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COME AS YOU ARE: ISLAMIC RELIGIOUSNESS AS A CONTEXT FOR MENTAL ILLNESS BELIEFS AND TREATMENT

A Thesis

presented in partial fulfillment of requirements

for the degree of Master of Arts

in the Department of Psychology

The University of Mississippi

by

ELIJAH P. MUDRYK

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ABSTRACT

The United States is home to approximately three million Muslim-Americans, a diverse and growing demographic group that has woven itself into the fabric of American life. Hailing from many regions around the world, Muslims in the U.S. are varied in racial and ethnic backgrounds and not dominated by any particular race or ethnicity. National pride and a strong religious identity are shared aspects among U.S. born Muslims and immigrants alike (Pew, 2018). In addition to the typical challenges of daily life, Muslim-Americans have experienced high levels of religious and ethnic discrimination. Post-9/11, Muslim-Americans suffered a 1600% increase in reported hate crimes including violence, threats, and property destruction relating to group stigmatization after the attacks (Takyar, 2019). These increased animosities were compounded by anti-Muslim political rhetoric and a Muslim travel ban after the 2016 presidential election. Such adverse experiences negatively impact mental health and have led to disproportionate rates of distress, anxiety, and mood disorders suffered by this demographic (Abu-Ras et al., 2018). Despite mounting mental health concerns, Muslim-Americans have encountered barriers to accessing mental health services and remained underserved. Barriers to care are multifaceted and include the factors of availability and access, education, stigma, fears of discrimination, and religious or cultural beliefs that may differ from medical professionals (Amri & Bemak, 2013; Padela & Curlin, 2013). Supporting this notion, past studies indicated that Muslims who reported higher Islamic religiousness tended to prefer spiritual healers (Meran & Mason, 2019). Other research indicated that belief in a mixed etiology for mental illness (stemming from biological or spiritual causes) was associated with the endorsement of multiple treatment options (Western

biomedical services, Islamic faith healers; Moodley et al., 2018). A more complete understanding of Muslim Americans' conceptions of mental illness and their associated religious and cultural beliefs can help treatment providers understand patterns of help-seeking and inform culturally responsive models of care. This study sought to explore the relationship between religious beliefs and concepts of mental illness among Muslim Americans using Kleinman's comprehensive explanatory model approach. The explanatory model (EM) includes a range of beliefs, from recognition of the problem, to beliefs about etiology, symptom communication and impact, stigmas, appropriate help-seeking, preferred type of provider or treatment, and goals for treatment outcomes. Based on previous findings, it was anticipated first-generation immigrant status, female gender, and being married participants would be predictive of higher Islamic religiousness. For attitudes towards mental health services, it was expected that higher Islamic religiousness would predict negatively predict acculturation but stronger spiritual beliefs about mental illness, which in turn would predict more negative attitudes towards mental health services. It was also expected that lower levels of Islamic religiousness would positively predict acculturation and stronger biological beliefs about mental illness, which in turn would predict more positive attitudes towards mental health services. The results gave insight into how demographic, sociocultural, and religious factors interact with various aspects of a patient's explanatory models and how religiousness is predictive of mental illness beliefs and willingness to seek mental health services.
Keywords: Islamic religiousness, mental illness beliefs, attitudes toward mental health services

DEDICATION

This work is dedicated to Doctors King, Spalek, Wallace, Lagroix, O'Doherty, Patton, Costigan, Taknint, and Johnson. Thank you for passing your passions to me through our adventures together. I cherish you all and think of you often.

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CHAPTER 1

INTRODUCTION

The United States of America is home to millions of resident and immigrant Muslim-Americans who experience the unique integration of Western life with their own cultural traditions. These Muslim-Americans experienced the challenges, trials, and successes that reflect the overall experience of present-day Americans; however, they have also experienced challenges based on their country of origin, ethnic and racial status, religious preferences, and mental health stigma (Phillips & Lauterbach, 2015). The public fallout from the September 11, 2001 terrorist attacks in New York City has been linked to a 1600% increase in hate crimes with accompanying social exclusion and mental health crises for Muslim-Americans (Abu-Ras et al., 2018; Takyar, 2019). These adverse experiences are compounded by anti-Muslim political rhetoric and a federally-mandated Muslim travel ban in 2016. Despite these increased mental health concerns, research indicates that many Muslim-Americans have encountered barriers to treatment relating to cultural health beliefs and they are hesitant to seek treatment (Martin, 2015).

According to a recent report, within the United States there are over three million Muslim-Americans (3.45 million) who make up an estimated 1.1% of the country's general population (Mohamed, 2018). Muslim-Americans have contributed unique perspectives to intercultural contact (Abu-Ras & Hosein, 2015), scientific advancements (Sudan, 2017), and psychological understandings of religion (Haque, 2004) which benefits these respective fields and the country's overall advancement. Muslim-Americans also represent a rapidly growing demographic of Americans as the proportion of Muslim-Americans is projected to double by the year 2050

(Mohamed, 2018). Taken together these statistics indicate this rising population has faced mental health risks relating to ethnic and racial discrimination. Despite this, little research provides avenues for culturally competent care or the reduction of help-seeking barriers.

There has been a growing push in psychology to recognize the context and perspective of Muslims patients through the *Journal of Muslim Mental Health*. This journal has published numerous research studies focusing on cultural stigma, coordinated spiritual treatment, and the integration of cultural values into treatment (Philips & Lauterbach, 2015; Hamdan, 2008; Razali et al., 2018). Multiple clinical studies in Southeast Asia have also noted that reported Islamic religiousness negatively predicts preferences for clinical services due to incompatibility with medical professionals' biologically-based beliefs about mental health and the accompanying treatment options (Phang et al., 2018; Razali et al., 2018).

Few studies have analyzed Muslim-Americans' reported Islamic religiousness as a factor influencing their mental health beliefs and attitudes towards treatment. This absence means the existing research has not gone beyond recognizing the presence of increased Muslim-American mental health concerns to the next step of building methods of culturally competent care. It is to the credit of the American Psychological Association (2006) that they advocated for an increased recognition of the role of religion to understand a patient's context and to plan treatment; however, a gap still exists between mental health professionals and the increasing Muslim-American populations beliefs about mental health and preferences for mental health services.

Health beliefs are relevant for Muslim-Americans because the Islamic faith is a unifier across diverse cultures, countries, citizenship and socioeconomic statuses, and racial boundaries (Khan et al., 2019). Despite these inherent differences, these groups' health beliefs share underlying fundamentals based on the teachings of Islam. These religious principles represent the major

ways Muslim patients will interpret their health symptoms, what avenues of care they will seek, and how they will receive medical advice (Rassool, 2015; Khan et al., 2019). Seeking mental health services has been seen by some patients as indicating a lack of faith which has resulted in significant portions of the Muslim-American population avoiding these services (Amri & Bemak, 2013).

These findings highlight the importance of understanding different explanatory models of mental illness which contribute to treatment barriers and lack of treatment services for Muslim-Americans. An expanded understanding of explanatory models will give treatment providers an enhanced understanding of how to address these communication breakdowns that cause attrition from the professional realm of care and will enhance culturally competent care where it is needed.

Muslim-Americans in the United States

Ethnicity can be defined as a group membership and status based on country of origin, racial heritage, and affiliated culture (Berreman, 1981). Fifty-eight percent of Muslim-Americans arrived as immigrants while the remainder were born in the United States to immigrant (18%) or American-born (24%) parents. There is a broad diversity of homelands among the foreign-born Muslims in the United States, with no single country producing more than 15% of first-generation Muslim-American immigrants (Pew, 2017). Recent reports estimated 35% of first-born Muslim-Americans hail from South Asia (Pakistan, India), 25% from the Middle East/North Africa (Iraq, Egypt), 23% from Asia-Pacific regions (Iran, China) and 9% from Sub-Saharan Africa (Zimbabwe, Uganda). These waves have translated into high citizenship rates with 82% of Muslims in the United States holding citizenship status (42% born in the U.S.; 40% naturalized) and 18% not holding citizenship (Pew, 2017).

While the majority of Muslim-Americans have described their racial ethnicity as White (41%), this category encompasses a wide variety of regional homelands and skin tones (Arab, Middle Eastern, Persian; Pew, 2017). Approximately 28% of Muslim-Americans reported identifying with an Asian ethnicity while 20% identify as Black. The Muslim-American population is predominantly young with a median age of 35 and the highest demographic being between ages 18-29 (35%), followed by 30-39 (25%), and 40-54 (26%).

Muslim-Americans have indicated a strong religious identity with 64% ranking their religion as important (24% somewhat important), 45% attending religious ceremonies in a given week (31% once or twice a month), and 69% reporting they engage in prayer behaviors daily (with 9% praying weekly and 7% monthly; Pew, 2014).

Mental Health Beliefs

Existing research has shown that Islamic cultures are traditionally collectivist, endorse commitment of one's beliefs and thoughts to scripture, and emphasizes deference to authority figures who provide spiritual guidance (Springer et al., 2009; Keshavarzi & Haque, 2013). These findings indicated that participants' endorsement of Islamic beliefs can serve as a predictor of their mental health beliefs given that traditional Islamic scripture teaches health as stemming from Allah with illness being sent as a test of faith to be healed through spiritual sources (Sudan, 2017). Etiological beliefs about mental illness can be categorized among 3 domains: biological (mental illness as a bodily disease; Kleinman, 1980), supernatural (caused by evil magic, spirits, or divine punishment from Allah; Amri & Bemak, 2013), or social (stress from persecution or interpersonal conflict; Amri & Bemak, 2013). While the above research adequately describes the overall health beliefs of Islam, further research into the health beliefs about mental health will provide possible insights into why Muslim-Americans are underserved by mental health services.

Similar studies have examined Muslim perceptions of mental illness' origins through a variety of sources. Bagasra & Mackinem (2014) found that Muslim-Americans endorse eclectic health beliefs where biological, supernatural, social causes are each attributed etiological roles of mental illness. Their study noted that besides mentioning Allah as the source of health and sickness, explicit supernatural beliefs from Islamic scripture (possession, evil spirits) were absent as explanations for mental illness. Instead, the responses represented dominantly Western realities with a "flavor" of spiritual and Middle Eastern influences (Bagasra & Mackinem, 2014).

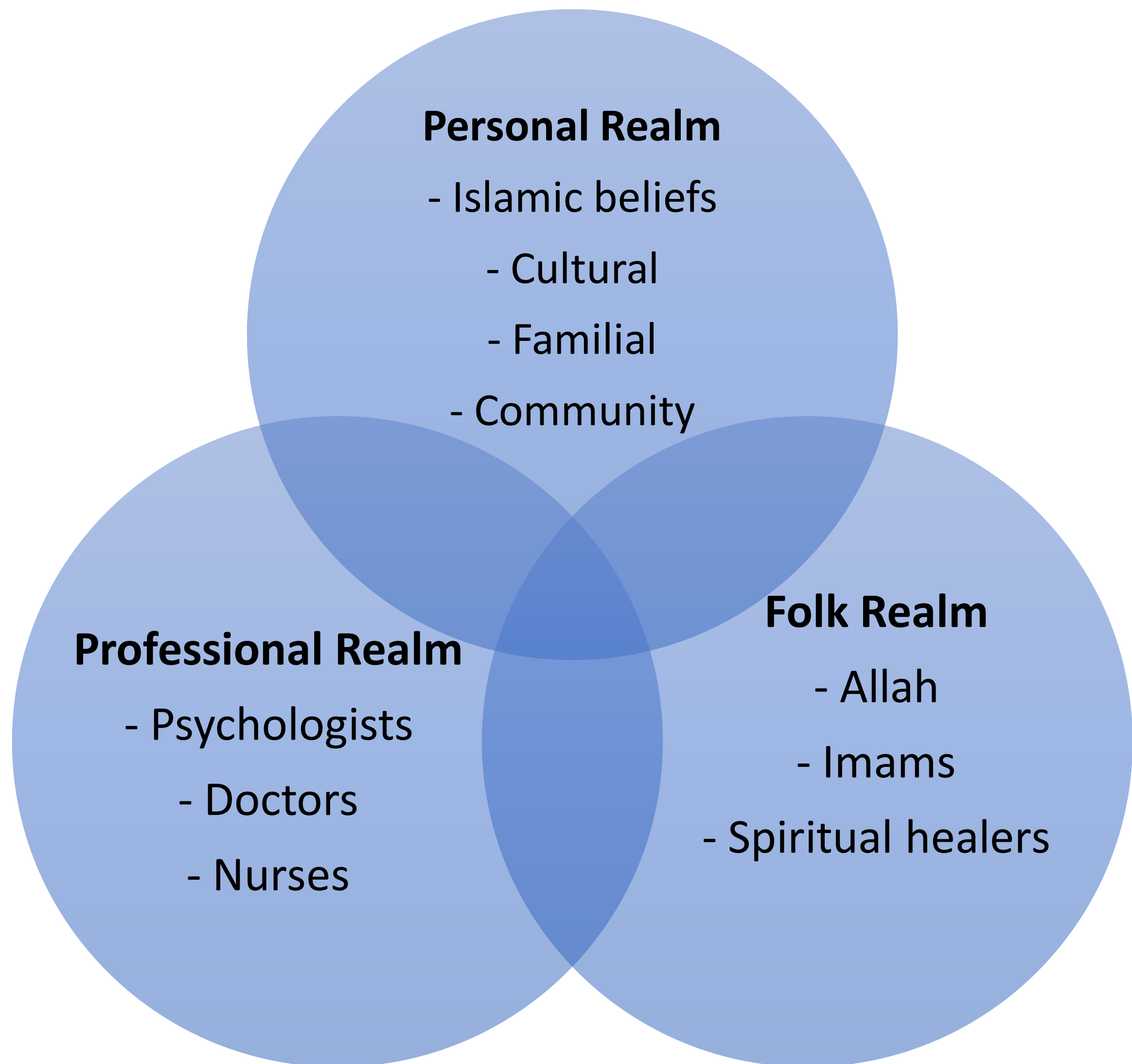
In their study of Muslim faith healers, Ally & Laher (2008) found the healers also endorsed Western biomedical beliefs about mental illness yet simultaneously endorsed their unique spiritual perspective based on their experience as traditional healers. Taken together the above studies provide promising insights into the link between Islamic religiousness and health beliefs; however, a connection with attitudes towards mental health services can provide a stronger understanding of the existing barriers to treatment.

Explanatory Models

Through his medical anthropological work with patients of diverse cultures, Kleinman (1980) developed the *explanatory models* (EMs) approach to understanding patient's beliefs about their illness. An EM encompasses the patient's pre-existing beliefs about their illness including the etiology, physical and social implications, preferred treatments, and expectations about recovery. These EMs are taught to the perceiver through social learning from family and community members. Generally, the fundamentals of these EMs reflect the culture, religion, and geographic location in which the social teachers formed their own health beliefs. Mental health services may not be emphasized during this transmission leading to their devaluation as a treatment consideration when Muslim-Americans experience mental illness symptoms.

Per Kleinman (1980), the options for health services are categorized into three realms: *popular*, which consists of the patient's social contacts of family and community; *folk*, which consists of culturally-based, non-medical healers such as shamans and Imams; and *professional*, which consists of doctors and psychologists of the medical system. Kleinman (1980) asserted that healthcare institutions are not objective centers of medical knowledge, instead they are bounded by Western conceptions of mental health and hold different EMs than other cultures. This has contributed to poor communication, resistance to treatment, and avoidance of professional services by Muslim-American patients. Understanding distinct EMs is essential for communicating specialized understandings of mental illness and treatment along with the culturally competent accommodation of the patient's own beliefs (Johnson et al., 2017; Johnson & Sandhu, 2010).

Figure 1. Explanatory Model Realms



The Western professional system conventionally defined diseases through a biologically-based model of physical or mental disorder; in contrast, cultural health beliefs encompass the subjective, experience-based interpretations of the disease by the individual (Kleinman et al., 1978). Marsella & Yamada (2010) expanded upon this research by delving into the process by which EMs are transmitted. They noted that cultural health beliefs are transmitted from family and community members of the popular realm through social learning, subjective interpretation of the information the patient has access to, and the alignment of folk healers with the patient's

own cultural practices. These insights lend a framework for understanding the EMs of Muslim-American patients in this study as the Islamic faith endorses collectivist communities, the belief of health and illness stemming from Allah, and assert the role of Imams as spiritual counselors for understanding adversity. Such factors differ from Western EMs of mental illness and contribute to the underutilization of professional services. While these findings do offer insight into how EMs can be formed, the influence of a Western context must be considered given the acculturation experiences of Muslim-Americans with Western conceptions of mental illness.

Factors Affecting Mental Health Beliefs

Previous research on the relation between acculturation with Islamic religiousness and mental health beliefs is limited but provides an initial understanding of demographic variables for Muslim-Americans. Acculturation refers to interaction of the heritage culture (where an individual hails from and has been socialized with culturally-transmitted values) with aspects of the host culture (the new mainstream culture where an individual has a sustained experience). Through these experiences with separate cultures the individual may adapt their behaviors, interests, or values to align with either of the cultures based on their personal preference, social networks, or cumulative experiences (Berry, 1997). Identification with aspects of the heritage culture is referred to as enculturation while identification with aspects of the host culture is called acculturation.

The balance of acculturation with enculturation can be categorized into four domains: integration, where the individual endorses aspects of both the host culture and their heritage culture; assimilation, where the individual strongly identifies with the host culture but distances themselves from their heritage culture; separation, where the individual rejects aspects of the host culture and retains their heritage culture through the new context; and marginalization,

where the individual distances themselves from both the host culture and their heritage culture (Berry, 1997). An individual may move through domains based on experience and choice but only inhabit one domain at a given time.

Acculturation is relevant for Muslim-Americans due to the distinct differences from their heritage culture that come into focus in everyday experiences while in the host culture. These experiences include experiencing ethnic discrimination, struggles with language difficulties, having non-normative religious beliefs (seeing health as stemming from Allah), and being part of a group portrayed as dangerous by social leaders and political organizations (Al Wekhian, 2016). In this context, the divide between these Muslim beliefs and practices comes into a transaction with American culture and help-seeking behaviors for health issues (individualism, seeing doctors for health issues). Such experiences have led to the discrimination of these minorities by broader society and are linked to increased mood and anxiety disorders (Abu-Ras et al., 2018), yet have the potential to alienate these affected individuals from Western systems of care.

On the other hand, Pew (2018) has cautioned against a homogenous view of Muslim-American behaviors and values. Domestic- and foreign-born Muslim-Americans hold widely differing endorsement of American and Islamic values based on their individual experiences and co-occurring membership in gender, age, and socioeconomic groups despite the unifying trait of Islam. These interacting background experiences may result in certain individuals strongly endorsing Islamic behavioral practices but holding weaker Islamic beliefs, or vice versa. Muslim-Americans' personal experiences with their family, diverse friend groups, and ethnically-mixed communities contribute to this individual expression.

These multiple memberships have been examined as factors of acculturation, but there is early research examining the conjunction of these categories with reported Islamic religiousness to understand patient EMs.

Acculturation Factors

In their survey of second-generation early adult Muslim-Americans, Amer & Hovey (2007) stated that female Muslim-Americans were more likely to have lower acculturation into American traits and report higher Islamic beliefs and behavioral practices. The authors explained this as an application of a cultural role for Muslim-American women to teach aspects of the heritage culture to the younger generation and from the religious expectation for women to wear the traditional head garments. This would align most with the separation domain established by Berry (1997) where the individual is retaining aspects of their heritage culture in the new cultural context. While age, educational attainment, and socioeconomic status (SES) of Muslim-Americans were cited as non-significant factors in acculturation, single Muslim-Americans report significantly lower Islamic religiousness and behavioral practices compared to their married counterparts (Amer & Hovey, 2007). This provides an understanding of how Muslim-Americans' demographics impact their religiousness and possible willingness to seek treatment. Further research speaks to the connection between religiousness and reluctance to seek mental health treatment.

In his meta-analysis of Muslim-American acculturation experiences in the United States, Al Wekhian (2016) asserted that younger, second-generation Muslim-Americans indicated lower endorsement of their heritage culture and stronger endorsement of American interests, behaviors, and values. His analysis also revealed that Muslim-Americans were more likely to endorse American traits the longer that they were in the United States; however, he noted that more

frequent Islamic behavioral practices and stronger endorsement of Islamic beliefs were negatively associated with acculturation to American culture. This finding has been replicated in other studies of acculturation factors for Muslim-American youth (Goforth et al., 2014).

Through their acculturation study of help-seeking behaviors of immigrants of European, African, and Asian origin in Norway, Markova et al. (2020) reported that stronger endorsement of the heritage culture was positively correlated with help-seeking behaviors towards traditional and informal healers. This exemplifies the separation domain of acculturation (Berry, 1997) where individuals retain aspects of their heritage culture throughout their new context and choose treatment options that reflect these cultural values. In contrast, stronger endorsements of the host culture were positively correlated with seeking biomedical models of care considered conventional in the host culture. This exemplifies the integration domain established by Berry, where the individual embraces aspects of the host culture and chooses help-seeking options that reflect the host culture's beliefs about treatment options. This study provides initial evidence that acculturation has a demonstrable impact on treatment preferences. Taken together, these findings provide initial insights into the predictive value of demographic and acculturation factors on reported Islamic religiousness and mental health EMs. They also highlight the need for deeper understandings of how Islamic EMs differ from Western mental health services.

The Islamic Faith as Context for Mental Health

Translated from Arabic, *Islam* means "peace through the voluntary submission of your will to Allah" (Hankir et al., 2015). The term *Muslim* refers to individuals who practice the Islamic faith. The Islamic faith found early prominence in the Middle East through the Arabic language and, as of 2015, Muslims comprise roughly 24% of the world's population (Mohamed, 2018).

Muslims read from a book of scripture called a Qur'an, attend group worship every Friday in buildings called mosques, and engage in a kneeling prayer five times per day on a religious mat pointing east (Haque, 2004; Thomas et al., 2017). The figures who lead prayers and worship ceremonies are called Imams who also serve as spiritual counselors to Muslim congregants in times of strife and stress (Martin, 2015). Islamic worshippers hold five "pillars" which supports their faith: worshipping Allah above all other deities with Mohammed as his prophet; engaging in the kneeling prayer five times per day; donating a percentage of one's earnings; fasting for one month per year during the sunlight hours of the Ramadan period; and performing a Mecca pilgrimage at least once in a lifetime (Hodge & Nadir, 2008). Islam scripture emphasizes that all forms of health stem from Allah and that sickness serves as a test of faith. As such, strong worship and spiritual guidance from Imams can be used to overcome sickness (Weatherhead & Daiches, 2010). These principles form key considerations to understanding Muslim-Americans' health beliefs and attitudes towards treatment.

In their analysis of posttraumatic stress disorder symptoms and mental health for Iranian war veterans, Aflakseir and Coleman (2009) concluded that religion functions as a coping mechanism for mental illness and was predictive of higher functioning with mood symptoms. For Muslim patients, religion functioned as a coping mechanism to promote resilience, strength, and explanations for negative events (Hamdan, 2008). The function of religion for coping with sickness has been applied in a study with chronically ill Muslim patients by Irajpur & Moghimiyan (2018). Their study concluded that higher endorsement of Islam as a coping mechanism was predictive of adaptive pain management, reduced mortality fears, and acceptance of difficult situations beyond their control.

Taken together, these findings show the capacity for Muslim-Americans to use Islamic principles and resources as an alternative to formal services when addressing mental illness experiences (Moodley et al., 2018).

The American Psychological Association (2006) has advocated for an increased recognition of the role of religion when examining a patient's context and has emphasized the need for an expanded understanding of religion in overall therapy. Piedmont et al. (2009) also emphasized the need for religion and spirituality to be understood as similar, yet distinct, concepts in psychology. Building from this framework, Islamic psychologists argue that religion and spirituality are intimately related in the Islamic faith and are both necessary to live a complete life (Sudan, 2017). In their interviews with Muslim-American military personnel, Abu-Ras and Hosein (2015) report that Islamic spirituality provided these personnel with meaning and a sense of balance, bolstered their resilience, and helped them cope with adversity.

In their study of how Pakistani-Muslims used the Islamic faith during times of stress, Khan & Watson (2006) asserted that religious practices were significantly related to positive coping, reduction of mood symptoms, and maintenance of positive functioning. These findings indicated that religiousness serves as a beneficial help-seeking outlet during difficulties with mental illness. This is especially relevant when Muslim-Americans face barriers to conventional mental health services and turn instead to spiritual healers (Amri & Bemak, 2013). Given the promising research on the relationship between religiousness, mental health EMs, and treatment preferences, it is important these concepts be explored further in the present study.

Attitudes Toward Mental Health Services

Research examining Muslim-American attitudes toward mental health services has produced differing perspectives on their motivations for seeking treatment. In his literature review of the

help-seeking preferences of Muslim-Americans, Ali (2016) reported that they prefer and seek Imams and spiritual healers first when first experiencing mental illness. This preference is attributed to Imams and spiritual healers giving culturally competent care that aligns with the patients EMs and the principles of Islam. This finding supports Kleinman's (1978) theory that cultural and spiritual healers are sought for treatment first due to their congruency with the patient's own health beliefs; however, Ali's (2016) study did not sufficiently recognize the impact that beliefs about the causes of mental illness has on treatment preferences.

When examining Muslim university students' preferences for mental health treatment, Khan & Watson (2006) indicated that the participants recognized psychological therapy as valid treatments for mental health concerns. Despite this, concerns emerged among participants that mental health services lack the perspective to address the spiritual needs which also suffered due to mental illness. These reports emphasized that spiritual healers can be adjunctively integrated for successful treatment (Khan & Watson, 2006). These results of this study establish that religious beliefs can predict attitudes toward treatment, which can then be explored further by assessing the participant's reported level of religiousness.

In their meta-analysis of Muslim-American health experiences, Padela & Curlin (2013) concluded that when patients seek help their treatment choices have been limited by which options accommodate Islamic values. Patients expressed concerns about their modesty being violated, cross-gender contact with medical professionals, and aggressive treatments indicating a lack of faith in Allah as a source of health. This study has raised questions about the capacity and willingness of Muslim patients to approach and interact with mental health professionals; however, a small number of studies have explored Muslim traditional healers' attitudes toward mental health services. In these studies, the healers recognized the need for professional services

to address serious mental illness issues beyond the spiritual domain. Because of this, they endorsed integrating treatment with professionals to guide the patient and facilitate compliance (Abu-Ras et al., 2008; Ally and Laher, 2008). These findings established the foundations for avenues of research into the predictive value of etiological beliefs about mental health (biological and spiritual) for attitudes toward mental health services.

Later studies also supported the finding that traditional Islamic healers hold positive attitudes towards mental health services. In their interviews with Islamic spiritual leaders about mental health treatment, Moodley et al. (2018) reported that Imams who understand mood disorders as biologically-based illnesses advocated for treatment by mental health professionals; however, all healers interviewed also expressed beliefs that the disorders had simultaneous spiritual roots and advocated for their coordinated spiritual treatment. They also noted that their training makes them effective at treating the spiritual aspects of sickness, but their capacity to treat biological aspects was limited (Moodley et al., 2018). These findings support Khan & Watson's (2006) conclusion about flexible help-seeking behaviors being associated with mixed etiological beliefs about mental illness while offering support by giving the perspective of Muslim-American healers'. Similar patterns have emerged in further studies of Muslim-American healers' etiological beliefs about mental illness and their treatment recommendations (Ali & Milstein, 2012; Meran & Mason, 2019). It must be recognized the utility of these findings is limited because previous research has found it is negative attitudes towards mental health services that has formed barriers to treatment.

Amri & Bemak (2013) presented a different explanation from previous findings through their interviews with Muslim-American about their views on psychotherapy. They reported that Muslim-American participants reject medical professionals because of fears they would

recommend treatments that ignored Islamic principles. For example, participants reported worries that professional healers did not understand the spiritual aspects of the individual's health beliefs (evil eye, spirits, divine punishment) and could leave these aspects unattended, so instead they sought help from Muslim faith healers in time of sickness (Amri & Bemak, 2013). Meran & Mason (2019) indicated similar pattern of results in their interviews with Muslim faith healers. Participants who strongly believed mental illness to be spiritually-based also presented as most likely to recommend spiritual counseling as the primary treatment due to concerns about ethical boundaries and spiritual needs; however, these healers also recognized biomedical causes of mental illness and accepted Western treatments as valid options.

While the above studies reported pluralistic views towards the causes of mental illness and multiple preferences for treatment, it is also important to understand how strong levels of reported religiousness are associated with different effects. In their examination of treatment preferences across religions, Crosby and Bossley (2012) examined this phenomenon and labeled it "the religiosity gap", where patients who significantly endorsed high religiousness were most likely to prefer religiously-based treatment. The authors explained this religiosity gap as a reflection of participants' EMs of mental illness: it is a spiritual sickness, so through spiritual treatments it can be healed. These findings provide an overview of general religious considerations for participants; however, a focus on Muslim-American participants is needed to provide insights for this underserved population.

Present study

As seen through the above literature review of religiousness, mental health beliefs, and treatment attitudes, the path from experiencing illness to seeking treatment is impacted by a number of factors. Specifically, previous studies indicate that understanding the function of

religion, cultural EMs, and demographic subgroups is integral to reducing treatment barriers from mental health services. However, to date these studies do not sufficiently examine the effect of Muslim-Americans EMs on attitudes towards mental health services. The present study seeks to expand the literature by examining the extent to which endorsement of Islamic beliefs and practices provides insights into how culturally competent care can be integrated for this growing demographic of the American population**.**

Although previous studies provide significant insights into how EMs can affect treatment, those studies focus more on the patients who have reached treatment despite Kleinman's (1978) assertion that non-Western cultures experience barriers from formal mental health services. These studies have yet to examine help-seeking behaviors of Muslim-Americans and how these relate to underlying health beliefs and their reported level of Islamic religiousness. For the purpose of this study, participants' etiological beliefs about mental illness and preferences for help-seeking treatments (spiritual healers, mental health services) will represent EMs. Trust towards and willingness to utilize mental health treatment are operationalized as attitudes towards mental health services. Overall, this study seeks to examine two primary questions: (1) Do demographics have predictive value of reported Islamic religiousness, and (2) to what extent does Islamic religiousness predict treatment preferences?

Hypotheses

The following hypotheses are proposed:

Hypothesis 1: Demographic Main Effects

A multivariate regression analysis of the participants' demographic factors will account for a majority of the variance in reported Islamic religiousness, as measured by the Religiosity of Islam Scale

1a: First-generation citizens will be more like to report higher Islamic religiousness

1b: Female participants will be more likely to report higher Islamic religiousness

1c: Married participants will be more likely to report higher Islamic religiousness

Hypothesis 2: Attitudes Towards Mental Health Services

A serial mediation model that uses reported Islamic religiousness as the predictor variable, controls for significant demographic factors from H1, and uses acculturation and etiological beliefs as consecutive mediators will predict attitudes towards psychological services, as measured by the Attitudes Towards Mental Health Services scale.

2a: Islamic religiousness will predict treatment attitudes towards mental health services, this will be mediated by acculturation and spiritual beliefs about the etiology of mental illness. Specifically, higher Islamic religiousness will predict negative treatment attitudes towards mental health services, this will be mediated lower levels of acculturation and stronger spiritual beliefs about the etiology of mental illness.

2b: Lower levels of Islamic religiousness will predict more positive attitudes towards mental health services, this will be mediated by higher levels of acculturation and stronger biological beliefs about the etiology of mental illness.

CHAPTER 2

METHODS

Participants

The present study explored the attitudes of Muslim-Americans aged 18-64 (M=32.11, SD=12.57) towards mental health services. Participants were 122 Muslim-Americans across the United States who responded to an invitation to complete the online survey sent to student and religious organizations, advocacy groups, and business alliances. Fifty-five percent of the participants identify as female (*N*=66) and 44% percent as male (*N*=52) with one participant identifying as third gender.

The largest percentage of the participants have never married (52%), followed by married (41%), divorced (5%), separated (2%), and widowed (1%). For citizenship status, the majority of participants reported being first- or second-generation (40.2% each, *N*=49) with 14.8% reporting third generation or later status (*N*=18) and 4.9% preferring not to answer (*N*=6). Sixty-nine participants reported not using mental health services in the past three years (56.6%), 16 reported using them one or two times (13.1%), 9 indicated using them three to five times (7.4%), and 28 reported using mental health services more than five times in the past three years (23%).

Procedures

The study was first approved by the Internal Review Board at the University of Mississippi. Recruitment was multifaceted and included reaching out personally to a local Muslim student organization and posting an invitation to national Muslim organizations, on the forum website Reddit, and making it available for participants to send forward as part of a snowball sampling

method. The study administered questions in an online format to accommodate restrictions presented by the COVID-19 pandemic. Following informed consent, participants received a Qualtrics survey link. Once participants confirm their consent, their adult status (i.e., over 18 years old), and that they are a Muslim living in the United States, the next page began the study's measures. The measures were also administered in counterbalanced order to control for potential order effects

Measures

Demographics Questionnaire: Adapted from Aloud's (2004) previous Muslim demographic questionnaire, this measure gathered background information from the participants about citizenship generation, socioeconomic status, ethnicity, gender, marital status, age, and educational attainment. Responses were provided through a combination of open responses and multiple choice selections.

Religiosity of Islam Scale (RoIS): This measure from Jana-Masri & Priester (2007) has been used to assess participants' endorsement of Islamic beliefs using the researchers' culturally competent knowledge of the scripture. The RoIS is a 19-item self-report scale comprised of two subscales: Islamic Beliefs and Islamic Behavioral Practices. Responses are given along a 7-point Likert scale, ranging from 1 (Strongly Agree) to 7 (Strongly Disagree), with a midpoint of 4 (Neither Agree nor Disagree). Scores are summed with higher scores indicating higher religiousness among each subscale. Sample items from the Islamic Behavioral Practices subscale include "I read the Qur'an more than two times per week" and "I go to the mosque on Friday". Sample items from the Islamic beliefs subscale include "I believe the Qur'an is the final word of Allah" and "I seek knowledge because it is a Muslim religious duty". The Islamic Beliefs subscale yielded an alpha of .66 and the Islamic Behavioral Practices subscale yielded an .81

alpha during the development and validation of the RoIS. In the current study, the Islamic Beliefs subscale yielded an alpha of .83, the Islamic Behavioral Practices subscales an alpha of .72, and the overall scale an alpha of .86.

Vancouver Index of Acculturation (VIA; Ryder et al., 2000): The VIA is a widely used self-report measure of a participants' identification with aspects of American culture and the heritage culture of their family. This scale prompts participants to rate how strongly they agree with 20 items which are scored along a 9-point Likert scale ranging from 1 (Disagree) to 9 (Agree), with a midpoint of 5. Scores are summed with higher scores indicating higher acculturation among each subscale. All odd-numbered items represent the *Heritage* subscale (e.g., I believe in the values of my heritage culture; I often behave in ways that are typical of my heritage culture). Even-numbered items represent the *Mainstream* subscale (e.g., I often participate in mainstream American cultural traditions; I believe in mainstream American values). Higher scores indicate stronger endorsement of the host culture, in this case American, in light of simultaneous valuation of the heritage culture. In the development and validation of the VIA with culturally heterogeneous populations, the Mainstream subscale produced alpha coefficients ranging from .85 to .89, while the Heritage subscale yielded a range from .91 to .92 (Ryder et al., 2000). In the current study, the Mainstream subscale yielded an alpha of .86, the Heritage subscale an alpha of .88, and the overall scale an alpha of .89.

Conceptions of Mental Illness Scale (CMIS; Bagasra & Mackinem, 2010): This measure of clinical reality was developed primarily for Muslim-American participants' attributions of the causes of mental illness. The CMIS is a 15-item self-report scale comprised of three subscales: Western biological attributions (mental illness is a disease), traditional Islamic attributions (sinful actions are often the causes of mental illness), and spiritual attributions (mental illness can be caused by the use of black magic). Responses are given along a 5-point Likert scale

ranging from 1 (Strongly Agree) to 5 (Strongly Disagree), with a midpoint of 3 (Neither Agree nor Disagree). Scores are summed with higher scores indicating stronger conceptions of mental illness in relation to each subscale. The initial development of the scale yielded a Cronbach's alpha of .78 (Bagasra, 2010), and the author's follow-up use of the scale (Bagasra & Mackinem, 2014) reported the factor analysis yielding eigenvalues above 1.0. The current study also produced an alpha of .78.

Attitudes Towards Mental Health Services Scale (ATMHS; Fischer & Turner, 1970): Originally developed by (Fischer & Turner, 1970), this measure of treatment attitudes is used to assess how strongly participants agree to statements about mental health services. It has since been updated by Paris & Pace (2000) for use in modern contexts. The ATMHS consists of 21 questions scores along a 5-point Likert scale ranging from 1 (Strongly Disagree) to 5 (Strongly Agree), with a midpoint of 3 (Neither Agree nor Disagree). Scores are summed with higher scores indicating more positive attitudes among each subscale. Results of the ATMHS are grouped into three subscales: Confidence in Mental Health Services (I am confident that many mental health problems can be helped with counseling), Fear of Stigma (I would be embarrassed to admit to needing professional mental health services), and Coping Alone (In most cases, mental health problems can be overcome by a strong character).

The current study added two questions along the same Likert scale about behavioral intent to seek treatment through clinical mental health services or spiritual counseling if the participant were to develop mental illness symptoms. The development and validation of the scale yielded a consistency rating of .83, with subscale reliabilities ranging from .62 to .74 (Fischer & Turner, 1970), while recent studies using the updated versions of the scale reported reliability ratings ranging from .73 to .84 (Lawrence, 2004), and .69 to .90 (Paris & Pace, 2000).

Reliability coefficients in the current study were .77 (Confidence in Mental Health Services), .86 (Fear of Stigma), .73 (Coping Alone), and .87 (overall scale).

Data Analysis

Survey data was analyzed using the Statistical Package for Social Sciences (SPSS version 26). The analysis of the Demographics Hypothesis involved a multivariate regression analysis grouping the demographic variables as predictors by gender (1=female, 2 = male), marital status (1=never married, 2=married), and citizenship status (1=first-generation, 2=second-generation or later) with Islamic religiousness being used as the outcome variable.

To examine whether reported Islamic religiousness' association with attitudes towards mental health services is mediated by etiological beliefs and acculturation, a serial mediation model was used in PROCESS (Model 6, Hayes 2017). This included controlling for demographic variables from Hypothesis 1 and using a bias-corrected 95% confidence interval and examining direct and indirect effects based on 5,000 bootstrapped samples. A significant effect was indicated by a confidence interval that did not include zero.

These analyses were conducted to answer the following research questions: (1) Do demographics have predictive value of reported Islamic religiousness, and (2) to what extent does Islamic religiousness predict treatment preferences and attitudes towards treatment? The covariate demographic variables found significant in the Demographic Main Effects Hypothesis were controlled for in these analyses to understand the predictive value of reported Islamic religiousness above and beyond other significant factors.

CHAPTER 3

RESULTS

Descriptive Statistics

Descriptive statistics were calculated for all independent and dependent variables used in the study. Mean scores and standard deviations for Islamic religiousness were based on 119 participants. Mean scores for the Islamic Beliefs subscale were 5.74 (SD=.93) and 5.78 (SD=.87) for the Islamic Behavioral Practices subscale. These subscales combined into the Religiosity of Islam Scale resulted in mean scores of 5.76 (SD=.81). One hundred and two participants completed the Vancouver Index of Acculturation which resulted in mean scores of 6.54 (SD=1.46) for the Heritage culture subscale, 5.87 (SD=1.45) for the American culture subscale, and 4.66 (SD=.84) when these were combined into the total acculturation scale.

For the Conceptions of Mental Illness scale, the responses of 106 participants resulted in mean scores of 3.95 (SD=.57) for the Biomedical Conceptions subscale and 3.11 (SD=.89) for the Spiritual Conceptions subscale. Ninety-nine participants fully completed the Attitudes Towards Mental Health Services scale and mean scores were 4.18 (SD=.53) for the Confidence in Mental Health Services subscale, 2.13 (SD=.95) for the Fear of Stigma subscale, and 2.23 (SD=.68) for the Coping Alone subscale. 89 participants completed the additional questions about behavioral intent to seek services in the event of difficulties with mental illness with mean scores of 4.27 (SD=.96) for professional mental health services and 3.78 (SD=1.27) for spiritual counseling.

Demographic Main Effects (H1)

A multivariate regression analysis of the demographic data was then used to examine which sociodemographic factors would have predictive utility of Islamic Religiousness to enter into later regression analyses. In the overall model, $R^2 = .09$, $F(3,108) = 3.5$, $p = .02$, meaning that demographics accounted for 9% of the overall variance. This multivariate analysis reveals citizenship status as the only significant predictor of Islamic Religiousness, $B = -.45$, $t(108) = -.3$, $p = .004$, meaning that H1 was partially supported. In the current study, gender does not predict Islamic Religiousness $B = .09$, $t(108) = .61$, $p = .55$, and neither does marital status, $B = -.12$, $t(108) = -.81$, $p = .42$.

The results of the Demographic Main Effects hypothesis suggest that Muslim-Americans are more religious when they are first-generation citizens and then, on average, are less religious as they proceed to second- and third-generation status or later.

Attitudes Towards Mental Health Services – Spirituality Model (H2a)

A serial mediation analysis was then conducted to determine the impact of Islamic Religiousness on Attitudes Towards Mental Health Services as mediated by acculturation and etiological beliefs while controlling for citizenship status.

Attitudes Towards Mental Health Services. Islamic Religiousness was found to be a significant predictor of Acculturation, $b = -.26$, SE=.11, $p = .017$, CI: -.47 to -.05, and spiritual etiological beliefs, $b = .70$, SE =.09, $p < .001$, CI: .51 to .88, but was not found significant for service attitudes, $b = -.06$, SE=.07, $p = .45$, CI: -.20 to .09. Acculturation was not predictive of spiritual beliefs, $b = .06$, SE=.09, $p = .48$, CI: -.24 to .11. When acculturation and spiritual beliefs were entered as mediators of the relationship between Islamic religiousness and attitudes towards mental health services, acculturation was not a significant predictor of attitudes towards services,

b=.05, SE=.07, *p*=.54, CI: -.10 to .19. Spiritual beliefs were also not significantly predictive of attitudes towards services *b*=.14, SE=.09, *p*=.10, CI: -.31 to .03; Model *F*(4, 91) = 1.34, *p*=.26, R^2=.06.

The indirect path from Islamic religiousness to acculturation to service attitudes was not significant, *b*= -.01, SE=.02, CI: -.07 to .02. The indirect path from Islamic religiousness to spiritual etiological beliefs to service attitudes was not significant, *b*= -.10, SE=.06, CI: -.22 to .02. Finally, the indirect path from Islamic religiousness to acculturation to spiritual beliefs to service attitudes was not significant, *b*= -.002, SE=.005, CI: -.01 to .01. Taken together, these results suggest that greater Islamic religiousness predict more difficulties with acculturation into American culture and stronger spiritual beliefs about mental illness; however, religiousness does not directly predict service attitudes as a standalone predictor nor as a mediated variable through acculturation or spiritual beliefs.

Attitudes Towards Mental Health Services – Biomedical Model (H2b)

A serial mediation analysis was then conducted to determine the impact of Islamic Religiousness on Attitudes Towards Mental Health Services as mediated by acculturation and etiological beliefs while controlling for citizenship status.

Attitudes Towards Mental Health Services. Consistent with Hypothesis H2a, Islamic religiousness was found to be a significant predictor of acculturation, *b* = -.26, SE=.11, *p* = .017, CI: -.47 to -.05. It also emerged as a significant predictor of biomedical etiological beliefs, *b* = .22, SE=.07, *p*=.004, CI: .07 to .37, but not for attitudes towards mental health services, *b* = -.06, SE =.07, *p* =.45, CI: -.20 to .09. Acculturation was not predictive of biomedical etiological beliefs, *b*=.01, SE=.07, *p* = .89, CI: -.13 to .15. When acculturation and biomedical beliefs were entered as mediators of the relationship between Islamic Religiousness and service attitudes,

acculturation was not a significant predictor of service attitudes, *b*=.05, SE=.07, *p*=.47, CI: -.09 to .19. However, biomedical beliefs emerged as a significant predictor, *b*=.36, SE=.10, *p*<.001, CI: .16 to .57; Model $F(4, 91) = 3.94$, *p*=.005, R^2=.15.

The indirect path from Islamic Religiousness to Acculturation to attitudes towards services was not significant, *b*= -.01, SE=.02, CI: -.06 to .02; however, the indirect path from Islamic religiousness to biomedical etiological beliefs to service attitudes was significant, *b*=.08, SE=.04, CI: .02 to .18. Finally, the indirect path from Islamic religiousness to acculturation to biomedical beliefs to service attitudes was not significant, *b*= -.0009, SE=.007, CI: -.02 to .01. Taken together, this extends from the findings of Hypothesis H2a that Islamic religiousness predicts difficulties acculturation difficulties and adds that it also predicts stronger biomedical beliefs about mental illness. In turn, stronger biomedical beliefs about mental illness predict more positive attitudes towards clinical mental health services. Biomedical beliefs about mental illness predict service attitudes either as a standalone predictor or as an intermediate step between Islamic religiousness and service attitudes. The serial mediation results from Hypothesis 2a are graphed in *Figure 1* below and the results from Hypothesis 2b are graphed in *Figure 2*.

Figure 2. Mediation model of Hypothesis 2a (*p<.05; **p<.01)

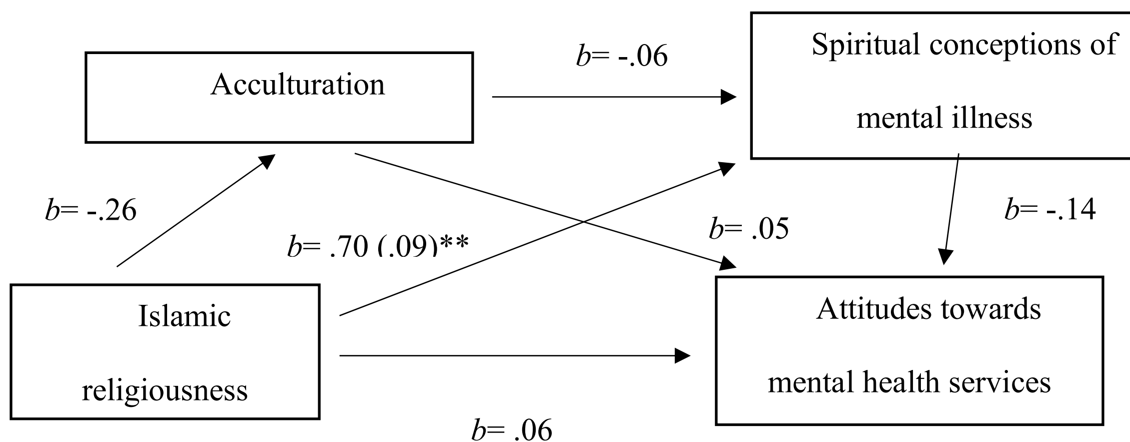
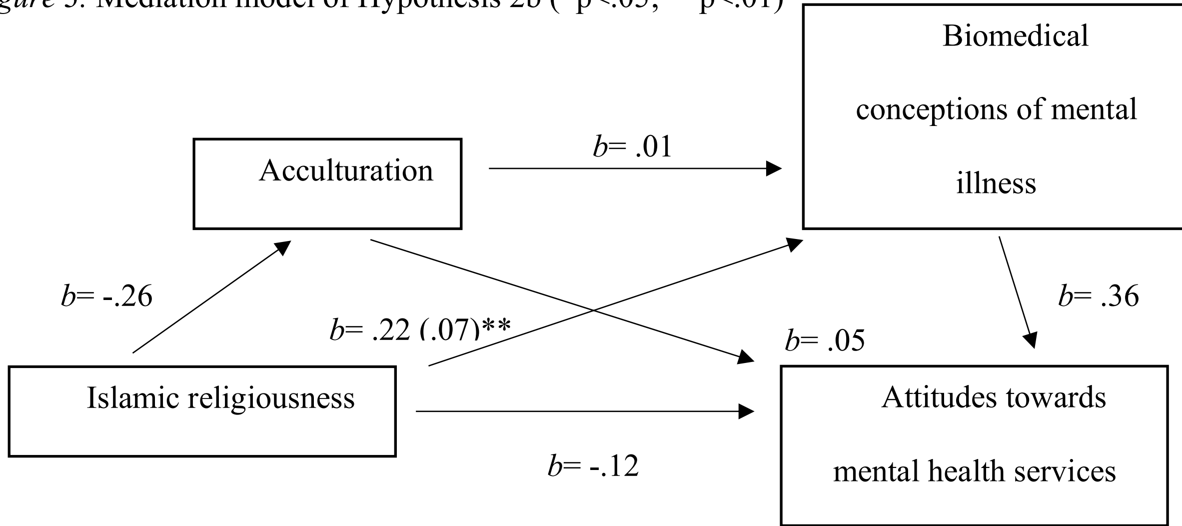


Figure 3. Mediation model of Hypothesis 2b (*p<.05; **p<.01)



Exploratory Analyses. The exploratory analysis began by examining which demographic variables demonstrated predictive value of the study variables. Age, gender, marital status, citizenship generation, education level, and family income were all entered as predictor variables in the multivariate regression analyses. Islamic religiousness, heritage enculturation, American acculturation, spiritual beliefs about mental illness, biomedical beliefs about mental illness, and attitudes towards mental health services were entered as outcome variables in six separate analyses.

Results indicated that American acculturation was significantly predicted by demographic variables, $R^2 = .15$, $F(6, 88) = 2.45$, $p = .03$. Of the demographic variables, citizenship generation emerged as significant, $b= .56$, $t(88)= 2.01$, $p=.04$, as well as education level, $b= .36$, $t(88)= 3.0$, $p=.003$. Spiritual beliefs about mental illness were also significantly predicted by demographic variables, $R^2 = .13$, $F(6, 92) = 2.26$, $p = .04$. Once again, citizenship generation emerged as a significant predictor, $b= -.37$, $t(92)= -2.24$, $p=.03$, as did education level, $b= -.21$, $t(92)= -2.93$, $p=.004$. Finally, attitudes towards mental health services were predicted by demographic variables, $R^2 = .26$, $F(6, 85) = 5.03$, $p < .001$. Of the demographic variables, gender emerged as a

significant predictor, $b = .47$, $t(85) = 4.56$, $p < .001$, as well as marital status, $b = .28$, $t(85) = 2.14$, $p = .04$. For Islamic religiousness, no new demographic variables emerged as significant predictors in the first analysis $R^2 = .12$, $F(6, 105) = 2.38$, $p = .03$. Heritage enculturation was not significantly predicted by any of the demographic variables, $R^2 = .10$, $F(6, 88) = 1.55$, $p = .173$, and neither were biomedical beliefs about mental illness $R^2 = .06$, $F(6, 92) = 1.04$, $p = .41$.

When comparing means among the significant variables, Muslim-Americans reported increasing levels of American acculturation in relation to education status proceeding from high school ($M = 4.33$, $SD = .51$), to some college ($M = 5.56$, $SD = .76$), a 2-year degree ($M = 6.09$, $SD = 1.09$), a 4-year degree ($M = 5.58$, $SD = 1.65$), a professional degree ($M = 6.10$, $SD = 1.46$), and a doctorate ($M = 6.70$, $SD = 1.20$). The reverse was found for spiritual beliefs about mental illness where they were decreased in relation to education status proceeding from high school ($M = 3.9$, $SD = .66$), to some college ($M = 3.27$, $SD = .77$), a 2-year degree ($M = 3.16$, $SD = .99$), a 4-year degree ($M = 3.2$, $SD = .81$), a professional degree ($M = 3.01$, $SD = .96$), and a doctorate ($M = 2.69$, $SD = .96$).

First-generation Muslim-Americans reported lower American acculturation ($M = 5.47$, $SD = 1.39$) compared to Muslim-Americans of second-generation or later ($M = 6.24$, $SD = 1.41$); however, first-generation Muslim-Americans reported stronger spiritual beliefs about the causes of mental illness ($M = 3.21$, $SD = .76$) compared to later generation Muslim-Americans ($M = 2.97$, $SD = .94$). Finally, females reported more positive attitudes towards mental health services ($M = 4.15$, $SD = .49$) compared to males ($M = 3.69$, $SD = .53$).

Non-married participants also reported slightly more positive attitudes ($M = 3.99$, $SD = .51$) compared to married participants ($M = 3.90$, $SD = .60$).

Taken together, these results indicate that first-generation Muslim-Americans reported less acculturation to American culture but endorse higher spiritual beliefs about mental illness compared to their later generation counterparts. It is also indicated that acculturation increased with higher levels of education; conversely, spiritual beliefs about mental illness will decrease with further educational attainment, possibly speaking to extended experiences with Western culture through education institutions or the lack of heritage country principles in Western post-secondary curriculums. Finally, the results emphasize that females and non-married Muslim-Americans hold more positive attitudes towards mental health services compared to their male and married counterparts, respectively.

Given that acculturation was the only predictor variable that did not directly or indirectly predict attitudes towards mental health services, additional analyses were conducted to explore why this might be the case. First, a correlation analysis was conducted to examine the relationship between the subscales of acculturation with the subscale components of service attitudes. This analysis found that endorsement of the heritage culture was moderately associated with intent to seek psychological services, $r(100) = .29$, $p < .01$. Endorsement of American culture was moderately associated with help-seeking intent for psychological service $r(100) = .27$, $p < .05$, confidence in mental health services, $r(100) = .26$, $p < .05$ and citizenship, $r(100) = .25$, $p < .05$. This finding may be explained as Muslim-Americans who identify with their heritage culture or American culture both seeing mental health services as an option; however, those who identify more with American culture may be more likely to believe these services will have an impact.

With this finding in mind, two supplementary mediation analyses were run under similar conditions to Hypotheses 2a and 2b with the exception that acculturation was replaced by the

heritage acculturation subscale (H2a) and the mainstream acculturation subscale (H2b) that matched the cultural EM of the etiological belief of the hypotheses. All other conditions were kept the same as the initial hypotheses plan.

Both of these analyses yielded null results where Islamic religiousness failed to predict acculturation nor enculturation, and these variables did not predict beliefs about mental illness nor attitudes towards mental health services.

CHAPTER 4

DISCUSSION

The present study extends previous research findings by exploring the relationship between Islamic religiousness and attitudes towards clinical services in the context of acculturation and etiological beliefs about mental illness. Consistent with previous studies, citizenship generation demonstrated predictive value of Islamic religiousness; however, gender and marital status did not emerge as significant predictors. Islamic religiousness also emerged as a predictor of acculturation and etiological beliefs about mental health for Muslim-Americans. In turn, beliefs about the causes of mental illness predict attitudes towards mental health services.

Acculturation did not predict services attitudes when viewed alone or as part of mediational pathways in both components of Hypothesis 2. These findings indicate that citizenship generation along with the culturally-based EMs of religiousness and conceptions of mental health impact the interactions between Muslim-Americans and service providers, thus reflecting ongoing barriers to treatment. The partial support for the study's hypothesis also revealed that acculturation does not predict conceptions of mental health nor attitudes towards mental health services; however, through exploratory analyses the subscales of the Vancouver Index of Acculturation did produce significant correlations with help-seeking behaviors and confidence mental health services. These results support the use of acculturation in further studies of religiousness, cultural connection, and attitudes towards mental health services. Taken together, these results support the utility of citizenship generation, Islamic religiousness, and conceptions of mental illness as central constructs in future studies involving Muslim-Americans and for

service providers. The following sections will elaborate the relationship between these constructs, detail the clinical and research implications of the current study, recognize limitations, and conclude with suggestions for future research.

Citizenship generation

Out of the three sociodemographic factors in the study's hypotheses, only citizenship generation showed predictive value of Islamic religiousness. Specifically, first-generation Muslim-Americans indicated higher religiousness while later generations reported less religious beliefs and behaviors. These results mirror the consistent findings in the cultural literature on decreasing religiousness through ongoing generations (Al Wekhian, 2016; Goforth et al., 2014). However, although female gender and married status were found to be predictive of Islamic religiousness in previous studies, these results were not found in the current study. Future studies can explore these inconsistencies by conducting purposive sampling based on immigration status, gender, and marital status to identify sources of variability within these groups.

The partial support for this hypothesis may be attributed to variable religious attitudes within the sample. Although participants were recruited and engaged with the study through their identity of being Muslim-American there are likely to be varying degrees of religious endorsement and the centrality of Islam to one's identity. In addition, religious attitudes may experience high and low periods of importance throughout individual lifetimes and it is important to recognize that the survey captures evolving attitudes that have developed through a lifetime of experiences. For example, religiousness may have been important to an individual when they were younger and the principles were reinforced through their family and community but received less centrality to their identity throughout the new contexts and social relationships.

With this context in mind, another factor that may influence religiousness is the social network of the respondent and provides new avenues of focus for future studies.

Islamic Religiousness Pathway

Islamic religiousness was significantly and negatively predictive of acculturation. This indicates that Muslim-Americans who endorse higher religiousness are less likely to engage with attitudes, behaviors, and beliefs of the mainstream culture. It is possible this occurred because of the collectivist nature of the Islamic faith which may encourage Muslim-Americans to seek out and spend more time with others who have similar beliefs, values, and daily habits. This finding is consistent with previous studies of religiousness and acculturation among Muslim-Americans which had solely focused on second-generation early adults (Amer & Hovey, 2007) and extends those findings across citizenship generations and age groups. These findings can be analyzed further in future studies by assessing positive and negative experiences with American culture as an influential factor of acculturation due to the rising presence of discrimination and exclusion (Abu-Ras et al., 2018). The relationship between Islamic religiousness and acculturation may prove useful in studies examining cultural connections and the settlement experiences of Muslims coming to the United States. This may prove especially useful in a targeted approach given that first-generation citizenship status was found to be predictive of religiousness.

When applied to etiological beliefs about mental illness, Islamic religiousness emerged as a significant and positive predictor of spiritual beliefs and biomedical beliefs. As such, these results indicate that Muslim-Americans who endorse higher religiousness are more likely to recognize mental illness as being caused by spiritually-based factors, such as Allah's will or a lack of faith, and as caused by biologically-based factors, such as genetics or chemical imbalances in the brain. This may be because of the integrated view of health and faith in the

Islamic tradition where ones' health is viewed as an indicator of faith in Allah and, as such, physical and spiritual symptoms can be viewed holistically. These findings provide support for earlier research on eclectic beliefs about mental health among Muslim-Americans and spiritual community members (Bagasra & Mackinem, 2014; Moodley et al., 2018). Future research can extend these constructs in studies of what participants endorse as effective treatments for specific categories of mental illness as a means of assessing what disorders are reaching clinical services and which are falling untreated. Studies using clinical samples and/or clinical case vignettes of different disorders may further illuminate disorder-specific help-seeking beliefs and trajectories.

Taken together, Islamic religiousness positively predicted attitudes towards mental health services when biomedical conceptions of mental health were used a mediating variable; however, Islamic religiousness did not display significance as a direct predictor of service attitudes, nor did it reach significance when acculturation or spiritual conceptions of mental illness were used as mediators. These results mean that Hypotheses 2a and 2b were partially supported. Islamic religiousness failing to significantly predict service attitudes was surprising especially in light of the emerging research on religiousness being a barrier and cultural consideration for Muslim-Americans during interactions with service providers. It is possible that the current study integrating multiple constructs of separate studies helped distinguish the predictive value of Islamic religiousness from conceptions of mental health, and that these constructs may have confounded each other in previous analyses. Future studies can benefit from including both variables to examine their relative utility.

The current study also added to acculturation's emerging use as a predictor in the literature on Muslim-American health beliefs and service attitudes. These null findings were surprising given that they contrast with previous studies on the impact of acculturation on help-seeking behaviors.

Supplemental testing with heritage and American acculturation and treatment attitudes found that endorsement of the heritage culture was positively correlated with intent to seek help from psychological services. Endorsement of American culture was also significantly associated with psychological service intent and was also associated with confidence in mental health services and citizenship. This reflects the integration model of acculturation (Berry, 1997) where participants who held stronger heritage enculturation still valued Western health services as a treatment option despite it not aligning with their endorsed values; however, those who reported higher American acculturation were distinguished by their confidence in these services, thus indicating a stronger degree of integration or possible assimilation.

These correlation findings add external validity to Markova et al. (2020) by supporting the findings by administering the Vancouver Index of Acculturation to a Muslim population in the United States. While Markova found that identification with the Norwegian host culture was positively associated with endorsement of psychological services, this study adds the distinction from heritage culture endorsement in that host culture endorsement is also correlated with confidence in mental health services. This indicates that while people who identify with both cultures may intend to seek these services, those who affiliate more with the host culture may have stronger belief in these services benefitting their health. Overall this finding supports the utility of the Vancouver Index of Acculturation in further studies while providing future research directions for how acculturation predicts trust in services and confidence in their efficacy.

As a whole, the current results indicate biomedical beliefs about mental illness increase when Islamic religiousness is stronger, and in turn higher biomedical conceptions lead to more positive attitudes towards and endorsement of clinical mental health services. Such findings provide support for the conclusion of Amri & Bemak (2013) that religious Muslim-Americans endorse

multiple causes of mental illness and recognize the utility of clinical mental health services. These findings support the conclusion that Islamic religiousness is an important factor in understanding attitudes towards mental health services and future studies can deepen this understanding by exploring what specific obstacles patients endorse as reasons for avoiding such institutions.

Limitations

A strength of the current study is that it represents a variety of ages (18-64) and drew from a community sample using online recruitment across the United States. This was done to accommodate the restrictions posed by the COVID-19 pandemic but also underscores limitations of the sample. First, drawing from a broad sample bolsters the external validity of the study at the expense of internal validity given there was less control over participants who engaged in the study and no pre-screening data of diagnosis history or possible confounds was assessed. Second, the onset of the COVID-19 pandemic has been accompanied by public attention to the biological aspects of illness which may have influenced Muslim-American health attitudes as part of a history effect. Finally, a portion of the data collection overlapped with the Islamic month of Ramadan during the summer of 2020 and the presence of an ongoing religious event may have impacted participants' reports of Islamic religiousness, acculturation, or spiritual conceptions of health and illness. This is an important consideration as it may have prompted a greater proportion of practicing Muslim-Americans with higher religiousness to participate in the study and emphasize beliefs about spirituality, while those with lower religiousness or were not engaging with Ramadan may have declined the invitation to participate.

Group status may have impacted participants' responses in the survey as the study's outreach was geared towards Muslim-Americans. Although the study encouraged participants to give their

open opinion, there may have been pressure to represent their personal faith in a positive light and downplay doubts or conflicting opinions about the role of Islam in mental health. The Likert format of the questions also limits ways that participants can express these nuanced opinions. As such, the results may reflect a social desirability bias and may not capture a broader range of attitudes about religiousness and spirituality within mental health.

While acculturation did not significantly predict treatment attitudes or beliefs about mental illness, it was found that acculturation and enculturation showed correlations with treatment intent and subscales of treatment attitudes, thus reflecting Berry's (1997) theory about the four domains of acculturation through the context of help-seeking behaviors. This provides supporting evidence that future studies involving acculturation, mental health beliefs, and treatment attitude can gain informative insights by utilizing the Vancouver Index of Acculturation.

With the limitations kept in mind, the overall results give informative data on the role of Islamic religiousness on acculturation, conceptions of mental health, and attitudes towards mental health services. Further studies can add to the literature by gathering qualitative data through interviews, photovoice, and open-ended questionnaires to allow Muslim-Americans a capacity to express unique perspectives.

Research Implications

Clinical psychologists have made promising and informative discoveries about the EMs and cultural considerations of Muslim-Americans. However, many of these studies have examined the isolated phenomena of acculturation, etiological beliefs, or treatment preferences without exploring the relationship between these constructs. The results of this study can be furthered by exploring the observed effects through purposive sampling of first-generation citizens and across

age groups. The broader impact of positive or negative experiences on acculturation may also be explored in ongoing studies due to the potential for experience to impact one's endorsement of American beliefs, attitudes, and behaviors. This may especially relevant for language difficulties among Muslim-Americans as this barrier may obstruct them from experiencing American culture or receiving new information to incorporate into their EMs.

The role of spiritual coping was not explored in the current study although religiousness and sense of community inherent to Islam have been established in the literature as a protective factor against adversity and symptoms of mental illness. It would be interesting to explore how spiritual coping through adversity impacts Muslim-Americans' beliefs about the spiritual aspects of mental illness. Finally, given the positive predictive value of religiousness on biomedical beliefs and service attitudes it will be informative to examine which categories of mental illness (e.g., anxiety disorders, personality disorders, etc.) are considered for conventional treatment and which fall unrecognized or unconsidered for clinical attention. Spirituality has been established as a coping mechanism in previous studies and holds potential in the treatment of severe cases of physical and mental illness.

Applied Implications

The results of this study provide clinicians and service providers a nuanced understanding of clinical attitudes among Muslim-Americans. One surprising result of the study is that 56.6% of respondents reported not using clinical services in the past three years which indicates that many individuals with mental health difficulties are not receiving clinical services despite rising rates of stress and clinical disorders. The exploratory analysis also highlighted that male Muslim-Americans hold more negative attitudes towards treatment services compared to females, and thus may be underserved. With this in mind, future efforts of service providers can be directed

towards community outreach to provide information about treatment options and the availability of services. There may even be options to target a portion of these efforts towards male Muslim-American groups or networks to bolster their openness towards these services.

Given that higher religiousness has been indirectly tied to positive service attitudes among Muslim-Americans, a new avenue of clinical outreach is available through coordinated care with spiritual counsellors and religious institutions (Amri & Bemak, 2013; Meran & Mason, 2019). Spiritual counsellors have indicated openness to treating spiritual ailments in coordination with mental health service providers to act as cultural bridgeways and direct potential patients towards clinical services. This approach has been endorsed by the World Health Organization and has been practiced through simultaneous care, sequential care with warm handoffs between providers, or even localized treatment programs with integrated teams of practitioners (Johnson & Sandhu, 2010). These partnerships can address current barriers to treatment and foster multi-faceted approaches to health for Muslim-Americans.

CHAPTER 5

CONCLUSION

The present study explored the relationship Islamic religiousness has with acculturation, conceptions of mental illness, and attitudes towards clinical mental health services. The goal of this research was to address the questions of how demographics predict Islamic religiousness and to what extent does Islamic religiousness predict treatment preferences. The results of the study provide partial support for the hypotheses in that citizenship status predicts Islamic religiousness, and that Islamic religiousness predicts acculturation and spiritual conceptions of mental illness, and that it predicts service attitudes through the context of biomedical conceptions of mental illness. These findings open avenues for further research on the influence of spirituality and conceptions of mental illness to understand barriers to seeking treatment. They also underscore the need for coordinated care with spiritual counsellors and institutions to aid outreach to large proportions of underserved Muslim-Americans who are not having first contact with the mental health system.

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VITA

ELIJAH P. MUDRYK, B.A.

GRADUATE STUDENT

THE UNIVERSITY OF MISSISSIPPI

EDUCATION

B.A. Simon Fraser University, Clinical Psychology April 2017

Graduated on Dean's Honor Roll

Minor in Sociology

HONORS AND AWARDS

Caribbean Regional Conference in Psychology Early Scholars Grant 2021

APA Division 36 Research Grant 2021

University of Mississippi Graduate Student Fellowship 2020 (ongoing)

Incoming student scholarship based on academic excellence and high percentile GRE scores

NSERC Undergraduate Scholarship 2017

Research scholarship used for a cognitive study examining the attentional blink event-related potential using EEG technology

Simon Fraser Undergraduate Open Scholarship 2017

Simon Fraser Undergraduate Open Scholarship 2016

Simon Fraser Alumni Scholarship 2016

RESEARCH EXPERIENCE

BRANCH Intercultural Psychology Lab, University of Victoria 2018 to 2020

Affiliate Researcher, Dr. Catherine Costigan

- Conducted literature review and interview analysis with Syrian refugees to recommend community programs intended to foster intercultural connection
- Findings advised the federal members of the Resilience BC program aimed at reducing anti-Asian discrimination resulting from COVID-19 stigma

Attention and Memory Psychology Lab, Simon Fraser University 2016 to 2017

Research Assistant, Dr. Thomas Spalek

- Ran EEG experiments examining attentional blink paradigms during cognitive focus tasks
- Trained new lab members on ethical research protocols and administration of physiological response technology

TEACHING EXPERIENCE

University of Mississippi, Oxford January 2021 to May 2021

Teaching Assistant, Psy 311 Abnormal Psychology

- Assisting Professor Christian Courson with a 124-student undergraduate class teaching symptoms, base rates, and gold standard treatments for the most common disorders from the DSM-5
- Duties included essay and test marking, teaching limited aspects of the course, and mentoring for individual students during office hours

University of Mississippi, Oxford August 2020 to December 2020

Teaching Assistant, Psy 201 Introduction to Psychology

- Assisting Professor Christian Courson with a 94-student undergraduate class teaching basic psychological theory, research methods, and applications of the science in daily life
- Duties included test and assignment marking, identifying and reaching out to struggling students, and auditing lecture material to ensure comprehensibility and veracity

PUBLICATIONS

Journal Publications

Lagroix, H., Cork, T., Jankovic, N., Mudryk, E., Richardson, A., Thompson, K., ... & Spalek, T. (2018). The PR: An ERP index of the reactivation of spatially-specific memories. Journal of Vision, 18(10), 974-974.

Costigan, C.L., Taknint, J.T., Mudryk, E., Al Qudayri, B. "Building Community: Connecting Refugee and Canadian Families," Journal of Cultural Diversity and Ethnic Minority Psychology (in press)

PRESENTATIONS AND INVITED LECTURES

Poster Presentation, “Come as You Are: Islamic Religiousness as a Context for Treatment Preferences Among MENA-Americans” AMENA-PSY 2021 Conference, September 24, 2021

Paper Presentation, “Black Minds, Fast Times: How the Legacies of Racial Activism and Modern Academic Experiences Inform the Activism of Black Students” Identity Across the Curriculum Conference, March 18, 2021

Workshop Leader, “Croft Institute Travel Abroad Workshop” Croft Institute. November 2020; February 2021; November 2021

Panel Member, “Life as a Graduate Student” Psychology Club/PSI-CHI Event. November 2020; November 2021

Paper Presentation, “Worlds Meeting: Branching Newcomers with Local Canadian Families” Ole Miss Diversifying Psychology Conference, September 19, 2020.

Paper Presentation, “Diverse Perspectives on Refugee Social Inclusion: Designing Community Programs to Build Genuine Connections” Society for Research on Adolescence Conference, March 19, 2020.

Research Presentation, “The PR Indication of Spatially-Specific Memories” NOWCAM Conference, May 12, 2017.

PROFESSIONAL TRAINING

The Art of Effective Antiracist Allyship Certification

Dialectical Engagement in Antiracism Certification Psychologists, Online Synchronous Seminar, February 2021

Dialectical training in practicing and promoting antiracist behaviors for marginalized communities in organizational settings

Clinical Suicidology Certification

National Register of Health Service Psychologists, Online Synchronous Seminar, October 2020

Clinical training in recognizing and reducing the risk of suicidal behavior for at-risk patients receiving mental health treatment

PROFESSIONAL AFFILIATIONS

University of Mississippi Psychology Department Diversity Committee, 2021-Present

Organizing a peer mentorship program in the psychology department involving supervision of mentors, allocating the annual budget to bi-monthly department diversity events, and creating a handbook on diversity training for incoming students.

University of Mississippi Diversity Equity and Inclusion Committee, 2020-Present

Ongoing member of task force mandated to establish a unified set of goals and actionable steps to increase diversity and establish bias-prevention training across the university's graduate departments

Stronger Together Social Action Group, 2020-Present

Coordinating with the Director of the Ole Miss Centre for Inclusion and Cross-Cultural Engagement with local initiatives in the Northern Mississippi area to recognize and address interracial tensions

University of Mississippi Psychology Chair's Graduate Advisory Committee, 2020-2021

Attending regular board meetings with Doctor Rebekah Smith, Chair of the Psychology Department, to discuss student concerns about the program, new department initiatives, and the impact of ongoing initiatives

PROFESSIONAL SERVICE

Founder

PEERS Social Skills Group, 2021

Social skills group for preadolescents with developmental and neurodiverse difficulties on how to make friendships, manage rejection and conflict, and connect with others

TEDx Speaker

TEDxUniversityOfMississippi, 2021

https://www.ted.com/talks/elijah_mudryk_you_are_not_your_worst_day_voices_of_diverse_resilience

LANGUAGES

English: Native Language

Spanish: Novice Speaker

French: Novice Speaker

OTHER

Hobbies: Currently creating a Diversity Survey for the University of Mississippi Graduate School. Weightlifting, hiking, playing with my dog Davina, learning about spies, Japanese cookbooks.

Citizenship: Canadian; F-1 Student Visa in U.S.

References

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