FACTORS AFFECTING ATTITUDES TOWARD SEEKING AND USING FORMAL MENTAL HEALTH AND PSYCHOLOGICAL SERVICES AMONG ARAB-MUSLIMS POPULATION

DOCTORAL DISSERTATION

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ABSTRACT

Despite the increase knowledge and understanding of help-seeking attitudes toward seeking formal mental health services of various minority groups in the U.S., the experience of the Arab-Muslim population has been largely understudied. The dominant Arab-Islamic research suggested individuals’ attitudes toward formal mental health services are rather negative, and that the majority of Arabs and Muslims people tend to have less knowledge about and familiarity with mental health care system.

The purpose of this study was to investigate the attitudes toward seeking and using formal mental health and psychological services among Arab-Muslim population residing in Columbus, Ohio. Four independents variables were selected and tested based on a developed model - Help Seeking Pathways for Arab-Muslim (HSPAM). Three hundreds and sixty survey questionnaires were mailed and distributed to Arab-Muslims residing in Columbus, Ohio via five Arab-Islamic Organizations of which 285 returned and used in Multiple Regression analysis. The results indicated that Arab-Muslim favorable or unfavorable attitudes toward seeking formal mental health services is most likely to be affected by cultural and traditional beliefs about mental health problem, knowledge and familiarity with formal services, perceived societal stigma, and the use of informal-indigenous resources. Implications of these findings for social work practice, mental health research, mental health policy, and local Arab-Islamic Organizations are discussed.
Dedicated to Saleh, Asha, Wafaa, and Rayyan and Feras
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TABLE OF CONTENTS

ABSTRACT.................................................................................................................. ii
DEDICATION.............................................................................................................. iii
ACKNOWLEDGMENTS............................................................................................... iv
VITA............................................................................................................................ v
LIST OF TABLES....................................................................................................... vi
LIST OF FIGURES..................................................................................................... vii

CHAPTERS:

1. INTRODUCTION
   1.1 Background........................................................................................................ 1
   1.2 Rational for the Study....................................................................................... 5
   1.3 The Significance of the Study .......................................................................... 6
   1.4 Research Questions........................................................................................... 8
       1.4.1 Research Question 1................................................................................. 8
       1.4.2 Research Question 2................................................................................. 8
       1.4.3 Research Question 3................................................................................. 8
   1.5 Research Hypotheses....................................................................................... 8
       1.5.1 Hypothesis 1............................................................................................. 8
       1.5.2 Hypothesis 2............................................................................................. 8
       1.5.3 Hypothesis 3............................................................................................. 9
       1.5.4 Hypothesis 4............................................................................................. 9
   1.6 Definitions of Terms........................................................................................ 9
       1.6.1 Mental health professional/Practitioners ................................................ 9
       1.6.2 Formal mental health/Psychological service............................................ 9
1.6.3 Mental health/psychological problem ................................................. 10
1.6.4 Attitudes toward seeking formal mental health services ................. 10
1.6.5 Arab-Muslim individual ..................................................................... 10
1.6.6 Cultural and traditional beliefs about mental health problem .......... 11
1.6.7 Knowledge/familiarity with formal mental health service ............. 11
1.6.8 Perceived societal stigma ................................................................ 11
1.6.9 Help seeking preferences ................................................................. 12

2. REVIEW OF RELATED LITERATURE

2.1 Arab-Muslims’ cultural heritage and religious belief systems ................. 13
2.2 Factors affecting mental health utilization among Arab-Muslims .......... 15
2.2.1 Cultural and traditional beliefs and definition of mental health .......... 15
2.2.2 Knowledge and familiarity with formal mental health care .............. 18
2.2.3 Arab health cultural style ................................................................. 21
2.2.4 Perceived of societal stigma ............................................................. 21
2.2.5 Negative Attitudes and lack of confidence in formal services .......... 23
2.2.6 Preference and Overuse of Indigenous-informal Resources .......... 26
2.2.7 Acculturation Influence ................................................................. 29
2.2.8 Economical factor ......................................................................... 30
2.2.9 Institutional factors ......................................................................... 31
2.3 A Model of Mental Health Help-Seeking Pathways for Arab-Muslim ... .34
2.4 The study’s Theoretical Framework .................................................... 37
2.5 Social Work mental health practices and ethnic minority groups .......... 40

3. METHODOLOGY

3.1 The Study’s Design ............................................................................ 44
3.2 Study’s Participants and Sampling Method ......................................... 45
3.3 Data Collection Procedures ................................................................. 46
3.4 Description of the Research Instruments ............................................. 48
3.4.1 Attitudes Toward Seeking Formal Mental Health Service ............. 50
3.4.2 Cultural beliefs about mental health problem.................................51
3.4.3 Knowledge and Familiarity with Formal Services...............................52
3.4.4 Demographic information sheet .......................................................52
3.5 Method of Data Analysis..........................................................54

4. RESULTS AND DATA ANALYSIS

4.1 Treatment of the Data..........................................................56
4.2 Descriptive Analysis of Participants’ Demographic Characteristics...........57
4.3 Summary of Responses to Research Instruments..................................63
4.4 Multiple Regression analysis......................................................65
   4.4.1 Assumptions of Regression Analysis........................................66
   4.4.2 Examination of the Correlation Matrix.......................................70
   4.4.3 Recording categorical Variables in regression analysis....................71
   4.4.4 Test for significance of the Regression Models.............................73
4.5 Help Seeking Preferences and Selected Demographics.........................79

5. SUMMARY AND INTERPRETATION OF DATA

5.1 Summery of the study..............................................................83
5.2 Major Demographics Findings....................................................85
5.3 Relationships Between Attitude and Study’s Primary Variables..............88
   5.3.1 Cultural and traditional beliefs and help seeking attitudes.............90
   5.3.2 Knowledge and familiarity and help seeking attitudes...............92
   5.3.3 Fear of societal stigma and help seeking attitudes.....................94
   5.3.4 Help seeking preference and help seeking attitudes.....................96
5.4 Arab-Muslim help seeking pattern and preferred resources.....................100
5.5 Arab-Muslim Help Seeking Attitudes and their Actual Behavior.............102
5.6 Implications of the Study findings..............................................104
5.7 Limitations of the study ..........................................................109
5.8 Suggested major area for future research.......................................112

APPENDICES..................................................................................113

LIST OF REFERENCES...................................................................130
# LIST OF TABLES

<table>
<thead>
<tr>
<th>Table</th>
<th>Description</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>Demographic Characteristics of Study’s Participants</td>
<td>56</td>
</tr>
<tr>
<td>4.2</td>
<td>Means, Standard Deviations, and Reliability coefficients of the instruments</td>
<td>59</td>
</tr>
<tr>
<td>4.3</td>
<td>Means and Standard deviation according to demographic breakdown</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>for ATSFMHS, Stigma, CBMHP, KFFMHS</td>
<td>60</td>
</tr>
<tr>
<td>4.4</td>
<td>Correlation Matrix of the study’s Primary Variables</td>
<td>68</td>
</tr>
<tr>
<td>4.5</td>
<td>Hierarchical Regression of attitudes on selected Independents Variables</td>
<td>74</td>
</tr>
<tr>
<td>4.6</td>
<td>Characteristics of Study’s Participants by first preference source of help</td>
<td>77</td>
</tr>
</tbody>
</table>
## LIST OF FIGURES

<table>
<thead>
<tr>
<th>Figure</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>A Model of Mental Health Help-Seeking Pathways and Modifying Factors among Arab-Muslim Populations</td>
</tr>
<tr>
<td>2.2</td>
<td>The Study’s Theoretical Framework: Factors Affecting Arab-Muslim help seeking attitudes toward formal mental health services</td>
</tr>
<tr>
<td>4.1</td>
<td>Scatterplot to test the assumption of linearity between the primary independent variables and attitudes</td>
</tr>
<tr>
<td>4.2</td>
<td>Standardized residual plot against the standardized predicated values when the dependent variable was attitudes</td>
</tr>
<tr>
<td>4.3</td>
<td>Histogram and Normal Probability plot to test the assumption of normality when the dependent variable was attitudes</td>
</tr>
</tbody>
</table>
CHAPTER 1

INTRODUCTION

1.1 Background

The underutilization of formal mental health services has been an ongoing problematic issue within the mental health field. A recent study has shown that only one fourth of individuals in the U.S. who experience mental health difficulties receive care (Pescosolido & Boyer, 1999). Another study estimated that only 8% of the U.S. population attends mental health facilities and seeks professional treatment, even when in need of professional intervention (Algeria, Kessler, & Bijl, 2000).

The problem of mental health services underutilization has been the subject of numerous recent studies among minority groups in the U.S., including African Americans (Alvidrez, 1999; Snowden, 2001), Asian Americans (Cachelin et al., 2001; Leong & Lan, 2001; Kim & Omizo, 2003; Zhang & Dixon, 2003), Latinos (Alvidrez, 1999; Kouyoumdjian, Zamboanga, & Hansen, 200; William & Steven, 2001), and American Indians (Johnson & Cameron, 2001). Several explanations have been proposed for the underutilization phenomenon (Leong, Wagner, & Tata, 1995). These explanations include negative attitudes toward
mental health services and their providers, cultural beliefs related to the cause of mental illness, the social stigma attached to mental illness, inaccessibility and a lack of culturally compatible services, the use of alternative informal resources, and individuals’ unfamiliarity with the existence of formal services. While some researchers focus on the influence of external variables such as affordability, accessibility, or the availability of health services on help-seeking behaviors, others concentrate on the contribution of internal variables such as individuals’ perceptions and their attitudes toward mental health and psychological services and helping professionals.

Researchers have found that a person’s attitudes toward seeking and using formal mental health services can significantly affect the decision to seek out professional services when the symptoms of mental health problems occur (Ajzen, 1988, 1991; Ajzen & Fishbein, 1980; Leong, Wagner, & Tata, 1995; Greenley, Mechanic, & Cleary, 1987). The link between an individual’s attitudes and his or her subsequent behavior can provide much needed insight concerning cultural differences in help-seeking behaviors. It is documented that ethnicity continues to play a role in understating the patterns of mental health services utilization among various ethnic and racial groups in the U.S. (Alvidrez, 1999; Leong, Wagner, & Tata, 1995; Leong & Lan, 2001; Johnson & Cameron, 2001, Snowden, 2001; DHHS, 2001; William & Steven, 2001).

The Arab-Muslim population within the U.S. has been reported to experience and encounter a wide range of cultural, social, and political problems
which clearly indicate increased levels of social stressors and suggest the need to ensure the availability of affordable, accessible, and culturally acceptable health and mental health services for this group. Such issues as cultural adjustment and immigration problems, domestic violence, and child abuse -- all of which are highly correlated with mental health status -- have been reported (Abu Ras, 2003; Farrag & Mammad, 2002; Kulwicki, Miller, & Schim, 2000). Furthermore, the event of September 11 has contributed significantly to the development of emotional and mental health problems – mainly depression and post-traumatic stress disorders – for many Arab individuals (Farrag & Mammad, 2002; Pierre, 2002). A new report by the FBI showed that attacks on Muslim individuals has increased 1,500% in the current year as compared to the year 2000 (Lynn, 2002). Similarly, a survey published by the Council on American-Islamic Relations (CAIR) found that a disproportionate number of Arabs and Muslims have reported discrimination following the attacks of September 11 (CAIR, 2002).

Unfortunately, the representation of Arab-Muslim individuals in the health care system in general and in the mental health care system in particular has not corresponded to the population’s predicted need for services. A review of the literature indicates that Arab-Muslims tend to avoid seeking professional mental health services due to a number of potentially treatable factors (see Al-Krenawi, 2002). One factor underlying the general hesitancy of Arab-Muslims to seek mental health services may be their unfavorable attitudes toward these services and their providers (Al-Adawi et al., 2002; Savaya, 1998, 1995; Hague-
Khan, 1997). Research has shown that individuals who view formal mental
health services favorably is likely to seek them when mental health and
psychological difficulties are presented (Cash, Kehr, & Sclzbach, 1978, Fisher &
care behavior are likely to be influenced by various personal and environmental
in the mental health care setting need to recognize and understand the factors
that may influence or change Arab-Muslims’ attitudes toward the seeking of
formal mental health services. Since Arab and Islamic cultures tend to play a
significant role in shaping an Arab individual’s attitudes and behavior,
particularly when it comes to seeking and using health care, mental health
professionals in general and social work practitioners in particular can gain
much knowledge about their Arab clients by understanding their cultural and
religious values, beliefs, and practices.

The relationship between culture and mental health is of particular
importance to social workers in the mental health field. Green (1999)
emphasized the need to recognize the role culture plays in help-seeking
behavior, particularly among individuals with mental health problems.
Speaking specifically to professional social workers, Green (1999, p. 52) stated
that “despite what appears to be general acceptance of the notion that there are
cultural differences among the people seen by social workers, and that those
differences are important in services relationships, it is surprising to find so little conceptualization within social work about what that means.”

1.2 Rationale of the Study

The primary purpose of this study is to uncover and explore the underlying factors that influence the utilization of mental health services among a sub-set of Muslim population, namely, Arab-Muslims residing in Columbus, Ohio. Because to the best of the researcher’s knowledge there is no existing data on the rate of mental health services utilization by the Arab-Muslim population, the study focuses instead on Arab-Muslim individuals’ attitudes toward the seeking of formal mental health care.

Research on health behavior and help seeking has shown that intention to engage in a particular behavior is a function of the individual’s attitudes toward that behavior and that attitudes are consistent with behavior (Ajzen, 1988, 1991; Ajzen & Fishbein, 1980; 2000). Thus, the attitudinal factor was deemed important in this study and variables related positively or negatively to help-seeking attitudes were considered predictors of the likelihood of formal mental health services utilization.

The current study intends to assess the effect of a) cultural beliefs about mental health problems and their causes and treatment; b) knowledge about and familiarity with mental health problems, mental health services, and mental health professionals; c) the perceived societal stigma; d) help seeking preferences;
and e) selected demographic characteristics on the attitudes of Arab-Muslim individuals toward the seeking and using of formal mental health services.

1.3 The Significance of the Study

The significance of this study is its potential to provide mental health professionals, mainly clinical social workers, with an overview of Arab-Muslims' cultural beliefs, traditional practices, and religious values, along with the potential impact of these beliefs, practices, and values on individuals’ attitudes toward seeking health care in general and mental health services in particular. The study is expected to provide empirical data about the influence of selected factors on Arab-Muslim attitudes, which in turn may impact their utilization of formal mental health services.

This study is warranted for several reasons. First, the study would contribute to the social work profession by examining the issue of barriers to mental health services among a relatively new population in the U.S., a population which exists in a cultural context in which enormous political, economic, and sociocultural changes are operating. Social work practitioners as well as other mental health professionals are expected to add to their practice knowledge base and increase their attention toward the impact of cultural, structural, and personal factors on the seeking of appropriate formal mental health care. Additionally, this study is expected to add to the current cultural competence movement in the social work profession, particularly concerning
practice interventions with the Arab-Muslim population. As many cultural competence theorists propose, social work practitioners’ understanding of clients’ personal and cultural belief systems are of particular importance in providing and practicing successful interventions (Green, 1999; Lum, 1999).

Second, the present study is expected to bring both organizational and governmental attention to mental health problems among the Arab-Muslim population, particularly its new immigrants and deprived refugees, along with the expected underutilization phenomenon that may occur. The city of Columbus has been the choice of residence for many Arab-Muslim families, specifically those of Somalian and Iraqi decent. Consequently, increased demand for appropriate mental health care is observed (ISGC, 2004). Social and mental health policy changes and public attention toward the social and health needs of this neglected population are expected as a result of this study.

Finally, this study intends to provide empirical support for a theoretical model - Mental Health Help-Seeking Pathway for Arab-Muslims (HSPAM) -, which has been theoretically developed but not empirically tested. The study is expected to validate the significant contribution of the model to explain help seeking attitudes and behavior among Arab Arab-Muslim population.
1.4 Research Questions

1. What are the socio-demographic characteristics of the Arab-Muslim population residing in Columbus, Ohio?

2. Among the Arab-Muslim population residing in Columbus, Ohio, which of the following factors best explain individuals’ attitudes toward the seeking and using of formal mental health services: a) cultural beliefs about mental health problems and their causes and treatment; b) knowledge about and familiarity with mental health problems, mental health services, and mental health professionals; c) the perceived societal stigma; d) help seeking preferences, controlling for length of stay in the U.S., gender, age, education, and income?

3. What is the pattern of help-seeking behavior among the Arab-Muslim population residing in Columbus, Ohio? Are there any significant associations between help-seeking preferences and the following factors: gender, age, country of birth, education, socioeconomic status, marital status, nationality, occupation, and type of health insurance plan?

1.5 Research Hypotheses:

Controlling for length stay in the U.S., gender, age, education, and socioeconomic variables,

1. Arab-Muslim individuals with more culturally traditional beliefs about mental health will report less favorable attitudes toward formal mental health services;
2. Arab-Muslim individuals with less knowledge about and familiarity with mental health problems, mental health services, and mental health professionals will report less favorable attitudes toward formal mental health services;

3. Arab-Muslim individuals who perceive higher levels of shame associated with the seeking of formal mental health services will report less favorable attitudes toward formal mental health services;

4. Arab-Muslim individuals who choose informal resources as their most preferred help resource will report less favorable attitudes toward formal mental health services than Arab-Muslim individuals who choose formal resources as their most preferred help resource;

1.6 Definition and Initial Operationalization of Terms

**Mental Health Professionals/Practitioners**

A “mental health professional” is defined as “one who has specialized training and skills in the nature and treatment of mental illness. Mental health professionals include psychiatrists, psychologists, social workers, and members of some other disciplines” (Barker, 1999, p. 299).

**Formal Mental Health/Psychological Services**

“Formal mental health/psychological services” are defined as public and private mental health services staffed with mental health and human service
professionals. Such practitioners as psychiatrists, psychologists, counselors, and social workers are considered “mental health professionals.”

**Mental Health Problems**

The term “mental health problems” is defined as “impaired psychosocial or cognitive functioning due to disturbances in any one or more of the following processes: biological, chemical, physiological, genetic, psychological, or social” (Barker, 1999). The term may be used to describe temporary reactions to painful events (e.g., a death in family), stress, or external pressures. The term is also used to describe long-term psychiatric conditions such as depression or anxiety.

**Attitudes Toward Seeking Formal Mental Health Services**

An “attitude” is defined as “a mental predisposition or inclination to act or react in a certain way” (Barker, 1999). The attitude of individuals regarding the seeking of formal mental health services is defined as those individuals’ perceptions and feelings that cause them to respond either favorably or unfavorably toward the seeking of services or consultation for mental or emotional health concerns.

**Arab-Muslim Individual**

“Muslim” is defined as an individual who follows the religion of Islam and practices its five pillars. An “Arab” is defined as an individual who migrated from, or was born to individuals who migrated from, any country within the
Arab League of the United Nations: Saudi Arabia, Kuwait, Bahrain, Qatar, United Arab Emirates, Oman, Yemen, Jordan, Iraq, Syria, Lebanon, Palestine, Egypt, Sudan, Libya, Tunisia, Algeria, Morocco, Mauritania, Djibouti, Comoros, and Somalia.

**Cultural and Traditional Beliefs About Mental Health Problems**

“Belief” is defined as a state or habit of mind in which trust or confidence is placed in some person or thing (Merriam-Webster, 2004). “Cultural beliefs” are defined in this study as a state of mind characterized in part by a traditional or religious view of the causes and treatment of mental health problems.

**Knowledge About and Familiarity with Mental Health Services**

“Knowledge about and familiarity with mental health service” is defined as the extent to which participants a) acknowledge the role of mental health professionals; b) acknowledge the availability of mental health services within the community and public sectors; c) show familiarity with descriptions of mental and psychological disorders; and d) show familiarity with the intervention and treatment models associated with mental health problems.

**Perceived Societal Stigma**

“Societal stigma” is defined as a mark on an individual, either visible or invisible, that contributes to a negative view of him or her (Fisher & Turner, 1970).
This stigmatizing mark isolates the person having this characteristic from his/her community, marking him or her as somehow deviant. In the case of mental health issues, the utilization of mental health services could be perceived as stigmatizing.

**Help Seeking Preferences**

“Help seeking preferences” are defined as the preferences of Arab-Muslims related to the available resources within the community to whom Arab-Muslims might turn for mental health or psychological interventions. Formal resources such as professional mental health practitioners and family doctors and informal resources such as religious consultants (the Sheik), family members, or close friends are considered as potential sources of help available to Arab-Muslim individuals experiencing mental health problems.
CHAPTER 2

REVIEW OF RELATED LITERATURE

This chapter presents a review of the literature relevant to the purpose of the study. It is divided into four sections. The first section sheds light on the Arab culture’s values and religious beliefs and assesses the impact of these traits on individuals’ views concerning mental health and psychological problem and its treatment. Section two examines the most significant factors that influence Arab-Muslim individuals’ tendency to seek formal mental health care. Section three briefly discusses the study’s theoretical framework, which was developed specifically for this current study. Section four addresses the issue of role of social work practice with individuals of ethno-racial groups.

2.1 Arab-Muslims’ Cultural Heritage and Religious Belief Systems

The classification of the term “Arab” largely refers to individuals living mainly in the Middle East region who share a common language (Arabic) and cultural identity. A person who believes in Islam and Muhammad as his prophet is a Muslim. To the majority of Westerners, Arab and Muslim are synonymous,
but that connection is not necessarily accurate. Among over one billion Muslims scattered all over the world, only 20% share an Arabic identity (Zahr & Hattar-Pollara, 1998). It has been estimated that the number of Muslims currently in the U.S. is around 6 million and that only 12% can be regarded as Arabic (Zahr & Hattar-Pollara, 1998). Arabs have been in the U.S. since the 1890s and their number dramatically increased in the early 1990s as a result of political and economic reasons.

Islam is a major vehicle by which Arab culture is both driven and guided. Nearly 90% of the Arab population believe in Allah as God and Muhammad as Messenger (Zahr & Hattar-Pollara, 1998). Islam is considered both a religion and a complete way of life and guides individuals’ thought process, family roles, and child raising practices, to name but a few. The Quran, Muslim Holy Book, is viewed as the primary guide for individual behavior and is referred to as the source of ethics and values determining a person’s attitude and relationship with others. In Muslim society, guidelines are taught in both formal and informal settings and children receive most of the attention, particularly those in early ages.

In Arab-Muslim communities, the family is the central and most prominent social unit and thus loyalty to the family is religiously and culturally valued. In order to understand any culture, particularly Arab culture, family structure should be considered an important element. Arabs are born into
extended families that value relationship and use it to accomplish daily life activities and reach goals throughout their lifespan (Abudabbeh & Aseel, 1999; Al-Krenawi & Graham, 2003). It is within this extended family system that an individual experiences security, emotional support, and belonging. It is also within this system that an individual obtains a sense of identity.

2.2 Factors Affecting Mental Health Utilization Among Arab-Muslims

Contemporary Arabs mental health literature has revealed that Arab patients tend to underutilize health services in general and mental health services in particular. This phenomenon has been attributed to some extent to the fact that Arab individuals’ cultural sensitivity and strong religious beliefs substantially influence their attitudes and behavior toward mental health services. A number of potential factors affecting Arab-Muslim individuals’ health care seeking behavior are presented in this section.

2.2.1 Cultural and Traditional Belief / Definitions of Mental Health Problems

The influence of culture on mental health has been studied extensively, particularly among ethnic and minority groups in the U.S. (Cachelin et al., 2001; Kim & Omizo, 2003; Zhang & Dixon, 2003; Kleinman, 1992; DHHS, 2001; Green, 1995 William & Steven, 2001; ). One perspective shared by mental health researchers interested in the topic is that culture establishes not only what
constitutes an illness, but also the response to that illness (Kleinman, 1987). Thus, what may be considered a mental health problem requiring professional treatment in one society may be seen simply as a routine hassle of daily living in another (Green, 1995). Evidently, then, a person’s perception of and response to mental health/psychological problems is greatly swayed by his or her society’s cultural, religious, and traditional norms, values and beliefs.

Among Arab-Muslim individuals, cultural and religious formation, attribution, and conceptualization play an important role in identifying one’s mental health or psychological problem and selection of specific services. Thus, Arab-Muslims often tend to attribute mental illness primarily to possession by supernatural entities such the demons “Jinn”; the evil eye “Nathla”; or the magic “Seher” (Al-Adawi et al., 2002; Al-Issa, 2000; Al-krenawi, Graham, Kandah, 2000; Al-Subaie and Al-Hammed, 2000).

Al-Adawi and his colleagues (2002) examined attitudes toward mental illness in the gulf country Oman. Four hundred sixty eight survey respondents comprised three populations; medical students (37%), relatives of psychiatric patients (13.8%), and the general public (49.4%) responded to the study. Al-Adawi et al., found no association between attitudes toward people with mental illness and selected demographic factors (gender, age, education, marital status, and experience with mentally ill individuals). However, the study found that the majority of participants tend reject the genetic explanation for mental illness and
rather attribute the cause of mental illness to spirits. The study concluded with the suggestion that cultural and traditional beliefs about the cause of mental illness be altered with more education and exposure to general mental health services.

Al-Krenawi, Graham, and Kanduh (2000) investigated the utilization of mental health services among a sample of 87 (male = 61, female = 26) non-psychotic mental health outpatients in Zarka, Jordan. The study’s objective was to assess the extent to which Arab-Muslims differ in their seeking and use of formal biomedical services based on their gender. The study showed no difference between men and women in terms of their actual use of formal mental health services. Nevertheless, these Arab individuals tended to attribute mental illness to the evil eye, magic, or envy and the majority favored informal resources and traditional healing over biomedical services. The study also found that older individuals, less educated people, and females tended to attribute mental illness to the evil eye more than any other subgroup.

It is also common for Arab-Muslims to believe that mental illness is caused by Allah, either as a punishment for sins or as a test. This belief leads individuals to tolerate the disease, subjecting themselves to Allah’s will, which may inhibit their use of treatment. The belief in Allah’s control and wisdom is assumed to persuade Muslim individuals who suffer from mental illness to be tolerant, considering the “test” as a reflection of Allah’s mercy. In sum, beliefs
about the causes of mental health/psychological problems may influence patterns of help seeking and response to treatment among individuals from Arab and Muslim backgrounds. That is, these individuals’ traditional beliefs may lead to the underutilization of formal mental health services along with the overuse of informal, cultural and traditional healing methods.

2.2.2 Knowledge About/Familiarity with Formal Mental Health Care

An additional antecedent believed to impact Arab Muslims’ attitudes toward the seeking of formal mental health services involves individuals’ misperceptions regarding the onset of mental illness and formal mental health services, along with a lack of familiarity with professional providers. In Arab-Muslim societies, it is commonly believed that a person is healthy as long as he or she lives normally, interacts with others within community, and meets personal and family needs. Among the majority of individuals, general medical care and mental health services are only considered when these responsibilities can no longer be performed effectively.

In many Eastern cultures, including the Arab culture, concepts of health pertain primary to physical health, and, unlike in Western cultures, distinctions between physical and psychological health are not widely common (El-Islam, 1994; El-Islam, 1982; El-Islam & Ahmed, 1971). Arab-Muslim literature reveals that Arab-Muslim clients do not distinguish emotional or psychological distress
from physical illness and that the majority of populations tend to somatize their illness (El-Islam, 1982; El-Islam & Abu Dagga, 1971; Okasha, 1999; Al-krenawi & Graham, 2000; Al-krenawi, Graham, & Kandah, 2000). Somatization disorders -- in which the client expresses an emotional disorder in the presentation of physical symptoms -- are among the most highly prevalent mental health problems among Arab-Muslim patients (Okasha, 1999; Okasha & Okasha, 1999; Al-Issa, 2000; Al-Subaie and Alhammed, 2000).

The fact that Arab-Muslim individuals usually express their mental illness in physical symptoms has been attributed to cultural factors. Al-krenawi and Graham (1999) found that Arab patients tend to strongly believe that mental illness is best treated through traditional or religious healing services and this belief correlated negatively with individuals' perceptions and attitudes toward formal mental health services. That is, the more that beliefs about mental illness were traditional, the higher the use of indigenous treatment within the Arab community.

Arab-Muslims’ reluctance to seek formal help has also been linked to their lack of familiarity with the formal health care system. In her recent study, Abu-Ras (2003) examined factors influencing social services utilization among Arab immigrants experiencing domestic abuse in Dearborn, Michigan. The study utilized a cross sectional survey and interview schedule with 67 Arab women who were victims of partner abuse. The study showed that among the most
significant barriers to selection of formal services was the lack of knowledge about existing services and their providers. Approximately 93 percent of the women who responded to the survey reported having no knowledge about how existing services work. Similarly, Al-krenawi and Graham (1999) found that Arab individuals had a difficult time differentiating between mental health practitioners (e.g., psychiatrists vs. psychologists vs. clinical social workers) and the type of services offered by these professionals (e.g., medication, psychotherapy, or counseling).

By the same token, Arab-Muslims have also been found to demonstrate less familiarity with contemporary Western models of treatments such as psychotherapy (Erickson & Al-Timimi, 2001; Al-krenawi, 2002, Al-krenawi, Graham, & Kandah, 2000). Erickson and Al-Timimi (2001) argued that one major barrier to the seeking of formal mental health services by Arab Americans is the fact that the majority of these individuals “lack of experience with Western counseling approaches” (p. 315). Even among Arab-Muslim mental health practitioners, Western approaches are not widely practiced and if they are utilized, they are usually integrated with Islamic approaches to therapy (Al-Issa, 2000). Thus, it is not surprising that Arab-Muslims tend to utilize informal methods of treatment that are more closely tied to cultural values and Islamic beliefs.
2.2.3 Arab Health Cultural Style

Arab health style is another factor that may affect formal health services utilization and individual’s tendency to toward help seeking. That is, although Arabs experience mental health and psychological difficulties, seeking help for these problems may rank very low on their list of priorities (Dwairy, 1998). Broadly speaking, Arab-Muslims tend to tolerate mental health problems for along time before considering any formal or informal intervention (Abudabbeh & Aseel, 1999; Dwairy, 1998; Kulwicki, Miller, & Schim, 2000). This has been attributed to the traditional cultural value which views individuals’ complaints about pain as negative a aspect of their personalities (Abudabbeh & Aseel, 1999; Dwairy, 1998; Savaya, 1998). Only when the problem becomes unbearable so Arab-Muslims seek outside help and intervention (Al-Krenawi and Graham, 2000; Al-Krenawi, Graham, & Kandah, 2000; Dwairy, 1998). This cultural value and other traditional habits have become less popular among modern Arab-Muslim individuals, but their underlying influence still remains, particularly among older generations (Hague-Kahn, 1997). For individuals who are highly acculturated, this may not be an issue.

2.2.4 Perceived Societal Stigma

Assuming that individuals are interested in seeking out formal mental health services, other barriers abound that may prevent them from doing so.
Social stigma is probably the single largest hidden contributor to the burden that mental illness imposes on many individuals (DHHS, 2001). It impacts individuals, families, societies, professionals and institutions alike. Mental disorders are conditions of which Arab-Muslim people highly disapprove, and traditional Arab beliefs tend to regard the seeking of mental health services and the consumption of psychiatric medications as shameful actions (Abudabbeh & Aseel, 1999; Abu Ras, 2003, Al-Adawi et al., 2002). Hence, mental health problems are generally undisclosed due to the fear of stigmatization, which often affects the social standing of the family and the integration of individuals within the community.

Influenced by traditional cultural values, Arab individuals are forced to deal with their problems by themselves and seek help only from their family members (Abudabbeh & Aseel, 1999). Thus, some Arab individuals consider it shameful and inappropriate to acquire help with psychological and social problems from outsiders. Abu Ras (2003), investigating barriers to services utilization among abused Arab immigrant women, found that nearly 70% of respondents reported feelings of shame and 62.7% reported feelings of embarrassment associated with the seeking of formal services. Al-Krenawi, Graham, and Kandah (2000) theorized that the shame experienced by Arab individuals in relation to the seeking of formal mental health services might
convince them to delay treatment or seek less stigmatizing traditional methods to overcome the problem.

Not only the individual patient, but also his or her family might attach a stigma to the utilization of formal mental health services (Abudabbeh & Aseel, 1999; Abu Ras, 2003; Al-Subaie and Alhammed, 2000). In the Arab community, family reputation is considered as highly important and the attachment of mental illness to one member often affects both the individual’s and his/her family’s status within the community. Al-Subaie and Alhamad (2000) claimed that Arab persons often deny the existence of mental health problems because they think the problem may shame their families as well as affect their individual well being within their community. Al-Krenawi (2002) explained that the pattern of seeking and acquiring formal mental health services among Arab individuals is highly influenced by the social stigma attached to psychiatric and mental health services. According to Al-Krenawi, Arab cultural views about psychiatric symptoms often attach a deep sense of shame and stigma to the patient, which affects his/her social status within the community.

2.2.5 Negative Attitudes/Lack of Confidence in Formal Services and Providers

Arab-Muslim attitudes and perceptions of mental health services and professional providers have been also linked to the underutilization of formal service and low help seeking pattern within Arab-Muslim community. Research
has revealed that Arab-Muslim tend to hold negative attitudes toward formal mental health and psychological services (Al-Adawi et al., 2002; Al-krenawi & Graham, 2003, 2000, 1999; Haque, 1997; Savaya, 1998, 1995). Conversely, Arab-Muslim individual tend to hold positive attitudes toward informal traditional and religious services.

Negative attitudes and evaluation of formal services has been linked to other external factors such as cultural belief of mental illness and wide social acceptability of indigenous treatments and services. For example, cultural beliefs about the cause of mental illness often negatively affect individuals’ tolerance of, and tendency toward the care and evaluation of, psychological problems and mental illness (Al-Adawi et al., 2002; El-Islam, 1994; El-Islam, 1982; El-Islam & Abu Dagga, 1992; El-Islam & Ahmed, 1971). Hence, the negative attitudes Arab-Muslims hold toward mental health services and their limited familiarity with formal services and practitioners may discourage their utilization and use of formal services and encourage their silence about mental illness.

Al-Krenawi and Graham (2000) argued that clients of ethnic Arab origin tend to mistrust and thus underutilize formal mental health services because of the negative attitudes they hold toward both the services and the professionals who provide them. The authors stated “although there were some expectations, based on the level of education and the degree of acculturation, it could be assumed that the majority of Arab clients view mental health services in a

24
negative light, and consequently the use of formal mental health services is limited” (p. 15). This negative attitude often causes the majority of individuals who experience psychological problems to seek other alternative community services such as religious healing or traditional treatment. Al-Krenawi (2002) explained that because a great proportion of mental health professionals were trained in and apply Western interventions that are not compatible with Arab cultural and religious values, Arab individuals tend to hold negative attitudes toward mental health professionals, and conversely have positive perceptions about informal traditional and religious healing systems.

Erickson and Al-Timimi (2001) pointed out that Arabs’ attitudes toward the seeking of professional services are most likely to be affected by their beliefs that formal services are ineffective and that mental health specialists are sought only by “crazy people.” The authors concluded that in order to alter the resistance to seeking formal mental health services among the Arab population, mainstream mental health professionals need to utilize some traditional techniques and collaborate effectively with indigenous practitioners. According to Erickson and Al-Timimi, the adaptation of indigenous methods is assumed to increase trust toward mainstream professionals and increase the use of their treatment models.
2.2.6 Arab-Muslims’ Preference and Overuse of Indigenous-Informal Resources

The notion that health care utilization patterns might vary significantly due to religious practices and the role of spirituality has been observed by many leading health services researchers (for review see Preston, Levin, & Schiller, 1988). Green (1995), seeking to develop a help-seeking model for ethnic and racial groups, argued for the importance of accounting for individuals’ cultural and religious practices with regard to the seeking and using of formal human services. Likewise, Mechanic (1972) has explained how an individual’s religious practices and values influence his/her illness behaviors and help-seeking patterns.

Research among the Arab-Muslim population shows that traditional and religious healers play a major role in the primary mental health care received by this population (Al-Subaie and Alhammed, 2000, Al-Issa, 2000; Al-Krenawi, 2002, Al-Krenawi, Graham, Kandah, 2000; Al-Krenawi and Graham, 2000, 1999). These studies reported consistently that Arab-Muslim individuals often seek traditional or religious intervention before making formal contact with primary health and mental health care providers. Since the majority of the Arab population are Muslim, researchers have argued that it is likely that Arab patients would tend to seek and use informal health care resources, particularly religious and traditional healing, or “Rugia”, as opposed to seeking formal interventions (Al-Subaie and Alhammed, 2000; Al-Issa & Al-Subaie, in press).
Arab-Muslims have shown that they prefer consultation with the Sheik (religious consultant) or Mata’wa (traditional healer) when emotional or mental health difficulties are experienced (Al-Krenawi and Graham, 2003, 2000, 1999; Al-Issa & Al-Subaie, in press; Al-Subaie and Alhamad, 2000). Savaya (1998) studied help seeking processes among 242 Arab women in Israel who were seeking professional help for psychological problems. According to Savaya’s study, Arab women preferred to visit traditional healers or consult with religious leaders more than they preferred professional practitioners. Findings among Arab and Muslim populations about the overuse of informal resources seemed to attribute this pattern of use to the fact that traditional healers and religious leaders live in the individuals’ community, share their worldview, make no labeling diagnoses, and use brief and spiritual treatments. Therefore, Arabs’ reliance upon informal resources and their overutilization of traditional and religious services might be a possible barrier to the accessing and use of formal health services.

Another significant variable that often determines whether an Arab-Muslim individual with mental or psychological problems seeks or does not seek formal services involves the availability of a caring family and friendship networks. Help-seeking literature refers to this dimension as the “social network influence,” and there have been numerous studies that assessed the impact of this factor on individual help seeking patterns (Heaney & Israel, 2002). Arab and Muslim individuals often live in extended families where emotional support,
psychological help, and financial assistance are provided (Al-Krenawi and Graham, 2003, 2000, 1999). Usually, individuals seek outside help only when the family is no longer able to control the situation. Even when outside help is sought for mental and psychological difficulties, Arab individuals rely on community resources such as friends and relatives. Again, formal mental health services are seldom sought and are often considered to be a last resort (Abudabbeh & Aseel, 1999; Al-Krenawi & Graham 2003, 2000, 1999; Savaya, 1998).

In his review of mental health services utilization among Arab populations, Al-Krenawi (2002) stated that the Arab-Muslim people’s behaviors related to help seeking for mental health and psychological reasons are arranged in a hierarchical pattern. First, individuals seek help from family members; next, they seek help from close friends or traditional healers; and lastly, they seek help from general medical doctors. It is only when the first two strategies fail that Arab individuals seek out formal mental health services. In sum, because Arab-Muslim individuals tend to live in extended family environments and are often surrounded by supportive social networks, mental health professionals may not be considered as primary sources of help for emotional and psychological problems.
2.2.7  Acculturation Influences

For individuals residing in host countries, the acculturation factor may serve to increase the likelihood that such individuals would seek and use formal mental health services. The influence of acculturation on attitudes toward seeking mental health and psychological helps has been well documented in the literature (Cachelin et al., 2001; Kim & Omizo, 2003; Kouyoumdjian, Zamboanga, & Hansen, 2001; Zhang & Dixon, 2003. In recent published study, Zhang and Dixon (2003) found a significant relationship between acculturation level and students attitudes toward seeking psychological professional help among Asian international students in the U.S.

In her qualitative study that assessed Muslim women’s attitudes toward mental health, Haque-Khan (1997) found that although Muslim women in general were less likely to seek assistance for emotional and psychological problems, the less acculturated women were much less likely to seek services than were the highly acculturated women. Other barriers linked to associated with individuals level of acculturation such as lack of language skills have also been observed to impact Arab-Muslim patients’ decision to seek and access formal mental health care (Al-Krenawi, 2002; Kulwicki, Miller, & Schim, 2000; Savaya, 1998; Haque-Khan, 1997).
2.2.8 Economic Factors

Economic and policy literature have repeatedly suggested that a major factor that determines the use of health services in general and mental health care in particular is the extent to which individuals have financial resources. Data reflecting the impact of economic factors are inconsistent across the field of mental health services research, particularly among mental health economists. In his recent paper, Mechanic (2002, p. 8) stated “insurance coverage is probably the most significant factor affecting whether persons with need receive appropriate care”. The Mental Health Surgeon Report (DHHS, 2001) has concluded that there was a high and significant correlation between an individual’s socio-economic status and his or her access to and utilization of formal mental health services.

Not surprisingly, financial status has also been found to influence the seeking and utilization of formal mental health services among Arab-Muslim individuals (Al-Krenawi, 2002; Savaya, 1998, 1995; Kulwicki, Miller, Schim, 2000). Kulwicki, Miller, and Schim (2000) examined health behavior among Arab-Americans in Dearborn, Michigan, using a qualitative research approach. Focusing on individual and group interviews, the authors detected various themes which identified several personal, structural, and economic barriers to the seeking and using of general health services. Lack of ability to pay was found to be a major obstacle to the seeking of formal medical services. In study
conducted by the Arab Community Center for Economic and Social Service (ACCESS) in Michigan, Mustafa (2001) reported that about 20% of Arab families have an average income that is below the federal poverty level.

Often self-employed or employed in low paying jobs with minimal benefits, the majority of the Arab-Muslim population in the U.S. tends to be without health insurance coverage. Lack of health insurance or inadequate health coverage is often associated with low economic and educational status. Thus, Arab-Muslim persons experiencing mental health/psychological problems are more likely to postpone treatment or seek less expensive services provided by family (lay consultation) or community members (traditional healing).

### 2.2.9 Institutional Factors

One particular reason for the difficulties Arab-Muslims might experience in acquiring adequate mental health care involves the fact that they are seriously underrepresented in the health care system (Al-krenawi & Graham, 2003; Erickson & Al-Timimi, 2001; Kulwicki, Miller, & Schim, 2000; Hague-Khan, 1997; Savaya, 1998). The limited numbers of Muslim professionals or even community volunteers working in mental health facilities may lead many individuals experiencing mental health/psychological problems to postpone treatment or seek informal support.
Likewise, the lack of knowledge about Arabic culture and Islamic teaching by non-Muslim health practitioners, particularly in the area of mental illness, has led an unknown but perhaps sizable number of mentally ill persons to acquire alternative resources of service (Kulwicki, Miller, & Schim, 2000). This point has been noted by Jafari (1993), who argued that the sensitivity of American Muslims to this situation is thought to make practicing Muslims -- although open to counseling in general -- reluctant to go to Western practitioners because they feel the counselors will not understand their values and instead try to impose Western values.

Lack of transportation may also increase the difficulties that Muslim groups encounter when seeking mental health care. With many individuals experiencing significant poverty and low socio-economic status, limited transportation could be a major factor in reducing the numbers of Arab-Muslim individuals who access formal care systems. Kulwicki, Miller, and Schim (2000) argued that one major factor that might minimize the number of Arab patients within U.S. health care facilities involves the fact that many lack transportation, language skills, and health insurance.

Lastly, another significant factor may involve the paucity of culturally appropriate approaches within U.S. human services agencies. Kulwicki, Miller, and Schim (2000), discussing the existence of health care barriers among Arab-Americans, claimed that U.S. health care systems lack so-called “culturally
competent services.” The authors concluded that it is imperative to implement culturally compatible approaches in order to increase Arab individuals’ utilization of services. Mental health services utilization research has shown significant outcomes when such approaches were used among various ethnic and racial minority groups within the U.S. (Sue, Fujino, & Takeuchi, 1991; Lum, 1999, Takeuchi, Uehara, & Maramaba, 1999). Thus, it can be hypothesized that the lack of culturally competent approaches may be one reason for negative attitudes toward the seeking of formal mental health services among Arab-Muslim minority groups in the U.S.

In sum, Arab-Muslim attitudes toward the seeking of formal mental health services are likely to be affected by cultural and traditional beliefs about mental health problems; lack of knowledge about and familiarity with mental health problems, their treatment, and their treatment providers; negative beliefs about the effectiveness of formal services; feelings of shame associated with utilizing professional help; and lastly, the tendency of Arab-Muslim individuals to seek informal resources and rely on indigenous healers. Arab-Muslims might also be deterred from seeking formal intervention due to socio-economic realities and organizational obstacles. These and other factors seem likely to explain conceptually the tendency of Arab-Muslim clients to underutilize formal mental health care.
2.3 A Model of Help-Seeking Pathways for Arab-Muslims

This study will employ a model of the Mental Health Help-Seeking Pathways of Arab-Muslims (HSPAM; see Figure 2.1) - proposed by the researcher- as a theoretical framework to identify the role of Arab and Islamic cultures (including beliefs, values, and norms) on the Arab-Muslim tendency toward the seeking/using of mental health and psychological services. Limited research among the Arab-Muslim population shows that individuals’ tendency toward seeking and accessing formal mental health facilities is often influenced by cultural or religious dimensions (Al-Adawi et al., 2002; Al-Subaie & Alhamad, 2000; Al-Issa, 2000; Haque-Khan, 1997). The HSPAM model was mainly developed based on previous help-seeking theories and models (Cauce et al., 2002, Wills & Depaulo, 1991; Goldsmith, Jackson, & Hough, 1988; Kadushin, 1969). The model is also informed by literature on the mental health services utilization and help-seeking behaviors of Arab-Muslim populations (Al-Adawi et al., 2002; Al-Krenawi, 2002; Al-krenawi & Graham, 2003, 2000, 1999; Al-Krenawi, Graham, & Kandah, 2000; El-Islam, 1994; El-Islam, 1982; El-Islam & Abu Dagga, 1992; El-Islam & Ahmed, 1971; Kulwicki, Miller, & Schim, 2000 Haque-Khan, 1997; Savaya, 1998, 1995).

The HSPAM model proposes that Arab-Muslim individuals, upon discerning that they are experiencing mental health/psychological problems, tend to go through three identifiable stages: 1) problem awareness and
recognition; 2) the decision to seek help; and 3) services selection. The model theorizes that an afflicted Arab-Muslim individual tends to encounter a wide range of personal, professional, and organizational obstacles when passing through these theoretical stages, which in turn may prevent him/her from seeking the proper help. For example, in the first stage (problem awareness and recognition), Arab-Muslims’ help-seeking pattern is likely to be influenced by such factors as cultural and religious definitions of mental illness, individuals literacy of mental disorders and their treatment, and the Arab health style.

In the second stage (the decision to seek help), Arab-Muslim ambivalence toward the seeking of formal mental health services can be a result of such factors as the societal stigma associated with mental illness, negative attitudes and lack of confidence toward formal services and their providers, and the availability of alternative (family, community networks) resources. In the last stage (service selection), Arab-Muslims’ help-seeking patterns are likely to be influenced by their tendency to use indigenous informal resources, particularly family and religious resources (Ruqia); a lack of awareness of available formal services; acculturation influences; as well as economic and institutional barriers.
Figure 2.1: A Model of Mental Health Help-Seeking Pathways and Modifying Factors among Arab-Muslim Populations
Finally, Arab cultural practices and Islamic teachings are proposed to have broad influences on all of the HSPAM model’s dimensions to a lesser or greater extent. Likewise, demographic characteristics are theorized to indirectly affect Arab-Muslim help seeking behavioral patterns at each stage. It is important to emphasize that the current model is set to be an exploratory model developed based on current Arab and Muslim mental health literature. Further studies are needed in order to assess the significant contribution of HAPAM to explain Arab and Muslim help seeking attitudes and behaviors toward seeking and using formal mental health or psychological counseling services.

2.4 The Study’s Theoretical Framework

Because of the comprehensiveness of the HSPAM model, which requires several studies to affirm its validity, an adapted version (see Figure 2.2) - which is considered the theoretical framework for the present study - was designed. In this new model, help seeking stages were collapsed into one single stage (help seeking attitude) and four variables were selected and assessed based on contemporary Arabic and Islamic mental health literature. It is important to note that the new model examines only the attitudinal dimension -- individuals’ tendency to seek formal mental health services – which is only one of three dimensions in the help-seeking behavior equation. Even though it has been argued that other variables (see Figure 2.2) such as perceived needs for services
or structural and demographic barriers are also significant predictors of help seeking behavior, it was decided that the assessment of their effects to be carried out in further research.

The following factors are assessed in the adapted model: selected demographics (length of study in the U.S., gender, age, educational attainment, and socioeconomic status), cultural beliefs about mental health/psychological problems (stage one), knowledge about and familiarity with formal mental health services (stages one and three), negative attitudes toward seeking formal mental health services (stage two), perceived societal stigma associated with the seeking of formal mental health services (stage two), the use of informal and traditional healing resources (stage three), and acculturation influences as represented by length of stay in the U.S. (stage three). It is the researcher hope that further investigation of other proposed factors would be carried out to validate the overall significance of HSPAM model.
Figure 2.2: The Study’s Theoretical Framework: Factors Affecting Arab-Muslim Attitudes Toward Formal Mental Health Services
2.5 Social Work Mental Health Practices and Ethnic Minorities

The roles of social work direct practice interventions in the mental health setting have been evident. Social work practice can be distinguished from the other mental health disciplines such as psychiatry, psychology, and medical sociology in the extent to which direct efforts are made toward the recognition of client, family, and environmental factors in clinical intervention. Social work has also moved further to emphasize the non-hierarchical collaborative relationship where the client is considered an equal partner.

Unlike other mental health disciplines, which mainly emphasize the role of psychotherapy, clinical social work practice utilizes a wide range of tools in helping a mentally ill person overcome his/her problem. These include teaching and modeling life skills, integration of family and the significant other in the therapeutic process, linking and integrating agency services in the interest of the client, and locating community resources.

The multicultural movement has positively impacted the field of social work as well as other disciplines in the areas of assessment, practice, and research. Social work practitioners are committed to the values of their profession to consider, develop, and practice suitable intervention models to better serve their culturally diverse clientele. Proponents of social work multiculturalism have criticized the use of psychiatric-psychological oriented approaches with clients of different cultural and diverse groups because they
lack the effectiveness and feasibility with these neglected populations (Lee, 1996; Al-krenawi & Graham, 2000, Al-krenawi, 2002). A new social work practices method devoted specifically to ethnic and racial clients has been developed.

The most recent, effective, and culturally valid social work approach in working with clients from different ethnic and racial backgrounds is called “Cultural Competence Practice.” Although cultural competence is a new concept in the social work profession, it has been developed as a result of long professional practice interventions with clients of different racial and ethnic identities. With the encouragement of the National Association of Social Work (NASW) and Council of Social Work Education (CSWE), several cultural competence models have started to emerge in the profession. These include A Multi-ethnic Approach (Green, 1999), Cultural Competence Attainment Model (McPhatter, 1997), and Culturally Competent Practice (Lum, 1999).

Lum (1999) defined “Cultural Competence” in social work as the ability to understand the dimensions of culture and cultural practice and to apply them to clients and their cultural-social environment. He further argued that social work practice with people of color and various ethnic groups has evolved from ethnic-sensitive approaches, to cultural awareness, to cultural diversity, and recently to cultural competence in the past two decades. The cultural competence practice model, according to Lum (1999), focuses on four areas: 1) social work practitioners’ personal and professional awareness of clients’ ethnic and racial
identity, 2) social work practitioners’ knowledge of culturally diverse practice, 3) the skill development in working with culturally diverse clients, and 4) practitioners’ inductive learning and knowing.

With respect to the impact of cultural competence in the area of help seeking behavior and human services utilization, Green (1999) argued that social workers explore the help seeking behavior of clients. He claimed that ethnic minority clients have their own approach of acquiring and receiving services, which often stems from cultural and religious values and teachings. According to Green (1999), culture and oftentimes religious traditions determine how problem is defined, prioritized, and treated. Without understanding and accounting for these influences, social workers cannot know what type of intervention and assistance clients may be seeking and what type of help would be compatible with their cultural views and religious laws. Green (1999) proposed that while social work practitioners are the main target of this approach, agencies and human services organizations should also be examined for cultural compatibility.

Research has proven the effectiveness of Cultural Sensitive Approach to enhance the formal services utilization. Sue et al. (1991) found that therapist-client matching was associated with length of treatment for Asian American, African American, and Mexican American clients. Takeuchi et al. (1999) reviewed empirical studies that show the relationship between ethnic and
language matching and decreases in dropout rates and increases in the use of formal services by different cultural and ethnic clients. The study concluded that the use of ethnic-specific mental health services centers is significantly related to more use of formal services, less dropout of the first session, and higher function scores at discharge.
CHAPTER 3

METHODOLOGY

The present study sought to assess the effect of a) cultural beliefs about mental health problems and their causes and treatment; b) knowledge about and familiarity with mental service; c) perceived societal stigma; d) help seeking preferences; and e) selected demographic factors on the attitudes of Arab-Muslim individuals toward seeking and using formal mental health services.

This chapter sets forth the study’s research methods. The following sections describe the design of the study, respondents’ characteristics and the method by which respondents were selected, the study’s data collection procedures, the research instruments used, and the study’s data analyses.

3.1 Study Design

This is an exploratory, descriptive-associational study that examines the underlying factors that influence Arab-Muslims’ attitudes, and perhaps their actual behavior, toward seeking and using formal mental health care. To the best of the researcher’s knowledge, this study is the first to quantitatively assesses
Arab-Muslim help seeking attitudes controlling for the effect of cultural beliefs; individuals knowledge and familiarity about mental health; Societal stigma; help seeking preferences; and selected demographic characteristics. Thus, the utilization of an exploratory, descriptive research design was deemed appropriate.

Descriptive-associational research has been used widely to assess individuals’ perception and utilization of professional mental health services, particularly among ethnic and racial minority populations (Kim & Omizo, 2003; Zhang & Dixon, 2003; Savaya, 1998; Huge-Khan, 1997). Descriptive-associational research offers advantages such as efficiency in data collection and the facilitation of objectivity in data analysis and interpretation.

3.2 Study Participants and Sampling Method

The present study involved a population of Arab-Muslims living in the U.S. The target population included Arab-Muslim community residents and college students residing in Columbus, Ohio, during October 23 – November 23, 2003. The accessible population included Arab-Muslim individuals associated with five Islamic organizations providing religious, social, political, and educational services within Columbus.

The study utilized a non-probability, convenience sampling method to recruit research participants. The snowball sampling strategy was deemed appropriate since the researcher is well known to most of the Islamic
organizations in the city of Columbus, while he is not familiar with all Arab-Muslim individuals in the area.

Although a random sample was desired in order to strengthen the generalizeability of the findings, a compromise was reached between the non-representative random sampling method and the fairly representative non-random convenience sample. Because of the uniqueness of this type of research among this population, and because of the lack of complete demographic data on the Arab-Muslim population living in Columbus, the researcher employed a non-random sampling method to select the study participants. To increase the generalizeability of the findings, the study sample was restricted to individuals who are 18 years old or older, identify as Arab-Muslim, and currently live in Columbus, Ohio.

3.3 Data Collection Procedures

A total of 360 questionnaires were distributed via five Islamic non-profit community organizations as follows: a) 160 through the Islamic Society of Greater Columbus (ISGC); b) 110 through the Counsel on American-Islamic Relations (CAIR); c) 25 through the Islamic Foundation of Central Columbus (IFCO); d) 30 through the African Refugees Cultural and Educational Center (ARCEC); and e) 35 through the Iben-Timiah Masjed. The ISGC served as the primary site for recruitment purposes because it is the largest Islamic organization serving Muslim individuals in Columbus, providing services
through three facilities: the Aumr-Ibn Alkatab Mosque, the Sunrise Academy, and the Muslim Student Association. To ensure the accurate assessment of the total number of returned questionnaires, each survey packet was coded and each returned envelope was numbered. Two hundred eighty five participants responded to and returned the study questionnaire and the overall response rate was approximately 79%.

The researcher first contacted administrators in each organization described above and asked for their permission to conduct the study (see Appendix F). The purpose, plan, and implications of the study were clearly explained to each organization’s leadership before their assistance with survey distribution was requested. Administrators and selected participants voluntarily helped distribute and collect the questionnaires from Arab-Muslim individuals who were members or attendees of these organizations. Except for CAIR, which used mail service to distribute the study packets, all questionnaires were distributed individually by organization administrators or participant volunteers. In order to insure an acceptable response rate, a cover letter explaining the purpose of the study and its implication to Arab and Muslim community in Columbus was attached to each instrument (See Appendix A) and an Islamic cassette tape (a Quran recitation) was provided as an incentive.

The Ohio State University Human Subjects Protocol, which sets forth research ethics concerning individuals’ personal data, was strictly followed to
ensure confidentiality. The Internal Review Board’s approval of the survey research was obtained prior to the data collection process (See Appendix G). The survey questionnaire contained no questions that could directly or indirectly identify a respondent. All respondents received a cover letter prior to their participation which informed them that their participation was voluntary and that there would be no personal, political, economic, or other consequences for refusing to participate. Return of the questionnaire by respondents indicated voluntary consent to participate in the study. Again, only those Arab-Muslim individuals who were eighteen years of age or older were invited to participate in the study.

3.4 Description of the Research Instruments

Developing a valid research instrument was an integral aspect of the study because of the lack of standardized instruments assessing Arab-Muslims’ cultural beliefs about mental health problems, knowledge about and familiarity with mental health services, and help-seeking attitudes related to mental health problems. The construction of the questionnaire was informed by existing literature on help-seeking and mental health services utilization among Arab and Muslim populations.

Several procedures were followed in developing the research instrument. First, informal focus group discussions regarding attitudes toward and
perceptions of mental health, cultural beliefs about mental health, and knowledge of mental health problems were utilized on two occasions with 25 individuals from the Arab-Muslim community in Columbus. The outcomes were informative and as a result several items were adopted and included in the final version of the questionnaire. A panel of experts from The Ohio State University, Arab-Muslim professionals within the community, and Arab-Muslim mental health professionals working in the U.S. were also consulted to evaluate the cultural and content validity of the instrument. Next, the instrument was pilot tested with a sample of 20 Arab-Muslim respondents prior to the data collection process as a way to obtain feedback regarding the instrument’s clarity, readability, format, and length. Lastly, suggested changes were incorporated and the final vision of the questionnaire was administered.

The initial plan was to construct an additional Arabic version of the questionnaire, but examination of the target population’s education level indicated an acceptable level of spoken English among this group, which suggested administration of the instrument in English. However, Arabic and Somali translations were provided in a few situations to a few participants. Such translations were in response to inquiries about various terms and concepts.

The 57-question survey was divided into four sections: a) attitudes toward seeking and using formal mental health/psychological services; b) cultural beliefs about mental health/psychological problems; c) knowledge about and
familiarity with formal mental health services; and d) a demographics sheet that also inquired about the potential sources of help Arab-Muslims might seek when experiencing mental health difficulties.

3.4.1 Section I: Attitudes Toward Seeking Formal Mental Health Services

Fischer and Turner (1970) developed the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH) to facilitate the exploration of the relationship between help-seeking attitudes and personality variables. Because of its high established validity (.89) and reliability (.86) in assessing individuals’ beliefs and attitudes and because it is the most widely used instrument in exploring help-seeking attitudes among ethnic and racial minority groups, an adapted version of the ATSPPH was developed. The Attitude Toward Seeking Formal Mental Health Service (ATSFMHS) instrument was constructed based on a Likert-type scale (1 = Strongly Agree, 2 = Agree, 3 = Disagree, 4 = Strongly Disagree). Comprehensive revision was made to account for Islamic and Arabic terms and concepts and to make it understandable by ordinary Arab-Muslim participants. For example, a question in the ATSPPH reading “A person with a strong character can get over mental conflicts by himself, and would have little need of a therapist,” was changed in the ASFMHS to read “A person with strong IMAN [faith] can get rid of a mental health or psychological problem without the need of professional help.” In addition, five
supplemental items (items 3, 6, 11, 14, and 18) were added in (ATSFMHS) instrument to assess the perceived societal stigma associated with seeking and using formal mental health/psychological services (see Appendix B). Reliability analyses conducted separately on each set of items yielded Cronbach’s Alphas of .74 (ATSFMHS) and .72 (stigma items), respectively.

3.4.2 Section II: Cultural Beliefs About Mental Health Problems

This instrument was developed specifically for the present study to assess the influence of cultural, traditional, religious beliefs about the causes and treatment of mental health/psychological problems among Arab-Muslim people. The instrument consists of eleven Likert-type items (0 = False, 1 = Probably False, 2 = Probably True, and 3 = True). Two items, “Mental health or psychological problems can be caused by biological factors (e.g. genetic illness inherited from parents or grandparents” (item 21); and “Mental health or psychological problems can be caused by environmental factors (e.g. social stress, war experience, etc.” (item 22) were reverse-scored to test the consistency of participants’ responses. A reliability analysis of all items yielded a Cronbach’s Alpha of .73 (see Appendix C).
3.4.3 Section III: Knowledge About and Familiarity with Formal Mental Health Service

This instrument was developed specifically for the present study to examine the extent to which Arab-Muslims are familiar/unfamiliar with the types of mental health/psychological problems, For example, whether they recognize classified medical/behavioral mental health or psychological disorders such as depression, anxiety, schizophrenia, etc. The section also examined respondents’ familiarity with the role of various practitioners in mental health settings, the location of and means of contacting local formal mental health providers, and common formal mental health interventions. The section consists of eleven Likert-type items (1 = Not at All, 2 = Very Little, 3 = Somewhat, and 4 = Very Familiar). A reliability analysis conducted on all items yielded a Cronbach’s Alpha of .88 (see Appendix D).

3.4.4 Section IV: Demographic Information Sheet

This section contains 12 questions that assessed basic demographic information (e.g., gender, age, length of stay in the U.S.) and respondents’ previous use of formal services for both psychical health concerns and mental health problems. The following questions asked respondents about their prior use of formal physical/mental health services (see Appendix E): “In the past three years, approximately how many times have you visited a medical doctor
for a physical health concern?”; and “In the past three years, approximately how many times have you visited a mental health professional (psychiatrist, psychologist, or a clinical social worker) for a mental health or psychological concern?”

Respondents’ help seeking preferences were assessed via three items (items 55, 56, and 57) related to potential help resources individuals may utilize if they perceive a need for mental health/psychological care. These items were designed to tap religious, family, community, and professional resources. These items’ scores were transformed via dummy coding to include this categorical variable help seeking preferences in the regression analysis.
3.5 Data Analysis

The Statistical Package for the Social Sciences (SPSS v 12.0) was used to analyze the study’s data. Descriptive statistics, including frequency distributions, measures of central tendency, and measures of variability, were employed to describe the sample’s primary characteristics. These characteristics include demographic factors such as gender, age, education level, socioeconomic status, etc.

Apart from the preliminary analysis, a correlational procedure was also conducted to describe associations (relationships) among the demographic characteristics and primary factors. Correlations (Pearson’s $r$) among the attitude variable; cultural beliefs about mental health problems and their causes and treatment; knowledge about and familiarity with mental health problems, mental health services, and mental health professionals; the perceived societal stigma associated with mental health problems or their treatment; preferred help resources; and selected demographic variables were computed and tentatively analyzed.

A multivariate approach (standard hierarchal multiple regression analysis) was conducted to predict the best determinants of Arab-Muslims’ attitudes toward the seeking and using of formal mental health services. The dependent variable (ATSFMHS) was regressed on various combinations of primary variables, including: selected demographic variables (gender, age,
educational level, income, and length of stay in the U.S. (Block I); cultural and traditional beliefs about mental health problems (Block II); knowledge about and familiarity with formal mental health service (Block III); the societal stigma associated with mental health problems or their treatment (Block IV); and help seeking preferences (Block V). F-tests were computed to determine the significant, cumulative variances explained by each single model. Similarly, t-tests were conducted to determine the relative importance and contribution of each single predictor in the regression equation over and above other variables.

Lastly, chi-square analysis was conducted to assess whether there were relationships between help seeking preferences and the demographic variables: gender, age, education, income, nationality, occupational status, and type of health insurance coverage. Chi-square product moment correlation was used to determine the significance of the associations among the variables.
CHAPTER 4

RESULTS AND DATA ANALYSIS

The present chapter contains the results, data analysis, and interpretation of the data obtained in this study. This chapter is organized as follows: a) the first section illustrates the initial treatment of the data; b) the second section provides a descriptive statistics of participants’ demographic characteristics; c) the third section summarizes participants’ responses to the research instrument; d) the fourth section presents the study’s multiple regression analysis; and e) the fifth section discusses the relationship between selected demographic variables and respondents’ help seeking preferences for mental health/psychological help.

4.1 Treatment of the Data

All data analyses were executed using the Statistical Package for the Social Sciences (SPSS v 12.0). Prior to hypotheses testing, the variables a) gender; b) age; c) education; d) income; e) length of stay in the U.S.; f) cultural beliefs about mental health problems; g) knowledge about and familiarity with formal mental health service; h) perceived societal stigma; and i) attitudes toward the seeking
and using of formal mental health services were examined for accuracy of data entry, missing data, and whether the variables satisfied the assumptions of regression analysis. Four cases were removed from the study based on their nationality (two were Native American, one was African, and one was Asian). Hence, 281 participants were included in the study.

4.2 Descriptive Analysis of Participants’ Demographic Characteristics

Descriptive statistics were generated on all demographic/background variables obtained from the 281 Arab-Muslim participants who responded to the survey. In summary, of the 281 participants, 60.5% were male and 38.8% were female (n=279). Participants’ average age was 35 years (SD=11.4, range=18-78). Most subjects (91.5%) were foreign-born, while only 7.8% were born in the U.S. The majority of the subjects (n=279) identified as Somali (29.5%), while 20.6% identified as Palestinian and 12.1% identified as Egyptian. The remaining participants were divided among all of the remaining Arab nationalities. Interestingly, almost every Arabic country was represented in the sample.

With regard to respondents’ educational level, 8.2% had less than a high school education, 23.8% had completed or were currently enrolled in high school, 13.5% had achieved or were currently seeking an associate’s degree, 29.2% had achieved or were currently seeking a bachelor’s degree, 14.9% had achieved or were currently seeking a master’s degree, and only 9.6% indicated that they had
achieved or were currently seeking a Ph.D. degree (n=279). Socioeconomic status occurred disproportionately, with the category $30,000-$39,000 being the median point. Of 277 participants, 19.9% reported their income above $70,000, 18.5% reported their income as between $20,000-$29,000, 17.1% reported their income as between $10,000-$19,000, and 12.5% reported their income as less than $10,000, while the remaining participants were almost equally divided among the remaining income categories.

With regard to the level of general health care utilization, 28.5% reported having sought help for physical concerns 3-5 times, 27.8% reported having sought help 1-2 times, 22.8% reported having sought help more than 5 times, and only 19.9% reported having sought no help in the past three years (n= 278). Inversely, only 9.6% of respondents reported that they had visited a mental health practitioner at least one time in the past three years. Approximately 89% indicated that they had not visited a mental health practitioner in the past three years (n=276).

Approximately 50% of respondents reported that they had commercial health insurance, while 5.7% reported that they had a Medicare plan, 20.6% reported having a Medicaid plan, and 22.1% reported having no health insurance at all (n=276). Most (24.8%) respondents’ occupations were classified as professional or technical, while 22.1% were students and the rest were equally
distributed as housewives (10.1%), office employees (10.7%), manual workers (10.1%), or small business owners (10.3%).

Note that not all respondents provided complete demographic information. Since the number of incomplete responses was small and since such responses initially appeared to be randomly scattered across the demographic variables, no further examination was made to determine the randomness of the missing data.
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4.3 Summary of Responses to the Research Instrument

Tables 4.2 and 4.3 summarize participants’ responses to the research instruments and list the instruments established reliability coefficients. Arab-Muslims on average endorsed generally less favorable attitudes (2.36, SD=.37, range=1.20-3.33) toward the seeking and using of formal mental health services. Participants reported a moderate level of cultural and traditional beliefs about mental health problems (mean=2.41, SD=.48, range=1.27-3.45), significant feelings of shame associated with the seeking of help for mental health problems (mean=2.76, SD=.55, range=1-4), and low levels of knowledge about and familiarity with mental health problem, formal services and professional providers (mean=2.02, SD=.62, range=1-3.91).

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<td>2.02</td>
<td>.62</td>
<td>1.00 - 3.91</td>
<td>281</td>
<td>.88</td>
</tr>
</tbody>
</table>

Table 4.2: Means, Standard Deviations, and reliability coefficients of the study’s instruments.

¹ Attitudes toward the seeking/using of formal mental health services; higher scores indicate more favorable attitudes toward the seeking of formal help.
² Perceived societal stigma; higher scores indicate more feelings of shame associated with the seeking of formal help.
³ Cultural beliefs about mental health problems, causes and treatment; higher scores indicate more adherence to cultural explanations for mental health problems.
⁴ Knowledge about and familiarity with mental health problems, services and professionals; higher scores indicate more awareness.
### Table 4.3: Means and Standard deviation according to demographic breakdown for ATSFMHS, STIGMA, CBMHP, KFFMHS.

<table>
<thead>
<tr>
<th>Variable</th>
<th>ATSFMHS⁴</th>
<th>STIGMA²</th>
<th>CBMHP³</th>
<th>KFFMHS⁴</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>N</td>
<td>Mean</td>
<td>SD</td>
<td>Mean</td>
</tr>
<tr>
<td>Total</td>
<td>277</td>
<td>35.52 (5.72)</td>
<td>13.83 (2.78)</td>
<td>26.56 (5.28)</td>
</tr>
<tr>
<td>Gender</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>169</td>
<td>35.51 (5.87)</td>
<td>13.83 (2.86)</td>
<td>26.86 (5.47)</td>
</tr>
<tr>
<td>Female</td>
<td>109</td>
<td>35.55 (5.45)</td>
<td>13.85 (2.64)</td>
<td>26.17 (5.02)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18-25</td>
<td>55</td>
<td>34.40 (5.29)</td>
<td>13.63 (2.51)</td>
<td>28.89 (4.35)</td>
</tr>
<tr>
<td>26-35</td>
<td>98</td>
<td>35.25 (5.88)</td>
<td>14.03 (2.73)</td>
<td>26.91 (4.93)</td>
</tr>
<tr>
<td>36-45</td>
<td>77</td>
<td>36.09 (5.20)</td>
<td>13.76 (3.02)</td>
<td>25.35 (5.48)</td>
</tr>
<tr>
<td>+46</td>
<td>43</td>
<td>36.30 (6.38)</td>
<td>13.88 (2.86)</td>
<td>25.11 (6.11)</td>
</tr>
<tr>
<td>Education</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High School/Less</td>
<td>90</td>
<td>34.55 (5.80)</td>
<td>14.02 (2.81)</td>
<td>28.87 (4.35)</td>
</tr>
<tr>
<td>Associate's/Bachelor's</td>
<td>119</td>
<td>35.89 (5.48)</td>
<td>13.71 (2.67)</td>
<td>26.57 (5.00)</td>
</tr>
<tr>
<td>Master's/Ph.D Degree</td>
<td>69</td>
<td>36.17 (5.86)</td>
<td>13.82 (2.93)</td>
<td>23.61 (5.52)</td>
</tr>
<tr>
<td>Income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0,000 – 19,000</td>
<td>83</td>
<td>34.00 (5.46)</td>
<td>13.91 (2.69)</td>
<td>29.15 (4.40)</td>
</tr>
<tr>
<td>20,000 – 39,999</td>
<td>78</td>
<td>36.08 (5.30)</td>
<td>13.87 (2.77)</td>
<td>27.42 (4.76)</td>
</tr>
<tr>
<td>40,000 – 69,000</td>
<td>60</td>
<td>35.81 (5.36)</td>
<td>13.40 (2.98)</td>
<td>25.10 (4.84)</td>
</tr>
<tr>
<td>+ 70,000</td>
<td>55</td>
<td>36.69 (6.64)</td>
<td>14.12 (2.72)</td>
<td>23.05 (5.33)</td>
</tr>
</tbody>
</table>
4.4 Multiple Regression Analysis

The selection of the independent variables and the order in which they were entered into the regression analysis was based on a prior model (HSPAM). Four variables were selected and tested on their effect on help seeking attitude toward formal mental health service (see the study’s theoretical framework, Figure 2.2). These independent variables were: a) cultural and traditional beliefs about mental health problems; b) knowledge and familiarity with formal mental health services; c) perceived societal stigma; and d) help seeking preferences.

Demographic characteristics (gender, age, education, and socioeconomic status, length stay in the U.S) were treated as controlled variables rather than predictors in the regression analysis.

Hierarchical regression analysis was selected to address the study’s second research question: “Among the Arab-Muslim population residing in Columbus, Ohio, which of the following factors best explain individuals’ attitudes toward the seeking and using of formal mental health services: a) cultural beliefs about mental health problems and their causes and treatment; b) knowledge about and familiarity with mental health problems, mental health services, and mental health professionals; c) perceived societal stigma; d) help seeking preferences., controlling for length of stay in the U.S, gender, age, education, and income?”
4.4.1 Assumptions of Regression Analysis

Before the data was analyzed in regression analysis, it was first examined to determine if any of regression analysis assumptions have been violated. For the regression analysis to be accurate, the data requires to be examined for violation of three assumptions: a) the assumption of linearity, b) the assumption of Homoscedasticity, and c) the assumption of normality.

To test the assumption of linearity, residual plots of the attitudes data and partial regression plots for each primary independent variable were generated (see Figure 4.1). Examination of the residual plots indicated no systematic variation of the error terms for any level of any independent variable. Similarly, violation of linear scatter was not observed in any of the partial regression plots.

To test the whether the observed variance was constant, standardized residual values were plotted against the standardized predicted values (see Figure 4.2). Again, no systematic deviations from the response plane and no systematic variation of the error terms for predicted values were observed. The results indicated that the assumption of Homoscedasticity was not violated.

Lastly, the assumption of normality of error term distribution was assessed using a histogram of the residuals and a normal probability plot test (see Figure 4.3). Visual inspection of two plots showed that error term distribution closely resembled a normal pattern. The results indicated that the assumption of normality was not seriously violated.

66
Figure 4.1: Test of the assumption of linearity between the primary independent variables and attitudes toward seeking/using formal mental health services
Figure 4.2: Standardized residual values vs. standardized predicted values with the dependent variable being attitudes toward seeking/using formal mental health services
Figure 4.3: Test of the assumption of normality with the dependent variable being attitudes toward seeking/using formal mental health services
4.4.2 Examination of the Correlation Matrix

An intercorrelational matrix was generated which displays the zero-order correlation coefficients and their statistical significance for all variables examined in the regression analysis (see Table 4.4). Mean and standard deviation scores are also presented. Pearson product moment correlations were observed to range from low to moderate among all independent variables. The last row in the correlation matrix was examined for purposes of the present study. Table 4.4 shows that the independent variable having the highest zero-order correlation with the dependent variable is help seeking preferences - seeking help from formal resources - \((r = .46)\), followed by perceived societal stigma \((r = -.33)\), cultural and traditional beliefs about mental health problem \((r = -.31)\), and knowledge about and familiarity with formal mental health service \((r = .25)\).

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. Such investigation requires the use of Multiple Regression Analysis. In light of HSPAM model, which suggests that steps in the help-seeking process occur in sequence, Hierarchical Multiple Regression Analysis was utilized to determine the unique contribution of each variable in equation.
4.4.3 Recording Categorical Variables in the Regression Analysis

As was previously mentioned, demographic variables were treated as controlled variables rather than predictors in the regression analysis, so initially transformation (dummy coding) was not utilized for any variable in this set. However, dummy-coding method was used to add the categorical variable (help seeking preferences) into the regression analysis. The original six help resource categories were first collapsed into three: formal sources (mental health practitioners, family doctors), informal sources (the Sheik, family members, close friends), and no preferred help. Then, because few respondents indicated that they had no preferred help resource, only the formal help resources (coded = 1) and informal help resources (coded = 0) categories were included.
<table>
<thead>
<tr>
<th>Variables</th>
<th>X1</th>
<th>X2</th>
<th>X3</th>
<th>X4</th>
<th>X5</th>
<th>X6</th>
<th>X7</th>
<th>X8</th>
<th>X9</th>
<th>Mean</th>
<th>SD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender (X1)¹</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age (X2)</td>
<td></td>
<td>.17**</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td>35</td>
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<td>Education Level (X3)²</td>
<td></td>
<td></td>
<td>.23**</td>
<td>.21**</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>4</td>
<td>1.45</td>
</tr>
<tr>
<td>Annual Income (X4)³</td>
<td></td>
<td></td>
<td></td>
<td>.03</td>
<td>.22**</td>
<td>.49***</td>
<td></td>
<td></td>
<td></td>
<td>3</td>
<td>2.47</td>
</tr>
<tr>
<td>Length of Stay in the U.S. (X5)</td>
<td></td>
<td>.06</td>
<td>.42**</td>
<td>.22**</td>
<td>.58***</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>11.7</td>
<td>9.7</td>
</tr>
<tr>
<td>Cultural Beliefs (X6)</td>
<td></td>
<td></td>
<td>-.06</td>
<td>-.26**</td>
<td>-.37**</td>
<td>-.42**</td>
<td>-.41**</td>
<td></td>
<td></td>
<td>2.41</td>
<td>.48</td>
</tr>
<tr>
<td>Knowledge/Familiarity (X7)</td>
<td></td>
<td>-.03</td>
<td>.20**</td>
<td>.28**</td>
<td>.20**</td>
<td>.25**</td>
<td>-.29**</td>
<td></td>
<td></td>
<td>2.02</td>
<td>.62</td>
</tr>
<tr>
<td>Perceived Societal Stigma (X8)</td>
<td></td>
<td>-.00</td>
<td>.03</td>
<td>.00</td>
<td>.00</td>
<td>.02</td>
<td>.06</td>
<td>-.12*</td>
<td></td>
<td>2.76</td>
<td>.55</td>
</tr>
<tr>
<td>Help Seeking Preference (X9)⁴</td>
<td></td>
<td>.05</td>
<td>.14*</td>
<td>.02</td>
<td>.08</td>
<td>.12*</td>
<td>-.27**</td>
<td>.12*</td>
<td>-.22**</td>
<td>.46</td>
<td>.49</td>
</tr>
<tr>
<td>Attitudes (Y)</td>
<td></td>
<td>-.00</td>
<td>.07</td>
<td>.08</td>
<td>.13*</td>
<td>.03</td>
<td>-.31**</td>
<td>.25**</td>
<td>-.33**</td>
<td>.46**</td>
<td>2.36</td>
</tr>
</tbody>
</table>

* p<.05  ** p<.01  *** p<.000

Table 4.4: Correlation Matrix (n=281)

¹ 1=Male, 0=Female
² 1=Less than High School, 2=High School, 3=Associate’s Degree, 4=Bachelor’s Degree, 5=Master’s Degree, 6=Ph.D. Degree
³ 1=<$10,000, 2=$10,000-$19,000, 3=$20,000-$29,000, 4=$30,000-$39,000, 5=$40,000-$49,000, 6=$50,000-$59,000, 7=$60,000-$69,000, 8=>$70,000
⁴ 1=Formal Resources, 0=Informal Resources
4.4.4 Test for Significance of the Regression Models

As depicted in the HSPAM model (Figure 2.1, p 36), demographic variables were not expected to exert a direct significant influence on the help-seeking stages. Therefore, these variables were all entered into the first block (Model I) in the regression analysis (again, length of stay in the U.S. was deemed a demographic variable). The four remaining variables were separately entered into the regression analysis one at time.

The independent variable cultural beliefs about mental health problem was entered in the second block (Model II); the independent variable knowledge about and familiarity with formal mental health service was entered in the third block (Model III); the independent variable perceived societal stigma was entered in the fourth block (Model IV); and finally the independent variable help seeking preferences was entered in the fifth block (Model V). Table 4.5 presents the five hierarchical regression models.

As can be seen in the first model, attitudes was regressed on the independents variables gender, age, education level, income, and length of stay in the U.S. This model yielded an insignificant $R^2$ of .008 ($F=1.45, p>.20$), suggesting that the linear combination of these selected demographic variables does not explain much variance in the dependent variable (attitudes of Arab-Muslims toward the seeking and using of formal mental health services).
In the second regression analysis, cultural and traditional beliefs about mental health problem variable was added to regression equation including selected demographics characteristics. The second model yielded a statistically significant R² of .09 (p<.000), suggesting that this model’s variable set accounted for 9% of the variance in the dependent variable. An examination of the R² change revealed that the cultural and traditional beliefs variable contributed significantly (F=27.67, p<.000), accounting for additional 8% of the variance in the attitudes variable above and beyond effects of selected demographics characteristics. Further examination of the standardized, partial regression coefficients indicated that two of the primary variables were related to help seeking attitudes. When all other variables were controlled, statistically significant betas were found for length of stay in the U.S. (β=-.168, p<.03) and cultural and traditional beliefs about mental health problem (β=-.35, p<.000). However, none of the other demographic variables appeared to be related to help seeking attitude.

In the third regression analysis, the independent variable knowledge about and familiarity with formal mental health service was added to regression equation including selected demographic characteristics and cultural and traditional beliefs about mental health problem. This model yielded a statistically significant R² of .13 (p<.000), suggesting that this model’s variable set accounted for 13% of the variance in the dependent variable. An examination of the R²
change produced by the model indicated that the variable knowledge about/familiarity with formal mental health services explained additional 3% (F=12.54, p<.000) of the variance in the attitudes variable over and above the effects of other independent variables in the regression equation. An examination of the standardized, partial regression coefficients indicated that, when all other variables were controlled for, cultural and traditional beliefs about mental health problem (β=-.32, p<.000) again emerged as significant predictors of attitudes, along with knowledge about/familiarity with formal services (β=.21, p<.000). With the exception of length of stay in the U.S., none of the other demographic characteristics emerged as significant variable.

In the fourth regression model, perceived societal stigma variable was added to regression equation including selected demographics characteristics, cultural and traditional beliefs about mental health problem, and knowledge and familiarity with formal mental health services. The produced model yielded a statistically significant R² of .21 (p<.000), suggesting that this model's variable set accounted for 21% of the variance in the dependent variable (attitude). An examination of the R² change indicated that the variable perceived societal stigma contributed significantly to overall model (F=28.98, p<.000) and explained about additional 8% of the variance in the attitudes above and beyond effects of other variables included in the model. Further assessment of the standardized, partial regression coefficients indicated that, when all other variables were
controlled for, cultural beliefs about mental health problem ($\beta=-.29$, $p<.000$), knowledge about/familiarity with formal services ($\beta=.17$, $p<.003$), and perceived societal stigma ($\beta=-.28$, $p<.000$) were the best predictors of attitudes toward seeking using of formal mental health services. Again, with the exception of length of stay in the U.S., none of the other demographic characteristics emerged as significant predictors of attitudes.

The fifth model was the full model and included help seeking preferences (formal) in addition to all of the demographics variables, cultural and traditional beliefs about mental health problem, knowledge about and familiarity with formal mental health services, and perceived societal stigma. This complete model yielded a statistically significant $R^2$ of .30 ($p<.000$), suggesting that the linear combination of these independent variables accounted for nearly 30% of the variance in the dependent variable (attitude). An examination of the $R^2$ change indicated that the help seeking preference variable was statistically significant ($F=38.02$, $p<.000$), and explained additional 9% of the variance in the attitudes variable above and beyond effects of other variables in the model. Examination of the standardized, partial regression coefficients indicated that, when all other variables were controlled, statistically significant betas were again found for cultural beliefs about mental health problem ($\beta=-.20$, $p<.001$), knowledge about/familiarity with formal services ($\beta=.16$, $p<.000$), and perceived societal stigma ($\beta=-.22$, $p<.000$), as well as for help seeking preference ($\beta=.33$,
p<.000). With the exception of length of stay in the U.S., none of the selected demographic characteristics appeared to be related to the dependent variable attitudes toward seeking and using formal mental health services.

The results of the final hierarchical regression model supported the four research hypotheses, which were generated based on the second research question. The negative betas ($\beta$) weights on cultural beliefs about mental health problems and perceived societal stigma in the U.S. indicate a negative relationship between attitudes toward seeking formal mental health services and these two predictors. Inversely, the positive betas ($\beta$) weights on help seeking preferences and knowledge about and familiarity with mental health formal services demonstrate a positive relationship between attitudes toward seeking formal services and individuals’ awareness of formal mental health services and their preference for formal help resources over informal help resources.

In other words, the less cultural and traditional beliefs about mental health problem, the less perception of shame associated with seeking formal mental health services, the more knowledge and familiarity with formal service; and lastly, the higher preference for formal help resources over informal help resources, the more likely Arab-Muslim individual is to hold favorable attitudes toward the seeking and using of formal mental health services.
Table 4.5: Hierarchical Regression of the Dependent Variable Attitudes Toward the Seeking of Formal Mental Health Services on the Independent Variables (n = 281)

<table>
<thead>
<tr>
<th>Variables</th>
<th>Model I</th>
<th>Model II</th>
<th>Model III</th>
<th>Model IV</th>
<th>Model V</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>( B )</td>
<td>( \beta )</td>
<td>( B )</td>
<td>( \beta )</td>
<td>( B )</td>
</tr>
<tr>
<td>Gender (Male)</td>
<td>-0.40</td>
<td>-0.03</td>
<td>0.14</td>
<td>0.01</td>
<td>0.36</td>
</tr>
<tr>
<td>Age</td>
<td>4.01</td>
<td>0.08</td>
<td>2.01</td>
<td>0.04</td>
<td>1.02</td>
</tr>
<tr>
<td>Education Level</td>
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<td>0.02</td>
<td>-0.25</td>
<td>-0.06</td>
<td>-0.45</td>
</tr>
<tr>
<td>Annual Income</td>
<td>0.37</td>
<td>0.16</td>
<td>0.24</td>
<td>0.10</td>
<td>0.27</td>
</tr>
<tr>
<td>Length of Stay in the U.S.</td>
<td>-5.64</td>
<td>-0.09</td>
<td>-9.87</td>
<td>-0.16*</td>
<td>-0.11</td>
</tr>
<tr>
<td>Cultural Beliefs</td>
<td>-0.38</td>
<td>-0.35***</td>
<td>-0.34</td>
<td>-0.32***</td>
<td>-0.31</td>
</tr>
<tr>
<td>Knowledge/Familiarity</td>
<td>-0.59</td>
<td>-0.28***</td>
<td>-0.46</td>
<td>-0.28***</td>
<td>-0.46</td>
</tr>
<tr>
<td>Perceived Societal Stigma</td>
<td>-0.59</td>
<td>-0.28***</td>
<td>-0.46</td>
<td>-0.22***</td>
<td></td>
</tr>
<tr>
<td>Help seeking preference (Formal)</td>
<td>3.88</td>
<td>0.33***</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Constant</td>
<td>33.12</td>
<td>45.86</td>
<td>41.94</td>
<td>49.60</td>
<td>43.67</td>
</tr>
<tr>
<td>( R^2 )</td>
<td>0.16</td>
<td>0.33</td>
<td>0.39</td>
<td>0.48</td>
<td>0.57</td>
</tr>
<tr>
<td>Adjusted ( R^2 )</td>
<td>0.008</td>
<td>0.09</td>
<td>0.13</td>
<td>0.21</td>
<td>0.30</td>
</tr>
<tr>
<td>( R^2 ) Change</td>
<td>1.45</td>
<td>27.67***</td>
<td>12.54***</td>
<td>28.98***</td>
<td>38.02***</td>
</tr>
</tbody>
</table>

* \(< .05\)  **\(< .01\)  ***\(< .001\)
4.5 Help seeking Preferences and Selected Demographic Characteristics

The research instrument contained three questions concerning Arab-Muslim respondents’ preferred sources of help for mental health/psychological problems. These questions asked participants to identify their first, second, and third choice for help, respectively. Because of the redundancy of the data obtained via each question and because the first preferred source of help is often the significant indicator of help seeking, the decision was made to analyze data obtained from only the first question.

Participants were asked to choose from among six categories: a) mental health professionals, b) the Sheik (Quranic Healer), c) family doctors, d) family members, e) close friends, or e) no one. As is shown in Table 4.6, Arab-Muslim respondents in this study are most likely to first choose family doctors (33%) for help with mental health/psychological problems, followed by family members (21.6%), the Sheik (19%), mental health practitioners (11%), and close friends (9%). Approximately 6% indicated they would not seek help from anyone for mental health/psychological problems. Three respondents were excluded from the analysis because they selected the same category for all three questions, that is, they indicated the same source of help as being their first, second, and third choice.

Chi-square analysis was conducted to respond to the study’s third research question, that is, to examine the relationship between various
demographic characteristics and Arab-Muslim preferred help source for mental health or psychological problem. As can be seen in Table 4.6, country of birth, marital status, income, nationality, occupation, and the availability of health insurance were all significantly related to respondents’ preferred sources of help for mental health/psychological problems. Arab-Muslim Individuals who were born in the U.S. were more likely than foreign-born individuals to consult mental health professionals, friends, and family members for emotional and psychological help ($\chi^2 = 12.06, p < .03$). Individuals who are divorced or widowed tended to use their family doctors as the first source of help, while individuals who are married or single were more likely to use mental health professionals or close friends as primary sources of help ($\chi^2 = 18.19, p < .05$). Help seeking preference was also related to socioeconomic status ($\chi^2 = 29.14, p < .01$), nationality ($\chi^2 = 31.80, p < .007$), occupation ($\chi^2 = 32.34, p < .000$), and type of health insurance ($\chi^2 = 22.80, p < .01$). Inversely, gender, age, and education appeared to be unrelated to first preferred help source selected by Arab-Muslim individuals.
Table 4.6: Demographic Variables by Most Preferred Help Resource

<table>
<thead>
<tr>
<th>Variables</th>
<th>M.H.P^a</th>
<th>Sheik^b</th>
<th>F.D.^c</th>
<th>F.M.^d</th>
<th>C.F.^e</th>
<th>Nobody</th>
<th>Total</th>
<th>χ^2</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>f       %</td>
<td>f       %</td>
<td>f      %</td>
<td>f      %</td>
<td>f      %</td>
<td>f      %</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
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<td>52 19.0%</td>
<td>90 33.0%</td>
<td>59 21.6%</td>
<td>25 9.25%</td>
<td>16 5.9%</td>
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<td></td>
<td></td>
</tr>
<tr>
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<td>20 11.8%</td>
<td>33 19.4%</td>
<td>57 33.5%</td>
<td>33 19.4%</td>
<td>14 8.2%</td>
<td>13 7.6%</td>
<td>170</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>12 11.1%</td>
<td>19 17.6%</td>
<td>33 30.6%</td>
<td>29 26.9%</td>
<td>11 10.2%</td>
<td>4  3.7%</td>
<td>108</td>
<td></td>
<td></td>
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Table 4.6: Demographic Variables by Most Preferred Help Resource

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This chapter presents a summary of the research findings, explores the implications of study, discusses the study’s limitations, and suggests recommendations for future research.

5.1 Summary of the Study

The purpose of this study was to examine the factors that influence help-seeking attitudes toward seeking and using formal mental health and psychological counseling services among Arab-Muslim individuals. Four factors: a) cultural beliefs about mental health problem, b) knowledge and familiarity with formal services, c) perceived societal sigma, and d) help seeking preferences were selected and tested in the light of Help Seeking Pathways of Arab-Muslim (HSPAM).

A secondary purpose if this study was to explore the help-seeking patterns among individuals from Arab and Muslim descent and to determine whether there is association between the help-seeking preference variable and
the study’s primary demographic factors including gender, age group, education level, income level, place of birth, marital status, selected nationality groups, and type of health insurance.

Two hundred eighty-one Arab-Muslim subjects were recruited through their affiliation and memberships in six Arab and Islamic community and religious organizations in Columbus, Ohio. Two data collection methods were utilized; the mail survey and the snowball sampling methods. Participants responded to four instruments that assess their attitudes and stigma (ATSFMHS), cultural beliefs about mental health problem (CBMHP), knowledge about and familiarity with formal services (KFFMHS), in addition to completing a demographic information sheet that includes help seeking preferences. The reliability and validity of these instruments were measured and the Cronbach’s Alpha coefficients were between .72 - .88.

A descriptive -correctional research design was employed and included three questions and four research hypotheses. Descriptive statistics that included measures of central tendency, variation, and frequency were used to answer research question # 1. Multiple Regression analysis was performed to answer research question # 2 and to test for the significance contribution of HSPAM. Chi-Square analysis was employed to answer the study’s research question # 3 and to assess whether or not the selection of each outside resource is independent or associated with selected demographic characteristics.
The results revealed a statistically significant relationship between the dependent variable attitudes (ATSFMHS) and the linear combination of the 4 independent variables beyond and above the effects of selected demographic factors. Findings supported the overall premises of the HSPAM (figure 2.1, p 36), but clearly confirmed the study's adapted theoretical framework (figure 2.2, 39). Similarly, results obtained from Chi-Square analysis supported previous findings about the statistical significance of the use of informal sources over the formal resources on Arab-Muslim help-seeking attitudes and perhaps their actual utilization of formal mental health services. Specifically, a different pattern of help seeking was found for the variables: place of birth, martial status, socioeconomic status, selected nationality groups, occupation, and health insurance. However, no gender, age group, education were associated with help-seeking preferences. Discussion of these two data analysis are presented in the section that follows.

5.2 Major Demographic findings

A descriptive analysis of the major characteristics of the Arab-Muslim population in relation to gender, age, marital status, place of birth, country of region, level of education, socioeconomic status, occupation of individual, as well as level current of general health and mental health care utilization was performed. Several interesting findings were observed and noticed in this study. One is related to representation of the sample to the current Arab-Muslim
population in city of Columbus. For example, the demographics result obtained from the nationality characteristics revealed that there were three major subgroup of Arab-Muslim; Somalis 29.5%, Palestinians 20.6%, Egyptians 12%. This result appears to be consistent with Arab and Muslim organizations estimates about the nationality characteristic of Arab and Muslims in the city of Columbus. Such organizations as the Islamic Society of Greater Columbus (ICGS) and Council on Islamic American Relationship (CAIR) have estimated that the number of Arab-Muslim living in Columbus, Ohio, is between 25,000-35,000 with Somalis, followed by Palestinians being the two majority groups (CAIR, 2004, ISGC, 2004).

Other significant demographic data found in the study related to the level of education and socioeconomic status of the Arab-Muslim group. In general, the Arab-Muslims populations in Columbus tend to have a higher level of education and maintain an average level of income. The result indicated that the majority of individuals who responded to the study survey reported to had achieved or were enrolling in at undergraduate degree and a sizable number reported some graduate level of education. This finding appears to be consistent with other studies conducted within the U.S that found similar results among Arab immigrants, Arab Americans, or Arab-Muslims (Abu Ras, 2003; Kulwicki, Miller, & Schim, 2000; Hague-Kahn, 1997). Although the result may suggest that the Arab-Muslim population in Columbus, Ohio is highly educated and
economically advantaged, this finding should be interpreted with caution. With the dramatic increased in the Arab and Muslim population, particularly from Somali and Iraqi sub-groups- usually have less education and a lower income-, conclusion drawn from these results may not reflect the accurate facts. To illustrate, data obtained about Somali groups in the sample indicated that these individuals tend to be younger, less educated, having a lower income level, and most importantly, are a new population in Columbus with a recent dramatic increased growth rate.

Another significant demographic finding relevant to the topic of this study was the level of health and mental health services utilization. As previously shown that Arab-Muslim participants reported more use and utilization of general health care system than mental health care system. Utilization differences based on gender and nationality were also observed and reported. The fact that Arab-Muslim respondents in this study reported much more use of formal services for physical reasons than for mental health reasons is not surprising. This is congruent with the notion that Arab-Muslim individuals tend to be more comfortable seeking and using medical doctors for a physical problem than they are consulting with mental health practitioners for mental health reasons (Al-krenawi and Graham, 2003, 2000, 1999 Al-krenawi, Graham, Kandah, 2000; Savaya 1998, 1995; Abu Ras, 2003; Kulwicki, Miller, & Schim, 2000).
However, the intriguing thing observed in the present study was the low number of visits to mental health practitioners reported by individuals. Among 281 participants who responded to the study questionnaire, only 9% had visited a mental health specialist in the past three years. Several explanations have been provided. The first is concerned with the level of knowledge and familiarity with formal mental health setting and the link between knowledge of services and formal services utilization (Abu Ras, 2003; Al-Krenawi & Graham, 2000; Jorm, 2000). As the results of this study indicted, on the average, Arab-Muslim people tend to have less or no knowledge at all about the existence of formal mental health services and the role of its providers. The second explanation involves the lack of appropriate culturally sensitive mental health services within the Columbus public mental health services that accommodate Arab and Muslim cultural and religious needs. Lastly, it is possible that what so-called “Somatization” plays a major role in provider choice, that is, most of the afflicted Arab individuals refer themselves to general medical practitioners instead of using mental health providers.

5.3 Relationships Between Attitude and Study’s Primary Variables

The study’s main goal was to explore and understand the extent to which attitude toward seeking formal mental health and psychological services among Arab-Muslims relates to their cultural and traditional beliefs about mental health
problem, their level of knowledge and familiarity with formal service, the perceived societal stigma, and help-seeking preference. Assessing and validating the proposed model (HSPAM) was also sought. The result of the multivariate analysis (Hierarchical Multiple Regression) revealed a statistically significant relationship between the dependent variable attitude (ATSFMHS) and the linear combination of independent variables: a) cultural beliefs about mental health/psychological problem; b) knowledge about and familiarity with formal services; c) perceived societal stigma, d) help-seeking preferences (formal resources), beyond and above the effect of selected demographics characteristics.

The finding in the regression analysis indicated the linear combination of these variable explained 30% of the variation in Arab-Muslim attitudes toward seeking and using formal mental health services.

This finding supported the HSPAM Model that suggests the sequential ordering of the process of Arab-Muslim help-seeking pathways. As the HSPAM depicts, the Arab-Muslim individual often passes through three stages when they encounter psychological stressors and attempt to seek formal help. The HSPAM model posits that in each stage, individuals face predisposing factors that either impede or enable their help-seeking behaviors.

Using a Hierarchical Regression procedure to enter the variables in the light of prior theory (HSPAM), the results revealed that cultural beliefs about mental health/psychological problem, knowledge and familiarity with formal
mental health services, perceived societal stigma, and lastly help-seeking preferences were the best predictors of Arab-Muslim attitudes toward formal mental health services and perhaps their actual help seeking behavior of formal mental health services. However, with the exception of length of study in the U.S., none of the selected demographics variables appeared to be statistically related to help seeking attitude. Discussion of the regression analysis results, in the light of current Arab and Muslim studies and research, is presented in section that follows.

5.3.1 Cultural and Traditional beliefs and help-seeking attitudes

According to the HSPAM model, a cultural and traditional belief about mental health problems (CBMHP) plays an important role in shaping the process of help-seeking pathways among Arab-Muslim people. Therefore, CBMHP was entered as the first predicator (Model II) in the regression equation after the demographic variables were controlled for, including length of stay in the US variable. The result supported the first research hypothesis and showed the variable cultural beliefs about mental health problems contributed significantly to prediction of Arab-Muslim help seeking attitudes. CBMHP was found to account for an additional 8% of the variations in Arab-Muslim attitudes toward formal mental health services. Thus, this study confirms the inverse relationship – as suggested by HSPAM- between cultural beliefs about mental health and Arab-Muslim individuals’ attitude toward seeking and using formal mental
health services. Higher scores on CBMHP (measure of cultural and traditional beliefs) indicated that an individual who embraces Arabic and Islamic interpretations of the cause and treatment of mental health problems tended to report less favorable attitudes toward seeking formal mental health services.

This research finding regarding cultural influence on help-seeking attitudes supports and adds to the knowledge base of previous Arab and Muslim research studies investigating the relationship between cultural and traditional attributions of mental illness and the level of use of the biomedical health system (Al-Krenawi & Graham, 2000, 1999; El-Islam, 1994; El-Islam, 1982; El-Islam & Abu Dagga, 1992; El-Islam & Ahmed). Specific cultural value dimensions assessed by the cultural beliefs instrument (CBMIPP) were beliefs in external factors, mainly evil eye “Aieen”, magic “Seher”, and spirits “Jinn” in addition to the use of the religious treatment “Ruqia”. These culturally, traditionally, and religiously based explanations of mental health/psychological symptoms seemed to be driven by Arabic and Islamic cultures which tend to attribute individual problems to external factors, mainly “God’s will” and supernatural causes. Taken to gather, seeking formal mental health care, as seen in the study results, was influenced by the extent to which Arab-Muslim individuals adhere to their cultural and traditional manifestations, etiology, and treatments of mental health and psychological problems.
There was an interesting finding with respect to cultural beliefs about mental health problem in this study. It was found that there was an inverse relationship between cultural beliefs about mental health problems and age variable. Correlational analysis showed that high adherence to cultural and traditional beliefs was found more among younger participants than older participants. This is a counter-intuitive finding against previous research, which reported that younger individuals more than older individuals tend to be less adherent to cultural and traditional explanations of mental health problems (Al-Adawi et al., 2002; Hague-Kahn, 1997). Following the suggestion made by El-Islam and Abu Dagga (1992) that cultural beliefs may be related to individual level of education, a partial correlation analysis was conducted. The results showed that when education variable was factored in, the significant relationship was diminished, suggesting that the observed significant relationship between age and cultural and traditional beliefs was mediated by level of education.

5.3.2 Knowledge and Familiarity about Services and Help Seeking Attitude

The second independent variable (Model III) to enter the regression model was knowledge about and familiarity with formal mental health services by Arab-Muslim persons. According to the HSPAM model, knowledge and awareness of formal mental health providers, facilities, and treatments determine how individual view and use formal mental health services. Accordingly,
KFFMHS (measure of knowledge and familiarity) was entered as the second predictor in the regression equation after the controlled variables (demographic factors) and first predictor (cultural beliefs) were already included. The result supported the second research hypothesis and showed the variable knowledge and familiarity with formal mental health services was statistically significant and accounted for an additional 3% of the variance of the Arab-Muslim help seeking attitudes.

The results of this study were found to be congruent with help-seeking theories and health behavior models (Wills & DePaul, 1991; Andersen & Newman, 1973; Gross et al., 1979; Goldsmith et al., 1988; Jorm, 2000). According to the model developed by Gross et al., (1979), an individual must have a knowledge about existing services in order for help-seeking to occur. Wolf et al., (1996) investigating the correlates of help seeking attitudes among community participants, attributed the negative correlation between attitudes toward seeking psychological professional services and some selected demographics (e.g. educational level) to the participants’ lack of knowledge and familiarity with existing of formal mental health services. Wolf and his colleagues found that the majority of the study participants were to be less familiar with mental illness and other related problems.

Findings also lend support to previous Arab and Muslim studies that noted a significant correlation between individual knowledge of the service
location and providers and his/her tendency toward seeking and using professional social and mental health services (Abu Ras, 2003; Al-Krenawi, 2002; Al-Krenawi & Graham, 1999; Savaya, 1998, 1995; Kulwicki, Miller, & Schim, 2000). Researches in the Arab world as well as in Western countries has been consistent in arguing that the Arab and Muslim populations tend to have less knowledge and are less familiar with formal mental health care systems, providers, and treatments (Kulwicki, Miller, & Schim, 2000; Al-Krenawi & Graham, 2000; Erickson & Al-Timimi, 2000).

To date no study has specifically examined the extent to which level of knowledge and familiarity of formal services affect help seeking behavior among Arab-Muslim populations. The lack of such a study to assess the influence of this factor has limited the interpretation of the findings of this study. However, it goes without doubt that ethnic minority groups in general and Arab-Muslims in particular are less aware or do not have such knowledge about the roles of mental health practitioners, type of treatments, and the existing and locations of services (Al-Krenawi and Graham, 2000; Kulwicki, Miller, Schim, 2000).

5.3.3 Fear of Societal Stigma and Help Seeking Attitude

The third predictor (Model III) variable added to the regression model in research question 2 was perceived societal stigma attached to seeking and using formal mental health services. Again, the selection and the entry order of this variable in the regression analysis was informed by the HSPAM model
hypothesis. The result supported the third research hypothesis and confirmed the inverse relationship between perceived societal stigma and help seeking attitude as hypothesized in HSPAM. The regression finding showed that the variable perceived societal stigma was statistically significant and accounted for an additional of 8% of the variance in the dependent variable (attitude), suggesting that nearly 8 percent of the variance in Arab-Muslim help seeking attitudes can be explained by whether or not individual views seeking formal services as a stigmatizing event.

The result from this investigation appeared to be congruent with the findings of recently published Arab and Muslim research (Al-Adawi et al., 2002; Abu Ras, 2003; Al-Krenawi, Graham, & Kandah, 2000; Al-Krenawi & Graham, 1999; Savaya, 1995), but contrary to findings of other studies (Savaya, 1998, Hague-Khan, 1997). These two studies that reported no statistical association between stigma and help seeking attitudes and behavior were found to have problems with sample selection (only women were studied) and measurement and statistical errors. However, the fact that a feeling of stigma is attached to seeking professional mental health services is indeed prevalent among Arab and Muslim people and has been extensively documented. In recent published study in the U.S., Abu Ras (2003) found that nearly 70.6% of women victims of partner abuse, reported feeling of shame to associated with seeking formal social services.
and 62.7% indicated some type of embarrassment associated with reporting their problem to individuals outside their family.

In Arab cultural society, in particular, effects of stigma have been viewed to go beyond affecting individuals’ status and reputation to hereditary flaws that shame the family and its members. As Al-krenawi, Graham, & Kandah (2000) analyzed that among Arab women, labeling with stigma may cause damage to their future marital life and this, according to him, could explain why fewer women than men seek help in the biomedical care system. Arab-Muslims, traditionally, are encouraged to deal with their personal and emotional problems by themselves, and if that fails, to seek help from family members or close friends. Consequently, some Arab-Muslims view it is as especially shameful to seek and use extrafamilial interventions for emotional and psychological difficulties because this may cause problems for their reputations in judgmental Arab societies. These Arab and Muslim recent studies provide obvious examples about the substantial role that societal stigma plays in shaping help seeking attitudes and, perhaps, the actual utilization of formal mental health services by Arab-Muslim people.

5.3.4 Help seeking preferences and Help Seeking Attitudes

The last and fourth factor to be tested in the regression analysis in research question 2 was help seeking preference (Formal vs. Informal). Again, the order entry of this variable in the Hierarchical regression procedure was
performed in the light of the HSPAM hypothesis. This variable was found to be statistically significant and accounted for an additional 9% of the variation in the dependent variable attitudes. As the result has shown that the individual who selected formal resources (coded 1 = mental health practitioners or family doctors) as their first outside help choice were found to hold more favorable attitudes toward seeking formal services than individuals who selected informal resources (coded 0 = Sheik, family member, or close friend). An examination of the partial correlation coefficient indicated that the variable help seeking preference was the most significant predictor (β = .33) of Arab-Muslim attitudes toward seeking formal mental health/ psychological services.

This finding supported the fourth research hypothesis and indicated that individuals who showed greater preference for informal resources over formal resources tended to demonstrate less favorable attitudes toward seeking formal mental health and psychological services. This result is consistent with Arab and Muslim literature about the effect of community informal resources on the use and utilization of formal mental health (Al-Krenawi, 2002; Alkrenawi and Graham, 2003, 2000, 1999; Savaya, 1998, 1995). Arab and Muslim social scientists and researchers have been consistent in their argument about the effects of such community sources as traditional healing system, religious treatment “Ruqia” often performed by Sheik, and family and friends consultation on individuals help seeking attitudes and mental health services utilization (Al-Krenawi,
Graham, & Kanduh, 2000; Al-Krenawi & Graham, 2003, 2000, 1999; Al-Subaie and Alhammed, 2000; Savaya, 1998, 1995; Al-Subaie and Al-Issa, in press). Al-Krenawi and Graham (1999) observed help seeking behavior among Bedouin Arabs in Negev and found that consulting with family or friends was the most widely pattern, follow by seeking general medical help.

Though the result of the positive relationship between help seeking preferences and help seeking attitudes – individual who preferred formal resources scored higher on attitudes - is not surprising and was expected. However, it is a worthwhile endeavor to offer an explanation as to why individuals who favor informal over formal resources as their first selection tended demonstrate less favorable attitudes toward seeking formal and professional services. There are several reasons to explain this observed negative association. First, it may be that Arab-Muslim individuals, regardless of their ethnic and racial group, still consider the family, follow by friendship as the primary resorts for help, particularly when it comes to emotional and psychological reasons. As previously mentioned, Arab studies in the area of mental health and social services repetitively agree upon the major role that the family unit plays in treatment and recovery for its members (Erickson & Al-Timimi, 2000; Abu Ras, 2003; Kulwicki, Miller, Schim, 2000; Al-krenawi, 2002; Al-Krenawi, Graham, & Kandah, 2000).
Another possible explanation concerns with the influence of cultural barriers, mainly the stigma attached to seeking and using formal mental health services. As previously discussed, fear of stigma was negatively related to help seeking attitudes and mental health services. Therefore, Arab-Muslim participant’s preference of informal resources over formal is more likely have been affected by fear of stigma labeling with seeking and using formal services for mental health reason. In summary, the results suggested that Arab-Muslim individuals still attach stigma labeling to seeking formal mental health services regardless wherever they reside and what level of education they achieved.

Mental health researchers in the Arab world argued that fear of stigma as well as preference of informal sources over formal resources are common among Arab and Muslim individuals regardless of their education and socioeconomic status (Al-Krenawi & Graham, 2000; Savaya, 1998).

The last potential reason for the observed negative association could be related to the cultural and traditional beliefs among Arab-Muslim individuals that attributes mental health difficulties to supernatural causes and thus individuals as well their families tend to favor informal over formal as primary source of help, particularly Quranic treatment “Ruqia” and traditional prescribed medicine. As Al-Krenawi, Graham, and Kandah (2000) explained, Arab individuals using of traditional and Quranic healing systems are influenced by such factors as widely trusted, strong beliefs on the effectiveness, and
availability and accessibilities within Arab communities. Therefore, it is not surprising to observe that Arab-Muslim individuals tend to undermine the role of professional mental health and, instead, select other informal practitioners as their primary provider in curing their illness or solving their problem.

Additional discussion of the association between selection for resources for help and study’s primary demographic variables are detailed in the sections that follows.

5.4 Arab-Muslim Help seeking Pattern and Preferred Help Resources

The last objective of the present study was to examine and assess the pattern of help seeking among Arab-Muslim people and whether there is a relationship between selection for first help source and the following variables of gender, age, country of birth, martial status, education level, income level, selected nationality, occupation status, and type of health insurance. The findings of the study revealed that the majority of participants identified family doctors 33%, follow by family member 21.6 %, Sheik “Quranic healers” 19%, mental health practitioners11.4% as their primary outside resources from whom they would seek mental health or psychological help. The results appeared to contradict with findings of previous Arab and Muslim studies, where individuals often reported a family member or close friend, followed by Quranic and traditional healers, and general medical doctors as their primary sources for mental health or psychological consultation (Savaya, 1998, 1995; Al-Krenawi &
Several possible interpretations can be provided to explain this discrepancy between this study’s results and other previous Arab studies concerning help seeking pattern of Arab-Muslim. First, it may be due to the fact that Arab-Muslims tend to somatize their mental health and psychological problems and thus they seek general medical health services, rather than consulting with mental health practitioners (Okasha, 1999; Okasha & Okasha, 1999; Al-Krenawi, Graham, & Kandah, 2000; El-Islam, 1994;Al-Issa, 2000). Instead of seeking the services of mental health specialists, many Arab-Muslim may look at their somatic symptoms and consider a general medical practitioner rather than mental health practitioner. Somatization in Arab cultures and society has been extensively well documented and is attributed to several reasons (Okasha & Okasha, 1999). For example, it has been argued that in the Arab traditional culture, mental illness and psychological feeling may carry with it serious societal stigma, indicating a weak will and spirit (Al-krenawi, 2002). Hence, it is not unexpected that Arabs tend to deny their emotional or psychological problems or express them in physical symptoms instead.

Another explanation of the different help-seeking pattern observed in this study may be related to the fact that the educational attainment was higher in this study than other studies conducted within the Arab world. Higher level of
education often associates with increased knowledge and more awareness of formal services. Thus, because they are more educated than their counterparts in the Arab world, Arab-Muslim people in the U.S. consider family doctors as their first choice. The last possible explanation could also relate to the lack, within Arab and Muslim communities in the U.S, of available qualified Quranic and traditional leaders – considered as primary sources of help in the Arab world. This in turn may limit the use of such services and as result left individuals with no other choice than to consider a formal professional to treat his/her illness.

5.5 Arab-Muslim Help Seeking Attitudes and their Actual Behavior

Investigating Arab-Muslims help seeking attitudes toward formal mental health services and the factors that impede or enable this process is considered an important step to next assessing their actual utilization. By becoming more aware of most contributory factors that influence Arab-Muslim help seeking attitudes, research in Arab and Muslim help seeking behavior and mental health service utilization can move to another level to examine the association between attitudes and actual behavior. Fishbein and Ajzen (2000) in their Theory of Reason Action (TRA) and Theory of Planned Behavior (TPB) theorized about the link between individual attitudes toward seeking help and the actual behavior. As the current study adapted theoretical framework (see Figure 2.2, p 39) proposes – based on theory of Reasoned Action (Ajzen and Fishbein, 1980, 2000) – that there would be a correlation between what Arab-Muslim people perceive
and their further action when they experience such a need for mental health or psychological reasons. The framework also hypothesized that there are three dimensions that assess formal mental health services utilization. For scientific and statistical reasons, the present study was designed to only examine one part of the framework, which is the affect of attitudinal dimension on mental health services utilization. Findings from the study confirmed the adapted theoretical framework and supported the overall Help Seeking Pathways of Arab- Muslims (HSPAM).

However, the lack of adequate studies to examine the relation between help seeking attitudes and actual use of mental health services among Arab- Muslims may limit the current study findings and the significance of the proposed HSPAM. Fischer and Farina (1995) argued that the relationship between attitudes and actual behavior is unclear and there is more work to be done to validate such findings. Savaya (1998) attempted to assess the link between Arab women attitudes toward psychological counseling and their actual consumption of these services in Israel. Although the Savaya found no link between these two dimensions, she attributed such findings to a set of personal and structural barriers that may have affect respondents of the study. Hence, additional studies to assess the remaining factors of the HSPAM model and, specifically, to examine the link between Arab attitudes and their actual
utilization behaviors are needed to in order to develop a meaningful empirical framework to guide future Arab and Muslim mental health research.

5.6 Implications of the Study findings

The findings in the present study regarding Arab-Muslim attitudes toward seeking formal mental health services and factors that enable or imbed their help seeking for mental health reasons have enormous implications for clinical social work practice, research, mental health policy, as well as for local Arab and Islamic community organizations.

For clinical social workers practicing in mental health settings, this study provides significant information about Arab-Muslims cultural, traditional, and religious views concerning their perceptions of mental health services. Better care requires taking into account cultural and traditional barriers and personal and situational obstacles including symptom manifestations, awareness and familiarity with formal services, shame and stigma, as well as use of informal and lay resources. Therefore, it is of particular importance that mental health practitioners, in general, and clinical social workers, in particular, educate themselves about Arab and Muslim cultural and traditional beliefs, religious practices, and sociopolitical situations, which all have been found to mediate the relationship between needs for professional mental health services and Arab-Muslim help seeking attitudes toward formal care systems.
The strong inverse association between help seeking preference and Arab-Muslim help seeking attitudes toward formal mental health services should alert social workers practicing in mental health settings about the process and pattern of help seeking pathways that individuals from Arab and Islamic backgrounds pass through when seeking help for mental health reasons. The study has demonstrated that Arab-Muslim individuals often tend to exhaust all informal resources before making contact with formal services providers. An awareness and understanding of the complex dynamic of the help seeking process among Arab-Muslim people will help mental health practitioners, in general, and clinical social workers, in particular, to be aware of the significant role that informal resources play in determining how formal mental health care is sought.

As for the research implications, this study has significantly confirmed the fact Arab-Muslims tend to hold less favorable attitudes toward seeking formal mental health services, which in turn may effect their overall utilization. Though under-utilization of formal mental health services has been documented in the Arab world (for a review see Al-Krenawi, 2002), this is study is probably the first stud in the U.S. that assesses the presence of this phenomenon among specific Muslim group, the Arab. Another research implication of this study is that it has expanded the frontier over and above the existing level of understanding of help seeking attitudes of ethnic-racial minority groups. The results obtained have remarkably supported the Help seeking pathways for Arab-Muslim (HSPAM).
In the pertinent psychiatric, psychological, and sociological theories in health care seeking behavior, the subjective nature Arab-Muslims group perceptions about their attitudes and utilization of formal mental health services were not explained relating to the cultural and traditional beliefs, knowledge and familiarity with existing services, as well as the use of informal resources. As a result of this study, it is empirically evident that the assessment of cultural and religious dimensions, the account for level of knowledge and familiarity with formal service, and the report of informal use of resources, are crucial to explain the overall attitudes and perhaps the actual utilization of formal mental health services by Arab-Muslims.

There are no studies about Arab and Muslim mental health status in the U.S. and only a few studies have been conducted in area of cultural competency and clinical practice (Abu Ras, 2003, Kulwicki, Miller, Schim, 2000; Hague-Khan, 1997). Despite the fact the these studies have generated some attention on the issue of mental health needs, services barriers, and help seeking behavior, they were found to lack the use of an appropriate framework to guide the research design and interpret the findings. The development of mental health Help Seeking Pathways model for Arab-Muslim (HSPAM) is one significant step in this regard to generate more rigorous research among this population. In summary, the study may render an important contribution to Arab and Muslim mental health literature by developing the HSPAM model to guide further help
seeking behavior and mental health service utilization among this group of population.

This study also has implications for mental health policy changes and provisions. Results from this study imply that innovative strategies are mandatory to bring the attention to the urgency of making available, accessible, acceptable, affordable, culturally sensitive mental health services for the Arab Muslim population. Specifically, establishment of ethnic specific facilities, clients matching on ethnicity and language, and community outreach programs are believed to increase the likelihood of formal services use, lower dropout rates, and better intervention outcomes. Findings among ethnic groups in U.S. show the significant implications of these types of strategies and organizational accommodations to enhance and increase the level of formal mental health services use among individuals from ethno-racial groups (Leong & Lau, 2001; Lum, 1999; Takeuchi, Uehara, & Maramaba, 1999; Kim & Omizo, 2003; Snowden, 2001). Arab and Muslim researchers and writers have suggested that services that are cultural sensitive toward specific minority group; mainly their cultural values and religious beliefs, may facilitate use and improve the attitudes toward formal services (Al-Krenawi, 2002; Al-Krenawi and Graham, 2003; Kulwicki, Miller, & Schim, 2000; Savaya, 1998, 1995).

Arab-Muslims are probably the fastest-growing ethnic group in city of Columbus. This significant demographic development poses unique challenges
to health care system in general and mental health services system in particular. The demographic expansion of the Arab and Muslim population within Columbus is assumed to be associated with an increase in the numbers of individuals at risk for mental health or psychological problems—especially among new immigrant and refugee such as Somalis and Iraqis—and the number requiring treatment. Thus, the public mental health system in Columbus needs to consider and facilitate practical programs that are culturally sensitive and family and community oriented to meet the increased demands for mental health services among this neglected population. Untreated mental health and psychological problems are more likely to be accompanied with family and community problems that often result in social problems, family stressors, and economic losses.

Lastly, implications of this study’s findings for local and state Arab and Muslim community organizations are also warranted. This study provides both local and state Islamic and community organizations with perhaps the first demographics and statistical findings about the Arab and Muslim population in Columbus, Ohio. Despite the study’s limitations, particularly with regard to sample selection and research method, the study has generated empirical data about various demographic characteristics and background information that can be utilized in many ways to bring it to the attention to Arab and Muslim people in the city of Columbus. The lack of such scientific information has prevented
these organizations from making such accurate assessment of their members and followers concerning their demographics and social and human needs (ISGC, 2004; CAIR-OHIO, 2004). Another implication is that this study provides Arab and Islamic organizations with empirical data to enable them to apply for county and state public funding to establish local Islamic social services to meet the population increased demand. As the study results indicate, the majority of Arab-Muslims tend to seek support from sources that differ from those of the general public because of the lack of public culturally sensitive services as well as the paucity of local community services. Educating and encouraging local Arab-Muslim mental health practitioners, Imams (religious consultants), as well as local social services volunteers to take part in this movement will insure accessible, acceptable, and highly utilized services. Particularly, training Imams about the basic mental health intervention and referral procedure in case of crisis is first significant step in this regard.

5.7 Limitations of the study

Beyond the significant results of this study and its vital implications, there were a number of limitations to the findings. In particular, the study lacks the external validity (generalizeability of findings across persons, settings, and time) due to the use non-probability sampling method. While not possible for this study, random sampling could have been employed to strengthen the external
validity of the study. Similarly, the study was conducted among community and students populations who were not clinical mental health clients. Therefore, this study’s findings are limited to Arab-Muslim non-clinical clients who responded to the study survey questionnaires. Replication of this study with random sampling and among individuals currently receiving counseling services may generate different valid results and would confirm the significance and feasibility of these results.

This study may also be limited by the methodology selection – the survey research method. Survey research lacks the control of extraneous factors that affect the overall findings and thus conclusion of the study may not be warranted. The lack available mental health data about Arabs or Muslims in the area of mental health services has contributed to the selection of the survey design, rather than utilizing stronger approach of research (experimental or quasi-experimental design). Such powerful research designs that include random selection and random assignment of the subject would insure the external validity of the result and thus would allow generalizing the results to a wider range of population.

Apart from the external validity, problems concerning the use of non-standardized measurements may pose a great threat to the study’s internal validity. Among four instruments used in the study, only one was a known standardized scale - Attitudes Toward Seeking Professional Psychological Help
(ATSPPH)- that was developed by Fisher and Turner (1970). This instrument was also substantially modified to account for Arab and Muslim cultural and linguistics needs (cultural validity). Three instruments were developed specifically for this particular study. Although all instruments were assessed in terms of their content and face validity and that obtained reliability coefficients were in the acceptable and desired level (.72 - .88), caution toward the study results should be taken. Future assessments of Arab and Muslims mental health help seeking attitudes and utilization behaviors are suggested to employ these instruments and test their validity and reliability coefficients among different populations and in different settings. Constructing culturally valid and reliable measurements that take into considerations Arab-Islamic beliefs, norms, and values are highly encouraged to insure future research and findings.

Lastly, in addition to these general limitations to external and internal validity, this study is limited by the method used in data collection procedures. The use of snowball sampling method, participants’ volunteers, as well as mail survey techniques to collect for data form sensitive participants can not be achieve without problems. Ethnic minority group in general and Arab-Muslim in particular tend to be highly sensitive toward research and data collection. Respondents may have been reluctant to honestly apprise their help seeking attitudes, given the stigma about mental illness that prevails. Thus, result from this study should be interpreted and inferred with caution. However, insuring
participant’s complete anonymity, use of mail services to return the questionnaires, in addition to effective survey campaign plan may have lessened the effect of “social desirability” influence on the overall study’s results. Future research with qualitative component is recommended to assure validity of quantitative result.

5.8  **Suggested Major Area for Future Research**

Despite a fair amount of research in the area of mental health clinical practice and intervention with Arab and Muslim individuals, comparatively little rigorous research has been undertaken in area of mental health services utilization and help seeking behavior in the U.S. To rectify the current lack of studies and researches, the following areas are suggested to be investigated:

a. Comparative and needs assessment studies to assess the difference between the Arab-Muslim group and other ethno-racial minority groups in the U.S. in terms of prevalence of mental health, help seeking attitudes, and personal and structural barriers.

b. Local community studies to examine the help seeking pattern for mental health reasons and the most preferred sources of help by Arabs and Muslims.

c. Studies to explore use and value of alternative sources including traditional healing, Quranic treatment, family counseling among Arab and Muslim in the U.S. and their effect on the use of formal service.
APPENDICES
APPENDIX A

Cover Letter to Arab-Muslim participants
October 23, 2003

Dear Respected Brother/Sister,

I am a student at The Ohio State University seeking to complete my Ph.D. degree in Clinical Social Work. I invite you to participate in a study that will assess the Arab-Muslim perceptions about the use of social, psychological, and mental health counseling services. I hope the results of this study will contribute to the enhancement of the health service system for the Arab and Muslim population in the city of Columbus. Without you, this research would not be possible and, more importantly, the Arab and Muslim community health needs cannot be determined and fulfilled. I assure you complete anonymity and confidentiality; your name, address, or any other identification are not requested, and your responses will be used only for research purposes.

Enclosed you will find a questionnaire that contains four sections. Each section includes several questions concerning a specific area. The questionnaire can be completed in approximately 20-30 minutes. For me to make accurate conclusion, it is very important that you provide a response to every question. After completing the questionnaire, kindly mail it back in the enclosed envelope (already addressed and stamped) within a week. Please accept the Quranic tape as a token of my deep thanks for returning the completed questionnaire.

Thank you for your time, consideration, and honest responses regarding this issue. I am asking Allah to reward you for helping both your brother as well as your community by participating in this project. Should you have further questions, please contact us through email (aloud.1@osu.edu), phone (614-271-1177), or mail (at the address above).

Sincerely Yours,

Nasser S. Aloud, MSW
Ph.D. Candidate
College of Social Work

Keith Kilty, Ph.D.
Dissertation Chairperson
The Ohio State University
APPENDIX B

Attitudes Toward Seeking Formal Mental Health Services Instrument (ATSFMHS)
DEFINITIONS

Professional mental health or psychological counseling services (professional help): clinics within the community, hospital, or school where practitioners, such as psychiatrist, psychologist, or clinical social worker, 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 counselling or psychotherapy, drug treatment and/or lifestyle change.

Please remember NO ONE WILL KNOW that this information belongs to you because no name, address, or any other identification will be obtained in this questionnaire. Therefore, please provide your honest beliefs, perceptions, and feelings about the issues included.

SECTION I

Below are some statements concerning your perception toward seeking formal mental health or psychological services. Please carefully read each statement and indicate whether you Strongly Agree, Agree, Disagree, or Strongly Disagree with the each one. I am interested in your honest perceptions, beliefs, and opinions in regard to mental health and counseling services.

Please select only one response for each statement.
For Example: if you tend to agree with such statement, mark your answer as:
1. __Strongly Agree           2. ___Agree           3. __Disagree           4. ___Strongly Disagree

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.
1. __Strongly Agree           2. ___Agree           3. __Disagree           4. ___Strongly Disagree

2. A person with strong IMAN (faith) can get rid of a mental health or psychological problem without the need of professional help.
1. __Strongly Agree           2. ___Agree           3. __Disagree           4. ___Strongly Disagree

3. A person would feel uncomfortable seeking mental health or psychological services because of others’ negative opinions.
1. __Strongly Agree           2. ___Agree           3. __Disagree           4. ___Strongly Disagree

4. Discussing mental health or psychological concerns with a mental health professional is a poor way to solve mental health or psychological difficulties.
1. __Strongly Agree           2. ___Agree           3. __Disagree           4. ___Strongly Disagree

5. If I believed I need professional mental health or psychological counseling, I would get it no matter what people say or think.
1. __Strongly Agree           2. ___Agree           3. __Disagree           4. ___Strongly Disagree

6. I would feel embarrassed to tell others that I used psychological or mental health services.
1. __Strongly Agree           2. ___Agree           3. __Disagree           4. ___Strongly Disagree
7. I would seek professional counseling services only if I experienced psychological problem for a long period of time.
   1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

8. If I decide to seek psychological or mental health services, I am confident they would be helpful.
   1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

9. I might need to contact professional mental health or psychological services in the future.
   1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

10. Most mental health and psychological problem can be solved by individual himself/herself without the assistance of professionals.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

11. Using mental health or psychological services is more difficult than using general medical service because of the shame (societal stigma).
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

12. Considering the high cost of service, I would NOT seek professional help even if I needed it.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

13. Seeking psychological and mental health services should be the last choice to use after trying all other options (e.g. self-help, family or friend counseling).
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

14. I would be concerned about what others might think or say if I use professional mental health services.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

15. I would rather be advised by a close relative or friend than by a mental health professional, even for serious psychological problems.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

16. I would rather live with certain mental health or psychological problems than going through the process of seeking professional help.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

17. Mental health and psychological difficulties, like many things, tend to go away over time.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

18. People would think negatively about individual who uses mental health or psychological services.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

19. If I decide to seek mental health or psychological help, I would rather contact Arab or Muslim professionals than professionals from other cultures or groups.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

20. Family members should have the final say (decision) whether or not individual seeks professional help for psychological or mental health problem.
    1. __Strongly Agree           2. __Agree           3. __Disagree           4. __Strongly Disagree

118
APPENDIX C

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

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

Please select only one response for each statement.

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

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

21. 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

22. 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

23. Mental health or psychological problems can be caused by “**Aieen**” (evil eye).

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

24. Mental health or psychological problems can be caused by “**Seher**” (magic).

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

25. Mental health or psychological problems can be caused by “**Jinn**” (spirits).

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

26. 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

27. 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

28. Mental health or psychological problems can be treated using “**Ruqia**” (Quranic Recitation).

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

29. There are certain mental health or psychological problems that might **NOT** be treated using mental health or psychological treatment; rather they require “**Ruqía**” (Quranic Recitation).

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

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

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

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

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

Knowledge and Familiarity with Formal Mental Health Services Instrument (KFFMHS)
SECTION III

Below are statements pertaining to your knowledge and familiarity with mental health and psychological disorders, types of formal services, as well as mental health professional providers.

How much familiar are you with:

32. The type of problems that might require professional mental health or psychological intervention (e.g. mental instability, an abnormal fear or feeling, a depressed mood, etc)?
   1. __Not at all           2. __Very little           3. __Somewhat           4. __ Very familiar

33. The availability of mental health and psychological services in your community (e.g. location, phone #, type of care)?
   1. __Not at all           2. __Very little           3. __Somewhat           4. __ Very familiar

34. The psychiatrist's role in mental health and psychological counseling settings?
   1. __Not at all           2. __Very little           3. __Somewhat           4. __ Very familiar

35. The psychologist's role in mental health and psychological counseling settings?
   1. __Not at all           2. __Very little           3. __Somewhat           4. __ Very familiar

36. The clinical social worker's role in mental health and psychological counseling settings?
   1. __Not at all           2. __Very little           3. __Somewhat           4. __ Very familiar

How much do you know about:

37. Classified medical/behavioral mental health or psychological disorders (e.g. depression, anxiety, schizophrenia, etc.)?
   1. __Nothing         2. __Very little           3. __Some              4. __ A great deal

38. The type of treatment models/clinical interventions (e.g. psychotherapy) used in professional mental health clinics?
   1. __Nothing         2. __Very little           3. __Some              4. __ A great deal

39. How to get professional mental health or psychological counseling services when needed (e.g. procedures and requirements)?
   1. __Nothing         2. __Very little           3. __Some              4. __ A great deal

40. Common drug treatments prescribed to individuals with mental health or psychological problem?
   1. __Nothing         2. __Very little           3. __Some              4. __ A great deal

41. The Arab and Muslim professionals who practice mental health or psychological counseling within your local community (Columbus, OH)?
   1. __Nothing         2. __Very little           3. __Some              4. __ A great deal

42. Your eligibility for mental health care under your current health insurance plan?
   1. __Nothing         2. __Very little           3. __Some              4. __ A great deal
APPENDIX E

Demographic Backgrounds Sheet
SECTION IV

In this section, I would like to have some general background information. Please respond to the following few questions by checking the appropriate corresponding answer. It is very important that you answer every question. Again, please remember that no name or other identifications are asked, so no one will know that this information belongs to you.

43. What is your Gender?
   __Male    __Female

44. When were you born (years)?
   19 ___ ___

45. Were you born in the U.S.A.?
   __Yes    __No

46. How do you describe your original nationality (If you are a U.S. citizen, select your father’s original nationality)?
   __ Algeria  __ Kuwait  __ Qatar  __ Tunisia
   __ Bahrain  __ Libya  __ Lebanon  __ U.A. E
   __ Djibouti __ Mauritania  __ Saudi Arabia  __ Yemen
   __ Egypt  __ Morocco  __ Somalia
   __ Iraq  __ Oman  __ Sudan
   __ Jordan  __ Palestine  __ Syria
   __ OTHER (specify) ______________________

47. What is your marital status?
   __Single  __Married  __ Divorced  __Widowed

48. How many years/months have you lived in the U.S.?
   Year/s ____  Month/s____

49. What is your highest (or current) level of education?
   __Less than high school  __Associate degree  __ Master degree
   __High school  __Bachelor’s degree  __ PhD degree

50. Which category best matches your family’s annual income?
   __Less than10, 000  __20,000-29,999  __40,000- 49,999  __60,000-69,999
   __10,000-19,999  __30,000-39,999  __50,000- 59,999  __70,000 or more

51. In the past three years, approximately how many times have you visited a medical doctor for a physical health concern?
   __Never  __1 or 2 times  __3 to 5 times  __More than 5 times
52. In the past three years, approximately how many times have you visited a mental health professional (psychiatrist, psychologist, or a clinical social workers) for a mental health or psychological concern?

- Never
- 1 or 2 times
- 3 to 5 times
- More than 5 times

53. Which of the following describes your occupation?

- Professional / administrator
- Student
- Unemployed
- Office employee / support staff
- Manual worker
- Other (specify)
- Personal business
- Housewife

54. What type of health insurance do you have?

- No health insurance
- Medicaid
- Medicare
- Commercial / Group

55. To whom would you go First if you were to consider seeking outside help for mental health/psychological counseling (select one only)?

- Mental health professional
- Family doctor (M.D.)
- Close friend
- Sheik (to obtain a Ruqia)
- Family member (e.g. father, etc)
- Nobody

56. To whom would you go Second if you were to consider seeking outside help for mental health/psychological counseling (select only one different from question # 54)?

- Mental health professional
- Family doctor (M.D.)
- Close friend
- Sheik (to obtain a Ruqia)
- Family member (e.g. father, etc)
- Nobody

57. To whom would you go Third if you were to consider seeking outside help for mental health/psychological counseling (select only one different from question # 54 and 55)?

- Mental health professional
- Family doctor (M.D.)
- Close friend
- Sheik (to obtain a Ruqia)
- Family member (e.g. father, etc)
- Nobody

* * * * * * *

May Allah Reward You

Please place this questionnaire in the stamped, addressed envelope provided to you and mail it as soon as you can. Thank you.

Comments:
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________
APPENDIX F

Letter of Support from The Islamic Society of Greater Columbus (ISGC)
May 23, 2003

Office of Research Risks Protection
310 Research Foundation Building
1960 Kenny Road
Columbus OH 43210-1063

Re: Letter of Support: Nasser Aloud

Dear Sir/Madam

This is a letter of support for Ph.D candidate, Nasser Aloud, to conduct his research activity, titled “Factors influencing attitudes toward seeking formal mental health and counseling services among Arab-Muslim population in Columbus, Ohio” within the Islamic Society of Greater Columbus (ISGC) facilities. We understand that the researcher will use the collected data for research purposes only and that no access to these documents will be given away to any other party without permission of the ISGC. The ISGC will provide adequate support for the researcher, giving full access to all ISGC facilities and events.

The ISGC appreciates this opportunity to support and help the OSU students and faculty. We are looking forward for further cooperation. If you have any questions, please do not hesitate to contact me at (614) 496-3796.

Yours Truly,

[Signature]

Hazem Gheith, Ph.D
President of the Islamic Society of Greater Columbus
APPENDIX G

The Ohio State University Human Subject Approval Form
Research Involving Human Subjects

ACTION OF THE INSTITUTIONAL REVIEW BOARD

- Full Committee Review
- Expedited Review
- Original Review
- Continuing Review
- Amendment

With regard to the employment of human subjects in the proposed research protocol

2003B0154 FACTORS INFLUENCING ATTITUDES TOWARD SEEKING FORMAL MENTAL HEALTH AND COUNSELING SERVICES AMONG ARAB-MUSLIM POPULATION IN COLUMBUS, OHIO, Keith M. Kilty, Nasser Aloud, Social Work

The Subjects were deemed NOT AT RISK and the protocol was unanimously APPROVED WITH CONDITIONS by means of expedited review (category 7) on June 6, 2003

the Behavioral and Social Sciences IRB has taken the following action:

- APPROVED
- DISAPPROVED
  - APPROVED WITH CONDITIONS *
  - WAIVER OF WRITTEN CONSENT GRANTED

* Conditions stated by the IRB have been met by the Investigator and, therefore, the protocol is APPROVED.

- No procedural changes may be made without prior review and approval from the IRB.
- You are reminded that you must promptly report any problems to the IRB.
- You are also reminded that the identity of the research participants must be kept confidential.
- It is the responsibility of the principal investigator to retain a copy of each signed consent form for at least three (3) years beyond the termination of the subject’s participation in the proposed activity. Should the principal investigator leave the University, signed consent forms are to be transferred to the Human Subjects IRB for the required retention period.

Date: June 6, 2003

Signed: [Signature]

Thomas E. Nygren, Chair
LIST OF REFERENCES


Farrag, M.F., Hammad, A. (2002). Reactions of Arab Americans to September 11, Terrorist Attacks. Arab American Community Center for Economic and Social Services (ACCESS). Detroit, Michigan


The Islamic Society of Greater Columbus. *The Islamic Social Services Committee*. Columbus, Ohio.


