HELP-SEEKING BEHAVIORS IN MULTICULTURAL COMMUNITIES

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DEDICATION

To Papa, for being my strength, my inspiration, and my compass; for showing me how to live, love and give wholeheartedly.
To Mama, for being there for me in every way you knew how, and every time I needed you, regardless of any limitation you had.
To Anooshey and Faiz, for being the single reason I work hard to be better every day. ou inspire me and are my lifeline. Being your mom is the best part of my life.
I love you all so much.
To every minority and individual of a marginalized community- this is proof that we can achieve our goals, regardless of the adversity that comes in our way. Persistence wins.
To every ally and advocate of minorities, the marginalized and those who are disadvantaged, thank you for your support, advocacy and for using your privilege for others who need it and can thrive because of that. It is your voice and influence that got me here. I am indebted to you. Keep making a difference in lives like mine.

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"In any given moment we have two options; to step forward into growth or to step back into safety." Abraham Maslow

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ABSTRACT

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The study examined Help-Seeking likelihood and its association with Islamoprejudice and self-stigma in faith groups. Statistical analysis was completed to assess the effects of stigma against Help-Seeking Behavior. The perception of Islamoprejudice in Christian, Agnostic, Atheist and Muslim Americans was studied. The study looked at the perception of Islamophobia and its association with help-seeking likelihood behavior for the Muslim participants. Data was collected using various personal contacts and crowdsourcing tool Prolific (Peer, Samat, Brandimarte, & Acquisti, 2016), only from participants who live in the United States.

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CHAPTER I

INTRODUCTION

Studying intergroup relations in diverse societies has become more important than ever before, especially from a mental health perspective. From civil rights to desegregation, prejudice to discrimination, radicalization to terrorism, and marginalization to pluralism, these concepts warrant understanding for citizens of society in general (Simpson & Yinger, 2013). Across the globe racial, ethnic, and religious inequalities have become apparent as waves of immigrant populations enter societies and nations and then impact the economic, social, and political tapestry of that society (Hall & Cuellar, 2016; Wright, Turanovic & Rodriguez, 2014). The United States is no different. Racial tension in the United States of America has been higher currently, compared to previous years (Heldreth, 2015; Hitlin & Matsa, 2015; Pew Research, 2017).

Newspapers today are filled with examples of discrimination against African-Americans, Hispanics, and Native Indians, and religious communities such as Jews, Mormons, and Muslims (Heldreth, 2015). In a recent *New York Times* article, Kendi (2018) highlighted the new emerging vocabulary that allows some to escape admission of racism. The terms include *war on drugs*, *model minorities*, *reverse discrimination, achievement gap*, *race card*, and *All Lives Matter*. This majority-minority dynamic highlights an opportunity to assess potential impact in every walk of life, family therapy, and other mental health services included.

One of the marginalized populations among those at the receiving end of prejudice in the US is the Muslim-American community. Estimated at almost 6 million in the US and 1.6 billion in the world, Muslims hold their place as the second largest faith in the US and the world (Council on American-Islamic Relations, 2006; Haque & Davenport, 2009; Pew Research Center, 2017). This population is one to be easily misunderstood (Haque & Davenport, 2009; Pew Research Center, 2017) , given the many facets of its principles as they are quoted in the Quran, or the complicated interpretations of Islamic law as seen debated on TV by Islamic and other experts. This attention to the faith is mainly due to some critically important global events, such as the terrorist attacks of September 11, 2001 in the US, consecutive attacks in England and Spain, the Israel Palestine conflict, and Pakistan's struggle between radical and moderate Islam (Ahmed & Reddy, 2007; Inayat, 2007; Ellis, 2018). Understanding family resilience is an important component of understanding different faith population for many reasons (Patterson, 2002). This includes minority faith groups such as Atheists and Agnostics and other cultural groups as well (Esses, Hodson & Dovidio, 2003).

Stereotyping diverse ethnicities just on the basis of religion portrays a challenge for mental health professionals who may ignore the in-group variation in this group and therefore limit their multicultural competence (Sirin et al., 2008; Vogel, Wester, Wei & Boysen, 2005). In a meta-analysis of 345 published studies about Muslims, Ahmed and Matthes (2017) found that Muslims are more likely to be negatively portrayed while Islam is portrayed as a violent religion. The pressures faced by the American-Islamic community of North America includes hate crimes, surveillance, and institutional

discrimination (Amer & Bagasra, 2013). This population will require competence in culturally sensitive interventions so they can be supported in their well-being.

For the American Muslims who participated in the Pew Research survey conducted in the beginning of 2017, 75% said there is much discrimination against Muslims in the US, while 60% stated that U.S. media coverage of Muslims is unfair (Pew Research Center, 2017).

Alongside this rising hostility, there have been many protests and rallies to show compassion and support to Muslims (Reiger, 2017). The negative impact on this community is significant. The generalization of Muslims as radicals perpetuates Islamophobia as they are presented as a threat to the cultural identity of the in-group. Many studies show that perceived threats to in-group values by immigrants and minorities have an effect on stronger negative attitudes towards them (Velasco Gonzalez, Verkuyten, Weesie, & Poppe, 2008). Symbols related to Islam and the word 'Muslim', have been associated with initiating hate victimization (Hendricks, Ortiz, Sugie, & Miller, 2007).

Statement of the Problem

Given the self-stigma around seeking mental health services (Gary, 2005) and the perception of Islamophobia (Pew Research Center, 2017) in the Muslim-American communities, the need for strong research dedicated to American Muslims comes hand in hand with the heightened visibility of this community. With around 5 million Muslims in the US (Sirin & Fine, 2007), this community is expected to grow steadily, and mental health professionals are more likely to interact with this population and require training

and evidence-based literature to strengthen their multicultural competence to support this community (Amer & Bagasra, 2013). The impact of religious stigma on the identity of Muslims living in societies that are suspicious of Islam and its values is a topic that needs the mental health profession's attention (Kunst, Tajamal, Sam, & Ulleberg, 2008).

Many studies have highlighted the disparities in access to mental health services due to cultural barriers, language impact, as well as the economic disadvantage in minority groups (Cook, Doksum, Chen, Carle, & Alegría, 2013; Chow et al., 2003; Stockdale, Tang, Zhang, Belin, & Wells, 2007; Wei, Sambamoorthi, Olfson, Walkup, & Crystal, 2005).

This study analyzed participants' faith association with their help-seeking likelihood behavior, assessing Christian, Atheist, Agnostic, and Muslim communities in the United States of America. A unique component of this study was that data was collected from adults of all backgrounds to compare various groups in their help-seeking likelihood behaviors as well as perceptions about the Muslim-American community in the United States of America.

Purpose of the Study

The purpose of this online quantitative survey was to understand the relationship between key components of accessing and resisting mental healthcare in a minority community experiencing prejudice while comparing these components with other majority and minority faith groups.

While studies have shown that client satisfaction and functional improvement is high with family therapy (Doherty & Simmons, 1996), this study focused on uncovering

elements that hinder clients' willingness to access therapy. In addition to seeking feedback from participants of all backgrounds about help-seeking likelihood behavior, this study emphasized on looking at the perceptions about Muslim-Americans to see if their choice of selecting a therapist or mental health professional is impacted by their experience of adverse treatment. Similar relationships were assessed for other participants to measure disparities between majority and minority faith groups.

To be included in this quantitative study, participants had to be living in the United States, be at least 18 years of age, and be able to read, write and comprehend the English language at a fifth-grade level or higher. Participants were recruited using a snowball method through my various social and work related networks across the country as well as Prolific, a crowdsourcing tool where participants are paid to participate in a study (Peer et al., 2017). They completed a 30-minute online survey regarding their religion, including religious beliefs, help-seeking likelihood behaviors, stigma associated with help-seeking likelihood, and perceptions about Muslims and Islam.

This study used a multicultural approach to collect data around help-seeking likelihood behaviors in a minority group experiencing adverse treatment and comparing it with other minority and majority groups belonging to different religious backgrounds.

Research Questions

This study aimed to investigate the following research questions:

1. How does help-seeking likelihood of Muslim-Americans compare to other religious groups in the United States? What role does self-stigma play in help-seeking likelihood?

2. How is the perception of Islamoprejudice in Muslim-Americans compared to the perception of Islamoprejudice in other faith groups in the United States?
3. What is the association between Perceived Islamophobia and Help-seeking likelihood Behavior in Muslim-Americans in the United States?

Definitions

Discrimination

When dominant group members express their stereotypes in a way that adversely affects the interest of individuals in a minority group, it is termed *discrimination*. Through this process, the dominant groups can afford advantages and privileges that they deny minority groups (Sue et al., 1991). An example would be a white client refusing to work with a Muslim therapist or a client refusing to work with an immigrant or person with verbal delay due to their speech not being regular.

Islamophobia

The term *Islamophobia* has been used to describe fear of the religion of Islam and its followers (Kunst, Sam, & Ulleberg, 2013)

Prejudice

Prejudice is a cognitive and affective response serving those who may generalize and embrace negative stereotypes (Gary, 2005). It is usually denoted by thoughts and feelings that members of a group have about individuals in another group based on stereotypes and unsubstantiated claims. In the US, prejudice impacts several minority communities as well as those with mental illness (Wei et al., 2005).

Self-stigma

Stigma refers to a collection of beliefs, negative attitudes, thoughts, and behaviors that have an impact on an individual or community to fear, reject or discriminate against people (Atkinson, Jennings & Liongson, 1990; Gary, 2005). Examples would be prejudice against a minority community or disrespect for those with mental illness.

Theoretical Framework

While theories offer approaches and interventions to address many challenges and problems of today, including tools and interventional techniques, practitioners using them do translate and adapt them to operationalize them to fit emerging needs and circumstances (Stiles, 2007). Today, theory building is looked at as an evolving process where an observation may change the theory by modifying or refining it, also known as the 'diffusing metaphor', while the researcher still maintains their task of making the systematic observations.

While qualitative methodologies for theory building may look different from the quantitative methodologies, codifying insight and developing theoretical contributions is not an easy task (Klag & Langley, 2013). Ideas such as 'conceptual leaps' have been introduced as a way of stimulating and integrating epistemological and conceptual foundations of theory building.

The concept of 'abduction' has been introduced in research (Rock, 2016). Locke talked about the idea of the data coding process in that the data analysis may break down the data but there is still the need to understand it holistically which is aligned with the systems theory of understanding information (Bertalanffy, 1972; Drack, Apfalter, &

Pouvreau, 2007). Having a playful approach is recommended to unlock creativity and imagination and theorize in a different way.

The theoretical framework of this research project has been carefully selected to represent the philosophical foundation on which this research takes place. It links the theoretical aspect to the practical components of the quantitative investigation that is pursued in this study. The goal is to help explain the methodologies utilized to gather and analyze the data and explain the results.

Symbolic interactionism focuses on the connection between symbols or shared meanings and interactions or verbal and nonverbal actions and communications. In other words, it is the frame of reference for understanding how human beings create symbolic worlds in concert with one another and how these worlds in turn shape human behavior (Rock, 2016). This is a preferred model to understand society, particularly the influence of culture of any society or community in terms of human behavior as well as how it places an individual in it. Herbert Blumer (1986) is the leading mind behind this theory.

The Muslim-American Community is a community that warrants a better understanding given that it is impacted by the adverse association with terrorism and radical thought. The term ‘terrorist’ may symbolize the stereotype which perpetuates the concept of Islamophobia (Ahmed & Matthes, 2017) leaving Muslim-Americans struggling to defend their identity in response to negative treatment they may be subject to (Ahmed & Reddy, 2007; Bonet, 2011; Cho & Squier, 2013).

Symbolic interactionism’s unique contributions to family sciences is by acknowledging families as social groups and that it gives the individuals in these groups a

sense of self and develop their identities through this social interaction (Farrelly et al., 2015). The questions around race/ethnicity, religion, class, income, and time related to these groups become very important to scientist of the symbolic interactionism theory. For example, if a family therapist is Muslim, will it influence the therapeutic alliance given what being a Muslim symbolizes for the client? Symbolic Interaction is structured around seven assumptions that echo three fundamental themes around human behavior, self-concept, and society in general (Blumer, 1986; Carter & Fuller, 2016).

The importance of meaning for human behavior is the first theme under which there are three assumptions: (i) human beings act toward things on the basis of the meanings that the things have for them, (ii) meaning arises in the process of interaction between people, and (iii) meanings are handled in and modified through an interpretive process used by the person in dealing with things him or her encounters (Carter & Fuller, 2016).

The development and importance of self-concept is the second theme where symbolic interactionists assume a nondeterministic view of behavior by considering the position that an individual has an absolutely social and active self. The assumptions are (iv) individuals are not born with a sense of self but develop self-concepts through social interaction and (v) self-concepts, once developed, provide an important motive for behavior.

The third theme is about society and the social process. All the different symbolic interactionism theorist focused (Blumer, 1986; Farrelly et al., 2015; Rock, 2016) on the social process between individual freedom and societal constraints and maintained that

the paradox was to take a position somewhere in the middle which sought simultaneously to account for order and change. The assumptions are (vi) individuals and small groups are influenced by larger cultural and societal processes, and (vii) it is through social interaction in everyday situations that individuals work out the details of social structure (Carter & Fuller, 2016).

Considering the outline of this chapter, the purpose of the study, and the research questions presented, this study is better placed with the theoretical perspective of symbolic interactionism. With the focus of this study being to understand what perceptions are keeping a minority population that is at the receiving end of adverse treatment from seeking mental health support. Their social interactions, self-concepts, societal processes, and meanings that are symbolic of behaviors preventing engagement need to be studied and understood.

Summary

In summary, this study seeks to broaden our understanding on help-seeking likelihood behavior in a marginalized community with negative associations, as well as the impact on caregivers from this community. Through quantitative analysis, I examined the relationships help-seeking likelihood behavior has with immigration status, religiosity, and ethnicity between participants from different ethnic and religious backgrounds.

This chapter introduces a background on majority/minority relations and issues of discrimination, which lead to my interest in focusing on one of the marginalized populations. With one in four Americans viewing Islam as a religion of violence and

hatred (Council on American-Islamic Relations, 2006), mental health professionals will need to develop a strong multicultural competence to support this distressed community.

As the population of diverse therapists and counselors from a multicultural background increases, it is important to consider the level of acceptance they have in the larger community of individuals who seek counseling. Stigma experiences have shown to predict higher levels of in-group identification among minorities (Kunst et al., 2013). This community and its mental health professionals could be at risk of isolating themselves from the larger American community, thereby perpetuating radicalism is counter to the growth and acculturation of the Muslim-American community.

CHAPTER II

LITERATURE REVIEW

Help-Seeking Likelihood and Immigration History

When a person immigrates to a different country, health literacy may not be something they bring to the country, and this may influence their overall physical and mental health in the long run (Mantwill & Schulz, 2017). In general, lack of health literacy has been associated with poor self-reported mental and physical health (Bennet, Chen, Soroui, & White, 2009; Wolf, Gazmararian, & Baker, 2005). Cultural and language barriers play a role in limiting the access to mental health care for the immigrant populations. When Mantwill and Shulz (2017) studied three different language-speaking immigrants in Switzerland, they found that even after spending a considerable amount of time in their host country, when ethnic groups that socialized with those who are similar to them; the possible segregation precluded them from acquiring language skills. This in turn can affect how much they access the healthcare system, including mental health support (Singleton & Krausse, 2009). There are many components that make up ethnic identity such as peoplehood within a group, in-group affiliations, and experiences over time and include individual and group identities (Phinney & Ong, 2007; Chung, Wei, Lin, & Wen, 2016).

The process of self-identifying as a Muslim-American involves a combination of personal beliefs and group affiliation to which a person may feel a sense of belonging after exploration. Some elements of Muslim family dynamics are presented below. The Pew Research Center (2017) estimated that 58% of Muslims in the U.S. are first

generation, meaning they were born outside the U.S. Language and cultural barriers are highly likely to impact their access to mental health care. This population may also be at risk for double stigma, including discrimination based on minority group status and living with mental illness (Gary, 2005).

Help-Seeking Stigma in Cultural Minority Groups

Studies have shown that ethnic minorities feel that issues regarding race and ethnicity are important in their experience of counseling (Gary, 2005; Constantine et al., 2001; Meyer & Zane, 2013; Tseng & Hsu, 2018). The U.S. Surgeon General's Report on Mental Health, Culture, Race and Ethnicity (2001) recognized that ethnic and racial minorities are not only underserved, but also ineffectively served by mental health professionals (Burnett-Zeigler, Schuette, Victorson, Wisner, 2016; Glover, Sims & Winters, 2017). Counselors are encouraged to increase their knowledge about Islam and its impact on a Muslim person's daily life and challenges (Inayat, 2007).

In a study focused on American Asians and white patients, Asian-Americans reported lower confidence and service satisfaction that were attributed to a lack of culturally responsive therapy (Zane, Enomoto, & Chun, 1994). In similar studies, including the Institute of Medicine (IOM), it is evident that Hispanics and African-American patients had a higher likelihood of reporting dissatisfaction with their providers (Glover, Sims & Winters, 2017; IOM, 2002).

Mental health organizations such as the American Association of Marriage and Family Therapists (AAMFT), American Psychological Association (APA), and the American Counseling Association (ACA) have emphasized multicultural competence and

integrating discussions of race and ethnicity in their training programs (AAMFT Code of Ethics, 2016; ACA, 2015) with the goal to increase this competence in their clinical practitioner population.

According to the AAMFT, around 90% of their clinical members are White. This makes a racial match, which makes the occurrence of mental health clients and providers sharing the same race or ethnicity very unrealistic (Meyer & Zane, 2013). Studies with minority populations have confirmed that a racial match is associated with more utilization, less dropout, and greater satisfaction (Flicker, Waldron, Turner, Brody, & Hops, 2008; Maramba & Hall, 2002; Meyer & Zane, 2013; Sue, Fujino, Hu, Takeuchi, & Zane, 1991). Moreover, there is limited empirical research that focuses on clients' experiences with therapy as far as racial issues are concerned (Chang & Berk, 2009; Robinson-Wood, 2016).

With the majority of therapy and counseling services being provided by therapists who are Caucasian (AAMFT, 2015), there is a larger population of therapists and counselors following the Christian faith, and they may therefore be more exposed to the Christian perspective than other faiths. When a study looked at six Christian agencies across the United States that did Christian therapy (Wade, Worthington, & Vogel, 2007), they found that while clients were equally close to their therapists in secular agencies compared to religious agencies, clients who reported having high religious commitment felt greater closeness with their therapist when receiving religious interventions (Macleod, 2014). Unfortunately, for Muslim clients, this may not be possible given the lack of Muslim therapists in the United States in general (AAMFT, 2015).

Muslims in America

There are three major groups of Muslim communities in the U.S. The South Asian Muslims have heritage from Bangladesh, India, and Pakistan and make up 28% of the Muslim community in the United States (Pew Research Center, 2017). US born Muslims are more likely than Immigrant Muslims to be Black at 32%. The Arab-American group, including the Middle Eastern countries, also comprises about 25% of this community. Other smaller ethnicities include Malaysian, Indonesian, Turkish, African, Central and Eastern European as well as White and Latino converts (Sirin et al., 2008). The percentage of Muslims that identify as white is 41% but includes some Arab and Iranian ethnicities who also identify as White.

The radical Islam that sells well on media seems like the one Thobani (2011) explained as the virtual Islam followed by an 'imagined community' and is void of the complexity of the social reality and is skeletal and uniformed. The only problem is that it fails to reflect the complex, multi-layered and multi-voiced phenomena that they experience and practice the faith in multiple ways across the Muslim world. This negative image feeds into the perception of Muslim-Americans being viewed as an out-group with differences in values, norms and beliefs, theirs being extreme (Velasco Gonzalez et al. 2008).

Perception of Islamophobia

The sensationalizing of radical Islamist acts may have contributed towards the increasing prejudice towards the Muslim community in the United States of America. Understanding this community is imperative for mental health practitioners for many

reasons. Intolerance toward Muslims is widespread in the United States today. A USA Today Gallup Poll of 1,007 Americans conducted in 2006 discovered that 39% of respondents said they feel at least some prejudice against Muslims (Saad, 2006). The same number of participants favored requiring U.S. citizens who are Muslims, to carry a special ID to support preventing terrorist acts in the US (Raiya, Paragament, Mahoney, & Trevino, 2008).

Based on numerous studies, it seems like fear sells well on media (Graber & Dunaway, 2017). Adding to the confusion is the perception about certain Islamic beliefs induced by the small population of the radical Muslims with a strong 'celebrity like' presence on U.S. television, which appears to sensationalize the atrocities practiced by the various culturally influenced radicals that most Muslim communities condemn, but result in being misunderstood as the strongly held Islamic beliefs of the Muslim community around the globe (Ahmed & Reddy, 2007; Bonet, 2011).

Islamophobia is a form of discrimination that many Muslims face today. The term explains a mono-dimensional mindset with consequences of grave proportions for Muslims (Inayat, 2007), including prejudice expressed in everyday conversation and reflected in media, exclusion from employment, management and politics related jobs, discrimination in employment related practices or in providing services such as health or education; and finally, violence involving verbal abuse, vandalizing property, and physical abuse.

Due to the traumatic experiences that many in the Muslim community endured in the aftermath of September 11th, there is a strong sentiment of fear among the

community in utilizing mental health services (Rousseau, Jamil, Bhui & Boudjarane, 2015; Rassool, 2016; Zine, 2001). The challenge of being a young Muslim and to carve out a hyphenated identity amidst a global conflict is not an easy task for the Muslim-American Youth while they are being watched under a somewhat collective suspicion (Sirin & Fine, 2007). The development consequences for this population of young minds of a society being disrupted are yet to be evaluated, especially for Muslim youth in the U.S. (Sirin & Fine, 2007).

Islamoprejudice - Perception of Religiosity as Radicalism

Following the attacks of September 11th, around 83% of Muslims have experienced racism or discrimination of various intensities (Sheridan, 2006). Feelings of belonging to an out-group can negatively impact the Muslim-American identity that spans 77 countries. Integrating a healthy bi-cultural identity can be challenging for this community, especially its youth (Sirin & Fine, 2007; Sirin, et al., 2008).

The report included a meta-analysis of 345 studies published about the Muslim community between 2001 and 2015 found that Muslims tend to be negatively framed, while the religion is presented as violent. The research topics mostly covered terrorism, war, and migration; which promote the image of Islam as radical (Ahmed & Matthes, 2017), and may increase Islamoprejudice.

Religiousness and religiosity are sometimes used interchangeably with a substantive and a functional component. Religiosity includes intellectual and institutionalized beliefs as well as public and private rituals related to whatever is considered divine.

Per religious coping theory, since the Muslim community has been on the defensive, perceiving that something sacred is violated or threatened, they engage in efforts to preserve and protect these values and become more rigid and hold on to them (Raiya, Paragament, Mahoney & Trevino, 2008). The original aim of Islam was 'guidance,' and this guidance was synonymous with man's 'education' (Alavi, 2013).

Thobani (2011) explained that at the core of these controversies is the relationship of 'knowing Islam' and 'being Muslim', and a presumed sense of what being Muslim entails; which is influenced by what media encourages and covers more. With the Muslim community on the defensive with media and social attacks on the faith, the perception that something sacred is violated or threatened can be easy. This results in the most vulnerable age group getting influenced to channel their passion towards efforts to preserve and protect what they may be led to believe are their sacred values and honor, by participating in the extremist activities (Boss, 1993; Carr, 2006; McGilloway, Ghosh & Bhui, 2015).

Soliman et al. (2016) showed that psychosocial factors, such as fairness-seeking and experiencing intolerance, have an effect on radicalism and that intolerance of others affects radical behavior (Taylor & Quayle, 1994) that may perpetuate prejudice. It would be naïve for the United States to not consider that Islamoprejudice may be feeding into radicalism and therefore perpetuating terrorism as a self-fulfilling prophecy (Taylor & Quayle, 1994; Taylor & Horgan, 2006).

The debate regarding the true spirit of Islam continues within the Muslim Community between the secularists who prefer separating religion from politics,

reformers who believe Islam is aligned with democracy and modernity, traditionalists who think otherwise, and radicals who would want to enforce Islamic law sooner than later (Amer & Bagasra, 2013).

Multicultural Competence in Family Therapy and Counseling

The validation of a multicultural philosophy in a nation which endorses that cultural diversity is good for society helps create a level of confidence among those living in a diverse community, especially those who are minorities because it decreases the perception of group threat leading to a more positive attitude towards immigrants and minorities (Verkuyten, 2006; Ward & Masgoret, 2006). Multiculturalism has been adversely associated with prejudice as attempting to achieve it may reduce national identity (Velasco Gonzalez et al, 2008; Yogeeswaran & Dasgupta, 2014).

An integral part of working with a multicultural family is a cultural assessment that gives the practitioner insight on what different dimensions of the culture mean to the client's presenting problem. Whether it is their culture or acculturation to the United States, social class, commitment to religion, birth order or the impact of the Islamic environment, gender or sexual orientation (Ahmed & Reddy, 2007; Ibrahim & Dykeman, 2011); a systemic approach with a multicultural orientation is warranted. The adolescent population is one for mental health professionals to pay close attention to, with care and sensitivity, offering a safe and supportive space.

In reality, the Muslim population in the US is very diverse in that it represents many micro communities, from various Muslim cultures in the world. With a Somali Muslim concentration in Minnesota to an Arab Muslim population in Michigan and a

Pakistani, Indian and Bangladeshi population in Chicago and New York, these sub-cultures practice Islam with a uniqueness that sets them apart from their fellow brothers and sisters of the faith.

For example, the African-American population of Muslims is the largest within the Muslim sub-group representing almost half of the Muslim population of the US according to various research sources (McCloud, 2014; Pew Research Center, 2017). When these clients present themselves for therapy, the label 'Muslim' would be a dangerous stereotype for a therapist's consideration, because while they do share a common religion, the influence of ethnicity, their acculturation in the U.S., their socioeconomic class, education level and secular, reformist or radical views of Islam make them an extremely heterogeneous community to understand (Amer & Bagasara, 2013; Haque & Davenport, 2009; Ibrahim & Dykeman, 2011).

A multicultural competence is essential to supporting this unique community that represents around 77 nationalities in the US (Pew Research Center, 2017). While research has consistently reported that counselors of a different race or ethnicity have reported higher levels of multicultural competence than their white colleagues, the number of white counselors still outnumbers counselors of minority races and ethnicity tremendously (Constantine et al., 2001; Robinson-Wood, 2016). This study may help emphasize the importance of multicultural competence for Marriage and Family Therapists (MFTs) and more training programs to strengthen competence in this area.

The areas of functioning that affect the underutilization of mental health services in the Muslim community include mistrust of service providers, fear of racism and

discrimination, issues of culture, and fear of treatment (Inayat, 2007; Rassool, 2015). Due to these and other practices of negative treatments, educational aspirations of Muslims as well as outcomes, psychosocial abilities, and sense of belonging have been adversely impacted (Bonet, 2003; Rassool, 2015).

Individuals with mental illnesses are often inappropriately put in prisons (Buchanan & Leese, 2001; Marrast, Himmelstein, & Woolhandler, 2016). Minority populations have implications for how other communities perceive them, given the context of Islamophobia or racism (Chung et al., 2016). It does not help the stigma when U.S. produced films portrayed a disapproving view of Arabs and Muslims (Shaheen, 2003), thereby influencing American perspectives of the Muslim-American community.

Summary

This chapter lays a foundation for this multicultural study in explaining concepts and research about where we are today in the area of working with various faith communities as well as Muslim-Americans.

Communities cannot be understood without a basic orientation into intergroup dynamics, racism, and discrimination as well as the experience of counseling and mental health access for various groups including Muslim Americans.

This chapter explores the socio-cultural environment in which families socially engage and carry out their roles as citizens, neighbors, community members, and more importantly as members of a family system. Meanings were understood more after the survey was operationalized and feedback was asserted by looking at the relationships between the variables explained in the next chapter.

The news media covering Muslim Americans in a negative light was also covered in this chapter, which adds to the negative projection of this community (Sirin et al., 2008).

CHAPTER III

METHODOLOGY

This online quantitative study investigated the association between help-seeking likelihood behaviors and stigma in majority and minority faith communities. This study also looked at the Muslim-American community and aimed to understand its help-seeking behaviors relative to other communities given the adversity of Islamophobia in today's American society (Amer & Bagasra, 2013). With the aim of identifying associations to support mental healthcare practitioners in various ethnic and religious groups, this study was designed with a multicultural perspective.

Research Design

This study followed a quantitative approach to determine the relationships between key variables. An online questionnaire was used for data collection.

Protection of Human Subjects

An application was submitted to the Texas Woman's University Institutional Review Board (IRB) before the start of the research. The goal of this step was to protect the integrity of the study and the participants. Once the approval was granted by the IRB (see Appendix A), the survey was uploaded to psychdata.com and sent to the various recruitment sources described in the procedures section.

The researcher utilized Psych Data, an online survey tool, to create the online survey. The website link to the study was included on the recruitment email (see Appendix B). Participants could access the survey on a PC, tablet, or smart phone.

Consent was the first step for participants accessing the survey, and only accepting the online consent would take participants to the next page where the survey questions began (see Appendix C). The confidentiality of all participants was maintained, and possibility of harm and confidentiality were addressed in the IRB application.

Participants

The current study recruited participants who lived in the United States. A total of 375 participants completed this online study in order to meet the criteria for the statistical calculations requirement for the model utilized to research the date collected. Participants were 18 years or older and read, wrote, and understood English at a 5th grade level or higher. Participants living in the US for at least 2 years at the time were included in the study. They also had access to the internet or a smart phone to complete the online survey.

The analysis was conducted using data from 306 participants after removing data with missing files and incomplete forms, and redundancy was verified. The present data includes 162 participants from Prolific and 144 participants from personal and professional recruitment efforts (see Table 1). Descriptive Statistics and frequencies between the two groups are presented in the Results section. It was noted that Recruited and Prolific groups differed significantly on all demographic variables showing that each group comprised of differences in gender, education, income, and race. This is explained in the preliminary analysis. Frequencies and percentages for the categorical demographic variables are displayed in Table 1.

There were 195 females, 107 male, and 4 participants who identified as other. The largest race reported was Caucasian at 206, which made up 67.3% of the valid responses. Asians came in second at 23.9% and African-Americans at 7.8% of the participant pool. Only three participants identified as Native-American or Alaskan-Indian at 1% of the data.

Education level of the participants ranged from 115 of the participants having an Associate's Degree or less to 100 participants having a Graduate degree or higher. There were 91 participants who reported having a Bachelor's degree in the participant pool. The income levels presented 95 participants at $49,999 or less, 81 participants at $99,999 or less, 48 participants at $149,999 or less, and 82 participants at $150,000 or more. Most of the participants were employed (64.4%) with the remaining being a mix of students (13.1%), Homemakers (7.2%), Unemployed (6.5%), Retired (5.2%), Unable to work (2.6%) or out of work (1%). These are presented in Table 1.

The largest religious group in the sample was Christian (39.9%). The remaining larger religious affiliations included Agnostic (18%), Atheist (13.7%), and Muslim (13.1%). Therefore, for Research Question Three, only 40 participants were included in the analysis as the question focused on Muslims only.

Instruments

One survey and four scales were used in this study. The first part of the survey included a consent and demographic information. This was followed by the Self-Stigma of Seeking Help Scale (SSOSH), the Help-Seeking Likelihood Scale, the Perceived Islamophobia Scale, and the Islamoprejudice scale was utilized for this study.

Demographic Information

The information collected included questions about the participants' age, sex, race/ethnicity, sexual orientation, education level, income, employment, immigration history, and marital status. Qualifying questions such as the participants' zip code and county of residence was included to confirm they meet the criteria to participate being they have to be 18 years of age and residing in the US for at least 2 years at the time the survey is taken.

Likelihood of Help-Seeking from a Therapist or Counselor

There were nine questions in the survey that focused on asking participants about their likelihood to get therapy when faced with challenges. Situations such as marital discord, substance abuse, depression, anxiety, intimate partner violence, parenting, sexual difficulties, parenting, family member with special needs, and an 'other' option were included. Possible mean scores ranged from 1 to 5, (1 = *not at all*, 2 = *not very much*, 3 = *moderately*, 4 = *quite a bit*, and 5 = *very much so*). Higher scores indicated more likelihood of using family therapy and counseling. Chronbach's alpha for this study was at .93 presenting a strong scale consistency.

Self-Stigma of Help-Seeking

The SSOSH was used to measure attitudes of self-stigma. The SSOSH includes 10 questions that assess the mediating effects of stigma and attitudes associated with help-seeking likelihood behaviors, such as counseling or family therapy (Vogel, Wade & Hacker, 2007). Vogel et al., (2007) described stigma as the perception that a person who is looking for psychological treatment is perceived as undesirable or socially

unacceptable (Vogel, Wade & Haake, 2006). Questions were answered on a 5-point scale (1 = s*trongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, and 5 = *strongly agree*). Mean scores of items were coded such that higher scores indicated higher self-stigma with help-seeking likelihood attitudes.

The 10-item scale has exhibited strong internal consistency reliability and a good 2-month test-retest reliability, with a confirmatory factor analysis indicating that a unidimensional factor model provided a good fit to the data. Vogel et al. (2006) found internal consistency on this instrument ranged from .86 to .90 while test-retest was .72 showing construct, criterion and predictive validity across the study samples. This scale has presented a unidimensional factor structure and validity through correlations with attitudes toward seeking professional help and intention to seek counseling and distinguished between college students who utilized mental health services from those who did not. (Vogel et al., 2006). However, when utilized in this research, Chronbach's alpha was at .47, presenting a lower scale consistency.

Perception of Islamophobia

The 12-item PIS, which has been validated in two studies conducted by Kunst et al. (2013), was used to measure this variable (see Appendix E). Kunst et al. (2013) created this instrument with the goal of measuring the perception of society as it interacts with Islam and Muslim cultures. This scale has been tested for criterion and convergent validity of the PIS with comparisons to already validated scales such as the Perceived Discrimination Scale (Flores et al., 2008), and the Perceived Stress Scale (Cohen, Kamarck, & Mermelstein, 1983). This scale was adapted to replace 'German' with

'Americans'. Questions were answered on a 5-point scale (1 = s*trongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, and 5 = *strongly agree*). Mean scores of items were used in the analysis such that higher scores meant a stronger negative perception of Muslims and Islam. Items that were reverse coded in the survey are 87, 88, 89, 94, 95, and 96, per the original survey (Kunst et al., 2013). Cronbach's alpha was strong at .86 confirming high scale consistency. The purpose of using this scale is to measure Muslims' own perceptions of societal Islamophobia and compare it with non-Muslims' perception of the Muslims.

Islamoprejudice

The commission on British Muslims and Islamophobia proposed criteria to measure Islamoprejudice. From this criteria, eight of the 19- items used to measure Islamoprejudice are included in the survey. Questions were answered on a 5-point scale (1 = s*trongly disagree*, 2 = *disagree*, 3 = *neither agree nor disagree*, 4 = *agree*, and 5 = *strongly agree*). Questions are adapted for use in the US and used to measure this variable (Imhoff & Recker, 2012). This scale has been validated in a previous study where it was tested by exploring its factorial structure and convergent validity. Items 97, 99, 101, and 103 in the survey are reverse-coded, so that the high scores are indicative of high Islamoprejudice. The constructs covered in this scale include subscales on Islam (see Appendix F). Cronbach's alpha was .48, which represents low scale consistency, possibly impacted by the removal of eleven questions from the survey.

Procedure

Purposive and snowball sampling techniques were used to obtain a diverse and multicultural sample for this study. The study announcement was distributed through community email list serves and online message boards in order to recruit participants from various ethnic and religious communities. The researcher contacted the various interfaith and faith-based organizations to disseminate the research announcement among their members through their email lists and discussion boards.

It was when the third round of reminders were not yielding participation and I had collected only 215 surveys (only 144 of these were eventually included in the final analysis), I utilized internet based crowdsourcing tool Prolific (Peer et al., 2016) to complete the study. Prolific is a tool for online crowdsourcing that assists in data collection through online surveys for compensation (Stewart, Chandler, & Paolacci, 2017). Prolific was selected to help complete the data collection. Prolific crowdsourcing samples have proven to show reliable data collection with well-established demographic diversity and valid data for social and cognitive psychology-based research (Peer, Brandimarte, Samat, & Acquisti, 2017; Horton, Rand, & Zeckauser, 2011; Estellés-Arolas & González-Ladrón-De-Guevara, 2012).

Participants residing within the United States were recruited and compensated at the rate of approximately $3.50 to complete the survey, via Prolific to complete the survey. The zip code question assisted me in further eliminating responses that may come from non-U.S. residents, yielding 160 completed surveys.

Participants were able to exit at any time. Once they completed the survey, a thank you message, as well as a list of national family therapy and counseling resources were provided. Participants were asked if they would like a copy of the executive summary of the findings of the study, for which their email address was required. This address was stored separately. Once 375 participants had completed it, the survey was closed.

The data was collected through PsychData the online survey tool. The participants were informed that their participation is voluntary and given information about its limitations (see Appendix H). Participants were informed they have a right to withdraw from participation at any time. The study remained open until 375 participants responded.

Table 1

Frequencies and Percentages for Demographic Variables by Gender, Education, Income, Religion, Race, Sexual Orientation, Relationship Status, and Employment

Demographic Variable	Recruited		Prolific		Total	
	n	%	*n*	%	*n*	%
Gender						
Male	22	15.3	85	52.5	107	35.0
Female	122	84.7	73	45.1	195	63.7
Education						
Lower than Bachelors	16	11.1	99	61.1	115	37.6
Bachelor's Degree	44	30.6	47	29	91	29.7
Graduate Degree or higher	84	58.3	16	9.9	100	32.7
Income						
Less than $49,999	17	11.8	78	48.1	95	31.0
$50,000 to $99,999	20	13.9	61	37.7	81	26.5
$100,000 and above	107	74.3	84	14.2	130	42.5
Religion – Main Groups						
Christian	66	45.8	56	34.6	122	47.1
Agnostic	13	26.4	42	25.9	55	21.2
Atheist	3	9	39	24.1	42	16.2
Muslim	38	2.1	2	1.2	40	15.4
Race						
Caucasian	91	63.2	115	71	206	67.3
African-American	5	3.5	19	11.7	24	7.8
Asian	48	33.3	25	15.4	73	23.9
Sexual Orientation						
Heterosexual	133	92.4	123	75.9	256	83.7
Homosexual	2	1.4	8	4.9	10	3.3
Bi-sexual	7	4.9	22	13.6	29	9.5
Relationship Status						
Married	112	77.8	38	23.5	150	49
In a relationship	11	7.6	49	30.2	60	21.8
Single	10	6.9	70	43.2	80	26.1

Table 1 Continued

Demographic Variable	Recruited		Prolific		Total	
	n	%	*n*	%	*n*	%
Divorced	8	5.6	3	1.9	11	3.5
Widowed	3	2.1	2	1.2	5	1.6
Employment Status						
Employed	100	69	97	59.9	197	71.6
Homemaker	20	13.9	2	1.2	22	8
Student	5	3.5	35	21.6	40	14.5
Retired	13	9	3	1.9	16	5.8

Summary

This quantitative study investigated the relationship between help-seeking likelihood behaviors in communities belonging to different faith communities. Noteworthy is the diverse sample of Christian, Atheist, Agnostic, and Muslim samples. Self- stigma and its association with help-seeking likelihood behaviors was also studied. A variety of selection tools generated a diverse pool of 306 participants who completed the questions in the anonymous online survey questionnaire using PsychData. The questionnaire included the Likelihood of Help-Seeking Scale, SSOSH Scale, the PIS, and the Islamoprejudice Scale along with the demographic questions to support the analysis.

CHAPTER IV

RESULTS

The current study examined Help-Seeking Behavior likelihood and its association with Islamoprejudice and Stigma in various faith groups. This study paid particular emphasis on the Muslim-American community and aimed to understand its help-seeking likelihood behaviors relative to other communities given the adversity of Islamophobia in today's American society (Amer & Bagasra, 2013). The study explored the association between perception of Islamophobia and its association with help-seeking likelihood behavior for the Muslim participants in the study.

Preliminary Analysis

Preliminary analyses were conducted to compute descriptive statistics and assess relationships between variables.

Descriptive Statistics

To begin, I examined descriptive statistics in order to better understand the sample. Frequencies and percentages for the categorical demographic variables are displayed in Table 1.

Prolific versus Recruited Participants

Due to the different sampling methods, I examined the differences between Prolific and recruited sampling methods using *t*-tests, correlations, and ANOVA analyses. When looking at the differences between the participant pools from recruited sources versus the participants from Prolific, there are some significant demographic differences observed between recruited and Prolific groups. For instance, the majority of

the recruited sample was female (84.7%) while the Prolific sample was almost equally divided for gender with 45.1% females and 52.5% males. This difference was statistically significant, χ^2 (1) = 48.86, $p < .001$.

In addition, the racial make-up of the two groups was different. Caucasians made up the largest number of participants in both groups by race, with Prolific reporting 71% and the recruited sample at 63.2%, other races were not similar percentages in both groups. For example, Black or African-Americans made up 3.5% of the Recruited Group while they made up 11.7% of the Prolific Group. Similarly, Asians made up 33.3% of the recruited group versus 15.4% of the Prolific Group. Overall these racial differences were statistically significant, χ^2 (3) = 20.22, $p < .001$.

Finally, a large difference in the two populations was in Income and Education. Nearly 75% of the recruited population earned $100,000 or higher per annum, whereas only 14% of the Prolific sample earned the same amount. While the recruited sample had 58.3% participants with a master's degree or higher, the Prolific sample contained only 9.9% of the same. Therefore, it is evident that each group differed significantly on gender, income, education, and race. Further breakdowns of the final sample are shown in Table 1.

Demographic Differences in Key Variables

T-tests were conducted to compare each group of participants (recruited and Prolific) on variables of interest. The variables included were self-stigma, help-seeking likelihood, perception of Islamophobia, and Islamoprejudice. This was done to determine whether data should be analyzed separately or together for the differently recruited

populations. Results revealed that there were significant differences among the two groups on nearly all outcomes (see Table 3). This indicated that there needs to be further analysis to confirm if a method effect was present (i.e., recruitment strategy may have impacted responses).

Chi-square tests were conducted to find out how the groups were different on outcomes. The test revealed that income, education, religious affiliation, and gender were different between the two groups, confirming that this is likely the reason that the *t*-tests were significant for those outcome variables (see Table 2).

The above analysis confirmed that the group differences were mainly because they were demographically different and not because of recruitment methodology, thereby eliminating the need to analyze the data of these groups separately.

The demographic difference makes the method effect unidentifiable and makes it difficult to test (Henson, 1998). There is an attempt to show the data both together and with group separation where appropriate. Demographics were the main reason they were different (see Tables 1 and 3).

Table 2

Verification of Method Effect –

T-Tests comparing recruited to Prolific participants on key variables

Variable	*n*	*M*	*SD*	*t*	*p*
Help-Seeking Likelihood				8.89	.000
Recruited	144	4.11	.68		
Prolific	162	3.33	.84		
Self-Stigma (SSOSH)				-5.23	.000
Recruited	144	1.91	.62		
Prolific	162	2.34	.80		
Islamoprejudice				2.50	.013
Recruited	135	3.22	.43		
Prolific	161	3.08	.54		
Perception of Islamophobia				2.01	.045
Recruited	135	3.52	.63		
Prolific	161	3.58	.68		

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Descriptive Statistics of Key Variables

Table 3

Descriptive Statistics of Predictor Variables

Predictor Variable	*N*	*M*	*SD*	Min	Max
Help-Seeking Likelihood	306	3.70	.86	1.00	5.00
SSOSH	306	2.14	.75	1.00	4.43
Islamoprejudice	296	3.14	.50	1.63	4.75
Perception of Islamophobia	296	3.55	.66	1.92	5.00

Gender Differences in Key Outcome Variables:

An independent samples *t*-test was conducted to compare the means of the variables of ethnic identity, religiosity, self-stigma, help-seeking likelihood, perception of

Islamophobia, and Islamoprejudice. Results revealed that men and women differed on all key variables except Islamoprejudice, $p < .05$.

Table 4

Means and Standard Deviations for Gender

Variable	*n*	*M*	*SD*	*t*	*p*
Help-Seeking Likelihood				6.65	.00
Female	195	3.93	.78		
Male	107	3.28	.85		
SSOH				-2.98	.00
Female	195	2.05	.71		
Male	107	2.31	.80		
Islamoprejudice				1.38	.17
Female	188	3.17	.51		
Male	104	3.08	.47		
Perception of Islamophobia				2.48	.01
Female	188	3.63	.65		
Male	104	3.43	.65		

Income and Key Outcome Variables

Pearson *r*-value was checked to see if income had a positive or negative relationship with key variables. The *p*-values were looked at to see if the relationship is significant. Results indicated that income correlated with help-seeking likelihood ($r = .30$, $p = .00$).

Education and Key Outcome Variable

When checking to see if a relationship existed between education and the key outcome variables, a univariate analysis of variance (ANOVA) was conducted. The ANOVA indicated that the *F* values were significant, therefore confirming there is a relationship.

Table 5 ANOVA

Means and Standard Deviations for Key Variables by Education

	n	*M*	*SD*	*F*	*p*	η^2
Self-Stigma				9.28	.00	.058
Lower than Bachelors	115	2.35	.83			
Bachelor's	91	2.09	.72			
Graduate Degree or Higher	100	1.93	.61			
Help-seeking likelihood				15.76	.00	.09
Lower than Bachelors	115	3.37	.89			
Bachelor's	91	3.80	.80			
Graduate Degree or Higher	100	3.99	.76			
Perception of Islamophobia				.534	.587	.00
Lower than Bachelors	115	3.58	.70			
Bachelor's	85	3.59	.69			
Graduate Degree or Higher	96	3.50	.57			
Islamoprejudice				6.57	.00	.04
Lower than Bachelors	115	3.02	.52			
Bachelor's	85	3.26	.48			
Graduate Degree or Higher	96	3.19	.46			

Note. Means with different superscripts differ significantly, $p < .05$.

Age and Key Variables

To assess if a relationship existed between age and the key outcome variables, a correlation analysis was conducted. The results indicated that there is a significant relationship between age and Help-seeking likelihood, $r = .30$, $p < .01$. There was also a significant negative relationship between Age and Stigma, $r = -.32$, $p < .01$.

Immigration History and Key Variables

When checking to see if a relationship existed between immigration history and the key outcome variables, a univariate ANOVA was conducted. The ANOVA

indicated that the *F* values were significant for help-seeking likelihood and Islamoprejudice, therefore confirming there is a relationship (see Table 6).

Table 6 ANOVA

Means and Standard Deviations for Key Variables by Immigration History

	n	*M*	*SD*	*F*	*p*	η^2
Self-Stigma				3.10	.05	.02
First Generation	77	2.00	.61			
Second Generation	37	2.37	.84			
Third Generation or More	192	2.15	.78			
Help-seeking likelihood				10.89	.00	.07
First Generation	77	4.07	.79			
Second Generation	37	3.39	.86			
Third Generation or More	192	3.62	.85			
Perception of Islamophobia				1.63	.20	.01
First Generation	72	3.44	.64			
Second Generation	37	3.58	.64			
Third Generation or More	187	3.60	.65			
Islamoprejudice				3.85	.02	.03
First Generation	72	3.28	.43			
Second Generation	37	3.17	.42			
Third Generation or More	187	3.09	.53			

Note. Means with different superscripts differ significantly, $p < .05$.

Main Analyses

This section presents the findings for this study, addressing three questions for which data was analyzed using software SPSS (Osterlind, Tabachnick, & Fidell, 2001) with the results explained below.

Research Question One: Comparing Faith and Help-Seeking Likelihood

To test whether a relationship exists between help-seeking likelihood and religion, an analysis of covariance (ANCOVA) was run with covariates of age, gender, and immigration history. Results indicated that there was no significant difference between the results of religious groups and help-seeking likelihood when controlling for the above demographics (see Table 7). In other words, it is not religion that influences help-seeking likelihood, but covariates such as age, gender, and immigration history.

Table 7

ANCOVA Examining Religious Group Differences in Help-Seeking Likelihood.

Help-seeking likelihood	*n*	*M*	*SD*	*F*	*p*	η^2
Age				11.30	.00	.04
Gender				26.13	.00	.08
Immigration history				6.71	.01	.02
Religious Main Groups				1.30	.27	.01
Christian	130	3.85	.86			
Agnostic	80	3.51	.87			
Atheist	41	3.25	.78			
Muslim	44	4.00	.74			

Note. Age, Education, Income, and Gender were entered as covariates. Means with different superscripts differ significantly, $p < .05$. Adjusted means are reported

Research Question One (Part Two): Self-stigma and Help-Seeking Likelihood

To test whether self-stigma is associated with help-seeking likelihood, a regression analysis was conducted expecting a negative correlation. This means that when feelings of self-stigma increase, the help-seeking likelihood decreased. In other words, when one experiences self-stigma, they have a reduced chance of seeking help in

comparison to someone who does not experience self-stigma. The results indicated that there was a significant relationship between these two variables, $R^2 = .16$, F (1,305) = .57.24, $p < .001$. This showed that self-stigma was a significant predictor of Help-Seeking Likelihood with a standardized regression weight for Self-stigma was -.40, $p < .001$ (See Table 8).

Table 8

The Relationship between Religious Main Groups and Self-stigma of Seeking Help

SSOSH- Self-stigma	*n*	*M*	*SD*	*F*	*p*	η^2
Religious Main Group				3.48	.79	.00
Christian	122	2.14	.78			
Agnostic	55	2.18	.75			
Atheist	42	2.19	.68			
Muslim	40	2.04	.66			

Note. Means with different superscripts differ significantly, $p < .05$. Pearson Correlation confirmed Self-stigma is related to Help-seeking likelihood.

Research Question Two: Islamoprejudice

To test if Islamoprejudice in Muslim-Americans compared to the perception of Islamoprejudice in other Americans, a one-way ANOVA was conducted to determine if likelihood of seeking therapy differed by participants' religious affiliation. There were four main religious groups in the sample; Atheist (n = 42), Agnostic (n = 55), Christian (n = 117) and Muslim (n = 35) (see Table 8).

Table 9

ANCOVA- Means and Standard Deviations for Islamoprejudice by Religious Groups

Islamoprejudice	*n*	*M*	*SD*	*F*	*p*	η^2
Education				4.88	.03	.02
Religious Main Groups				6.96	.00	.07
Christian	130	3.07	.50			
Agnostic	83	3.15	.51			
Atheist	42	3.06	.46			
Muslim	41	3.47	.39			

Note. Means with different superscripts differ significantly, $p < .05$.

Data was recoded to focus on these main religious groups. One way ANOVA had four categories in the religious affiliation variable. Results indicated there are religious group differences in prejudice with Muslims (see Table 9). Tukey's post hoc tests revealed Muslims were significantly higher from Atheist ($M_{diff} = .45$, $p < .01$), Agnostic ($M_{diff} = .34$, $p < .01$), and Christian samples ($M_{diff} = .43$, $p < .01$).

An ANCOVA test was conducted to determine if there was any difference in the results if the control variables of Education were entered.

Results revealed that controlling demographics did not have a significant impact on perception of Islamoprejudice and were still significant, F (3, 233) = 6.92, $p < .001$, $\eta^2 = .075$.

Research Question Three: Perceived Islamophobia and Muslim Americans

To test the association between Perceived Islamophobia and Help-Seeking likelihood Behavior in Muslim-Americans, the possibility of a bivariate relationship between these continuous variables (Perceived Islamophobia and Help-Seeking

likelihood Behavior) was examined among Muslim-Americans (n = 35), using regression analysis. The results indicated that there was no significant relationship between these two variables, R^2 = .01, F (1,129) =.37, p = .54.

Summary

This chapter presents the statistical analyses strategies and the results of a quantitative research study, including a description of the sample, and analyses of items on the questionnaires that were collected from 306 participants using multiple recruitment methods.

Multiple linear regression, ANCOVA, ANOVA, and simple quantitative analysis were used to address the three research questions. For research question one, there were significant differences in Likelihood to seek help. Post hoc comparisons revealed that Muslims and Christians help-seeking likelihood was significantly higher than Agnostics and Atheist. All religious main groups had similar views on self-stigma. The one-way ANOVA test conducted to determine if there were religious group differences in Prejudice with Muslims, confirmed that Muslims' experience of Islamoprejudice was significantly different from the Christian, Agnostic, and Atheist participants. For Research Question Three, when looking at the possibility of a relationship between Perceived islamophobia and help-seeking likelihood behavior, the results indicated there was no significant relationship between these two variables.

Finally, given the sample size of the study, it must be considered that the p-values may be susceptible to showing significance even if the effect size is low.

CHAPTER V

DISCUSSION

This study investigated help-seeking likelihood behaviors in different faith groups in the United States, including Christian, Agnostic, Atheist, and Muslims. The role of self-self-stigma in help-seeking likelihood, as well as perception of Islamoprejudice, was examined through statistical tools such as ANOVA, regression, and correlation. Results indicated that there is a reverse relationship between help-seeking likelihood and self-self-stigma of seeking help. Income is related with help-seeking likelihood where higher income predicts higher likelihood of seeking help. Finally, help-seeking likelihood of Muslim-Americans was similar to those of Christian Americans and different from the likelihood of Atheist and Agnostic participants. Immigration history was associated with Islamoprejudice and help-seeking likelihood. Gender had an effect on help-seeking likelihood, where men were less likely to seek help than women did.

Faith and Help-Seeking Likelihood

The results of this study indicated that there was no significant relationship between help-seeking likelihood and religion, controlling for age, gender, and immigration history. This may suggest that therapy and counseling efforts need to pay more attention to the men who may experience more perceived barriers impacting their help-seeking likelihood than women. What one perceives about help-seeking through religion may not be clear, but the association of religiosity and seeking help from a higher power has been well documented (Verkamp, 1991). The conflict in ones' religious values may impact their willingness to be vulnerable to a person who belongs to a different

group (Sniderman, & Hagendoorn, 2007). This could include ones' religious affiliation. Immigration status may contribute to this result in that with assimilation and acculturation, help-seeking stigma may be reduced over time. This is where age could have an effect on these variables as well (Vogel et al., 2007)

Self-Stigma and Help-Seeking Likelihood

This study also aligns with previous studies confirming the relationship between self-stigma of help-seeking and help-seeking likelihood (Gary, 2005; Mehta et al., 2015; Vogel et al., 2007; Wahto & Swift, 2016). Therefore, the chances of help-seeking likelihood increase if the experience of self-stigma is lower. Social norms influence male utilization of help (Pattyn, Verhaeghe, & Bracke, 2015).

Individuals and families from ethnic minority groups experience double self-stigma where racism adds to the internalized self-stigma of mental illness and deters help-seeking likelihood (Gary, 2005). Compounding this effect after 9/11, a study examining perceived discrimination and appropriate use of coping for Asians reported that there was a delay for the participants in experiencing and responding to their psychological symptoms (Inman, Tummala-Narra, Kaduvettoor-Davidson, Alvarez, & Yeh, 2015). Similarly, the findings of this study seem to suggest the same for men in its sample.

Similar to previous research, this study also found that women were more likely to seek help than men. Studies have indicated that perceived barriers or negative outcome in a counseling or family therapy experience is related to whether a person will continue in therapy or not (Heath, Seidman, Vogel, Cornish, & Wade, 2017; Kim & Zane, 2016).

Gender stereotypes may be influencing the stereotypes about mental illness for men (presented as weakness) to negatively impact help-seeking likelihood behavior (Judd, Komiti, & Jackson, 2008; Wahto & Swift, 2016).

Islamoprejudice

The results of this study presented that Islamoprejudice was significantly different when experienced by Muslims than Christians, Atheists, and Agnostics. Specifically, controlling for age, gender, income, and education did not have a significant impact. This confirmed results from previous research that Muslim-Americans' perception of Islamoprejudice is high compared to other groups (Ahmed & Reddy, 2007; Bonet, 2011; Raiya et al., 2008; Thobani, 2011); therefore, the perception of Islamophobia may pose negative implications for this population. This suggests that Muslims' perception of Islamoprejudice and perceived Islamophobia may be experienced by the Muslim population in a manner that could be more distressing than others could.

Perceived Islamophobia and Muslim-Americans

The results of this study also pointed out that help-seeking likelihood behavior is not related to perceive Islamophobia for Muslim Americans. This could mean that even if Islamophobia is perceived, there may be no relationship between a Muslim seeking therapy or counseling and other mental health services. However, given there were approximately 40 participants who identified as Muslim, this result could differ based on many elements from the location of the participants within the United States (for example in areas with a higher concentration of Muslims) to the recency of media promoted events such as political elections or attacks conducted by radicals (McCauley, 2012; Terman, R.,

2017). Even though the relationships are reported more significantly related to self-stigma of mental health support and cultural or ethnic influences (Clement et al., 2015; Gary, 2005); this community may present as vulnerable posing mental health challenges.

Clinical Implications for Practice

Symbolic interaction theory was used as a guide to understand this study. The United States has consistently included an enriched community of people with a growing diversity of cultures, ethnicities, races, and faiths. These communities continue to evolve and create symbols of shared meanings with their words and actions. Sometimes, this 'making sense of the world' can be fear induced and negative. Social interaction influences how communities identify and how their following generations continue to shape those meanings.

Stigma of seeking help, help-seeking likelihood, and Islamophobia are a part of this trajectory of identities and influence human behavior in societies. Husting (2015) studied traveling individuals and described an experience he termed the 'flayed' self; having a temporary identity consisting of discomfort and self-consciousness (Carter & Fuller, 2016). The results of this study support the assumptions of the symbolic interactionist theory where the symbolic meaning of the word Muslim may have negative implications for many living in the United States. This in turn can influence negative interaction between those belonging to the Muslim group and those outside the group. These negative meanings associated with the word 'Muslim' has an opportunity to be modified through the interpretive process as explained by the Symbolic Interaction Theorists (Carter & Fuller, 2016).

Examination of the major findings of this study has clinical implications that may benefit the U.S. society and Muslim-American community. For example, studies show that talking about racism with African-American clients may enrich the therapeutic process by building trust and creating a safe space for emotional processing (Clark et al., 1999; Clement et al., 2015; Gary, 2005; Mishra, Lucksted, Gioia, Barnet, & Baquet, 2009). It could be helpful for clinicians to ask Muslim clients about their experiences of Islamoprejudice, just like it is important to talk about racism with African-American clients.

The results of this study also present that income is related to help-seeking likelihood confirming that higher income increases the likelihood of seeking therapy. Specific to the provision of mental health services, the results of this study point attention needs to be paid to provide access to family therapy and counseling to members of the diverse population that may be financially disadvantaged.

The results of this study also pointed to the importance of working on Psychoeducation to remove stigma for the male population within the Muslim-American community and outside. Specifically, perceived barriers for help-seeking likelihood may be higher for a Muslim-American family if there is mental illness and may prevent or hinder help-seeking likelihood.

It must be considered that the responsibility of diluting stigma cannot just be the responsibility of mental health treatment providers. This responsibility must extend to community workers; including physicians, nurses and other healthcare professionals, and workers (Colvin & Bullock, 2016; Wood, 2012). The biopsychosocial model (Clark et

al., 1999) of collaborative care can work as a guiding lens to work on the self-stigma around help-seeking likelihood with men, a marginalized population, and compounded stress.

Limitations

Although this study contributes to the present literature and research on self-stigma of seeking help, help-seeking likelihood, perception of Islamophobia, and Islamoprejudice, various limitations also exist warranting future research.

First, the demographic features of the samples included limited diversity in faiths. The Christian population was the largest in this sample; whereas one of the goals of this study was to compare the Muslim-American population. The Muslim-American sample in the final analysis included 40 participants, which was the lowest number between the four main groups studied. The racial mix of the sample was also not as diverse with Caucasians and Asians making up most of the sample. More participants had a graduate degree and therefore the population sample had a higher average for income with more than 30% of the sample earning more than $100,000 per year.

Another limitation of the research was that while self-stigma and help-seeking likelihood was studied, it was not studied in a longitudinal or experimental research setting. An experimental research design could assess how help-seeking likelihood changes over time with or without interventions such as psychoeducation or multicultural therapy (Tummala-Narra, 2015). This would result in data with empirical evidence for clinical and community implications. Because the study was not limited to a specific location in the United States, finding a concentration of Muslim-Americans or options for

longitudinal studies was limited. Islamoprejudice and perception of Islamophobia may have a different response if data collection was in those specific neighborhoods and communities where there is a larger population of Muslim-Americans such as in the states of Michigan, Illinois, or New Jersey. Future research can assess this difference to see if the results would be different.

Finally, a limitation of this study was that the scales of Islamoprejudice as well as Self-Stigma had low scale consistency. For the Islamoprejudice scale, the reason for this may have been the elimination of eleven questions from the original scale. It was not clear why Alpha scores were lower for the SSOSH scale

Based on the results of the present study, various future directions can be taken to better understand the help-seeking behaviors of the Muslim-American population. Future research should consider focusing on middle and lower income families within the Muslim-American community. This is important as a large population of Muslims also includes Asians (Pew Research, 2017), which puts them in the category of 'Model Minorities' or termed financially strong. There is an opportunity for more research efforts to be focused on the refugee and poverty impacted populations within the Muslim-American community to understand this community's need. Interventions and treatment plans can be more focused on this segment of the Muslim-American population.

Recommendations for Future Research

The variety of results found in regard to self-stigma of help-seeking likelihood behavior also warrant further investigation to better understand how cultural influences impact different communities within the Muslim-American Diaspora. Given Muslims in

America come from a variety of countries and cultures, it is important to look at the cultural component of their emotional process.

According to this study, self-stigma impacts help-seeking likelihood. There is an opportunity to study the limited availability of therapists and counselors from similar cultures (AAMFT, 2015; APA, 2010; Chow et al., 2003; Chao & Zang, 2017) and its association with the likelihood of seeking help. The perception of unavailability of culturally similar therapists and counselors can be a deterrent for ethnic-identified minorities (Atkinson, Jennings, & Liongson, 1990).

Although the results from the present study are neither causal nor longitudinal, the findings of this study provide opportunities for clinicians to be effective and appropriate in their interventions when designing collaborative care for the Muslim-American population. Working with healthcare professionals, such as physicians and surgeons, is important as they are the first point of contact for most individuals and could prove valuable. Equipping healthcare professionals with tools on how to assess for opportunities of mental health support needed for a family or individual, presents a tremendous opportunity for collaborative research in mental health, family therapy, and counseling.

Conclusion

Globally and in the United States of America there are racial, ethnic, and religious inequalities with waves of immigrant populations entering societies and nations that in turn impact the economic, social, and political blend of that society (Hall & Cuellar, 2016; Wright, Turanovic, & Rodriguez, 2014). Racial tension has been higher currently,

compared to previous years (Heldreth, 2015; Hitlin & Matsa, 2015; Pew Research Center, 2017) in the United States. Ethnic Minorities and men are among those that are disproportionately deterred by self-stigma (Clement et al., 2015). With more than two-thirds of the Muslim-American population being of an ethnic minority (Pew Research, 2017), this population seems more vulnerable; due to the negative projection of Muslims in the media. This study highlighted important factors that are related to the mental well-being of the Muslim-American community. The relationship of help-seeking likelihood and self-stigma point to the opportunity to design interventions that may benefit this community at large, given their struggles with experiencing Islamoprejudice. An opportunity for future research and clinical implications such as collaborative care with the Muslim-American community and their help-seeking barriers may positively impact the mental health of this population.

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APPENDIX A

IRB Approval

TEXAS WOMAN'S UNIVERSITY
DENTON DALLAS HOUSTON

Institutional Review Board
Office of Research and Sponsored Programs
P.O. Box 425619, Denton, TX 76204-5619
940-898-3378
email: IRB@twu.edu
http://www.twu.edu/irb.html

DATE: May 3, 2018

TO: Dr. Sheeza Mohsin
Family Sciences

FROM: Institutional Review Board (IRB) - Denton

Re: Approval for Help Seeking Behaviors in Multicultural Communities (Protocol #: 20085)

The above referenced study has been reviewed and approved by the Denton IRB (operating under FWA00000178) on 5/3/2018 using an expedited review procedure. This approval is valid for one year and expires on 5/3/2019. The IRB will send an email notification 45 days prior to the expiration date with instructions to extend or close the study. It is your responsibility to request an extension for the study if it is not yet complete, to close the protocol file when the study is complete, and to make certain that the study is not conducted beyond the expiration date.

If applicable, agency approval letters must be submitted to the IRB upon receipt prior to any data collection at that agency. A request to close this study must be filed with the Institutional Review Board at the completion of the study. Because you do not utilize a signed consent form for your study, the filing of signatures of subjects with the IRB is not required.

Any modifications to this study must be submitted for review to the IRB using the Modification Request Form. Additionally, the IRB must be notified immediately of any adverse events or unanticipated problems. All forms are located on the IRB website. If you have any questions, please contact the TWU IRB.

cc. Dr. Jerry Whitworth, Family Sciences
Dr. Aaron M. Norton, Family Sciences
Graduate School

APPENDIX B

Email to network

Dear Colleagues and Friends,

I hope this email finds you well and getting ready for summer. I am writing today because I will need your help. As many of you know, I am in the final phase of my Doctoral Degree and getting ready to propose my research to my University.

Given your network and reach, I am requesting your assistance in recruiting participants to complete my survey. For some of you belonging to faith based, culture based or common interest-based groups, thank you for your willingness to send the survey link out to your list serves and posting on your web pages. Getting a diversity of participants and a significant number of participants to complete my survey is going to be an integral part of my research. In order to make this study a valid one, some information about the study will be withheld until the completion of the study.

The survey is intuitive; participants can stop at any time and will be requested to commit 30 minutes to complete it. Attached please find 2 flyers you can use to give your community or those you forward this survey link to. The flyer gives possible participants some more information about the survey

If you have suggestions for others I can contact, please forward this email with an introduction.
If there are events I can attend to promote participation that would be fantastic. I am hoping you will take my survey as well.

I am attaching below a suggested script to use to reach out to participants. Please add your own words to customize it as long as you are not coercive or using any form of force to make participants complete this.

Your support in this endeavor is much needed and so appreciated. I am anticipating launching it in May of 2018. Contact information is added below for any questions you may have.

Warm Regards

Sheeza

Sheeza Mohsin, ABD, LMFT-A
PhD Candidate, Texas Woman's University
smohsindhanani@twu.edu Phone (Google Voice): 817 668-0417

Research Supervisor:
Aaron Norton, PhD
anorton@twu.edu
940-898-2677

First email – Suggested script
Subject line: Invitation to participate in an online survey

Dear [Community],
I am reaching out to you to participate in an online survey to support the research of a [friend/supporter/ally] of our community. Your responses are much appreciated as they will help Sheeza complete her degree requirements but also further research and add knowledge to an important topic. The survey should take you 30 minutes or less to complete. I am attaching the flyer to this message which includes a link to the survey.
Please add personal message here...
If you have any questions, please contact me at [email address] or [phone number].
Sincerely, [Community Leader / Friend]

Second reminder email – Suggested script
Subject line: Your participation is so appreciated in the online survey

Dear [Community],
A few days ago I sent you a link to an online survey to complete to support the research of our friend Sheeza Mohsin. Since participation is anonymous I do not have a way of knowing if you have completed it. If you have already completed and submitted the survey, thank you for your valuable input. If not, please complete your survey [link to survey], and submit your responses by [date].
I am attaching the flyer to this message which includes a link to the survey.
Please add personal message here...
Sincerely, [Community Leader / Friend]

Final reminder email – Suggested script
Subject Line: Final Reminder to complete the online survey

Dear [Community],
The survey I had emailed you about a few days ago is getting ready to close. If you have already completed and submitted the survey, thank you for your valuable input. If not, please complete your survey [link to survey], and submit your responses by [date]. The survey should take you 30 minutes or less to complete.
I am attaching the flyer to this message which includes a link to the survey.

Please add personal message here...
If you have any questions, please contact me at [email address] or [phone number].
Sincerely, [Community Leader / Friend]

APPENDIX C

Consent to Participate in Research

By completing this survey and clicking next to start, you are giving your informed consent to act as a participant in this research.
The purpose of this research is to allow the Principal Investigator to use the results as part of their dissertation, for conference or other presentations and/or: research compilations such as books or publications.

Information is collected anonymously; therefore, the information you provide cannot be linked to your name or personal information. Confidentiality will be protected to the extent that is allowed by law.
It is expected to take approximately 30 minutes to complete this survey.
There is a potential risk of loss of confidentiality in all e-mail, downloading, and internet transactions. However, surveys will be downloaded onto a secure computer which is only accessible to the Principal Investigator. Data will be stored in secure computer files.
No identifiable data is collected for this research.
Participation is voluntary. A decision not to participate will not affect your current or future relationship with the organization requesting participation or Texas Woman's University. You may withdraw from this study at any time.
In order to make this study a valid one, some information about the study will be withheld until the completion of the study.

Once you complete the survey, you will be able to read a 'Debriefing Statement' which gives you more information on the purpose of the study and the Principal Investigator's contact information so you can ask questions.
At the end of the survey, you will be given the opportunity to enter your name and contact information to participate in a gift card drawing. Please note that the contact information you provide will be collected at an external survey site, not connected to the site on which you enter your answers to the survey questions. Thus, there will be no way of linking your contact information to your answers.
Thank you in advance for completing this survey. Should you have any questions about this project, or the results of the survey, please contact Sheeza Mohsin (Principal Investigator) at smohsindhanani@twu.edu or at 817-668-0417 or Aaron Norton, Ph.D. at 940-898-2677 or anorton@twu.edu.
Please begin.
Thank you in advance for completing this survey. Should you have any questions about this project, or the results of the survey, please contact Sheeza Mohsin (Principal Investigator) at smohsindhanani@twu.edu or at 817-668-0417 or Aaron Norton, Ph.D. at 940-898-2677 or anorton@twu.edu.
Please begin.

APPENDIX D

Self-Stigma of Seeking Help Scale Items

INSTRUCTIONS: People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

1.I would feel inadequate if I went to a therapist for psychological help.

1 - Strongly Disagree 2 - Disagree 3 - Agree & Disagree Equally 4 - Agree 5 - Strongly Agree

2.My self-confidence would NOT be threatened if I sought professional help. *

5 - Strongly Disagree 4 - Disagree 3 - Agree & Disagree Equally 2 - Agree 1 - Strongly Agree

3. Seeking psychological help would make me feel less intelligent.

1 - Strongly Disagree 2 - Disagree 3 - Agree & Disagree Equally 4 - Agree 5 - Strongly Agree

4. My self-esteem would increase if I talked to a therapist. *

5 - Strongly Disagree 4 - Disagree 3 - Agree & Disagree Equally 2 - Agree 1 - Strongly Agree

5. My view of myself would not change just because I made the choice to see a therapist.*

5 - Strongly Disagree 4 - Disagree 3 - Agree & Disagree Equally 2 - Agree 1 - Strongly Agree

6. It would make me feel inferior to ask a therapist for help.

1 - Strongly Disagree 2 - Disagree 3 - Agree & Disagree Equally 4 - Agree 5 - Strongly Agree

7.I would feel okay about myself if I made the choice to seek professional help. *

5 - Strongly Disagree 4 - Disagree 3 - Agree & Disagree Equally 2 - Agree 1 - Strongly Agree

8. If I went to a therapist, I would be less satisfied with myself.

1 - Strongly Disagree 2 - Disagree 3 - Agree & Disagree Equally 4 - Agree 5 - Strongly Agree

9. My self-confidence would remain the same if I sought professional help for a problem I could not solve. *

5 - Strongly Disagree 4 - Disagree 3 - Agree & Disagree Equally 2 - Agree 1 - Strongly Agree

10. I would feel worse about myself if I could not solve my own problems.

1 - Strongly Disagree 2 - Disagree 3 - Agree & Disagree Equally 4 - Agree 5 - Strongly Agree

*Note. Items 2, 4, 5, 7, and 9 are reverse scored.

Vogel, D. L., Wade, N. G., & Hackler, A. H. (2007). Perceived public stigma and the willingness to seek counseling: The mediating roles of self-stigma and attitudes toward counseling. *Journal of Counseling Psychology*, *54*(1), 40.

APPENDIX E

Perceived Islamophobia Scale

Please rate the following items rated from 1 (*totally disagree*) to 5 (*totally agree*)

1. Many Americans avoid Muslims.
2. Americans are suspicious of Muslims.
3. In general, Americans trust Muslims.*
4. Overall, only few Americans are afraid of Islam.*
5. Most Americans feel safe among Muslims.*
6. Many Americans get nervous in the presence of Muslims.
7. A lot of Americans are afraid that Muslims are going to take over America.
8. Many Americans fear an "Islamization" of America.
9. A lot of Americans consider Islam a threat to American values.
10. American media always presents Muslims as dangerous people.
11. Islam is always presented as a threat to American culture in the media.
12. American media spreads a lot of fear of Muslims and Islam.

General fear: item 1–6; Fear of Islamization: item 7–9; Islamophobia in the media: item 10–12.

Kunst, J. R., Sam, D. L., & Ulleberg, P. (2013). Perceived Islamophobia: Scale development and validation. *International Journal of Intercultural Relations*, *37*(2), 225-237.

APPENDIX F

Survey

Perceptions on Seeking Mental Health Services in the United States

TEXAS WOMAN'S UNIVERSITY

CONSENT TO PARTICIPATE IN RESEARCH

BY COMPLETING THIS SURVEY YOU ARE GIVING YOUR INFORMED CONSENT TO ACT AS A PARTICIPANT IN THIS RESEARCH.

The purpose of this research is to allow the Principal Investigator to use the results as part of their dissertation, for conference or other presentations and/or: research compilations such as books or publications.

Information is collected anonymously; therefore, the information you provide cannot be linked to your name or personal information. Confidentiality will be protected to the extent that is allowed by law.

It is expected to take approximately 30 minutes to complete this survey.

There is a potential risk of loss of confidentiality in all e-mail, downloading, and internet transactions. However, surveys will be downloaded onto a secure computer which is only accessible to the Principal Investigator. Data will be stored in secure computer files. No identifiable data is collected for this research.

Participation is voluntary, and your response will be anonymous.

A decision not to participate will not affect your current or future relationship with the organization requesting participation or Texas Woman's University. You may withdraw from this study at any time.

In order to make this study a valid one, some information about the study will be withheld until the completion of the study.

Once you complete the survey, you will be able to read a 'Debriefing Statement' which gives you more information on the purpose of the study and the Principal Investigator's contact information so you can ask questions.

At the end of the survey, you will be given the opportunity to enter your name and contact information to participate in a gift card drawing. Please note that the contact information you provide will be collected at an external survey site, not connected to the site on which you enter your answers to the survey questions. Thus, there will be no way of linking your contact information to your answers.

Thank you in advance for completing this survey. Should you have any questions about this project, or the results of the survey, please contact Sheeza Mohsin (Principal Investigator) at

smohsindhanani@twu.edu or at 817-668-0417 or Aaron Norton, Ph.D. at 940-898-2677 or anorton@twu.edu.

Please begin

Part 1: Demographic Information

Please do NOT indicate your name anywhere on this questionnaire. For the following items, please select a response that is most descriptive of you or fill in the blank as appropriate.

What is your residential zip code?

_____

What year were you born?

_____

What is your sex?

- Female
- Male
- Other (please state): _____

Please specify your race

- White or Caucasian
- Hispanic or Latino
- Black or African American
- Native American or American Indian
- Asian / Pacific Islander
- Other

Are you Spanish, Hispanic, or Latino or none of these?

Which of the following best describes your sexual orientation?

- Heterosexual
- Homosexual (Gay or Lesbian)
- Bisexual
- Other (please state): _____
- Prefer not to say

What is your educational background?

- No schooling completed
- Nursery school to 8th grade
- Some high school, no diploma
- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Trade/technical/vocational training
- Associate degree
- Bachelor's degree
- Master's degree
- Professional degree
- Doctorate degree

Please indicate your family Income

- Less than $25,000
- $25,001 $50,000
- $50,001 to $75,000
- $75,001 to $100,000
- $100,001 to $125,000

- $125,001 to $150,000
- $150,001 to $175,000
- $175,001- $200,000
- Greater than $200,000

What county in the US do you live in?

Employment Status

- Employed for wages
- Self-employed
- Out of work and looking for work
- Out of work but not currently looking for work
- A homemaker
- A student and working
- A student and not working
- Military
- Retired
- Unable to work

Which of the following best describes your relationship status?

- Single
- In a relationship
- Married
- Divorced
- Widowed

What is your religious preference?

- Christian

- Muslim
- Jewish
- Hindu
- Buddhist
- Sikh
- Agnostic
- Atheist
- Humanist
- Something else (Please Specify): _____

Country of Birth

- US
- Other: _____

Immigration History

- First Generation (Born in in another country)
- Second Generation (Born in the US, parents outside the US
- Third Generation (Parents born in the US, ancestors outside the US)
- Family Ancestry is American for 4 or more generations

Mother's Country of Birth

- US
- Other: _____

Father's Country of Birth

- US
- Other: _____

Immigration Status:

- US Citizen
- Lawful Permanent Resident (green card holder)
- Other (non-LPR) lawful immigration status
- Undocumented
- Unknown

Part 2: Help-Seeking Behaviors

People at times find that they face problems that they consider seeking help for. This can bring up reactions about what seeking help would mean. Please use the 5-point scale to rate the degree to which each item describes how you might react in this situation.

- I would feel inadequate if I went to a therapist for psychological help.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- My self-confidence would NOT be threatened if I sought professional help.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- Seeking psychological help would make me feel less intelligent.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- My self-esteem would increase if I talked to a therapist.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- My view of myself would not change just because I made the choice to see a therapist.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- It would make me feel inferior to ask a therapist for help.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- I would feel okay about myself if I made the choice to seek professional help.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- If I went to a therapist, I would be less satisfied with myself.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- My self-confidence would remain the same if I sought professional help for a problem I could not solve.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

- I would feel worse about myself if I could not solve my own problems.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

People at times find that they face problems that they consider seeking help from a therapist or counselor. How likely would you be to seek help from a counselor or therapist if you were experiencing? Check all that apply.

- Relationship or marital challenges?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Substance abuse?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Depression?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Intimate partner violence?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Anxiety?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Sexual issues or difficulties?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Emotional or physical abuse?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Parenting or help with your child(ran)?

5-Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Family member with medical or special needs

5 Very much so 4-Quite a bit 3-Moderately 2-Not very much 1-Not at all

- Other: _____

Part 3: Perceptions of a minority population

This section includes questions about your perception of a minority population. Please select responses that best fit your perspective.

Please indicate your agreement with the following items rated from 1 (*Strongly disagree*) to 5*(strongly agree*)

Many Americans avoid Muslims.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Americans are suspicious of Muslims.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

In general, Americans trust Muslims.*

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Overall, only few Americans are afraid of Islam.*

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Most Americans feel safe among Muslims.*

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Many Americans get nervous in the presence of Muslims.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

A lot of Americans are afraid that Muslims are going to take over America.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Many Americans fear an “Islamization” of America.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

A lot of Americans consider Islam a threat to American values.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

American media always presents Muslims as dangerous people.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Islam is always presented as a threat to American culture in the media.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

American media spreads a lot of fear of Muslims and Islam.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Please indicate your agreement with the following items rated from 1 (*Strongly disagree*) to 6 (*Strongly agree*).

Islam and Christianity share the same universal ethical principles.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Islam is an outdated religion, unable to adjust to the present.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

I don't think it is justified to speak of a clash of the culture between Islam and the West.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Today it is not unusual to be doubtful of Muslims.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Hostility against Muslims is an inexcusable form of discrimination.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

Although some women willingly wear a veil one should not ignore that for some women it also means coercion.

1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

The criticism of so-called fundamentalists only fuels the taunting against all Muslims and should be labeled racism.
1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree

The term Islamophobia can be misused to make all Muslims feel like victims and thus prevent a necessary conflict between moderate and fundamentalist groups of the community.
1 Strongly Disagree 2 Disagree 3 Agree & Disagree Equally 4 Agree 5 Strongly Agree.

Based on the questions you answered in this survey, is there anything you would like to share with the researcher? Please answer truthfully. (Do not share contact information here.)

Texas Woman's University
Debriefing statement for participants of this research

Purpose of the Study:

You were previously informed that the purpose of the study was to study help-seeking behavior in Multicultural families. You were not informed is that this research includes studying biases in selecting a therapist or counselor as well as the perception of islamophobia and Muslims in the US.

The reason to limit sharing this information was to not influence participants in any way and get authentic responses. The researchers are hoping to utilize the information to further education and learning in these areas, and to eventually design interventions and programs that can help various populations.

We realize that some of the questions asked may have provoked strong emotional reactions. As researchers, we do not provide mental health services. However, we want to provide every participants in this study with a list of clinical resources that are available, should you decide you need assistance at any time. Please see information pertaining to resources at the end of this form.

Request for Confidentiality:

Please do not disclose research procedures and/or hypotheses to anyone who might participate in this study in the future as this could affect the results of the study.

Final Report:

If you would like to receive a copy of the final report of this study (or a summary of the findings) when it is completed, please feel free to add your email address to the link provided in the next section.

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, please contact Sheeza Mohsin at smohsindhanani@twu.edu or call 817-668-0417 or Aaron Norton, Ph.D. at anorton@twu.edu or call 940-898-2677.

Mental Health Resources:

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance please click on the following links to get information on a mental health expert who can help you:

National Behavioral Health Treatment Service Locator:

By typing your city or zip code, the following link will give you information on your nearest mental health, substance abuse, healthcare resource.

https://findtreatment.samhsa.gov/

Find a list of licensed Marriage and Family Therapist here

http://www.aamft.org/imis15/AAMFT/Content/Directories/Find_a_Therapist.aspx

Find a list of Licensed Counseling Professionals here:

https://www.counseling.org/aca-community/learn-about-counseling/what-is-counseling
Find a list of Licensed Psychologist here.
http://www.apa.org/helpcenter/index.aspx

Thank you for your participation.

If you would like to receive an executive Summary for the findings of this survey, please click on the link below to add your email address. Your information will not be associated with your responses.

https://www.psychdata.com/auto/surveyedit.asp?UID=92100&SID=182237

Please note that there is a potential risk of loss of confidentiality in all e-mail, downloading, and internet transactions. However, surveys will be downloaded onto a secure computer which is only accessible to the Principal Investigator and her supervisor.

APPENDIX G

Study Announcements

Research Participants needed

Ever Considered Counseling? This researcher wants to hear from you!

How do you decide which Counselor to work with? What matters to you?
What comes in your way of taking the step to go to counseling?
Which communities from your perspective would be more resistant or less resistant to go?
If you are 18 years or older, living in the US for 2 years, we need your participation!
Participation in this research is completely voluntary and you may withdraw from the survey at any time.

Please click on the link below to get started. Thank you for your interest and contribution to research.
https://www.psychdata.com/s.asp?SID=181971

This research is separate from and not sponsored by the organizations/individuals sending out recruitment information.
Participants' relationships with any organizations/ individuals helping with recruitment will not be affected if they choose to participate or choose to decline
There is a potential risk of loss of confidentiality in all email downloading, electronic meetings, and internet transactions.

If you have questions, please contact Sheeza Mohsin at 817-668-0417 or email her at smohsindhanani@twu.edu. You may also contact her advisor, Dr. Aaron Norton at 940-898-2677 or email him at anorton@twu.edu. As with any electronic submission there is a potential risk of loss of confidentiality in all email, downloading and internet transaction.

RESEARCH VOLUNTEERS NEEDED

FOR A STUDY ABOUT HELP-SEEKING BEHAVIORS AND MULTICULTURAL FAMILIES

Researchers at Texas Woman's University, Department of Family Sciences, are interested in how individuals and families access Mental Health Services

What we need:

ADULTS 18 YEARS AND OVER AND LIVING IN THE US FOR AT LEAST 2 YEARS

What is involved?

FILL OUT A CONSENT FORM AND COMPLETE AN ONLINE QUESTIONNAIRE

What do you get?

ENTERED INTO A DRAWING FOR 4 AMAZON GIFT CARDS WORTH $25 AND 10 GIFT CARDS WORTH $10

Ready to start?

Please click on the link below to get started. Thank you for your interest and contribution to research.

https://www.psychdata.com/s.asp?SID=181971

If you have any questions, please contact Sheeza Mohsin at smohsindhanani@twu.edu

or Aaron Norton at anorton@twu.edu

This research is separate from and not sponsored by the organizations/individuals sending out recruitment information.

Participants' relationships with any organizations/ individuals helping with recruitment will not be affected if they choose to participate or choose to decline.

In order to make this study a valid one, some information about the study will be withheld until the completion of the study.

There is a potential risk of loss of confidentiality in all email downloading, electronic meetings, and internet transactions.

APPENDIX H

Debriefing Statement

Texas Woman's University
Debriefing statement for participants of this research

Purpose of the Study:

You were previously informed that the purpose of the study was to study help-seeking behavior in Multicultural families. You were not informed is that this research includes studying biases in selecting a therapist or counselor as well as the perception of islamophobia and Muslims in the US.

The reason to limit sharing this information was to not influence participants in any way and get authentic responses. The researchers are hoping to utilize the information to further education and learning in these areas, and to eventually design interventions and programs that can help various populations.

We realize that some of the questions asked may have provoked strong emotional reactions. As researchers, we do not provide mental health services. However, we want to provide every participants in this study with a list of clinical resources that are available, should you decide you need assistance at any time. Please see information pertaining to resources at the end of this form.

Request for Confidentiality:

Please do not disclose research procedures and/or hypotheses to anyone who might participate in this study in the future as this could affect the results of the study.

Final Report:

If you would like to receive a copy of the final report of this study (or a summary ofthe findings) when it is completed, please feel free to add your email address to the link provided in the next section.

Useful Contact Information:

If you have any questions or concerns regarding this study, its purpose or procedures, please contact Sheeza Mohsin at smohsindhanani@twu.edu or call 817-668-0417 or Aaron Norton, Ph.D. at anorton@twu.edu or call 940-898-2677.

Mental Health Resources:

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with a qualified clinician may help. If you feel you would like assistance please click on the following links to get information on a mental health expert who can help you:

National Behavioral Health Treatment Service Locator:

By typing your city or zip code, the following link will give you information on your nearest mental health, substance abuse, healthcare resource.

https://findtreatment.samhsa.gov/

Find a list of licensed Marriage and Family Therapist here

http://www.aamft.org/imis15/AAMFT/Content/Directories/Find_a_Therapist.aspx

Find a list of Licensed Counseling Professionals here:

https://www.counseling.org/aca-community/learn-about-counseling/what-is-counseling

Find a list of Licensed Psychologist here.
http://www.apa.org/helpcenter/index.aspx