Removing Barriers to Therapy with Muslim-Arab-American Clients

by

Jennifer Smith

B.A., New York University, 2005
M.S., Antioch University New England, 2009

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The undersigned have examined the dissertation entitled:

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by

Jennifer Smith

Candidate for the degree of Doctor of Psychology

and hereby certify that it is accepted*.

Dissertation Committee Chairperson:
Susan Hawes, PhD

Dissertation Committee members:
Gargi Roysircar-Sodowsky, PhD
Barbara Belcher-Timme, PsyD

Accepted by the
Department of Clinical Psychology Chairperson

Kathi A. Borden, PhD

on 10/24/11

* Signatures are on file with the Registrar's Office at Antioch University New England.

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Abstract

Extensive research has shown that members of ethnic minority groups tend to underutilize mental health care services. In light of both the great amount of trauma that many Muslim Arab Americans have experienced and the amount of discrimination this population has faced especially since September 11, 2001, their relative underutilization of therapeutic services could mean deprivation of the enrichment and aid that mental health care could provide. The assumption underlying this study was that a greater cultural understanding of Muslim Arab Americans' reasons for not choosing psychotherapy could help inform designs for more successful outreach efforts between mental health practitioners and people of Muslim-Arab-American backgrounds. This study elicited the attitudes of a select group of Muslim Arab Americans toward psychotherapy and explored their beliefs as to why members of this group of Americans tend not to use mental health services. Three semi-structured focus groups of Muslim-Arab-American participants provided the data for thematic analyses. Participants' comments during focus group discussions were consistent with the literature reviewed, and included themes of (a) culturally influenced conceptions of mental illness (including biologically based, spiritual/supernatural, and environmental causes); (b) acknowledgement of therapy as a potentially useful practice; (c) views of psychotherapy as unnecessary (and preferences for spiritual healing, help from friends and family, and/or medical advice); (d) views of psychotherapy as an ineffective practice; (e) perceived conflicts between psychotherapy and Islam; (f) adherence to a model of external locus of control; (g) adherence to a model of internal locus of control; (h) fear of stigma and shame; (i) cultural attitudes toward interpersonal openness and secrecy; (j) mistrust of mental health workers (regarding confidentiality, lack of cultural knowledge, biases, and motives); (k) lack of awareness of mental health services; (l) lack

of access to mental health services; and (m) suggested solutions. Strengths and limitations of the study, as well as suggestions for further research, are addressed.

Chapter 1

There is very little information available on the Muslim-Arab-American population's relationship with psychology and, specifically, with psychotherapy. This dearth of information is in stark contrast to the multitudes of information available on other cultural groups' attitudes toward therapy, including Asian Americans, African Americans, and Hispanic Americans. However, it is readily acknowledged by many researchers (e.g., Sue & Sue, 1990) that culture has a significant influence on ethnic groups' attitudes toward therapy and the specific attitude-related barriers that may interfere with this population's entry into therapy and ability to establish rapport with mental health providers.

The literature that exists on the attitudes of the Muslim-Arab-American population's attitudes toward psychotherapy demonstrates the large number of problems that this population encounters but does not discuss with mental health professionals. Instead, the research suggests, this population tends to seek help through extensive social and religious networks or through medical doctors, often avoiding psychotherapeutic services due to the large amount of stigma placed on seeking such services (Aloud, 2004). While social, religious, and medical resources can provide extensive support, serious mental illnesses, such as schizophrenia, post traumatic stress disorder (PTSD), major depressive disorder, or severe anxiety disorders, may require more psychological aid than these networks can reasonably provide. As a result, it is essential that research begins to explore some of the barriers that prevent this population from entering therapy. In identifying the specific barriers that prevent potential Muslim-Arab-American clients from entering psychotherapy, psychologists may be able to: (a) identify ways to recruit more Muslim-Arab-American clients into mental health services, (b) retain more Muslim-Arab-American clients who have entered therapy and (c) design outreach programs which can

specifically address the psychological needs of the Muslim-Arab-American population. While this is an extensive process that will require much more research and exploration, this study was designed to be one step in this process.

Statement of the Problem

Since its creation, the field of psychology has made great advances in understanding and addressing diverse populations. However, despite the advances of psychology in this regard, research suggests that racial and ethnic minorities within the United States continue to underutilize mental health services (Alberti, 2006; Alvidrez, 1999). While researchers continue to explore the influence of culture on underutilization of mental health services with some ethnic groups, only a few researchers are investigating the reasons for this occurrence within the Muslim-Arab-American population.

The relationship between Muslim-Arab-American culture and the greater American culture is a relatively complex one tied to an extensive and complex history of interactions between the "Western" American or European world and the "Eastern" Arab world. People from Arab countries first began immigrating to the United States in the 1880s, and there are now over 3.5 million people of Arab descent living in the United States, about 24% of whom are Muslim (Arab American Institute, *Demographics,* 2006). In facing immigration, Muslim Arab Americans must deal with the stress of acculturation, accompanied by the challenges of alienation, loss of social status, loss of social support, and sometimes unemployment and poverty (Ahmed & Reddy, 2007). Many Muslim Arab Americans also must confront some degree of prejudice given the United States' complex political and social relationship with Arab nations and Islam. As recent research shows, the Muslim-Arab-American population is facing increasingly levels of acculturative stress and prejudice since September 11, 2001 due to the

large degree of sociopolitical backlash caused by this event. For example, in 2001, the Federal Bureau of Investigation (FBI) reported a 17% increase in anti-Arab violence within the United States (Amer, 2005). In addition, since September 11, 2001, the American government has detained and interrogated large numbers of Arab Americans without any indication that crimes have been committed (Singh, 2002). While many Muslim Arab Americans display great resilience in their responses to these events (Arab American Institute, *Healing,* 2002; Beitin & Allen, 2005), the increased stress experienced by the Muslim-Arab-American population corresponds with an increase in mental health complaints to primary care physicians and spiritual leaders (Aloud, 2004; Brinson & Al-Amri, 2006). In fact, some extant research (e.g., Ahmed & Reddy, 2007) suggests that Arab Americans may have higher rates of anxiety and depression as compared to the general American population and the general Arab population, and Muslim Arabs may have have higher rates of PTSD than the general population of the United States.

Nonetheless, recent studies (e.g., Abu Ras, 2003; Aloud, 2004) have shown that this population is continuing to underutilize psychotherapy as a source of help. While some research has been done on the reasons for this occurrence in the past decade, to date the research has been largely contradictory and has lacked practical suggestions for solutions. Accordingly, it is important to continue to explore the beliefs and attitudes of this population in order to discover which barriers prevent this population from utilizing mental health services and to subsequently work to remove these barriers.

Rationale for the Study

In light of the changing political environment in the United States after September 11, 2001, the Muslim-Arab-American population in particular may be experiencing more psychological stress related to discrimination and acculturation than is being acknowledged

(Amer, 2005). While researchers are publishing more information about the potential reasons why this population is underutilizing therapy, most of the suggested solutions rely on the presence of this population at community mental health centers or private practices. However, it is important that we learn more about the specific barriers this population faces not only to educate psychologists, but also to design specific outreach programs which facilitate this population's entrance into psychotherapy. It is the present researcher's belief that exploring the barriers which prevent the Muslim-Arab-American population from entering therapy and then designing culture- and problem-specific outreach efforts could help recruit people in need of mental health services within this specific population into psychotherapy.

Research Questions

In order to contribute to existing research on the Arab and Muslim populations' underutilization of psychotherapy, this research seeks to address the following questions:

1. What are some of the culturally influenced conceptualizations of the causes and presentation of mental illness?
2. What are some of the predominant themes that arise in discussions about psychotherapy with Muslim-Arab-American participants? Are these themes consistent with the extant literature?
3. What are some of the negative expectations or predominant fears this population faces when entering psychotherapy?
4. What information might increase motivation for participants to engage in psychotherapy?
5. What can therapists do to be more accessible or appealing to these participants?

Operational Definitions

Because many terms used in this paper are used in a specific way or may be unfamiliar to readers, it is important to define each of these terms. The following definitions are provided based on the information available in the reviewed literature.

Arab-American. Although the term "Arab" is often misunderstood (Arab American Institute, *Demographics,* 2006), a person's identification as Arab-American neither means that the person is Muslim, nor does it mean the person is necessarily from the Middle East. The definition of what classifies a person as "Arab" is largely contested, but the most commonly used definition of "Arab" is a person whose ancestry can be traced to one of the 22 Arabic-speaking countries in the Arab League (countries spanning the Middle East and Africa). These countries currently include: Algeria, Bahrain, Comoros, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Mauritania, Morocco, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, and Yemen (Arab American Institute, *Demographics,* 2006). For the purposes of this study, Arab Americans are defined as any person of Arab descent (i.e., whose family came from one of the 22 countries in the Arab League), who currently lives in the United States and identifies as Arab-American.

Etic/Emic. Much anthropological research uses the terms "etic" and "emic" to describe scientific approaches. Anthropological theory defines an etic viewpoint as an "outsider's" perspective, or a perspective that attempts to objectively describe a culture from the outside but is affected by the outsider's biases. While some may see an etic perspective as stereotypical because it overlooks individual differences in an attempt to create a universalistic understanding of a culture, the etic perspective is also invaluable to clinicians as it can promote cultural understanding and cultural sensitivity. An emic viewpoint, conversely, is an "insider's"

perspective, meaning that the viewpoint comes from someone who lives within the culture. The emic perspective attends to individual differences of people within a certain culture which can arise from differing idiosyncratic experiences, levels of acculturation, socioeconomic status, and so on (Lee, 1996).

Hasad. Hasad is also referred to as the "evil eye," which is generally seen as the unintentional effect of envy (El Islam & Ahmed, 1971). The evil eye is essentially "the power of a wish" (El Islam, 1982, p. 6) and is created when someone envies another person's success, health, or prosperity. In general, people with blue or light-colored eyes are seen as more capable of inflicting the evil eye, and infants and children are believed to be especially vulnerable to its effects (Gorkin & Othman, 1994).

Imam. Imams are spiritual leaders in Islam who often lead worship services within the mosque. Imams frequently provide informal supportive counseling to people within the religious community and may provide advice based on interpretations of *hadith* and the Qur'an (Abu Ras, Gheith, & Cournos, 2008).

Jinn. *Jinn* are supernatural, good or evil beings who can take human or animal forms (Okasha, 1999) and are often thought to be made of "smokeless fire" (Gorkin & Othman, 1994, p. 226). The Qur'an occasionally refers to jinn, describing them as inferior to angels. Legends of jinn depict them as easily offended (El Islam & Ahmed, 1971) beings that occasionally choose to interfere with the lives of humans through possession or other means. The Arabic word for "mad" or "crazy," *majnoon,* originates from the word *jinn.*

Qur'an/Ahadith. The Qur'an is the holy book of Islam which is considered the word of God as revealed by the Prophet Mohammad. *Ahadith* (the plural of *hadith*) are collections of narratives which convey the words and actions of the Prophet Mohammad. Over the centuries,

Islamic scholars collected, recorded, and evaluated the accuracy of these narratives. Scholars consider *ahadith* to be important tools for understanding the Qur'an, especially the *Hadith Qudsi*, or sacred *hadith*.

Sheikh. A sheikh (also spelled shaikh, shaykh, or sheik) is an elder, wise man, or Islamic scholar. The term generally describes an older man (generally over 40 or 50 years old) who is revered by others and has often extensively studied Islam to the extent where he can give lectures in Islamic principles. Visiting the tomb of a deceased sheikh is in many ways similar to the Christian notion of praying to saints, as sheikhs are believed to be able to confer blessings (*baraka*) to people who come to their tombs and ask for help (El Islam, 1982).

Sheitan/Shaytan. *Sheitan* can refer to either "the Devil" or "devils," alluding to beings who rebelled against God. Many people believe that *sheitan* can plant negative thoughts or ideas in people's minds in attempts to lead them astray. The Arabic word for these ideas, obsessions, or temptations to commit sins is *wiswas* or *waswas*.

Sorcery (Sihr). The word *sihr* describes black magic performed by individuals such as witches or sorcerers who wish to do harm. Many people believe that witches or sorcerers form an alliance with *sheitan* and will call upon evil spirits to cause harm to or to attack others (El Islam, 1982).

Chapter 2

Review of Related Literature

This chapter addresses the literature that exists on the cultural influences on attitudes toward therapy and more specifically the culturally influenced barriers that may prevent Muslim Arab Americans from entering therapy. The sections of this literature review are, as follows: (a) general theories on help-seeking attitudes; (b) the influences of culture on help-seeking attitudes; (c) the background of mental health care and psychology within Arab countries; (d) the pattern of therapy underutilization that exists within the Muslim, Arab, and Muslim-Arab-American populations; (e) specific research that exists on the barriers that impede the Muslim-Arab-American population from engaging in mental health services (including biological or somatically focused conceptions of mental illness, spiritual/supernatural conceptions of mental illness, religious ideas which may conflict with therapy utilization, external locus of control, interpersonal openness within the Muslim and Arab populations, mistrust of mental health workers, and lack of awareness of mental health services or lack of access to mental health services); (f) previously suggested solutions which may aid in removing barriers to therapy with this population; and (g) a conceptual framework which summarizes existing research and proposes a theory on the nature of psychotherapy underutilization in this specific population.

Influences on Help-Seeking Attitudes

Over the last few decades, researchers have begun to explore what factors influence clients to seek professional help from a psychotherapist or other mental health worker. Fischer and Turner (1970) were among some of the pioneers to research this field, creating a test called the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPHS). Fischer and Turner standardized the test using a sample of college students varying in age, background, and

institutional affiliations. The test uses 29 Likert scale items to divide attitudes toward seeking professional help into four dimensions: Need, Stigma, Openness, and Confidence. The first dimension, "Need," describes the person's recognition of need for psychological help, which is inversely correlated with the belief that emotional problems will resolve themselves without help. The second dimension, "Stigma," expresses the person's ability to tolerate the stigma/shame associated with receiving psychological help. The third dimension, "Openness," explores the person's openness to discussing his/her problems with others, which is a concept related to his/her belief that problems should be discussed with others to be resolved. The fourth and final dimension, "Confidence," describes the person's confidence that the mental health professional would be able to help him or her.

In their research, Fischer and Turner (1970) concluded that the first dimension, Need, and the fourth dimension, Confidence, are strongly correlated and are most directly related to actual help-seeking behavior. Stated in another way, the most essential factors in a client's decision to seek professional help are that they (a) recognize the need to receive psychological help and (b) trust that the psychologist will be able to help. Fischer and Turner (1970) discovered that in general women tend to have a significantly more positive attitude toward psychotherapy than men, and people who attend psychotherapeutic services in the past tend to have significantly more positive views toward psychotherapy. Several subsequent researchers have utilized the ATSPPHS to find trends in help-seeking attitudes with specific populations.

Cultural Influences on Help-Seeking Attitudes

Extensive research has shown that ethnic minorities as a whole significantly underutilize mental health care services (Al Krenawi & Graham, 1999; Alberti, 2006; Alvidrez, 1999; Sue & Sue, 1990). While the idea of seeking therapy holds a stigma for almost any population, the

results of the national comorbidity study (NCS-R) showed that people from racial and ethnic minority backgrounds are significantly less likely to use mental health services than Caucasian people (Alberti, 2006). People of racial and ethnic minority backgrounds also tend to have a lower rate of retention within the mental health care system (Al Krenawi & Graham, 1999; Sue & Sue, 1990). Patterns of underutilization and poor retention remain even when separated from insurance coverage and socioeconomic status (Alberti, 2006), suggesting that there may be a culturally-specific reason why ethnic minorities underutilize therapy.

Several researchers hypothesize that ethnic minority groups' underutilization of mental health services is closely related to confidence in mental health workers' competency, a construct which comprises the fourth dimension of the ATSPPHS, "Confidence." Researchers suggest that underutilization may be attributable to some ethnic minority clients' mistrust of mental health care professionals resulting from fear that professionals who are racially or ethnically dissimilar to themselves will not understand their beliefs, and/or will be racist or biased (Constantine, Chen, & Ceesay, 1997; Leong, Wagner, & Tata, 1995; Sue & Sue, 1990). There may be added discomfort or lack of confidence in the effectiveness of psychotherapy if clients have difficulty speaking English (Marwaha & Livingston, 2002; Sue & Sue, 1990) or if clients are unfamiliar with one-on-one counseling and find it to be overly formal, disingenuous, and "alien" (Sue & Sue, 1990, p. 28). Potential clients from minority backgrounds who are unfamiliar with counseling also may not understand what makes therapy efficacious, and therefore may believe therapy will not be effective for certain problems (Hall & Tucker, 1985).

Research also suggests that ethnic minority clients may underutilize mental health services because of differing conceptions of the causes of mental illnesses. In a study conducted by Marwaha and Livingston (2002) on ethnic elders' views of psychotherapy, they found that this

particular group of clients may see non-psychotic illnesses such as depression as a spiritual problem or as a problem resulting from alienation. This conceptualization of symptoms of mental illnesses may lead ethnic elders to seek help from their friends, family, or spiritual leaders rather than therapists or medical professionals.

The History of Mental Health Services in the Arab World

As Okasha (1999) states, the earliest references to psychological concepts are found in Egyptian scrolls dating back to 1900 BC which refer to psychological ideas (albeit outdated ones) such as hysteria. Other papyri refer to depression, anxiety or worry, suicide, and psychosis (Okasha, 1999). Many of these scrolls depict an interest in the connection between organs, mood, and mental health. Since ancient scholars attributed many mental health problems to somatic causes, these disorders were often treated through some combination of physical/biological and magical/supernatural means. At this time, the most common solution for problems (often involving the heart) was the "Temple sleep." Ideally, this sleep would produce dreams which provided spiritual insight into the nature of and the solution for the problem (Okasha, 1999).

The introduction of Islam to the region accompanied a slightly different view of the causes of mental illness. Traditionally mystical or superstitious beliefs, such as beliefs in the influence of supernatural beings (*jinn*, *sheitan*, angels, etc.) remained. However, Islam brought an increased focus on the struggle between the spiritual/pure self and the physical/impure self. Mental illness was more frequently conceptualized as a defective relationship with God or a punishment for sins committed (Abu Ras et al., 2008). Cures for mental illness most frequently involved treating symptoms of depression, anxiety, etc. with *salat* (prayer), fasting, repentance, and recitation of the Qur'an (Abu Ras et al., 2008).

Over time, the philosophy of Galen began infiltrating the area, as Arab scholars translated and preserved many of the Galenic texts on the origins of mental illness during the Middle Ages (Retso, 2003). Galenic beliefs about the influence of humors (fluids in the body) on mental health and temperament continued to remain in favor for centuries. This period marked a return to ideas about somatic/biological causes of mental illnesses. During this time, extended families often cared for most people considered mentally unwell, and cures for mental illness often involved rehabilitative activities in the countryside (Okasha, 1999). Eventually, Arab countries began constructing mental hospitals or delegating sections of general hospitals for treatment of the mentally ill. As a general rule, more psychotic or violent patients were sent to these institutions (Al Krenawi, 2005); most people who might be labeled as "neurotic" relied on treatment through sheikhs or traditional supernatural rituals (Okasha, 1999).

In several countries, such as Lebanon, Iraq, Kuwait, and Saudi Arabia, psychology as a discipline only emerged in universities in the 1950s, and independent psychology departments were not established until the 1970s or 1980s (Ahmed, 1992). Currently, few countries offer graduate degrees in psychology and the great majority of graduating psychologists enter academia instead of practice (Al Krenawi, 2005). In the meantime, psychiatric hospitals and outpatient clinics tend to struggle to receive adequate funding, and are largely affected by economic and political factors (Okasha, 1999). While a handful of psychiatric hospitals and outpatient clinics exist in Arab countries, they are most often used by people with only the most serious mental illnesses, such as schizophrenia (Okasha, 1999). The majority of mentally ill Arabs continue to rely on traditional, religious, or medical healing methods (Al Krenawi, 2005; El Islam & Ahmed, 1971; Okasha, 1999).

Mental Health Service Underutilization in the Middle East

Research conducted in several countries outside of the United States, such as in countries in the Middle East, shows a general pattern of therapy underutilization by Muslim and Arab populations. For example, research done by Al Krenawi (2002) in Israel showed that non-Jewish Arabs in Israel were less likely to use mental health services than Jewish people in Israel as recorded by national data on mental health clinic utilization; while Arabs make up approximately 19% of the population in Israel, they only comprise 2.8% of the consumers of mental health services there. In addition, research conducted in Jordan showed a strong preference for medical or traditional supernaturally based healing techniques versus psychotherapeutic interventions. As noted by Al Krenawi, Graham, and Kandah (2000), a sample of 87 nonpsychotic outpatients in Jordan (especially younger female participants) tended to prefer seeing general practitioners or traditional healers over psychotherapists. Similar findings were noted in research conducted by El Islam and Ahmed (1971) on a sample of 153 Egyptian outpatients, who tended to describe psychiatric symptoms as resulting from bodily weakness or supernatural causes, leading many to seek mental health services as a last resort.

Mental Health Service Underutilization in Australia

In recent years, there has been an increase in research done on the Muslim and Arab populations in Australia. Australian research showed that Arabic-speaking populations attended therapy significantly less frequently than English-speaking populations (McDonald & Steel, 1997; Tobin, 2000). In addition, McDonald and Steel found that Middle Eastern clients in Australia used community mental health services less frequently than the general population and were less likely to be voluntarily hospitalized for schizophrenia, depression, or anxiety than the general population. However, Middle Eastern clients on average had a longer hospital stay than

other clients. These findings on Arab or Middle Eastern populations in Australia, while not directly applicable to Arab populations in the United States, support the idea that there is a cultural component to this population's therapy underutilization.

Mental Health Service Underutilization in the Muslim-Arab-American Population

While the annual national percentage of Americans who attend therapy in their lifetimes is not significantly high, reaching approximately 4% (Olfson, Marcus, Druss, & Pincus, 2002), several studies suggest that the percentage of Muslim Arab Americans who attend therapy in their lifetimes may be significantly lower than the general population. For example, in a sample of 3000 students in Pennsylvania, Levy, Critchfield, Hill, Lopez-Castro, and Lukowitsky (in press) found that Muslim Americans were more than six times less likely than Christian Americans to seek mental health services. Other studies (e.g., Amer, 2005; Haque-Khan, 1997) support this finding, suggesting that Muslim Americans may be less likely to seek help than Americans of other religions. In addition, research by Khan (2003) indicated that Arab Americans are less likely to use counseling services than Caucasian Americans or African Americans.

While it is somewhat unclear why a person's identification as Muslim, Arab, or both corresponds with underutilization of mental health services, research has attributed this occurrence to several possible causes. One common explanation of mental health service underutilization is that cultural differences in conceptions of the causes and symptoms of mental illness may cause potential clients to seek alternative healing techniques other than psychotherapy (Al-Adawi et al., 2002; Aloud, 2004; El Islam, 1982; El Islam & Abu Dagga, 1992; Haque-Khan, 1997; Okasha, 1999). For example, clients' tendencies to somaticize psychological distress may lead them to seek medical services instead of psychotherapy (Jamil et

al., 2005; Okasha & Okasha, 1999). Additionally, due to stigmatizing cultural conceptualizations of causes of mental illnesses (due to *sheitan* or lack of faith), as well as potential consequences to mental health diagnoses (such as decreased marriage potential for women), potential clients face large amounts of stigma against seeking mental health care (Abu Ras, 2003; Dwairy & Van Sickle, 1996; Haque-Khan, 1997). Moreover, clients often have expectations that mental health workers will not be culturally competent (Abu Ras, 2003; Aloud, 2004; Aroian, Katz, & Kulwicki, 1997; Dwairy & Van Sickle, 1996; Haque-Khan, 1997), and many potential clients lack awareness about mental health services (Abu Ras, 2003; Aloud, 2004; Brinson & Al-Amri, 2006).

Although women generally have a more positive view of psychotherapy than men (Fischer & Turner, 1970), previous research has shown that Arab women tend to be less likely to engage in psychotherapeutic services than Arab men (Abu Ras, 2003; Al Krenawi, 2002). One proposed reason for this occurrence is the fact that Muslim Arab women may be more likely than men to attribute mental illness to spiritual or supernatural causes such as sorcery and the evil eye and therefore may be more comfortable or familiar with traditional spiritual cures (Al Krenawi & Graham, 1999). Another hypothesis ties to the fact that Arab (and specifically Muslim Arab) women traditionally hold the larger burden of a family's honor (Abu Ras, 2003; Al Krenawi et al., 2000; Douki, Zineb, Nacef, & Halbreich, 2007; El Islam, 1982), and the act of disclosing family affairs to someone outside of the family is seen as shameful and dishonorable (Abu Ras, 2003; Haj-Yahia, 1995). As a result, if a woman seeks psychological services and is diagnosed with a mental illness, she is more likely than a man to be ostracized by her family, divorced, abused, or possibly even murdered (World Health Organization, 2000). Therefore, researchers hypothesize that Muslim Arab women often see mental health as a lower priority and are more

likely to avoid mental health services and hospitalization despite the fact that they tend to experience higher rates of anxiety and depression (Douki et al., 2007). When a woman begins showing signs of mental illness, her extended family may take over her everyday roles until her symptoms remit to preserve her marriage and other relationships (El Islam, 1982). However, some studies have shown that older women may have more positive views toward psychotherapy than younger women (D'Alessandro, 2007), which may correspond with a higher level of freedom and mobility (Al Krenawi, 2002).

It is important to note that there are also several noted individual differences among people within this population that may affect willingness to seek professional psychological help. Some of these differences include acculturation level (Haque-Khan, 1997), formal education level (Al Darmaki, 2003; Al Krenawi, 2005; El Islam & Abu Dagga, 1992; Khan, 2003; Ojanen, 1992), degree of collectivistic versus individualistic thinking (Al Krenawi & Graham, 1999), religious traditionalism (Al Adawi et al., 2002; Aloud, 2004; Ojanen, 1992; Haque-Khan, 1997), gender role adherence (Al Krenawi, 2002; Haque-Khan, 1997), generational status (Al Adawi et al., 2002; Al Krenawi, 2005; Marwaha & Livingston, 2001), marital status (Al Krenawi, 2005), family views about psychotherapy (Al Darmaki, 2003), perceived prejudice from mental health providers (Haque-Khan, 1997), coping skill development (Haque-Khan, 1997), and perceived need for help (Khan, 2003). Most of these studies show that younger, less culturally traditional, more highly educated, acculturated, individualistic, and modern people have more positive views toward therapy.

Interestingly, some studies (e.g., Al Darmaki, 2003) indicate that there is no significant difference between nationalities in help-seeking attitudes—for example, Al Krenawi, Graham, Dean, & Eltaiba (2004) found no significant differences among women from Egypt, Jordan and

the United Arab Emirates on help-seeking attitudes as measured by a modified Orientation for Seeking Professional Help (OSPH) questionnaire. However, prevalence of mental health services varies significantly between countries (Al Krenawi, 2005; Brinson and Al Amri, 2006) and therefore may affect attitudes toward psychotherapy through familiarity.

Interviews with Muslim Arab Americans suggest that there are certain issues which would lead an individual to seek mental health services more readily. For example, many respondents stated that they would seek mental health care or encourage a family member to seek mental health care if they displayed memory loss, aggression, lack of control over actions, substance abuse problems, or suicidal feelings (Haque-Khan, 1997). Some research also indicates that Arab couples may be more likely to enter therapy than families (Abudabbeh & Aseel, 1999), or that Muslim Arabs would be more likely to enter therapy for marital problems or family problems than individual problems (D'Alessandro, 2007; Haque-Khan, 1997).

Biological/somatic conceptions of mental illness. Research shows that the Muslim-Arab population tends to experience and express mental illness, especially depression and anxiety ("nervousness"), through description of somatic symptoms (Dwairy, 1998; El Islam & Ahmed, 1971; Okasha, 1999). Clients who are later diagnosed with mental illnesses often initially visit family practitioners presenting with vague physical complaints such as "bodily weakness" (El Islam & Ahmed, 1971) rather than emotional and cognitive aspects of mental illness (Al Krenawi, 2005; Dwairy, 1998). For example, Arab women, especially divorced women (Al Krenawi, 2005), often present with classic conversion symptoms such as breathlessness, vomiting, pareses, jerking movements, speech disturbances, and sometimes temporary blindness (El Islam, 1982). In fact, diagnoses of conversion disorder are uncharacteristically high among Arab outpatients and inpatients, constituting 8% of inpatients in

Saudi Arabia, 10.9% of inpatients in Egypt, and 10% of inpatients in the Sudan (Dwairy, 1998). Many researchers believe that the degree of somatization within this population is due to the high stigma attached to mental illness, as some people attribute symptoms of mental illness to lack of faith and nonadherence to the rules laid out by Islam (Al Krenawi, 2005; El Islam, 1982; Okasha & Okasha, 1999; Roysircar, 2003). Other researchers (e.g., Erikson & Al-Timimi, 2001) argue that somatization may be affected by a heightened awareness of the mind—body connection or linguistic differences in symptom expression among this population. As Okasha (1999) proposes, mental illnesses may also be expressed through somatic symptoms more frequently (especially in men) as somatic responses receive more acceptance and nurturing responses, versus psychiatric symptoms, which are disregarded, heavily stigmatized, and labeled. In addition, as Sayed (2003) proposes, people in the Arab world tend to view illnesses from a medical model or a biologically based perspective. As a result, people from Arab cultures may be more likely to turn to pharmacotherapy for a "cure" instead of psychotherapy "just to talk" when a psychological or psychiatric problem is identified.

Spiritual and supernatural conceptions of mental illness. As El Islam and Abu Dagga (1992) argue, supernatural explanations of mental illness are deeply embedded in Muslim Arab culture. Reliance on traditional, supernatural explanations and mystical cures for mental illness is present in all segments of the Muslim-Arab population, even highly educated medical students in Arab countries (Al Adawi et al., 2002). There are four primary supernatural occurrences to which mental illnesses are attributed: possession by *jinn*, sorcery, the evil eye or *hasad*, or effects of Allah or the devil (El Islam & Ahmed, 1971). Supernatural causes are often blamed for bizarre behaviors or psychotic symptoms, and as a result, traditional spiritual rituals tend to be

the most common initial solution for these types of diagnoses (El Islam, 1982; El Islam & Ahmed, 1971).

Jinn are one of the more common explanations of mental illness. The traditional belief is that evil *jinn* will possess a person in retribution for making them angry (El Islam & Ahmed, 1971). Traditional legends dictate that *jinn* can be angered through subtle actions. Since they are often believed to be disguised or invisible, a person may offend *jinn* by stepping in a puddle and unintentionally splashing the being (El Islam & Ahmed, 1971). If a person suspects he or she may be possessed by a *jinn*, he or she will often visit a traditional healer who can use several means (e.g., horoscope reading, channeling of spirits) to diagnose this problem (Gorkin & Othman, 1994).

Another traditionally believed cause of mental illness is *mas,* sorcery or intentional black magic cast on a person for malicious reasons (El Islam & Ahmed, 1971). The traditional cure for this occurrence is sorcery-undoing rituals, which may or may not be successful. The evil eye, in contrast to *mas*, is believed to cause problems unintentionally through the evil-eye-caster's envious fantasies (El Islam & Ahmed, 1971). Problems caused by the evil eye, in contrast to sorcery, tend to be seen as relatively easy to resolve.

Finally, many people believe that mental illness results either from *sheitan* or Allah as punishment for a lack of faith or failure to conform to the guidelines of Islam (El Islam, 1982). As Mohamed (1995) argues, one of the ways individuals are believed to become "prone to mental and spiritual sicknesses" (p. 15) is by deviating from Islam or *fitrah* (one's innate good nature). Some Muslims also believe that *sheitan* will plant *waswas*, or worrying thoughts, in one's mind (El Islam, 1982) when one begins to stray too far from the religion. Given the nature of this attribution for mental illness, mental illness seen as resulting from this cause carries a

large degree of stigma. People who attribute psychological symptoms to this cause will most likely acknowledge the need for spiritual guidance versus psychotherapy.

There are several traditionally accepted remedies for these supernatural causes of mental illness, including particular suras in the Qur'an, amulets inscribed with Qur'anic verses, *hejab* (pieces of paper covered in suras or symbols which can be carried, ingested, or burned), hypnosis, massage, visits to the burial sites of sheikhs, *zaar* (a depossession ritual for evil spirits which sometimes involves sacrifices), and/or sorcery-undoing rituals (El Islam & Ahmed, 1971; El Islam, 1982; Gorkin & Othman, 1994). Generally, people seek to cure the evil eye through use of amulets and sheikh-visiting, while they may use multiple means to attempt to remedy possession and sorcery (El-Islam & Ahmed, 1971). Some people find that these remedies alleviate their symptoms, although some researchers (e.g., Gorkin & Othman, 1994) note that the healer acts as a therapist by encouraging catharsis through conversations about one's life and experienced symptoms. Many other people do not find that traditional cures help and will eventually attempt mental health services. For example, in a study by El Islam and Ahmed (1971) done with a sample of patients from outpatient clinics in Cairo, 2/3 of the patients had tried traditional supernatural rituals which had not worked and led them to seek medical and psychiatric advice. Within many mental health services, most if not all of clients have previously attempted traditional healing techniques (Al Krenawi et al., 2000).

Conflicting religious views. As many scholars emphasize, there is nothing overt in Islamic texts that states that Muslims should not attend psychotherapy or seek help outside of the religion or the religious community. There is instead more of an implicit, culturally embedded attitude that seeking help from outside sources is unnecessary (El Azayem & Hedayat-Diba, 1994). Many people believe that the Qur'an along with hadith provides all necessary answers

(or the way to find the answers) on how to prevent and treat emotional distress or everyday problems (Abu Ras et al., 2008). Islam places a high emphasis on the importance of faith, devotion, gratitude, patience, and perseverance (El Azayem & Hedayat-Diba, 1994). Generally, displays of devotion to God such as prayer (*salat*), fasting (*sawm*), repentance (*tawbah*), and recitation of the Qur'an (*dhikr*) are the most culturally accepted ways of preventing and treating problems that may be seen as symptoms of mental illness, which may encourage devout Muslims not to seek help from outside sources immediately.

However, there are a few more overt religious beliefs that may lead people to avoid psychotherapy. First, a potential client may see paying money for help with personal problems as inconsistent with the teachings of Islam (Brinson & Al-Amri, 2005). This may occur because some people view the practice of receiving money for providing aid as dishonorable and greedy. As one traditional healer stated, "It is forbidden to request money for assisting in God's work" (Gorkin & Othman, 1994, p. 222). Moreover, some people believe that talking about their problems in psychotherapy is complaining, and some of the *hadith* communicate that "complaining to anyone other than God is a disgrace" (Dwairy & Van Sickle, 1996).

In addition, as Jafari (1992) argues, many of the values of Western psychotherapy are seen as fundamentally inconsistent with Islam. For example, the author argues, Western psychotherapy tends to encourage the therapist to provide unconditional positive regard, while Islam places an emphasis on acknowledging sinful behavior, repenting, asking for forgiveness, and promising not to engage in sinful acts again. In addition, Western psychotherapy encourages self-fulfillment, which diverges from Islam's emphasis on "righteous benevolence." Moreover, Western psychotherapy encourages happiness and freedom while Islam emphasizes a preservation of innocence, faith, community-mindedness, and accountability (Jafari, 1992).

External locus of control. First, it is important to note that Muslim Arab Americans may be more likely than other Americans to assign an external locus of control to their problems (Dwairy, 1998). Many Muslim Arab Americans view events in their lives as the influence of God, which may serve some larger purpose (Dwairy, 1998). As a result, they may be more inclined to either accept problems as the will of God or seek help and guidance from God instead of attempting to resolve their concerns on their own (Brinson & Al-Amri, 2005). The external locus of control present in Islam is displayed through one of the most commonly used phrases in Arabic, *"in sha'a Allah,"* which means "if God wills it" and indicates submission to the will of God (Aloud, 2004). Depending on the way this attitude is adopted, this external locus of control may foster passivity and sometimes a sense of helplessness (Dwairy, 1998).

Interpersonal openness. As previously noted, there is a cultural taboo against exposing personal or familial problems to people outside of the family or close social network (Ahmed & Reddy, 2007). This is especially the case with women, whom the culture generally acknowledges as the bearers of a family's honor, and who could ruin their prospects for marriage by engaging in this taboo act (Abu Ras et al., 2008). This emphasis on privacy and repression of authentic thoughts and feelings is adaptive in what Dwairy (1998) labels the "authoritarian collectivistic society" that exists in many Arab countries. As Dwairy (1998) argues, in this culture, it is essential to express feelings and thoughts which will not conflict with the expectations and demands placed upon people by their families and greater society.

Mistrust for mental health workers. Another influence in Muslim Arab Americans' low utilization of psychotherapy is mistrust for mental health workers. In some cases, this includes disbelief that American mental health workers will know about Arab culture and will be sensitive to cultural norms without attempting to promote American values of independence,

unbounded freedom, and secularism (Abu Ras et al., 2008; Brinson, 2005; D'Alessandro, 2007; Haque-Khan, 1997; Jafari, 1992). Many Muslim Arab Americans are aware of the secular, individual-focused nature of most psychotherapy (Jafari, 1992). As one Muslim woman expressed,

> If [a therapist] wants to say like Americans, if it makes you feel good then go and do it, this doesn't work. I don't know if every American counselor says that, but a lot of counselors say that. It doesn't work and I don't support that at all. And as a Muslim, it is going to create more problems because you have this dichotomy or schizophrenic personality. They have their value systems and you have your *shariah* [Islamic law] that tells you what to do in many cases. And then you go to a counselor and he tells you if it feels good then go do it. (Haque-Khan, 1997, p. 129)

As this quote suggests, many Muslims may feel that American psychologists will promote American values which will complicate their lives and exacerbate their problems by isolating them from their traditional families and the religious community (Haque-Khan, 1997; Jafari, 1992). As a result, they may avoid traditional psychotherapy and prefer to go to mosques, family, friends, or religious institutes (Abu Ras et al., 2008). Many other Muslim-Arab-American people see use of therapy (e.g., sitting around and talking) as self-indulgent. As one Muslim-Arab-American woman in a study done by Haque-Khan remarked, some people "think [you enter therapy] because you are bored and you have nothing else to do" (p. 177).

There is also a large fear of confidentiality and privacy when entering psychotherapy, especially since seeking therapy is generally viewed as a large taboo in Muslim-Arab culture

(Ahmed & Reddy, 2007). Many clients, especially illegal immigrants and refugees, may fear that therapeutic documentation may be used against them. This may also be a problem for Muslim-Arab-Americans who fear being tracked or monitored as a result of the political unrest in the United States since September 11, 2001.

Lack of awareness of or access to resources. While it is less referenced than other causes, another suggested reason for underutilization of therapy by Muslim Arab Americans is lack of awareness of mental health resources or lack of access to these resources (Abu Ras, 2003; Ahmed & Reddy, 2007; Aloud, 2004). For example, in a study conducted by Abu Ras (2003) of Arab immigrant battered women in Detroit, approximately 93% (n = 62) of his sample indicated that they were unaware of the mental health services that existed in their area or how these services worked, and approximately 93% (n = 62) indicated that they avoided services due to the fact that services were not affordable. This lack of knowledge of services or access to services can be influenced by several factors, including language barriers, poverty, unemployment, and lack of social support and social networks, factors which may be especially high in refugee populations (Ahmed & Reddy, 2007). Without financial resources, transportation, knowledge of the language and customs, and others to rely upon to attain knowledge and resources, it is difficult for a potential client to learn about mental health service accessibility and engage in mental health services.

Suggested Solutions

Although the APA (2003) promotes several guidelines for conducting therapy with multicultural populations in a culturally sensitive way, many potential clients may be unaware of these guidelines and may hear of some practitioners who have not fully followed these guidelines. As a solution to the underutilization of therapy by Muslim Arab Americans, many

psychologists (e.g., Al Krenawi & Graham, 2000; Erickson & Al Timimi, 2002) suggest that therapists should seek greater education about Arab culture and the tenets of Islam. In order to competently see Muslim-Arab-American clients, therapists should understand that marriages in this population are often more pragmatic and gender roles tend to be more hierarchical in nature (Erickson & Al Timimi, 2002; Hall & Livingston, 2006; Hall & Tucker, 1985). In these areas, therapists should accept that Muslim-Arab-American clients may have a different worldview than themselves without attempting to change it.

Moreover, they suggest that therapy with Muslim Arab Americans should involve the family if possible (Ahmed & Reddy, 2007) and should be concrete and structured (Dwairy & Van Sickle, 1996). Therapists should also be clear about the empirical support for psychotherapy, as potential clients will most likely value supporting evidence on psychotherapeutic efficacy (Abu Ras et al., 2008). Therapists may benefit from implementing an eclectic approach of psychoeducation and cognitive-behavioral interventions (Al Krenawi & Graham, 2000; Erickson & Al Timimi, 2002) or may want to use more narrative approaches to show respect and value for cultural conceptualizations of mental illness (Ahmed & Reddy, 2007). Several scholars suggest these approaches because many Muslim Arab Americans may enter therapy seeking short-term solutions (Al-Krenawi et al., 2000; Douki et al., 2007) and concrete advice (Jafari, 1992). On the other hand, the concept of catharsis and the curative process of expressing one's feelings are somewhat foreign ideas, because the Arab culture does not place as much of an emphasis on talking about feelings as the larger American culture (Ben Ari, 1998; Haque-Khan, 1997). In fact, many Muslim-Arab-American people believe that introspection is one of the causes of mental illness (Dwairy & Van Sickle, 1996). When treating Muslim Arab Americans,

researchers note, it is also important to avoid using excessive jargon in treatment of Arab clients who may not speak English as a first language (Ahmed & Reddy, 2007).

If possible, many psychologists also advise integrating Muslim spirituality or traditional indigenous healing into the therapy (Al Krenawi, 2005; Hamdan, 2007). By incorporating the beliefs of a client, the therapist communicates respect for a client's culture and is working to build a therapeutic alliance. In a similar light, it may be helpful to work in collaboration with a community center to target group level beliefs about therapy (Alberti, 2006) and also perhaps provide imams with information about mental illness and some basic intervention techniques (Abu Ras et al., 2008).

Conceptual Framework

Research has shown that ethnic minorities tend to use mental health services less than Caucasians (Alberti, 2006; Al Krenawi, 1999; Alvidrez, 1999), and specifically that Muslim Arabs tend to underutilize mental health services (Abu Ras, 2003; Aloud, 2004). This underutilization seems to stem from several sources, including: (a) perception of lack of need for mental health services, stemming from a lack of awareness of what the causes and symptoms of mental illness are, and a tendency to attribute events to somatic or spiritual causes and therefore seek alternative help; (b) a high degree of stigma from acknowledgement of mental illness and seeking mental health services, which may be fueled by the existence of an authoritarian collectivistic society; (c) a cultural emphasis on maintaining privacy and keeping issues/needs within the family or at least the greater cultural community; (d) mistrust of mental health professionals stemming from fears of racism, cultural incompetence, or general lack of knowledge and ignorance; and (e) lack of awareness of the benefit of psychotherapy and what services may be available or lack of access to resources. The strength of these themes may vary

based on a participant's age, gender, marital status, education, level of acculturation, cultural and religious traditionalism, and coping skills or degree of need. Extant research suggests that it is possible that provision of information about the nature and causes of mental illness, confidentiality in mental health services, cultural competence of therapists, and the availability of services may improve this population's utilization of therapeutic services.

Chapter 3

Methodology and Research Design

Due to the goal of this study to learn more about Muslim Arab Americans' beliefs about and attitudes toward psychotherapy in order to inform treatment and outreach efforts, a qualitative study appeared to be most appropriate fit. As noted by Phillion (1995), qualitative research is especially appropriate in research done with specific cultures as it allows members of the specific cultural group to express phenomena in their own culturally influenced language. Researching the specific use of language in these phenomena can help to shape psychotherapy and other interventions so that it is more appropriately tailored to specific populations.

This study was conducted utilizing three semi-structured focus groups designed to explore participants' attitudes toward therapy and their suggestions for potential solutions to this population's underutilization of mental health services. Focus groups allow participants opportunities to openly express their opinions and collaboratively make sense of a problem in an informal environment supportive of self-disclosure (Wilkinson, 2003). Focus groups also provide the researcher opportunities to observe and analyze the interactions between participants (Krueger, 1997).

In this chapter, I discuss the constructivist (Mertens, 2005) scientific paradigm that informs this study's methodology, Interpretive Phenomenological Analysis (IPA), the research methods of this study (participants and sampling, procedure and data collection, data analysis, and quality control), ethical considerations of the research methods, and the validity and transferability of the study's results.

Research Paradigm and Epistemology

The research done in this study is founded upon a constructivist paradigm, which assumes that all knowledge is socially constructed and that researchers should focus on studying individuals' lived experiences as they understand them (Mertens, 2005). This paradigm asserts that there are multiple subjective, socially constructed realities that emerge in social interactions, which are affected by history, human culture, education, age, gender, social class, and social environment (Creswell, 2007; Mertens, 2005). As argued by Lee (1996), a constructivist paradigm is especially appropriate in cross-cultural studies such as this one, as it aims to prevent either an overly universalistic or a stereotypical view of participants. The constructivist viewpoint sees participants as individuals who are, to differing degrees, shaped by implicitly or explicitly expressed cultural beliefs and attitudes, the language used by peers, family, and significant others in their environment, and the actions of those around them. As such, constructivist paradigms encourage the researcher to see both the individual person who has ideographic experiences and the way that his or her culture and environment affects these experiences (Lee, 1996).

This research also adheres to a pragmatic research paradigm, as the research was designed to explore participants' personal experiences and points of view in depth with the pragmatic objective of using these points of view to suggest potential solutions to the widespread problem of mental health service underutilization among this population. As such, the research was conducted with a greater focus on resolution of the problem than on conducting research that supports the existence of this phenomenon or potential cause and effect relationships that exist.

Methodology

This study's methodology integrates a Focus Group method with Interpretive Phenomenological Analysis (IPA). The latter method explores participants' perceptions of the phenomenon of underutilization of therapy in depth, with an understanding that participants' perceptions of this phenomenon may be influenced by differing individual experiences, as well their levels of acculturation, adherence to gender norms, and so on. Interpretative Phenomenological Analysis attempts to achieve an "insider's perspective" (Smith & Osborn, 2003, p. 51) by interviewing several individuals and analyzing the themes that emerge in their statements. An IPA researcher assumes that there is a connection between the expressed opinions of participants and their perceptions although there are many factors that complicate this relationship. An IPA researcher acknowledges that participants may have trouble expressing their opinions because they may have difficulty interpreting their thoughts and feelings, they may be hesitant to openly self-disclose when in an unfamiliar environment, and they may change their opinions because of social interactions with other participants (Smith & Osborn, 2003). As a result, it is important for the researcher to interpret the expressed thoughts and feelings of the participants with the expectation that these factors are influencing what a participant expresses, and that the expressed opinions are not permanent or universal.

Role of the Researcher

The role of the researcher in IPA research is to ask questions that allow him or her to conduct a detailed analysis of participants' perceptions. As argued by Smith and Osborn (2003), the most appropriate way to engage in this analysis is through use of semi-structured interviews as this format allows the researcher and participants to engage in a dialogue about the

phenomenon with the added freedom of being able to probe different areas of interest during the interview.

To conduct effective research in this manner, a researcher should do everything in his or her power to build rapport and trust with participants who may be suspicious about his or her motives. As a result, I saw it as necessary at the beginning of each group to briefly describe the rationale for the research: to study the underutilization of psychotherapy by Muslim Arab Americans, who may have several unaddressed mental health needs, in order to educate psychologists on potential solutions to this problem. In addition to standard questions about confidentiality, several participants took this time to ask questions about my motives for conducting the study and about how I became interested in this topic. I found it necessary to provide the answers to these questions while still withholding my own theories about the potential reasons for therapy underutilization. Throughout the focus group discussions, participants occasionally continued to ask questions about the reasons for my questions. I attempted to address these questions without providing too much information from the literature in order to avoid guiding participants to provide specific answers.

Participants and Sampling

Participants were recruited using snowball or convenience sampling methods (Mertens, 2005), a sampling technique in line with a pragmatic research paradigm, in order to maximize participant involvement. After speaking with and obtaining approval from community links in several Islamic and Arab cultural centers in New England, I distributed fliers (Appendix A) via email and listservs requesting participants for focus groups that were intended to explore Muslim Arab Americans' views about therapy. Personal acquaintances and friends with links to the Muslim-Arab-American community were also contacted with the same fliers. These fliers

specified that I was looking for participants who were first or second generation Arab Americans and who identified as Muslim, discussed the rationale and nature of the study, disclosed my goal to make therapeutic services more culturally sensitive and more accessible to Muslim Arab Americans, and addressed potential concerns about confidentiality. The fliers also provided a list of sample questions (Appendix B) and my email address and phone number to encourage questions about the study. Participants were informed that there would be food and beverages provided during the discussion, and that each participant would receive $10 for their participation, which could also be donated to the cultural center with which they were affiliated. All questions about the reasons for the study, inclusion criteria, and participant concerns were addressed via email correspondences, phone conversations, or both.

As a recent convert to Islam, the community members accepted me as a Muslim "sister." As a result, it was significantly easier to recruit female participants, who welcomed me into their homes and were often accompanied by friends to aid in my research. On the other hand, I had greater difficulty recruiting male participants, and most male participants who had agreed to participate in the research did not participate in the focus group discussion. While there may be a variety of complex factors that led to this outcome, given the sometimes strict division between genders in Muslim culture (Aroian, Katz, & Kulwicki, 2006), it is possible that it felt improper or uncomfortable for a group of men to meet with me, a female researcher. In the end, I recruited 14 participants, 4 of which were male, and 10 of which were female, for a total of 3 focus group discussions lasting approximately 1.5 to 2.5 hours.

Groups were organized in an attempt to create semi-homogeneous groups as recommended by Krueger (1997); however, group members' availability and mobility were limited, making a more pragmatic grouping of participants necessary; in this case, location was

the primary grouping principle. Group size ranged from 2 members to 9 members. While the researcher aimed for the standard 6 to 10 participants (Krueger, 1997), participants canceling, not showing up, and bringing friends and acquaintances to group discussions impacted group size.

Participants came from varying educational backgrounds and occupations. The majority of female participants had completed a high school education, and 4 female participants had completed a college degree, with one participant having received a master's degree. Many of the women in this group were housewives and mothers; some also worked outside of the home as teachers in the local *madrasa* [Muslim school]. One female participant worked full time as a high school teacher. The male participants tended to be highly educated. All of the male participants had completed college educations, with some having received masters or doctoral degrees. The male participants worked as professionals in the fields of information technology, medicine, education, and finance.

The study's participants came from differing countries of origin (some countries of origin included Egypt, Lebanon, Morocco, Algeria, Syria, and Jordan). All participants spoke fluent English. Although some first-generation participants had some difficulty expressing certain concepts in English, they relied upon other group members to translate certain terms or phrases from Arabic into English.

The first focus group was conducted with 9 Muslim-Arab-American women who were all associated with a particular Islamic center located in New England. These women ranged in age from 18 to 65, 6 of whom were first-generation and 3 of whom were second-generation. The second focus group was conducted with 2 Muslim-Arab-American men associated with the same Islamic center; although initially more men had been recruited, most of them failed to show up on the day of the focus group. The two male participants were both first-generation

professionals who were 30–40 years old. The third focus group was conducted with 2 Muslim-Arab-American men and 1 Muslim-Arab-American woman, who were recruited through either a colleague or a cultural liaison with ties to the Muslim-Arab-American community. This group of participants was also comprised of participants ranging in age from 30–50, who were highly educated professionals. Two of the participants in the third group were first-generation, and one participant was second-generation.

Procedure and Data Collection

At the beginning of each focus group, I distributed and reviewed the informed consent forms (Appendix C). As outlined by Locke et al. (2000), the informed consent forms explained: (a) the purpose of the research was to explore culturally influenced attitudes toward therapy in the Muslim-Arab-American population, (b) the protection of participant confidentiality through removal of identifying information, (c) the taping procedure and the fact that the tape was erased after focus group discussion transcription, (d) the immediate and broader social benefits to participating, (e) the participants' ability to discontinue participation in the study at any time without risk of reprisal and ability to not answer questions during the discussion, and (f) the names of people to whom participants could direct questions (Appendix C). Each participant kept his or her own individual copy of the signed informed consent form.

In order to show cultural sensitivity and respect for more conservative or traditional participants, this researcher made concerted efforts to dress modestly and appropriately, as suggested by Aroian, Katz, and Kulwicki (2006). As a result, this researcher wore *hijab*, including a headscarf, a tunic or *kurti*, and minimal makeup for each the focus group.

At the start of each discussion, I reviewed the “ground rules” for each focus groups: (a) to respect the confidentiality of others and not to discuss any information which may be disclosed

during the group, (b) to allow everyone who wants to speak a chance to speak, (c) to be respectful of differing opinions, and (d) to try to speak loudly and clearly so that the audio tape could be transcribed accurately. This followed the procedure outlined for focus groups by Krueger (1994), who states that the researcher sets the tone and safety of the group by reviewing group rules and by sanctioning and encouraging differing opinions. At the end of the review, participants agreed to follow these ground rules.

Throughout each focus group's process, I strove to maintain a relaxed, conversational atmosphere in which, with an attitude of genuine curiosity, I introduced open-ended questions prepared in advance. I maintained a balance between the goals of covering the prepared list of questions (Appendix B), and probing topics that fueled further discussions or needed further clarification at the time. As a result, focus groups tended to focus on different aspects of the same subject (e.g., one group focused more on the biological and spiritual aspects of mental illness, while another focused on the role of religion versus culture in attitudes toward therapy). For the most part, I encouraged group members to discuss any subjects that they found relevant, as it allowed participants a chance to openly express any associations to the topic.

Quality Control

In order to help support the trustworthiness of the study, interviews were transcribed from digital recordings within a few weeks of the focus group discussions. Digital recordings were reviewed at least twice to insure accuracy of the transcription. Transcriptions were then broken down into discrete comments, with any notes, associations, and interpretations recorded in another column on the data analysis sheet. These comments were then associated with the superordinate themes discussed in the literature (Appendix D).

Validity

While focus groups have strong face validity because participants can easily understand the research procedure and the researcher explicitly asks the questions of interest in the study (Krueger, 1997), there are also several factors that can diminish validity of focus group research. First, focus group participants may attempt to provide answers that they believe the researcher wants (Krueger, 1997). Although this researcher attempted to prevent this factor by encouraging participants to be entirely open and honest, participants may have felt that it would be impolite to fully disclose negative feelings about psychotherapy or psychologists. Second, participants in focus groups decidedly encounter social pressure by other participants that may impact their ability or comfort to disclose their true opinions, especially if they contradict other participants' opinions (Krueger, 1997). However, this is social pressure that exists outside of the focus group discussion itself, and is therefore an important factor to attend to within the study.

In addition, due to the pragmatic nature of this study, the transferability (the criterion in qualitative research that parallels external validity) is limited. The research described was only conducted with a small sample of Muslim Arab Americans in the Northeast and, therefore, should not be used to describe all Muslim Arab American people. The descriptions provided in this study are meant to broaden psychologists' understanding of the specific culturally influenced attitudes that members of this population may adopt.

Chapter 4

Results

In the first part of this chapter, I discuss the way that the transcribed qualitative data was organized, analyzed, and then divided into superordinate themes using an IPA based methodology. After briefly reporting the data analysis procedure, I discuss the most important superordinate themes that came out the analysis of the three focus group discussions, and tie the material mentioned to the topics described in the literature review.

Data Analysis

As is the case with most qualitative research (Mertens, 2005), the focus group research described underwent a prolonged data analysis process. In the case of this study, the data was analyzed using Interpretive Phenomenological Analysis methodology. First, the tape recorded focus groups were transcribed and reviewed several times for accuracy. After multiple rereadings of the transcripts, each thematically separate comment was numbered and entered into a spreadsheet (Appendix D). While reading each of the numbered comments, I recorded comments in the third column based on my observations, assumptions, interpretations, and associations. These comments also often included preliminary themes, which included themes such as “Preference for help from family,” “Views of Qur’an as healing,” “View of therapy as secondary aid” and so on. These preliminary themes were then transcribed and several flow charts were created in an attempt to link preliminary themes and create superordinate categories which were tied to the themes present in the reviewed literature. The superordinate categories were then entered into the fourth column of the spreadsheet presented in Appendix D. The superordinate themes discovered in this analysis are listed below in Table 1.

Table 1

Superordinate Themes Observed in Focus Group Discussions

Theme	Brief Description
Differing Conceptions of Mental Illness	Language use when discussing mental illnesses, broken down into biological, spiritual, and environmental causes
Biological causes of mental illness	The role of genetics, hormones, and "chemical imbalance" in mental illness
Spiritual causes of mental illness	The role of Allah, sheitan, jinn, possession, curses, and the evil eye in mental illness
Environmental causes of mental illness	The role of isolation, social support, and trauma in mental illness
Therapy as a Potentially Useful Practice	Acknowledgement of the uses of therapy
Therapy as Unnecessary	Participants' preferences for other forms of healing, including religion/faith, friends and family, and medical doctors
The healing power of faith	The belief that religion, faith, and imams can provide aid instead of psychotherapy
A preference for close friends or family	The culturally-rooted tendency to speak to family or friends before going to therapy
A preference for medical doctors	Belief in the role of doctors and medication in healing in lieu of psychotherapy
Therapy as not Effective	Disbelief in the potential effectiveness of Psychotherapy
Perceived Conflicts Between Therapy and Islam	Views of psychology as a secular field which could contradict religious principles
External Locus of Control	Belief in the role of the will of Allah
Internal Locus of Control	Expression of an individualistic, independent attitude toward solving problems without accepting aid from others

(Table 1 cont.)

Theme	Brief Description
Fear of Stigma and Shame	Negative attitudes toward seeking psychotherapy which could affect individuals or their families
Interpersonal Openness and Secrecy	Cultural attitudes toward disclosing secrets to strangers outside of the family
Mistrust of Mental Health Workers	Potential issues impacting trust of psychotherapists, including confidentiality, lack of knowledge, biases, and disreputable motives
Fears about confidentiality	Expressed anxiety about therapists discussing problems with others
Fears about lack of knowledge	Expressed anxiety about therapists' lack of cultural competency
Fears about biases	Expressed anxiety about prejudice/ignorance
Mistrust for therapists' motives	Expressed anxiety about therapists being greedy or unethical
Lack of Awareness of Mental Health Services	Lack of knowledge about the practice of psychotherapy or how to research psychotherapeutic services
Lack of Access to Mental Health Services	Lack of time for psychotherapy
Participants' Suggested Solutions	Participants' suggestions to psychotherapists about how to best address the needs of Muslim-Arab-American clients

Differing Conceptions of Mental Illness

In focus group discussions, participants raised and discussed several conceptions of mental illness. Participants unilaterally saw mental illness as a negative occurrence which is heavily stigmatized, and which is a problem of "the brain," of "behavior," and of "the soul."

Participants acknowledged that mental illness could either present suddenly (which suggested possession or other supernatural causes to some participants) or develop over time (which, as one participant stated, suggested chemical imbalance). Some participants emphasized or expressed views of mental illness as curable, referring to mental illness as a problem that can be "solved" or "resolved." Other participants expressed hopeless attitudes toward the mentally ill, making references to mental illness that suggested some could never be resolved or would be lifelong problems. One such expression was:

> Some people can't even be cured by therapy. Some people are just so far gone that they're just living in their own world...living in one of those homes or in the psych ward and that's it. They're gone. They can't be cured.

Another participant said, "Some mental illness...those people are like dead. They're not responsible anymore, whatever they did, they're innocent. I think they're going to heaven." Several also discussed their observations that mentally ill people are pitied and even given special treatment because of the pity others feel toward them.

The general language participants used to describe mental illnesses had strong negative connotations, and focused largely on deficiencies. Mental illness was described by various participants as the brain going "out of control" (emphasizing the role of biology in mental illness), the mentally ill person becoming "sick" (a medical concept), mental illnesses as "shortcomings" (acknowledging the ties between mental illness and personality or temperament), and people undergoing "punishments" or "tests" by God (a spiritual view of mental illness). The word "crazy" was used frequently, and usually referred to someone who experienced positive psychotic symptoms (hallucinations or delusions) or engaged in socially unacceptable behavior (thinking about suicide, self-harming, harming other people, or acting in a bizarre manner).

Diagnoses that were specifically mentioned in conversations about mental illness included schizophrenia, major depression, postpartum depression or psychosis, bipolar disorder, psychopathy, obsessive-compulsive disorder, anxiety, kleptomania, and substance abuse or addiction. Although participants did not use the term "post-traumatic stress disorder," they alluded to it several times in discussions about the impact of trauma and experienced symptoms of nightmares, hypervigilance, flashbacks, and avoidance of feared situations. In addition, in one group the subject of homosexuality was raised in the context of being classified as another mental illness, and was hypothesized to result from a combination of trauma, socialization, parenting, and genetics.

There was also a distinct difference between problems and mental illness in many participants' views. Several participants distinguished between "having problems" and "having a mental illness," with one participant stating, "We [Muslim-Arab-Americans] have problems but it doesn't lead to deep mental illness or mental problems." Generally, environmental causes of mental illness such as emotional trauma, physical trauma such as accidents, medical problems, death of loved ones, and so on, were seen as problems and not necessarily precipitants of mental illnesses.

Biological causes of mental illness. Many participants in the group discussions emphasized the role of biology in mental illness, specifically discussing the role of genetics, the brain, neurotransmitters, and hormones in thoughts, behaviors, and feelings. Biological bases of mental illnesses were especially emphasized when participants discussed their own mental health history or of friends and family. For example, one participant, when talking about her experience with postpartum depression, stated, "That [postpartum depression] can also be due to hormones and some of it can just be chemical imbalance." This seems consistent with the assertion of Al

Krenawi (2005), who states that mental illnesses are often attributed to biological causes in this population as it decreases blame and therefore stigma. Biological roots of mental illness were particularly emphasized in diagnoses of drug and alcohol addiction, obsessive-compulsive disorder, major depression, and postpartum depression.

Some participants also alluded to the role of genetics in mental illness. One participant stated that mental illnesses have come from "people fornicating and doing all the sins that were not done in the past generations," adding that as a result "you start seeing ailments in them that were not in the people before them." However, this participant also stated that some diseases are perceived in modern times because "we have better screening tools and the science is more advanced these days."

Mental illness was also conceptualized as a result of the brain being an organ that can deteriorate from poor care or can go "out of control." These participants' statements implied a causal relationship between biological problems and behavioral problems or emotional problems. One participant stated that drug use could change the way the brain works and as a result cause mental illness: "We saw some people who have mental illness because they do drugs and stuff, not regular people...those people [people who do drugs] have like mental illness."

The roles of "chemical imbalance" and hormones were also emphasized by participants. In the words of one participant:

> Some things could be, you know, [a] chemical imbalance that affects you. I mean there are medical reasons, so it is a fact, so some people can be bipolar and there's some reason for it, some people can be depressed, and it's because [of a chemical imbalance].

When discussing potential biological causes of mental illness such as the ones mentioned, the cures discussed most frequently were improving nutrition, improving sleeping habits, increasing

exposure to sunlight, increasing exercise levels, and, if necessary, using psychotropic medications.

Spiritual causes of mental illness. The most commonly discussed cause of mental illness was supernatural or spiritual; these included divine punishment or testing, interference from or possession by *jinn*, *mas* or demonic possession, *sheitan*, curses, and the effect of the evil eye.

When discussing the role of God in mental illnesses, participants often discussed the concept of either being punished for doing something wrong or of being tested. These concepts were sometimes expressed distinctly but were more often used in conjunction as alternative explanations for the same phenomena. This was a particularly common explanation in the first focus group, which was comprised of more religiously conservative women. Women in this focus group expressed that life itself was a test, and, in particular, challenging problems like mental illnesses or severe difficult to treat physical illnesses were tests. Participants expressed that it was important for people being tested by God to show patience, humility, gratitude, devotion, and faith through submission to God, Qur'an reading, increasing prayers and other signs of devotion. The concept of "patience" was mentioned several times and referred to avoiding self-pity and not complaining. People who displayed these revered qualities in response to challenges were believed to receive a reward from Allah in the afterlife.

Other participants were more overt about mental illness being a punishment or symptoms of mental illness being a "wake up call" from God, who was telling people to be good. As one participant said:

> It's definitely—anything we did wrong, if God wants a punishment, or not even a punishment, but just wants to wake us up, He's gonna [send] something to wake up, like

> 'wake up, you did this wrong.... We know we did something wrong, because of course we know God is not going to punish us without reason.

This viewpoint was reinforced by another participant, who told a story about a man who started experiencing negative events after beginning to sell liquor at his restaurant. The solution for mental illness as a punishment for wrongdoing was, similarly to the view of mental illness as a test, to submit to God and to ask forgiveness for wrongs.

Many participants also expressed the belief that mental illness as a punishment was something to be thankful for, as people could either be punished on earth, repent, and redeem themselves or alternatively be punished in the afterlife:

> These people might have illnesses because they did something and He's punishing them now as opposed to later, because later it's worse. So if you're a family of someone, you should be grateful that happened to them, because they must have done something really wrong and they're being punished for it now as opposed to later.... It's good for us to get like, to get it here than get it there at the day of judgment. It clears us here before we go there.

This viewpoint supports the stigma of mental illness due to belief that mental illnesses can be caused by "straying from the religion" or "lack of faith," as observed in the studies by El Islam (1982) and Mohamed (1995). In contrast, participants expressed that mental illness could often be avoided by being a "good Muslim." This included reading and following the Qur'an and hadith, praying every day, avoiding sinful behavior, having faith in and love for God, being involved in the community, and having close relationships with family. As one of the participants stated, "many Muslims do not practice Islam and they fall prey to these illnesses many times," later adding that, "all of the problems as Muslims are because we don't read our

Qur'an; once we study, everything will change." This participant also added that people can avoid mental illness by "leaving what is bad for you and leaving what all these—we can call it sins or sinful acts—that will lead us to the diseases and illnesses." This viewpoint of mental illnesses as a punishment for not being a "good Muslim" was contested or qualified by some participants, who argued that people with mental illness have not necessarily done something wrong and tend to be seen in a compassionate (and occasionally pitying) light. These participants more strongly advocated for the view of mental illnesses as a test, a less stigmatizing view of mental illness.

One participant also suggested that people with mental illnesses were on earth to provide other people with examples of problems for comparison, to help others feel grateful and appreciative for the things they have. As she stated, "It's like God wants to give an example to other people, like if someone has a tumor or has something bad in his body or something."

The role of *sheitan* in everyday problems and symptoms of mental illness was another frequently discussed subject. In general, *sheitan* were blamed for worries, suicidal thoughts, obsessive thoughts, auditory hallucinations, and marital conflicts. As one participant stated, "bad thoughts that we have in our brains are not necessarily our thoughts—they could be *waswas* from *sheitan*." Another participant more thoroughly elaborated on this view of *sheitan* as the cause of mental illness symptoms:

> I think people who have like really mental problems, like hear voices and all that, I think because I'm Muslim I think it's *sheitan*, like evil, devil-whispering, and that's why I think like a lot of people that have strong faith, this doesn't affect them. It's when you have low faith and you're not doing certain things in the religion that *sheitan* will be after you and talk you into doing things like killing, for example, like these people, a lot of the stuff

> they do is against the religion…. I don't know about depression, about the people who think about killing themselves, whether *sheitan* have anything to do with that...

This participant continued, asserting that people with mental illness symptoms may be thought of as having lower faith in God. This is connected to the role of *sheitan* in sorcery and curses:

> You have to denounce the Qur'an, you have to denounce the religion. [An imam] would go around and find the Qur'ans in sewage, in the sewers, in toilets at the *masjid*. You have to actually take the Qur'an and throw it in the sewer or throw it in the toilet, or step on it, or do really disgusting things to it. That way *sheitan* know you're serious about denouncing your faith.

Although the evil eye, jinn, and possession (*mas)* were also mentioned in discussions about causes of mental illnesses, they were mentioned infrequently, suggesting that these explanations were less salient with the focus group participants than other explanations.

Environmental causes of mental illness. Generally, participants mentioned environmental causes of mental illness less often. The most commonly acknowledged environmental cause of mental illness was isolation, a theme that reinforces the idea of the collectivistic nature of Muslim and Arab communities. Isolation was conceptualized as causing mental illness in two main ways. Some participants acknowledged that isolation from the community or religion may cause sinful behavior:

> Isolation is where the wolf eats the sheep. When the sheep is alone it's easier for the wolf to eat the sheep and it's the same for man—that wolf could be *sheitan* or that wolf could be depression, or it could be illness, whatever that might be.

Other participants saw isolation as a more direct cause of depression, as it led people to feel lonely and isolated.

Several participants also acknowledged that traumas, such as witnessing the death of a loved one, experiencing serious injury or losing bodily function, could cause depression. However, no participants discussed or expressed familiarity with the symptoms of PTSD. Participants disagreed on the cures for these traumas. One participant acknowledging the role of family or support from others in recovery, stating:

> Normally if you lead a normal life, then you get into an accident, car accident or something and your life changed, like you lost your legs, your hands...that leads to really bad depression if you don't find someone to help your family around you.

Another participant expressed hopelessness about recovery from trauma, stating:

> If you're stuck by a trauma, you would never get away from it. Ever. I don't care how great you are as a therapist or a friend or—but it will be always here, when you're wounded, you're wounded here [in your heart]. Absolutely not. But like I said—and I go back to my first comment, it's like you have to deal with it inside. So every day you wake up, you think how do I go through my day side by side with my trauma...? Sometimes you cope without touching and sometimes if you touch it you get depressed or something, but you try always to keep that distance. But at the same time, it will go everywhere you go, you will never get away from it, ever.

This latter view of the role of trauma in mental illness reflects a more individualistic approach to dealing with problems, which tends to be more characteristic in Muslim-Arab-American males (Al Krenawi & Graham, 1999), which was the gender of this participant.

Therapy as a Potentially Useful Practice

In all of the focus group discussions, participants acknowledged that there could be situations in which therapy may be useful. Some of these situations included: (a) improving self-

awareness, (b) assessing areas for self-improvement, (c) dealing with "failure" (which could lead to depression), (d) adjusting to an accident or diagnosis of a serious medical illness, (e) treating "emotional problems" or schizophrenia, (f) addressing sexual difficulties in a relationship (such as impotence), and (g) working through trauma or a history of abuse. None of the clients in focus groups mentioned substance abuse issues as a potential reason for entering therapy, and only a few clients touched upon suicidality as a potential reason for entering therapy.

The most frequently mentioned situation where participants acknowledged that therapy could be helpful was for resolving marital or family conflict by improving communication skills, a finding reinforced in studies by Abudabbeh and Assel (1999), D'Alessandro (2007), and Haque-Khan (1997). Below is one participant's consideration of therapy to resolve conflicts with her teenage children:

> In a teenager situation, should we take them to a therapist or what? [laugh] I hope so, because it's very hard to deal with them…sometimes they're fine, sometimes they're upside down. You cannot tell what's going on in them.... And you don't know what to do with them. If you hit them, you're going to be in jail, so I don't know what to do to calm them down and make them respect you again! Maybe I should send them to you, my teenage boys!

As conveyed in this comment, people may be more apt to turn to therapy when there is a high degree of distress and frustration and there are no readily available answers. It is likely that in situations such as this one, the participant would also expect to receive concrete, direct advice about how to "deal with" teenagers in a culture that tends to be less respectful of elders and does not allow corporal punishment. In cases such as this, the therapist may be relied upon as a cultural liaison or guide.

Most participants stated that therapy could be more relevant when problems are "really big," while small problems could be discussed with friends, family or religious officials. Many participants saw discussing major problems with a therapist as most helpful because therapists may have access to helpful advice that is backed by research. In contrast, they observed that imams may not have a full understanding of the problems and will therefore sometimes give simplistic, unscientific, or even counter-therapeutic advice. As one participant stated, "I don't think imams are going to know what you feel, what you're feeling, if you *really* have problems." Another participant raised the topic of a Muslim activist who visited an imam with concerns that he was attracted to men:

> He said I'm having these homosexual urges, what do I do? He [the imam] told him go get married and that will take care of all the urges that you have, because the amounts of testosterone you have are not enough, and that's why you have these homosexual urges. But once you get married you will have a surge in the levels of those hormones and then you will be functioning completely normal…. So what is the background of this imam, I'm not sure completely what his background is, but that's somebody who obviously did not understand his boundaries and he violated, um, his field of expertise and gave a wrong opinion to someone who would probably benefit from therapy.

This participant viewed this advice as potentially damaging because this man could have gotten married and "made his wife miserable" because he was not attracted to her. In this participant's opinion, therapy is often preferable to guidance from imams because many types of therapy, such as cognitive-behavioral therapy, are supported by scientific research and perceptible changes in neurological functioning post-therapy. This participant also discussed the way that cognitive-behavioral therapy can be seen as consistent with Islam:

> There are tips in the hadith and the Qur'an that behavior can be changed by changing the thoughts and changing the feelings, and vice versa...which is what is known as cognitive-behavior therapy, so…this model that scientists came up with is very well known to us as Muslims.

As these participants suggest, therapy can be useful as it can provide insight into the nature of thoughts and behavior and help provide advice to change these thoughts and behavior without contradicting the principles of Islam.

Therapy as Unnecessary

The healing power of faith. Several participants expressed that therapy seemed unnecessary given the extensive guidance provided by Mohammad on how to live everyday life. Some of the themes that arose in this discussion were the healing power of faith and submission to God, belief that mental illness can be prevented when people are "good Muslims," the superfluous nature of therapy as solutions for problems are provided by Islam, and the fact that therapy could not be as effective as counseling from imams as it does not deal with "matters of the soul." However, several participants said that psychotherapy and psychopharmacology could be secondary sources of aid, if Islam did not appear to be helping.

As mentioned, a recurring theme was the resilience provided by Islam through having faith in a higher power and that whatever happens is the will of Allah. As one participant stated, it staves off mental illness to "believe something deep—like religion…soul food." Reading the Qur'an and praying were seen as particularly helpful healing acts because of the feelings of relief, strength, and faith that resulted from them. As one woman stated, when you ask Allah for help with problems, "you feel relieved inside...this stuff don't build up and get worse…. That's why it's rare to see someone depressed in like Arabic society...maybe that's the reason why...."

The above statement reflects the concept of catharsis, of feeling relief from discharging feelings. Another woman stated:

> When I feel I'm alone and depressed a little bit, what do we do? We go pray, we read the Qur'an...that's it. We don't feel—I'm not depressed anymore. We don't let it go until we need therapy.

Both these participants emphasized that by submitting to Allah through Qur'an reading and prayer, they felt rejuvenated, strong, and hopeful, so therapy did not feel as necessary. Participants also emphasized the value of feelings of gratitude that come from reading the Qur'an and being reminded of less fortunate people. As one woman stated, "You read the Qur'an, you think of the dead, you think of the grave, you think of other people's misery – they don't find food— and you say thanks God, that's [what you are going through is] nothing." Other participants echoed this statement, about the strength that results from having a more realistic view of problems in comparison to the problems of others.

Several participants also stated that if people are "good Muslims" who "have faith in Allah," they would not become depressed or suffer from mental illness. In the words of one participant, "If you are a good Muslim, you are never going to have a mental illness." They said that being a "good Muslim" could prevent mental illness as it prevented wrong doings, such as crime, substance use, and doing harm to others. For example, one woman stated "the good Muslim isn't gonna have a criminal mind, because he is already deep in his mind he cannot harm anybody. It is prohibited…. There is crime, but it is because he [the criminal] is far away from God. They don't – they don't care." In addition, after hearing a participant's story about a mentally ill teenager who killed his family in response to pressure from his parents to study, one woman stated, "They're [the parents are] not a good Muslim, they don't understand." The

stigmatizing implications of these statements are that mental illness results from failure to follow Islam.

Many participants asserted that therapy was unnecessary or superfluous because there is "a cure for anything from the Qur'an." In many cases, the referenced solution to problems is recitation of a sura, which will ward off supernatural beings, or reading a *du'a* (supplication to Allah). As one participant indicated, if she was depressed, she'd look for a *du'a* for depression before trying anything else. Another stated, "I heard some types of mental illness can be cured with the Qur'an. If you read—I can't remember which sura—someone said that if you read the sura at someone who's mentally ill, he will wake up, be [a] regular, normal person." Another participant stated, "Every morning say…the *mu'awwidhatayn* [sura verses that ask Allah for refuge] *wa fatiha* [opening of the Qur'an] and then every afternoon, then you'll be all set all morning from the devil stuff and all afternoon you'll be all set."

In some cases, the Qur'an provides solutions for problems aside from *du'a*. As one woman stated:

> That's probably why we don't use therapy, I think that's the main reason. Because everything is written for us, we know—we have guidelines that we live by our whole life, everything…. And religion—it's life. It's not like religion is religion and life is different.

The Qur'an and hadith were referred to as "the cure for every depression, every mental illness" as it provides advice and guidance to the reader. Participants cited several passages of the Qur'an that encouraged exercise and self-care, self-knowledge, introspection, charitable behavior toward others (to prevent greed), and abstinence from addictive substances. As one participant who was knowledgeable in psychological theory and Islam explained, "in a way the field of psychology is almost mixed with—almost derived from Islamic texts and Islamic knowledge."

This participant argued that in many ways the prescriptions of Islam are similar to cognitive-behavioral therapy, as it prescribes separating yourself from your thoughts and negating them:

> The bad thoughts that we have in our brains are not necessarily our thoughts—they could be *waswas* from *sheitan*, they could be an illness or it could be something else. So Islam tells us to separate these thoughts from us, as me and as you, that's why you say *audhubillah min sheitan wa jinn* [I seek refuge in God from demons and *jinn*]. Alright, so there is something bad that comes into your brain, you don't just act on that and say well it is me, it came to my brain, I had to do it—in Islam, you have to separate, say *audhubillah*, this is not you—this is a bad thought that came to your head, you have to know how to negate these—I learned these are called ANTS, automatic negative thoughts, ANTS—so you have to smash these ants and make sure they don't come to you and overtake your brain.

As this participant stated, disowning "bad" thoughts by believing them to come from *jinn* or *sheitan* gives the ability to separate people and their identities from thoughts that may be troublesome and may inspire problematic behaviors.

Many participants also expressed that seeing a therapist could not be as helpful as Islam in resolving problems because they would not address the primary source of the problem, which would be a spiritual or supernatural source. As one participant argued, psychotherapy is dealing with "matters of the soul" without having adequate knowledge about the soul to be effective:

> OK, it [psychotherapy] is a behavioral thing—why is this person behaving this way? And then there is a question of why does he have certain thoughts in his mind, which could be related to the soul. And purifying the soul comes from the *din* [spiritual realm/ religion]…somebody who doesn't know anything about the *din*, he can give you a

> solution, he can tell you what to do and what not to do. But there is a fine line between drawing what is—what is considered a matter of pure *dunia* [physical realm/everyday matters] in the field of psychology and what we can draw from our religion and our Qur'an and hadith…. We cannot really leave the therapist completely on his own and say, "OK, you know it better so you can deal with it on your own," because really he is touching on the soul…. So in a way there is a very fine line—there are some times that the therapist is dealing with behavioral issues, which can be simply matters of *dunia*...and how to explain what's going wrong, it's not always that easy.

In this participant's opinion, imams are better therapeutic resources because they can interpret problems that extend beyond the immediate behavioral realm into the realm of the *din* or the soul. This was an opinion that was shared by several other participants, one of whom referred to imams as "our [Muslims'] psychologists." Another participant stated:

> I think those imams are therapists—they are therapists, because I saw a show where they [were] solving life's problems, and this sheikh is answering people's questions, and they call him and ask him my wife is doing this, this, this, or my husband doesn't like, he doesn't spend money on me, he doesn't stay home, he goes with his friends and does this, this, this, and the sheikh answers questions depend on religion, like...what you should do, what you shouldn't do, and I think that's a kind of therapist.

Many participants viewed imams as better sources of advice than psychologists because imams could advise on what was *haram* (forbidden) or *halal* (allowed) and if they had basic knowledge of psychotherapeutic principles, "they can be beautiful examples of psychotherapists." However, several participants also expressed that there would be times that *du'a* or imams might not be

able to help, in which case "maybe a pill will help" or, as one participant states, "maybe a deeper analysis—or not deeper, but a different type of analysis—needs to be taken care of."

A preference for close friends. Several of the female participants expressed their preference for discussing problems with people in their social network instead of a doctor or a psychologist, although they would consider therapy as an alternative if there were no people to talk to. This was a theme that was not mentioned by the male participants, who seemed to prefer going to imams for spiritual counseling or handling problems on their own. As one female participant stated:

> In our society, our culture, we don't go to a doctor—we talk to like a best friend, mostly, you know, mom or sister, someone you trust.... That's why I think most people—most Arabic people—don't go to doctors, because they already have a solution to solve this—their problems.

Several of the other female participants in this focus group agreed with this participant, and added that they would go to their family (sisters, brothers, parents) or a best friend first before considering psychotherapy. The existence of a close social network, even outside of immediate family and with other Muslims in the community, seemed to preclude the need for therapy for many women.

However, a few women also expressed that it may be preferable to seek help outside of one's immediate community because family members or friends may be involved in the problematic situation, and this makes discussing the problem much more difficult. As one participant stated, it feels more comfortable sometimes when "you don't know her, she doesn't know anything about you...you just talk." Another participant shared, "I think that if a person has a small issue and goes to a therapist it would probably help because they don't have someone

to talk to or they don't want to tell people about this problem that they're having. That—therapy might work for." While this woman seemed to consider therapy a possible solution for small problems, she also had identified social support as the primary resource for problem-solving.

A preference for medical doctors. Throughout the focus group discussions of mental illness, there were a few participants who placed a strong emphasis on the biological bases of mental illness and related that they would likely go to a medical doctor for help before seeing a therapist. While several participants expressed that they would be hesitant to go to a psychiatrist out of fear that he or she would prescribe medication, some participants saw medications as a potential necessity to help people "calm down," to "ease their pain," or to "treat" or "cure" mental illnesses. One participant suggested that taking medication for mental illness can be seen as treating a physical illness (illness of the brain) with medicine, which makes it more acceptable and more of a matter of *dunia* instead of *din.*

Therapy is Not Effective

A few participants expressed the view that therapy was ineffective, but this was rare in these focus groups. This may have occurred because participants wished not to offend me, knowing that I am training to be a clinical psychologist. Whenever this subject came up, participants discussed it hesitatingly or in a tentative manner. It was usually not often represented as participants' own views; instead, participants assigned the viewpoint to their family members, friends, or Muslims in general.

Despite their hesitation, several participants discussed the opinion that therapy is ineffective. For example, one participant expressed his disbelief that couples therapy could be effective:

> Absolutely. That's it. That's it, you kidding me? So you go to a guy and he says oh, you need to hold hands and talk to each other and buy flowers to each other, and that's going to make it better? Absolutely not.

While this participant acknowledged that he was oversimplifying the concept behind couples therapy, he maintained that there was very little someone outside of the couple could do to resolve the couple's problems.

Several participants shared stories of friends or members of the community who had attempted therapy and had not been "cured." One participant said:

> I told you about this woman...she [had] been to therapy the first time and they let her go home, and then she want to make suicide again. She did it twice. And I don't know if she [is] going to do it a third time but I hope not. But it really didn't help her.

A few other participants also shared stories about friends or family members who had attended therapy and did not appear to be aided by it.

Psychology and psychiatry were also confused in several discussions, but were both seen as ineffective and even counter-therapeutic. In the words of one participant, who stated that "therapists here cover everything up with medication":

> You have depression, here take this. You have this, take that. So it just covers it up and you don't really deal with it...a lot of times people go to therapy and they just get prescribed medication for no reason.

This viewpoint, that psychologists or psychiatrists might come up with superficial solutions which do not resolve larger underlying problems, was reiterated by other participants. In addition, some participants expressed that therapy might not just be ineffective, but may in fact

cause more problems. As one participant stated, “They [psychologists] make you question yourself a lot (laugh), to the point where you do become crazy.”

Perceived Conflicts Between Therapy and Islam

In general, these focus group participants insisted that there was nothing inherent in Islam that would discourage therapy. As identified above, one participant stated that he felt psychotherapy and Islam were complementary as “psychotherapy many times focuses on developing healthy habits, which we as Muslims believe in.” Instead, participants stated negative attitudes toward therapy came from cultural attitudes rather than religious beliefs.

On the other hand, participants said that therapy is usually viewed as a secular field that could oppose or directly contradict religious principles. For example, many participants talked about how the “feel good” values of psychology come into conflict with the values of Islam:

> You will find people who will say you know what, these people [homosexual people] feel better when they come out of the closet, right? When they do what they think is urging them to do what they do, they feel better, versus feeling depressed if you repress the urges...so psychiatrists would say—a generic psychiatrist/psychologist will say you don't have to feel bad about anything, you should feel well about yourself. So if you're feeling miserable because of what you feel, then I suggest you come out of the closet and be whatever—be yourself. So I think here's where psychology and Islam come at odds—when there's an ethical question.

In another example:

> Let's say also, if somebody has a problem with his mother or his father... in the non-Muslim society, yes, she's your mama, you have to respect her, and if you badmouth her it's bad but, you know, it's OK, you know you just gotta control your mouth. But in

> Islam, it's absolutely not acceptable—not even saying "oof" to your mother. So in Islam, something like that is not accepted at all and for psychotherapy to come and say OK, you've made a mistake, let's resolve it slowly...in a way, I think Islam would disagree because Islam would say OK, this is completely out of line, off limits, that kind of thing.

In these examples and others involving alcohol, stealing, or other acts seen as contrary to the values and principles of Islam, participants emphasized the more stringent rules and consequences that Islam imposes which they believed a psychologist might not reinforce. This leniency was seen as potentially detrimental to someone's spiritual well being.

Despite some mention to discomfort with therapists accepting money in the reviewed literature, no participants mentioned that it was contrary to religious principles to accept money for psychotherapeutic services. As one participant stated, "It's their job, they want to live too…. If it's gonna be free, you're not going to find anyone that's going to do it." Another participant agreed with this statement, stating, "he [the therapist] does a lot of effort and they spend a lot of time and money."

External Locus of Control

In most focus group discussions, participants expressed a belief that Allah controls what happens in their lives, an attitude that can be classified as showing an external locus of control. As one participant stated, Allah is responsible for whether or not a disease is cured: "If the ailment is hit by the treatment, it will be cured by the will of Allah…." In another participant's words: "We think that Allah does everything for a reason.... Basically everything happens for a reason, that's how we think about it." The idea that Allah controls events in people's lives may contribute to underutilization of mental health services because participants are also encouraged to be "patient." One participant said:

> If you have [a] problem, if you say to yourself, if I'm going to be patient, then I'm going to get [a] reward from God, that's just [a] test from God... gonna test me if I'm going to be patient or what I'm going to do. Always ask God for help, you know. It's like God is the doctor, you always ask God, please help me solve this problem.

This participant also stated "[if] that's what God wants to happen to me, I'm not going to do anything—that's how it is...God wanted this to happen to me, I accept it. What am I going to do? I accept it and thanks God for that." As implied in this participant's statements, the concept of "patience" involves accepting the events that happen in one's life, good or bad, as the will of Allah who should not be questioned. Instead, Muslims are encouraged to ask Allah for help and even thank God for negative events (which, as previously discussed, are often seen as tests occurring now instead of in the afterlife).

Internal Locus of Control

Also present in focus group discussions was the theme of internal locus of control, or the belief that an individual is responsible for what happens to them and solving his or her own problems. This attitude was present mostly in men, as predicted by the women in one focus group who stated "they [Arab men] think they can solve [problems] themselves." Several men in focus groups expressed an attitude that if they know what is right (*halal*) and what is wrong (*haram*), they can rely on the strength of their will to make any necessary changes. One male participant said:

> I think therapy's inside us, you know what I mean, you take care of your problems with your inside or you don't. You don't need—by all respect to the doctor and things unless it's like, you cannot, you're not…able to use all your ability to think and you need someone else, but I think—I don't believe about it. I believe about therapy within the in

> [within oneself]. It's like, you take care of your problem through your inside and you reject the whole thing where you don't want and you accept what you want inside.

This participant added,

> I thought about it before, I'm not dumb, I can make the difference between this and that, but I think and I believe that if you cannot help yourself, no one can help you. And that's what I believe and that's my moral life. If you cannot help yourself, no one can help you…. I will not stop. I will keep going and keep going and find a way to do it.

This participant expressed a belief in the inferiority of people who seek external help as they should be able to resolve problems on their own. According to several (primarily male) participants, if a person knows they must make a change in their lives to better adhere to the lifestyle choices dictated by Islam, he or she should be able to make that change without the aid of anyone else, by simply relying on his or her own willpower. This belief was contradicted by a couple of participants, who insisted that sometimes people are unable to stop something on their own even when they know it is "wrong." As one participant stated, "The assumption is that if you know something is wrong, you will not do it—which is not true many times. It's not enough because you need something else, you need the means to stop doing it, and that's what psychology does. The psychologist teaches you the means to stop doing these horrible things." However, it appeared that for many participants, the viewpoint was clear that intelligent people should be able to resolve problems on their own, and there was a high degree of stigma associated with admitting need for help and therefore admitting inability to use "your ability to think."

Fears of Stigma and Shame

Participants seemed very sensitive to cultural views of psychiatric patients as lazy, self-absorbed, weak, crazy, inadequate, and deficient, and they reported that it would be very difficult for them to admit that they had a mental illness or an emotional problem. Several participants also acknowledged that going to a therapist is difficult because it requires "admitting you have an issue," admitting "there is something wrong with you," and acknowledging that a psychologist may diagnose a mental illness. The shame associated with admission of a mental illness was seen as a particularly strong barrier for Arab people in particular. One woman stated, "With Arabs sometimes, it's like they don't want to out their shame, they want to keep it a secret...so even with an outside person they'll just bottle it up, bottle it up, until they crack." The same woman said,

> Some people, they feel ashamed—the Arab people. They don't like to tell when they have a problem too. So even if their daughter or son have that problem, they just hide it, try to fix it until it's really become really bad. So they go but they hide it. It's like they don't want to say that it's crazy. So it's a secret, they go…but they don't tell anyone.

Most participants stated that the high degree of stigma in the Muslim-Arab-American population was not due to anything explicitly stated in Islam, but had more to do with fear of having "a bad image among the community and…peers" and having "everybody look at you like you have a problem and this and this." People feared being seen by other members of the community and being gossiped about or pitied, which also was the reason why participants felt an aversion to entering group therapy. The stigma that might be assigned to someone entering therapy was conveyed when a few participants commented that therapy was for people who were weak and could not engage in introspection, who were using it as a fashionable status symbol, or who were

self-absorbed and had nothing better to do with their time. Interestingly, no participants mentioned any personal experiences with therapy.

Although several participants expressed their belief that there is a strong stigma against mental illness in the larger American population (across races and religions), the group discussions were primarily focused not only on the judgments that would be made by themselves, their friends, and their family, but also on the larger community participants belonged to. Participants' expressions of concern about the negative reactions of the larger community suggested that the collectivistic orientation of the Muslim-Arab-American community may have a particularly great impact on their desire to seek therapy.

While most participants discussed their fear about how stigma would impact themselves individually, a few participants expressed fears about how their diagnosis with a mental illness would impact their family. As one participant stated,

> I think it's—I think in Arabic culture it's more about the family than you. Cause you're always like thinking about your family first. The family name in Arabic culture is big. So you do anything to prevent anything happening to that name. That's it. I think it's more about the family than anything else…. It's all about reputation too.

Because mental illness diagnoses carry a high amount of shame from the biological, spiritual, and environmental causes they are attributed to, mental illness may have a particularly strong impact on family reputation and even perhaps on family cohesion within Muslim Arab culture. Moreover, as the previously cited statement implies, the collectivistic nature of Muslim Arab society places a high amount of importance on family reputation and family cohesion, meaning that there may be a higher amount of shame and stigma associated with mental illness diagnoses in the Muslim Arab culture. This idea was reinforced by the reaction of one woman to a story

about a mentally ill teenage boy who killed his family because he was feeling stressed. After hearing the story, the woman responded that the boy's parents must not have been good Muslims because they pushed their son too hard. This response reflects the judgments that may be made of a mentally ill person's family if or when they are diagnosed.

In general, it was the female participants who expressed concerns about the stigma that seeking mental health services would place on their family:

> At least me, as a mother, I feel like I'm the one who can either hold up this family or put them down, that's what I feel. Like I feel that if I'm weak then my whole family is weak and if I'm strong then my whole family is strong. Like being seen as weak may also affect my family.

Several women also expressed that being a woman diagnosed with a mental illness could have a devastating impact on their family because "everybody know[s], if it's a girl she's not going to get married." Women implied that being diagnosed with mental illness and having to be cared for by their family would be a source of great shame for them individually and for their families.

Interpersonal Openness and Secrecy

Some participants (primarily male participants) discussed the importance of keeping things a secret or keeping things within the family:

> There is a saying in Algerian, it means "Our oil, only in our flour." You put your oil only in your flour. And it means if you have a problem, you keep it in the family. Only in the family. Which that's how we do it over there. Like she mentioned, hey, you don't share the whole thing, keep it inside.

Interpersonal openness and secrecy was often raised in conjunction with the fear of problems being discussed or gossiped about in the larger community:

> And it's not because of what people might think about you but just the curiosity people think—which I would be probably too if I see somebody, like oh my God, what's wrong, what's wrong? Not in a mean way.

As one participant stated, "They're [Muslim Arab Americans] usually raised to keep it within the family because they don't want outsiders to know." When problems are shared with family, one participant stated, "if something happened to you, you go to your mom, you go to your friends and they cover up and they blah-blah-blah and they keep going, you know?" As was the case with this participant, friends and family who knew he had a traumatic experience crafted a cover story to share with people who asked what had happened to him. The participant stated that this was helpful because it prevented him and his family from being pitied and discussed at length.

However, this participant's story also revealed that the close relationship shared by family members in collectivist cultures may prevent traumatic experiences from being shared and discussed. As he stated, if his family members knew the extent of what happened to him, "it would kill them." As a result, this participant's particular traumatic experience has never been discussed in depth.

Mistrust for Mental Health Workers

Fears about confidentiality. A few participants shared that they would have fears about confidentiality if they were to see a therapist, emphasizing the importance of being able to trust the therapist not to discuss their problems with others. While many participants were aware that therapists were required to maintain confidentiality with their clients, there was still a fear expressed that the therapist may not keep certain information confidential. This fear was also expressed of the information obtained during the focus group interviews, as participants asked if the information was being collected to aid with "profiling." When asked what the worst case

scenario would be if seeking help with a therapist, one participant also stated, "You might see your whole interview on YouTube." While this was not a concern voiced by many participants, it shows that there is still some mistrust of therapists' abilities to maintain confidentiality.

Fears about lack of knowledge. A few participants also expressed a belief that therapists may not be knowledgeable about Islam, Arab culture, or both. This was an issue for clients who believed that either a therapist "won't understand" or that a therapist might encourage them to do something contrary to their religion, which would cause inner conflict (debating whether or not to do that thing) and would require them to go against the therapist's advice. In the words of one participant, "If I were to go to a psychologist because I am having a problem or an issue, I would be concerned that he would advise me to do things that I might not feel comfortable with." Another participant stated:

> You have to know what they're telling you to do. Like if you have social issues - you can't go dating, for example, as a Muslim. And if the therapist says it, you have to tell them "I cannot do that." And some of them [therapists] will understand and say "I'm sorry, I shouldn't have said that," and some of them will not understand, they will insist.

This may be a particularly challenging conflict to deal with as in the Muslim culture there is a degree of deference to the expertise of doctors or other authorities. However, following the advice of a doctor who is not culturally sensitive to the guidelines of Islam could cause a great degree of guilt, shame, and conflict with family members.

One woman also raised the subject of the questions a therapist asked her husband, which were seen as offensive as they did not appear to be culturally sensitive. Her husband, who had recently experienced a physically devastating accident, was asked by the therapist about current or past suicidality and about substance use or abuse. He found these questions offensive as in

some ways it implied that he was a bad Muslim (because good Muslims would accept the event as the will of Allah and would not consider doing these things). This was another issue that was a potential source of discomfort.

Fears about cultural biases. One of the main reasons for mistrust for mental health workers was fear of biases that can result from either mainstream prejudicial attitudes about Muslim Arabs or which can result from ignorance. Only a few participants were aware that psychologists' ethical standards included guidelines on cultural sensitivity (as explained by a participant with some knowledge of mental health services); one participant was particularly surprised to hear this:

> I never heard of cultural psychology that actually the therapist actually takes into consideration the background of the individual. I never really heard of that before—especially when it comes to religion.

However, participants were also aware of several instances of times when these ethical standards were not followed because of their own beliefs about spirituality or religion. As one participant stated:

> Some unethical practices come from back home...where if somebody comes with an obsession with *wudu* [cleansing for spiritual practices], having to make *wudu* for half an hour, they would say just don't make *wudu*, *halas* [stop]. Easy way out. Don't make *wudu*. And if someone's obsessing with *salat* [prayer], they would say just don't make *salat*. I've seen people who say things like that and these are psychiatrists.

In this example, a psychiatrist's biases led him or her to recommend actions which were contrary to the practices of Islam. While the suggestions were, as the participant stated, the "easy"

solutions to the problems, the psychiatrist was not engaging in culturally sensitive practice by encouraging his or her patients to stop engaging in religious practices.

This participant also explained that some psychiatrists he had met had biases about the mental health of Muslims:

> I had a psychiatrist who used to be my teacher, he used to think I had OCD, that Muslims had OCD because we pray five times a day and that is a lot. You cannot pray five times a day, you're obsessive, something is wrong with you. So this is where things start to be unethical, where people put their own perspectives about life—and especially if they are extremist or biased.

In this case, the psychiatrist's own beliefs about prayer interfered with his ability to appropriately diagnose clients. This was an occurrence that two other participants expressed fear of, that a mental health practitioner would recommend actions contrary to the religion because of his or her own biases about what is "normal"—for example, dating, drinking alcohol, fighting with family members, and so on. As these participants expressed, it was frightening to think that a psychologist could hold biases against Islam or could have racist beliefs, and it was also frightening to think that he or she could give advice which might result from those biases.

Mistrust for therapists' motives. Although it was not mentioned in much of the literature, several participants also expressed fears about the therapist being dishonest in an attempt to make more money. Therapy was seen as a "business," and as a result participants saw it as beneficial for therapists to diagnose mental illnesses in an attempt to keep clients in therapy. This perception was further complicated by the fact that many participants did not differentiate between psychologists and psychiatrists, and as a result they expressed apprehension of the association between therapists and prescription medications. As one participant stated, "I heard a

lot of them have something with the pharmacy too, so they're both benefiting from it...they always prescribe that medication for you. It's just a business." Another participant shared:

> How do you know when you go to a psychiatrist that they'll be 100% honest with you about the problem you're having, or are they just, you know? Cause it's like a business, you make a lot of money off of it. So how do I know they're not going to give me a script and say this is what you have and come back for our next session, and not really try to help...? There are some people out there who might do that—who do you trust, you know?

This comment was reinforced by another participant's comment that if he did not see his problem resolved within a few sessions, he would feel like the therapist was "milking" the therapy:

> You want to know…that they're not going to milk you. And by milk you, I mean open-ended where you're putting your credit card on the table and stuff like that and paying out for it. I want to get it solved. I mean, I don't want this thing to be a drawn-out…[I want] someone that's good and can get to the point and can get it - if it's resolvable quickly - can get it resolved and not milk it. Because I see that, with doctors and chiropractors I see that. Someone that's, you know, an honest broker in that case. Yeah, you're solved, you don't need me anymore, or this and you'll be done quick. Cause let's face it, it's a money business and if someone can get away with it, I'd think a lot of people would want to. Let's face it, a lot of people are motivated by the dollar, and if business is low, I mean I don't know how they do it salary-wise but heck, if they have to make a mortgage payment I'm sure they want me to be in therapy a little longer.

This view of therapists as businesspeople who might extend therapy to improve their salaries appeared to be relatively common. As this participant expressed, he would want to see his problem resolved in a quick and efficient manner.

Lack of Awareness of Mental Health Services

A few participants expressed that they did not know any Muslim or Arab Americans who had attended therapy. As one participant stated, "We never heard a story about a Muslim who has a mental illness and he gets in trouble." In the words of another participant, "I've never heard of an Arab doing that [going to therapy], I don't know." This lack of awareness suggests that therapy is not often discussed within the Muslim-Arab-American community. As a result, some participants expressed that they were unaware of "what kind of problems people go to therapy for," what therapy would look like, or whether they would be diagnosed or prescribed medications immediately. In fact, several participants expressed that one of their only sources of information about therapy was television shows, which can often be inaccurate.

Other participants expressed that they were unsure where they could go to get a suggestion for a therapist, as asking other people in the community would come across as offensive (as it suggests they may need mental health services themselves). One participant stated, "You can't just open the yellow pages and be like, I'm going to go to that guy." In response to a question of how participants might find a therapist, one participant responded:

> I have no idea! Now that's…I mean it reminds me, my friend and I are going down doctors and we're basing doctors based on what their names were! And we're like, this is not scientific! This person's this, this person's that, and we realize, this is not scientific. So…I don't know, it'd have to be, it'd have to be, you know, it's like any other research, anything else. If you're going to have open heart surgery, bringing that example, I'd

> want to do a little research on the doctor. So it'd be some work, and I have no one that I would—so far I would not know who to go to at all.

This lack of awareness of how to find a therapist appeared to be a common barrier to therapy usage.

Lack of Access to Services

Mention of a lack of access to services was unexpectedly absent in the focus groups' discussions. Only one participant made a reference to this theme:

> The Arab-American community here in the U.S. is highly educated, but there is another issue, and that is they are so busy working. They come here to this country (that is mostly immigrants) and they are just working, working, working...so that could be another reason they don't go, is because they are busy working.

This comment suggests that there does not appear to be a perception that mental health services are inaccessible because of difficulty obtaining transportation or because mental health services appear to be sparsely distributed, but instead there is the perception that therapy takes time, and immigrant populations may not have time to attend therapy as they are too busy working.

Participants' Suggested Solutions

Participants suggested a few solutions that might aid psychologists in recruiting and retaining clients in therapy. One of the most frequently mentioned solutions was to ensure that psychologists were knowledgeable about Islam if they were not Muslim themselves. Participants wanted to see a psychologist who was "well versed in the *din* [religion]," "who understands your background as a Muslim," 'who actually utilized knowledge of Islam," who "could incorporate like Islamic knowledge into it [therapy]," and who is "very well versed in all *hadith* and all the texts that deal with anxiety or depression or sadness or conflict." If psychologists were not

knowledgeable about Islam, one participant suggested that they collaborate with imams in cultural centers to learn more about the religion:

> Maybe [they should] talk to an imam as well. It would really help if there was an imam who could collaborate with a psychologist or therapist...the imam might be able to give you more information about the din and like religious solutions.

Many participants expressed that they wanted a therapist who could engage in religious discussions without imposing biases. It was important to these participants that psychologists not be preoccupied with keeping therapy secular, and showed some comfort in discussing God and religion in an open manner, without imposing their own beliefs on clients.

One participant also suggested that psychologists speak with imams about therapy, either encouraging them to promote therapy as an option or training imams in basic psychological techniques so that they could intervene more effectively when a community member came to them for help. As the participant said, "many of those scholars are very knowledgeable and if they are given basic psychological knowledge they can be beautiful examples of psychotherapists."

In addition, one participant recommended that psychology provide more information about therapy to the Muslim-Arab-American community. Some of the information he stated would be essential to share included basic psychoeducation on the nature of mental illness, "that mental illness is not something that is just related to how you feel, what you do, it could be much more related to the brain, to your environment," and on "the importance of seeking therapy when needed." This participant also suggested psychologists share information "that the psychologist is functioning under ethical standards," and that "we can use scientific evidence to show that therapy helps."

Chapter 5

Discussion

In general, the focus group research suggested that the Muslim-Arab-American population could have predominantly negative views of therapy, although some positive views of therapy or views of therapy as necessary were also shared in discussions. The study produced several themes that participants believed might explain the underutilization of therapy by the Muslim-Arab-American population. Some of these themes included: (a) predominantly spiritual or biological conceptions of causes of mental illness, leading potential clients to seek help from imams or medical doctors; (b) preferences for discussing problems with acquaintances or family members; (c) perceptions that therapy is ineffective and not based in empirical science; (d) belief that problems are often the will of Allah and should be faced with patience and gratitude; (e) belief that problems should be resolved on one's own without the aid of others; (f) belief that is improper to disclose personal information to strangers; (g) fear of being stigmatized as an individual or as a family by seeking mental health services; (h) belief that mental health workers may not honor confidentiality, may be biased, or may be greedy or dishonest; (i) lack of awareness of mental health services; (j) lack of access to services; and (k) suggested methods that psychotherapists can use to better accommodate the needs of the Muslim-Arab-American population.

In this section, the themes are summarized and discussed in light of the literature reviewed. In addition, suggestions are made for psychotherapists who wish to treat this population based on the information attained from the literature, participants' suggestions, and this therapist's observations. Finally, this section addresses strengths and limitations of the study, as well as possible directions for future research.

Conceptions of Mental Illness and Psychotherapy

In general, the results of this study supported but further explored the culturally-influenced attitudes in the Muslim-Arab-American population as discussed in the extant literature. When asked about the potential causes of mental illness, participants tended to talk about causes from either a spiritual or biological perspective, or sometimes a combination of both. A few participants also acknowledged the role of environment (trauma, isolation, intense stressors, lack of social support) in causing mental illness, a theme not discussed in much of the literature.

Participants' descriptions of somatic causes were generally more sophisticated and scientific than descriptions present in the literature. Unlike descriptions in the literature of descriptions such as "bodily weakness" (El Islam & Ahmed, 1971), participants acknowledged that genes, hormones, or physical problems with the brain (which could be caused by drug use) could be responsible for mental illness. This change may be the result of increasing amounts of scientific research on biological bases of mental illness, improved popular awareness of causes of mental illnesses, or both.

Moreover, several participants discussed the ways that mental illness was a "soul" problem, or a spiritual problem, which reinforced the findings of El Islam and Ahmed (1971). Several participants stated or implied that if the mentally ill followed the guidelines of Islam more clearly or had greater faith in God, they would not be sick, a concept proposed by Mohamed (1995) in his discussion on the causes of mental illness through deviation from *fitrah* (innate good nature). Some participants also saw mental illness as a "test" or "wake up call" from God, who was encouraging them to be "patient." This idea was not discussed in the reviewed literature, which tended to focus primarily on the cultural beliefs in supernatural causes

of mental illness. Several participants, especially women, as discovered by Al Krenawi and Graham (1999), adopted this more supernatural perspective. However, women in focus group discussions tended to focus on curses and *sheitan* and not necessarily the evil eye or *jinn*. As described in the research by El Islam and Ahmed (1971), the participants who expressed beliefs in spiritual or supernatural causes of mental illness tended to feel that imams or reading the Qur'an would be more appropriate sources of help than a therapist.

The idea that mental illness can be prevented through religious faith, a concept often discussed in psychological theories of resilience (e.g., Peres, Moreira-Almeida, Nasello, & Koenig, 2007), was a theme that arose frequently. Participants discussed the fact that having faith in God, regularly reading the Qur'an and praying or saying *du'a* (supplications to God), faithfully practicing Islam and the rules laid out by the hadith, avoiding sinful behaviors (such as committing crime, using substances, or doing harm to others), and being reminded of things to be grateful for left them feeling strong, rejuvenated, relieved, and hopeful. This was another theme that this research explored and described which was less prevalent in the existing literature on this population.

In general, therapy was seen as an unnecessary resource; participants stated that they could always talk to their close friends, family members, other members of the community, imams, or, if medication was necessary, medical doctors or psychiatrists. There is an apparent contradiction between this cultural preference for seeking help from friends, family, imams, or doctors, and the cultural predisposition for keeping things "private." This was a contradiction that many participants appeared to struggle with; however, it appears that both preferences are present. Many participants seemed to prefer to resolve things themselves first by turning to religion (therefore preserving their privacy), and then if necessary turn to family or close friends.

It appears that participants would only want to broach their family's privacy if utterly necessary because other resources do not appear to be effective.

Participants also stated that they felt therapy was unnecessary because their religion and faith provided them with faith, hope, and multiple solutions for problems (including specific advice from suras and prescriptions for *du'a* to say in times of need). Other participants (predominantly men) said that they could easily resolve their problems on their own and that was their preference. Preferences for alternative resources were reinforced by views of therapy as an unscientific, ineffective, and even potentially harmful practice, which was a viewpoint that stemmed from several personal stories about friends or family members. Aside from the viewpoint of therapy as potentially harmful, a theme mentioned in the research of Haque-Khan (1997), these themes were largely unexplored in previous research with this specific population.

On the other hand, therapy was acknowledged as potentially useful if other efforts had been ineffective, if problems were "big" and therefore could not be resolved by other resources, or if the problem involved other people in the community and could therefore cause interpersonal problems if shared with social networks. Situations where clients would consider therapy included increasing self-awareness and boosting self-improvement, dealing with stressful situations such as trauma, abuse, failure, accidents or serious illnesses, dealing with "emotional" or psychotic problems, and addressing problems or resolving conflicts in relationships. Interestingly, no participants mentioned memory loss, aggression, or substance abuse problems, as participants did in Haque-Khan's (1997) research, perhaps because several participants expressed that "true" or "good" Muslims would not be aggressive or abuse substances.

In general, participants reinforced scholars' assertions (e.g., El Azayem & Hedayat-Diba, 1994) that there is nothing inherent in Islam that suggests Muslims should not attend therapy.

They contradicted ideas suggested by Brinson and Al-Amri (2005) and Gorkin and Othman (1994) that psychotherapists should not accept money, arguing that therapists "want to live too…." However, participants did agree with Jafari's (1992) theory that Muslim-Arab-Americans may believe the values of Islam and the traditionally secular "Western" values of psychotherapy can come into conflict with each other. Several participants expressed worries about their therapists being unaware of Muslim values and suggesting solutions that may interfere with their religion (e.g., dating, drinking alcohol, separating from their families, etc.), which was a theme present in much of the literature (e.g., Abu Ras et al., 2008; D'Alessandro, 2007; Haque-Khan, 1997; Jafari, 1992).

Participants' statements also reinforced the literature suggesting a predominantly external locus of control in Muslim-Arab-American culture. As stated by Dwairy (1998) and Brinson and Al-Amri (2005), many participants believed that most things happen because it is the will of Allah, which seems to foster a passivity or encouragement to be "patient" in waiting for a resolution. One theme that was not predicted in the literature was several male participants' beliefs in internal locus of control, which showed a less collectivistic, more individualistic attitude that may be related to acculturation or perhaps differing political and cultural attitudes than what is acknowledged in most of the literature.

Similarly, expressed fear of stigma and shame revolved primarily around individually confronted stigma, and less on the impact the stigma of psychotherapy would have on participants' families within the larger community. However, some women did acknowledge the impact that seeking psychotherapy may have on their family, as they "hold up" the family and maintain its strength and honor, a theme suggested by several researchers, including Abu Ras (2003), Al Krenawi et al. (2000), and El Islam (1982). Women also stated that if a woman was

diagnosed with a mental illness, it was unlikely that she would get married, and she would most likely be cared for by her family, a great source of shame in the larger community. Interestingly, several participants also discussed cultural attitudes toward secrecy and privacy within the Muslim-Arab-American culture, as suggested by Ahmed and Reddy (2007), which was a theme that was tied to fear of stigma, but had more to do with a cultural attitude than explicit worry about external judgments from the community.

Many participants expressed mistrust or cautiousness when discussing choosing therapists. Several participants did not only express worries about conflicts between therapists' values and Muslim values due to prejudice or lack of knowledge, but also expressed fears about confidentiality, worries about being "milked" for money or being diagnosed with a serious condition to boost a therapist's business, and being asked potentially offensive questions (such as questions about suicidality, substance abuse, and other acts forbidden by Islam). Participants were generally unaware that therapists underwent multicultural competency training, which some participants stated improved their opinion of psychotherapists and made them feel more trusting.

Finally, participants touched upon the subject of lack of awareness or lack of resources as a barrier to therapy with the Muslim-Arab-American population. In contrast to the research (e.g., Ahmed & Reddy, 2007), few participants mentioned lack of resources as a potential barrier, although one participant mentioned that immigrants may not have time for psychotherapy as they are working long hours. However, several participants reinforced Abu Ras's (2003) findings of lack of awareness of the existence of mental health services, how mental health services work, and how to enroll in services.

Suggestions for Psychotherapists

The findings of this research suggest that in general, the Muslim-Arab-American population may have little exposure to the concept of psychotherapy. Due to the stigma which is often tied to ideas of mental illness resulting from poor adherence to religion, mistakes made by family members, defective genes, or an "out of control" or "sick" brain, as well as ideas that seeking mental health services indicates weakness and self-absorption, mental health services are not frequently discussed, and positive experiences with mental health services seem less discussed than negative experiences. As a result, it is strongly suggested that psychotherapists collaborate with imams or Arab or Islamic cultural centers to provide in-services on the causes and symptoms of mental illness, and to attempt to normalize consumption of mental health services. One participant also suggested that it may be helpful for psychologists to teach imams some basic psychotherapeutic techniques. In doing so, psychologists may build relationships with cultural liaisons, help normalize psychotherapy with religious leaders, and perhaps even receive referrals for clients who have more severe disorders that imams cannot address.

One of the biggest suggestions expressed in the literature and in participants' comments was the importance of being culturally knowledgeable and respectful. Therapists should make concerted efforts to educate themselves in the customs and beliefs of Arabs and Muslims, as dictated by the APA Guidelines (2003). Specifically, therapists working with Muslim clients in particular should learn about some of the basic beliefs and practices of Islam. It is highly recommended that therapists strive to educate themselves in this religion as mainstream American society tends to be ignorant or misinformed. This education can be achieved by visiting one of the several Islamic cultural centers in the United States that are easily contacted,

accessible, and friendly to visitors. These centers tend to be open to providing education on the pillars of and basic practices of Islam without proselytizing or attempting to convert visitors.

Since there are increasing numbers of Muslim immigrants entering the United States, it is also highly recommended that universities include information about religious beliefs and norms (including Islam, along with other religions) in the multicultural training component of doctoral programs. Although generally psychology is seen as a secular science, many clients have strong religious and spiritual beliefs which aid in building resilience to stress, and it is important that psychologists are knowledgeable about these beliefs to avoid contradicting them in therapy.

Psychotherapists should also make concerted efforts to be culturally sensitive and respectful (which also includes dressing appropriately and modestly) with Muslim and Arab clients. Although questions about substance or alcohol use, suicidality, dating, and premarital sex should not be avoided, especially in situations where such questions are warranted, therapists should approach these subjects in a sensitive, unassuming manner, with the understanding that in Islam these practices are not acceptable. Moreover, therapists should be especially careful not to pathologize Muslim-Arab cultural norms or to provide advice that might run counter to the practices of Islam, such as suggesting a client pray or make *wudu* less frequently. A therapist should also be sensitive not to impose his or her own values on being independent from one's family, drinking, dating, wearing modest clothing, etc. with a client.

Several researchers (e.g., Al Krenawi, Graham, & Kandah, 2000) note that cognitive-behavioral approaches may be most appropriate with this population, because people from collectivistic cultures tend to revere authority and prefer active, directive treatment. However, it is also important to note that narrative or postmodern approaches may also be very appropriate in this population given the participants' apparent tendency to externalize problems,

as well as the focus on meaning making. Moreover, a postmodern approach such as narrative therapy allows a client the ability to collaborate in his or her treatment, use his or her own language in discussing the problem and the treatment, and be in greater control of the biases or invisible assumptions that a therapist may experience or express in the course of therapy. As a result, therapists working with this population may also want to consider an integrative approach using a combination of cognitive-behavioral and postmodern approaches to best suit this population's needs.

Strengths and Limitations of the Study

This study sought out to expand the existing research on the Muslim-Arab-American population, and in exploring themes of the conducted focus groups, the study succeeded in providing more in depth information about potential barriers and also in identifying several themes that were not described in the literature. The study reinforced existing research, showing consistency with the existing research on culturally influenced attitudes toward therapy in addition to research on Muslim and Arab populations. Due to the pragmatic nature of the research conducted and the small sample size of focus group participants, the study's transferability is limited. However, the large number of themes identified shows variability and diverse viewpoints within the small group of participants who participated in the study and therefore improves the otherwise limited transferability.

One of the unique aspects of this study that constitutes a strength and also a limitation was the diverse age and educational range represented within the participant sample. The sample was more representative of the general population than some studies as it did not utilize a college aged and college educated sample, but rather utilized participants of varying ages, educations, and occupations. However, the diversity within the participant sample was also likely

responsible for the large variability in expressed opinions about stigma, causes of mental illness, and therapy in general. As a result of the small sample size and diversity of opinions expressed, the study cannot be used to prove differences in opinions among this population. However, as previously stated, the study is useful because it instead provides a cross-section of the diversity of opinions that emerge in discussions of psychotherapy within this population.

An additional detail of note in this study is the fact that the majority of women who participated in this study were recruited from an Islamic cultural center which is often acknowledged by outsiders to be a somewhat traditional, more religiously conservative center than other cultural centers in the region. It is possible, if not probable, that participants recruited from outside of Islamic cultural centers with differing degrees of religious identification or religious traditionalism could have differing opinions on the usefulness of seeking therapy from imams, supernatural explanations of mental illness, and several of the other topics discussed in this study.

One of the major problems present in this study's design were the limited number of men who participated in focus group discussions. While several men are quoted in the dissertation, the viewpoint of male Muslim-Arab-Americans is not heavily represented within this study. It would be beneficial if future research could elaborate on the themes identified in this study as they specifically apply to the male population, as Muslim-Arab-American men confront different stigma than women when entering psychotherapy.

Future Directions for Research

While there has been an increase in research on Muslim Arab Americans in recent years, the information available on the cultural norms and beliefs of this population as it applies to psychology and psychotherapy is still relatively scarce. Therefore, it is essential that research

continues to be performed that informs psychotherapists about this population and the best ways to be effective and culturally sensitive with this particular population.

Given the present research that exists on the barriers to therapy this population faces, it may be helpful to the field of psychology (and in particular the field of multicultural psychology), to design an outreach program which targets these particular barriers by providing psychoeducation on the nature and symptoms of mental illness, by collaborating with imams to learn about therapeutic practices which are concordant with the beliefs and principles of Islam, and by implementing a culturally sensitive, spiritually focused therapy which may have cognitive-behavioral roots. This research should likely involve a control group and should study whether there is a statistically significant impact through these interventions on the attitudes toward therapy, stigma about seeking help from mental health professionals, and utilization of psychotherapeutic services.

In addition, given the limited number of male participants in this study and the fact that most literature written on the Muslim and Arab populations within the last few years appears to focus on women, this is an area that future researchers would benefit from learning more about. It would be helpful to learn more about what barriers men in particular face, including fears of being especially stigmatized in accepting help from others (given the prevalent focus on internal locus of control in male participants in this study), potential feelings about having a female psychotherapist, and so on. This type of research could greatly improve existing knowledge.

Some of the themes that were raised in this study which have not been explored in great detail in previous studies included the primarily male viewpoint involving internal locus of control, the specific effects of *du'a* and reading the Qur'an on anxiety, depression and perhaps psychotic symptoms, the concept of "patience" in resolving problems as it relates to help-seeking

attitudes, particular anxieties about “Western” advice that therapists may provide, the effect on devout Muslims when therapists make suggestions that run counter to their religious beliefs, and perhaps the conversations that occur when American or ”Western” values come into conflict with Arab and/or Muslim “Eastern” values. These areas would likely be well-suited to a qualitative approach, which could supplement existing quantitative literature as this study has done.

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APPENDIX A

Dissertation Flier

Research participants needed!

My name is Jennifer Smith, and I'm working on my dissertation for my doctoral degree in clinical psychology at Antioch University New England. I am looking for Arab-American Muslim men and women who are willing to participate in a group discussion about how psychologists can better serve the Arab-American Muslim population. Groups will be comprised of 4-6 people, and discussions will last approximately 2 to 2 ½ hours. Participants should be 18 or older, first or second generation Americans, and should identify as both Arab and Muslim.

In my research so far, I have found that only about 3% to 5% of Arab-American Muslims attend therapy every year, in part because of the great stigma of seeing a psychologist. I would like your help to better understand this trend. My intention in conducting this research is to educate psychologists about how to be more helpful with Arab-American Muslim clients.

The two hour long discussion group will include refreshments, and you will receive $10 in appreciation of your participation (this can alternately be donated to an Islamic center in the area). You may know other participants as they may be affiliated with the same community center. However, participation is voluntary and you can choose to withdraw from the discussion or leave the group at any time. **The questions that will be asked in the discussion are attached.**

****If you have any questions or may be willing to participate in this study, please contact Jennifer Smith at XXXXXX. I will briefly meet with interested participants individually to discuss the research in more detail and obtain informed consent.****

APPENDIX B

Focus Group Questions

Opinions about therapy

-What are your general impressions about therapy?

-In your opinion, what would be some good reasons for someone to enter therapy?

-There are several different types of therapy, including individual, couples, family, and group therapy. Would you feel more/less comfortable in individual (…etc.) therapy?

-Who would you ask to recommend a therapist?

Mental illness

-What do you think of when I say "mental illness"?

-What causes mental illness?

-Can mental illness be cured? If so, how?

Perception of the community's opinions about therapy

-Have you ever known someone who was Muslim and Arab-American who has gone into therapy? (Don't say who, please!)

    -What was it that motivated this person to go into therapy?

    -What did this person think of therapy?

    -What did other people think of this person entering therapy?

-What issues do you think might motivate someone in your community to go to therapy?

-What do you think someone in your community would expect from therapy?

-What do you think people in your community would worry about when entering therapy?

-What are some topics people in your community might not want to discuss?

Expectations about therapists

-What would you want to know about a therapist before entering therapy?

-Would you feel differently about seeing a therapist of a different ethnicity, gender, or religion?

-Are there certain issues that you would prefer to discuss with an imam or with your family?

-If you could say *anything* to psychologists who want to work with Muslim-Arab-American clients, what would it be?

APPENDIX C

Informed Consent Form

Removing Barriers to Therapy with Muslim-Arab-American Clients

I am a doctoral student at Antioch University New England doing research for my dissertation. For my research, I am asking you to participate in a group discussion about your opinions of therapy.
I am doing this study because few Muslim Arab-Americans attend therapy and psychologists know very little about the reasons why. By learning more about your opinions and the opinions of your community, psychologists may become more competent in their work with Muslim Arab-Americans.

The group discussion procedure:
The group discussion will last 2 to 2 ½ hours and will be audio-taped. This tape will be destroyed after the interview is transcribed. I will not ask you for your full name, and questions have been designed to be relatively impersonal. Moreover, as stated, you can also choose not to answer questions that make you uncomfortable. Food and drinks will be provided during this time. For your participation, you will also receive $10.

Your identity will be protected.
I will not ask you for your full name, and no names or identifying information will be included in dissertation notes or the final dissertation. I also will not mention the name of the community center you were recruited from in the dissertation.

There are minimal risks to participating in this study.
It is possible that you may know other group members since I am recruiting group members from some of the same community centers. However, if you recognize someone in the group and this makes you uncomfortable, you are free to leave at any time. In addition, as stated, you can choose not to answer any questions that make you uncomfortable. In addition, I will not ask you any questions about your own mental health or any experiences you or your family may have had with therapy. Benefits include refreshments, $10, and the satisfaction of helping psychologists to better understand and serve the Muslim Arab-American population.

Participating is voluntary.
It is your choice to participate in this study. You are free to choose not to answer any questions during the discussion. There will also be no penalty to you if you decide to leave the study at any time.

If you have any questions about the study, you may contact Jennifer Smith, M.S., at telephone # XXX-XXX-XXXX or via email at XXXXXXXXXXXXX. If you have any questions about your rights as a research participant, you may contact Dr. Kevin P. Lyness, Chair of the Antioch University New England Human Research Committee, at XXX-XXX-XXXX.

I have read and understood the information above. The researcher has provided me with a copy of this form and has answered all of my questions. I consent to take part in a discussion about my opinions of therapy.

Participant Signature: _____ **Date:** _____
Witness: _____ **Date:** _____

APPENDIX D

Example of Focus Group Theme Analysis: Focus Group 1

Comment #	Comment	Associations, interpretations, preliminary themes	Superordinate Themes
6	2: "Sometimes you feel depressed but you need to talk to someone. But you know in our society, our culture, we don't go to a doctor, we talk to like a best friend, mostly you know mom or sister, someone you trust. And then you tell them your problem and stuff, and you feel good after that. That's why I think most people—most Arabic people - don't go to doctors, because they already have a solution to solve this—their problems."	Therapy useful for emotional problems Lack of need for social support outside of family/social circle/doctor Preference for speaking to close friend or relative Implied equal effectiveness of speaking to therapist or friend/relative	Reasons for therapy Perception of lack of need; Preference for close acquaintances
7	1: "Unless if it's really big…. If it's a small problem, you talk to your friend. But if you really, you know, hurt, you need someone. Like they go if they really depressed, really depressed."	Need therapy for "really big" problems Social support for "small" problems	Reasons for therapy
8	3: "And sometimes you need medications, that type of stuff, that kind of doctor. And some people maybe have abuse pasts, stuff they have to work out from when they were a child, and they might need to go to therapy. But still I think I've never heard of an Arab doing that, I don't know."	Need therapy for medications Therapy for abuse and trauma Arabs potentially less likely to enter therapy (and/or less likely to talk about it)	Reasons for therapy
9	1: "Some people they feel ashamed, the Arab people. They don't like to tell when they have a problem too. So even if their daughter or son have that problem, they just hide it, try to fix it until it's really become really bad. So they go but they hide it. It's like they don't want to say that it's crazy. So it's a secret, they go…but they don't tell anyone."	Sense of shame in admitting problems Fear of being seen as crazy Sense of secrecy—keeping problems within the family Arabs less likely to talk about therapy (secret)	Fear of stigma—self/family
10	5: "They're usually raised to keep it within the family because they don't want outsiders to know. And it's all	Keeping problems within the family Fear of impact on reputation	Fear of stigma—self/family

Comment #	Comment	Associations, interpretations, preliminary themes	Superordinate Themes
10 (cont.)	about reputation too…it depends on how bad the problem is."	Different approaches based on how "bad" the problem is	
11	5: "It would depend on what the problem was, to be like shameful. Like suicide or something like that. To like go and speak to a doctor."	Implies that it might be better to see a doctor with bigger/more shameful problems Expresses suicidal ideation as a major source of shame—this is based in religious ideas about suicide as especially sinful	Fear of stigma—self Reason for therapy
12	2: "What I think is people, because of religion—religion plays a big role in our life. So if you have problem, if you say to yourself, if I'm going to be patient, then I'm going to get reward from God, that's just test from God, gonna test me if I'm going to be patient or what I'm going to do. Always ask God for help, you know. It's like God is the doctor, you always ask God, please like help me solve this problem. So you feel relieved inside, this stuff don't build up and get worse if you really believe in religion. That's why it's rare to see someone depressed in like Arabic society, Muslims, real Muslims, (laughs) not fake Muslims, society, yeah, maybe that's the reason why there is less people go to the psychologist or make suicide because they automatically think that if they make suicide they're going to go to hell, straight, that's—this life is just a test for everybody, so they should learn how to deal with their problems instead of kill themselves. They can do other stuff. There is a solution, any problem has a solution."	People should be "patient"—this seems to often mean not seeking help immediately—in order to get a reward from God Life problems as a "test" from God (God as evaluator) Preference for seeking help from God (God as doctor) Prayer as a mood aid Idea that people who really believe in religion aren't as affected by problems Arabs/Muslims less frequently depressed—this is the reason less attend therapy Real vs. fake Muslims? Suicide as a sin—sends people to hell Reiterates that people should learn how to "deal with their problems" (echoes remark about patience). This seems to encourage people to handle problems on their own and find a solution since "any problem has a solution"	Locus of control Perception of lack of need; Preference for spiritual healing

Comment #	Comment	Associations, interpretations, preliminary themes	Superordinate Themes
13	2: "He should seek like, go to doctor and ask for help—he shouldn't stay. But mostly the family helps first, sisters, brothers, mother and father. And then if it's really really big problem they can consider doctor, psychologist."	Mentally ill people should get help from doctors Preference for help from family See a doctor/psychologist if it's a "really really big problem"	Perception of lack of need; Preference for close acquaintances
14	5: "Yeah. I think that maybe if they were like Criminal Minds ill, that they would be more likely to send them to the doctors."	Serious/dangerous mental illness more often sent to doctors Questions of morality more serious?	Reasons for therapy
15	5: "I think you can cure anything through the Qur'an. So I think that maybe they try that at first, and then if maybe going to an imam or something doesn't work then maybe they'll try something else."	Qur'an as healing Therapy as secondary option to speaking to religious leader (imam) or reading the Qur'an	Preference for religious healing

(modified from Smith & Osborn, 2003)