Young Adult American-Born Muslims and Mental Health:

An Exploration of Attitudes, Challenges, and Needs

Institute *for* Social Policy *and* Understanding

Report Author

Dr. Ben Herzig, Research Fellow,
Institute for Social Policy and Understanding;
Doctor of Clinical Psychology;
Antioch University New England

Report Editor

Stephen McGrath, Senior Communications
Manager, Institute for Social Policy and
Understanding

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Executive Summary

Despite the growing number of American Muslims in the United States, their frequent encounters with prejudice and their increased self-reports of emotional stress, little research has been carried out to understand attitudes toward mental health by Muslim Americans, specifically those born and raised in the United States. On the basis of current demographic trends, it is reasonable to suggest that American-born Muslims represent the future of Islam in the United States.

This study examined the mental health attitudes of 184 American-born Muslim college students. A primarily quantitative survey approach was employed. Additional comments by participants to an open-ended survey question richly described how some of the study's foci manifest themselves in real-life situations.

Participants indicated the presence in their community of concerning levels of depression, anxiety, social pressures, and family conflict. They reported flexible general coping strategies and positive reactions to seeking professional mental health treatment. Although religiousness was strongly associated with religious coping, neither of these was correlated with help-seeking attitudes; perhaps the process of seeking external help is different from seeking guidance from within the meanings of one's faith. Therefore, even highly religious Muslims in the survey who were apt to utilize religious coping strategies were just as willing to seek professional help as young adult American Muslims who were less religious, and this finding held true for both men and women.

Study respondents expressed a preference for individual therapy above all other treatment modalities. The professional characteristics most desired in treatment providers were multicultural competence and an understanding of developmental issues associated with young adulthood. Participants expressed concerns about the perceived lack of multicultural competence in the mental health field and the lack of Muslim treatment providers. It is hoped that the results of this study will provide mental health practitioners and other stakeholders such as community leaders and policy makers with a strong understanding of the beliefs and needs of American-born Muslims with regard to mental health care. Recommendations are offered in this report. Among them:

- Increase multicultural competence specific to treating young adult American-born Muslims for professional mental health treatment providers.
- Hire and train Muslim college chaplains.
- Educate the Muslim community and religious leaders on issues pertaining to mental health.
- Develop approaches to reduce mental health stigma in the American Muslim community through religious institutions.
- Increase funding for further research on the mental health needs of young adult American-born Muslims and American Muslims in general.

Introduction

RATIONALE

Islam is the fastest growing religion in North American. Estimates of its adherents in the United States range from three to about seven million,[1] or 1- 2% of the current U.S. population.[2] These statistics suggest that Islam may already be the second most practiced religion in the United States (behind Christianity). American Muslims are ethnically diverse, with the most represented groups by far being of Arab, South Asian, and African American backgrounds.[3] Although cultural differences create a fair amount of variability in the family values and social customs of American Muslims, the religion of Islam remains the central guiding force for the way that most Muslims of all backgrounds live their lives.[4]

There are many Muslims on college campuses.[5] Although precise figures could not be obtained for this study, it appears that most large colleges and many smaller ones have active Muslim student groups. On Facebook, the popular social networking website, one can find thousands of social groups geared toward Muslims. Many major American universities have Muslim chaplains or student advisors on staff.

Muslims who live in the United States are increasingly American-born.[6] This fact has two important implications for researchers. First, it can be said that these American-born Muslims reflect the changing face of Islam in America, and to study these individuals "ahead of the curve" is to learn about the future of American Muslims. Second, this group undoubtedly has had significantly different life experiences than the previous generation, many of whom were foreign-born immigrants, and it stands to reason that experiences unique to the United States have had an important influence on the identity, attitudes, and world views of this emerging population.

Over the past 45 years, millions of Muslims have come to the United States because of changes in immigration policy, an increasingly globalized economy, and advances in travel and communication. Many Muslim immigrants, the vast majority of whom were originally from the Arabic-speaking world (i.e., the Middle East and North Africa) or the Indian subcontinent (i.e., Pakistan, India, and Bangladesh), now have children who were born and raised in the United States and who are attending college; they represent an American Muslim baby boom.[7] Another group of young adult Muslims, African Americans, also have had different life experiences than their generational predecessors; these younger Muslims typically have been raised within the fold of traditional Islam, mainly attributable to their parents' religious origins in the Nation of Islam.

By some accounts, this new generation of American Muslims, particularly children of immigrants, is in many ways more religious than their parents.[8] For instance, many young Muslim women have adopted the traditional religious practice of wearing the *hijab*,[a] whereas their mothers might not hold themselves to the same standard of modesty. It has been proposed that these second-generation Muslims, having been raised in the United States and spared the first-generation acculturation process that is typically associated with immigration, have felt less pressure to hold any one aspect of their identity at a distance, and are comfortably developing their own understanding of what it means to be both an American and a Muslim.[9] It is pinning down how these attitudes translate into the arena of mental health that is at the heart of this study.

The American Psychological Association[10] has issued a set of guidelines emphasizing the importance of multicultural knowledge and awareness in the training of psychologists, which highlights the broad idea that cultural variables such as race, religion, and ethnicity are important to consider when conceptualizing an individual's identity and psychological functioning and when designing outreach, intervention, research, and organizational change. In this respect, the concept of multicultural competence of mental health treatment providers is especially important in considering the findings of the present study. A multicultural lens takes into account not only the religious perspectives of the Muslim participants in this study, but that many of them are identified as racial and/or ethnic minorities with specific identity attitudes.

PREVIOUS RESEARCH

Little quantitative research exists to document the attitudes of American Muslims in general.[11] Thus far, what professional literature there is typically has focused on examining the beliefs of adult Muslims in the United States, many of whom are immigrants. In the field of mental health, there is a paucity of research on these foreign-born American Muslims, let alone their American-born children.[12] Similar research has focused solely on Arab Americans, some of whom are not from Muslim backgrounds.

Studies of foreign-born Muslims in the United States and mental health have understandably made note of acculturative stress and how differences in customs affect treatment-seeking behavior. In general, this research has found that American Muslims are reluctant to seek mental health care for a variety of reasons, including having stigmatized beliefs about mental illness and distrusting the field of mental health and those who work in it.[13] It has also been suggested that some Muslims in the United States might feel that negative public perception of Islam would translate into ignorant clinical practice by Western treatment providers.[14] It is certainly possible that since 9/11 these doubts have grown, and American Muslims may not have developed a willingness to reach beyond their own community for support.

Despite some distrust of mainstream psychological services, it has been clear that since 9/11, demand for emotional support has risen among American Muslims.[15] Often, Muslims have turned to religious leaders for counsel.[16] In fact, coping with stress using religiously based methods such as prayer and interacting with

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a Hijab: A covering; usually used to mean a woman's head scarf.

one's faith community has been found to be common for Muslims.[17] Only one study could be found that sought to explicitly measure the mental health values of American Muslims without ethnic exclusions. This study took place before 9/11, and most of its participants were not born in the United States. It found that a majority of participants would prefer to seek counseling with a Muslim provider.[18] Of the minority of participants who did not indicate a strong preference between seeing a Muslim or non-Muslim counselor, most indicated that they would want their counselor to have an understanding of Islam and to possess similar personal values.

KEY TERMS

Help-Seeking

As might be expected, individuals in psychological distress may seek assistance in a variety of ways. The specific act of seeking help, whether from mental health professionals or elsewhere, is highly correlated with one's attitudes about the value of using others for support, and this finding is generally universal, including for various minority groups.[19] Despite the link between help-seeking attitudes and help-seeking behavior, there are significant differences in how ethnic and racial minorities choose to seek help, particularly the use of formal mental health services.[20] Among college students, for example, one study found that whites were much more likely to make use of traditional psychological services than were students from racial and ethnic minority groups.[21] Another study found that Arab Muslim adults in the United States would be more likely to seek help from a family physician or religious leader than they would from a mental health professional.[22]

In general, individuals who belong to racial and ethnic minority groups in the United States are more likely to seek formal mental health services if they have experienced greater acculturation to American society,[23] which might suggest that Muslims born in the United States would be more open than American Muslim immigrants to seek these types of services. Members of cultural minorities in the United States may be less likely to seek formal mental health services if they have a strong network of family and friends to draw upon.[24] Given that a strong sense of alliance with a mental health provider can be crucial to positive therapeutic outcomes,[25] minorities in the United States may be reluctant to seek counseling from providers with whom they have difficulty personally identifying.

Stigma

Individuals who encounter psychological difficulties may feel a sense of shame, embarrassment, or disgrace about these experiences because of perceived weak inner strength, loss of face, or a combination of these, which can lead to negative self-judgments and anxiety about the judgments of others.[26] These negative perceptions have persisted in American society despite efforts to dispel stigma and create greater awareness of mental illness.[27] This is especially concerning given that the presence of stigma about mental health problems is generally detrimental to well-being,[28] further complicating the process of treatment and recovery.

Arabs and Muslims may hold a stigma about mental illness that inhibits help-seeking behavior.[29] For example, in a study of Arab immigrant women who

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were victims of abuse, Wahiba Abu-Ras of the Institute for Social Policy and Understanding[30] found that a majority of participants felt shame in seeking formal mental health services. Some American Muslims may fear that mental health professionals will fail to understand the experiences of shame and vulnerability that often accompany disclosing emotional difficulties.[31]

Religiousness

Religion has long been viewed by social scientists as an integral component of one's identity.[32] The influence of religiousness on mental health has historically been a subject of debate. Sigmund Freud [33] posited that religiousness may pose a risk to the maturation of the psyche, whereas his contemporary, Carl Jung,[34] saw religion as potentially promoting healthy psychological development. Some studies suggest that religiousness is generally associated with positive mental health outcomes, whereas other studies have found it to be noncontributory or even detrimental in this respect.[35] Among college students, it has been suggested that religiousness may not be related to attitudes about mental health services.[36] Furthermore, if the goal is patient well-being in formal treatment settings, there may be little distinction between being an adherent to a particular faith versus possessing a more general sense of spirituality.[37]

A distinction is made in the present study between religiosity, which is sometimes used to describe conservative social and political attitudes, and the influence of religion, which here is being called religiousness. Studies on the effect of religion on psychology have yielded several important findings. Religious involvement is associated with greater longevity and better health outcomes.[38] Religious involvement has some stress-buffering effects in instances in which people are experiencing multiple negative life events.[39] Religion may also benefit an individual's mental health through greater social support and a healthier lifestyle due to religious prohibitions.[40] Religious coping with depression has been perceived as being relatively effective; however, if people do not believe that religion helps them to cope, then it may have less of an effect.[41]

It has been suggested that religious impairment be viewed as a clinically significant aspect in formulating and treating individuals in mental health settings.[42] Interventions that meld psychological services with a positive integration of religion and spirituality have shown some promise in group settings[43] and through the utilization of community religious organizations.[44] One consistent research finding has been that high levels of religiosity are associated with low levels of substance abuse.[45]

Coping

Broadly speaking, the concept of coping refers to the utilization of thoughts and behaviors in attempting to manage psychological stressors.[46] This often involves seeking formal mental health services, but it is also not uncommon for individuals to turn to their religion for solace. Religious coping, which might be thought of as the integration of one's religious identity, practices, and faith group in managing emotional discomfort, has been shown to be a generally helpful strategy for people of faith.[47] Just as with help-seeking behavior, culture plays a major role in determining how different people choose to cope.[48]

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Background

ISLAM IN THE UNITED STATES: NOW AND IN THE FUTURE

American Muslims Today

The polling organization Gallup[49] conducted a major survey that examined the attitudes and behaviors of many American religious groups throughout the 2008 calendar year. Findings specific to the 946 American Muslim participants were compared with data gathered from other religious communities in the United States and, in some cases, with recent Gallup surveys of Muslims around the world.

According to Gallup, American Muslims tend to be religious; 80% stated that religion is an important part of their lives. Only Mormons (85%) reported higher levels of religiousness, whereas 65% of the overall sample of adult Americans endorsed that statement. Muslims in Muslim-majority countries tend to report higher levels of religiousness than American Muslims (e.g., 100% in Egypt, 99% in Indonesia, 94% in Pakistan, and 89% in Turkey), whereas Muslims in other Western countries such as Great Britain (70%) and France (69%) appear to be less religious, on average, than Muslims in the United States.

Muslims are the only religious group in the United States for which male and female adherents report roughly equal levels of religiousness.

The Gallup survey also found that 41% percent of American Muslims attend religious services at least weekly, even though weekly communal prayers for Muslims are held midday on Fridays, when many adults are working, and attendance at these services is not mandatory for Muslim women. For American adults as a whole, this number is somewhat lower (34%). Interestingly, Muslims are the only religious group in the United States for which male and female adherents report roughly equal levels of religiousness; for every other religion in the United States, women report being significantly more religious than men. Still, Muslim women in the United States are more likely to attend religious services than other Muslim women worldwide. In fact, the United States is the lone country in which the number of Muslim women attending religious services rivals that of Muslim men, with only Bangladesh having comparable reporting. Consistent with Islam's prohibition of consuming alcohol, 86% of American Muslims report that they usually abstain from drinking—a number that is rivaled only by American Mormons (92%).

Muslims are also the only American religious group in which college graduation rates by women have reached that of men.

Muslims are among the most educated groups in the United States.[50] Gallup[51] reports that 63% of American Muslim adults have a college degree, even though 36% of the adult Muslim population in the United States is between the ages of 18 and 29, which would suggest that a significant percentage of this group may not have yet finished college.[52] Of all other religious groups, only American Jews (83%) have a higher rate of holding a college degree. Muslims are also the

only American religious group in which college graduation rates by women have reached that of men.[53]

American Muslims also boast high levels of employment.[54] Adult Muslims in the United States are more likely to be employed than any other religious group,[55] which might also reflect that the American Muslim population tends to be younger and therefore likely has fewer retirees. Muslims in the United States are more likely to be employed than Muslims in any other country.

Although American Muslims have relatively high rates of education and employment, they are far less likely than other religious groups to report being satisfied with their standard of living.[56] Sixty-five percent of Muslims in America report such satisfaction; the next highest group is Catholics (75%). Furthermore, American Muslims are least likely to report they are "thriving" (41%) and most likely to report that they are "struggling" (56%). Muslims are also less likely to report having strong social supports (75%) than the general population (85%).

It is especially concerning that American Muslims report surprisingly high levels of negative emotions. According to a Pew Research Center Report[57] of a study of more than 1,000 American Muslims, only 24% described themselves as "very happy," whereas the happiness rate of the general American population was twice as great as that. Gallup[58] found that compared with other major religious groups in the United States, Muslims were least likely to report feeling respected, well rested, or happy. Only 79% of Muslims report that they smile or laugh regularly, which is a much lower percentage than that of any other religious group. Also, Muslims are the least likely of any religious group in the United States to report experiencing enjoyment and learning in their lives. Finally, Muslims report the highest levels of anger, sadness, and worry.

The role of discrimination may be a major factor in Muslims' emotional struggles. Although American Muslims are likely to share the same general values and aspirations as their fellow countrymen,[59] there remains a strong anti-Muslim sentiment in the United States.[60] Gallup[61] reports that American Muslims are the least likely of any American religious group to report feeling safe. According to the Pew Research Center,[62] 25% of American Muslim adults report experiencing acts of discrimination after 9/11, 53% said that it had been more difficult to be a Muslim in the United States since 9/11, and 63% felt no conflict in being both American and Muslim. A more recent Pew study[63] found that 58% of Americans see Muslims as facing "a lot of discrimination." The next highest religious group in terms of perceived discrimination was American Jews, at 35%. Over the past year, a dramatic rise in Islamophobia and hate crimes toward Muslims has been observed, which has manifested itself in terms of community opposition to several proposed Islamic centers across the country, vandalism of *mosques*,[b] anti-Muslim rhetoric in the media, and violence toward American Muslims.[64]

There are now approximately 1,900 mosques in the United States.[65] As a population whose estimated size ranges between three and seven million, Muslims make up a significant minority of the population of the United States. American Muslims are the most racially diverse religious group in the United States.[66] About one-third of American Muslims are African American, with the rest being mostly of Arab or South Asian descent, along with smaller numbers of

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b Mosque: A Muslim place of worship.

people of Southeast Asian, Caucasian, Persian, Turkish, and Hispanic descent. Muslims in the United States are more ethnically diverse than Muslims in any other country.[67] Because of some of the common challenges that they have faced in the United States since 9/11, American Muslims have become further united across lines of race, class, and culture.[68]

Demographic Trends

The American Muslim population is much younger than the American population as a whole.[69] This trend is evident in reviewing the number of Muslims age 18 and under and ages 18–29. Gallup[70] reports that the average number of children under the age of 18 living in American Muslim households is 1.33—the national average is 0.75. The same national survey found that 36% of adult American Muslims are between ages 18 and 29, which is twice the national average. According to a study by Cornell University, the average annual population growth rate of Muslims in the United States is more than six times greater than that of the American population as a whole.[71]

There are also a growing number of Muslim students attending America's institutes of higher education.[72] According to Gallup,[73] nonworking American Muslim adults are more than three times as likely to be full-time students than their counterparts in the general American population. This number may be somewhat inflated by Muslim international students attending school on student visas. However, it is very likely that most of these students are American-born; the Pew Research Center[74] found that 20% of American-born Muslims are currently attending college.

YOUNG ADULT AMERICAN MUSLIMS

Experiences and Attitudes

Research suggests that young adult Muslims in the United States are likely more religious than their elders. According to the Pew study of Muslim Americans,[75] adult Muslims under the age of 30 are more likely than older Muslims to attend religious services, and younger adult American Muslims are also more likely to express a strong Islamic identity. The Pew study also found that of all adult Muslims in the United States, only 17% report believing Muslims in the United States are becoming "less religious."

According to Gallup[76] 77% of American Muslims aged 18–29 report they are religious, which is much higher than the general American population (54%). A study of 18- to 25-year-old American Muslims found that they were more committed on average to their religion than were their non-Muslim counterparts.[77] Given that young adult Muslims are increasingly American-born, it is not surprising that Muslims born in the United States report attending religious services more frequently than those born elsewhere.[78]

The Gallup survey,[79] which found that the American Muslim population as a whole is struggling to thrive in the United States, also produced concerning findings specifically for young adult American Muslims. Only 40% of American Muslims ages 18–29 described themselves as "thriving," which is significantly

less than any other religious group in the same age range; 18- to 29-year-old Catholics reported the next lowest levels of feeling they are thriving, at 54%. Furthermore, 18- to 29-year-old Muslims in the United States were at the bottom for their age group compared with their peers in reporting feeling respected by others and experiencing regular enjoyment. They reported the lowest levels of happiness and were the least likely to report smiling and laughing. They were by far the most likely of any group to report anger, and also reported the highest levels of worry. Surprisingly, even though so many American Muslims ages 18–29 are students, they were the least likely of any religious group to report feeling that they experience learning in their lives or that they are involved in interesting activities. Muslims in the United States ages 18–29 were the least likely of any major religious group to report having a strong social network, although they were more likely than American Muslims over the age of 29, many of whom are immigrants, to report having these social supports in place.

Like their elders, American Muslim youth and young adults report experiencing a great amount of discrimination. Muslim adolescents are especially likely to be teased because of their religion, and this may lead to them feeling uncomfortable at school.[80] Of all American Muslims, the 18–29 age group reports the greatest post-9/11 difficulty being a Muslim in the United States.[81] A 2005 study by the Muslim Public Affairs Council found that 70% of American Muslim youth have experienced negative reactions from others due to their religion.[82] Additional research has found that as many as 84% of American Muslims ages 12–18 and 88% in the 18–25 age group have encountered hardships in the United States due to being Muslim.[83] Gallup[84] found that only 59% of young adult American Muslims feel safe at night walking in their local communities, which is significantly below average for that age group.

Although research on American Muslim identity development remains lacking,[85] available scholarship and cultural observations suggest that adolescent, young adult, and native-born American Muslims are actively engaged in developing more cohesive identities that embrace aspects of both Islamic and American culture.[86] More Muslim female high school students are taking part in interscholastic sports while wearing hijab,[87] and 89% of American Muslim adolescents still celebrate the holidays of the countries of their heritage.[88] It has been generally true that American Muslims are more recently asserting themselves in the public square.[89] According to the Pew Research Center,[90] American-born Muslims are more than twice as likely as their foreign-born counterparts to support greater political involvement from their mosques. The same Pew study also found that native-born Muslims are more likely than foreign-born Muslims to believe that American Muslims should adopt American customs.

Although one recent study[91] suggests that American-born Muslims experience similar difficulties as their foreign-born counterparts with integrating their religious and American identities, other research has found that young adult American Muslims are generally reporting less conflict in feeling both American and Muslim.[92] These identities, however, do not evolve seamlessly and cannot integrate all aspects of both tradition and modernity. Significant generational differences in cultural values persist,[93] and a study of American Muslims between 18 and 25 years of age found that many members of this group may feel that their parents' generation is out of touch with the cultural and social influences acting on American young adults.[94]

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Islam on Campus

According to Gallup[95] 59% of American Muslims ages 18 to 29 are full-time students. This is significantly above the national average of 48% for this age group. It is likely that college education is especially stressed by parents of American Muslims.[96] Many of these young adults, particularly those who are not African American, grow up in financially stable families, are the children of professionals, and are expected to attend college and develop professional careers for themselves.[97] Although African American Muslim parents may not place as much emphasis on college, there is nonetheless great diversity within the Muslim college population.[98]

Prior to the resumption of Muslim immigration to the United States about a half-century ago, there was very little evidence of a communal presence of Islam on American campuses.[99] With the creation of the first campus chapters of the Muslim Students Association (MSA) in the 1960s, student life for Muslims became more vibrant and organized. At present, most colleges have MSAs or similar organizations for Muslim students.[100] Post-9/11, these organizations have become increasingly active,[101] and even less religious Muslim students are becoming integrated into these campus communities.[102] At this time, several major universities and colleges, including all eight Ivy League schools, employ Muslim chaplains or student advisors. The United States Department of State[103] has reported an increasing need for Muslim college chaplains in the United States.

With mental health issues among college students reaching unprecedented levels, the many added stressors that Muslim students face raise significant concerns about the onset or exacerbation of emotional difficulties for this population.

Outreach by college administrators to Muslim students appears to be on the rise. The University of Michigan installed footbaths for Muslim students to more easily complete the ritual ablution needed before offering prayers, and Harvard University has arranged for women-only gym hours so that Muslim women and other like-minded female students might use campus facilities to exercise with the comfort of not being observed by men.[104] The first Muslim sorority was established in 2005.[105] However, at many colleges, Muslim students feel that their needs are not being met.[106] Over the past decade, there has been increasing demand for the establishment of colleges dedicated solely for Muslim students in the United States that cater to Islamic academic and religious customs.[107] The first of these, Zaytuna College, opened in California, in 2010.[108]

American Muslim college students continue to feel uneasy about discriminatory post-9/11 government policies and negative media messages about Muslims,[109] and are frustrated by the perceived lack of concern from political leaders on these issues.[110] Although Muslim students have become more active in university life, they continue to face challenges. Many Muslim students may feel uncomfortable being visibly Muslim on campus, such as by adhering to Islamic codes of dress or refraining from social behavior prohibited in Islam.[111] Post-9/11, some female Muslim students stopped wearing hijab because they feared becoming targets for harassment.[112] Muslim students who experience discrimination at their colleges are less likely to spend time with peers outside of their faith,[113] while Muslim groups on campus have themselves been targets for discrimination.[114] With mental health issues among college students reaching unprecedented levels,[115] the many added stressors that Muslim students face raise significant concerns about the onset or exacerbation of emotional difficulties for this population.

ISLAM AND MENTAL HEALTH

History

The verses of the *Quran*[c] and the sayings of Muhammad provided the initial Islamic perspective on issues pertaining to well-being and mental illness. The Quran extols the virtues of patience and prayer, and stresses the importance of both romantic and fraternal companionship in promoting comfort and security.[116] It instructs Muslims to turn to Allah in times of trouble for hope and solace, and, in a well-known Hadith,[d] Muhammad is quoted as saying that Allah has put on Earth treatments for all afflictions, with the exception of old age. This sense of optimism is accompanied by an emphasis on compassion; the Quran implores Muslims to feed, clothe, and speak graciously to the insane.

In some early verses of the Quran, the word *majnun*, meaning possessed by evil spirits (*jinn*), is used in reference to accusations made against Muhammad by his opponents who sought to discredit him.[117] In fact, Muhammad himself questioned his own sanity upon receiving the first revelations of the Quran, and famously ran to his wife, Khadijah, crying, "Cover me! Cover me!" When he had calmed down he received assurance from her that he was not insane and that she believed in him.[118] On the basis of both the Quran and, in particular the Hadith literature, classical Islamic jurists established the consensus that insane individuals are not responsible before society for their behavior, nor will Allah negatively judge them for actions committed while insane. Individuals deemed to have no control of their behavior were thus classified as similar to children in terms of their accountability for their conduct.[119]

American Muslims

Depression and anxiety may be two of the more common mental health issues faced by Muslims in the United States. Particularly since 9/11, *imams*[e] have noticed a spike in depression and anxiety among their congregants.[120] American Muslims' perceptions of being discriminated against in the post-9/11 United States may contribute to a rise in anxiety and vigilance.[121] It has also been suggested that post-9/11 stress and family issues might be among the most common emotional struggles faced by American Muslims.[122] Given Islam's prohibition of substance abuse, this affliction might be less common for Muslims than for other groups.[123] Somatization of emotional difficulties has been observed in Arab clients, the majority of whom are Muslim, by psychologists in greater numbers than would expected to be found in the general American population.[124]

Some American Muslims may be more open to receiving psychopharmacological services rather than participating in psychotherapy.[125] Muslims might fear that their counselors are likely to project Western values in the course of therapy and will lack familiarity with Islam.[126] Even though conventional approaches to counseling may fail to accommodate their spiritual needs,[127] American Muslims have been increasingly seeking therapy.[128] A 2006 study[129] that surveyed mosque-attending Muslims in the United States about their attitudes toward counseling found that

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c Quran: Central religious text of Islam, which Muslims believe to be a revelation from God.
d Hadith: A collection of traditions containing sayings of the prophet Muhammad that, with accounts of his daily practice (the Sunnah), constitute the major source of guidance for Muslims apart from the Quran.
e Imam: A Muslim prayer leader.

It is imperative that health care providers who treat Muslim minorities in the West try to understand and value their patients' religious commitments.

men were about twice as likely as women to have negative attitudes toward counseling, but that women were somewhat more likely to indicate the need for counseling. These attitudes were strongly correlated with actual utilization of psychological services.

A report published in 2007 reported that there is no current research on effective mental health treatments specific to American Muslims.[130] In general, therapists who work with Muslims must recognize that attitudes about mental health can vary greatly depending on the client's cultural background.[131] There may even be somewhat of a built-in negative bias toward Muslims in America in the field of health care; an analysis of health care journals found that articles that discuss Muslims often have concerning undertones that may lead their professional audiences to believe that Islam does not generally promote healthy living.[132] However, it is imperative that health care providers who treat Muslim minorities in the West try to understand and value their patients' religious commitments.[133]

It is important for non-Muslim counselors who work with Muslims to attempt to understand what their Islamic identity means for these patients.[134] A study of Muslims in Ohio found that more than two-thirds of participants would always turn to prayer in times of discomfort,[135] and a study of Muslims in Australia found that they were likely to turn to their religion in coping with stress.[136] It is also important for Muslims who meet with therapists to have a sense that they are working with someone who possesses similar values as they do.[137] For Muslim therapists, it might be worthwhile to attempt to integrate religious practices into treatment for their more religious Muslim clients.[138] Finally, because Islam forbids immodesty between unrelated members of the opposite sex,[139] Muslims may be more comfortable meeting with practitioners of the same sex.[140] Some Muslim women may prefer to have the door open if meeting with a male provider.[141]

Reaching out to American Muslims who would benefit from psychological services should be a priority because it may be unlikely that this population will be able or motivated to identify and make use of available treatment resources.

Reaching out to American Muslims who would benefit from psychological services should be a priority because it may be unlikely that this population will be able or motivated to identify and make use of available treatment resources. This is complicated by the fact that relatively few mental health care providers in the United States are Muslim. Dr. Ingrid Mattson, President of the Islamic Society of North America, was asked by Gallup,[142] "What is the most important thing Muslim Americans must do in the next 5 to 10 years?" She replied as follows:

> *Muslim Americans must focus on developing and supporting a professional class of Islamic 'practitioners,' working in well-functioning institutions. We must accelerate the training and placement in our community of Muslim counselors, chaplains, imams, youth leaders, Sunday School teachers, social workers, and others who understand basic Islamic ethics.*

Since 9/11, some American Muslims have turned to their religious leaders for counsel. A 2008 study of 22 imams and 102 worshippers at New York City mosques found that imams were often called upon to provide counseling despite a lack of formal mental health care training.[143] However, mosque-going Muslims may be hesitant to seek help from an imam who was foreign-born.[144]

Young Adult and Native-born American Muslims

Research on the intersection between religion and mental health for Muslims born in America and/or young adult Muslims is in its nascence. A 2008 study found that Muslim adolescents in the United States are inclined to use their religion to help them cope with stress in their lives.[145] One study[146] found that young adult American Muslims may have more negative attitudes toward counseling than middle-age and older American Muslims. That study did not query participants' country of birth, but the researcher did find that African American Muslims, who would be more likely than other Muslims in an adult sample to have been born in the United States, expressed the greatest reluctance to seeking formal mental health services. Participants' level of education was not found to be correlated with attitudes toward mental health. A 2004 study[147] found that American-born Muslims may be more likely than those born in other countries to seek formal mental health services, but this conclusion might be viewed with caution given that only 22 of the researcher's 281 study participants were born in the United States.

Research on Muslim college students in Kuwait has suggested a strong link between religiousness and happiness,[148] and a recent study supported by the Institute for Social Policy and Understanding[149] of American Muslims between ages 18 and 25 showed that religiousness was significantly correlated with character strengths such as hope, kindness, and gratitude. Furthermore, results from the Gallup survey[150] suggest that young adult American Muslims are much less likely to binge drink than their peers. Still, Muslim college students in America likely face more cultural stress than their classmates.[151] Female college students have reported discomfort in outwardly practicing Islam, such as by wearing the hijab, but they also share concerns common to other young women, such as struggling with body image and anticipating difficulties balancing a career and family.[152] Support groups for young Muslim women may be helpful in managing these stressors.[153]

Brief interviews conducted by the present author with American-born Muslim college students in 2008 revealed that this population may be inclined to believe that emotional stress is a test from God and that it is not necessarily reflective of a lack of faith.[154] Participants also expressed openness to use their religion to help them cope with psychological difficulties. However, it could not be concluded from the results of these interviews the extent to which American-born Muslim college students might be open to receiving formal mental health services. Regardless, it is likely that country of birth plays a role in the answer to that question, because a 1994 study found that for college students, the foremost demographic correlate of attitude toward and use of psychotherapy was whether or not the student was born in the United States.[155]

Female college students have reported discomfort in outwardly practicing Islam, such as by wearing the hijab, but they also share concerns common to other young women, such as struggling with body image and anticipating difficulties balancing a career and family.

Data

PARTICIPANTS AND MEASURES

Participants in this study included 184 American-born Muslims who at the time of data collection were undergraduates at colleges in the United States. They were principally recruited using the e-mail lists of Muslim student groups. All data collection occurred in 2011. Participants were asked to verify the following five criteria: *1*) that they identified as a Muslim, *2*) that they were born in the United States, *3*) that they lived in the United States, *4*) that they were currently an undergraduate college student, and *5*) that they were at least 18 years of age. See Appendix A for further information about the study methodology, including a more detailed discussion of participants, measures, and procedures. Applicable endnotes (156–169) have been inserted therein.

Participants were asked basic demographic questions on topics such as their gender, age, and ethnic background. They were also asked about available resources for Muslims at their school and about their experiences being Muslim on campus. They then completed the Attitudes Toward Seeking Professional Psychological Help (ATSPPH) assessment, which measures openness to seeking formal mental health services. This was followed by additional questions pertaining to treatment-seeking attitudes. The next section of the survey contained the Brief Arab Religious Coping Scale (BARCS), a questionnaire that measures religious coping. This was followed by the COPE inventory, which generally assesses coping styles. Religiosity was then measured by the Sahin-Francis Scale. Appendix B presents advanced statistical analysis of quantitative data. Participants were also asked about specific conditions they perceived to be present in their community and their understanding of the presence of treatment for those issues, and were then given a chance to write additional written comments on their experiences and perceptions.

DESCRIPTIVE STATISTICS

College Experience

In the sample, 177 of 184 participants (96%) reported the presence of some type of Muslim student group at their college. Also, 79 of 184 participants (43%) reported that their college employed either a Muslim chaplain or a student advisor who served specifically as a resource for Muslim students. When asked how often participants interacted with other Muslim students on campus, 19 replied rarely (10%), 51 replied sometimes (28%), and 114 replied often (62%). Participants were also asked how difficult it was for them to be a Muslim at their college with responses being not difficult (1) to very difficult (4). The mean score was 1.61, and 54% of participants selected not difficult.

Attitudes Toward Seeking Professional Psychological Help Assessment

Of the 184 participants, 130 completed the ATSPPH assessment. These 15 items, several of which are reverse-scored, present participants with a scale of 1 to 4 for their responses, with the maximum possible score being 60 and the minimum possible score being 15. Higher scores indicate greater receptiveness toward seeking formal mental health services. The mean total score in the present study was 40.72, with a standard deviation of 5.53 and a range of 25 to 54. The item that drew the strongest disagreement was "Family members should have the final say whether or not an individual seeks professional help for a psychological or mental health problem." Of the 130 respondents, 120 (92%) either disagreed or strongly disagreed with this statement. The inversely related stigma scale, which consists of five items scored in the same scoring format as the ATSPPH assessment with higher scores indicating higher levels of stigma, yielded a mean of 13.37, with a standard deviation of 2.63 and a range of 7 to 19. This scale had a theoretical range of 4 to 20.

Treatment-Seeking

Questions in this section pertained to participants' views of different types of treatment modalities and treatment providers, along with more general attitudes toward treatment-seeking and providers. These questions were answered by 130 participants. The answer format was identical to that used in the ATSPPH assessment. Results of attitudes toward treatment providers are listed in Table 1, and results of attitudes toward treatment modalities are listed in Table 2. Among the most salient findings, which will be further discussed, were that respondents expressed a preference for individual therapy and would prefer therapists who are multiculturally competent and/or who understand issues concerning young adults. There was no significant difference between freshmen (n = 29, *mean* = 3.52), sophomores, (n = 24, *mean* = 3.71), juniors (n = 34, *mean* = 3.56), and seniors (n = 43, *mean* = 3.56) in terms of their expressed preference for therapists who are in tune with the developmental issues faced by young adults.

Participants reported a preference for utilizing therapy before trying psychiatric medication (see Table 3). With regard to others knowing about them seeking formal mental health services, participants were somewhat more concerned about the judgments of their Muslim friends and family than the perceptions of their non-Muslim friends (see Table 4). Participants also voiced a desire for more Muslim mental health professionals and were concerned about the lack of familiarity with Islam within the field of mental health care (see Table 5). Finally, although participants were apt to use religious coping strategies, they saw little conflict between using both religious coping and formal mental health services (see Table 6).

Table 1: *Treatment Provider Preferences* (*n* = 130)

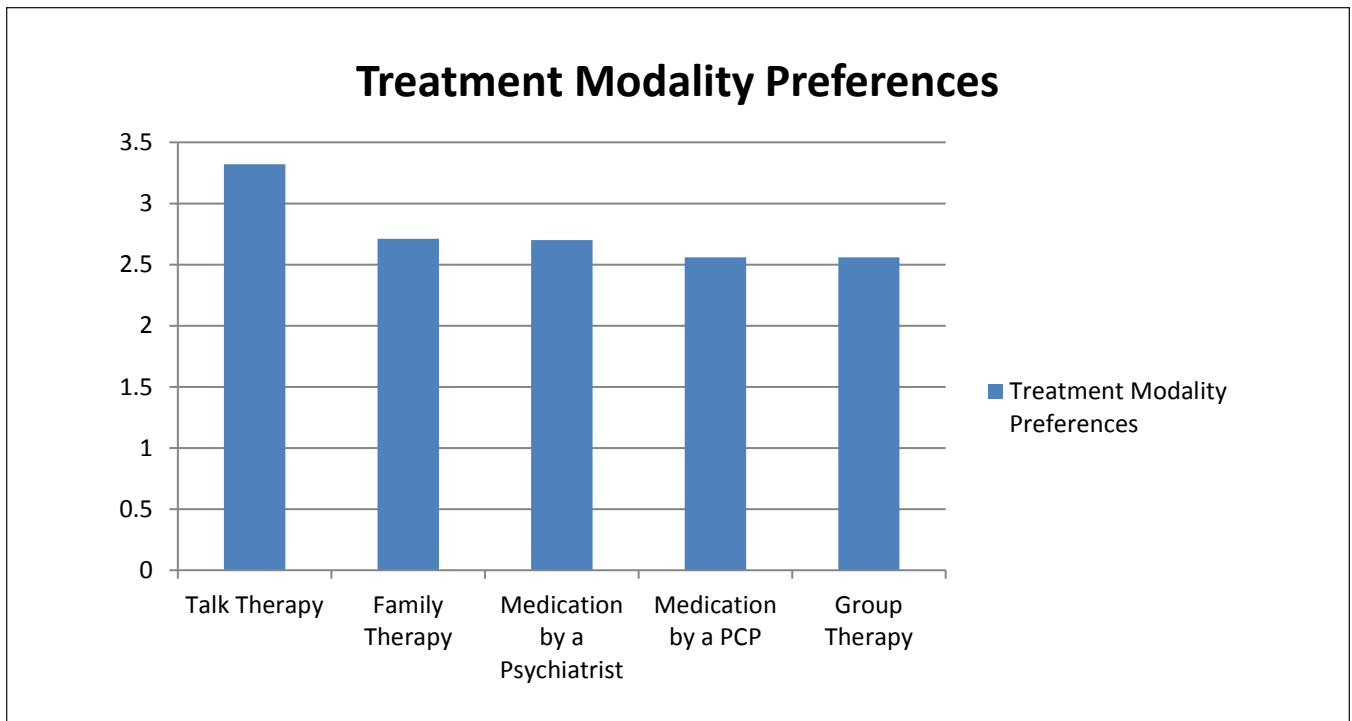| Item	Mean	Standard Deviation
If I were to see a therapist, it would be important that he or she be multiculturally competent, that is, who would have an orientation to treatment that involved interest in, respect for, and knowledge of different religions, cultures, and their values and practices, including my own.	3.61	0.60
If I were to see a therapist, it would be important that he or she have a good understanding of the issues that people of my age would be concerned with.	3.58	0.53
If I were to see a therapist, it would be important that he or she take an interest in my identity as a Muslim.	3.28	0.79
If I were to see a therapist, it would be important that he or she would be American-born or be someone who is clearly in touch with current American culture.	3.08	0.79
If I were to see a therapist, it would be important that he or she were to integrate my religious beliefs into treatment, such as helping or encouraging me to use the teachings and practices of my religion to improve my wellbeing.	3.04	0.90
If I were to see a therapist, it would be important that he or she would be the same gender as me.	2.89	0.97
If I decided to seek mental health or psychological help, I would rather contact Muslim professionals than professionals from other groups.	2.88	1.08
If I were to see a therapist, it would be important that he or she would be of the same ethnic background as me.	1.91	0.73
If I were to see a therapist, it would be important that he or she would be someone who is a friend or acquaintance of mine or my family.	1.58	0.66
1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree		

Also see the graph "Treatment Provider Preferences."
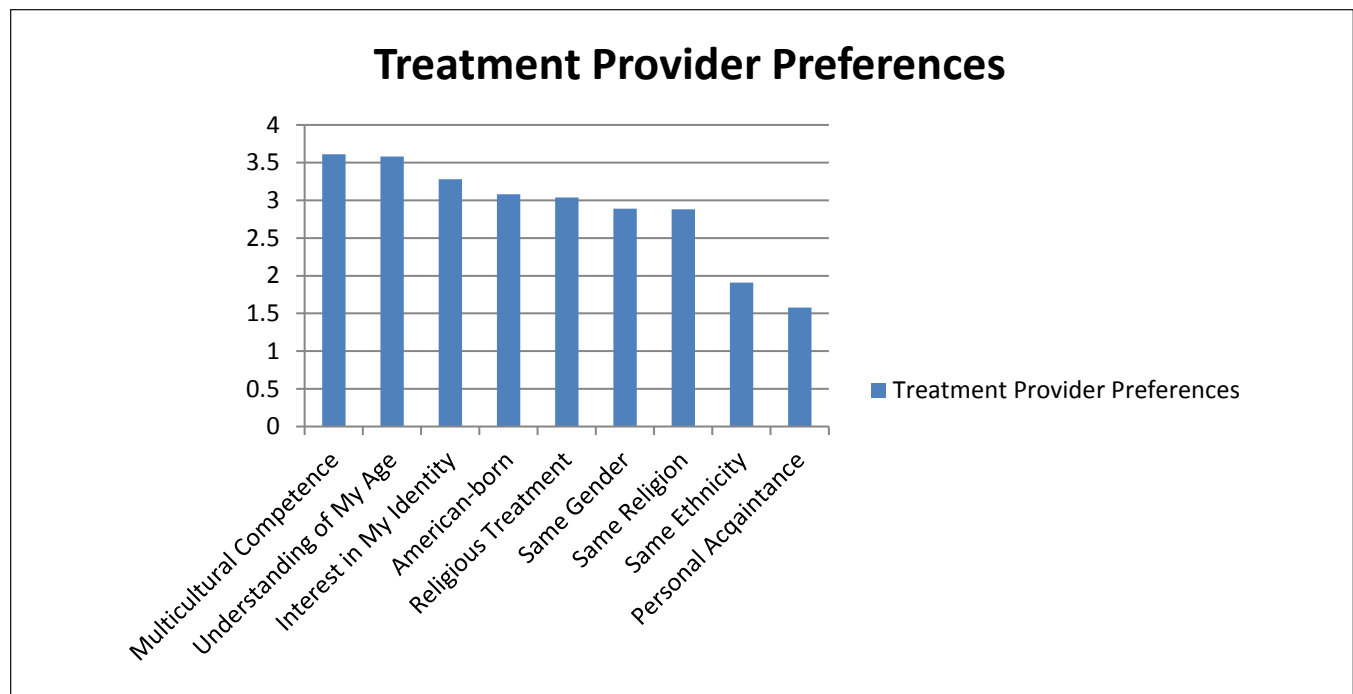
x-axis = preferences for the labeled characteristics in treatment providers
y-axis = level of agreement for category of preference, with higher numbers indicating greater levels of agreement

Table 2: *Treatment Modality Preferences* (*n* = 130)

Item	Mean	Standard Deviation
I would be open to receiving individual (one-on-one) psychotherapy (e.g., "talk therapy," counseling) from a professional therapist if I felt that I needed it.	3.32	0.61
I would be open to participating in family therapy if I felt that there was significant conflict within my family.	2.71	0.92
I would be open to seeing a psychiatrist who could prescribe appropriate psychiatric medications (e.g., anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents) if I felt that I needed it.	2.70	0.78
I would be open to seeing a general medical practitioner who could prescribe appropriate psychiatric medications (e.g., anti-depressants, anti-psychotics, mood stabilizers, anti-anxiety agents) if I felt that I needed it.	2.56	0.84
I would be open to participating in group therapy (e.g., "talk therapy" in a group setting guided by a group therapist) if I felt that I needed it.	2.56	0.88
1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree		

Also see chart "Treatment Modality Preferences."

x-axis = preferences for the labeled modalities of treatment
y-axis = level of agreement for category of preference, with higher numbers indicating greater levels of agreement

Table 3: *Medication versus Therapy* (*n* = 130)

Item	Mean	Standard Deviation
I would rather try therapy before trying psychiatric medications.	3.48	0.70
I would rather try psychiatric medications before trying therapy.	1.50	0.66
1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree		

Table 4: *Worry about Others' Perceptions* (*n* = 130)

Item	Mean	Standard Deviation
If I sought professional mental health treatment, I worry about what my Muslim friends or acquaintances would think if they knew.	2.52	0.88
If I sought professional mental health treatment, I worry about what my family would think if they knew.	2.48	0.88
If I sought professional mental health treatment, I worry about what my non-Muslim friends or acquaintances would think if they knew.	2.14	0.87
1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree		

Table 5: *Islam and Treatment Providers* (*n* = 130)

Item	Mean	Standard Deviation
I believe that there is a need for more Muslim mental health professionals.	3.45	0.74
I believe that most mental health professionals have a good enough understanding of Islam.	1.78	0.56
1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree		

Table 6: *Religious Coping and Formal Mental Health Services* (*n* = 130)

Item	Mean	Standard Deviation
I see no conflict between using religious coping and using professional mental health services.	3.23	0.75
If I had a mental health problem, I would use my religion to help solve it before seeking professional services.	3.01	0.83
1 = strongly disagree 2 = disagree 3 = agree 4 = strongly agree		

Brief Arab Religious Coping Scale

One-hundred thirty participants completed the BARCS. Its 15 items are scored in a zero through format, with a minimum possible score of 0 and a maximum possible score of 45. For the present study, the mean for the BARCS was 23.92, with a standard deviation of 9.04 and a range of 2 to 45. There was considerable within-group difference in the distribution of scores. Its most strongly endorsed item was "I asked God/Allah for a blessing" (*mean* = 2.34). The least endorsed item was "I got help from religious leaders," which had a mean of 0.71.

COPE

The adapted version of the COPE used in the present study, which has a 1 through 4 scoring response format, was completed by 123 participants. The highest possible total score on this version of the COPE is 136 and the lowest possible total score is 34. In the present study, the COPE yielded a total scale mean of 83.84, with a standard deviation of 10.95 and a range of 53 to 105. The most endorsed item was "I learn something from the experience" (3.37), and the least endorsed items were "I try to lose myself for a while by drinking alcohol or taking drugs" and "I drink alcohol or take drugs, in order to think about it less"; both items had means of 1.09. The COPE contains four subscales: Avoidance Coping, Active Coping, Emotion and Social Focused Coping, and Turning to Religion. Descriptive statistics pertaining to these scales are presented in Table 7.

Table 7. *Descriptive Statistics for COPE Subscales* (*n* = 123)

Scale	Number of Items	Mean per Item	Overall Mean	SD	Highest Score	Lowest Score
Avoidance coping	12	1.49	17.90	4.44	37	12
Active coping	10	3.02	30.24	5.98	40	15
Emotional and social-focused coping	8	2.85	22.81	5.84	32	11
Turning to religion	4	3.32	12.89	3.30	16	4
COPE totals	34	2.47	83.84	10.95	105	53
1 = I usually don't do this at all. 2 = I usually do this a little bit. 3 = I usually do this a medium amount. 4 = I usually do this a lot.						

Also see the chart "COPE Subscales (Mean per item)".

COPE Subscales (Mean per item)
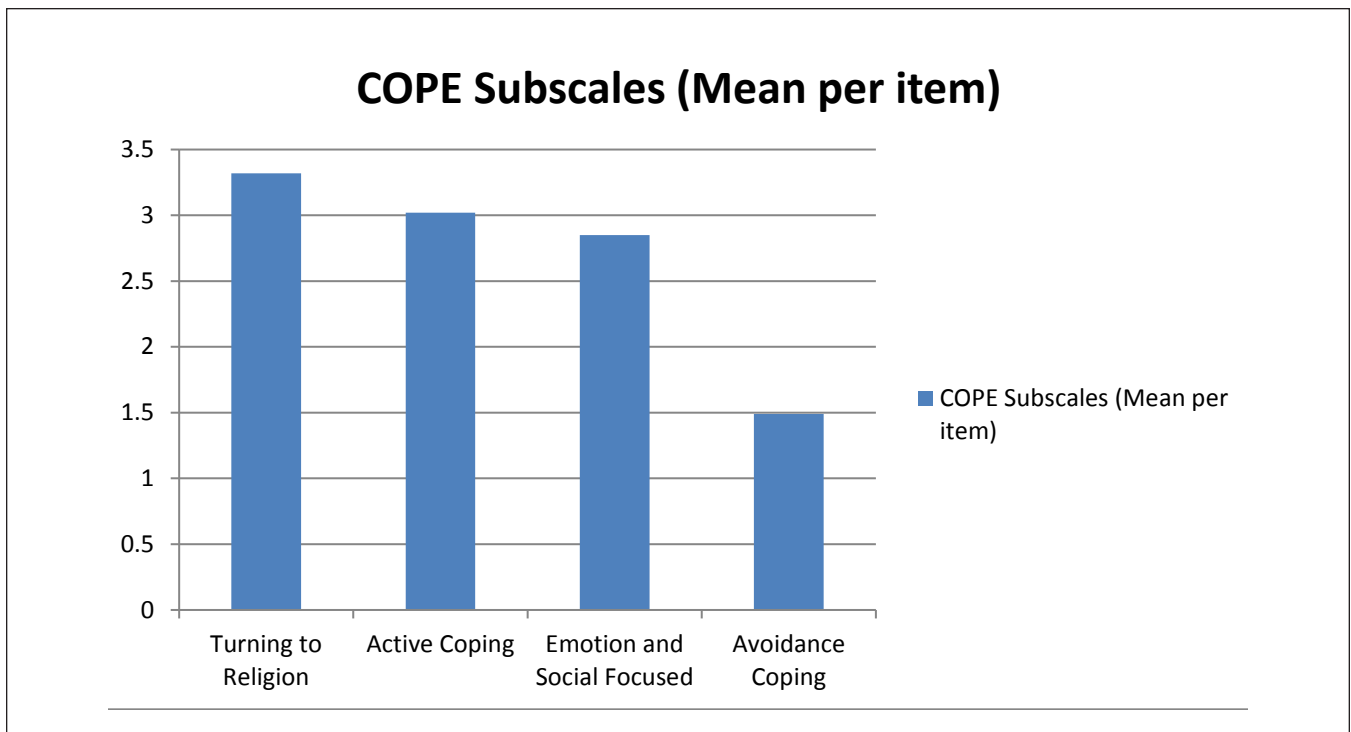
x-axis = categories of coping styles
y-axis = frequency of utilizing coping style, with higher numbers indicating greater levels of utilization

Sahin-Francis Scale

One-hundred twenty participants completed the Sahin-Francis Scale. Its 23 items are scored in a 1 through 5 format, with a minimum possible score of 23 and a maximum possible score of 115. For the present study, the mean for the Sahin-Francis Scale was 100.87, with a standard deviation of 13.27 and a range of 38 to 115. Its most strongly endorsed item, with a mean of 4.79, was "I believe that Allah/God helps people." Its least endorsed item was "I feel that I am very close to Allah/God," with a mean of 3.55, which, however, fell above the mid-point of the scoring scale.

Symptoms and Services

Participants were asked about their perceptions of mental illness and major stressors in the young adult American-born Muslim community. These participants (*n* = 119) were asked about eight specific challenges; namely: *1*) stress, *2*) social pressures, *3*) family conflict, *4*) anxiety, *5*) depression, *6*) substance abuse, *7*) eating disorders, and *8*) psychosis. Descriptions of each of these issues were provided on the survey, and each item was worded such that the condition or stressor described was of clinical significance. Participants were asked whether they had young adult American-born Muslims friends and/or family who suffered from these particular conditions or stressors over the past year and whether those individuals received professional treatment over the past year. They were also asked how common they believed those conditions or stressors to be among their community relative to the general population, with response options being Less common (1), About as common (2), and More common (3). Table 8 lists the results of this series of questions.

Table 8. *Presence of Mental Illness and Major Stressors Perceived among Young Adult American-born Muslims (n = 119)*

| Item	Perceived presence in peers: percentage of "Yes" responses	Knowledge of peers' treatment: percentage of "Yes" responses	Perception of how common relative to other communities
Social pressures	89.92%	12.61%	2.55
Stress	84.87%	23.53%	2.25
Family conflict	83.19%	10.08%	2.11
Anxiety	63.87%	20.17%	1.99
Depression	57.98%	31.09%	1.87
Substance abuse	36.97%	5.88%	1.35
Eating disorders	15.13%	3.36%	1.38
Psychosis	10.92%	8.40%	1.50
Total	99.16%	50.42%	1.87
1 = Less common 2 = About as common 3 = More common			

Also see the charts "Perceived Presence in Peers (Percentage of "Yes" Responses)," "Knowledge of Peers' Treatment (Percentage of "Yes" Responses)," and "How Common Relative to Other Communities."
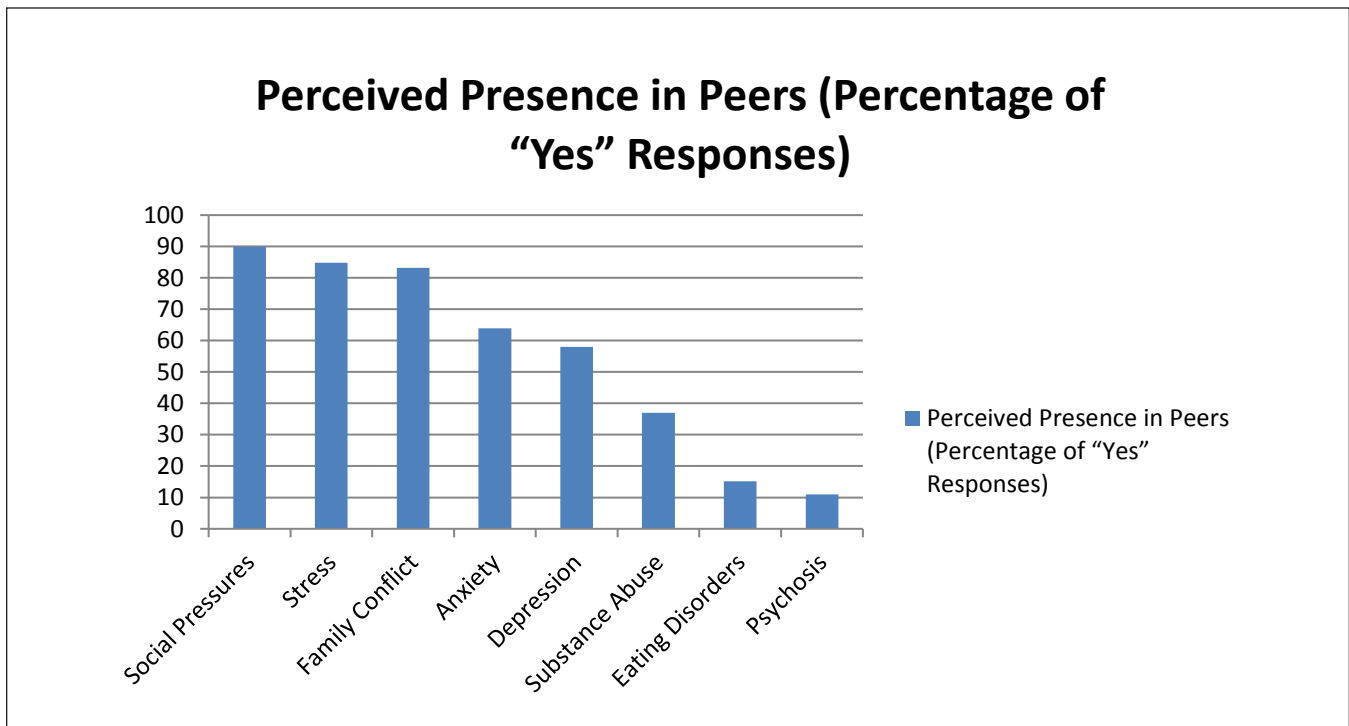
x-axis = category of mental illness or distress
y-axis = percentage of "yes" responses to questions about perception of categories' presence in peers

Knowledge of Peers' Treatment (Percentage of "Yes" Responses)
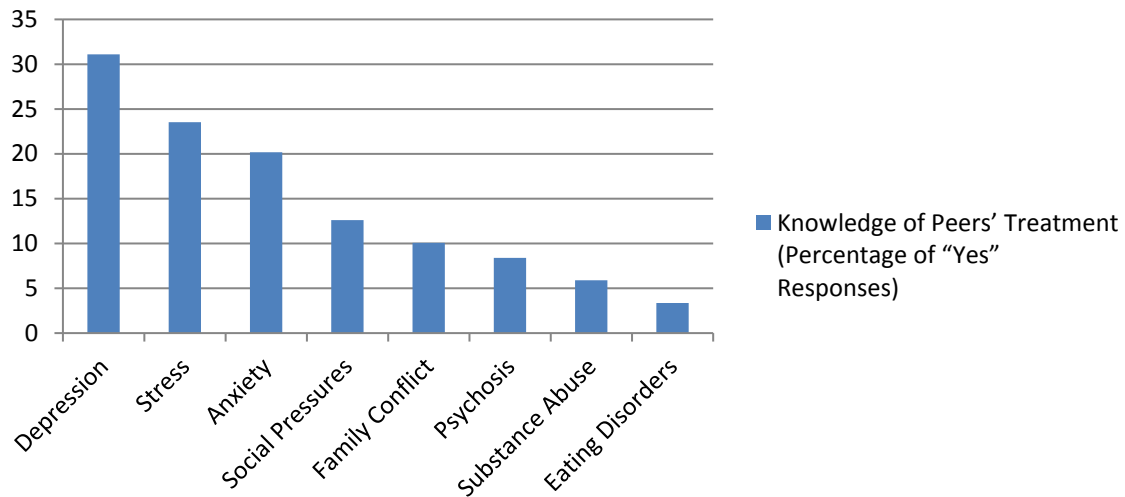
x-axis = category of mental illness or distress
y-axis = percentage of "yes" responses to questions about perception of categories' treatment in peers
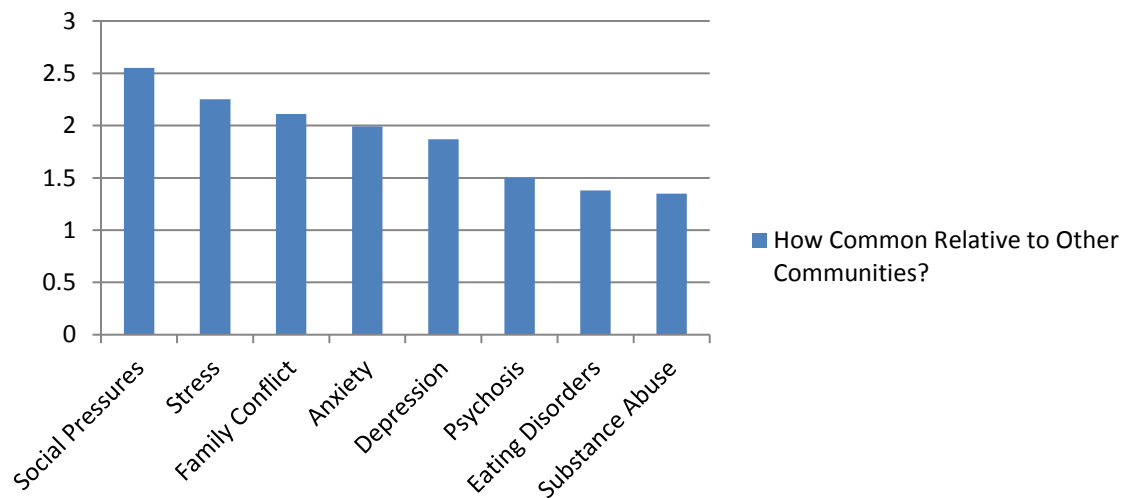
How Common Relative to Other Communities?

x-axis = category of mental illness or distress
y-axis = commonness of category compared to other communities, with higher numbers indicating greater presence

Participants were then asked whether there were any conditions of concern facing their community other than the eight listed, and were given the option to write brief responses. Fifteen participants provided responses, some of whom identified more than one issue of concern. This author performed a brief content analysis to simplify these responses into eight categories. The most represented were "pressure from family," which was mentioned by five participants, "sense of disempowerment," which was mentioned by four participants, and "community stigma toward mental health and/or lack of understanding within community," which was mentioned by three participants. Additionally, the following categories were each mentioned by at least two participants: "gender relations," "pornography and/or masturbation," "identity formation," and "physical and/or sexual abuse." Finally, one participant mentioned concerns that were categorized by this author as "discrimination."

Participants were then asked whether they had ever received formal mental health services. Of 119 participants, 23 reported having received formal mental health services at any time in the past (20 women, 3 men). They were then asked to select the type of provider from whom they received services. Participants were given the option of selecting more than one type of provider. They were also allowed to write in additional past treatment providers who were not listed as options on the survey, which two participants chose to do. Seventeen participants reported having received individual psychotherapy. Eight reported receiving individual treatment from a psychiatrist, and seven reported having received psychological care from their general medical practitioner. Two participants reported having been in group therapy, and two participants reported having participated in family therapy. Finally, one participant reported receiving counseling from an academic advisor, and one participant reported participation in meditation classes as a means of receiving professional care.

QUALITATIVE DATA

To better understand challenges facing the young adult American-born Muslim community, participants were given the option of providing additional written comments about the difficulties they have encountered and how they have been personally affected. Seventy of the 184 participants (38%) provided responses to the following question:

> Some American-born Muslims have reported difficulty with completely embracing their religious and/or cultural identities in modern Western society. These types of issues cover many topics, including social pressures, relationships with family, being in mixed-gender environments, feeling misunderstood by others, experiencing discrimination, feeling uncomfortable being outwardly Muslim (e.g., wearing hijab, praying in public, etc.), issues related to dating and marriage, educational and career decisions, and many other topics. If you wish to do so, please use this space to state whether or not these issues have impacted you personally and, if so, which particular issues have affected you and how your emotional wellbeing has been impacted.

This author conducted a content analysis of these responses and found that they typically fell into one of five categories: gender relations, balancing different identities, discrimination, intergenerational conflict, and feeling misunderstood.

Some participants' responses touched on many different subjects, including more than one of the categories discussed below.

Gender Relations

Difficulties with issues relating to gender relations were reported by both men and women, and tended to be expressed in terms of the struggle to reconcile Islam's emphasis on modest behavior between men and women with the American societal norm of dating. These concerns were raised by 43% of respondents. Some respondents wrote about how Islamic norms can complicate the process of finding someone to marry in American society, whereas others focused on the trials of navigating mixed-gender social situations. A second-generation female from a South Asian background who is a junior in college wrote:

> The biggest social pressure for me has been dating. I've never had a problem with turning down drugs and alcohol, but my weakness has been staying strong in the romantic aspect of life. I have made mistakes when I was younger that still impact me today, in the sense that I regret some decisions, and have gone through periods of minor depression. It has taken a lot to come to terms with the past, learn from mistakes, and pray for forgiveness. Allah is the Most-Merciful, after all.

Another second-generation woman from a South Asian background, a senior in college, expressed concern about the lack of community support and understanding related to these issues:

> Romantic relationships are very difficult for my American-born Muslim friends because it is unchartered territory. We have no advice, no good role models, and very few people to receive advice from because it is such a taboo topic. Many of my friends have undergone a lot of depression due to romantic feelings/relationships. I believe that because Muslim communities and families are less likely to accept and talk about romance, American-born Muslims often feel like they have to carry the burden of how they feel by themselves. We are not wise enough to handle this burden by ourselves.

For some young adult American-born Muslims, struggling with the issue of gender relations has had emotional consequences. A second-generation South Asian woman who is a freshman recounted:

> I ended up kind of dating a boy in my junior year of high school without telling my parents but that led to a lot of identity crises and hiding from myself and lying and I think I was very depressed. I hated my life, I used to think about death a lot and cry all the time and just always be fighting something. But now I don't really worry about it and I just focus on the things that I am meant to do, following my passions and helping people and I guess I've got bigger goals now.

Balancing Different Identities

Another theme that appeared in some of the responses was a sense of unease in balancing American and Muslim identities. These concerns were raised by 21% of respondents. One participant wrote about the difficulty of reconciling

his identity as an American with his discomfort with an American foreign policy that sometimes leads to the disenfranchisement of Muslims in other countries. Participants most notably indicated that it was difficult for them to balance their different identities in the social sphere, such as this second-generation South Asian woman, who is a college sophomore:

> I feel like how Muslim I am is dictated by who I hang around with, and it is really frustrating that I can't explore what being Muslim means to me because I have to find a balance between being around my friends from my MSA [Muslim Students Association] and my best friends that are not Muslim. Sometimes I feel like my friends who are not Muslim can be unsupportive of my actions because it will limit what they can try. We can't go into a bar together or go dancing. I can't wear shorts to the beach or date guys. However, they are respecting of my decision and understand that it is what I want to do, so even though they might resent it somewhat, they realize that it is my personal choice. However, around Muslims it's a whole other story. They might not pressure me into going to bars and to go crazy on spring break, but when they want to do something that I don't feel comfortable with due to the values I have, I cannot tell them that I don't want to do it with them because it hurts for someone to call you out on not being a good enough Muslim.

Discrimination

Some respondents (20%) reported feeling that others had discriminated against them or that they might be judged negatively because of their faith. Many participants spoke of subtle discrimination, such as a respondent who wrote that other people view him suspiciously and ask him incredulously where he is from, to which he replies, "Michigan." However, some experiences of discrimination have been more overt. A second-generation South Asian woman, a college senior, provided this story:

> When 9/11 happened, I was living in central Texas, and my family was the only Muslim family within a one-hour radius along with being one of the very few minority families in that same radius. Before 9/11, no one cared where I was from or what religion I followed. But after 9/11, I was asked the stupidest questions by classmates that I had known for years. They would ask if I knew where Saddam Hussein or Osama [bin Laden] were hiding, if I was related to them, and I heard other students say that they wish they could take a machine gun and shoot all the Muslims. The mother of my best friend at the time also told her daughter not to accept any food/sweets from me (this was right after the anthrax scare). Also some men came by my house and threatened my father with a gun and said that we needed to leave the town. So all this made a huge impact. I was already shy; this just made me even more shy and also embarrassed of who I was. I was scared to speak anything besides English outside and to admit my religion. If my relatives came to visit, I was much more hesitant to go outside with them since some of them wore scarves and some of the men had beards. However, we moved after a year. Even today, if I am outside with anyone who is outwardly Muslim in their appearance, I know other people are looking at us and I wonder what they think of us. However, I am not embarrassed or

Many participants spoke of subtle discrimination, such as a respondent who wrote that other people view him suspiciously and ask him incredulously where he is from, to which he replies, "Michigan."

afraid anymore. Especially in this diverse area [college], I am much more comfortable and proud of who I am.

Some participants mentioned fears of being viewed negatively by others because they dress according to religious customs. For example, an African American woman who is a junior in college voiced concerns about others' judgments of her as a female Muslim:

I can sense when people are discomforted by my appearance, being a *hijabi*[f] and all, and this causes me great concern and worry. I'm not sure where this weight on my shoulders comes from but it affects my emotional well-being at times. It's hard being a Muslimah [female Muslim] in this society, especially when since childhood it's been engraved in my mind that I'm equal to my [non-Muslim] counterparts when in reality I'm not. I'm anything but.

Intergenerational Conflict

"My mother is somewhat scared/ paranoid about discrimination against Muslims, so she doesn't like when I do overtly Muslim things."

Some participants noted that it can be disconcerting when parents do not understand the attitudes and behaviors of their young adult sons and daughters. This concern was raised by 27% of respondents. One respondent wrote about the distress she felt when her parents did not want her to begin wearing the hijab. In discussing various social pressures, another second-generation participant lamented, "Parents don't know that things are different [here] than where they were born." A male college sophomore, a second-generation American from a South Asian background responded:

I have adopted a more conservative interpretation of Islam than my family. While they are supportive, occasionally we get into arguments about some stuff, like when I don't want to buy a silk tie [In Islam, as a matter of modesty, men are not allowed to wear silk]. In addition, my mother is somewhat scared/paranoid about discrimination against Muslims, so she doesn't like when I do overtly Muslim things.

A college senior woman from an Arab background, a second-generation American, noted that these differences can extend into the realm of attitudes toward mental health:

I feel like many of our issues are overlooked by our parents who grew up in a different background. Their culture is different than ours and this causes problems for the youth. Also, many youth are confused because the way they learn about their religion is incorrect causing them to dislike it or find it too difficult to follow. Also, as far as I am concerned, it is taboo to be speaking about mental/psychological issues in the Arab/Muslim community and only recently, with the new generations, are we starting to change and progress, and accepting the fact that ALL people have the same issues regardless of religion or race. Still, some people stay more conservative to their cultural beliefs and avoid seeing professional help or taking their family members to professionals.

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f   Hijabi: A term used to describe a woman who wears a head scarf.

Feeling Misunderstood

Finally, respondents' comments indicated that many of them feel that others do not understand or appreciate the role that being a Muslim plays in their lives. These concerns were reported by 17% of participants. A white, female college senior and convert to Islam wrote:

> Some people cannot understand why I would want to be Muslim because it supposedly gives me second-class status as a woman. The reality is I actually feel more empowered as a Muslim woman than I did before I became Muslim. Also, people of course make ignorant impassioned comments about Arabs in general. I'm not Arab, but most people don't distinguish Arabs from Muslims. For the most part, the public is fine with me being Muslim but many people do take issue with it.

Similar concerns were mentioned by another white, female, junior college student and a convert to Islam:

> I have found that many Americans have difficulty understanding Islam, or have been exposed to biased/incorrect information about the religion. This is very disheartening to me. I try to be patient and explain each point that the other person does not understand. It's upsetting that the American media promotes such a distorted picture of a peaceful religion, and I very much try to correct misinformation when I'm exposed to it.

A male, second-generation American junior from a South Asian background stated that his fears about others' judgments have influenced his behavior and sense of self-worth:

> I am shy to pray in public because I do not want to feel like an outsider. It makes me feel bad about myself and makes me think I am a bad Muslim. I do feel that a lot of the time people don't quite understand my religion.

A female, second-generation American woman from a mixed-race background (white, black, Native American, and Arab) suggests that this lack of understanding from outsiders should lead young adult Muslim women to seek understanding and support from each other:

> I feel like there is a lot of pressure for young Muslim women to be 'perfect' and when those levels of perfection are not met (regarding social behavior, academic achievement, religiosity, etc.) there is a huge let down. She may feel isolated and it can be difficult to find a good group of women to talk to. I think *halaqas*[g] that have connections to professional help led by Muslims is extremely important. This way we have safe environments to discuss our problems and we can solve them with our *deen*[h] but also have any necessary help.

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g Halaqa: A religious study circle.
h Deen: Religion or Faith.

Findings

EMOTIONAL WELL-BEING

Presence of Mental Illness and Major Stressors

This study affirmed concerns raised by Gallup's survey,[170] which found that young adult American Muslims may be especially prone to difficulties in their emotional well-being. In the present study, participants were asked about their perceptions of the presence of different categories of mental illness and related concerns in their community. These specific emotional conditions and stressors were described with wording that clearly identified them as meeting criteria for clinical impairment. Furthermore, to control against over-endorsement, participants were asked to only report knowledge of these issues for their young adult American-born Muslim friends and/or family, and only for the presence of these afflictions in the past year. Despite these specifications, all but 1 of the 119 participants who completed this set of questions endorsed the presence of some type of mental illness or major stressor in their community.

With the presence of mental illness and significant stressors in the study sample's community established, it becomes important to understand the extent to which different conditions and stressors were represented. Social pressures, stress, and family conflict were all perceived at high levels in the sample. Additional statistical analysis revealed high correlations between perceived stress, anxiety, and depression, which suggested that participants may have viewed these issues as a broad constellation of symptoms belonging to a more wide-ranging construct, such as general distress. Despite the fact that family conflict was reported in the study sample's Muslim communities, participants seemed lukewarm to the idea of family therapy. Consistent with the Islamic prohibition on drug and alcohol use, participants perceived that substance abuse was much less common in their community than in others.

Psychosocial Stressors

Given the perceived stress, family conflict, and social pressures among the young adult American-born Muslim community, it was helpful that participants were able to contribute personal stories of these experiences. Some respondents felt that many people outside of the young adult American-born Muslim community, ranging from members of the dominant culture to their own parents, struggle to understand them. A recent study[171] suggested that young adult American Muslims may be frustrated by their parents' lack of understanding of the cultural influences and stressors that go along with being an American-born Muslim, and the present study echoed those concerns.

In their comments, participants also expressed concern that non-Muslims might be judgmental toward them or, even worse, might discriminate against them. This is consistent with a 2008 study,[172] which found that 88% of young adult

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American Muslims have encountered some type of hardship because of their religious background. While discrimination toward Muslims in the United States is sometimes blatant, it was not unusual for participants to report more subtle forms of insensitivity, such as when they are suspiciously asked, "Where are you from?" Derald Wing Sue,[173] a prominent researcher on topics of multicultural psychology, refers to these occasions as microaggressions. He notes that these experiences have become commonplace for many minority groups, invalidating their presence and identity in the United States, and that an accumulation of microaggressions is detrimental to one's emotional well-being.

Being Muslim at College

Although it has been suggested[174] that being outwardly Muslim on campus might be disconcerting for more religious Muslims, the present study found no correlation between religiousness and difficulty being Muslim at college. It was the case, however, that more religious Muslims were more likely to more frequently interact with fellow Muslims students, and participants who reported frequent interaction with other Muslims on campus also tended to report higher levels of comfort with being a Muslim at college. As such, it may be that the key for religious Muslims to feel comfortable on campus is to not self-isolate. No relationship was found between religiousness and gender, generational status, and whether or not participants were converts to Islam. The Muslim faith seems to override discrete characteristics, including demographic categories.

Despite post-9/11 reports[175] that female Muslim students were removing their head coverings in public for fear of discrimination on campus, the present study's finding suggested that gender and difficulty being Muslim at college are unrelated; it may be that these concerns were only especially heightened in the immediate post-9/11 period. Finally, one of the more notable findings was that there was a significant positive relationship between comfort being a Muslim at college and the presence of a Muslim college chaplain.

ATTITUDES TOWARD TREATMENT

Help-Seeking

The participants who had received formal mental health services expressed more positive help-seeking attitudes than those who had not. Also, participants who expressed a greater openness to utilizing different coping methods expressed a greater willingness to seek professional help. However, general openness to help-seeking was not associated with any of the other major variables to which it was related. Religiousness, gender, ethnic background, generational status, and openness to religious coping all evidenced no connection to help-seeking attitudes. There was a strong positive correlation between religiousness and religious coping, but the lack of any correlation found between religiousness and help-seeking was unexpected. Therefore, even highly religious Muslims in this community who are apt to utilize religious coping strategies showed similar levels of willingness to seek professional help as young adult American Muslims who are less religious.

The lack of association between gender and help-seeking attitudes for the present study is in direct contrast to the results of a study[176] of mosque-going American Muslims published in 2006, in which woman expressed a much greater

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willingness to seek formal mental health services than did men. Furthermore, for the present study, both the overall sample and the Arab subsample indicated a greater willingness to seek professional help than did a 2004 study[177] of Arab Muslims in the United States. One major difference between the present study and those by the aforementioned 2004 and 2006 studies is that all of the participants in the present study were American-born. Thus in addition to possible generation differences, it may be that being born and raised in America is the principal driver of this sample's willingness to seek mental health services. Indeed, individuals in minority groups who have experienced more acculturation in American society are more likely to seek professional mental health services.[178]

This finding would be consistent with the results of a 1994 study[179] of college students that found that although religiousness was not associated with help-seeking attitudes, the foremost predictor of openness to seeking professional help was whether participants were born in the United States. The present study appears to suggest also that for young adult American-born Muslims, openness to seeking help is not generally hindered by personal background, orientation to religion, or proclivity to use religious coping strategies. Therefore, to best understand how to meet the needs of this community, it is necessary to focus on participants' preferences for specific qualities in providers and for treatment modalities.

Treatment Providers

Participants expressed a strong preference for multiculturally competent providers. In the survey, multiculturally competent providers were defined as individuals "who would have an orientation to treatment that involved interest in, respect for, and knowledge of different religions, cultures, and their values and practices, including my [the participant's] own." Participants also expressed a strong preference for providers who were in touch with American culture and who were attuned to issues faced by young adults. Most participants—particularly those who were more religious and more likely to use religious coping strategies—preferred providers who would take an interest in their Muslim identity and who could integrate their religious beliefs into treatment. It may be that Muslim and multiculturally competent treatment providers, Muslim chaplains, and imams trained in mental health care can play an important role in meeting this need.

The sample as a whole did not express a preference for providers of the same ethnic background; this result was also found in a meta-analysis on multicultural treatment.[180] The participants in the present sample were not especially interested in meeting with providers who were friends or acquaintances of their families. Participants did, however, express a significant preference for seeking care from a Muslim provider. Still, it is unlikely that those providers are present or accessible; 92% of participants stated that there is a need for more Muslim mental health professionals. Participants were also generally in agreement that most mental health professionals lacked a solid understanding of Islam. This is a critical deficit, because a therapeutic alliance is strongly correlated with positive treatment outcomes,[181] and minority populations may feel the need to develop bonds, goals, and treatment processes with providers to whom they feel they can personally relate.

Women were more likely than men to prefer treatment providers of the same sex. Given the observance of gender roles in Muslim societies and the proscription

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of heterosexual closeness outside of marriage, this finding might be consistent with Muslim customs. Although women were more likely than men to express a preference for providers of the same ethnicity, only 17% of them suggested that this would be important.

In summary, these young adult American-born Muslim participants wished that there were more Muslim mental health professionals, but in the absence of this they might remain open to seeking help and are looking for specific personal attributes in treatment providers. A point to keep in mind is that given the participants' belief that most mental health providers lack a good understanding of Islam, it might be difficult for them to receive treatment from a provider possessing the one proficiency that this population values most—multicultural competence, which includes knowledge and understanding of client cultures/worldview and intersecting identities, in addition to cultural awareness/sensitivity, and skills.[182] Nonetheless, the present study has evidenced that Muslim youth would be interested in receiving care from providers who can at least appreciate and be sensitive to their identity as a Muslim and who are familiar with American culture and with issues of young adults in their developmental interface with the dominant culture.

Treatment Modalities

Participants reported a strong preference for individual therapy. This option was endorsed at much higher levels than group therapy, family therapy, or medication management from a psychiatrist or primary care physician. This finding again counters the results of a 2004 study[183] of a predominantly foreign-born sample of American Muslims, which found that the greatest preference for a provider of formal mental health services was for a general medical practitioner. In the present study, 92% of participants said they would prefer to try therapy before taking psychiatric medication. Nonetheless, 72% of participants in the present study were open to taking psychiatric medication if they felt it was needed.

ATTITUDES TOWARD COPING

Coping Style

Results from the present study indicated that young adult American-born Muslims are likely to possess flexible coping styles. In addition to using intrinsic religious coping strategies, participants were likely to use other people as resources and to proactively address the stressors in their lives. Participants were generally unlikely to report an avoidant coping style, such as trying to numb themselves with drugs and alcohol, or resigning themselves to the situation at hand. As would be expected, these more avoidant coping strategies were negatively correlated with those that were more proactive, and different types of proactive coping strategies were highly correlated with each other.

In the present study, people of South Asian ancestry were the most represented ethnic group. Additionally, women far outnumbered men, and the majority of participants were second-generation Americans. It is therefore instructive to examine some of the literature on South Asian women and their coping styles. Traditional Asian values tend to produce more avoidant coping styles, and this may especially be the case for women.[184] However, it is not unusual for coping strategies of women from India to vary on the basis of generational status,[185]

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and it has been suggested[186] that second-generation women of Indian ancestry may be likely to use more active coping strategies than their parents. The present study appears to confirm previous hypotheses and findings about Indian women, and this represents another instance in which generational status and being American-born may have a significant effect on the attitudes of young adult American-born Muslims. Furthermore, gender and ethnic background in the present study did not appear to predict participants' coping styles.

Religious Coping

Results suggested that participants who possessed a combination of positive help-seeking attitudes, flexible and general coping styles, and religiousness were likely to engage in religious coping.

Participants were likely to report using intrinsic religious coping strategies such as turning to prayer. Certain extrinsic strategies, such as spending time with one's faith group, were reported to be used sometimes but much less so than intrinsic strategies. Whereas religiousness and religious coping were highly correlated, it was also the case that religious coping was strongly correlated with a general openness to use many different types of coping strategies. Results suggested that participants who possessed a combination of positive help-seeking attitudes, flexible and general coping styles, and religiousness were likely to engage in religious coping. Although participants generally reported a preference for using religious coping strategies before seeking formal mental health services, 87% of them reported seeing no conflict between using religious coping strategies and professional mental health services. This finding concurs with results from interviews conducted by the present author[187] with American-born Muslim college students who reported not seeing mental illness from a solely religious perspective. There was no relationship found in the present study between the variables of gender and religious coping.

Limitations and Recommendations

LIMITATIONS

Indirect Epidemiological Data

A major limitation of the present study was that it used an indirect approach to gathering data about the presence of mental illness and significant stressors in the young adult American-born Muslim community. Instead of asking participants to report on their own mental health issues, they were asked about their knowledge of the experiences of similar individuals and about their perceptions of their community as a whole. Because of this, epidemiological data were not truly collected; additionally, participants' perceptions are not as valuable as reports of what they know to be true for themselves.

Furthermore, because the American Muslim community is tightly knit, it may have been the case that participants' knowledge of the struggles of their friends and family led to an over-endorsement of mental illness and psychosocial stressors in their community. Without a non-Muslim control group it was difficult to place in relative terms the overall presence of mental health issues in the American Muslim community. However, data from past major surveys[188, 189] suggest that emotional troubles are a concern for this population. Additionally, participants' perceptions of the presence of mental illness and major stressors in their community relative to that in other communities indicates that these afflictions are at least as prevalent among American Muslims as they are in other populations.

Attrition

Of the 184 participants who began the survey, 119 completed every item. An advantage of a 156-item survey is that a great amount of data can be collected, but a downside is the inevitable effect of attrition. For some series of questions, such as those concerning the experience of being Muslim at college, all 184 participants provided responses. However, as participants progressed through the survey, some dropped out, as was their right. The survey was set up so that each scale was on the same page, and participants could move to the next page only when all of the items in a scale were answered. This meant that there was no missing data within any of the scales, which was an advantage of this arrangement.

One interesting feature of the website that hosted the survey was that it could list the amount of time each participant spent on the survey. Because some participants may have been multitasking when completing the survey or taking breaks from it to attend to other matters, it is probably not instructive to calculate the mean amount of time spent on its completion. However, for the participants who filled out every item, the median completion time was just under 26 minutes (this author informed participants that the survey may take approximately 30 minutes to complete). As such, it is understandable that so many participants elected not to complete the entire survey, which was a relatively long pilot questionnaire.

Internet

An Internet-based study has inherent limitations in terms of its reliability and validity. For this study, verification of participants' identity could not be assured, and that participants could not be observed filling out the survey creates reliability concerns. Additionally, because the survey was advertised via e-mail groups subscribed to by Muslim students, it may be that participants were skewed toward a greater religious identification than Muslims in the general population.

Participant Demographics

Despite the fact that about 25% of Muslims in the United States identify as African American,[190] only 9% of participants in the present study reported being fully or partially of African descent. This discrepancy was surprising. Although the parents of African American Muslims may not place as much emphasis on college as Muslim parents from other backgrounds,[191] it was expected that African Americans would be better represented in the sample than they were. Still, level of education for American Muslims may not be correlated with attitudes toward mental health,[192] so it is possible that the findings of the present study can be tentatively extended toward young adult African American Muslims who are not presently enrolled in college. Additionally, the ethnic background of participants was not significantly correlated with any of the major dependent variables studied. However, given that the African American participants are likely not second-generation Americans, it may be difficult to disentangle ethnicity and generational status.

Another concern for the present study was that female participants (73%) were disproportionately represented in the sample. It is possible that analyses of gender differences might have been more robust if more men had participated. It is not clear why there was such a difference between the number of male and female participants. One possible explanation is that women may be generally more interested in participating in studies on mental health than men. Indeed, a 2005 study[193] of Arab Muslim adults using the BARCS also yielded a high number of female respondents (60%).

RECOMMENDATIONS

For Mental Health Professionals

It is thus imperative, as is stressed by the American Psychological Association, that providers work to develop greater multicultural competence.

Participants in the present study indicated that potential supports such as treatment providers and family members may not have a good understanding of their identities as young adult American-born Muslims and the associated stressors and challenges. Although participants were open to mental health treatment and valued multicultural competence, they may harbor doubts about treatment providers' familiarity with Islam. It is thus imperative, as is stressed by the American Psychological Association,[194] that providers work to develop greater multicultural competence. Training workshops may be held for providers to learn multicultural competencies for mental health work with young Muslim clients. Furthermore, participants may feel that their parents do not understand them and may be likely to experience family conflict, so a special prevention emphasis should be placed in both the field of mental health services and within the American Muslim community on developing approaches to improve family functioning.

For Colleges and Universities

Colleges and universities might also play a role in alleviating difficulties faced by their Muslim students. An interesting association was found between participants' level of comfort being a Muslim at college and the presence of a college chaplain who ministers specifically to Muslim students. Muslim college chaplains who develop pastoral counseling skills might become effective supports for students in need. Program development around the cross-training of Muslim chaplains and campus psychological service providers might greatly aid in this process. Colleges that do not yet have Muslim chaplains might at least reach out to their Muslim students to affirm the importance of their well-being and to work with them to develop helpful campus resources, such as facilitating the development of support groups, which have shown promise.[195]

For Religious Leaders

Although imams have been reported to provide effective counseling services,[196] a 2006 study of mosque-going American Muslims[197] found that participants would be unlikely to seek counsel from a foreign-born imam. Despite the fact the participants in the present study were interested in using religious coping strategies, most felt there was a need for more Muslim providers, had generally flexible coping styles, and had positive help-seeking attitudes, they expressed a great deal of reluctance to turn to religious leaders for help. However, participants did express a strong desire for assistance from individuals who had a good understanding of American culture and young adulthood and who respected the participants' Muslim faith.

This raises the question of whether young adult American-born Muslims feel that the imams in their communities, many of whom are foreign-born, lack the proficiencies that young adult Muslims prefer in mental health providers. After all, despite participants' preference for providers who had a good understanding of Islam or who were Muslim, who could appreciate the role of Islamic identity, and who could integrate religious practices into treatment, religious leaders were not seen as valuable resources. Study participants also indicated that their conceptions of mental illness were not from a strictly religious perspective, and they might have felt that imams in their community lack that appreciation.

It is thus strongly recommended that American Muslim communities invest in identifying and training community members, imams or otherwise, with the necessary skills to provide support and counsel to young adult American-born Muslims. Trained imams could work collaboratively with psychologists and mental health providers. Given the young Muslim population's possible openness to both professional help-seeking as well as religious coping, it would seem that trained community individuals would be an effective resource.

Imams could devote time in their weekly sermons to recognizing mental illness in an effort to remove stigma, publicize community resources, and encourage professional help-seeking behaviors while also educating congregants about the role that religious coping can play in managing stress. Because there appears to be a lack of Muslim mental health professionals, it may be that further validation within the Muslim community of the importance of mental health care might lead more young adult American Muslims to consider psychology as a field of study or a line of work.

It is thus strongly recommended that American Muslim communities invest in identifying and training community members, imams or otherwise, with the necessary skills to provide support and counsel to young adult American-born Muslims.

For Researchers

Because the present study took an indirect approach to gathering epidemiological data, it is strongly recommended that future research focus on gathering interview/screening/assessment base rate data on mental illness in young adult American-born Muslim communities and the American Muslim community at large. Additionally, future research might seek to delineate how this population understands the relationship between depression, stress, and anxiety, because the present study indicated that these may be viewed as a mixed construct.

Perhaps the most pressing need for future research on American Muslims and mental health involves developing a greater understanding of the dimensions of multicultural competence in working with this group. Participants in the present study reported that they valued multicultural competence above all other qualities that providers might possess, yet they felt that treatment providers lacked a solid understanding of Islam. Qualitative research involving interviews with young adult American-born Muslims and community stakeholders might provide more thorough information on what their understanding is of multicultural competence. Additionally, it may be worth investigating further the strong relationship found in the present study between the presence of a Muslim chaplain on campus and the ease of being a Muslim student. It may be that these chaplains themselves could have helpful insights to offer about what multicultural competence might entail in working with young adult American-born Muslims. Finally, given that Muslim immigrants in America have reported somatic symptoms of mental illness,[198] it might be worth investigating whether similar symptoms are expressed by American-born Muslims.

Summary

The young adult American-born Muslim population is diverse, vibrant, and resourceful, yet they have encountered notable stressors in different spheres of their lives. Results of the present study indicate that mental illness and psychosocial stressors are present in this community at concerning levels. Participants expressed openness to seeking formal mental health services, particularly individual therapy, and indicated a strong desire for providers who possessed multicultural competence. However, doubts were expressed about the extent to which those providers existed or were accessible. Participants also evidenced a multifaceted approach to coping, which included religious methods, proactive cognitive strategies, and using other individuals for support. Individuals who expressed high levels of religiousness or religious coping were no less likely than other participants to express a willingness to seek formal mental health services. Colleges, mosques, and the field of mental health in general might be involved in developing effective resources and strategies for supporting American Muslim communities. Finally, it will be especially important for future research to gather more complete and accurate epidemiological data and to focus on developing specific guidelines for multicultural competence in working with this important and emerging population.

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Appendix A: Methodology

PARTICIPANT CHARACTERISTICS

Participants included 50 men and 134 women. Their average age was 20.32 years; range, 18 to 33. The sample consisted of 39 freshmen, 43 sophomores, 48 juniors, and 54 seniors. The most represented ethnic, and/or cultural background was South Asian (90), followed by Arabs (44) and white Americans (15). Thirteen participants identified as African American or Americans from African nations. Participants also came from the following backgrounds: mixed race (9), Iranian (5), Afghani (4), Caribbean (2), and East Asian (2).

Twenty-one participants (18 women, 3 men) reported being converts to Islam. The majority of this subgroup identified as white (15). Additionally, there were two African American converts, one South Asian convert, one convert from an Iranian background, one convert from an East Asian background, and one convert who reported being of mixed race. The majority of participants (79%) reported being second-generation American Muslims (at least one Muslim parent not born in the United States). Of the 184 participants, 119 provided answers to all required questions.

MEASURES

Demographics and College Experience

Participants read an informed consent form and verified that they met the aforementioned criteria for taking part in the study, and were then administered 10 questions that gathered demographic information, along with basic information about the experience of being a Muslim at college. Participants were asked their gender, age, and year in college. They were also asked to select 1 of 13 designations that they felt best described their ethnic and/or cultural background. For participants who thought that none of the provided designations were accurate for them, they were offered a field on the survey where they could type their self-assigned cultural grouping. Participants were then asked whether they had converted to Islam and whether they were second-generation American Muslims. Participants were asked whether a Muslim student organization existed at their college and whether they had access to a Muslim chaplain or student advisor. Finally, participants were asked how often they interacted with fellow Muslim students and whether they felt it was difficult for them to be a Muslim at college.

Attitudes toward Seeking Professional Psychological Help (ATSPPH)[156–158]

Next, participants were asked to complete a 20-item adaptation of the ATSPPH assessment, a measure of openness to seeking formal mental health services. Fifteen questions pertained directly to attitudes toward mental health care, such as "If I believed I was having a psychological or mental health problem, the first thing I would do would be to seek psychological or mental health counseling." The scored response options were strongly disagree (1), disagree (2), agree (3), and strongly agree (4). An additional five questions within the scale specifically examined mental health stigma and were scored in the same format.

Treatment-Seeking

Additional questions, which were relevant to the previous 20 items that composed the ATSPPH adaptation, were administered in the same scoring format to maintain. The present author developed these treatment-seeking items, which made up the next 25 items. These treatment-seeking items were designed to specifically address attitudes toward psychotherapy, ideal characteristics of a treatment provider (e.g., gender, religion, and multicultural competence), preferred treatment modalities, and stigma. Examples of items were "If I sought professional mental health treatment, I worry about what my family would think if they knew," and "I would rather try psychiatric medications before trying therapy."

Brief Arab Religious Coping Scale[159, 160]

The following section in the survey consisted of a 15-item questionnaire, the Brief Arab Religious Coping Scale (BARCS). This survey has been used to measure religious coping for Arab Americans. It was developed by M.M. Amer,[161] who consented to the use of this scale in the present study and who was consulted on very minor revisions concerning the wording of certain items. This measure contains questions about how Arab Americans, many of whom are Muslims, might use religious coping strategies. The BARCS asks participants to read each item and select how often they engaged in specified behaviors when they have experienced a stressful situation or problem. Examples of items include "I prayed for strength," and "I got help from religious leader/s." Participants are asked to select responses of *not used at all or does not apply* (0), *used sometimes* (1), *used often* (2), or *used always* (3).

COPE[162, 163]

The COPE is a well-known measure of coping styles.[164] The original authors stated that the title of the scale is not an acronym but rather is meant to be reflective of the specific construct it claims to measure, namely, coping.[165] The COPE asks participants what they generally feel and do when they experience stressful events. Participants are asked to select responses of *I usually don't do this at all* (1), *I usually do this a little bit* (2), *I usually do this a medium amount* (3), or *I usually do this a lot* (4). Examples of items are "I discuss my feelings with someone" and "I use alcohol or drugs to make myself feel better."

Nigar Khawaja[166] set out to investigate the factor structure of the COPE on a sample of 319 Australian Muslims so that a more culturally sensitive assessment tool, such as an amended version of the COPE, could be developed for future use with Muslim and/or immigrant populations. Her analysis resulted in an amended version of the COPE that consisted of 34 items and four subscales, including a scale focused on religious coping. Khawaja's factor scales were labeled *Avoidance Coping*, *Active Coping*, *Emotion and Social Focused Coping*, and *Turning to Religion*. Of the 34 items, only four composed the "turning to religion" subscale. Khawaja consented to the use of her version of the COPE in this study. These 34 questions followed the BARCS in the survey.

Sahin-Francis Scale of Attitude toward Islam[167]

The next 23 items in the present survey were composed of the Sahin-Francis scale, which the authors consented to be included in the present study. This scale measures religiousness in Muslim individuals. The Sahin-Francis scale asks participants to simply select the most personally appropriate response for 23 statements regarding their religiousness. The response options are *disagree strongly* (1), *disagree* (2), *not certain* (3), *agree* (4), and *agree strongly* (5). Examples of items are "I find it inspiring to listen to the Quran" and "Attending the mosque is very important to me."

Symptoms and Services

The next 25 questions focused on perceptions of the presence of mental health issues, environmental stress, and substance abuse in present study's sample, along with participants' perceptions of whether members of their respective Muslim communities have received professional treatment for the endorsed mental health difficulties. These 25 items were developed by the author of the study. Participants were specifically asked if they had friends and/or family who were young adult American-born Muslims who had suffered from particular conditions or stressors over the past year and whether those individuals received professional treatment over the past year. Due to concerns about the author's responsibility and ability to intervene for subjects who disclosed severe distress on an anonymous Internet-based survey, participants were not asked directly whether they were suffering from specific disorders. Although several different types of mental illness and environmental stressors have been identified in the general American population,[168] this section of the survey focused on eight areas of concern for young Muslim adults: *1)* stress, *2)* social pressures, *3)* family conflict, *4)* anxiety, *5)* depression, *6)* substance abuse, *7)* eating disorders, and *8)* psychosis.

With regard to these eight areas of mental distress, participants were asked three questions for each disorder or category of stress. First, they were asked whether they had young adult American-born Muslim friends and/or family who had suffered from that particular condition or stressor in the past year. Second, they were asked whether they had young adult American-born Muslim friends and/or family who had received professional treatment for that particular condition or stressor in the past year. Finally, they were asked how common they believed each of those issues to be

in the young adult American-born Muslim community relative to other communities (*less common*, *about as common*, or *more common*). Participants were also asked to type in any other conditions not previously mentioned that they felt may be affecting the young adult American-born Muslim population. Additionally, participants were asked whether they had ever received mental health treatment themselves—and if so, from whom—so that the relationship between help-seeking attitudes and actual use of services could be analyzed. Last, participants were offered the opportunity to type into an open field in the survey any additional thoughts they had regarding any of the issues addressed in the survey they completed. After participants completed the entire survey, they could select one of two incentives or could choose no incentive at all. They could have money donated on their behalf to an Islamic humanitarian agency or they could enter into a drawing to win an Amazon.com gift card.

Procedures

Participants were primarily recruited through the email listservs of Muslim student organizations. This author used the Internet to locate representatives of Muslim student organizations whose representatives then forwarded information written by this author about the study to potential participants that were members of those e-mail groups. When a contact for a Muslim student organization could not be identified, another individual or office that might have been able to distribute the message, such as a college chaplain, office of diversity, student affairs representative, or student group composed of ethnic minorities that may include Muslims, was contacted. A wide geographic sampling that included 150 colleges in all 50 states and the District of Columbia was sought. A recruitment message explained the study's goals, potential benefits, and participant requirements.

It has been suggested[169] that Internet-based studies may help in gathering valid information about Arab Americans, many of whom are Muslim; the relative anonymity of this medium might reduce the role of stigma with regard to mental health disorders. Participants' confidentiality was maintained in this study. The website psychdata.com hosted the Internet survey. This website had the capacity to securely store data and exclude IP addresses of participants. Most importantly, the website had the ability to have participants taken to a separate survey at the end of the study in which participants could enter an e-mail address if they wished to enter the drawing for the gift card. The website was thus able to automatically download the e-mail addresses into a separate database to ensure the confidentiality of responses. As such, there was no way to definitively link participants' e-mail addresses to their responses. Those participants who won the gift card were sent the card electronically, via e-mail. Participants who chose to have five dollars donated on their behalf to charity did not need to provide any identifying information.

Appendix B: Advanced Statistical Analysis

COPE Inter-Scale Pearson Correlations and Subscale Alpha Coefficients

Scale	α		AV	AC	ESF	TTR	COPE
AV	.80	Pearson correlation	1.00	−.19*	.02	−.27**	.23*
		Significance		.04	.86	.00	.01
AC	.90	Pearson correlation		1.00	.30**	.39**	.74**
		Significance			.00	.00	.00
ESF	.88	Pearson correlation			1.00	.14	.72**
		Significance				.12	.00
TTR	.93	Pearson correlation				1.00	.48**
		Significance					.00
COPE	.84	Pearson correlation					1.00
		Significance					
AV, avoidance coping; AC, active coping; ESF, emotion and social focused coping; TTR, turning to religion. *Significant at the .05 level (two-tailed). **Significant at the .01 level (two-tailed).							

Correlations of Depression

	Family conflict	Anxiety	Substance Abuse	Eating Disorders	Stress
Correlation with depression	.21*	.39**	.19*	.31**	.35**
*Significant at the .05 level (two-tailed). **Significant at the .01 level (two-tailed).					

Post-hoc ANOVAs with Perceived Depression as the Independent Variable

Dependent Variable	df	Mean Square	F	P	ω^2
Family conflict	1	.73	5.36	.02*	.04
Anxiety	1	4.12	20.67	.00***	.15
Substance abuse	1	1.04	4.55	.04*	.04
Eating disorders	1	1.49	12.60	.00**	.10
Stress	1	1.91	16.70	.00***	.13
*Significant at the .05 level. **Significant at the .01 level. ***Significant at the .001 level.					

Multiple Regression of Attitudes toward Help-seeking, General Coping, and Religiousness as Predictors with Religious Coping as the Criterion Variable

Factor	B	SE B	β	t	P
ATSPPH	−.03	.11	−.02	−.23	.82
COPE	.22	.06	.27	3.57*	.00
Sahin-Francis	.36	.05	.54	7.39*	.00
ATSPPH, Attitudes Toward Seeking Professional Psychological Help. *Significant at the .001 level.					

Correlations among Standardized Measures of the Study

Scale		BARCS	ATSPPH	COPE	Sahin-Francis
BARCS	Pearson correlation	1.00	.06	.45*	.63*
	Significance		.26	.00	.00
ATSPPH	Pearson correlation		1.00	.22*	.03
	Significance			.01	.37
COPE	Pearson correlation			1.00	.35*
	Significance				.00
Sahin-Francis	Pearson correlation				1.00
	Significance				

About The Author

Dr. Ben Herzig is a research fellow at the Institute for Social Policy and Understanding. He received his doctorate in Clinical Psychology from Antioch University New England. Dr. Herzig has studied at Yale University, Tufts University, and the University of Pennsylvania, from which he graduated with a degree in Psychology and a minor in Religious Studies. He has provided psychological services in numerous settings, including community health centers, emergency rooms, schools, residential programs, state hospitals, and the federal prison system. Dr. Herzig has authored academic articles on topics related to media psychology and therapeutic change, and is a reviewer for the *Journal of Multicultural Counseling and Development*. Dr. Herzig's research interests are focused on the intersection of psychology and religion, and he has recently agreed to co-author a chapter on Islam and mental health for Johns Hopkins University Press. He has established counseling positions at Islamic schools and is an advisor to Muslim college students. He serves on the board of directors of the Center for Jewish-Muslim Relations.

Acknowledgments

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Institute for Social Policy and Understanding
1 (800) 920-ISPU (4778) • info@ispu.org

Michigan
6 Parklane Blvd, Suite 510
Dearborn, MI 48126
(313) 436-0523

Washington, DC
1110 Vermont Ave. NW, Suite 500
Washington, DC 20005
(202) 768-8749