation and issues related mental health (Lang at al., 1982; Neff, 1986;

Salgado de Snyder, 1987). Rogler et al. (1991) related that problems were associated with minimal knowledge of English language when immigrants joined a new society and culture. Hence, levels of psychological distress can increase because of failure to communicate. Dressier and Bernal (1982) considered that individuals with higher levels of acculturation can also go through psychological distress due to adapting to the cultural values of the host society.

Similarly, Kouyoumdjian and colleagues (2003) studied the barriers to mental health services for Latinos and reported that Latinos lean toward preserving a solid cultural identity, which makes it challenging for them to assimilate the cultural characteristics of the host culture with their cultural beliefs (Kouyoumdjian et al., 2003). Furthermore, Latinos have higher levels of acculturation that have been connected to different behavioral confusions (Neff & Hoppe, 1993). However, other studies reported that Latinos underutilize mental health services (Acosta, 1979; Alegria et al., 2002; Flaskerud & Hu, 1992; Garland et al., 2000; Padgett at al., 1994; Vega at al., 1998; Williams & Collins, 1995). This may be due to attributing symptoms of depression and anxiety as physical issues (Comas-Diaz & Griffith, 1988). Furthermore, one study centering on Arab Americans reported that a lack of English language skills was predictive of depression (Wrobel et al., 2009). "The fact that the alphabet itself is so distinct from the English alphabet makes relatively simple adaptations, like reading traffic signs or passing a citizenship test, more difficult than it may be for immigrants of Western origin" (Wrobel & Paterson, 2013, p. 201). Furthermore, culture "influences many aspects of mental illness, including how patients from a

given culture express and manifest their symptoms, their style of coping, family and community support, and their willingness to seek treatment" (Seyfi et al., 2013, p. 2).

There is limited research investigating acculturation levels and attitudes toward seeking mental health services among Arab Muslim Americans. Abdullah and Brown (2011) mentioned that people from the Middle East are often miscategorized as Caucasian. They conducted a study on mental illness stigma with this population, but it was difficult to know whether the outcomes for Middle Eastern Americans were the same as for Caucasians since they were not reviewed individually. This proposed study will provide a better understanding of how acculturation influences Arab Muslim American attitudes towards seeking mental health services.

## Attitudes toward Seeking Mental Health Services

Taking into consideration the effects of acculturation and attitudes toward seeking mental health services among Arab American Muslims, there is a lack of literature involving this specific population. However, research literature on other ethnic groups (e.g., Latinos and Asians) has demonstrated the effect of acculturation on attitudes toward seeking mental health services (Kim & Omizo, 2003; Kouyoumdjian et al., 2003; Zhang & Dixon, 2003). Some studies stated that individuals who have positive attitudes toward seeking mental health services have higher levels of acculturation to the American culture (Frey & Roysircar, 2006; Herzig, 2011; Zhang & Dixon, 2003). Frey and Roysircar (2006) stated in their study that high levels of acculturation to the American culture was related to seeking mental health services. Another study conducted with Asian American groups reported that lower levels of acculturation were

associated with negative attitudes toward the utilization of mental health services (Lee et al., 2009; Shea & Yeh, 2008; Wong et al., 2006; Zhang & Dixon, 2003). Similar results were reported with studies evaluating the association between acculturation and attitudes toward seeking mental health services between Mexican Americans (Keefe, 1982; Sanchez & Atkinson, 1983; Sanchez & King, 1986).

Inadequate research studies were found to report the relationship between acculturation and attitudes toward seeking mental health sevices among Muslim Arab Americans. One study conducted by Haque-Khan (1997) reported that Muslim women with low acculturation levels were less likely to seek mental health services. Since there is a solid relationship between acculturation level and attitudes toward seeking mental health services among different minority groups, it stands to reason that Arab Muslim Americans could exhibit similar patterns.

## Attitudes Toward Mental Health Services Among Minority Population

Mental health services are provided by licensed, professional, and certified practitioners who deliver therapeutic and psychiatric support and assistance for psychological and emotional disorders (Aloud, 2004). While there is no emphasis toward a particular type of mental health service, this definition includes psychiatric services. Thus, associated occupations include counselors, psychologists, social workers, and psychiatrists who are licensed to deliver therapeutic services (Aloud, 2004).

Ethnic minority groups are repeatedly underrepresented in mental health care services (Barrio et al., 2008; Snowden & Cheung, 1990; Sue et al., 1991). For example, Vega et al.

(1999) reported that only one-fourth of Mexican Americans with mental disorders utilized mental health services within the past year. Another study comparing veterans and non-veterans reported that the utilization of mental health services between Latino and Black non-veterans was critically lower than White non-veterans (De Luca et al., 2016). The results also showed that Black non-veterans had almost 60% lower chances of using mental health services than White non-veterans (De Luca et al., 2016). Alegria et al. (2008) studied individuals with depressive disorders and reported that 40% of White participants did not utilize treatment in contrast to 59% of Black participants, 64% of Latino participants, and 69% of Asian participants (Alegria et al., 2008). Alvidrez (1999) discussed the factors associated with the underutilization of mental health services between minority groups. These factors include availability of mental health services, low socioeconomic status, and accessibility. Nevertheless, when omitting the economic barriers, minority groups will still not use mental health services (Alvidrez, 1999; Temkin-Greener & Clark, 1988). A study by Alvidrez (1999) reported ethnic variations among European American, Latina American, and African American female participants. In this study, European Americans had more knowledge and exposure to the mental health system than both African Americans and Latina Americans. The utilization of mental health services has been strongly associated with attitudes toward mental health services (Aloud & Rathur, 2009; Erickson & Al-Timimi, 2001; Fung & Wong, 2007; Herzig, 2011; Tieu & Konnert, 2014; Williams, 2014). In another study, Temkin-Greener and Clark (1988) found that, among patients who had Medicaid insurance, Whites were more likely than non-Whites to access outpatient psychiatric services.

The use of mental health services has been strongly connected to attitudes toward these services (Tieu & Konnert, 2014; Williams, 2014). Several studies suggest that negative attitudes toward mental health between minorities are related to the refusal of using these services (Aloud & Rathur, 2009; Herzig, 2011; Williams, 2014). Some of these negative beliefs stem from the misconception that people with mental illness are dangerous, have no social skills, and cannot be cured (Segal et al., 2005). These beliefs are supported by societal stigma and have an impact upon attitudes toward seeking mental health services among minority groups with certain cultural beliefs about mental illness (Aloud & Rathur, 2009). Alvidrez (1999) studied cultural beliefs about mental health services between ethnic groups. His results revealed that African Americans were more likely to support the idea that mental illness is the result of supernatural and religious factors, while Latin Americans were less likely to support medical factors as the reasons for having mental illness. Cultural beliefs about the causes of mental illness have an important impact on seeking mental health services (Tieu & Konnert, 2014; Williams, 2014). Similarly, Fung and Wong (2007) studied the attitudes toward seeking mental health services among Chinese, Korean, and Vietnamese immigrant participants. They found that positive or negative attitudes were highly correlated with cultural beliefs. The participants who have strong cultural beliefs reported that mental illness was related to supernatural forces. However, cultural beliefs regarding the causes of mental illness can influence stigmatization of seeking formal services. Another study reported that any individual seeking mental health services will have a feeling of shame (Kwok, 2013; Lee et al., 2009). Seeking mental health services can be affected

tremendously by having negative attitudes toward such services. Attitudes toward formal mental health services can be predisposed by acculturation and religiosity, which will be discussed in the next sections.

## Acculturation and Seeking Mental Health Services

Acculturation may be a significant factor in shaping attitudes and cultural beliefs toward seeking mental health services. Acculturation is the amount a person acquaintances or participates with the host culture (Berry, 1994). Ethnic groups can be diverse in the way they understand and construct the concept of mental health (Saechao et al., 2012). Numerous studies on ethnic minorities have reported that culture has a strong effect on the expression, recognition, and admission of psychological illnesses (Han & Pong, 2015). Leong et al. (2011) stated in their study that attitudes toward mental illness and services among Asian American college students were not merely correlated with cultural beliefs of shame, but also with acculturation. Han and Pong (2015) discussed different factors that can affect acculturation, such as immigration status, English language proficiency, level of cultural salience, and length of stay in the U.S. Thus, the studies above suggest that acculturation can be related to attitudes toward seeking mental health services.

## Religion and Attitudes toward Seeking Mental Health Services

Religious values are considered an influential factor in seeking mental health services, much in the same way that cultural beliefs and attitudes toward mental illness are influential, especially for those who highly valued religion (Sood et al., 2012). Psychological symptoms can

be distinguished as a punishment from God. Because of this, people will seek help from a religious person instead of a mental health professional. Sood and colleagues (2012) reported in their study that participants who had a strong religious belief were more likely to seek help from a religious leader. Another study by Wilcox et al. (2007) stated that Indian mothers with children diagnosed with attention deficit hyperactivity disorder sought religious help more than psychological services. Therefore, if religious beliefs impact the utilization of mental health services, there may also be a correlation between religiosity and help-seeking attitudes toward mental health services.

### Attitudes toward Seeking Mental Health Services among Arab American Muslims

It is not easy to identify the precise percentage of Arab American Muslims seeking mental health services in the United States. Numerous studies proposed that Arabs Muslims avoid seeking mental health services (Al-Krenawi, 2005; Aloud & Rathur, 2009; Abu-Ras, 2007; Hussain, 2009; Martin, 2014; Nassar-McMillan & Hakim- Larson, 2003). Most of the literature that studied attitudes toward mental health services did not state if psychiatric services were involved. This distinction is critical because seeking mental health services may be dissimilar regarding specific types of mental health services, like psychiatric services, and counseling (Aloud & Rathur, 2009; Martin, 2014). Khan (2006) measured the attitudes toward seeking mental health services among Muslims in Toledo, Ohio. However, Khan's study omitted psychiatric services. The study included 459 Muslim participants (44 participants African American, 240 Arabs, 119 South Asians, and 56 classified as other). The results of the study

showed that male participants held fewer positive attitudes toward seeking mental health services for psychological problems. Explicitly, male participants of Arab origin were twice as likely to have negative attitudes toward seeking mental health than female Arab participants. The results also showed that Arab participants were less likely to seek counseling and were more likely to use prayer and family support as the main sources of consolation (Khan, 2006).

The attitudes and stigma toward mental health services is affected by the person's cultural beliefs and the stigma attached to mental illness (Aloud & Rathur, 2009; Herzig, 2011). Due to stigma attached to mental illnesses via cultural beliefs and mistrust toward mental health professionals, many studies report that Muslim Americans seem to be more uncertain about seeking mental health services (Aloud & Rathur, 2009; Herzig, 2011). Mistrust is dominant between minority groups toward health professionals, especially Muslim Americans who experienced discrimination (Amri & Bemak, 2013; Erickson & Al-Tamimi, 2001). The experience of doubt toward mental health professionals between minority populations in the United States is considered a significant obstacle in the utilization of mental health services (Amri & Bemak, 2013).

Nassar-McMillan and Hakim-Larson (2003) interviewed 10 mental health therapists of Arab descent serving the Arab American population in a large metropolitan city. The purpose of this study was to collect background information, barriers to counseling, presenting issues, and approaches to counseling among Arab Americans. The data suggested that country of origin and education level were related to openness to counseling or positive attitudes toward counseling.

For example, the data showed that countries that are more westernized such as Lebanon, had less prejudice against the West (Nassar-McMillan & Hakim-Larson, 2003). Most Arab American participants reported that the reason they hesitated to seek counseling is because they belief problems should stay within the family.

In another study, Aloud and Rathur (2009) explored the motivating factors that influence the choice to seek mental health services of Muslim Arab Americans living in Ohio. Within the previous three years, 9.6% of participants reported seeking mental health services at least once. Most of the participants endorsed unfavorable attitudes toward the use of mental health services. The results showed that the attitudes of Arab Muslim Americans toward seeking mental health services were mainly affected by cultural beliefs, knowledge and awareness, societal stigma, and preferences about seeking help with psychological problems. The participants likewise reported that they would seek a family doctor first for help with psychological problems, then family members, then by the *sheik* or religious figure in the Muslim community (Aloud & Rathur, 2009). Interestingly, Aloud and Rathur (2009) found that participants who were born in the United States were more likely to seek mental health services than foreign-born providers. The factors affecting negative attitudes toward mental health services among Arab Muslim Americans have not been entirely investigated and remain vague. The following sections examine the role that stigma and cultural beliefs play in shaping attitudes toward mental health.

## Mental Health Stigma

Studies have recognized several factors contributing to the underutilization of mental health, stigma being one of the most significant barriers to accessing mental health services (Amri & Bemak, 2013; Ciftci et al., 2013). Within many cultures mental illness and treatment is heavily stigmatized, but especially within the Arab Muslim community (Amri & Bemak, 2012). Stigma not only discourages individuals from seeking mental health services (Amri & Bemak, 2012), but it also can be a source of considerable distress (Phillips & Lauterbach, 2017). According Rassool (2004), some Muslims disapprove of mental disorders and consider it shameful to seek mental health services and use psychiatric medications. Muslims with such attitudes may hide mental health issues, potentially resulting in problems with interpersonal relationships and integration within the community (Rassool, 2014). This negative attitude toward seeking professional help may also be due to feelings associated with reputation among family, tribe, and society, which bear weight across a diversity of cultures (Ciftci et al., 2013). Stigma is a major barrier to mental health services among Arab Muslims (Dardas & Simmons, 2015). Arab Muslim societies are mostly collectivist, therefore individuals with mental illness may feel that they are bringing shame to their families (Abu-Ras, 2003; Aloud & Rathur, 2009). According to the Islamic traditions, Muslims are required to take care of their health; thus, when Muslims feel sick, they seek treatment for their weaknesses by turning to religion (Dardas & Simmons, 2015). Yet, because there is stigma and taboo associated with mental illness, the likelihood of utilizing formal mental health services is lowered (Gearing et al., 2014). Stigma

toward mental illness can also contribute to an increase in negative attitudes toward mental health services (Abu-Ras, 2003; Aloud & Rathur, 2009). In another study, Ciftci et al. (2013) explained the concept of double stigma and found that individuals who have mental illness and are of minority status are doubly stigmatized for being Muslims in America combined with the mental illness.

Few recent studies have been conducted to assess the outcomes of stigma toward mental health services and the attitudes toward the Arab Muslim community in the United States (Dardas & Simmons, 2015; Kira et al., 2014). Kira and colleagues (2014) conducted a study on Arab American, Muslim, and refugee clients that were obtaining treatment at a mental health clinic. Most of the participants were Arab Muslim. Of all participants, 43.8% were diagnosed with major depression, 42.3% were diagnosed with posttraumatic stress disorder, 7.7% generalized anxiety disorder, 3.1% psychotic disorder, 2.3% bipolar disorders, and .8% obsessive-compulsive disorder. The results revealed that Arab Americans, Muslims, and refugees had considerably greater rates of internalized stigma of mental illness when compared to non-Muslims, non- Arabs, and non-refugees (Kira et al., 2014). Furthermore, certain cultural beliefs regarding mental illness between Arabs and Muslims is another factor affecting attitudes toward seeking mental health services

## Cultural Beliefs and Mental Health

Ancient Arabic physicians and thinkers such as Ibn Sina (Avicenna) and Abu- Zaid Al-Balkhi differentiated between adaptive and maladaptive responses as well as psychoses and

neuroses as far back as 900-1000 C.E, (Khalili et al., 2002). These early philosophies proposed that the self is comprised of the physical self (Nafs) and the spiritual self (Ruh) and that a discrepancy between physical and spiritual self can cause illnesses of the mind and body. Al-Balkhi further proposed that neuroses, which he classified into four clusters (anger and aggression, fear and anxiety, sadness and depression, and obsessions), are the result of disparities between the body and spirit. Moreover, he claimed that mental wellness takes precedence over the physical and that curing psychological illnesses should take precedence over physical ones (Khalili et al., 2002). Studies exploring cultural beliefs and mental illness are in the infancy phases and more research is required in this area.

The Islamic standpoint on mental health considerably conflicts with the nonspiritual etiology of mental health (Rassool, 2015). This is significant since the Muslim community is racially, ethnically, and socioeconomically different, but at the same time connected by religious world views that cut across social lines to show how its followers seek help, consider distress, and interact with the healthcare providers (Padela & Curlin, 2013; Padela et al., 2012). However, the diversity inside this population means that clinicians need to understand the beliefs associated with the causes of mental illness, but also must be aware of the difference between culture and religion.

Several Muslims believe that depression arises due to absence of faith; individuals with this belief are less likely to accept symptoms or seek professional help due to the stigma (Amri & Bemak, 2013; Walpole et al., 2013). Accordingly, such Muslims are more likely to use other

informal resources that are more socially acceptable and fit their social beliefs (Ciftci et al., 2013; Haque & Keshavarzi, 2014). These informal resources can be a local sheikhs or imam, as religious figures are considered Divine specialists who can deliver different spiritual and non-spiritual services (Ciftci et al., 2013; Padela et al., 2011). Religious mentors have different overlapping parts, and imams have varied experiences and knowledge owing to the lack of an official, uniform ministry system (Padela et al., 2011). Studies show that imams play a significant role in how families and individuals view and react to illness (Ciftci et al., 2012). Muslims may also use a variety of religiously recommended coping strategies and beliefs (Padela et al., 2011; Walpole et al., 2013), beside orthodox psychiatric approaches (Walpole et al., 2013), without revealing such information to mental health professionals for fear of being judged (Samari, 2016). It is not unusual for Muslims to relate depression to supernatural powers, such as possessions by demons (known as *jinn*), being cursed by the evil eye (*al-ayn*), consequences for past sins, black magic (Amri & Bemak, 2013; Haque & Keshavarzi, 2014; Rassool, 2015), and witchcraft (Walpole et al., 2013).

Another common belief between Muslims is that mental illness is caused by the Divine as a punishment or as a test on the patience of the individual, which will then ease the mental illness, as such individuals are exposing themselves to God's will (Amir & Bemak, 2013; Walpole et al., 2013). These beliefs as to the causes of mental illness may affect help seeking behaviors and reactions to treatment (Amri & Bemak, 2013; Ciftci et al., 2013). Similarly, Youssef and Deane (2006) cross-examined 35 individuals of Arab origin living in Sydney,

Australia. Of all participants, 86% endorsed the belief that mental illness is caused by the devil, and 91% stated that anxiety and depression are not reflective of mental illness and that these symptoms are common among Arabs (Youssef & Deane, 2006).

Walpole and colleagues (2013) conducted an international literature review to determine the factors that practitioners should know about Muslim patients suffering from depression. The review highlighted the Muslim clients' beliefs about the cause of depression, as these beliefs affected their preference for therapy. Participants across several studies reported that depression is caused by supernatural phenomenon such as the evil eye, possession, jinn, curse, and witchcraft or magic (Dardas & Simmons, 2015; Walpole et al., 2013). Other causes of depression were related to religious beliefs, such as God's will, the absence of faith in God, or that the person does not pray regularly (Inayat, 2007; Walpole et al., 2013). Walpole and colleagues (2013) stated that some of the beliefs about healing among Muslims ranged from regretful prayers to God to bearing the test of God through acceptance and patience. These beliefs about causes of depression may have a great impact on help-seeking attitudes toward mental health services (Walpole et al., 2013).

Padela et al. (2012) examined the attitudes of providers and clients and concluded that both practioners and clients must share similar views on the causes and remedies for mental health issues. Help-seeking attitudes and behaviors may describe the underutilization of mental health services among Muslims (Rassool, 2015).

## Attitudes Toward Seeking Mental Health

The literature lacks sufficient data and research on the effects of acculturation and the act of seeking help toward mental health between Arab American Muslims. Studies on other ethnic groups, such as Latinos and Asians, reveal that attitudes toward seeking mental health services are influenced by acculturation (Kim & Omizo, 2003; Kouyoumdjian et al., 2001; Zhang & Dixon, 2003). Frey and Roysircar (2006) stated that there is a positive correlation between acculturation level to U.S. culture and the frequency of using mental health resources. Other studies state that individuals from racial and ethnic minority groups with higher acculturation to the American culture are more likely to have positive attitudes toward seeking mental health services (Frey & Roysircar, 2006; Herzig, 2011; Zhang & Dixon, 2003). Limited research was done to explain the relationship between acculturation and attitudes toward seeking mental health among Muslim Arab Americans. In another study, Haque-Khan (1997) reported that Muslim women with lower acculturation were less likely to seek services for psychological and mental problems. This strong association between acculturation status and attitudes toward seeking mental health services among different minority ethnic groups can also be found among Muslim Arab Americans.

## Religion

Numerous research studies have shown positive associations between religion and health (Hummer et al., 1999). Being part of a faith based or religious community can provide social support and coping strategies during difficult periods or events. Several scholars have reported

that seeking assistance for mental health or psychological problems from a *sheikh* or *imam* has increased after 9/11 (Abu-Ras et al., 2008). Abu-Ras and colleagues (2008) studied the psychotherapeutic roles of imams in different mosques around New York City. Of all participants, 22 were imams and 102 were attendees of the mosques, with most participants of Arab or Middle Eastern descent. Of all those surveyed, 94% considered the imam as a counselor and 59% pursued help to deal with stress after the 9/11 attack. Even though the participants reported having emotional problems, 14% pursued help outside the mosque, and only 3% pursued formal mental health services. Of the imams in the study, only one had official training in crisis interventions or western psychotherapy and 95% stated having some difficulty with signs and symptoms of mental illnesses. Furthermore, 91% stated having no knowledge of mental health services available in the communities and no referrals were made (Abu-Ras et al., 2008).

Research on the effects of religiosity and mental health among Muslims and Arabs is limited (Abdel-Khalea, 2006). Weatherhead and Daiches (2010) did a qualitative study to discover the understanding of mental health among Muslims living in the United Kingdom. Most of the 14 participants were immigrants from other countries including a few from Arab countries. Some participants reported viewing the cause of mental health problems as a test from God, similar to other struggles in life. Furthermore, participants reported religion as a coping mechanism during times of distress and some referenced religious texts as a means of justifying the utilization of professional mental health services (Weatherhead & Daiches, 2010). However,

other participants believed that those who have a solid faith in God do not need to use mental health services and instead need to accept the mental illness as God's will.

### Religion and Attitudes toward Seeking Mental Health in Arab American Muslims

There is limited literature on the effects of religiosity and mental health among Arab Muslims (Abdel-Khalek, 2006). With that being said, Abdel-Khalek (2006) studied the relationship between mental health and religiosity, happiness, self-esteem, physical health, anxiety, and satisfaction between Muslim adolescents living in Kuwait. The study recommended that religiosity plays a critical part in overall life satisfaction and mental health. In another qualitative study, Weatherhead and Daiches (2010) interviewed 14 refugees from other countries and some Arab countries. Some of the participants stated that mental illness is a test from God, while others viewed mental illness is a punishment and an obstacle to overcome. Other participant themes included: a) People with strong faith do not need to seek mental health services, b) the belief that mental health problems are a test from God and a part of life, like other challenges such as bereavement, and c) Religion as a coping mechanism when faced with agony. In addition, a few participants in the Weatherhead and Daiches (2010) study had used mental health services, but their replies were not matched to those participants who had not used mental health services. Consequently, the relationship between religiosity and seeking mental health services is unclear within this study and this relationship merits further study.

# CHAPTER III

# METHODOLOGY

This chapter introduces the methodology and design used to investigate the relationships among acculturation, religion, cultural beliefs, and attitudes toward mental health services among Arab American Muslims. This chapter begins with the purpose statement for the research study, followed by the research questions and hypotheses. An explanation of the research design used to test the hypotheses will be provided, followed by a description of the participant inclusion criteria and specific procedures. Next, the instruments used to measure each variable are presented, accompanied by a review of their psychometric properties. This chapter will conclude with a description of how the data was analyzed.

## Purpose Statement

The purpose of this survey research was to examine the association between personal characteristics/demographic information (gender, marital status, born in the USA, and presence/ absence of health insurance), acculturation, religion, cultural beliefs, and attitudes toward seeking mental health services among Arab American Muslims in the Midwestern States of USA. It was proposed that acculturation, religion, and cultural beliefs had an effect on whether an individual exhibits positive or negative attitudes toward mental health. Specifically, Arab American Muslims who highly validate Western values are foreseen to have more positive attitudes toward mental health than Arab American Muslims who do not. Since Religion and

cultural beliefs have been shown to influence the attitudes toward seeking mental health services and play a major role in daily life among Arab American Muslims, it was projected that religion would predict whether a person would have positive or negative attitudes toward mental health.

**Research Questions (RQ) and Hypotheses (H0)**

RQ1. What demographic variables predict attitudes toward seeking mental health services among Arab American Muslims?

H01. There is no relationship between demographic variables and attitudes toward s seeking mental health services among Arab American Muslims.

RQ2. Is there a relationship between acculturation and attitudes toward seeking mental health services in Arab American Muslims?

RQ3. Is there a relationship between religiosity and attitudes toward seeking mental health services in Arab American Muslims?

RQ4. Is there a relationship between cultural beliefs and attitudes toward seeking mental health services in Arab American Muslims?

H02. There is no relationship between acculturation, religion, cultural beliefs, and attitudes toward seeking mental health services among Arab American Muslims.

The null hypotheses for the present study were tested with the F distribution at the .05 level of significance.

## Research Design

This quantitative research used a non-experimental cross-sectional survey design since we were unable to manipulate the independent variables in this study. The independent variables were demographic information, acculturation, religion, and cultural beliefs. The survey design was appropriate for this study because the purpose was to classify differences between variables in a large sample of participants (Creswell & Poth, 2018). The dependent variable in this study was the attitudes toward mental health services; the dependent variable was measured using the Attitudes Toward Seeking Formal Mental Health Services scale (ATSFMHS, Aloud, 2004). The independent variables of this study were measured using the following scales: Acculturation was measured by the Psychological Acculturation Scale (Ghorpade et al., 2004), The Sahin-Francis Scale of Attitudes (Sahin & Francis, 2002) toward Islam instrument measured religion, cultural beliefs were tested using the scale Cultural Beliefs about Mental Health problems, their Causes and Treatments (CBMHP), and demographic information was measured with a scale designed by the researcher. The null hypothesis was tested with the *F* distribution at the .05 level of significance. The obtained data was analyzed through multiple linear regression analysis. The present study utilized confirmatory and exploratory analysis side by side, thus ensuring the fidelity of the obtained results (Tukey, 1977).

## Participants and Procedures

### Participants

To determine the sample size, a power analysis was conducted using G*Power Software (Faul et al., 2007). An *a priori* power analysis was conducted for the total $R^2$ value for a multiple regression analysis with 11 predictor variables, power = .80, and an alpha = .05. Results of the power analysis indicated a sample of 850 for a small effect, 123 for a medium effect, and 259 for a large effect. Grounded in earlier literature (Faul et al., 2007), it was hypothesized that the model would predict at least 25% of the variance, but an $R^2$ value between a small to medium effect (i.e., $R^2 = .30$) was used in this study to remain conservative. Cohen (1992) provided guidelines for small, medium, and large effect sizes that were used in calculating statistical power. For example, Cohen suggested that an $R^2$ value of .20 indicates a small effect, $R^2$ value of .49 indicates a medium effect, and $R^2$ value of .70 indicates a large effect. Therefore, the power analysis suggested a sample size of 119 for the analysis. Data were collected from Arab American Muslims living in the Midwest region of the United States. Although the minimum sample size was calculated to be 119 participants, to err on the side of caution and for attrition consideration, sample size was increased to 280.

The inclusion criteria for this study were that participants must: 1) be 18 years of age or older; 2) identify as Muslim; 3) have heritage in any of the Arab countries; and 4) identify as American or permanent resident. Potential participants identified as American in one of the following ways: 1) U.S citizenship/passport; 2) Green card; 3) refugee or asylum status; 4)

temporary visa (e.g., work, student); 5) permanently living in the U.S.; 6) living in the U.S for at least one year with plans of permanent residence; or 7) born in the U.S. The definition of identifying as an American was extended to those who have a visa or refuges since immigration is a lengthy and complicated procedure and it may take individuals years until they obtain U.S. citizenship. Participants were be removed if they did not self-identify as Arab American Muslim, did not live in the United States, and had a substantial amount of missing data on the main study variables. A detailed summary of participants in this study is provided in chapter four.

**Procedures**

After obtaining approval from the Institutional Review Board (IRB) from the University ofTexas Rio Grande Valley, a convenience and snowball sampling methods were used to recruit participants. Participants were conveniently sampled via a link to the online version of the survey or the paper version. Participants were recruited through various means to achieve a representative sample of the Arab American Muslims' population. Two recruitment techniques were used to obtain participants. The online version of the survey was generated using Qualtrics and was comprised of a demographic questionnaire and the measures previously mentioned (Berinsky et al., 2014; Curran, 2016). The survey was distributed to a wide array of sources (e.g., social media platforms) in order to diversify the sample. To recruit through email or social media, permission was required from numerous local Arab and Muslim social network communities (e.g., mosque and Muslim-owned businesses). Recruitment messages were sent via e-mail to affiliate individuals who meet inclusion criteria. The informed consent included in the recruitment e-mail. The link to the survey was also provided in the e-mail. Flyers included the

link to the online survey and a brief message of the purpose of the study was provided. Paper surveys were used for participants who did not have access to a computer or who preferred the paper format. To directly recruit participants, announce the study and distribute the paper surveys in religious settings, the researcher obtained permission. A sealed envelope was provided for participants to keep responses anonymous and confidential. Snowball sampling was also utilized. Participants who were successfully recruited were asked to invite their acquaintances who also met the criteria to participate. A return envelope was provided to mail the survey back.

A consent form informed the participants of the anonymous and voluntary nature of the survey, the approximate length of the survey, as well as the relative risks (e.g., slight discomfort of survey questions), and the benefits of their research involvement (e.g., advancing research on Arab American Muslims' mental health). In addition, each participant was given the opportunity to submit an email address for the raffle via link at the end of the survey. The winner of the raffle was contacted via email and sent a digital $20 amazon gift card to be used at their convenience.

The investigators of this study did not control the distribution of the survey to specific participants, which is intended to ensure that all participants had an equal opportunity of receiving a gift card. Finally, at the end of the survey, participants were provided with a link to access a psychoeducational brochure on mental health, contact information for the National Suicide Prevention Lifeline, and contact information of the doctoral student conducting the study in the event participants wish to debrief after their participation. Surveys were administered via Qualtrics as well as informed consent along with incentive raffle information. Papere format was

adminestred to an Exel sheet. After successful completion of data collection, results were transferred from Qualtrics to IBM SPSS Version 27. Participants' responses were saved to an encrypted USB drive and placed in a locked filing cabinet at the researcher's discretion.

## Instruments

### Demographic Questionnaire

Demographic information was gathered by using 11 questions that include age, gender, birthplace, country of origin of parents, marital status, legal status of living in the United States, and number of years lived in the USA. The main purpose of the demographic questionnaire was to verify that individuals meet the study's criteria in addition to obtaining basic background information. The demographic form is listed on the Appendix.

### Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS)

The ATSFMHS (Aloud, 2004) instrument is a 20-item self-report measure designed to assess attitudes between Arab-Muslim participants. The ATSFMHS instrument is a modified version of the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH, Fischer &Turner, 1970). The original instrument assesses the relationship between help seeking attitudes and personality variables. The ATSPPH has an internal reliability of between .82-.86 and is broadly used between ethnic and racial minority groups (Fischer & Turner, 1970). The ATSPPH also has test-retest reliability of .89, .82, and .73 at 2, 4, and 6 weeks, separately (Fischer & Turner, 1970). The modified version used in this study has been altered and improved to include

Islamic and Arabic expressions and perceptions to make it more relevant to the Arab-Muslim population (Aloud, 2004). The items encompassing the ATSFMHS measure are based on a Likert-type scale: 1 = *strongly agree*, 2 = *agree*, 3 = *disagree*, 4 = *strongly disagree*. The measure assesses participant agreement with various statements related to the attitudes toward seeking mental health services(e.g., "A person with strong *iman* [faith] can get rid of a mental health or psychological problem without the need of professional help").

This instrument measures participant understanding with various statements related to attitudes toward mental health services. Five additional items were added to the ATSFMHS instrument to evaluate societal stigma related to the use of formal mental health services. However, the extra items that encompass the societal stigma subscale was not used in this study. The scoring of the ATSFMHS scale has a maximum total of 60 and the minimum is 15. The sum of the response items is calculated in order to produce a total score. Higher scores on the ATSFMHS instrument indicate greater openness and more positive attitudes toward seeking formal mental health services. Although validity on the measure was not reported, the 15-item ATSFMHS instrument has a Cronbach's alpha reliability of .74, respectively (Aloud, 2004).

**The Psychological Acculturation Scale (PAS)**

The PAS (Tropp et al., 1999; Ghorpade et al., 2004) is a 10-item self-report measure intended to measure levels of acculturation. The original PAS designed by Tropp and colleagues (1999) was used to measure levels of acculturation among Puerto Rican immigrants. Tropp and colleagues (1999) conducted validation studies on Puerto Ricans living in the United States.

They adapted items from traditional acculturation scales that included cultural behaviors, preferences, and language use. Migration history and language use were used as validation indexes. They reported convergent and discriminant validity on the PAS in both studies. Psychological acculturation was found to be a stronger and more consistent correlate of participants' cultural behaviors and preferences than the amount of time spent in the U.S (Tropp et al., 1999).

Ghorpade et al. (2004) modified the scale to include all racial/ethnic minority groups. Item responses are scored on a 7-point Likert-type scale, ranging from 1 (mostly my own racial/ethnic cultural group) to 7 (mostly Anglo/American cultural group). The midpoint score of 4 is defined as a bicultural orientation. Items on the PAS include the emotional attachment, understanding, and appreciation of the values, beliefs, attitudes, and behaviors of the two cultural groups (Tropp et al., 1999; Ghorpade et al., 2004). Example items include, "With which group of people do you feel the most comfortable?" and "In which culture do you know what is expected of a person in various situations?"

The total score is calculated by the mean of the responses; therefore, the maximum total score would be 7 and the lowest is 1. A higher score shows a higher level of acculturation to American culture and a lower score shows a lower level of acculturation to American culture. A middle score indicates a bicultural orientation. This assumes that the respondent has an integrated acculturative status in which there is more equal balance between the two cultural groups. Ghorpade and colleagues (2004) reported Cronbach's alpha reliability of .92.

**Sahin-Francis Scale of Attitudes toward Islam**

The Sahin-Francis Scale of Attitudes toward Islam (Sahin & Francis, 2002) is a 23-item self-report intended to measure the religiosity of Muslims (see Appendix D) and is modified from the Francis Scale of Attitudes toward Christianity (Francis, 1978). The Francis Scale of Attitudes toward Christianity has been used in over 100 independent studies and translated into different languages (Sahin et al., 2008). The scale has also been amended into the other world faiths such as Judaism, Hinduism, and Islam. The Sahin-Francis Scale of Attitudes toward Islam uses a Likert-type five-point scale (1 = *strongly disagree*, 2 = *disagree*, 3 = *not certain*, 4 = *agree*, 5 = *strongly agree*). Items on the scale assess participants' agreement with various statements related to their religiousness (e.g., "I find it inspiring to listen to the Qur'an"). The maximum possible score is 115 and the minimum is 23. Four items out of the 23 are reverse scored (e.g., "I think going to the mosque is a waste of my time"). All items are then summed to produce a final total score. Sahin and Francis (2002) developed the Sahin-Francis Scale of Attitudes toward Islam and distributed the questionnaire to 381 Muslim participants living in the United Kingdom. The alpha coefficient for internal consistency reliability was reported as .90. Additionally, Sahin, Francis, and Al-Failakawi (2008) reported an internal consistency reliability of .85 within their sample of Muslims living in Kuwait; however, validity of the measure was not reported. Items associated with higher levels of religiosity relate to prayer and closeness to God. For example, "Prayer/Salat helps me a lot" ($r = 0.60$) and "I love to follow the life/sunnah of the Prophet" ($r = .58$) were strongly correlated with the overall scale (Sahin et al., 2008).

**Cultural Beliefs about Mental Health problems, their Causes and Treatments (CBMHP)**

This is an 11-item instrument, developed by Aloud and Rathur (2009) that measures the influence of cultural, traditional, and religious beliefs about the causes and treatment of mental health or psychological problems. It was originally developed for a study that investigated attitudes towards mental health help seeking among Arab Muslims. The scale inquires respondents to report on a four-point scale from 0 (false) to 1 (probably false) to 2 (probably true) to 3 (true). The initial study developing this scale reported a Cronbach's alpha of .73.

**Variable Selection and Data Analysis**

Data management and analyses were conducted using the IBM Statistical Package for the Social Sciences (SPSS) 27.

*Independent and Dependent Variables.* In this study, the following were identified as independent variables – demographic information, acculturation, religion, and cultural beliefs. Dependent variable (DV) was identified as attitudes toward seeking mental health services, which is identified as ordinal data in the study.

*Data Analyses.*The data analyses used in this study include descriptive statistics, correlation analysis, and multiple regression. Pearson product-moment correlation coefficient *was used to* measure the strength of a linear association between the variables. These values can range between positive one to negative one. A value of zero indicates no association between the two variables. A positive association represents a relationship that shows that, as the value of one variable increases, so does the value of the other. A negative association represents a relationship

that shows that as the value of one variable increases, the value of the other decreases. The stronger associations are those with values closer to zero.

Additionally, a multiple regression statistical analysis was utilized to analyze the research questions of this study. Multiple regression analysis was used to determine the relationship between multiple independent variables and one dependent variable. Multiple regression analysis was also used to determine the overall fit (variance explained) of the model and the relative contribution of each of the independent variables to the total variance explained. Four research questions were statistically tested. Multiple linear regression analysis was used to test the research questions. By using multiple linear regression, the researcher was able to examine if acculturation, religion, and cultural beliefs were predictors of attitudes toward seeking mental health services. Prior to finalizing the multiple linear regression test, steps for data formulation and testing assumptions were followed, which will be discussed in the next chapter.

# CHAPTER IV

# RESULTS

The Purpose of the current study was to explore the association between personal characteristics/demographic information, acculturation, religiosity, cultural beliefs, and attitudes to seeking mental health services among Arab American Muslims in the Midwestern States of USA. The overall purpose was to gain a comprehensive understanding of the factors that play a vital role upon the attitudes of the Arab American Muslims to mental health services. Specifically, Arab American Muslims who highly validate Western values are foreseen to have more positive attitudes toward mental health than Arab American Muslims who do not. It was proposed that acculturation, religion, and cultural beliefs would influence the attitudes of Arab American Muslims toward mental health.

## Data Collection

Before conducting the analyses, several steps were taken to prepare the data and to address assumptions that are necessary for performing a multiple linear regression analysis. This section describes the steps to data management. Data from survey responses was downloaded from Qualtrics.com and inputted into SPSS 27. Originally, 280 individuals consented and participated in the study and completed the survey either in full or in part. Since there were specific inclusion criteria for participating in the study, those who did not meet the criteria

were omitted from the analysis. This omission did not affect the sample size as we originally had 310 surveys, and then ended up with 280 complete surveys, wich is larger than the sample size proposed.

## Descriptive Statistics

Descriptive statistics was used to characterize participant demographic information and explore research question 1: *What demographic variables predict attitude toward seeking mental health services among Arab American Muslims? (see Tables 1 – 4).* Table 1 presents the demographic characteristics of the study participants in terms of gender, age, and marital status. Females comprised 50.7% (142) of the participants, males 48.2% (135) and 1.1% (3) of the participants identified themselves as other. All the participates were 18 years and above. Of them, 7.9 % of the participants were between 18-20 years old, 40.7% of the patients were between the age of 21-30, 29.3% were between the age of 31-40, 8.9% were between 41-50, 8.9% were 51-60, and 4.3% were in the range 61-70 years old. Approximately half of the participants, 50.7%, reported being married and the rest, 49.3%, were not married (see Table 1).

**Table 1**

*Demographic Information on Gender, Age and Marital Status*

| Variable | Frequency | % |
|---|---|---|
| **Gender** | | |
| **Male** | 135 | 48.2% |
| **Female** | 142 | 50.7% |
| **Others** | 3 | 1.1% |
| | | |
| **Age** | | |
| **18-20** | 22 | 7.9% |
| **21-30** | 114 | 40.7% |
| **31-40** | 82 | 29.3% |
| **41-50** | 25 | 8.9% |
| **51-60** | 25 | 8.9% |
| **61-70** | 12 | 4.3% |
| | | |
| **Marital Status** | 138 | |
| **Married** | | 49.3% |
| **Not Married** | 142 | 50.7% |

Table 2 presents the residency status of the participants. Most of the participates, 58.2 %, were born in the USA and 41.8% were foreign-born. From the total participants, 23.2% reported living in the USA for the past 15 years or less, 53.6% reported living in the USA between 16-30 years, and 23.2% reported living in the USA between 31-60 years. For the residency status, 3.9% were on temporary visa, 11.8% were permanent residence, 61.4% were USA citizens, 9.3% were first generation living in the USA, and 13.6% were second generation living in the USA.

**Table 2**.
*Demographic Percentages on Residency in the USA*

| Variable | Frequency | % |
|---|---|---|
| **Born in the USA** | | |
| **Yes** | 163 | *58.2%* |
| **No** | 117 | *41.8%* |
| **Years Living In the USA** | | |
| **0-15** | 65 | 23.2% |
| **16-30** | 150 | 53.2% |
| **31-60** | 65 | 23.2% |
| **Residency Status** | | |
| **Temporary Visa** | 11 | 3.9% |
| **Permanent** | 33 | 11.8% |
| **Residency** | 172 | 61.4% |
| **USA citizen** | 26 | 9.3% |
| **First Generation** | 38 | 13.6% |
| **Second Generation** | | |

*Note: percentage displayed are representative of what was observed and analyzed in the sample*

In terms of education and health insurance, the majority of participants (36.1%) held a bachelor's degree (see Table 3), 3.2% of the participants reported having less than 12$^{th}$ grade education, 21.1% reported having a High School Diploma, 16.1% reported having an Associate Degree, 18.9% reported having a Graduate degree, and 4.6% reported being currently in college. Approximately 83.6% of the participants reported having health insurance, and 16.1% did not have any health insurance,

**Table 3**

*Demographics Percentages for Educational level and Health Insurance*

| Variable | Frequency | % |
|---|---|---|
| **Educational Level** | | |
| **Less than 12th grade** | **9** | **3.2%** |
| **High School** | **59** | **21.1%** |
| **Diploma** | **45** | **16.1%** |
| **Associate Degree** | **101** | **36.1%** |
| **Bachelor's Degree** | **53** | **18.9%** |
| **Graduate Degree** | **13** | **4.6%** |
| **Currently in college** | | |
| **Health Insurance** | | |
| **Yes** | **235** | **83.9%** |
| **No** | **45** | **16.1%** |

*Note:* percentage displayed are representative of what was observed and analyzed in the *sample*

The participants' country of origin varied between the 22 Arabic countries (see Table 4). Most of the population, 13.6%, reported their country of origin as Palestine; 9.3% were from Iraq;, 7.1% from Algeria, 6.4% were from Bahrain; 7.9% were from Djibouti; 7.9% were from Egypt' 2.9% were from Kuwait; 2.9% were from Libya; 1.4% were from Mauritania; 3.2% were from Morocco; 1.4% were from Oman; 1.8% were from Qatar; 5% were from Lebanon; 7.9% were from Saudi Arabia; 1.1% were from Somalia; 0.4% were from Sudan;5% were from Syria; 3.9% were from the United Arab of Emirates; 0.7% were from Yemen; 5.4%were from Jordan; and 5.7% reported as others.

**Table 4**
*Demographic Percentages for Country of Origin*

| Variable | Frequency | % |
|---|---|---|
| **Country of Origin** | | |
| **Algeria** | 20 | 7.1% |
| **Bahrain** | 18 | 6.4% |
| **Djibouti** | 22 | 7.9% |
| **Egypt** | 19 | 6.8% |
| **Iraq** | 26 | 9.3% |
| **Jordan** | 15 | 5.4% |
| **Kuwait** | 8 | 2.9% |
| **Lebanon** | 14 | 5.0% |
| **Libya** | 8 | 2.9% |
| **Mauritania** | 4 | 1.4% |
| **Morocco** | 9 | 3.2% |
| **Oman** | 4 | 1.4% |
| **Palestine** | 38 | 13.6% |
| **Qatar** | 5 | 1.8% |
| **Saudi Arabia** | 22 | 7.9% |
| **Somalia** | 3 | 1.1% |
| **Sudan** | 1 | 0.4% |
| **Syria** | 14 | 5.0% |
| **UAE** | 11 | 3.9% |
| **Yemen** | 2 | 0.7% |
| **Others** | 16 | 5.7% |

*Note:* percentage displayed are representative of what was observed and analyzed in the *sample*

## Correlation Analysis

Pearson product moment correlations were observed to range from low to moderate among all independent variables. Table 5 shows that the independent variable having the highest zero-order correlation with the dependent variable is acculturation (PAS) r = -.47. Overall, zero-order correlations obtained in the matrix suggested the need to further examine each variable's effect on attitudes, controlling for the influence of other variables.

**Table 5**

*Bivariate Intercorrelation Matrix Table for the Predictor/Independent variables and the Dependent/Criterion Variables*

| | **ATSMHS** | **PAS** | **SFSATI** | ***CBMHP*** | **Gender** | **Marital status** | **Born in the USA** | **Health Insurance** |
|---|---|---|---|---|---|---|---|---|
| **ATSMHS** | 1 | -.38** | .37** | .18** | .04 | .22** | .00 | .20** |
| **PAS** | | 1 | -.47** | -20** | -.03 | -.16** | -.24** | -.10 |
| **SFSATI** | | | 1 | .38** | .06 | .17** | .10 | .10 |
| ***CBMHP*** | | | | 1 | .47** | .10 | .02 | .03 |
| **Gender** | | | | | 1 | .14** | -.03 | .002 |
| **Marital status** | | | | | | 1 | .01 | -.05 |
| **Born in the USA** | | | | | | | 1 | .16** |
| **Health Insurance** | | | | | | | | 1 |

*$p < .05$; **$p < .01$; ***$p < .001$

## Inferential Statistics

### Regression Analysis

*RQ1 and H01*: *What demographic variables predict attitudes toward seeking mental health services among Arab American Muslims?*

A multiple regression analysis was utilized to address the relationships between the independent variables (gender, marital status, born in the USA, do you have health insurance) and the dependent variable (attitudes toward mental health services). Multiple linear regression analysis was used to analyze the obtained data. The *H01: There is no relationship between demographic variables and attitudes toward seeking mental health services among Arab American Muslims* was tested. Multiple regression coefficient between attitudes toward seeking mental health services and gender, marital status, born in the USA, and health insurance squared is .10. Thus the multiple linear regression coefficient squared is .10, meaning that about 10% of the total variance in attitudes toward seeking mental health services was accounted for, or explained by, the independent variables or predictor variables and linear combinationas shown on (Table 6).

**Table 6**
*Multiple Linear Regression*

| Model | R | R squared | Adjusted R Squared | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .31 | .10 | .08 | 3.05 |

The *F* distribution was used to test the null hypothesis at the .05 level of significance. The multiple linear regression coefficient between the dependent variable attitudes toward mental health services and the independent variable gender, marital status, born in the USA, do you have health insurance is is .31 $\underline{F} = 7.14$, (df= 4,268) ($p < .05$), see (Table 6 and 7).

**Table 7**

*Multiple Linear Regression between Dependent Variable Attitudes toward Mental Health and the independent variable (gender, marital status, born in the USA, do you have health insurance).*

| Model | | sum of squares | df | Mean Square | F |
|---|---|---|---|---|---|
| **1** | Regression | 264.77 | 4 | 66.19 | 7.14* |
| | Residual | 2486.133 | 268 | 9.28 | |
| | Total | 2750.908 | 272 | | |

*$p < .05$; **$p < .01$; ***$p < .001$

The standardized regression coefficients, or beta coefficients ranged from -.008 for gender to a .235 for marital status. Two variables were significant at the .01 level (Marital status, and health insurance). The other two descriptive variables (Gender and Born in the USA) were not significant at the .05 level (See Table 9). The standardized beta coefficients were explored to

find which predictor among the four predictors and in what amount accounting for the variance (See Table 8). The interpretation of the standardized beta coefficient indicates that marital status and presence of health insurance were significant at the p<.05 level and p<.01 level .

**Table 8**

*Standardized Beta-Coefficients Between the Dependent/Criterion Variable Attitudes toward Mental Health Services and the Independent/Predictor Variables: Gender, Married, Born in the USA, and Do you have health insurance.*

| **Independent variables** | **Standardized Coefficient Beta** | **t** |
|---|---|---|
| **Gender** | -.01 | -.14 |
| **Married** | .23* | 4.00* |
| **Born in the USA** | .03 | -.59 |
| **Do you have health insurance.** | .22* | 3.7* |

*$p < .05$; **$p < .01$; ***$p < .001$

The adjusted multiple regression coefficient is .083. According to these results, the alternative hypothesis is accepted, and the null hypothesis is rejected indicating that there is a statistically significant relationship between demographic variables and attitude toward seeking mental health among Arab American Muslims.

**Null Hypothesis 2 (H02)**

There is no relationship between attitudes toward seeking mental health services and acculturation, religion, and cultural beliefs. The multiple linear regression coefficient between attitudes toward seeking mental health services and acculturation, religion, and cultural beliefs is .44 ($p<.05$) (see Table 9). Thus the multiple linear regression coefficient squared .19, meaning that approximately 19% of the total variance in attitudes toward seeking mental health services was accounted for, or explained by, the independent variables or predictor variables (acculturation, religion, and cultural beliefs) and linear combination, (s ee Table 9).

**Table 9**
*Multiple Linear Regression*

| Model | R | R squared | Adjusted R Squared | Std. Error of the Estimate |
|---|---|---|---|---|
| 1 | .44 | .19 | .18 | 2.9 |

The *F* distribution was used to test the null hypothesis at the .05 level of significance. The multiple linear regression coefficient between the dependent variable attitudes toward mental health services and the independent variable acculturation, religion, and cultural beliefs is .44, $\underline{F} = 19.58$ ($df = 3, 255$, $p < .05$) (see Table 9 and 10).

**Table 10**

*Multiple Linear Regression between Dependent Variable Attitudes toward Mental Health and the independent variable (Acculturation, Religion, Cultural Beliefs).*

| Model | | sum of squares | df | Mean Square | F |
|---|---|---|---|---|---|
| **1** | Regression | 498.20 | 3 | 166.07 | 19.58 |
| | Residual | 2137.51 | 252 | 8.48 | |
| | Total | 2635.72 | 255 | | |

*$p < .05$; **$p < .01$; ***$p < .001$

The standardized regression coefficients, or beta coefficients ranged from .05 for cultural beliefs to a -.25 for religion. Two variables were significant at the .01 level (acculturation, and religion). Cultural beliefs were not significant at .05 level. (See Table 11).

**Table 11**

*Standardized Beta-Coefficients Between the Dependent/Criterion Variable Attitudes toward Menta Health Services and the Independent/Predictor Variables: PAS, SFSATI, and CBMHP.*

| Independent variables | Standardized Coefficient Beta | t |
|---|---|---|
| PAS | -.25 | -3.86*** |
| SFSATI | .24 | 3.53*** |
| CBMHP | .05 | .73 |

*$p < .05$; **$p < .01$; ***$p < .001$

The adjusted multiple regression coefficient is.18. According to these results, the hypothesis is accepted, and the null hypothesis is rejected indicating that acculturation and

religion would have an effect on whether an individual exhibits attitudes seeking toward mental health services.

## Additional Results

To test for the assumption of normality (Kurtosis Test), for the independent variables, the researcher performed an evaluation to determine whether the errors were normally distributed or not (Araiza-Aguilar et al., 2020). The normal distribution has kurtosis equal to zero. This test determines whether the kurtosis of the data is statistically different from zero. The generated histograms (see Figures 1-4) indicate that the data distribution is generally normal, therefore a visual inspection of the histograms is normal, indicating that the variables are normally distributed, and all four histograms indicated a robust correlation to the theoretical quartiles.

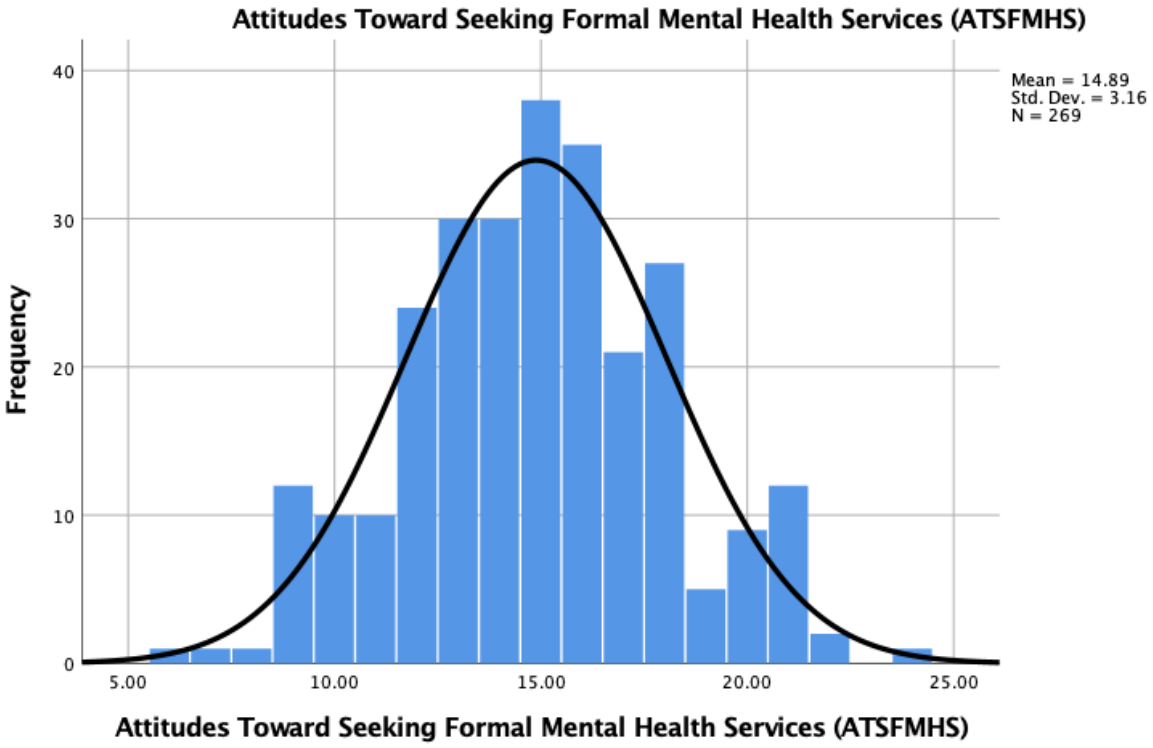


**Figure 1.**

*Normality Histogram for Attitudes toward Seeking Mental Health Services by Frequency*

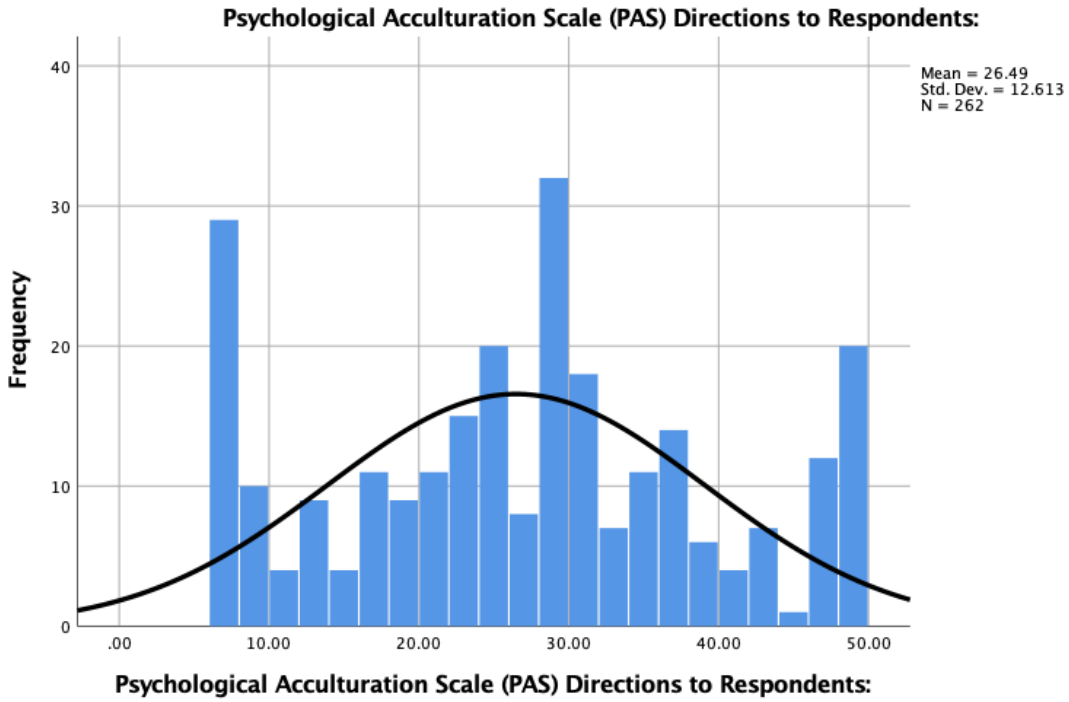


**Figure 2**

*Normality Histogram for Psychological Acculturation Scale (PAS) by Frequency*

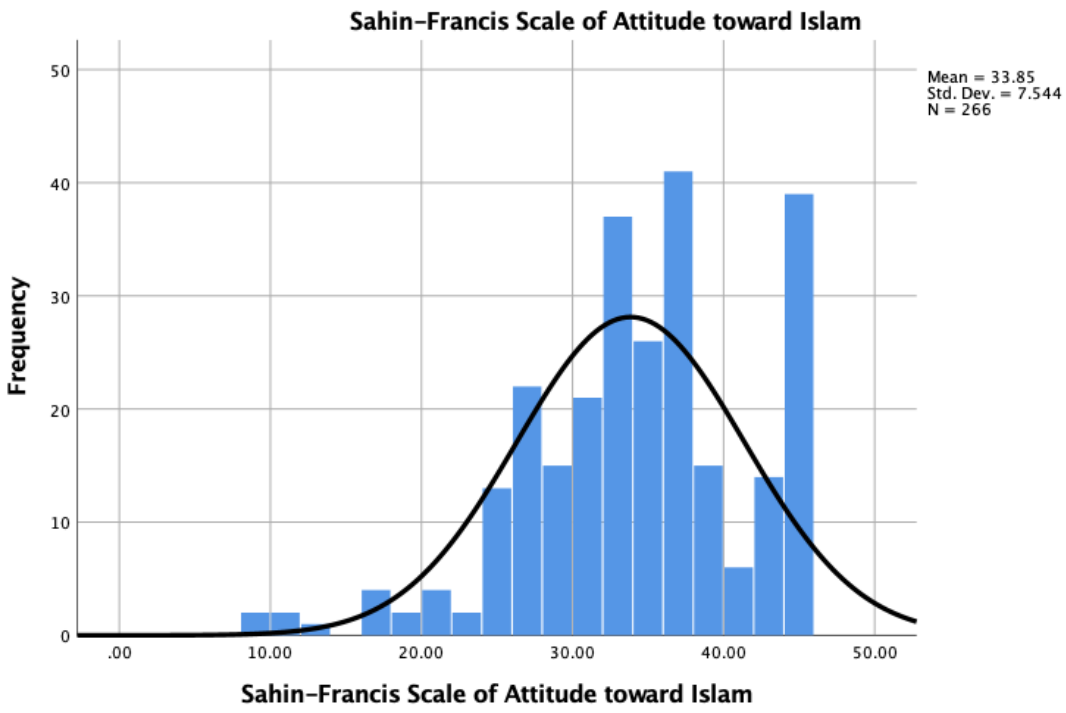


**Figure 3**

*Normality Histogram for Sahin-Francis Scale of Attitudes toward Islam by Frequency*

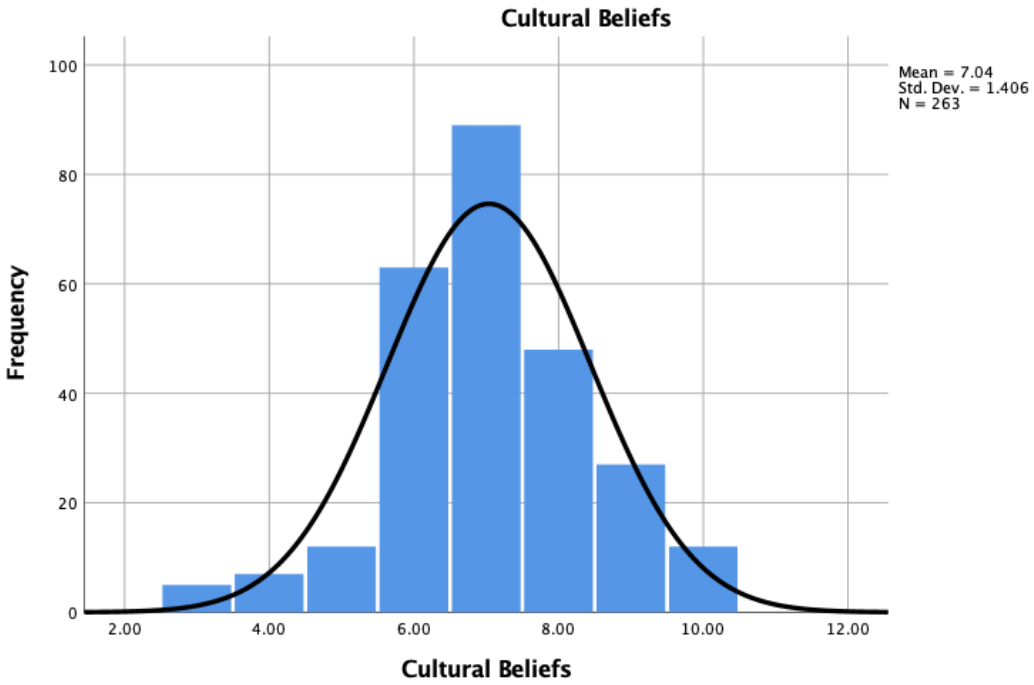


**Figure 4**

*Normality Histogram for Cultural Beliefs By Frequency*

## Summary of Results

A total of 280 individuals participated in this survey. The data analysis and results were presented in this chapter. Several variables including demographics, acculturation, religion, and cultural beliefs were hypothesized to influence how Arab American Muslims seek mental health services. The findings supported both hypotheses. Multiple liner regression was used to test the relationship between help seeking attitudes and acculturation, religion, and cultural beliefs. Additionally, demographic characteristics were tested, two variables were significant (born in the USA, and Do you have health insurance). Therefore, the null hypotheses were rejected. The next

chapter will discuss the findings of each research question and will provide a comprehensive rationalization of all findings conceded from the current study, in addition to limitations. The findings will be compared against earlier studies completed on this subject matter. Finally, implications for clinical rehabilitation practices and recommendations for future research will be presented.

# CHAPTER V

# DISCUSSION

The purpose of this study was to investigate whether acculturation, religion, and cultural beliefs influence the attitudes of individuals who identify themselves as Arab American Muslims toward seeking mental health services. Additionally, this study examined whether some demographic characteristics influence individuals' attitudes towards seeking mental health services. Mental health is perceived differently by various minority populations based on cultural differences and access to mental health services in their countries of origin. In many countries mental illness is highly stigmatized, increasing negative attitudes towards seeking mental health services (Williams, 2014). Exploring acculturation, religion, and cultural beliefs can provide clinicians with knowledge about the impact of these variables on the attitudes towards of Arab-American Muslims toward mental health services. This chapter discusses the findings of each research question relative to the literature field, study limitations, implications for clinical rehabilitation practices, and recommendations for future research.

## Interpretation of the Findings

Research Question 1 focuses on whether there was a relationship between demographic characteristics and attitudes toward seeking mental health services. For this research question, the data indicated statistically significant results ($F = 7.14$; 4,268, $p < .01$). According to these results, the alternative hypothesis was accepted, indicating that there is a statistically significant relationship between demographic variables and attitude toward seeking mental health services

among Arab American Muslims. In addition, significant demographic data found in the study related to marital status and health insurance, as these factors were predictors of attitude towards seeking mental health services. The reason for this is that, like many ethnic groups, finances may serve as a barrier for Arab Americans to recive mental health services. For example, in a study of Iraqi refugees, Vermette and colleagues (2015) reported that the Iraqi refugees sensed that the United states healthcare system appeared to function as a business, rather than as a humanitarian organization. For example, these immigrants had arrived from countries where healthcare treatment had little cost, or nothing at all, to having to pay large sums of money in the United States. In addition, individuals who had Medicaid in the study above could not afford treatment because many healthcare professionals within their travel range would not accept Medicaid. (Reimann et al., 2007; Vermette et al., 2015). Even when Medicaid applications were sent for renewal, sometimes the individual would not hear back for months and would be left wondering about their insurance status (Vermette et al., 2015). In addition, Vermette et al., (2015) found that Arab American participants who were married tended to have health insurance after having a family and providing for their kids.

In a study conducted by Aloud (2004), a low number of visits to mental health practitioners were reported by individuals who had health insurance or access to mental health srvices. Among 281 participants, only 9% had visited a mental health specialist in the past three years. Several expalnations were given for this result, the first being the lack of knowledge and familiarity with mental health services (Abu Ras, 2003; Al-Krenawi & Graham, 2000; Jorm,

2000). Aloud (2004) indicated in his study that Arab Muslim participants tended to have little or no knowledge about available mental health services and the role of its providers. The second reason was the lack of appropriate culturally sensitive mental health services that accommodate Arab and Muslim cultural and religious needs. Lastly, most of the troubled Arab individuals referred themselves to general medical practitioners instead of using mental health providers (Aloud, 2004). These findings appear consistent with other studies conducted within the U.S among Arab immigrants, Arab Americans, or Arab-Muslims (Abu Ras, 2003; Kulwicki et al., 2000; Hague-Kahn, 1997).

The second finding of interest pertains to acculturation, religion, cultural beliefs, and relationship to attitudes toward seeking mental health services. The findings for RQ2-4 are collectively discussed in this section. As shown in Chapter 4, the results of this study suggest that acculturation and religion predict attitudes toward seeking mental health services among Arab American Muslims.

Arab American Muslims have a unique array of acculturation that is outstanding from that of other ethnic and religious groups. Although there is a rich tradition of hereditary connections in Islam, secularization and opposing powers of modernism weaken the significance of traditional values adopted within the Arab and Muslim culture. For Arab Muslims living in the United States, the process of acculturation bestows additional burden and stress. Several studies on the relationship between seeking mental health services and acculturation among Arab American Muslims have supported these findings. In a study conducted by Jadalla and Lee

(2012), acculturation was found to be an important reason in seeking mental health, which supported our finding in this study that acculturation has an impact on seeking mental health services. In contrast, another study by Aprahamian et al. (2011) found that the relationship between acculturation and seeking mental health services within the Arab American population was not significant. Earlier studies report consistent findings of levels of acculturation being linked to attitudes toward seeking mental health services among different ethnic groups (Lee et al., 2009; Shea & Yeh, 2008; Wong et al., 2006; Zhang & Dixon, 2003). Subsequently, insufficient studies have examined the relationship between acculturation and attitudes toward seeking mental health services, specifically among Muslim Arab Americans. Equally, few studies have been done on the relationship between religion and cultural beliefs and attitudes toward seeking mental health services in Arab Americans Muslims.

In this study, we found that religion was significant and influenced the attitudes of Arab American Muslims toward seeking mental health services. In some Arab and Muslim countries, supernatural beliefs about mental health are predominant. Some of these beliefs embrace that mental illness is due to possession by Jinn or evil spirits, black magic, or evil eye (Alrahili etal.,2016). Arab Muslims who believe in supernatural origins may favor a traditional therapeutic treatment known as *ruqyah* (the recitation of specific Qur'anic verses to cure Jinn possession, black magic, or the evil eye and is usually performed by religious healer). In addition, Arab Muslims who have more inclinations for these resources exhibit fewer positive attitudes toward seeking formal mental health and psychological services (Weatherhead & Daiches, 2010). Arab

Muslims might also prefer religious behaviors such as prayer or fasting and reading the Qur'an. Empirical studies suggest that religion has an influential role in the lives of Muslims and their attitudes toward seeking mental health services. Individuals who face stressful issues begin to identify strength in their relationship with God, which may lead them to think positively and may help them to deal with the deleterious impact of mental health issues (Abu-Raiya et al., 2020; Horton & Loukas, 2013).

A study exploring the relationship between religion, stigma, and coping mechanisms toward mental health services reported that religious individuals were more likely to use religion as a coping mechanism, the findings also reported that religion is a critical factor in mental health among Muslim Americans. (Herzig et al., 2013). Although there may be a common belief that individuals who are religous should not have to seek formal mental health services, doing so does not make an individual less religious. Therefore, seeking mental health services can be seen as an additional option to religious coping skills or services. Hence, the interpretations of religious values may have a strong influence on shaping the individuals' attitudes toward seeking mental health services. In addition to the common religious values that Muslims share, they are from different ethnic and cultural backgrounds that structure their worldviews and impact their behaviors. This interplay between religion and attitudes makes Muslim mental health an interesting experience to study (Awaad et al., 2019). However, the relationship between religion and attitudes toward seeking mental health services has been examined in previous research

among Arab American Muslims, therfore, the findings of this study would be consistent with other research findings.

This study did not find cultural beliefs to be a significant factor affecting attitudes toward seeking mental health services among Arab Americans Muslims. While it is possible for Arab Muslims to have specific traditional values and cultural beliefs that influence their attitudes toward seeking mental health services (Al- Adawi et al., 2002; Hague-Kahn, 1997), it m ay be impossible to know which cultural belief or traditional value influences participants when measuring overall attitudes toward seeking mental health services. Fuurthermore, it may be more useful to assess specific cultural and traditional beliefs and attitudes toward seeking mental health services. Since it is acceptable to seek help from primary religious figures, close friends, or family members, seeking help from formal mental health services is still viewed as a potential option if other resources are exhausted. Although there are traditional cultural values that encourage keeping mental health problems contained within the family, the acceptance of seeking mental health services from a different source may be acceptable in some cases.

## Limitations

When interpreting the results of this study, there are important considerations to keep in mind. First, since this study was based on self-report data, the response bias should be considered. The measures in this study used a Likert scale, so participants may have felt inclined to respond in one direction, and possibly provide extreme responses on one side of the scale. Moreover, there is a possibility that participants under-reported or over-reported their responses,

due to feeling pressured to provide socially acceptable responses. Additionally, the motivation of the participant should be considered since it could have impacted the nature of their responses. The methodology used in this study may be a limitation, as participants needed to be able to read the English Language, consequently excluding the data that may have been obtained from those who were unable to participate because of the inability to read English. Further, this study used paper format and online survey, requiring individuals to have access to the Internet, thus limiting the sample to only those who could access the Internet or could have the paper format.

## Clinical Implications for Practice

This research study explores possible contributing factors that may influence Arab-American Muslims' attitude towards seeking mental health services. Due to enduring conflicts in some of the Arabic countries, there has been an increased entry of immigrants to the United States. Many of these immigrants may be experiencing depression, anxiety, immigration related stress, and most importantly, may have experienced trauma in their home countries. The awareness of rehabilitation counselors and mental health counselors regarding stressors and possible mental health disorders among this population would be useful and possibly assist in implementing appropriate interventions addressinh issues related to depressive disorders, anxiety disorders, and even trauma. Therefore, counselors should consider the findings of this study when working with immigrants from the countries of this study's participants. Furthermore, understanding the level of acculturation experiences (assimilation, integration, separation, or marginalization) of individuals from this minority group will enhance the counselor-client

relationship when working with Arab American Muslim clients and promote positive counseling outcomes.

Furthermore, this research can increase the level of knowledge and competence of counselors, affording clinicians the opportunity to provide culturally sensitive services as they modify their treatment plans accordingly. In addition, providing culturally sensitive mental health services will promote and motivate more individuals from this minority group in seeking mental health services. In addition, these findings can be used to educate Arab American Muslims who reside in the United States on the benefits of seeking mental health services and encourage them to adopt more positive attitudes towards the mental health field.

## Recommendations for Future Research

Due to the methodology limitations of this study, a possibly large sample of non-English speakers were excluded due to their inability to read English. Therefore, having translations of the study survey available in Arabic would provide more data. Future researchers should consider a longitudinal study of first generation participants and investigate whether attitudes may change overtime as they assimilate or integrate into a more individualistic society. Additionally, it may be fruitful to ask questions regarding their support system, acculturative stress when first relocating to the United States, the reasons for relocating, and the effect on their traditional beliefs about mental health issues. In addition, researchers should consider additional factors that can affect seeking mental health services, such as knowledge and familiarity with services, lack of language proficiency, limited access to care, lack of understanding or awareness

of metal health services, stigma, financial cost of treatment, fears of being misdiagnosed or misunderstood by rehabilitation counselors, and mistrust of the mental health care system. These barriers may contribute to the patient's mental illness. A research design that investigates these barriers can help rehabilitation counselors as well as the individuals themselves better understand their attitudes towards seeking mental health services. Furthermore, research that aims to appreciate this minority group within the context of mental health has been limited.While this study is limited in findings, it shows the complexity of attempting to understand their attitudes toward seeking mental health services. Furthermore, including Arab Muslim Americans as a subgroup in research is important to fill the gap in existing counseling literature.

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# APPENDIX A

APPENDIX A

## Demographic Survey

1. Gender
   a. Male
   b. Female
   c. Others

2. Age
   a. 18-20
   b. 21-30
   c. 31-40
   d. 41-50
   e. 51-60
   f. 61-70

3. What is your marital status?
   a. Single
   b. Married
   c. Divorced
   d. Widowed

4. Born in the USA
   a. Yes
   b. No

5. Years living in the USA
   a. 0-15
   b. 16-30
   c. 31-60

6. Educational Level
   a. Less than $12^{th}$ grade
   b. High school diploma or equivalent
   c. Associate degree
   d. Bachelor's degree
   e. Graduate degree
   f. Currently in college

7. Please check the category that best describes you.
    a. I have a temporary visa and plan to live in the USA
    b. I have a permanent residency.
    c. I am a USA citizen
    d. First generation (I am the first of my family to immigrate to the USA).
    e. Second generation (I am the first of my family to be born in the USA
    f. Third generation (my grandparents were the first to move to the USA)
    g. Others

8. How do you describe your original nationality (if you are a U.S. citizen, select your father's original nationality)?
    a. Algeria
    b. Bahrain
    c. Djibouti
    d. Egypt
    e. Iraq
    f. Kuwait
    g. Libya
    h. Mauritania
    i. Morocco
    j. Oman
    k. Palestine
    l. Qatar
    m. Lebanon
    n. Saudi Arabia
    o. Somalia
    p. Sudan
    q. Syria
    r. Tunisia
    s. U.A. E
    t. Yemen
    u. Jordan
    v. OTHER (specify)___

9. Level of religiosity
    a. Low
    b. Medium
    c. High

10. DO you have health insurance?

a. Yes
b. No

11. Have you been in therapy before?
    a. Yes
    b. No

12. Has anybody close to you been in therapy?
    a. Yes
    b. No

APPENDIX B

APPENDIX B

**Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS)**

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.

Definitions:

Professional mental health or psychological counseling services (professional help): clinics within the community, hospital, or school where practitioners, such as psychiatrists, psychologists, or clinical social workers, provide professional services to/or work with individuals or families to help overcome mental, emotional, or psychological problems. Psychological or mental health problems are terms used to describe temporary reactions to a painful event (e.g., death in family), stress, or external pressures. These terms are also used to describe long-term psychiatric conditions such as depression, anxiety. Help may take the form of counseling or psychotherapy, drug treatment and/or lifestyle change.

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

1. 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.
   a. strongly disagree
   b. disagrees
   c. agrees
   d. strongly agree

2. A person with strong iman (faith) can get rid of a mental health or psychological problem without the need of professional help.
   a. strongly disagree
   b. disagree
   c. agree
   d. strongly agree

3. Discussing mental health or psychological concerns with a mental health professional is a poor way to solve mental health or psychological difficulties.
   a. strongly disagree
   b. disagree
   c. agree 4
   d. strongly agree

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

a. strongly disagree
b. disagree
c. Agree
d. strongly agree

5. I would seek professional counseling services only if I experienced a psychological problem for a long period of time.
   a. strongly disagree
   b. disagree
   c. Agree
   d. strongly agree

6. If I decide to seek psychological or mental health services, I am confident they would be helpful.
   a. strongly disagree
   b. Disagree
   c. Agree
   d. strongly agree

7. I might need to contact professional mental health or psychological services in the future.
   a. strongly disagree
   b. disagree
   c. agree
   d. strongly agree

8. Most mental health and psychological problems can be solved by an individual himself/herself without the assistance of professionals.
   a. strongly disagree
   b. disagree
   c. agree
   d. strongly agree

9. Considering the high cost of services, I would NOT seek professional help even if I needed it.
   a. strongly disagree
   b. disagree
   c. agree
   d. strongly agree

10. 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).
    a. strongly disagree
    b. disagree
    c. agree
    d. strongly agree

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

    a. strongly disagree
    b. disagree
    c. agree
    d. strongly agree

12. I would rather live with certain mental health or psychological problems than go through the process of seeking professional help.
    a. strongly disagree
    b. disagree
    c. agree
    d. strongly agree

13. Mental health and psychological difficulties, like many things, tend to go away over time.
    a. strongly disagree
    b. disagree
    c. Agree
    d. strongly agree

14. If I decided to seek mental health or psychological help, I would rather contact Muslim professionals than professionals from other groups.
    a. strongly disagree
    b. disagree
    c. Agree
    d. strongly agree

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

a. strongly disagree
b. disagree
c. agree
d. strongly agree

**Psychological Acculturation Scale (PAS)**

Directions to Respondents

This section is aimed at minorities, those who did NOT identify themselves as White (Euro-American). For the 7-point scale given below, the left side (Point 1) is anchored to *My ethnic/cultural group*, and the right side (Point 7) is anchored to *White Anglo American cultural group*. When you answer the questions, please think of your own ethnic or cultural group. For each of the following issues, please use one number from this continuum that best represents how you feel:

| 1 | 2 | 3 | 4 | 5 | 6 | 7 |
|---|---|---|---|---|---|---|
| Mostly my ethnic group Arab) | | | Equally (Or both) | | | Mostly the white Anglo-American cultural group |

1. With which group of people do you feel you share most of your beliefs and values?
2. With which group of people do you feel you have the most in common?
3. With which group of people do you feel the most comfortable?
4. In your opinion, which group of people best understands your ideas (your way of thinking)?
5. Which culture do you feel proud to be a part of?
6. In which culture do you know how things are done and feel that you can do them easily?

7. In which culture do you feel confident that you know how to act?
8. In your opinion, which group of people do you understand best?
9. In which culture do you know what is expected of a person in various situations?
10. Which culture do you know the most about the history, traditions, and customs and so forth?

**Sahin-Francis Scale of Attitude toward Islam**

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

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

   1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

2. I know that *Allah*/God helps me.

   1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

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

   1 = disagree strongly

   2 = disagree

   3 = not certain

4 = agree

5 = agree strongly

4. Attending the mosque is very important to me. 1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

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

   1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

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

   1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

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

   1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

8. *Allah*/God helps me to lead a better life.

   1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

9. I like to learn about *Allah*/God very much.

   1 = disagree strongly

   2 = disagree

   3 = not certain

   4 = agree

   5 = agree strongly

10. Islam means a lot to me.

    1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

11. I believe that *Allah*/God helps people

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

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

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

13. I feel that I am very close to *Allah*/God.

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

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

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

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

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

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

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

17. *Allah*/God means everything to me.

    1 = disagree strongly

    2 = disagree

    3 = not certain

    4 = agree

    5 = agree strongly

18. *Allah*/God is very real to me.

    1 = disagree strongly

    2 = disagree

    3 = not certain

    4 = agree

    5 = agree strongly

19. I think praying/du'a' does no good.

    1 = disagree strongly

    2 = disagree

    3 = not certain

    4 = agree

    5 = agree strongly

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

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

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

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

22. I am happy to be a Muslim.

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

23. I love to follow the life/sunnah of the Prophet.

1 = disagree strongly

2 = disagree

3 = not certain

4 = agree

5 = agree strongly

**Cultural Beliefs about Mental Health problems, their Causes and Treatments (CBMHP)**

Below are statements regarding your belief about mental illness or psychological problems, their causative factors and treatments. Please carefully read each statement and select the response that best describes how true each statement is for you. It is important that you provide a response to each item.

Please select only one response for each statement.

For Example: if you tend to believe that such statement may be true, mark your answer as:

1. __ False 2. __ Probably false 3. _X_ Probably true 4. __ True

1. Mental health or psychological problems can be caused by biological factors (e.g., genetic illness inherited from parents or grandparents).

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

2. Mental health or psychological problems can be caused by environmental factors (e.g., social stress, war experience, etc.).

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

3. Mental health or psychological problems can be caused by "Ajeen"(evil eye).

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

4. Mental health or psychological problems can be caused by "Seher" (magic)

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

5. Mental health or psychological problems can be caused by "Jinn" (spirits).

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

6. Mental health or psychological problems can be treated using professional mental health or psychological counseling services.

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

7. Mental health or psychological problems can be treated using traditional prescribed medicines (e.g., black seed)

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

8. Mental health or psychological problems can be treated using "Ruqia" (Quranic Recitation).

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

9. There are certain mental health or psychological problems that might NOT be treated using mental health or psychological treatment; rather they require "Ruqia" (Quranic Recitation).

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

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

1. __ False 2. __ Probably false 3. __ Probably true 4. __ True

11. Mental health professionals often experience more psychological problems than their patients.

1. __ False 2. __ Probably false 3. __Probably true 4. __ True

BIOGRAPHICAL SKETCH

Dr. Tharwah Alzoubi, PhD., LCSW, LCDC, is a Licensed Clinical Social Worker, and Licensed Chemical Dpendency Counselor. Dr. Alzoubi was born in Jordan to a Palestinian's parents. She earned a bachelor's degree in Nursing from Jordan University of Science and Technology (JUST). She earned a master's in science degree in Social Work May 2018 from University of Texas Rio Grande Valley. She continued pursing her education and career goals while working on her Ph.D. to become a clinical rehabilitation counselor. In December 2022, Dr. Alzoubi attained a doctoral degree in Rehabilitation Services and Counseling from The University of Texas Rio Grande Valley. Dr. Alzoubi is a professional mental health therapist with a specialized background in mental health related to multicultural populations specifically within the Arab Muslim American population. She counseled individuals with mood disorders crisis, trauma, domestic violance, suicide attempts, addictions, and psychotic disorders; she demonstrated leadership within mental health, counseling, and social work with a specialized expertise within rehabilitative services and Latino communities. Dr. Alzoubi's research interests in disability, attitudes toward seeking mental health services, Arab Muslim American, and minority groups.

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