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**BETWEEN TWO WORLDS: ACCULTURATION IMPACT ON THE MENTAL
HEALTH STATUS OF ARAB AMERICANS**

By

Sara Abubotain

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Submitted in partial fulfillment of the requirements for the degree of

Doctor of Philosophy (PhD) in Health Sciences

Seton Hall University

2020

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SETON HALL UNIVERSITY

School of Health and Medical Sciences

APPROVAL FOR SUCCESSFUL DEFENSE

Doctoral Candidate, **Sara Abubotain**, has successfully defended and made required modifications to the text of the doctoral dissertation for the Ph.D. during the **Fall Semester 2020**

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ACKNOWLEDGMENTS

I am grateful for the support and guidance that I have received from many of my colleagues, faculty staff, committee, and family during my Ph.D. journey. I would like to recognize my dissertation committee members for their continuous support and feedback:

Dr. Cahill, I am grateful for all your support during every step of my program, especially during major dissertation milestones and the complete process. I sincerely thank you for your leadership and guidance and for enabling me to complete my study on this challenging topic. Thank you for believing in me and pushing me to excel during this whole journey.

Dr. DeLuca, I am grateful for challenging me during my journey, preparing me for the defense, and allowing me to excel in various fields. I am very thankful for your statistical support and technical guidance. I accredit my confidence in the statistical analysis during my research to your teaching and guidance. Thank you for your continuous support and guidance.

Dr. Battaglia, I am thankful for your support and guidance and for assisting me during my journey.

I am grateful to the expert panelists for their time and positive feedback. I am also thankful to all my colleagues who supported my dissertation and supported my research. Special thanks to Joann DeBerto for her continuous support during my program.

I would like to thank my father for pushing me to pursue this topic, my mother, sisters, and brother for their support, and my husband for pushing me to achieve my dream and for always being there for me and helping me, and kids, Laila and Lina. I would like to thank my mother and father in law for their continuous support during my journey.

DEDICATION

This dissertation research is dedicated to the memory of my father, Ahmed Abubotain. He encouraged and pushed me to pursue my Ph.D. in this vital field and assist Arab Americans, and my mother and sisters for their support. I also dedicate this dissertation to my husband, and my two kids, Laila and Lina.

TABLE OF CONTENTS

ACKNOWLEDGMENTS.....	iv
DEDICATION.....	vi
LIST OF TABLES.....	xiii
LIST OF FIGURES.....	xv
ABSTRACT.....	xvii
I. INTRODUCTION.....	1
Background: Who are Arab Americans?.....	1
Cultural Similarities.....	2
Migration to the U.S.....	2
The Arab American Migration Experience.....	3
Deteriorating Conditions.....	3
Cultural and Religious Conflicts.....	4
Statement of Problem	4
Acculturation	6
Arabs' Acculturation Choice	6
The Acculturation Decision.....	7
Theoretical Framework	8
Acculturation and Mental Health.	9
Reinforcing the Arab Culture for the Second Generation	10
Research Questions & Hypotheses.....	11
The Study Purpose.....	12
Need for the Study.....	12

Significance of the Study.....	12
II. REVIEW OF RELEVANT LITERATURE.....	13
Arab Culture.....	14
Arab American Population	14
Political Factors.....	16
Educational/Economic Factors	16
Acculturation and Mental Health Issues.....	17
Stigma	17
Bias.	18
Arab American Perception of Mental Health	19
Acculturation	21
Background of the Arab American Mental Health Status.....	23
Current Arab American Mental Health Status.....	23
Depression.....	23
Anxiety, Stress, and Risk of Suicide.....	24
Arab American Culture and Mental Health.....	24
Acculturation Processes, Stress, and Strategy.....	26
Mental Health Stressors.....	28
Stereotypes and Perceptions' Patterns and Images.....	28
Perceived Abuse and Psychological Distress Post 9/11.....	29
Arab American Attitudes towards Mental Health Services and Psychotherapy.....	29
Attitudes Toward Seeking Mental Health Services	30

Knowns in the Literature	32
Unknowns in the Literature	32
III. METHODOLOGY.....	34
Introduction.....	34
Research Questions.....	34
Overarching Research Question.....	34
Primary Sub-Questions.....	34
Theoretical Framework.....	35
Research Design.....	37
Sampling Procedure.....	37
Participants' Characteristics.....	38
Inclusion Criteria.....	38
Exclusion Criteria	39
Participant Recruitment	39
Study Recruitment.	41
Data Collection.....	41
Instrument Tools.....	41
Validity and Reliability.....	42
ATSMHS Validity and Reliability.....	42
KFFMHS Validity and Reliability.....	43
Data Collection.....	43
Onsite (face-to-face) Survey Process.....	44
For the Islamic Center.....	44

For the Outpatient Medical Center.....	45
Online Recruitment.....	47
For the Seton Hall University Participants.....	47
Questionnaire Collection Process.....	48
Online Survey Procedure.....	48
Egyptian American Youth Group.....	48
Seton Hall University.....	48
Data Analysis.....	49
Paper and Electronic Survey.....	49
IV. RESULTS.....	52
Research Findings.....	52
Demographic Survey Results.....	53
Gender of Participants.....	53
Participants' Original Nationality.....	54
Participants' Marital Status	55
Participants' Highest Education Level	56
Participants' Family Annual Income.....	57
Participants' Occupation.....	58
Participants' Thanksgiving Celebration	59
Research Questions.....	60
Medical Doctor vs. Mental Health Professional Visits.....	60
Outside Mental Health Counseling.....	63
Demographics Summary.....	64

ATSFMHS Similarities and Differences.	67
ATSFMHS Summary	66
KFFMHS Similarities and Differences	67
KFFMHS Summary.....	70
Statistical Assumptions.....	75
Follow-Up Univariate Tests (ANOVA).....	81
Acculturation ANOVA.....	82
Stratified Analysis by Low Education	83
Stratified Analysis by High Education	83
Stigma ANOVA.....	84
Seek ANOVA.....	85
Stratified Analysis by Low Income	86
Stratified Analysis by High Income	87
Perceive ANOVA.....	87
Stratified Analysis by Low Education	88
Stratified Analysis by High Education	88
Acculturation/Stigma ANOVA Summary.....	89
Seek/Perceive ANOVA Summary.....	89
Post-Hoc G Power Analysis.....	90
Review of Hypotheses (Accept or Reject).....	91
V. DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS.....	94
Introduction.....	94
Overview of the Discussion.....	94

Findings in Alignment with Literature Review.....	96
Unusual Findings.....	99
Novel Findings.....	100
Berry’s Acculturation Theory Revisited.....	101
The Multiculturalism Theory.....	102
Practical Implications.....	103
Limitations.....	104
Future Research.....	105
Study Significance and Conclusion.....	106
REFERENCES.....	107
Appendix A. IRB Certificate.....	117
Appendix B. Site Approval Letters.....	119
Appendix C. Data Collection Process	125
Appendix D. Script	126
Appendix E. Study Flyer.....	128
Appendix F. Written Confirmation to Utilize Instruments.....	130
Appendix G. Demographic Survey.....	131
Appendix H. Dissertation Proposal Hearing Approval.....	134
Appendix I. Solicitation Letter.....	135

LIST OF TABLES

Table 1. Berry's Acculturation Theory Illustration	8
Table 2. Cronbach's Alpha Reliability Statistics for ATSFMHS.....	42
Table 3. Cronbach's Alpha Reliability Statistics for KFFMHS.....	43
Table 4. Participants' Marital Status by Group.....	55
Table 5. Participants' Highest Education Level.....	56
Table 6. Participants' Family Income Level.....	58
Table 7. Participants' Mental Health Counseling Options.....	64
Table 8. First and Second Generation Demographics' Similarities and Differences.....	65
Table 9. Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS) First and Second Generation Participants' Similarities and Differences.....	66
Table 10. ATSFMHS Second Generation Arab Americans % who Disagreed.....	67
Table 11. Knowledge and Familiarity with Formal Mental Health Services (KFFMHS) First and Second Generation Participants' Similarities.....	68
Table 12. ATSFMHS First Generation Arab Americans who Agreed.....	69
Table 13. ATSFMHS Second Generation Arab Americans % who Agreed.....	69
Table 14. ATSFMHS First Generation Arab Americans % who Disagreed.....	70
Table 15. Multivariate Outlier - Chi-square.....	76
Table 16. Pearson Correlations of the 4 Variables.....	77
Table 17. Box's Test of Equality of Covariance Matrices.....	78
Table 18. Multivariate Tests - Pillai's Trace and Wilk's Lambda Values.....	79
Table 19. Multivariate Analysis of Variance (MANOVA) for all 4 Dependent Variables.....	80
Table 20. Multivariate Analysis of Variance (MANOVA) for all 4 Dependent Variables.....	81
Table 21. Follow-Up Univariate (ANOVA) Tests for Acculturation.....	83

Table 22. Follow-Up Univariate (ANOVA) Tests for Acculturation by the Low Education Level	83
Table 23. Follow-Up Univariate (ANOVA) Tests for Acculturation by the High Education Level.....	84
Table 24. Follow-Up Univariate (ANOVA) Tests for Stigma.....	85
Table 25. Follow-Up Univariate (ANOVA) Tests for Seek.....	86
Table 26. Follow-Up Univariate (ANOVA) Tests for Seek by the Low Income Level.....	86
Table 27. Follow-Up Univariate (ANOVA) Tests for Seek by the High Income Level.....	87
Table 28. Follow-Up Univariate (ANOVA) Tests for Perceive.....	88
Table 29. Follow-Up Univariate (ANOVA) Tests for Perceive by the Low Education Level	88
Table 30. Follow-Up Univariate (ANOVA) Tests for Perceive by the High Education Level	89
Table 31. Univariate (ANOVA) Summary of Findings – Acculturation & Stigma.....	89
Table 32. Univariate (ANOVA) Summary of Findings – Seek & Perceive.....	90
Table 33. Factors Impacting Arab Americans’ Attitudes Towards Seeking Professional mental health services.....	97
Table 34. Differences between the way first and second-generation Arab Americans seek professional mental health services.....	98
Table 35. Differences between the way first and second-generation Arab Americans Perceive professional mental health services.....	99
Table 36. Differences between the way first and second-generation Arab Americans seek professional mental health services.....	100

LIST OF FIGURES

Figure 1. Multiculturalism Acculturation Theory Illustration	9
Figure 2. A Priori G*Power Analysis to Determine Sample Size	38
Figure 3. Flowchart Summary of Methodology up to and Including the Reliability Assessment Post-IRB Approval from Seton Hall University	51
Figure 4. Bar Graph of Participants According to the Two Groups.....	52
Figure 5. Clustered Bar Graph of Participants According to the Two Groups with respect to those who Responded and did not Respond.....	53
Figure 6. Bar Graph of Participants According to Gender.....	54
Figure 7. Bar Graph of Participants According to Country of Origin.....	54
Figure 8. Bar Graph of Participants According to their Marital Status.....	55
Figure 9. Bar Graph of Participants According to their Highest Education Level.....	56
Figure 10. Bar Graph of Participants' Family Income Level.....	57
Figure 11. Bar Graph of Participants' Occupation.....	58
Figure 12. Bar Graph of Participants' Celebrating Thanksgiving.....	59
Figure 13. Clustered Bar Graph of First and Second Generation Celebrating Thanksgiving.....	60
Figure 14. Bar Graph of First and Second Generation Medical Doctor Visits.....	61
Figure 15. Bar Graph of First and Second Generation Mental Health Professional Visits.....	62
Figure 16. Clustered Bar Graph of First and Second Generation Medical Doctor vs. Mental Health Professional Visits	63
Figure 17. Clustered Bar Graph of First and Second Generation Knowledge of the Type of Problems Requiring Mental Health Services	71
Figure 18. Clustered Bar Graph of First and Second Generation Knowledge of Practicing Arab professionals in their Local Community.....	72
Figure 19. Clustered Bar Graph of First and Second Generation Knowledge of Psychiatrist's Role in Mental Health Counseling Settings.....	73

Figure 20. Clustered Bar Graph of First and Second Generation Knowledge of Psychologists' Role in Mental Health Counseling Settings.....	74
Figure 21. MANOVA Linearity Assumption Bar.....	75
Figure 22. Post-hoc G*Power Analysis	91
Figure 23. Reject or Accept? PI's hypotheses 2 & 3 – fail to reject the alternate hypothesis for each.....	93
Figure 24. Berry's Acculturation Theory and Arab Americans.....	102
Figure 25. Multiculturalism Acculturation Theory Illustration	103

ABSTRACT

Between Two Worlds: Acculturation Impact on the Mental Health Status of Arab Americans

SARA ABUBOTAIN

Seton Hall University, 2020

Dissertation Chair: Dr. Deborah DeLuca, M.S., J.D.

Background and Purpose of the Study: Arabs come from over 20 countries in Africa and Asia. Many of those countries either have an ongoing war, battle with terrorism, or political turmoil that may have resulted in mental health issues for Arabs migrating to America. Arab Americans continue to migrate to the U.S. Arab Americans have been experiencing stress due to the discrimination they face post 9/11, their acculturation method, cultural difference, pre-migration mental health conditions, and the Arab culture that discourages seeking mental health support from outside the family. The problems are Arab Americans' perception of mental health in general and available professional mental health services, professional mental health providers' knowledge of the Arab culture concerning mental health, and the relationship between Arab American attitudes towards mental health services and mental health issues. In addition, an increasing percentage of Arab Americans are second-generation, born in the U.S., and there is limited research to understand whether there are differences between the first and second-generations related to the way they perceive and seek professional mental health services.

Methods: This study utilized an exploratory, descriptive, and correlational design to understand: a) major factors involving the attitudes of Arab American populations toward

seeking professional mental health services b) how first and second-generation Arab Americans seek and perceive professional mental health services.

Results: Reliability for the Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS) instrument was good (Cronbach's Alpha $\alpha = 0.711$), and the reliability of the Knowledge and Familiarity with Formal Mental Health Services (KFFMHS) instrument was excellent (Cronbach's Alpha $\alpha = 0.927$).

Conclusion: This study added to the limited studies related to Arab Americans and mental health issues. There is a difference between the way first and second-generation Arab Americans perceive and seek professional mental health services. The study addressed the importance of educating mental health professionals about the Arab culture and how each generation perceive and seek mental health services. There is a correlation between the acculturation method and the development of mental health issues among Arab Americans. There were essential factors/differences behind first and second-generation Arab Americans' attitudes towards seeking professional mental health services, cultural beliefs, and other influences that governed their actions/attitudes. More research is imperative in other geographical areas with a large Arab population.

Keywords: Arab Americans, mental health, acculturation, 9/11, stigma, bias, discrimination

Chapter I

INTRODUCTION

Background: Who are Arab Americans?

Arabs come from over 20 countries in Africa and Asia, such as Saudi Arabia, Yemen, Jordan, Iraq, Syria, Lebanon, Palestine, Egypt, Sudan, Libya, and Tunisia (Erickson & Al-Timmi, 2001). Those countries either have an ongoing war, battle with terrorism, or political turmoil that may have resulted in mental health issues for Arabs migrating to America. Arab Americans are not recognized as a minority group, even though they represent over 20 countries, have unique norms and values, and share history, culture, language, and political issues. Currently, Arabs are included among the white race, where the white group classification now includes Arab countries in North Africa and Arab countries in Asia (Abuelezzam et al., 2018; Hasan & Moradi, 2004). The U.S. Census Bureau (2018) rejected the latest request for Arabs to be classified as their own group in the 2020 Census.

Arab Americans share common habits, especially with respect to seeking professional mental health assistance, even though they come from over 20 countries (Abuelezzam et al., 2018; Erickson & Al-Timmi, 2001; Khouri, 2016; Hasan & Moradi, 2004; Sechrist et al., 2003). Several definitions are utilized to define Arab Americans. According to the American Arab Anti-Discrimination Committee (AAAC), Arab Americans share the Arabic culture and language, and they reside in the U.S. Arab Americans are also defined as anyone whose ancestors come from over 20 Arab countries located in Africa and Asia who migrated to the U.S. (Abuelezzam et al.; Erickson & Al-Timmi; Khouri; Sechrist et al.).

Cultural Similarities

For Arabs, the family's reputation is paramount. It is expected of all family members, young and senior, to preserve that reputation and the family's name at all times, at all costs, even if this will negatively impact oneself (Fakhr Al-Islam, 2008; Carbonell et al., 2020). The importance of preserving family values is engraved in the minds of all members of the Arab family. To avoid family embarrassment, senior household members support their members, including those suffering from mental health issues. This traditional, culturally acceptable approach replaces seeking professional mental health services (Dardas & Simmons, 2015; Fakhr Al-Islam, 2008; Nydell, 2012). In the Middle East, the media and social media portray professional mental health services as services required solely by insane individuals who belong in asylums (Fakhr Al-Islam). As a result of the traditional Arab family's strong opposition to members seeing professional mental health services and limited means to address these mental health needs within their families, as Arabs migrate to other countries, they continue to protect their family's reputation instead of managing their mental health needs. Arabs, in general, are not known for sharing their weaknesses or their need for medical assistance with others, especially among Arab males (Fakhr Al-Islam; Dardas & Simmons; Nydell).

Migration to the U.S. Over the past decade, there was turmoil and disturbance in the Middle East that started with a few countries and expanded to several others, known by many as the Arab Spring. Due to political stress, the number of Arabs seeking refuge in the U.S. has increased significantly (Aloud & Rathur, 2009; Nadar, 2020). Most Arabs strongly believe in the freedom that America was founded upon. As a result, they exert all efforts to migrate to the U.S., not realizing the significant cultural difference between their country of origin and the United States' culture. This cultural difference can result in added stress for many Arab immigrants

(Aloud & Rathur; Wekhian, 2015). The United Nations (2020) World Migration 2020 report confirmed the large number of Arab immigrants who continue to migrate to the U.S. The report also confirmed that many migrants came from countries that suffer from political turmoil, such as Syria.

The Arab American Migration Experience

Deteriorating Conditions

Discrimination and stereotyping against Arab Americans in the U.S. is not a new phenomenon. After the 9/11 tragic disaster, the perception of Arab Americans changed negatively (Kader et al., 2020; Padela & Heisler, 2010). Incidents of prejudice against Arab immigrants and Arab Americans in general increased significantly. In addition to their acculturative choice, these hardships, whether to assimilate to the U.S. culture or not, significantly impacted Arabs' mental health status (El-Sayed & Galea, 2009; Kader et al.). Unfortunately, cultural and religious differences from mainstream Americans and increasing terroristic threats against the U.S. resulted in the Arab population suffering hardships while being acclimated to the American lifestyle. Additionally, according to El-Sayed & Galea (2009), when individuals experience cultures that challenge their original cultural patterns, they will suffer mental health issues. Although this applies to individuals from various backgrounds and cultures, Arab Americans are impacted more since many recent terrorist attacks in different parts of the globe, including the Middle East and lately in Europe and the U.S. were conducted by Arabs in the name of religion (Kader et al.). Arabs who migrated to the U.S. experience a society that remembers the 9/11 attack as committed by individuals of Arab origin (Bhugra, 2004; El-Sayed & Galea; Kader et al.).

To understand how Arabs experience the U.S. cultural experience, it is critical to begin with an appreciation of the Arab Culture. Many first-generation Arab Americans were living in the U.S. enjoying the American way of life and American liberty until September 11, 2001, a day that changed the world forever (Bhugra, 2004; Kader et al., 2020). From that day onward, Arab Americans have been struggling. Arab Americans, in general, have experienced a wide range of cultural, social, and political pressures (Bhugra). Unlike first-generation Arab Americans, the second-generation Arab Americans were born in the U.S. America is their homeland and not the Middle East. They may look Middle Eastern, however, putting the looks aside, they are 100% American, both culturally and in the way they live (Amer & Hovey, 2009; Kader et al.; Padela & Heisler, 2010).

Cultural and Religious Conflicts

The Middle East is known for its ironclad political structure and lack of freedom of speech. On the contrary, the U.S. political system is a democratic system that encourages freedom of speech and religion, which is the main driver for Arabs seeking migration/refuge in the U.S (Amer & Hovey, 2011; Wekhian, 2015). However, the American dream and the way of life that Arab Americans came to the U.S. to pursue had some strings attached, the American culture. Arab Americans were not entirely familiar with the American culture before migrating to the U.S. Arab Americans did not expect that they would not be welcomed in some areas and may be forced with difficult acculturation choices (Amer & Hovey; Awad, 2010; Wekhian).

Statement of Problem. Based on the increasing Arab American population, the fact that Arab Americans are experiencing stress due to the discrimination they face post 9/11, acculturation related stress, cultural difference, pre-migration mental health conditions, and the Arab culture that discourages seeking mental health support from outside the family, the

problems are Arab Americans' perception of mental health in general and available professional mental health services, professional mental health providers' knowledge of the Arab culture concerning mental health, and the relationship between Arab American attitudes towards mental health services and mental health issues. In addition, an increasing percentage of Arab Americans are second-generation, born in the U.S., and there is limited research to understand whether there are differences between the first and second-generations related to the way they perceive and seek professional mental health services.

Arabs, in general, are not known for sharing their weaknesses or their need for mental health assistance with others. Hence, there are currently very few studies related to Arab Americans and mental health services (Fakhr Al-Islam, 2008; Dardas & Simmons, 2015; Nydell, 2012; Pampati, 2018). The number of Arab immigrants to the U.S. has increased as they escape the Middle East's turmoil and political stress and seek refuge in the U.S. (Aloud & Rathur, 2009; Nadar, 2020). Arabs did not expect the significant cultural difference and the significance of their acculturative decision upon arrival in the U.S. that added to their mental health issues. Research has shown that an individual's attitudes toward seeking and using formal mental health services can significantly affect their decision to seek professional mental health assistance. Arabs' attitudes towards seeking professional mental health services and views of those services as taboos that will bring shame to the family impact their mental health wellbeing (Aloud & Rathur; Nadar).

Mental health professionals in Arab countries are very familiar with the Arab cultures, taboos, and the associated risks with seeking professional mental health services. Most mental health professionals in Arab countries were raised in similar circumstances (Aloud & Rathur, 2009; Dardas & Simmons, 2015). Studies have shown that minorities do not receive adequate

needed mental health services. Throughout their lives, Arabs have suffered significantly from mental health stress and did not expect to continue suffering upon coming to the U.S. (Pampati, 2018; Wekhian, 2015; Wells et al., 2001). Recognizing the unique challenges of immigrant populations, Horan (1995) advises that healthcare professionals will likely be needed. Healthcare professionals need to understand various patterns related to mental health services among different ethnic and racial groups in the U.S., especially Arab Americans (Horan, 1995; Dardas & Simmons; 2015; Nadar, 2020).

Acculturation

Arabs' Acculturation Choice

Upon migrating to the U.S., Arabs decide whether to try to fit in the new society or abstain from this new culture and way of life. This process is known as acculturation, where acculturation is a phenomenon when people from various cultures and backgrounds come into constant contact with challenges to their original culture patterns (Bhugra, 2004; Nadar, 2020). Arabs who migrated to the U.S. witnessed the culture change promptly upon arrival. The choice to abstain from American culture by isolating from the new culture is visible in many areas in New York, New Jersey, and Detroit. Many Arabs target certain cities/neighborhoods in those states to reside in because Arabs inhabit them in general, but specifically Arabs from their own country. In Queens, New York, Astoria has a large percentage of Arabs from Egypt and Morocco. In the Bay Ridge section of Brooklyn, New York, there is a large percentage of Arabs from Egypt and Palestine. In Paterson, New Jersey, a large percentage of Arabs from Palestine reside there. While these areas/cities were primarily settled by Arabs from different Arab countries, they have in common the following characteristics: the predominant language is Arabic, not English, most store signs/billboards are in Arabic, and local cafes show Arabic TV

shows and Arabic news. The Arab culture is so prominent in these areas/cities that visitors may think they are in an Arab country.

Arabs who migrated to the U.S. to escape the turmoil in their country of origin or those seeking asylum tend to seek residence in those heavily Arab populated areas to remain connected to their homeland. On the other hand, Arabs who moved to cities that do not have a concentrated Arab presence have to make the difficult choice whether to adopt the new culture or try to maintain their own culture without the community support of an Arab cultural presence. This matter increases in importance as Arab Americans represent a growing percentage of the American population (Aloud & Rathur, 2009). It is essential to address Arab Americans' acculturation choice and any mental health issues they may already have or develop due to the new culture's interfacing. According to Aloud (2009), it is expected that based on the way Arabs were raised in their country of origin, they will underutilize the available professional mental health services in the U.S. And, as a result of not addressing mental health issues on a professional level, the Arab American mental health issues worsen (Aloud & Rathur; Nadar, 2020; Pampati, 2018).

The Acculturation Decision

The acculturation question, although simple to understand, is challenging to answer. Arab Americans either assimilate the American culture or keep a safe distance and stick to their culture (Abuelezam et al., 2018; Berry, 2017). Because some states have a large population of Arab Americans, while others have a smaller Arab population, maintaining the Arab way of life is not always an easy decision. The consequences of the Arab American acculturation decision may result in Arab Americans' marginalization in those areas and possibly develop mental health issues (Abuelezam et al.; Berry).

Theoretical Framework. This study's theoretical frame utilized Berry's (2017) and Horan's (1995) acculturation theories. Berry's acculturation theory indicates that once Arab immigrants arrive at their new destination, they are forced with a choice to make, more specifically, an acculturation choice. The acculturation theory indicates that immigrants choose one of the following acculturative methods: assimilation, separation, integration, de-culturalization, or disengagement (Berry). Table 1 illustrates Berry's acculturation theory, where an immigrant, in this case, an Arab American, makes one of four choices. It is common to believe that the Arab culture is different from the American core culture, resulting in difficulty acculturating, regardless of the Arab Americans' background, education, and/religion. The acculturation theory provides various levels of adopting or abstaining from this new way of living. There are consequences for the acculturation method chosen (Abuelezam et al., 2018; Berry).

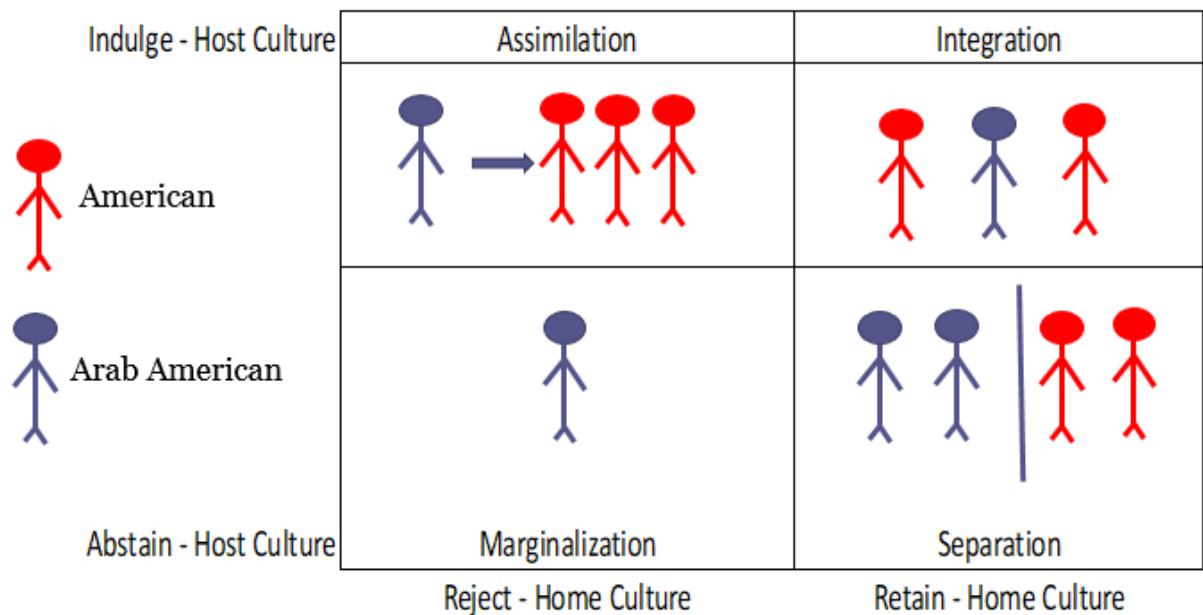


Table 1. Berry's Acculturation Theory Illustration (Berry, 2017)

The second theory is the multiculturalism theory (Horan, 1995). The multiculturalism theory encourages appreciation between different cultures and languages that exist in our society. This theory not only encourages individuals to welcome other cultures, but it also stimulates people to learn about the other culture and be more tolerant of others' beliefs when they contradict their own culture and beliefs (Horan). It portrays the good in each culture and allows individuals to view the other culture's positive aspects. All members of society must respect all people and groups of which this society is comprised. Multiculturalism recognizes the existence of a complex "plural society." This theory recommends that culturally diverse groups should attain a shared understanding to accept others' cultures (Horan). Figure 1 illustrates the Multiculturalism acculturation theory.

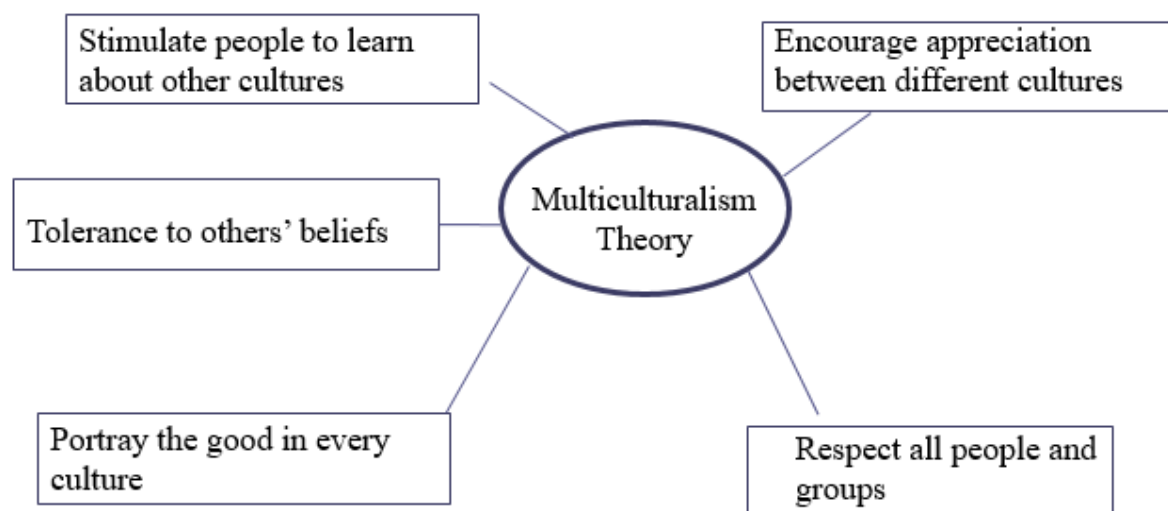


Figure 1. Multiculturalism Acculturation Theory Illustration (Horan, 1995)

Acculturation and Mental Health. Limited studies have considered whether there is a relationship between acculturation choice and the development of mental health issues (Amer & Hovey, 2005; Nadar, 2020; Shehadeh, 2011). As discussed, first-generation Arab Americans, who, unlike most second-generation Arab Americans, have spent a good percentage of their lives

in the Middle East in general and in their country of origin specifically. Their native language is the Arabic language, and everything surrounding them is in Arabic. They were raised cherishing family values and the importance of protecting that family name at all costs. They grew up in a particular political climate and may have witnessed the horror of an ongoing war either in their own country or in the vicinity. They grew up fully aware that freedom of speech is not exercised in the Middle East and may have experienced firsthand what happened to a family member or friend who did not follow the rules (Amer & Hovey, 2009; Padela & Heisler, 2010; Wekhian, 2015). Although many Arab Americans may have migrated years or even decades ago to the U.S., many of them still have strong ties back home and visit regularly. Other Arab Americans were not so fortunate since their homeland may be in a state of war, i.e., Syria, Iraq, Libya, and Yemen (Amer & Hovey; Kader et al., 2020; Padela & Heisler; Pampati, 2018).

Reinforcing the Arab Culture for the Second Generation. Depending on the second-generation Arab American's parents' acculturation level, some first-generation Arab Americans exert efforts connecting their offspring with their parent's homeland and continuously remind them that they are Middle Eastern and should adopt the Arab culture (Aloud & Rathur, 2009; Fakhr Al-Islam, 2008; Nadar, 2020). This may result in a personality/identity crisis for the second-generation as they struggle between two nationalities, identities, cultures, and ways of life. Many second-generation Arab Americans believe that first-generation Arab Americans do not understand their struggle as they try to fit in the American way of life. Many second-generation Arab Americans do not share any ties to the Middle East. They resent the Middle East due to their hardship in school and elsewhere merely due to the way they look, their Middle Eastern names, religion, and country of origin. Also, many second-generation Arab Americans have been rejecting any ties to the Middle East. Their parents, however, may be keen on getting

them attached to their culture and beliefs. First-generation Arab Americans reinforce the importance of the Arabic language and force their offspring to speak Arabic, at least at home. Many first-generation Arab Americans focus solely on Middle Eastern cultural and religious events/holidays instead of American holidays (Aloud & Rathur; Fakhr Al-Islam; Nadar). Second-generation Arab Americans were born in the U.S. to first-generation Arab Americans. The most challenging stage for the young inexperienced youth is high school. For Arab American kids, their struggle increased post the 9/11 tragic event (Amer & Hovey, 2011; Kader et al., 2020).

Research Questions & Hypotheses

RQ1. What are the factors (e.g., stigma, bias, acculturation, etc.) involved in the attitudes of Arab American population residing in the New York Metro area toward seeking professional mental health services?

RQ2. Are there significant differences between the way first and second-generation Arab Americans seek professional mental health services?

Hypothesis 2: There may or may not be significant difference between the way first and second-generation Arab Americans seek professional mental health services.

RQ3. Are there differences between the way first and second-generation Arab Americans perceive professional mental health services?

Hypothesis 3: There may or may not be differences between the way first and second-generation Arab Americans perceive professional mental health services.

The Study Purpose

Need for the Study

The need for this study is based on the gap in the literature pertaining to acculturation choice of first and second-generation Arab Americans and mental health issues and how each generation perceive and seek professional mental health services. It is crucial to address this gap in the literature because first-generation Arab Americans may have developed mental health issues due to their post-migration acculturation experience, first-generation Arab Americans are not prone to exposing their weakness to anyone, cultural and upbringing differences between Arab generations, post-9/11 stress, the relationship between acculturation choice and stress, and the differences between first and second-generation concerning mental health issues and support (Amer & Hovey, 2011; Fakhr Al-Islam, 2008; Kader et al., 2020; Nydell, 2012; Padela & Heisler, 2010). The purpose of this study is to explore Arab Americans' attitudes toward seeking professional mental health services and identify if differences exist between first and second-generation Arab Americans in seeking professional mental health services and their perceptions of professional mental health services.

Significance of the Study

Immigrant acculturation is a challenge involving considerable mental health stress. As a result of 9/11, and other subsequent terrorist attacks conducted by Arabs, Arab American acculturation is particularly stressful. Limited literature suggests differences between the acculturation of first and second-generation Arab Americans, particularly regarding mental health services (Amer & Hovey, 2011; Fakhr Al-Islam, 2008; Kader et al., 2020; Nydell, 2012; Padela & Heisler, 2010). This study addresses this gap in the literature.

Chapter II

REVIEW OF RELEVANT LITERATURE

It is crucial to study and comprehend the socio-cultural factors that influence Arab Americans' psychological status and stress to better inform future research and mental health services for this unique group (Abuelezam et al., 2018; Amer & Hovey 2005; Jadalla, 2007). This manuscript highlights the impact of culture and acculturation on Arab Americans to understand better their struggle related to their mental health needs. Discrimination and stereotype against Arab Americans in the U.S. is not a new phenomenon. After the 9/11 tragic event, incidents of prejudice against Arab Americans increased (Amer & Hovey, 2011; Kader et al., 2020; Padela & Heisler, 2010). Arabs migrated to the U.S. to escape political turmoil, poverty, and wide-spread corruption in their homeland. They were seeking the freedom upon which America was founded. Unfortunately, cultural and religious differences with mainstream Americans and recent terrorist events resulted in hardships getting acclimated to American life. These hardships have resulted in mental health issues (Amer & Hovey; Kader et al.; Nadar, 2020).

Arabs living in the U.S. come from diverse backgrounds, speak different dialects, and have different cultural, educational, and religious beliefs. Some Arab Americans were able to adjust to the western culture and way of life, while others are struggling to keep their Arabic identity (El-Khadiri, 2009; Nadar, 2020; Nydell, 2012). Unfortunately, the Arab culture does not condone mental health services, contributing to added adjustment difficulties, particularly for second-generation Arab Americans (El-Khadiri; Nydell).

Arab Culture

Arab American Population

According to Hasan and Moradi (2004), while Arab Americans are not officially recognized as a minority group, they have unique norms and values. From a linguistic and cultural aspect, Arab Americans are defined as people who share the Arabic culture and language (Al-Timmi & Erickson, 2001; Khouri, 2016; Moradi & Hasan; Sechrist et al., 2003). The challenge of such a definition is that there are people who can be perceived as Arab Americans, yet Arabic is not their first language, and thus, there is a need for an alternate definition. The American Arab Anti-Discrimination Committee (ADC) defines an Arab American as "anyone whose ancestors come from any of the 22 Arabic countries, located in Africa and Asia" (Al-Timmi & Erickson; Khouri; Moradi & Hasan; Sechrist et al.). Arab Americans come from diverse backgrounds and have different religious beliefs, yet, they are perceived as one ethnic identity. The general American population adopts this perception (Abuelezam et al., 2018; Jamil et al., 2002; Padela & Heisler, 2010). The term "Arabs" has been widely used to refer to Arabic-speaking people spreading from Morocco to Iraq. As a result, the word "Arab" has adopted a linguistic rather than an ethnic definition. Therefore, an Arab American can be defined as someone who has migrated to North America from any of the Arabic-speaking countries. Arab Americans are a heterogeneous population sharing a similar linguistic and cultural heritage (Jamil et al.).

There are two recognized waves of Arab American immigration to the U.S. The first wave dates back to the 1890s. The second wave migrated after World War I. The early Arab migrants were farmers and Christian merchants, whose migration was motivated by economic reasons. The second recognized wave of Arab immigrants moved to North America after the

Ottoman Empire's partitioning and the Middle East's subsequent colonization. Most of the second wave immigrants were Muslim and generally well educated. The second wave of Arab immigrants to the U.S. continues to this date (Amer, 2007). According to the Arab American Institute, by 2017 the Arab American population exceeded three million. Even though Arab Americans come from diverse nations, have different education levels, social class, religion, Arabic dialect, and acculturation level, they share some similarities (Abuelezzam et al., 2018; Amer). Among the similarities are the family's central role, respect for the elders, the importance of religious faith, and family values' precedence over personal aspirations. Unfortunately, the other common thing that Arab Americans share is the increased discrimination and traumatic experiences faced after the 9/11 terrorist attacks (Amer & Hovey, 2011; Kader et al., 2020).

Arab Americans represent a small sector of the overall U.S. population. Yet, they face unique challenges and pressures that result in an alarming level of anxiety, stress, and in many cases, depression (Nadar, 2020; Rothermel, 2009). Available studies of Arab American communities have identified a direct correlation between depression and anxiety disorders and various stressors that accompany immigration, acculturation, and assimilation (Nadar; Pampati et al., 2018; Rothermel). Mona Amer (2005) surveyed 611 Arab Americans who resided in 35 states and found that 25% of the sample population experienced severe or moderate anxiety. Amer found that 50% of the respondents reported severe-level symptoms of depression. There have been suggestions that incidences of anxiety and depression within the Arab American population may be higher than the actual findings. Researchers found a tendency of Arab Americans' emotional distress somatization, where the added stress resulted in significant physical disorder and pain (Hassan & Moradi, 2004). A more recent study that examined the impact of discrimination and the mental health well-being of Arab Americans in Michigan

revealed anxiety and depression symptoms. The participants also indicated that they suffer from poor health (Kader et al., 2020).

Additionally, the targeted discrimination of Arab Americans arising from 9/11 has led to compounded trauma, first because Arab Americans view America as their homeland and their loyalty is to America and not to their country of origin and second, as a result of the discrimination experienced after this tragic event (Amer & Hovey, 2011; Kader et al., 2020). Arab Americans feel that they were merely targeted due to their cultural and religious differences.

Political Factors

The majority of Arab Americans do not publicly criticize the American government, even though "freedom of speech" is an American right (Khoury, 2016; Erickson & Al-Timimi, 2001). They fear their views would be perceived as anti-American, which could result in federal prosecution or deportation. Arabs come from countries that are politically unstable and full of injustice (Khoury). Many had traumatic experiences before migrating to the U.S. (e.g., lost their jobs, family members, and friends or jailed for publically criticizing the government or for religious reasons). These unforgettable tragic memories and similar events that are still occurring regularly to their family and friends back home create enormous painful psychological pressure.

Educational/Economic Factors. Arab Americans come from various geographical, religious, and political backgrounds, and these differences contribute to economic factors (Aloud & Rathur, 2009; Nadar, 2020). It is understood by Arabs that education is vital for all Arabs who have the means to pursue it. For the rich, education can provide status and a way to attain more social respect/status. For the poor, education offers the only beacon of light to guide them to escape their miserable lives. In many cases, Arabs migrated to America solely for pursuing

higher education and better education for their children. As a result, Arabs living in the U.S. are highly educated and socially stable, working respectable jobs, or settling for less prestigious jobs than those previously held in their homeland. This results in a feeling of resentment, as unfortunate Arab Americans see no improvement to their social status before and post-migration to the U.S. A significant percentage of Arab Americans are either self-employed or have low-paying jobs with marginal benefits, if any. The lack of health insurance is another factor for not seeking any professional mental health services and their reliance on traditional healing methods and support from their families and friends (Aloud & Rathur; Nadar; Zolezzi, 2018).

Acculturation and Mental Health Issues. Generally, Arabs view mental health differently from Americans. Arabs are raised believing that seeking mental health services is a shameful act that brings stigmatization to their families and friends (Kader et al., 2020; Padela & Heisler, 2010; Howells et al., 2009). As a result, Arab Americans usually abstain from seeking mental health services and would instead seek comfort from their families, friends, or religious leaders. Only under extreme conditions, when all culturally acceptable means fail, do Arabs seek professional mental health services. Upon arriving in the U.S., it is common for Arabs to realize that they have lost their family's and friends' convenient support. They are forced to independently face the acculturation process (Padela & Heisler; Howells et al.).

Stigma. It is common for immigrants to experience mental health symptoms, such as depression, anxiety, hostility, and social isolation (Amri & Bemak, 2012; Xiaoming et al., 2006). Stigma describes a quality where an individual considerably disgraces another person in front of others (Goffman, 1963). Stigma negatively impacts how individuals view themselves. It is generally considered a quality utilized to separate affected individuals from the normalized social order. There are two types of stigma, "felt" and "enacted;" it is necessary to understand the

distinction between the two types (Xiaoming et al.). Gilmore and Somerville (1994) introduced the four key features of enacted stigma: the cause of the reaction, identification of the targeted group/individual, assessment of stigma to this individual or group, and the development of the stigmatizing response. Link and Phelan (2001) established another conceptual framework that defined stigma as a process during which five interrelated components converge: labeling, stereotyping, separation, status loss, and discrimination. Labeling refers to the process when others identify and label other human differences. Stereotyping is the process of labeling others with undesirable traits. Separation is the process of placing individuals in discrete categories, which creates a separation between different groups. Status loss is a process by which other individuals become degraded and devalued. Discrimination is the process of disapproving and excluding labeled individuals (Link & Phelan; Major et al., 2018).

Social, economic, and political factors usually dictate various societies' differences, leading to labeling and stereotyping. Enacted stigmatization is linked to power and cultural beliefs that dominate society; it is affected by social inequality and causes labeled individuals to be devalued and shamed and others to feel superior. Another type of stigma is the felt stigma, which focuses on the feelings that labeled individuals experience when they are exposed to negative responses and reactions from others. This may have a crucial role in affecting the mental health and behavior of those being stigmatized. Felt stigma is harmful because it may lead to depression, shame, guilt, low self-esteem, and society's isolation. Felt stigma may eventually lead to more devastating negative thoughts, resulting in suicide or harming others (Xiaoming et al.). Similar to stigma, bias also has an impact on mental health.

Bias. According to Snowden (2003), it is essential to isolate bias from other mental health care barriers and to understand bias at several levels. Epidemiological research

consistently reveals that African, Asian, Native, and Latino Americans needing outpatient care are unlikely to receive the proper care they require. Factors such as socioeconomic status, residence, and origin impact the healthcare needs for specific disadvantaged populations. This encompasses children, adolescents, and the elderly population. There is a greater unmet need for mental health care among African Americans and Hispanics relative to Whites (LeCook, 2017; Snowden; Wells et al., 2001). There is a need for new policies to improve access to mental health treatment across diverse populations. Minority groups seeking mental health treatment face another obstacle: a large percentage of patients will stop seeking therapy after only one treatment session (McGuire, 2008; Wells et al.). Researchers focus on the limited access issues and the gap between proper care provided to different groups and the quality of care provided to those minority groups (Alegria et al., 2016; LeCook; Wells et al.).

Arab American Perception of Mental Health. Mental health services can be stigmatizing, particularly for women (Al-Krenawi & Graham, 2000). First-generation Arab American women find psychiatric, psychological intervention, family, and marital therapies stigmatizing. In the Arab culture, the stigma of mental health services can damage a marriage, increase the probability of separation or divorce, and may even cause the husband to look for a new wife. The importance of the family role, which often overrides personal aspirations, contributes to the Arab Americans' worldview (Al-Krenawi & Graham). Families play a significant role. Members of all ages rely heavily on their families as primary support. Extended family members are also highly valued. The family must get involved, consulted, and take action during the time of need (Carbonell et al., 2020; Dardas & Simmons, 2015; Fakhr Al-Islam, 2008).

All Arab family members share one of their member's pain, suffering, or sickness. Their main concern is how to resolve this calamity. However, there is a negative side to receiving such support. In many cases, the family will intervene on behalf of the patient and attempt to steer the treatment process. Family interdependence makes it difficult for a patient to go for treatment alone. Family members usually accompany the patient to the therapist (Carbonell et al., 2020; Dardas & Simmons, 2015; Fakhr Al- Islam). Accompanying family members generally withhold certain information from the health provider that may be perceived as embarrassing or demeaning to the family. They may also divert the patient from seeking specific treatment to preserve the family's reputation (Fakhr Al-Islam). Family members usually accompany the patient throughout the treatment process. As a result, they determine the caregiver's treatment plan and forbid any mental health services, even when the patient is willing to follow this route (Nydell, 2012).

An individual's personal opinion is typically suppressed if it is contrary to that of the family. Decision-making must follow protocol, where the younger generation abides by their elders' expectations. An individual's happiness is not as valuable as the family's reputation and interest. It is essential and expected of all members to respect the traditional family values and status. In Arab culture, family members are expected to behave in their best behavior and avoid any act or conduct that local traditions deem unacceptable (Nydell, 2012). Any action that may bring shame to the family or jeopardize its reputation is not encouraged. Non-Arabs may view these rules of conduct as selfish and destructive to one's pursuit of happiness. Despite family pressure and expectation, there are advantages to individuals who are part of an Arabic family. For instance, in times of illness or hardship, the family offers extended social, emotional, and other needed support (Carbonell et al., 2020; Dardas & Simmons, 2015; Nydell).

In summary, Arab Americans, especially the first-generation, view mental health services from a negative perspective and may mistrust and underuse any available services. There are few exceptions where seeking mental health services are allowed by the patient's family. These exceptions are usually governed by the family's perspectives, education level, and degree of acculturation (El-Khadiri, 2009; Nydell, 2012). Most ethnic Arabs negatively view mental health services, and as a result, their use of available mental health services is limited. Ethnic Arabs view no distinction between psychiatrists, psychologists, or other professionals in the mental health field. Mainstream ethnic Arabs assume that only insane individuals seek mental health services (El-Khadiri; Kader et al., 2020; Nydell).

Acculturation

In the process of migrating from one nation or culture to the other, knowledge and expressions of distress accompany individuals. Upon migration, the new culture usually plays an active role in changing the old cultural identity/habits and encourages a degree of belonging. Acculturation can be defined as the change in one's values, attitudes, behavior, and self-identity due to moving from one culture to another. People exposed to a different culture exhibit tendencies trying to maintain their practices and culture and adopt the new life and culture (Bhugra, 2004; Nadar, 2020; Schumann et al., 2020). The struggle between keeping one's identity and, at the same time, adapting to all the changes represents a challenge. Bhugra (2004) presented a more precise definition for migration, where migration is a social change process where an individual or a group leaves to another geographical location for an extended or permanent stay due to economic, political, educational, or other reasons. As a result of this definition and as indicated by Bhugra, there is a strong relationship between migration and mental distress (Bhugra).

The migration process is complex since it involves leaving social networks, families, friends, and other support behind and experiencing a sense of loss, dislocation, alienation, and isolation upon arriving. The acculturation process involves several factors, such as the new environment, stress levels, the ability to cope with stress, and the ability to root oneself in this new culture (Hasan & Moradi, 2004). Acculturation is a challenging and difficult process for most immigrants, specifically Arab Americans today, due to their feelings of alienation from the mainstream and the identity crisis they face (Berry, 2017; Kader et al., 2020). Stressors faced include stereotypes and discrimination from the media, the general population, and governmental policies targeting Arab descent, resulting in increased isolation. These isolation factors cause more psychological stress and mental issues (Hasan & Moradi; Nadar, 2020).

The main reason for the difficulty acculturating is that migrants do not abandon their beliefs or idioms of distress, even if those factors were the cause of the migration (Bhugra, 2004; Nadar, 2020). Those deep-rooted beliefs influence their acculturation process. Bhugra (2004) introduced another definition for acculturation, where acculturation was defined as a phenomenon when people from various cultures and backgrounds come into constant contact with changes to their original culture patterns. During the process of acculturation, some aspects of identity are likely to change, including the concept of self. Changes will mainly depend on existing and new cultural contexts. Pre-migration trauma, post-migration factors such as loss of social roles, and socio-demographic characteristics such as age, sex, education, and economic status are other factors that impact the acculturation process. Bhugra (2004) highlighted other critical acculturation factors, such as the impact of cultural orientation: assimilation, separation, biculturalism (feeling reasonably comfortable in both cultures), marginalization, and being accepted by the host society.

Background of the Arab American Mental Health Status

Arab Americans may face economic hardships, racism, assimilation difficulties, and other socio-cultural factors that usually lead to stress (Carbonell et al., 2020; Shehadeh, 2011). Arab Americans strive to attain a healthy and fruitful life for themselves and their families. They are expected to seek medical treatments which abide with their Arabic culture and beliefs. Many still prefer seeking medical treatment from a health practitioner of the same gender. They usually frown upon medical counseling, yet they willingly take pills and injections for therapeutic treatment. Some Arab Americans, like their Middle Eastern counterparts, still perceive mental illnesses as an ominous spell from the devil (Carbonell et al.; Shehadeh).

Current Arab American Mental Health Status

The Arab American mental health status is impacted by several factors that include cultural and religious differences with Americans and their acculturation experience.

Depression

The depression level within Arabs varies according to gender (Abuelezam & Fontenot, 2017; Hamdan 2009). As Hamdan (2009) indicated, one in five women and one in ten men can expect to experience depression in their lifetime in the Arab world. Women are more likely to suffer from depressive illness due to the immense cultural and religious differences between Arab and American women. The conservative nature of Arab women usually leads to their isolation from the mainstream and denies them the opportunity to assimilate (Abuelezam & Fontenot; Hamdan). An earlier study that targeted elder Arab Americans' psychological well-being showed a correlation between immigration status and life satisfaction and depression (Ajrouch, 2007). Recent research indicated that second-generation Arab Americans showed less frequent feelings of depression than did the first-generation. Another finding was that second-

generation Arab Americans had greater life satisfaction than the first-generation (Kader et al., 2020; Pampati, 2018).

Anxiety, Stress, and Risk of Suicide

There is currently limited literature and studies addressing the psychological issues faced by Arab Americans and their relationship to suicide cases. First-generation immigrants reported more anxiety cases than second-generation Arab Americans. A vital factor that may lead to suicide among Arab Americans is a mood disorder that has been associated with committing suicide (Assari, 2017; Hedayat-Diba, 2000). Jamil et al. (2002) examined Iraqi refugees' mental health in a retrospective study of 375 client medical records. The results indicate that Iraqi refugees show a significantly higher post-traumatic stress disorder than non-Iraqis. The causes of this disorder have been attributed to their exposure to the war in Iraq. One of the main reasons for high-stress levels leading to depression resides in recent immigrants' high expectations upon coming to the U.S. Arab immigrants expect to find prestigious, well-paying jobs upon arrival. They never expected the hardships they faced finding a job or the demeaning job itself, which result in low self-esteem and a lack of confidence, particularly among male Arabs (Amer & Hovey, 2011). Another recent study examined the impact of discrimination and mental health well-being of 279 Arab Americans in Michigan revealed depression and anxiety symptoms (Kader et al., 2020). This study highlighted the need to address the mental health differences between Arab Americans and the importance of providing awareness regarding the relationship between discrimination and possible health impact.

Arab American Culture and Mental Health. The available literature on the usage of traditional healing methods among Arab Americans is scarce (Aloud & Rathur, 2009; Hassounah & Kulwicki, 2007; Stark et al., 2020; White & Fetters, 1993). Also, the available data's accuracy

is questionable. Culturally adapted means to seek assistance including visiting shrines, participating in certain healing cults, consulting the local herbalists, and seeking help from a known exorcist to expel the evil spirits. These standard methods' popularity depends on the country of origin and accepted cultural beliefs (Aloud & Rathur; Hassouneh & Kulwicki; White & Fetters).

Arab Americans tend to endorse joint decision-making. With respect to mental health matters, women usually have a more significant role in shaping younger people within the family (Awwad et al., 2008). In the event of a disagreement, women have the final say, especially among Arab Americans of Palestinian origin (Awwad et al.). Families where the young ones have lost a father at a tender age, are more prone to experience mental illness, and thus some respondents think men should have the final say (Awwad et al.). In Arab families, women are expected to express their feelings and fear, while men are expected to show no signs of any emotional distress or anxiety. Men are the head of the household and must have strong personalities and show no signs of weakness at all times (Abuelezam & Fontenot, 2017; Awwad et al.).

Arab Americans generally respond affirmatively when asked whether societal expectations are an issue of concern. Response to the topic of mental services and illness is always hampered by how they feel they will be viewed and perceived by the society they live in (Khouri, 2016). In the Arab American families' collectivistic nature, individuals are constantly pressured to meet societal expectations, regardless of their preferences/personal choices or abilities (Erickson & Al-Timimi). They are always expected to attain and hold a perfect attitude and exemplary behavior. Elderly males are even likely to continue to honor their family name/values and traditions (Dardas & Simmons, 2015; Erickson & Al-Timimi, 2001; Khouri).

Acculturation Processes, Stress, and Strategy. The acculturation process of Arab Americans is shaped by their experiences, such as pluralism, gender, education level, discrimination, and prejudice within society, family support, and economic status. The acculturation strategy adopted also contributes to the mental health of immigrants. Experiences such as discrimination may elevate mental illness, considering that some immigrants come from areas where they may have already been exposed to trauma in their country of origin (Nadar, 2020; Rothemel, 2009). Immigrants who are willing to integrate with the mainstream experience low acculturative stress (Amer & Hovey, 2011). Others who marginalize and isolate themselves from the mainstream suffer more acculturative stress (Amer, 2014). Some Arab Americans have experienced hardships acculturating despite being in the U.S. for several years. For those Arab Americans, they reject any ties that link them to their Arabic background and detest being associated with any Arabic linkages. They consider themselves white and usually socialize with other Americans and non-Arabs only (Amer; Awwad et al.; El-Khadiri; Fakhr Al- Islam). Generally, Arab Americans suffer significantly from the acculturation process because they feel unwelcome and rejected by the American culture. Feeling unwelcome leads to isolation and marginalization and makes the integration process extremely difficult. The acculturation stressors, including discrimination and stereotypes that Arab Americans are forced to face, increase the risk of having mental health issues (Amer; Nadar).

Throughout the years, discrimination against many groups has been deemed unethical and unacceptable (El-Khadiri, 2009; Major et al., 2018). However, discrimination towards Arabs and Arab Americans is still tolerated and encouraged by many high-ranking officials and reputable shows in the media. The discrimination Arab Americans face has been compared to the Japanese's discrimination during Pearl Harbor, where the Japanese lost their freedom and

properties and were victims of angry America (El-Khadiri). Arabs are sometimes viewed as a threat to national security and potential terrorists (Shehadeh, 2011). This is due to their mere affiliation with their religion, race/ethnicity, language, and country of origin. Among the reasons Arabs are viewed as threats were the recent changes to Home Land Security rulings, specifically addressing Arabs and Muslims. There is a need for empowerment and social support for Arabs and Arab Americans (Shehadeh).

Arabs have a rich heritage and history, yet they are misunderstood in the U.S. and have received little attention in mental health literature, if any (Horan, 1995). Mental health professionals should be educated about Arab history, culture, and current political issues (Horan). Research focusing on the mental health experiences of Arab Americans is essential to determine the characteristics of this group (Dardas & Simmons, 2015; Horan). Research should analyze Arab American mental health status, attitudes towards utilization of mental health services, and their satisfaction with the available mental health services (Shehadeh, 2011). Research conducted will enable mental health professionals to provide adequate and quality service to their Arab American clients (Dardas & Simmons; Horan).

Psychoanalytic theories related to understanding and treating Arab individuals and families in America were evaluated utilizing the scarcely available knowledge on psychotherapy's theory and practice with this underserved, misunderstood population (Shehadeh, 2011). There is a severe lack of data, studies, experience, and knowledge of Arab Americans. Even the available information lacks a theoretical framework to understand the uniqueness of this population (Shehadeh). Traditional and modern psychoanalytic theories of identity were reviewed, and some of their limitations in understanding Arab psychology were defined (Shehadeh). However, more studies are necessary to fully comprehend the migration impact on

Arabs mental health status (Fakhr Al-Islam, 2008; Dardas & Simmons, 2015; Nydell, 2012; Pampati, 2018). Even though Arab Americans are represented in the U.S. media (mostly for political and religious reasons), their mental health issues are rarely discussed. There is hardly any public health literature that pertains to them (Horan, 1995). Sentiment against Arabs in America and the negative view of Arabs, in general, are not new phenomena (Horan; Kader et al., 2020; Padela & Heisler, 2010). It is a fact that most Americans cannot differentiate between Arabs, Turks, Iranians, and even sometimes Sikhs and lump all of them as Muslims and Arabs (Horan).

Mental Health Stressors

Stereotypes and Perceptions' Patterns and Images

Frequent stereotypes about Arabs may lead to building negative attitudes by Arabs towards Americans in general, especially when Americans view Arabs as “bad guys,” “terrorists,” “violent to women,” and “backward, ignorant people” (Horan, 1995). Arab Americans are targets of mockery, prejudice, and discrimination. Arab Americans have been so concerned with their safety that their stress level and psychological issues increased significantly. Stereotypes against Arabs lead to a change in attitude and behavioral stress (Horan). As rich as the Arab culture and values are, Arabs have not successfully communicated their great civilization and historical achievements to Americans. Arab Americans are to be blamed partially because they were not successful in understanding the Western culture and providing an accurate portrait of Arabs (Kader et al., 2020). Americans view Arabs as opposition to what America was founded upon (Al-Timmi & Erickson, 2001; Horan; Khouri, 2016; Padela, & Heisler, 2010).

Arab Americans must utilize the mainstream media to change how they are viewed (e.g., dangerous desert Bedouins who ride camels, women abusers, and a significant threat to nations unwilling to accept their beliefs); also, some Americans view Arabs as friendly people, while others view them based on their homeland's relation with the U.S. policies (Al-Timmi & Erickson, 2001; Horan, 1995; Kader et al., 2020; Padela, & Heisler, 2010). Americans became accustomed to seeing Arabs routinely stereotyped in American movies and other media production. Arabs are hardly ever portrayed as victims of stereotypes. Arabs are mainly pictured as billionaires, terrorists, belly dancers, or Bedouins. These negative images impede the development of a positive ethnic identity (Al-Timmi & Erickson; Horan; Padela, & Heisler).

Perceived Abuse and Psychological Distress Post 9/11

There is evidence of abuse and discrimination received by Arab Americans post the 9/11 tragic event (El-Khadiri, 2009; Kader et al., 2020). Discrimination events are recognized as stressors that negatively impact mental health status. There is a direct correlation between the abuse/discrimination and psychological distress, level of happiness, and mental health issues (El-Khadiri). A study conducted in the greater Detroit area showed personal or familial abuse reports after 9/11 (Padela & Heisler, 2010). The study also showed accounts of bad personal experiences related to their ethnicity, especially among Muslim Arabs. The abuse/discrimination led to higher psychological distress levels, lower levels of happiness, and worse health conditions (Padela, & Heisler). Culturally sensitive partnerships should be established to assess and meet the health and mental needs of Arab Americans (Kader et al.; Padela & Heisler).

Arab American Attitudes towards Mental Health Services and Psychotherapy.

Imams (i.e., Muslim religious scholars) have reported an increase in Muslims seeking religious counseling. Imams argue that discrimination and isolation from the mainstream are the main

factors that influenced Arab American acculturation strategies and stress (Amri & Bemak, 2012; Ali & Milstein, 2012; Padela & Heisler, 2010). Unfortunately, only limited studies focus on discrimination experiences among Arabs in the U.S. (Kader et al., 2020; Padela & Heisler). Some believe that there is a direct relationship between perceived prejudice events and psychological distress. Psychologists should provide treatment to Arabs that do not contradict their culture (El-Khadiri, 2009). Psychologists need to be conscious of the role acculturation and discrimination experienced by the Arab Americans play. They also need to understand their religion and cultural heritage and establish appropriate suitable treatments for Arab Americans. If Arab Americans feel safe and heard, they will be willing to explore their discrimination experiences and become less isolated (El-Khadiri).

Attitudes Toward Seeking Mental Health Services. A person's attitude towards seeking and using formal mental health services can significantly influence one's decision to seek professional mental services when the symptoms of mental health problems do occur (Aloud & Rathur, 2009; Nadar, 2020). Ethnicity continues to play a vital role in understating the patterns of mental health services' utilization among various ethnic and racial groups in the U.S. The Arab Muslim population in the U.S. experiences cultural, social, and political pressure, which depicts increased social stressors and calls for affordable, and culturally acceptable mental health services. Arab Americans' mental health providers will benefit the Arab American community (Aloud & Rathur). In its conventional form, psychotherapy is a foreign concept to the Arab population, where the majority abstain from utilizing any mental health service (Sayed, 2003). Some Arabs seek psychotherapy as a tool to adjust to their new lifestyle away from family and friends. More research is needed to determine the psychological impact of Arab Americans'

migration from their homeland and their unique lifestyle (Fakhr Al-Islam, 2008; Dardas & Simmons, 2015; Pampati, 2018; Nydell, 2012).

Arabs, in general, rely on their families, friends, and religious means for mental health support. Unlike many ethnic/racial groups that migrated to the U.S., Arab Americans, especially the first-generation, tend to stick to their roots, isolate themselves from the mainstream American way of life, and view seeking mental health services as a stigmatizing disgraceful act. As a result, they face acculturation stress and psychological pressure. Arab Americans faced discrimination long before the 9/11 tragic event; however, the level of prejudice and stress increased after that terrorist attack. Arabs rely on their extended families and friends for mental support; they have not made proper use of the existing mental health services in the U.S. Ethnic Arabs are more reluctant to seek professional mental health services. Mental health professionals need to understand the Arabic cultural and religious core beliefs since they play a vital role in shaping Arab individuals' attitudes and behavior, particularly when seeking mental health services (Abuelezam et al., 2018; Erickson & Al-Timmi, 2001; Khouri, 2016; Sechrist et al., 2003).

Many second-generation Arab Americans do not share their parents' views and are more prone to utilize available mental health services. More work is warranted to analyze further the impact of acculturation, and discrimination experiences have on Arab Americans. Mental health provisions to the Arab population in the U.S. are extremely limited in scope compared to the community's needs (Carbonell et al., 2020; Nadar, 2020; Shehadeh, 2011). As Arabs continue to migrate to the U.S., mental health care professionals need to exert more work to provide the necessary care to Arab Americans. There is a need for special considerations and education to guide social work interventions in Western nations where ethnic Arabs reside, especially in the

U.S. Important factors such as gender relation, family role, common cultural beliefs among families and communities, and patterns of mental health services need to be accounted for (Al-Krenawi & Graham, 2000; Nadar, 2020; Wrobel & Paterson, 2014).

Knowns in the Literature

From the literature reviewed, several knowns were identified:

- Second-generation Arab Americans do not share their parents' views and are more prone to utilizing available mental health services (Carbonell et al., 2020; Nadar, 2020; Shehadeh, 2011).
- Mental health provisions for the Arab population in the U.S. are limited in scope compared to the community's needs (Carbonell et al., 2020; Nadar, 2020; Shehadeh, 2011).
- As Arabs continue to migrate to the U.S, there is a need for special considerations and education to guide social work interventions (Al-Krenawi & Graham, 2000; Nadar, 2020; Wrobel & Paterson, 2014).
- Essential factors such as gender relations, family role, common cultural beliefs among families and communities, and mental health services patterns need to be accounted for (Al-Krenawi & Graham; Nadar; Wrobel & Paterson).

Unknowns in the Literature

Additionally, several unknowns or gaps in the literature were identified:

- The impact of acculturation and discrimination experiences on Arab Americans is not well understood.
- The impact of acculturative factors on Muslim and Christian Arab Americans' mental health status is not well understood.

- It is not well understood how first-generation Arab Americans seek treatment from professional mental health care providers.
- It is not well understood how first-generation Arab Americans perceive mental health.
- It is not well understood how the second-generation Arab Americans view mental health.
- It is not well understood how the second-generation Arab Americans seek and perceive treatment from professional mental health care providers.

This study addresses those gaps. Chapter 3 will review the research design and methodology and the data collection process and data analysis.

Chapter III

METHODOLOGY

Introduction

This study is an exploratory, descriptive, and correlational design that aims to understand:

a) major factors involving the attitudes of Arab American populations toward seeking professional mental health services, b) how first and second-generation Arab Americans seek professional mental health services, c) how first and second-generation Arab Americans perceive mental health services, residing in the New York Metro area, and d) the impact, if any, of:

- a) Cultural beliefs regarding mental health services.
- b) Demographic factors pertaining to Arab Americans' attitudes towards seeking professional mental health.
- c) Knowledge of available professional mental health services.
- d) Acculturation method: fully acculturating or disassociating from the American culture.
- e) Perceived societal stigma on Arab Americans' mental health.

Research Questions

Overarching Research Question:

How do first and second-generation Arab Americans perceive mental health Services?

Primary Sub-Questions

This study has three research questions:

RQ1. What are the factors (e.g., stigma, bias, acculturation, etc.) involved in the attitudes of Arab American population residing in the New York Metro area toward seeking professional mental health services?

Hypothesis RQ1: Not Apply. Because this first question is descriptive explanatory in nature, there is no corresponding hypothesis.

RQ2. Are there differences between the way first and second-generation Arab Americans seek professional mental health services?

Hypothesis RQ2: There may or may not be a difference between the way first and second-generation Arab Americans seek professional mental health services.

RQ3. Are there differences between the way first and second-generation Arab Americans perceive professional mental health services?

Hypothesis RQ3: There may or may not be differences between the way first and second-generation Arab Americans perceive professional mental health.

Theoretical Framework

Two existing theories were utilized to inform this study. The first theory was the acculturation theory (Berry, 2017). According to Berry, upon migrating to another culture, immigrants usually choose one of four acculturation processes:

- Assimilation is the first process when immigrants choose to abandon their cultural beliefs and fully indulge in the new culture.
- Separation is the second process when immigrants decide to withhold their cultural beliefs and abstain from the new culture.
- Integration is when the immigrants decide to learn and indulge in the new culture while holding on to their own cultural beliefs.
- Deculturalization/disengagement is the final process when immigrants choose to abstain from their own culture and the new culture.

Immigrants who hold on to their cultural beliefs were influenced by their attitudes regarding their own ethnic culture. In contrast, indulging in the host's culture was a function of mainstream behavioral practice. Berry's theory proposed a relationship between the acculturation process adopted and the psychological adaptation. The "integration" process is believed to positively impact the immigrant's mental health status since the immigrant will receive support and resources from both their ethnic and host's culture. In contrast, the "marginalization" process is believed to have the most negative impact on the immigrant's mental health due to the associated poor or lack of social support (Berry, 2017).

The second theory was the multiculturalism theory (Horan, 1995). The multiculturalism theory encourages appreciation between different cultures and languages that exist in society. This theory enabled individuals to welcome other cultures and simulated people to learn about other cultures and be more tolerant of others' beliefs when they contradict their own culture and beliefs. It portrayed the good in each culture and allowed others to view the other culture's positive aspects. All society members were expected to respect all individuals and groups. The multiculturalism theory recognized the existence of a complex "plural society," this theory recommended that culturally diverse groups should attain a shared understanding to accept others' cultures (Horan).

This study comprehensively addressed the gaps in the literature. It was novel by including methodology that quantitatively evaluated the difference between first and second-generation Arab Americans' attitudes towards seeking professional mental health services for the effect of cultural beliefs, knowledge, and familiarity of available mental health, societal stigma, escalated stress, and selected demographic characteristics. As a result, using exploratory, descriptive research design was most appropriate. Also, descriptive research was broadly utilized

to efficiently measure individuals' perception and utilization of professional mental health services, specifically for ethnic and racial minority groups.

Research Design. This study is non-experimental in nature because it is survey-based. This study is correlational as it examines the relationship between first and second-generation Arab Americans. This study is exploratory; it comprehensively addressed the literature gaps and was novel by including methodology that quantitatively evaluated the difference between first and second-generation Arab Americans' attitudes towards seeking professional mental health services. This study is also descriptive as it described the characteristics of first and second-generation Arab Americans.

Sampling Procedure. This study utilized a convenience sample. The total targeted sample size was 102 first and second-generation Arab Americans. This sample size was determined using an a-priori power analysis calculated with an effect size of $d = 0.26$ (medium effect), $\alpha = 0.01$, and power $(1 - \beta) = 0.95$, representing a median average effect and 95% confidence interval range. The total sample size calculated using G-Power (Faul et al., 2009) was 102 (Figure 2).

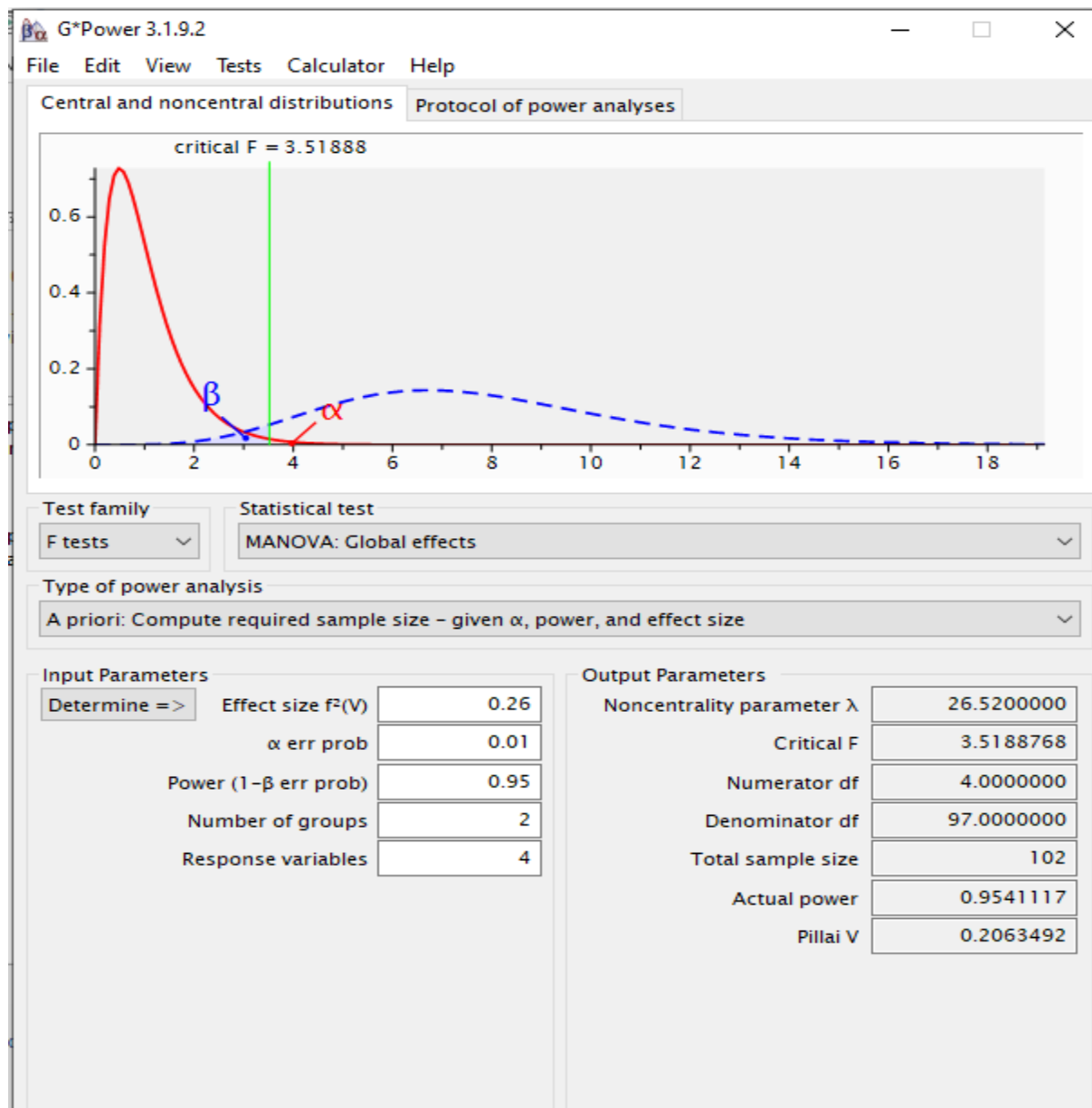


Figure 2. A Priori G*Power Analysis to determine sample size. With an effect size of .26 appropriate for MANOVA, an alpha level set at .01, power of .95, two groups (first and second-generation Arab Americans) and four dependent variables, the expected and anticipated sample size is 102 participants for the survey instruments.

Participants' Characteristics

Inclusion Criteria:

- Men and women aged 18 and older.

- First-generation Arab Americans who migrated from any of the 22 Arabic countries located in Africa and Asia. These countries are Algeria, Bahrain, the Comoros Islands, Djibouti, Egypt, Iraq, Jordan, Kuwait, Lebanon, Libya, Morocco, Mauritania, Oman, Palestine, Qatar, Saudi Arabia, Somalia, Sudan, Syria, Tunisia, United Arab Emirates, and Yemen.
- Second-generation Arab Americans born in the U.S. to first-generation Arab Americans.
- First-generation Arab Americans: aged 50 and older
- Second-generation Arab Americans: Between 18 and 50 years old, residing in the U.S.
- English speaking/reading individuals.

Exclusion Criteria:

- Less than 18 years of age
- Individuals whose ancestors were not from the 22 Arab countries.
- Second-generation whose parents were born in the U.S.
- Arab Americans who were third generation, fourth generation, etc.
- Non-English speaking/reading individuals.

Participant Recruitment

As discussed previously, Arab Americans share everyday habits, especially concerning seeking professional mental health assistance, even though they come from 22 different countries (Abuelezzam et al., 2018; Erickson & Al-Timmi, 2001; Moradi & Hasan, 2004; Nadar, 2020; Sechrist et al., 2003). Additionally, for this study, first-generation Arab Americans were operationally defined as born outside the U.S. and immigrated to the U.S. from one of the 22 countries. First-generation Arab Americans must be capable of speaking and reading English. For this study, second-generation Arab Americans were operationally defined in the following

manner: they were born in the U.S. to first-generation Arab American parents who spoke English. Also, second-generation Arab Americans were Arabs who resided in the U.S. between 18 and 50 years old.

In New York, the sample population consisted of members from an Islamic center and an outpatient medical center. Site approvals were obtained to solicit Arab American individuals associated with the two institutions that provide religious, social, medical, and educational services within New York City.

- Masjid Al-Farooq is an Islamic center located in the borough of Brooklyn at 556 Atlantic Ave, Brooklyn, NY, 11217. Most Arabs residing around this area are originally from Egypt, Morocco, Palestine, Algeria, Yemen, Sudan, and Tunisia (Appendix B).
- Ben Sinai outpatient medical healthcare site is located in the borough of Brooklyn at 6903 4th Ave #2R, Brooklyn, NY, 11209 (Appendix B).

In New Jersey: the sample population consisted of Arab American graduate healthcare students/professionals from the Department of Interprofessional Health Science and Health Administration at Seton Hall University. Approval from the Chair of Interprofessional Health Sciences and Health Administration School of Medical Sciences was obtained to solicit students (Appendix B).

The sample population also included members of the Egyptian American Youth Group online network group. This online network group is a non-profit organization that globally connects Egyptian youth. Lastly, a snowball recruitment approach was utilized with those who received the study solicitation digitally (i.e., students from the Department of Interprofessional Health Science and Health Administration at Seton Hall University (SHU) and the Egyptian American Youth group).

Study Recruitment. For the Islamic center and the medical outpatient center in New York, a convenience sample was utilized to analyze the general, non-targeted population results. With respect to the study participants at Seton Hall University, a non-random representative sampling was used, mainly due to the lack of Arab demographic/database, thus the need to target Arab Americans on campus.

Data Collection

Instrument Tools

The two existing survey tools that were utilized in this study were created by Dr. Nasser Aloud and were developed to be utilized with the Arab American population (Aloud & Rathur, 2009). The principal investigator (PI) contacted Dr. Aloud and received a verbal and written confirmation to utilize the ATSFMHS and KFFMHS instruments (Appendix F). The third survey was the demographic survey that was created by the PI. The first survey, the Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS), is an adaptation of the “Attitudes Toward Seeking Professional Psychological Help” (ATSPPH) scale, the most widely utilized instrument for determining attitudes among ethnic and racial minority groups (Aloud). ATSFMHS substitutes terminology that is familiar with Arab Americans. The ATSFMHS involved modified terms and language to fit Arab Americans’ cultural terms and language. The ATSFMHS is a 20-question survey. The ATSFMHS survey utilized a Likert scale in which the participant was asked to either “strongly agree,” “agree,” “disagree,” or “strongly disagree” with the survey questions. The second survey was the Knowledge and Familiarity with Formal Mental Health Services Instrument (KFFMHS). This survey is comprised of 11 questions. This instrument was developed to examine Arab Americans’ familiarity with mental health issues and professional health services practitioners' roles. The KFFMHS survey used a Likert scale.

Participants were asked about their familiarity level: “not at all,” “very little,” “somewhat,” “very familiar,” and their knowledge level: “nothing,” “very little,” “some,” and “great deal.” Both surveys had an electronic version and a paper version. For more information concerning the surveys, the reader can contact the survey author.

Validity and Reliability

The PI used two tools: the ATSFMHS and the KFFMHS (Appendices F and G). Because the PI was testing a novel population of first and second-generation Arab Americans, the PI prepared post-hoc reliability (Chron α) for each instrument.

ATSFMHS Validity and Reliability:

As stated prior, the ATSFMHS instrument is a modification of the ATSPPH to substitute Arab terms that will be better understood by the Arab American population. The validity of the modified ATSFMHS was addressed by a panel of experts from Ohio State University who worked with the author on establishing face and content validity for the instrument (Aloud & Rathur, 2009). The calculated reliability of the ATSFMHS was 0.72. Factor analysis using Cronbach’s alpha was used for reliability purposes. The Cronbach’s Alpha for the ATSFMHS survey $\alpha = 0.711$ is considered good/acceptable by George and Mallery (2003).

Table 2
Cronbach’s Alpha Reliability Statistics for ATSFMHS

ATSFMHS Reliability Statistics	
Cronbach's Alpha	N of Items
0.711	11

KFFMHS Validity and Reliability:

The validity of the KFFMHS was addressed via a panel of experts from Ohio State University who worked with the author to establish face and content validity for the instrument (Aloud & Rathur, 2009). The calculated reliability of the KFFMHS was 0.72. The Cronbach's Alpha for the KFFMHS survey $\alpha = 0.927$ (Table I) is considered excellent by George and Mallery (2003).

Table 3
Cronbach's Alpha Reliability Statistics for KFFMHS

KFFMHS	
Reliability Statistics	
Cronbach's Alpha	N of Items
0.927	11

The PI contacted Dr. Aloud and received a verbal and written confirmation to utilize the ATSFMHS and KFFMHS instruments (Appendix F). The PI also collected demographic information that was used for the data analysis (Appendix G).

Data Collection:

Category A – Onsite:

- Masjid Al-Farooq is located at 556 Atlantic Ave, Brooklyn, NY, 11217.
- Ben Sinai outpatient medical center is located at 6903 4th Ave #2R, Brooklyn, NY, 11209.

Category B – Online:

- Seton Hall University.

- Egyptian American Youth Group (Facebook page).

Onsite (face-to-face) Survey Process:

Face-to-face recruitment took place at Masjid Al-Farooq and Ben Sinai outpatient medical center.

For the Islamic center:

- The PI trained the research assistant (RA) with respect to the appropriate procedures needed to complete the entire data collection process (Appendix C). The RA was an Arab American who was very familiar with Arab culture.
- The PI familiarized the RA with a script to explain the study survey and the participation process (Appendix D). Once the RA training was completed, and the Institutional Review Board (IRB) approval was granted, participant recruitment began. The RA was only trained to collect data and was not qualified to answer questions. The RA merely read the script.
- Following IRB's approval, the PI forwarded the study flyer, which accented the inclusion criteria for participating in this study to the Islamic center, and when the onsite recruitment will occur. The Islamic center agreed to post the flyer on their bulletin board (Appendix E), informing visitors when the study solicitation will occur.
- The PI also forwarded the study solicitation letter (Appendix I), which provided more detailed information of the study to the Islamic center who agreed to post on their bulletin board.
- According to traditional norms, because the PI is a female, she only explained the purpose of the study, introduced the RA, and then joined the females in the female room.

- The RA utilized a script (Appendix D) prepared by the PI to understand the study's purpose better.
- For those who wished to participate and met the study criteria, the RA informed them about the solicitation letter (Appendix I).
- Due to cultural and modesty purposes, males and females have separate prayer rooms in many Islamic centers. The RA distributed the data collection instruments in one envelope to those in the male room, and the PI distributed the envelopes in the female room. The RA utilized the sound system for communicating with both the male and female rooms. The RA read the script, and for those who wished to participate, asked them to complete the enclosed surveys, place them back in the envelope, and deposit the envelope after sealing it in the box, which was located by the center's entrance.
- For those who did not wish to participate in the study, to preserve anonymity regarding who completed the survey, at their convenience in the hour following the RA reading of the script, they were advised to drop their blank or incomplete surveys in the envelope and drop the envelope in the collection box.
- The RA collected the boxes following each recruitment session and removed the sealed envelopes.
- Additionally, the RA requested participants if they know someone who is not present and may be interested in this study to advise them to attend one of the future recruitment sessions.

For the Outpatient Medical Center:

- Following IRB's approval (Appendix A), the PI forwarded the study solicitation (see Appendix I) to the outpatient medical center.

- The CEO and owner agreed to allow the PI to conduct onsite recruitment on Saturdays, the busiest day of the week, for patients from 11:00 AM to 5:00 PM. The CEO agreed to provide the PI with a conference room. The CEO agreed to post the study flyer (Appendix E) on the center's main entrance door, in the patients' waiting area, and on the clinic doors advising their members and patients when the PI will be onsite to recruit for the study. When patients arrived for their appointment, during their registration, the reception staff advised them of the opportunity to participate in this study, and those who were interested were directed to the assigned conference room. The PI explained the study's purpose to the patients and visitors.
- The PI forwarded the study flyer (Appendix E) to the outpatient medical center to inform when the study solicitation will occur.
- The PI visited the outpatient medical center.
- The PI explained the study's purpose to those who came to the assigned conference room and recruited people interested in the study.
- The PI advised the attendees of the collection box that was available to drop off their completed surveys.
- For those who wished to participate, the PI asked them to complete the enclosed surveys, place them back in the envelope and deposit the envelope after sealing it in the collection box located in the back of the room.
- For those who did not wish to participate in the study, to preserve anonymity regarding who completed the survey, at their convenience in the hour following the RA reading of the script, they were advised to drop their blank or incomplete surveys in the envelope and drop the envelope in the collection box.

- Additionally, the PI requested the participants if they knew someone who was not present and may be interested in this study to advise them to attend one of the future recruitment sessions.

Online Recruitment:

For the online Egyptian American Youth Group:

- The PI had a conference call with the online Egyptian American Youth group creator/owner.
- The PI explained the purpose of the study and survey.
- The group's creator/owner agreed to post the study solicitation on their Facebook page, which included a link to the SurveyMonkey® site survey (Appendix B).
- Those who met the criteria and wished to participate were advised to click on the link to take the survey.
- Those who wanted to opt-out were advised to close the browser at any time.
- Additionally, snowball sampling was utilized. Participants were encouraged to pass the survey information and SurveyMonkey® link to those who met the criteria and were willing to participate.

For the Seton Hall University Participants:

- The Department of Interprofessional Health Sciences and Health Administration agreed to forward the study solicitation to Ph.D. health students (Appendix B).
- Students who met the criteria and wished to participate were advised to click on the link to take the survey.
- Those who wanted to opt-out were advised to close the browser at any time.

- Additionally, snowball sampling was utilized; participants were encouraged to pass the survey information and SurveyMonkey® link to those who met the criteria and were willing to participate.

Questionnaire Collection Process

Online Survey Procedure

The PI activated the SurveyMonkey® study link post-IRB approval.

Egyptian American Youth Group:

- The PI provided the study solicitation (Appendix I) to the group owner, who agreed to post it on the Facebook page.
- Members of the online group who wished to participate in this study were advised to click on the study link, which directed them to SurveyMonkey®.
- Following arrival at the study site, individuals were presented with the study inclusion/exclusion criteria. Those who met the inclusion criteria were advised to participate in the study by clicking NEXT.
- Those who wanted to opt-out were advised to close the browser at any time.
- Additionally, snowball sampling was utilized, and participants were encouraged to pass the survey information and SurveyMonkey® link to those who met the criteria and were willing to participate.

Seton Hall University:

- The PI e-mailed the study solicitation to the Interprofessional Health Sciences and Health Administration School of Medical Sciences Chair at Seton Hall University (Appendix I).
- The Chair e-mailed the student body the solicitation letter (Appendix I) and the SurveyMonkey® link to the surveys.

- Students who met the criteria and wished to participate were advised to click on the link to take the survey.
- Additionally, snowball sampling was utilized. Participants were encouraged to pass the survey information and SurveyMonkey® link to those who met the criteria and were willing to participate.

Data Analysis

Paper and Electronic Survey

- The PI evaluated the paper and electronic surveys for completion.
- The data from the paper surveys were entered into the computer. Before the analyses were run, the data were checked against the raw data to ensure no discrepancies. This process is known as “data cleaning.” This step was vital to confirm the validity of the data analysis (Portney and Watkins, 2000).
- The SurveyMonkey® responses were exported directly to SPSS via the “Export All” option in SurveyMonkey®.
- The paper surveys were entered directly into SPSS.
- Following the guidelines sets forth by the IRB, the electronic data were transferred from SurveyMonkey® and saved on a password-protected USB and kept in a locked, secured physical site. The PI ensured the accuracy of the data post-transfer.

Descriptive statistics included frequencies, averages (means, medians, and ranges), and standard deviations for continuous data. For this study, the relationship between the two variables was tested: independent (first and second-generation Arab Americans) and dependent (acculturation method, stigma, bias, and cultural beliefs). The descriptive frequency was utilized

to determine the number of participants that fit into specific categories. The data were analyzed according to two groups, first-generation participants and second-generation participants.

To determine if there were differences between the way first and second-generation Arab Americans seek/perceive professional mental health services, the Multivariate Analysis of Variance (MANOVA) Global effects were the appropriate statistical tests to determine the difference between first and second-generation Arab Americans. MANOVA was utilized to determine if there was a significant statistical difference between the first and second-generation Arab Americans. MANOVA and individual Analysis of Variance (ANOVAs) were used to determine the differences for RQ2 and RQ3 and determine whether first and second-generation Arab Americans have a difference in perceiving and seeking professional mental health services. A Priori power analysis was conducted to determine the required sample size, which was now calculated to be 102 participants based on a medium effect size of 0.26, suitable for MANOVA. The input Power (1-Beta) correctly rejects the null hypothesis = 0.95 or 95% chance of rightly rejecting the null hypothesis. Figure 3 illustrates a flowchart summary of the methodology up to and including the reliability assessment post-IRB approval from Seton Hall University.

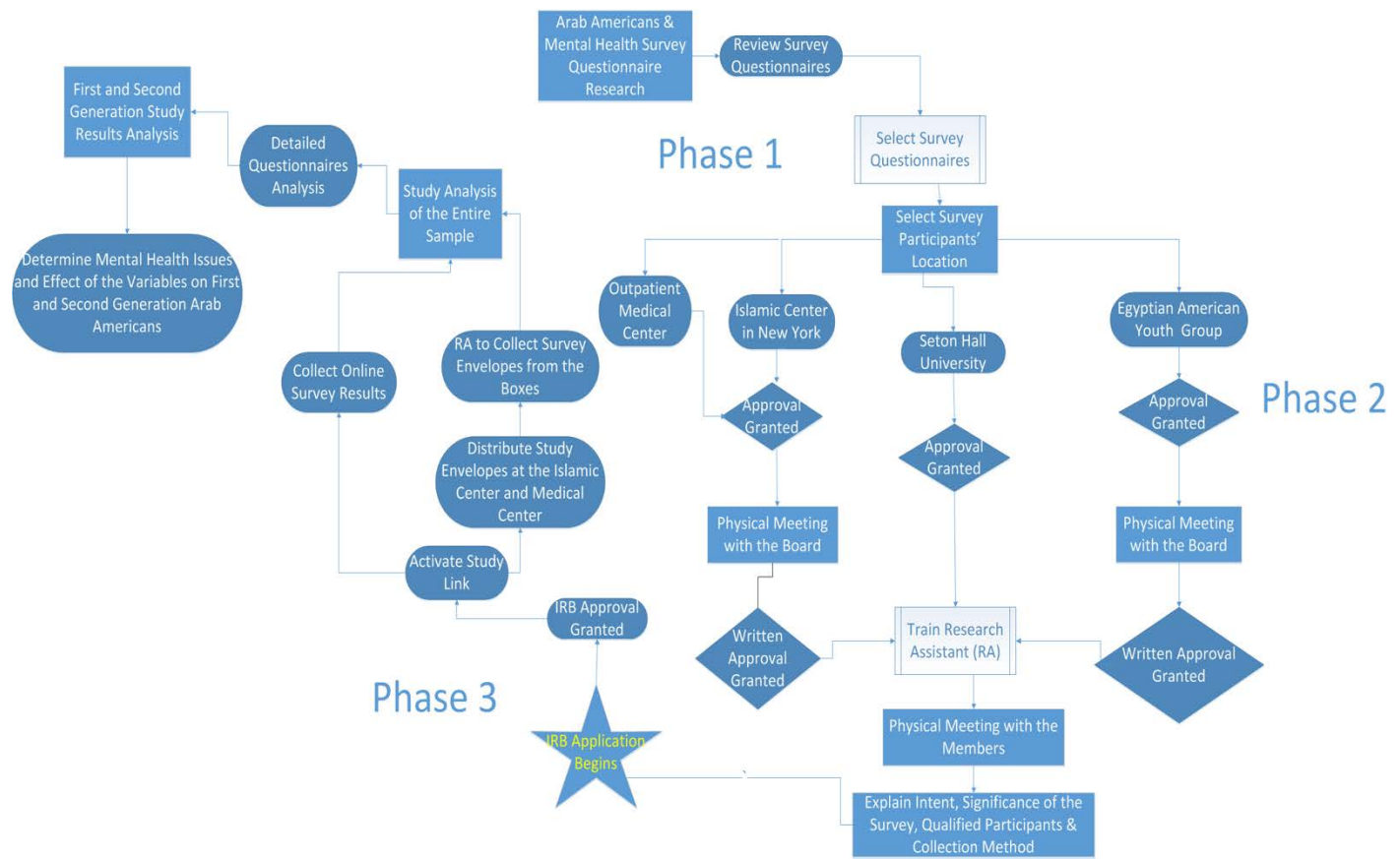


Figure 3. Flowchart summary of methodology up to and including the reliability assessment post-IRB approval from Seton Hall University

Chapter IV

RESULTS

Research Findings

This chapter presents findings from the following surveys: ATSFMHS, KFFMHS, and Demographic survey. According to the Priori power analysis, the required sample size was 102 participants. A total of 370 participants participated in the survey (Figure 4).

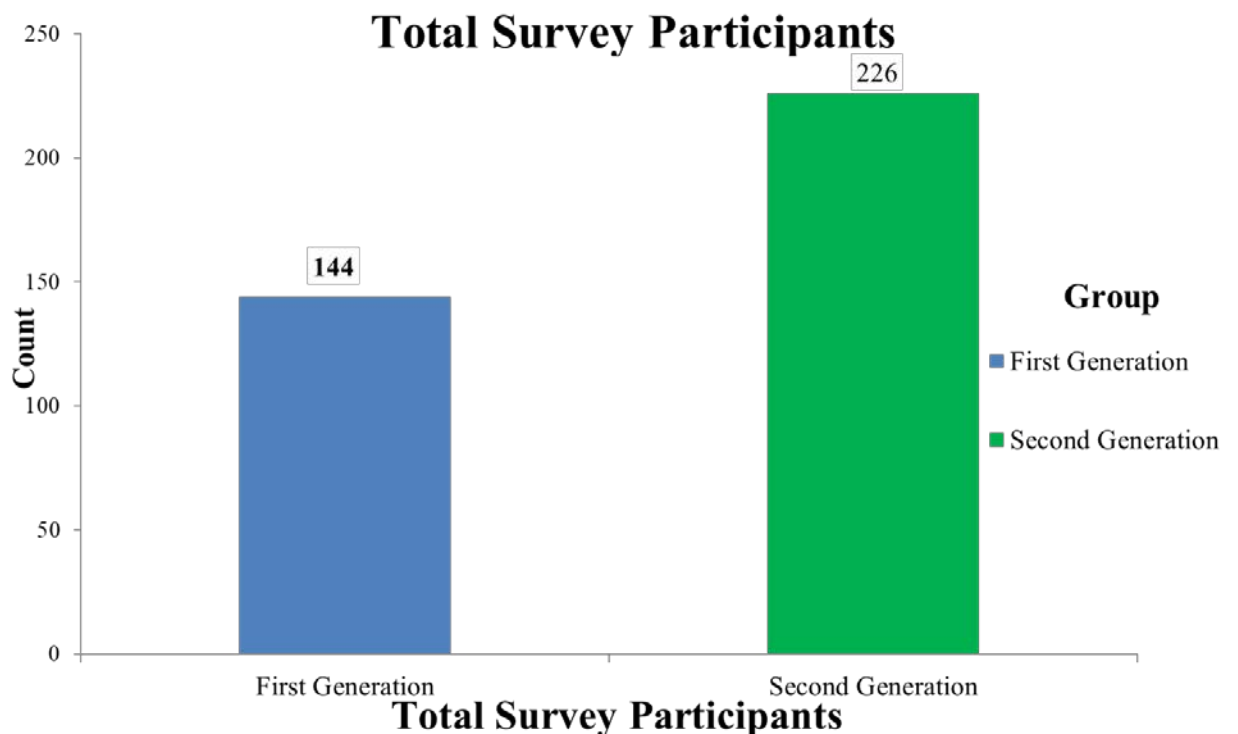


Figure 4. Bar graph of participants according to the two groups. The largest group of participants was second-generation Arab Americans.

Figure 5 shows the two groups with respect to those who responded and did not respond. The largest group of participants was second-generation Arab Americans.

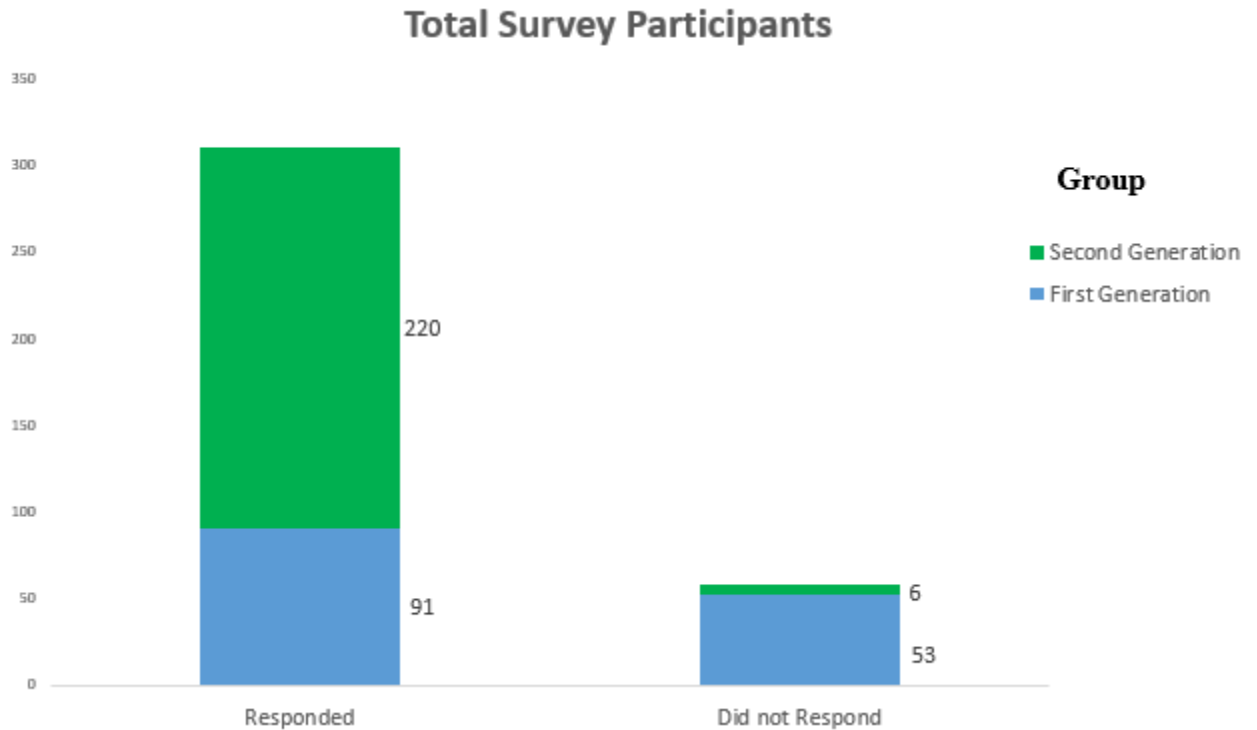


Figure 5. Clustered bar graph of participants according to the two groups with respect to those who responded and did not respond. The largest group of participants was second-generation Arab Americans.

Demographic Survey Results

Key participants' demographic results were reviewed before the data was analyzed according to the research questions. This was accomplished by analyzing several graphs that correspond to various demographic questions.

Gender of Participants. More females than males took this survey. Specifically, 55% (180) of the participants were females, and 45% (142) were males (Figure 6).

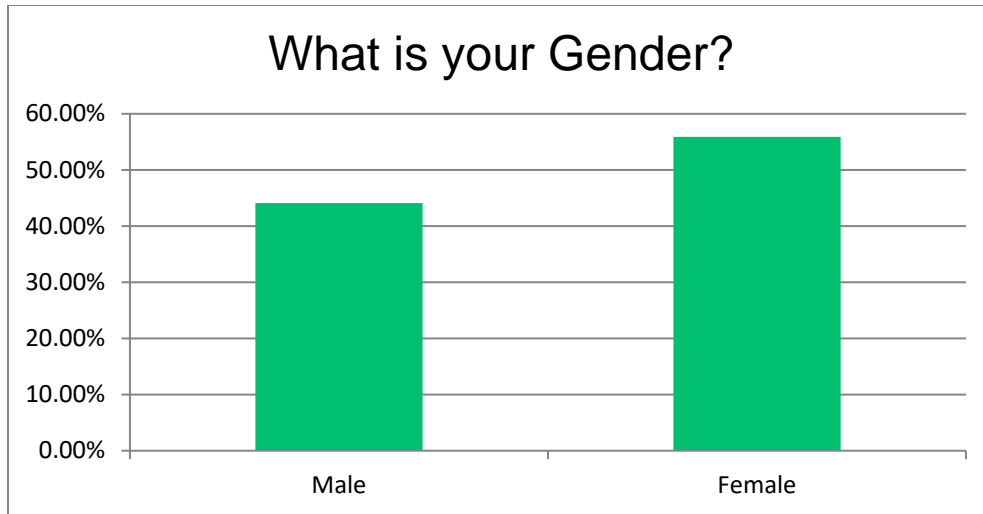


Figure 6. Bar graph of participants according to gender. The largest group of respondents were female Arab Americans.

Participants' Original Nationality. With both groups combined, the majority of participants were from Egypt (122), Palestine (27), Morocco, and Yemen, since the targeted New York Metro area has a high Arab population from those countries (Figure 7).

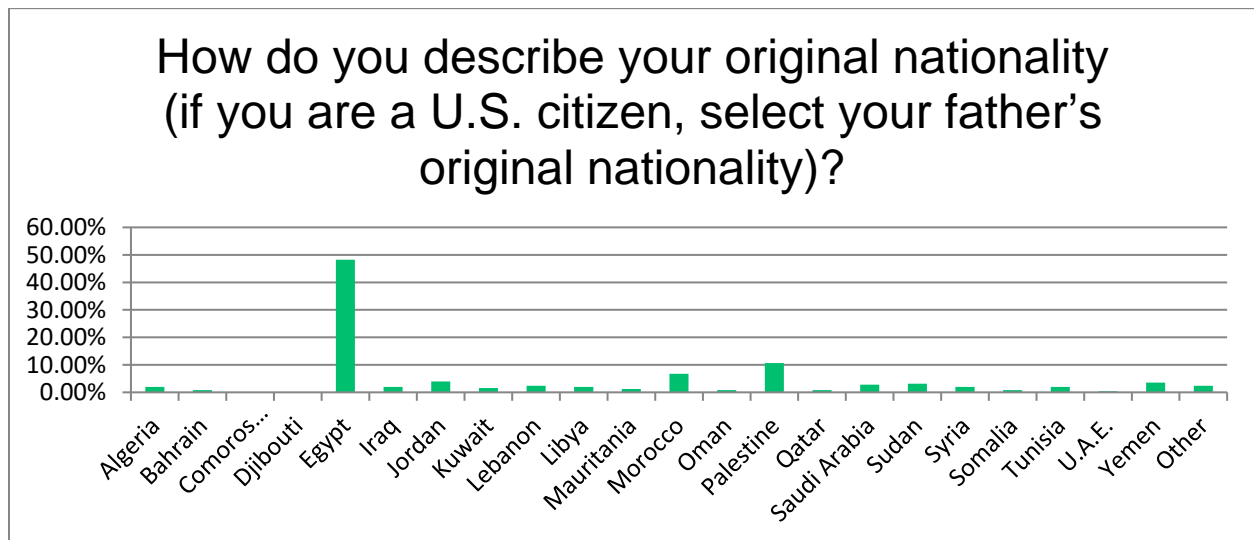


Figure 7. Bar graph of participants according to the country of origin. The largest group of participants were from Egypt.

Participants' Marital Status. Over 50% of the participants were married (169), and around 25% were single (78). The number of divorced (37) and widowed (31) participants was comparable (Figure 8).

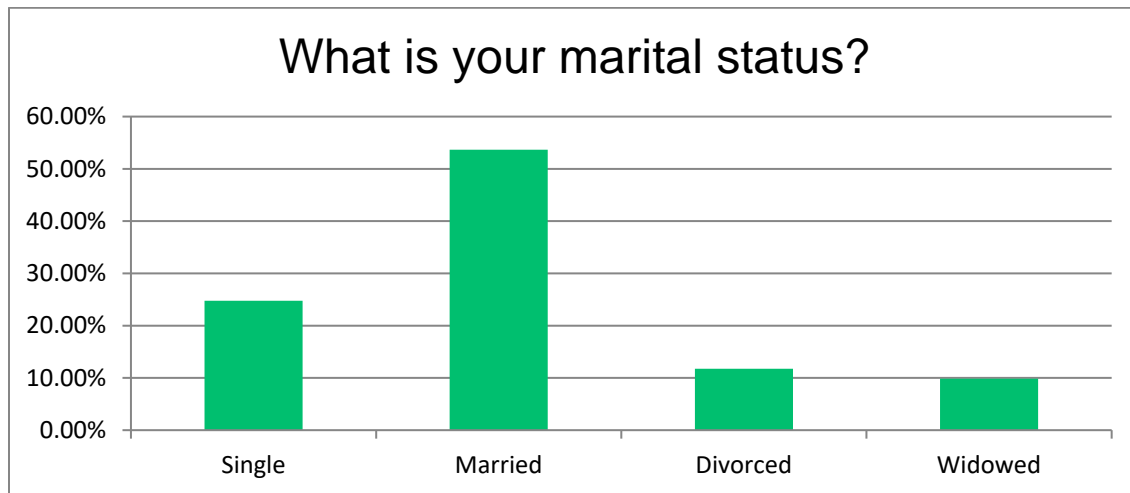


Figure 8. Bar graph of participants according to their marital status. The largest group of participants were married.

Table 4 shows the marital status of first and second-generation Arab Americans. The majority of the participants were married.

Table 4
Participants' Marital Status by Group

What is your Marital Status?		
	First Generation	Second Generation
Single	5	73
Married	49	118
Divorced	16	21
Widowed	23	8
Total	93	220
Didn't Answer in Total	51	6

Participants' Highest Education Level. Around 50% of the participants had a bachelor's degree (152), and 20% had a Master's degree (58) (Figure 9). A small percentage had less than high school (31), and around 10% had a Ph.D. (30).

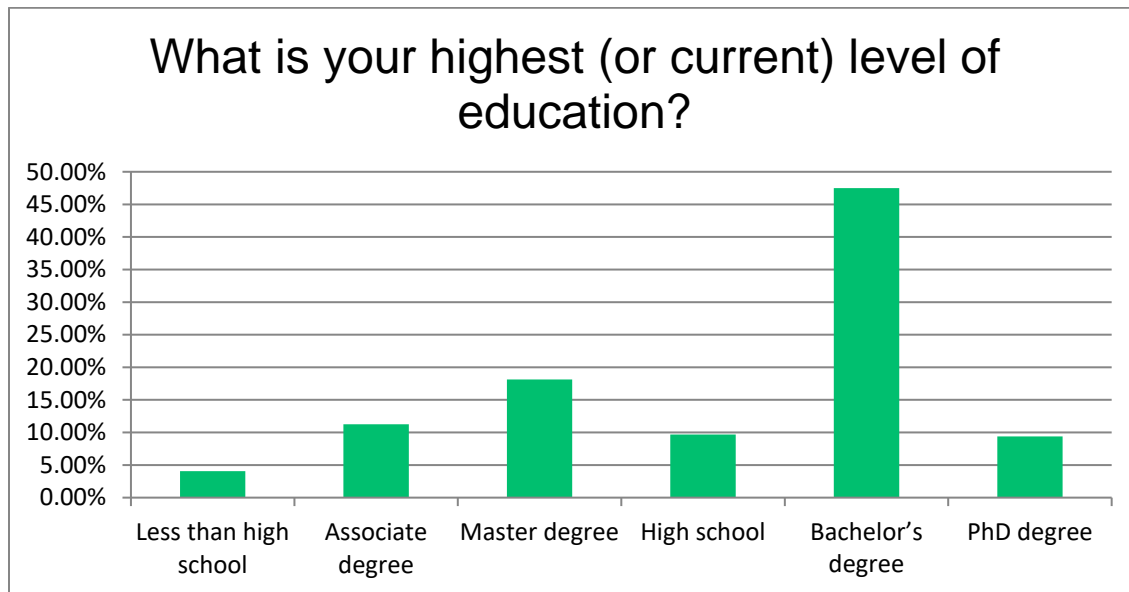


Figure 9. Bar graph of participants' highest education level. The largest group of participants had a bachelor's degree.

Table 5 showed the highest education level for first and second-generation Arab Americans. The majority of the participants had a bachelor's degree.

Table 5
Participants' Highest Education Level

What is your Current/Highest Education		
	First Generation	Second Generation
Less than High School	10	3
Associate Degree	13	23
Masters Degree	10	48
High School	6	25
Bachelor's Degree	42	109
Ph.D.	12	17
Total	93	225
Didn't Answer in Total	51	1

Participants' Family Annual Income. Concerning the family's annual income, over 70% of Arab Americans (122) had an annual family income of \$70,000 or higher, and a small percentage had a family income of less than \$20,000 (28). As seen in Figure 10, the majority of participants selected the highest annual income level.

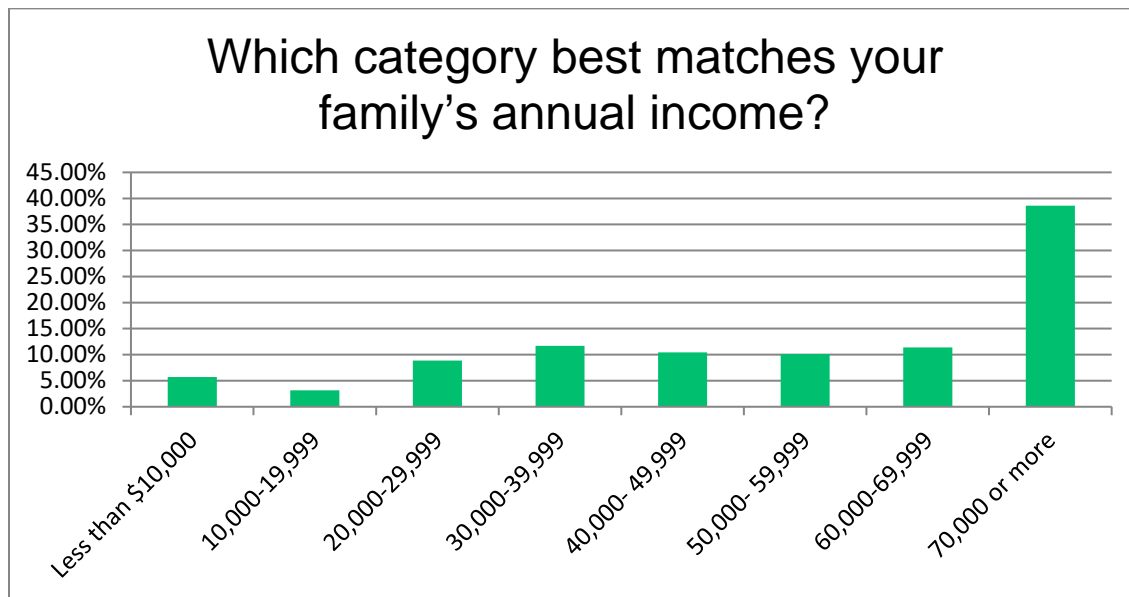


Figure 10. Bar graph of participants' family income level

Table 6 showed the highest family annual income level for first and second-generation Arab Americans. The majority of the participants had an annual family income of \$70,000 or greater.

Table 6
Participants' Family Income Level

Which Category Best Matches your Family's Annual Income?		
	First Generation	Second Generation
Less than 10,000	0	18
10,000 - 19,999	3	7
20,000 -29,999	8	20
30,000 -39,999	17	20
40,000 -49,999	3	30
50,000 -59,999	8	24
60,000 -69,999	16	20
70,000 or more	36	84
Total	91	223
Didn't Answer in Total	53	3

Participants' Occupation. Figure 11 showed over 30% of the participants were professionals or administrators (104), and around 20% had personal businesses (54). Only approximately 10% were unemployed (42), and about 10% were students (37).

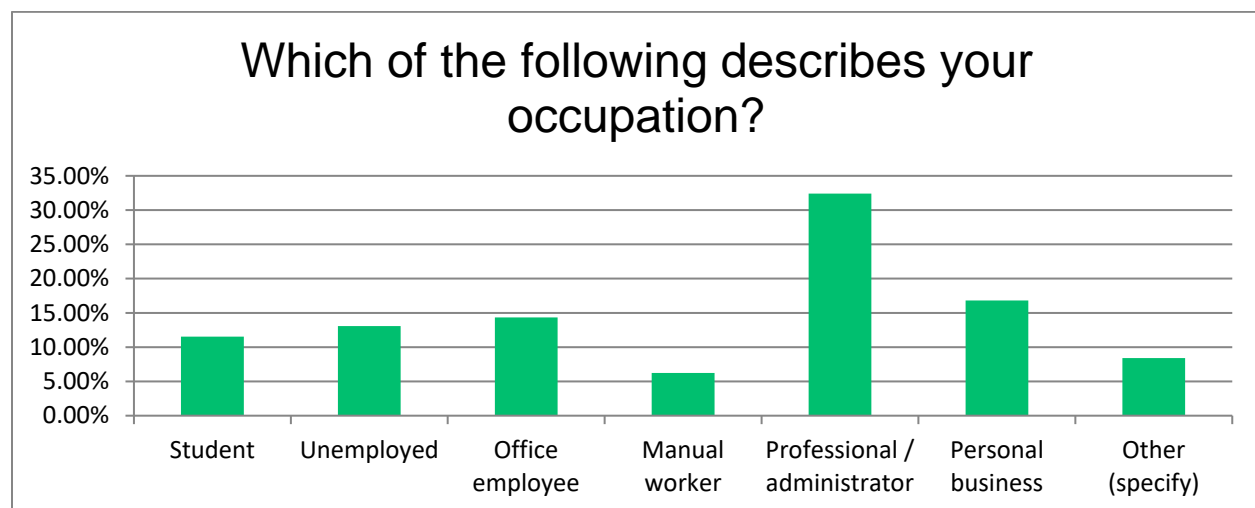


Figure 11. Bar graph of participants' occupation

Participants' Thanksgiving Celebration. Figure 12 showed Arab Americans who celebrate Thanksgiving. Around 40% of Arab Americans (120) do not celebrate Thanksgiving. This is a critical question as it relates to the acculturation method that was discussed prior. Figure 13 showed first and second-generation Arab Americans who celebrated Thanksgiving. The majority of the second-generation Arab Americans celebrated Thanksgiving, unlike the first-generation.

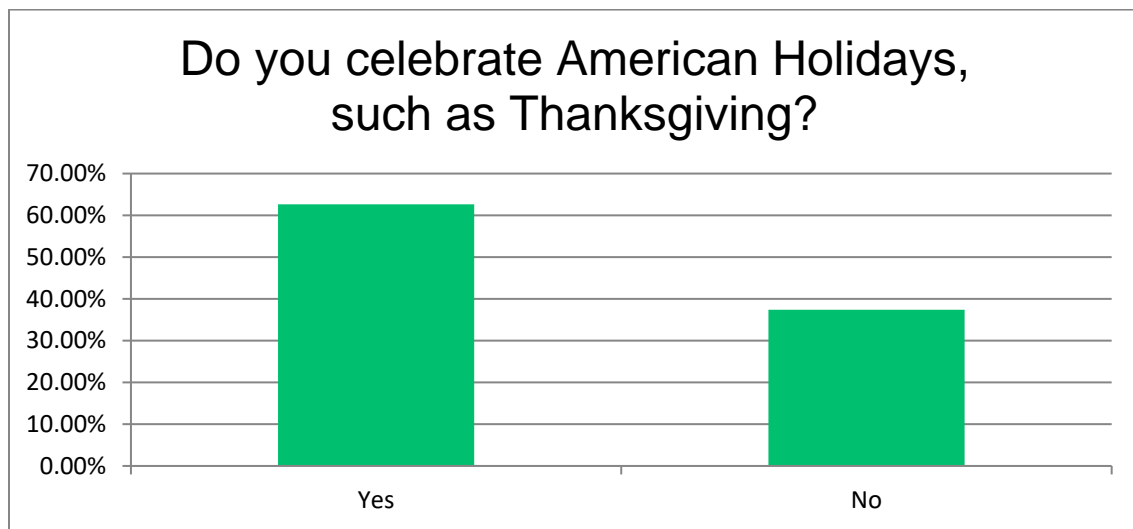


Figure 12. Bar graph of participants celebrating Thanksgiving

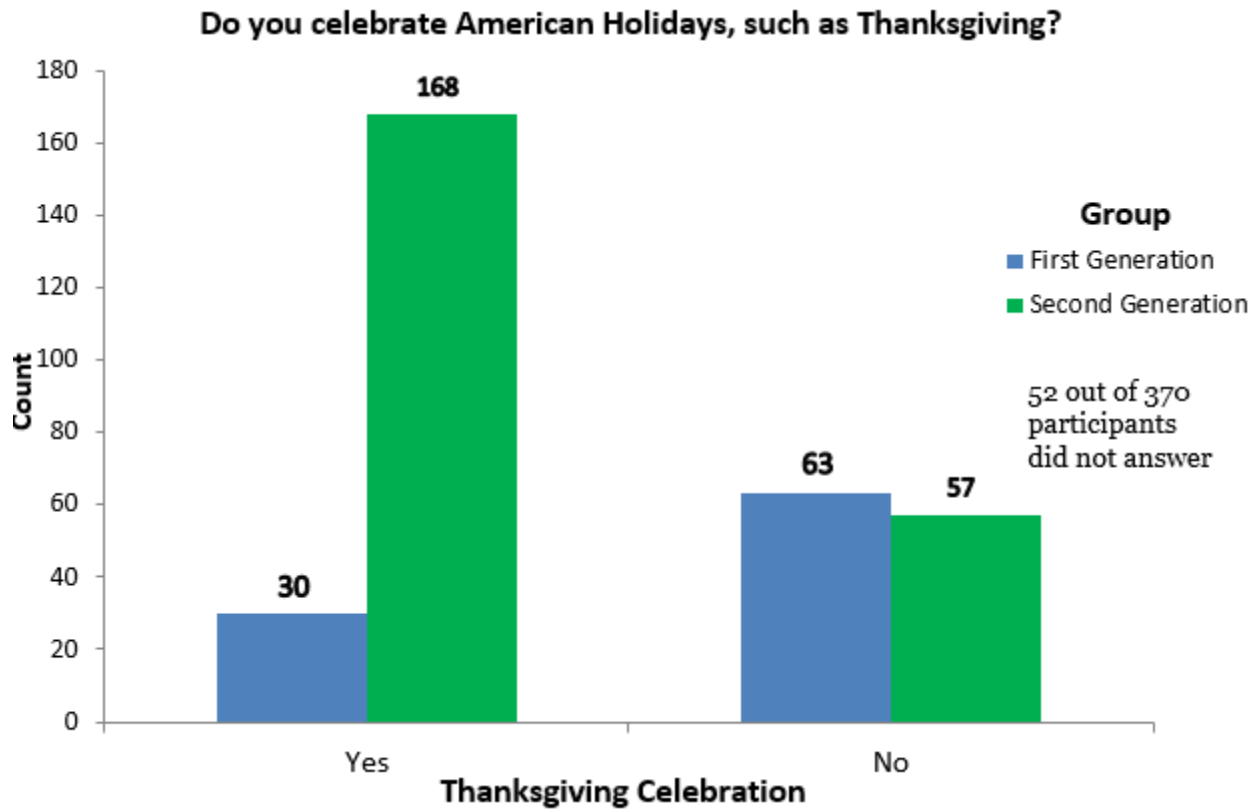


Figure 13. Clustered bar graph of first and second-generation celebrating Thanksgiving

Research Questions

RQ1. What are the factors involved in the attitudes of Arab American population residing in the New York Metro area toward seeking professional mental health services?

Medical Doctor vs. Mental Health Professional Visits

Regarding Arab Americans' medical doctor visits for physical health concerns for the past three years, 20% (60) of the participants have never been to their medical doctor for a physical exam, while 34% (109) have been to the medical doctor once or twice (Figure 14).

In the past three years, approximately how many times have you visited a medical doctor for a physical health concern?

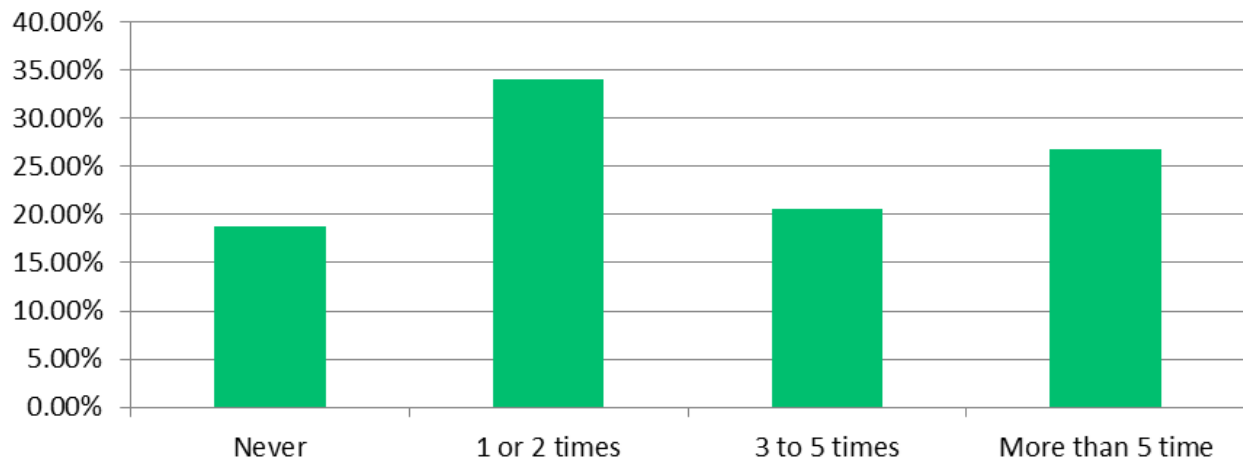


Figure 14. Bar graph of first and second-generation medical doctor visits

Regarding Arab Americans' mental health professional visits for the past three years, Figure 15 showed a very high 85% (272) of the participants have never been to mental health providers in the past three years compared to 3% (11) who visited professional mental health providers.

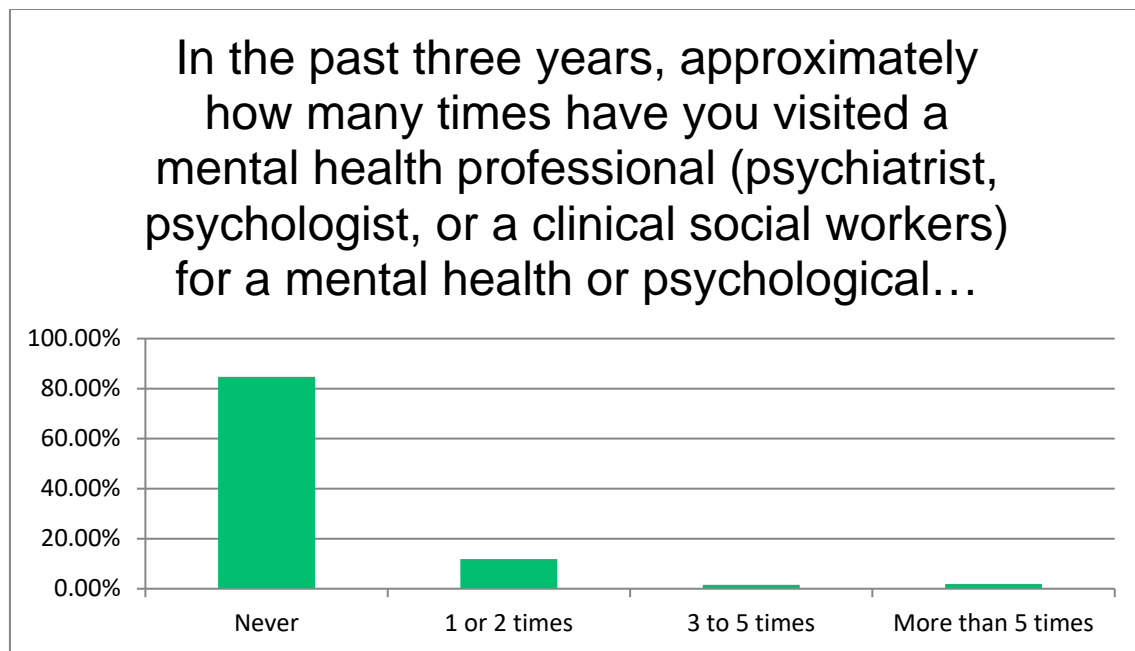


Figure 15. Bar graph of first and second-generation mental health professional visits

Figure 16 showed the breakdown by first and second-generation Arab Americans. A total of 55% (51) of first-generation Arab Americans visited a physical doctor more than five times, while 39% (88) of second-generation Arab Americans have been there once or twice. Concerning mental health professional visits for mental health concerns in the last three years, 85% (79) of first-generation Arab Americans and 84% (190) of second-generation Arab Americans indicated that they have never been to a professional mental health provider.

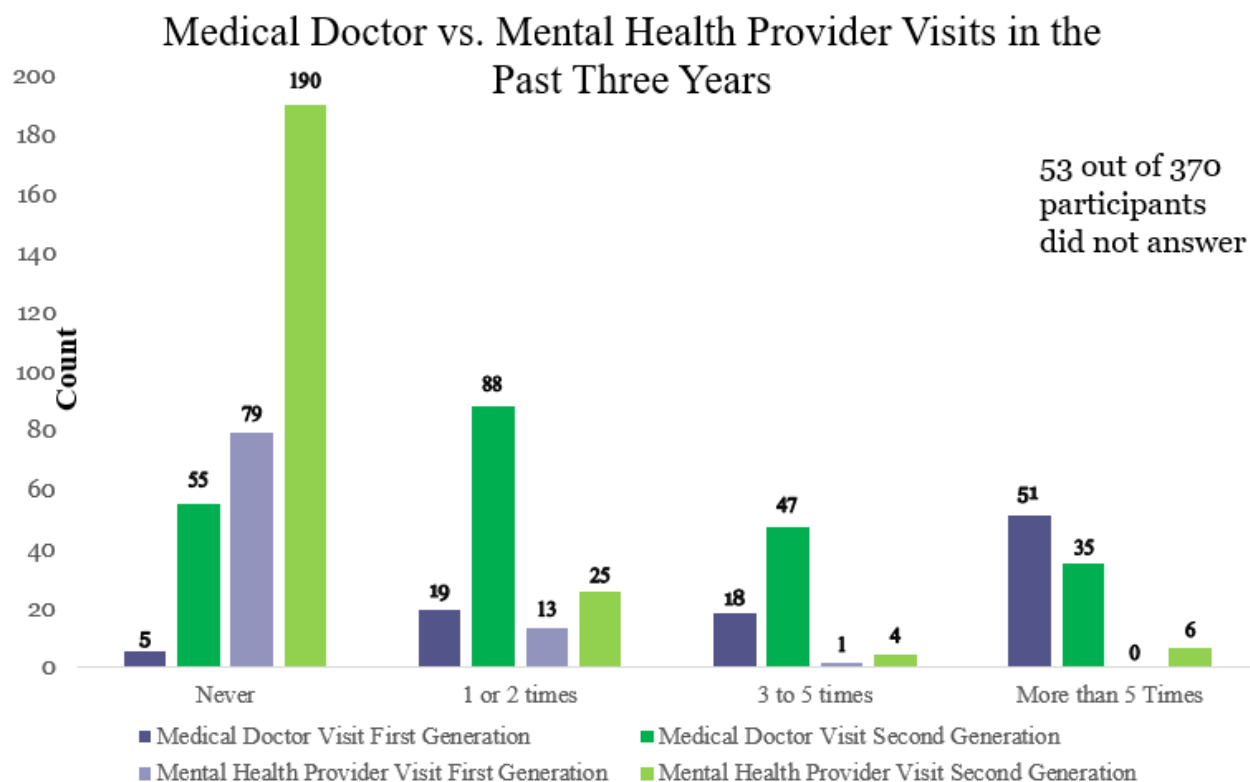


Figure 16. Clustered bar graph of first and second-generation medical doctor vs. mental health professional visits

Outside Mental Health Counseling

Regarding Arab Americans' choice for seeking outside help for mental health/psychological counseling, 40% (38) of first-generation Arab Americans and 34% (80) of second-generation Arab Americans chose a close friend as their first option. Only 6% (6) of the first-generation Arab Americans chose mental health professionals. 33% (31) of the first-generation Arab Americans chose family member as the second option for mental health/psychological counseling. In comparison, 31% (70) of second-generation Arab Americans chose mental health professionals as their second option for mental health/psychological counseling. Only 14% (13) of the first-generation Arab Americans chose mental health professionals as the second option. This represented an increase in the number of first-generation

who chose mental health professionals as their first option. 30% (28) of first-generation Arab Americans chose family doctor as the third option for mental health/psychological counseling, while 33% (74) of second-generation Arab Americans chose mental health professionals. Only 19% (18) of the first-generation Arab Americans chose mental health professionals.

As seen in Table 7, most first-generation Arab Americans did not choose mental health professionals as one of their options for outside mental health counseling. The number of first-generation Arab Americans who chose mental health professionals as their second and third option was higher than those who chose mental health professionals as their first option. Also, second-generation Arab Americans chose mental health providers as their second and third option. Table 7 showed the difference between the first and second-generation Arab Americans concerning their mental health counseling options. Results shown in Table 7 were in alignment with the literature review findings.

Table 7
Participants' Mental Health Counseling Options

	Arab Americans' Options for Outside Mental Health Counseling					
	First Option		Second Option		Third Option	
	First Generation	Second Generation	First Generation	Second Generation	First Generation	Second Generation
Close friend	40%	34%	16%	19%	12%	15%
Family member (e.g. father)	18%	17%	33%	20%	15%	18%
Family doctor (M.D.)	21%	20%	26%	21%	30%	17%
Mental health professional	6%	17%	14%	31%	19%	33%
Religious leader	10%	6%	10%	7%	15%	6%
No one	4%	6%	2%	3%	9%	11%
Did not Answer in Total	35%		35%		35%	

Demographics Summary. Table 8 provided the demographics' similarities and differences between first and second-generation Arab Americans. There were more female participants among first and second-generation Arab Americans. Most participants were married. Many participants among both generations had a bachelor's degree, had an annual family income of \$70,000 or more, and had commercial/group health insurance.

Table 8
First and Second Generation Demographics' Similarities and Differences

Similarities	Differences
There were more female participants for both generations; the percentage of male participants for both generations was comparable	Larger percentage of second generation were single
Most participants were married	Large percentage of first generation had their own personal business while the largest percentage of second generation were occupied as professionals/administrators
Large percentage of both generations had bachelor's degree	
Large percentage of both generations had a family annual income \$70,000 or more	
Large percentage of both generations had commercial/group health insurance	

ATSFMHS Similarities and Differences. Table 9 showed the similarities and differences between first and second-generation Arab Americans for the Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS) survey questions. A large percentage of both generations thought negatively about others who utilize mental health services, feel embarrassed to inform others that they use mental health services, and were concerned about what others may think if they use mental health services. There were crucial differences between both generations that included their intention to seek mental health counseling if they believe they were having mental health issues, their decision to seek professional mental counseling regardless of what others will say if they believe counseling was needed, their preference to be advised by close friends or family members instead of professional mental health professionals, and their feelings that they may seek professional mental health services in the future.

Table 9

Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS) First and Second Generation Participants' Similarities and Differences

Similarities	Differences
Think negatively about others who use mental health or psychological services	Seeking psychological or mental health counseling first if they believe they are having psychological or mental health problems
Feel embarrassed to inform others that use psychological or mental health services.	Seeking professional mental health or psychological counseling if they believe it was needed, regardless of what others would say or think
Feel uncomfortable seeking mental health or psychological services due to others negative opinions	Feeling that they may seek professional mental health or psychological services in the future
Concerned what others might think or say if they use professional mental health services	Preference to be advised by a close relative or friend than by mental health professional, even for serious psychological problems
Believe using mental health or psychological services is more difficult than using general medical service because of the associated shame	Preference to live with certain mental health or psychological problems than go through the process of seeking professional help

ATSFMHS Summary. More than half of the second-generation Arab Americans responded with disagreement that they would rather be advised by a close friend or family member for mental health issues. They also disagreed that families have the final say whether individuals should seek professional mental health services. They disagreed that strong faith could overcome mental health issues without professional mental health services (Table 10). Tables 10 and 14 showed how first and second-generation Arab Americans differed. The PI used the ATSFMHS without any modifications to the author's version.

Table 10
ATSEMHHS Second Generation Arab Americans % who Disagreed

Survey Question	(%)
Would rather be advised by a close relative or friend than by mental health professional, even for serious psychological problems	56%
Would rather live with certain mental health or psychological problems than go through the process of seeking professional help	53%
Discuss mental health or psychological concerns with a mental health professional is a poor way to solve mental health or psychological difficulties	52%
Believe strong faith can overcome psychological problem without professional help	51%
Believe family members should have the final say whether or not individual should seek professional mental health services	51%

KFFMHHS Similarities and Differences. Regarding the Knowledge and Familiarity with Formal Mental Health Services (KFFMHHS) survey, Table 11 showed both generations' very little familiarity/knowledge with most survey questions, such as mental health issues, the role of professional mental health professionals, availability of mental health services, and Arab mental health professionals.

Table 11
Knowledge and Familiarity with Formal Mental Health Services (KFFMHS)
First and Second Generation Participants' Similarities

Very Little Familiarity with
Mental health issues
Role of professional mental health and psychiatrist professionals
Availability of mental health services
How to get mental health services
Arab mental health professionals

Table 12 showed that more than half of the first-generation Arab Americans agreed that using mental health was more difficult (evident also from Figure 15) than using medical health services due to the associated shame. They would rather be advised by a close friend or family member than a mental health provider (evident from Table 7). They think negatively about others who utilize mental health services and believe seeking mental health services should be the last option after trying all other culturally accepted options (evident from Table 7).

Table 12
 ATSMHS First Generation Arab Americans who Agreed

Survey Question	(%)
Believe using mental health or psychological services is more difficult than using general medical service because of the associated shame	57%
Would rather be advised by a close relative or friend than by mental health professional, even for serious psychological problems	56%
Contact Arab professionals than professionals from other cultures if they decided to seek mental health services	54%
Think negatively about others who use mental health or psychological	53%
Would rather live with certain mental health or psychological problems than go through the process of seeking professional help	52%
Seeking psychological and mental health services should be the last choice to use after trying all other options	51%

Table 13 showed that more than half of the second-generation Arab Americans agreed that they think negatively about others who use mental health services. They also believed mental health services were more difficult than using mental health services due to the associated shame. They also believed they might seek mental health services (Table 13).

Table 13
 ATSMHS Second Generation Arab Americans % who Agreed

Survey Question	(%)
Think negatively about others who use mental health or psychological services	62%
Believe using mental health or psychological services is more difficult than using general medical service because of the associated shame	58%
May seek professional mental health or psychological services in the future	57%

Unlike the second-generation, where 57% believed they might seek professional mental health services in the future (Table 13), 58% of first-generation Arab Americans disagreed (Table 14).

Table 14
ATSFMHS First Generation Arab Americans % who Disagreed

Survey Question	(%)
May seek professional mental health or psychological services in the future	58%

KFFMHS Summary. Concerning Arab Americans’ knowledge of problems that might require professional mental health or psychological intervention, 47% (43) of first-generation Arab Americans and 33% (74) of second-generation Arab Americans answered: “very little” (Figure 17).

Type of problems that might require professional mental health or psychological intervention

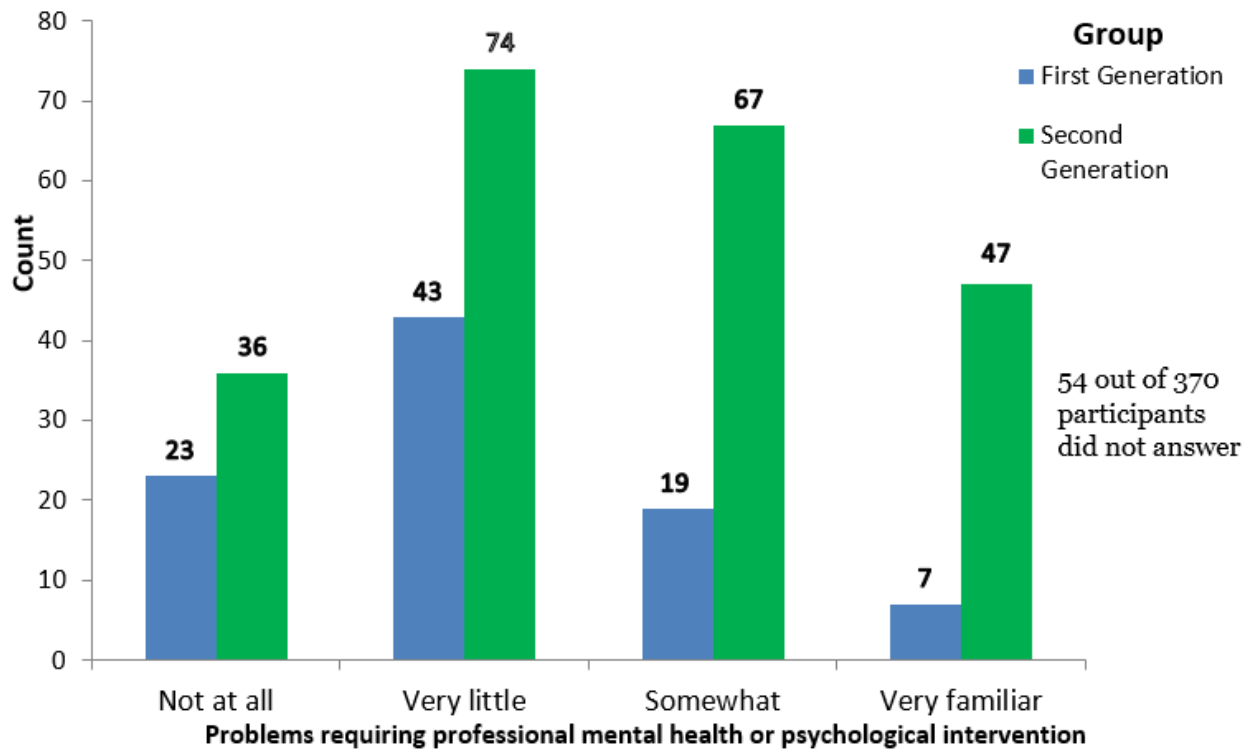


Figure 17. Clustered bar graph of first and second-generation knowledge of the type of problems requiring mental health services

Concerning Arab Americans’ knowledge of practicing Arab professionals in their local community, 51% (47) of first-generation Arab Americans and 39% (88) of second-generation Arab Americans answered: “very little” (Figure 18).

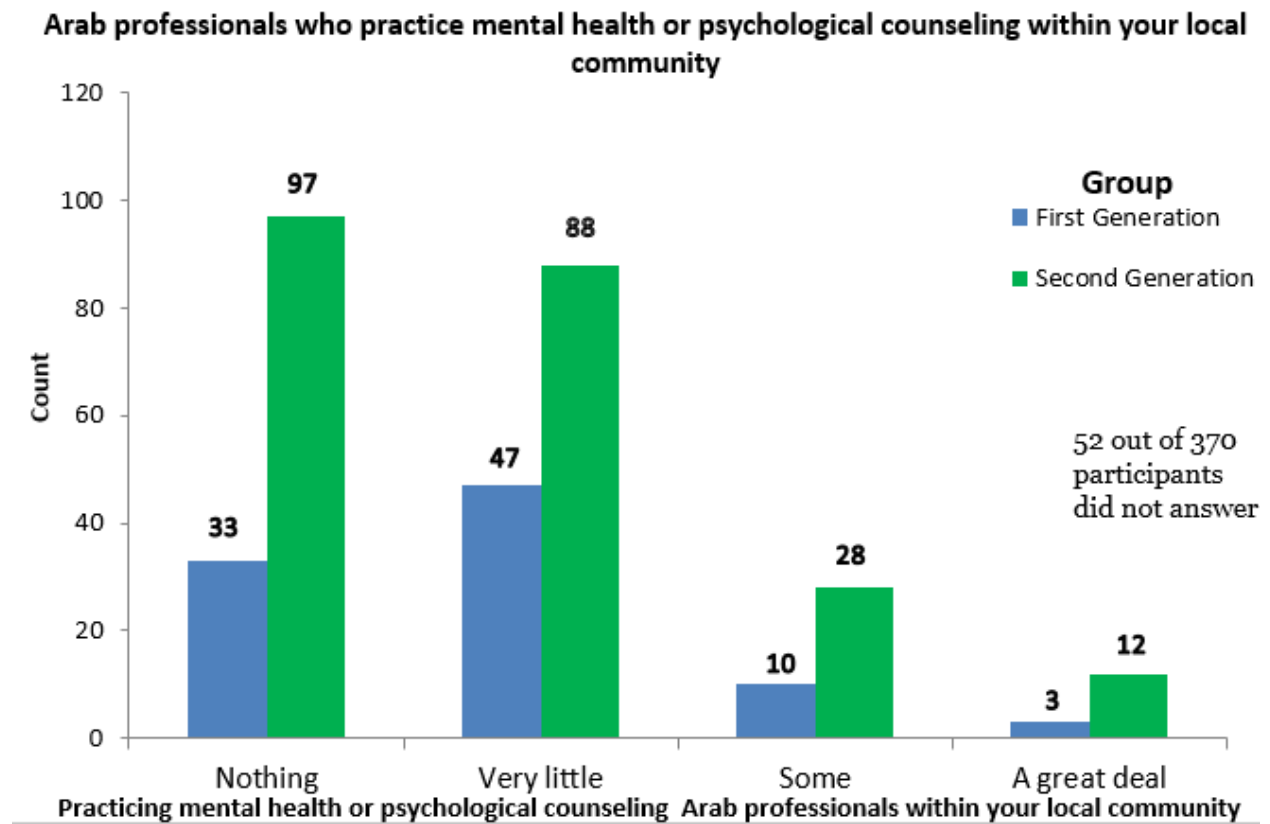


Figure 18. Clustered bar graph of first and second-generation knowledge of practicing Arab professionals in their local community

With respect to knowledge of the psychiatrist’s role in mental health and psychological counseling settings, 43% (40) of first-generation Arab Americans and 39% (87) of second-generation Arab Americans answered: “very little” (Figure 19).

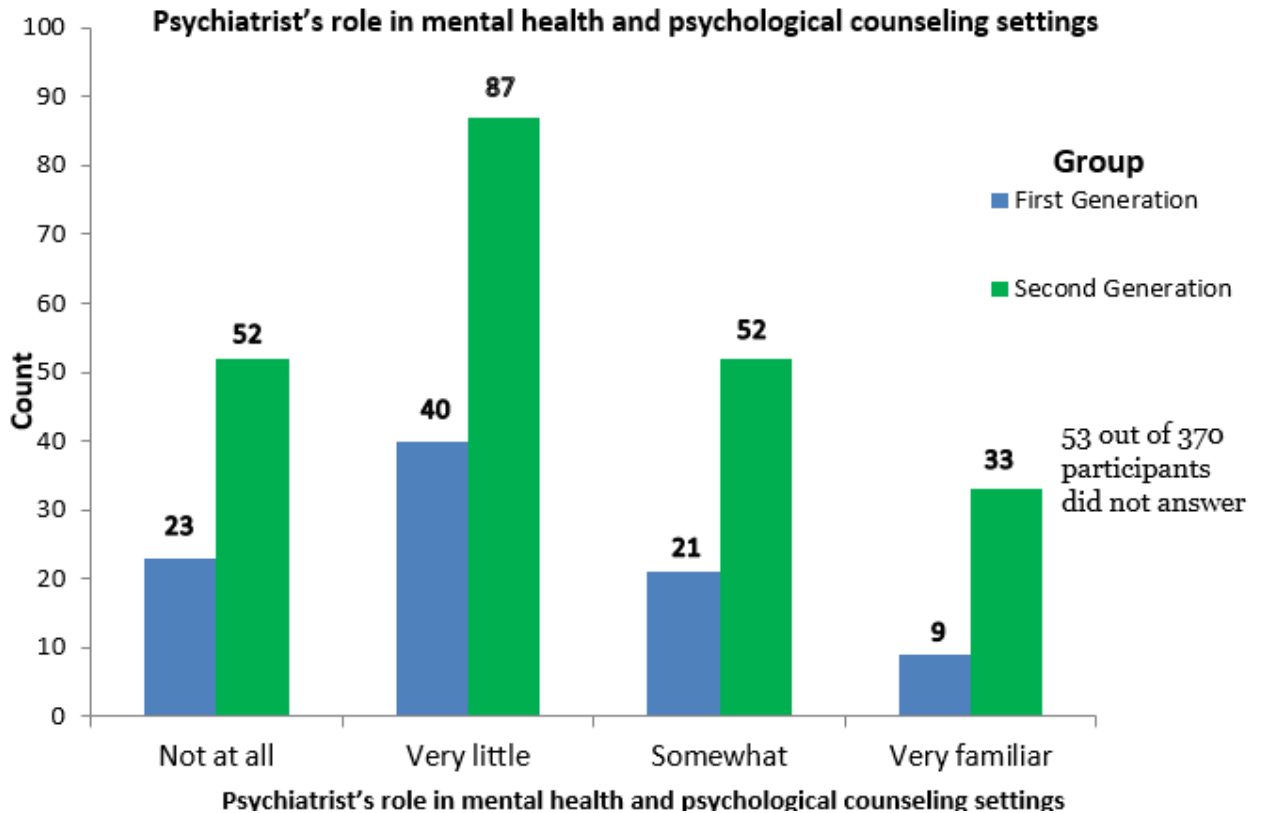


Figure 19. Clustered bar graph of first and second-generation knowledge of psychiatrist's role in mental health counseling settings

Concerning knowledge of the psychologist's role in mental health and psychological counseling settings, 41% (38) of first-generation Arab Americans and 35% (79) of second-generation Arab Americans answered: "very little" (Figure 20). The KFFMHS results showed the lack or little knowledge among first and second-generation Arab Americans about problems that might require professional mental health or psychological intervention, local Arab mental health professionals, available mental health services in the community, how to get mental health assistance, types of drug prescribed, and clinical social worker's role.

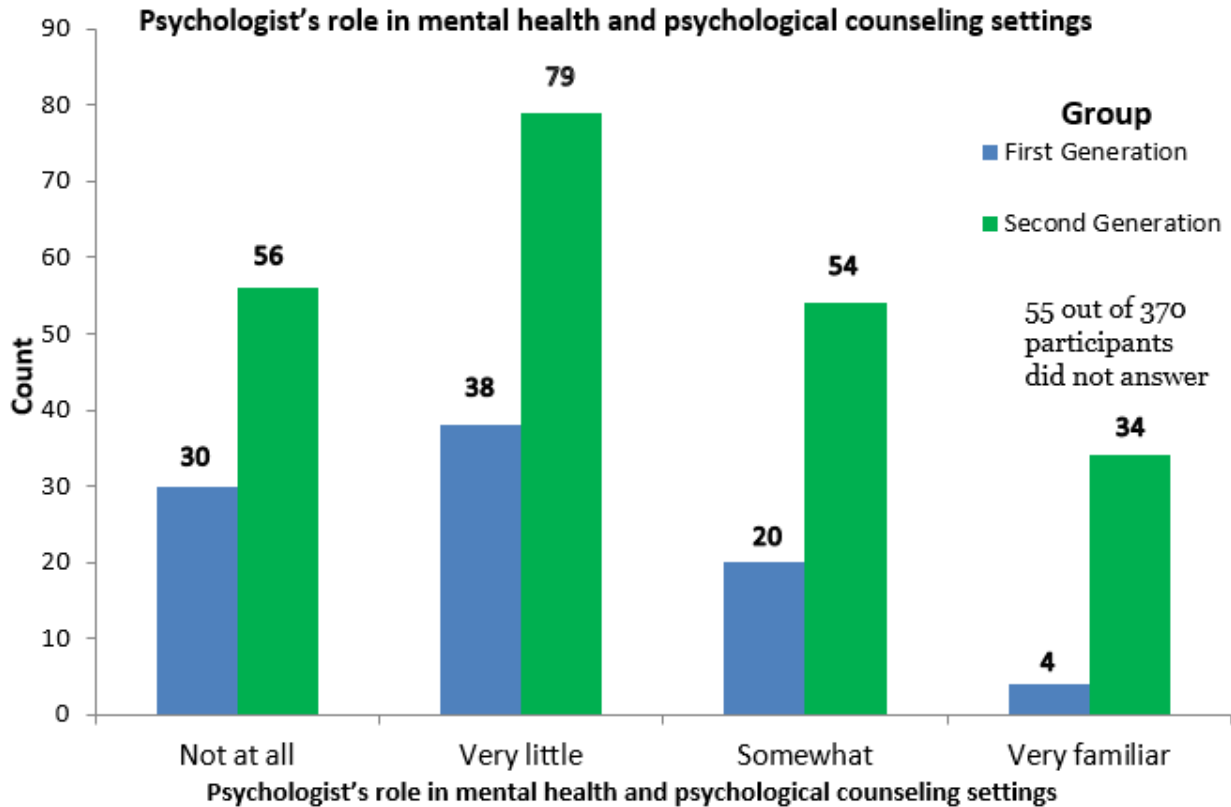


Figure 20. Clustered bar graph of first and second-generation knowledge of psychologists' role in mental health counseling settings

RQ2: Are there differences between the way first and second-generation Arab Americans seek professional mental health services?

The results of the Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS) Instrument, MANOVA, and ANOVA results provided answers to RQ2 and RQ3. The data will be divided into two groups: first and second-generation Arab Americans. There are four independent variables: acculturation, stigma, seek, and perceive. MANOVA was employed to determine the differences between first and second-generation Arab Americans. ANOVA was used for the four independent variables to assess the interaction, if any.

Statistical Assumptions

MANOVA has several assumptions: random sampling, multivariate, linearity, multicollinearity, independence of samples, and the requirement for larger sample sizes. The samples are independent of one another (Field, 2009). MANOVA is a linear combination of four components. A scatter plot matrix was used to assess linearity. Assumptions of a linear relationship were met (Figure 21).

The ATSFMHS instrument was utilized/grouped to create four (4) dependent variables based on survey questions 1-19:

- Component 1, C1: Acculturation
- Component 2, C2: Stigma
- Component 3, C3: Seek
- Component 4, C4: Perceive

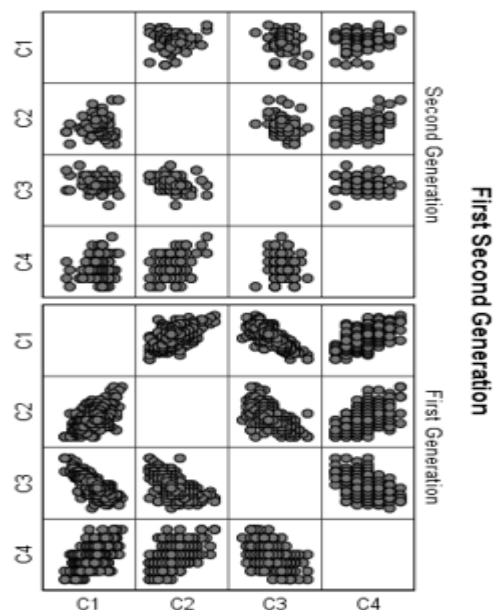


Figure 21. MANOVA Linearity Assumption

Concerning the multivariate outlier assumption, regression analysis was utilized. The value of 18.47 came from the chi-square table using degrees of freedom = 4 (dependent variables). Mahalanobis' distance that exceeded 18.47 were excluded (Table 15). Only four cases were multivariate outliers. They were excluded from the MANOVA analysis.

Table 15
Multivariate Outlier - Chi-square

<i>df</i>	Critical value
2	13.82
3	16.27
4	18.47

The correlation matrix was used to assess multicollinearity and the correlation assumption. The goal was to ensure the correlations between variables were small to medium (< 0.80 and > -0.80). As seen from the Pearson correlations (Table 16), the correlations between the variables were acceptable for each dependent variable.

Table 16
Pearson Correlations of the 4 Variables

Correlations					
		Acculturation	Stigma	Seek	Perceive
Acculturation	Pearson Correlation	1	.462**	-.701**	.449**
	Sig. (2-tailed)		0.000	0.000	0.000
	N	333	333	333	333
Stigma	Pearson Correlation	.462**	1	-.546**	.556**
	Sig. (2-tailed)	0.000		0.000	0.000
	N	333	333	333	333
Seek	Pearson Correlation	-.701**	-.546**	1	-.411**
	Sig. (2-tailed)	0.000	0.000		0.000
	N	333	333	333	333
Perceive	Pearson Correlation	.449**	.556**	-.411**	1
	Sig. (2-tailed)	0.000	0.000	0.000	
	N	333	333	333	333

** . Correlation is significant at the 0.01 level (2-tailed).

Box's Test (Table 17) was used to determine if the population covariance between each dependent variable pair was the same across groups/conditions (Field, 2009).

Table 17
Box's Test of Equality of Covariance Matrices

Box's Test of Equality of Covariance Matrices	
Box's M	99.276
F	9.751
df1	10
df2	149074.614
Sig.	0.000

$$F(10,149074) = 9.751, p=0.0001$$

Although the Box's Test was significant ($p = .0001$), it is understood that MANOVA is robust to violations of this assumption and, therefore, the PI continued to the multivariate tests and followed-up with univariate tests.

Multivariate measures, specifically, Pillai's Trace and Wilks' Lambda, were utilized for this study. Using Pillai's Trace, there was a significant difference between the first and second-generation concerning the dependent variables. $V=-.26$, $F(4,302) = 26.344$, $p < 0.0001$. Using Wilks' Lambda, there was a significant difference between the first and second-generation concerning the dependent variables. $\lambda = 0.74$, $F(4,302) = 26.344$, $p < 0.0001$. Table 18 showed the results were significant. The population means dependent variables were not the same for each variable.

Pillai's Trace test is considered the most robust to address violations of assumptions. Pillai's Trace is the sum of the proportion of explained variance on the discriminant functions (Field, 2009). As seen from Table 18, all four tests (Pillai's Trace, Wilks' Lambda, Hotelling's Trace, and Roy's Largest Root) showed significance for the multivariate. Since the number of second-generation Arab Americans was more than 1.5 times the number of first-generation Arab Americans, Pillai's trace results were evaluated, and the results were significant. The transformation of data was also utilized. The MANOVA was still significant.

Table 18
Multivariate Tests - Pillai's Trace and Wilk's Lambda Values

Multivariate Tests^a							
Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
Intercept	Pillai's Trace	0.994	11674.762 ^b	4.000	302.00	0.00	0.994
	Wilks' Lambda	0.006	11674.762 ^b	4.000	302.00	0.00	0.994
	Hotelling's Trace	154.63	11674.762 ^b	4.000	302.00	0.00	0.994
	Roy's Largest Root	154.63	11674.762 ^b	4.000	302.00	0.00	0.994
1 st /2 nd Generation	Pillai's Trace	0.259	26.344 ^b	4.000	302.00	0.00	0.259
	Wilks' Lambda	0.741	26.344 ^b	4.000	302.00	0.00	0.259
	Hotelling's Trace	0.349	26.344 ^b	4.000	302.00	0.00	0.259
	Roy's Largest Root	0.349	26.344 ^b	4.000	302.00	0.00	0.259

a. Design: Intercept + 1st/2nd Generation

b. Exact statistic

MANOVA showed significance between first and second-generation Arab Americans across all four variables, $p = 0.05$ (Table 19).

Table 19

Multivariate Analysis of Variance (MANOVA) for all 4 Dependent Variables – $p=0.05$

Tests of Between-Subjects Effects

Source	Dependent Variable	Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Acculturation	10.515 ^a	1	10.515	36.715	.000	0.107
	Stigma	2.362 ^b	1	2.362	6.974	0.009	0.022
	Seek	1.299 ^c	1	1.299	4.38	0.037	0.014
	Perceive	2.569 ^d	1	2.569	5.768	0.017	0.019
Intercept	Acculturation	2110.805	1	2110.805	7370.502	.000	0.96
	Stigma	1017.57	1	1017.57	3003.879	.000	0.908
	Seek	1354.733	1	1354.733	4569.03	.000	0.937
	Perceive	1358.009	1	1358.009	3048.368	.000	0.909
1 st /2 nd Generation	Acculturation	10.515	1	10.515	36.715	0.000	0.107
	Stigma	2.362	1	2.362	6.974	0.009	0.022
	Seek	1.299	1	1.299	4.38	0.037	0.014
	Perceive	2.569	1	2.569	5.768	0.017	0.019
Error	Acculturation	87.348	305	0.286			
	Stigma	103.319	305	0.339			
	Seek	90.434	305	0.297			
	Perceive	135.874	305	0.445			
Total	Acculturation	2472.094	307				
	Stigma	1365.08	307				
	Seek	1745.8	307				
	Perceive	1813	307				
Corrected Total	Acculturation	97.862	306				
	Stigma	105.682	306				
	Seek	91.732	306				
	Perceive	138.443	306				

a. R Squared = .107 (Adjusted R Squared = .105)

b. R Squared = .022 (Adjusted R Squared = .019)

c. R Squared = .014 (Adjusted R Squared = .011)

d. R Squared = .019 (Adjusted R Squared = .015)

MANOVA showed significance between first and second-generation Arab Americans for acculturation and stigma, $p = 0.01$ (Table 20). There were trends shown for seek and perceive.

Table 20

Multivariate Analysis of Variance (MANOVA) for all 4 Dependent Variables – $p=0.01$

Tests of Between-Subjects Effects							
Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
Corrected Model	Acculturation	10.127 ^a	1	10.127	35.204	0.000	0.103
	Stigma	2.435 ^b	1	2.435	7.192	0.008	0.023
	Seek	1.106 ^c	1	1.106	3.724	0.055	0.012
	Perceive	2.689 ^d	1	2.689	6.040	0.015	0.019
Intercept	Acculturation	2119.317	1	2119.317	7367.509	0.000	0.960
	Stigma	1024.022	1	1024.022	3025.035	0.000	0.908
	Seek	1366.298	1	1366.298	4598.251	0.000	0.938
	Perceive	1366.233	1	1366.233	3069.519	0.000	0.910
1 st /2 nd Generation	Acculturation	10.12681	1	10.127	35.204	0.000	0.103
	Stigma	2.434552	1	2.435	7.192	0.008	0.023
	Seek	1.106399	1	1.106	3.724	0.055	0.012
	Perceive	2.68855	1	2.689	6.040	0.015	0.019
Error	Acculturation	87.73546	305	0.288			
	Stigma	103.2473	305	0.339			
	Seek	90.62598	305	0.297			
	Perceive	135.7544	305	0.445			
Total	Acculturation	2472.094	307				
	Stigma	1365.08	307				
	Seek	1745.8	307				
	Perceive	1813	307				
Corrected Total	Acculturation	97.86228	306				
	Stigma	105.6818	306				
	Seek	91.73238	306				
	Perceive	138.443	306				

a. R Squared = .103 (Adjusted R Squared = .101)

b. R Squared = .023 (Adjusted R Squared = .020)

c. R Squared = .012 (Adjusted R Squared = .009)

d. R Squared = .019 (Adjusted R Squared = .016)

Follow-Up Univariate Tests (ANOVA)

Individual ANOVA tests were conducted, controlling for two covariates: education and income. For the main and interaction effects, the alpha was equal to 0.05. The education level was grouped into high and low education levels. The low education group comprises participants who had less than high school, high school, and associate degrees. The high education group includes participants who had a bachelor's degree, master's degree, and a Ph.D. The income

level was grouped into high and low-income levels. The low-income group comprises participants whose family's annual income was \$50,000 or less, and the other group includes participants whose family's annual income was greater than \$50,000. For every model, the main effects and all the two-way interactions were analyzed:

- First and second-generation and education level
- First and second-generation and family's annual income
- Highest level of education and family's annual income

Acculturation ANOVA. Individual ANOVA was conducted for the first component, C1: acculturation, controlling for two covariates: education and income, using $p = 0.05$. As seen in Table 21, there was a statistically significant difference between the first and second-generation Arab Americans regarding Acculturation ($p = 0.0001$). There was a strong trend in the interaction between first and second-generation Arab Americans and education ($p = 0.057$).

Table 21
Follow-Up Univariate (ANOVA) Tests for Acculturation

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Acculturation							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	3.04	0.052	58.256	0.000	2.937	3.142	0.918
1 st /2 nd Generation	-0.392	0.071	-5.545	0.000	-0.53	-0.253	0.092
[Low Income]	-0.011	0.112	-0.095	0.924	-0.232	0.21	0
[Low Education]	0.178	0.17	1.05	0.295	-0.156	0.512	0.004
[1 st /2 nd Generation] * [Low Education]	-0.313	0.164	-1.909	0.057	-0.635	0.01	0.012
[1 st /2 nd Generation] * [Low Income]	0.127	0.138	0.923	0.357	-0.144	0.399	0.003
[Low Income] * [Low Education]	-0.155	0.182	-0.851	0.395	-0.513	0.203	0.002

Stratified analysis by low education. A follow-up stratified analysis/individual model by education was performed. As seen from Table 22, there was a significant difference between first and second-generation Arab Americans among the low education group ($p = 0.0001$).

Table 22
Follow-Up Univariate (ANOVA) Tests for Acculturation by the Low Education Level

Parameter Estimates with Robust Standard Errors						
Dependent Variable: Acculturation						
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
Intercept	3.139	0.155	20.231	0.000	2.83	3.447
[1 st /2 nd Generation]	-0.606	0.133	-4.56	0.000	-0.871	-0.341

a. HC3 method

b. This parameter is set to zero because it is redundant.

Stratified analysis by high education. A follow-up stratified analysis/individual model by education was performed. As seen in Table 23, there was a significant difference between the first and second-generation Arab Americans among the high education group ($p = 0.0001$).

Table 23

Follow-Up Univariate (ANOVA) Tests for Acculturation by the High Education Level

Parameter Estimates with Robust Standard Errors

Dependent Variable: Acculturation

Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	3.014	0.051	59.435	0.000	2.915	3.114	0.939
[1 st]/2 nd Generation]	-0.357	0.064	-5.557	0.000	-0.483	-0.23	0.119

a. HC3 method

b. This parameter is set to zero because it is redundant.

Stigma ANOVA. Individual ANOVA was conducted for the second component, C2: stigma, controlling for two covariates: education and income, using $p = 0.05$. As seen in table 24, no statistically significant findings were observed. There was no significant difference between the first and second-generation Arab Americans concerning stigma. This finding was in alignment with the literature review.

Table 24
Follow-Up Univariate (ANOVA) Tests for Stigma

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Stigma							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	1.967	0.061	32.347	0.000	1.847	2.086	0.774
[1 st /2 nd Generation]	0.085	0.082	1.031	0.303	-0.077	0.247	0.003
[Low Income]	0.049	0.125	0.394	0.694	-0.196	0.294	0.001
[Low Education]	-0.033	0.197	-0.169	0.866	-0.42	0.353	0.000
[1 st /2 nd Generation * [Low Education]	0.007	0.177	0.041	0.968	-0.341	0.356	0.000
[1 st /2 nd Generation] * [Low Income]	0.117	0.152	0.766	0.444	-0.183	0.417	0.002
[Low Income] * [Low Education]	-0.289	0.193	-1.498	0.135	-0.668	0.09	0.007

Seek ANOVA. Individual ANOVA was conducted for the third component, C3: seek, controlling for two covariates: education and income, using $p = 0.05$. As seen in Table 25, there was no significant difference between the first and second-generation Arab Americans concerning seeking mental health services. There was a significant interaction between income and education ($p = 0.032$). Stratified analyses were performed.

Table 25
Follow-Up Univariate (ANOVA) Tests for Seek

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Seek							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	2.254	0.04	56.73	0.000	2.176	2.333	0.913
[1 st /2 nd Generation =1.00]	0.097	0.066	1.484	0.139	-0.032	0.226	0.007
[Low Income]	-0.128	0.099	-1.287	0.199	-0.323	0.068	0.005
[High Income]	0 ^b
[Low Education]	-0.224	0.156	-1.434	0.153	-0.532	0.083	0.007
[1 st /2 nd Generation] * [Low Education]	0.17	0.147	1.161	0.247	-0.118	0.459	0.004
[1 st /2 nd Generation] * [Low Income]	0.055	0.132	0.416	0.678	-0.205	0.314	0.001
[Low Income] * [Low Education]	0.381	0.177	2.154	0.032	0.033	0.729	0.015

Stratified analysis by low income. A follow-up stratified analysis/individual model by low income was performed. As seen in Table 26, there was a significant difference between the first and second-generation Arab Americans ($p = 0.01$).

Table 26
Follow-Up Univariate (ANOVA) Tests for Seek by the Low Income Level

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Seek							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	2.06	0.085	24.258	0.000	1.892	2.229	0.828
[1 st /2 nd Generation]	0.239	0.091	2.617	0.010	0.058	0.42	0.053

a. HC3 method

b. This parameter is set to zero because it is redundant.

Stratified analysis by high income. A follow-up stratified analysis/individual model by high income was performed. As seen in Table 27, there was a weak trend among first and second-generation ($p = 0.069$).

Table 27
Follow-Up Univariate (ANOVA) Tests for Seek by the High Income Level

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Seek							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	2.241	0.039	57.389	0.000	2.164	2.318	0.947
[1 st /2 nd Generation]	0.116	0.063	1.83	0.069	-0.009	0.241	0.018

a. HC3 method

b. This parameter is set to zero because it is redundant.

RQ3. Are there differences between the way first and second-generation Arab Americans perceive professional mental health services?

Perceive ANOVA. Individual ANOVA was conducted for the fourth component, C4: perceive, controlling for two covariates: education and income, using $p = 0.05$. As seen in Table 28, there was no significant difference between the first and second-generation Arab Americans concerning perceive. There was a significant interaction between income & education ($p = 0.022$). There was a weak trend towards significance between first and second-generation among education when controlling for the income ($p = 0.068$). A stratified analysis by education was performed (Table 29).

Table 28
Follow-Up Univariate (ANOVA) Tests for Perceive

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Perceive							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	2.29	0.098	23.451	0.000	2.098	2.482	0.643
[1st/2nd Generation]	0.148	0.111	1.335	0.183	-0.07	0.367	0.006
[Low Income]	-0.188	0.168	-1.125	0.262	-0.518	0.141	0.004
[Low Education]	0.356	0.208	1.708	0.089	-0.054	0.766	0.009
[1st/2nd Generation] * [Low Education]	-0.377	0.206	-1.83	0.068	-0.782	0.028	0.011
[1st/2nd Generation] * [Low Income]	0.246	0.187	1.315	0.190	-0.122	0.613	0.006
[Low Income] * [Low Education]	-0.485	0.211	-2.303	0.022	-0.899	-0.071	0.017

Stratified analysis by low education. A follow-up stratified analysis/individual model by low education was performed. As seen in Table 29, there was no significant difference between the first and second-generation Arab Americans.

Table 29
Follow-Up Univariate (ANOVA) Tests for Perceive by the Low Education Level

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Perceive							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	2.493	0.194	12.863	0.000	2.107	2.879	0.682
[1st/2nd Generation]	-0.039	0.166	-0.238	0.812	-0.369	0.29	0.001

a. HC3 method

b. This parameter is set to zero because it is redundant.

Stratified analysis by high education. A follow-up stratified analysis/individual model by high education was performed (Table 30). There was a significant main effect for the first and second-generation among the high education group ($p = 0.026$).

Table 30
Follow-Up Univariate (ANOVA) Tests for Perceive by the High Education Level

Parameter Estimates with Robust Standard Errors							
Dependent Variable: Perceive							
Parameter	B	Robust Std. Error ^a	t	Sig.	95% Confidence Interval		Partial Eta Squared
					Lower Bound	Upper Bound	
Intercept	2.239	0.089	25.175	0.000	2.064	2.414	0.734
[1 st /2 nd Generation]	0.219	0.098	2.241	0.026	0.026	0.411	0.021

a. HC3 method

b. This parameter is set to zero because it is redundant.

Acculturation/Stigma ANOVA Summary. Table 31 showed the ANOVA summaries for components acculturation and stigma. Regarding acculturation, there was a significant difference between the first and second-generation Arab Americans. Concerning stigma, there was no significant difference between the first and second-generation Arab Americans.

Table 31
Univariate (ANOVA) Summary of Findings – Acculturation & Stigma

Acculturation	Stigma
Significant difference between 1st/2nd generation	No significant difference (both groups act in similar fashion) between 1st and 2nd generation and stigma
Strong trend between 1 st & 2 nd generation and education.	
The education level has a significant impact on the acculturation level of 1st & 2nd generation.	

Seek/Perceive ANOVA Summary. Table 32 shows the ANOVA summaries for components seek and perceive. Regarding seek, there was no significant difference between the first and second-generation Arab Americans. There was a significant difference among the low-income group and a weak trend among the high-income group. Concerning perceive, there was no significant difference between the first and second-generation Arab Americans. There was a

significant difference between income and education and a significant difference in the high education group.

Table 32
Univariate (ANOVA) Summary of Findings – Seek & Perceive

Seek	Perceive
There is no significant difference between first and second generation with respect to seeking mental health services.	There is no significant difference between first and second generation with respect to perceiving mental health services.
There is a significant interaction between income and education.	There is a weak trend between first and second generation and education.
Among the low income group, there is a significant difference between first and second generation Arab Americans.	There is a significant interaction between income and education.
Among the high income group, there is a weak trend between first and second generation Arab Americans.	Among the low education group, there was no significant difference between first and second generation
	Among the high education group, there is a significant difference between first and second generation Arab Americans.

Post-Hoc G*Power Analysis

The post-hoc G*Power Analysis for F Test MANOVA Global Effects resulted in a power of 0.954 using an effect size of 0.26, alpha set at 0.01, two groups, and four dependent variables (Figure 22). Statistical power is the probability that a study will detect an effect when there is an effect to be detected. A high statistical power indicates a low probability of Type II error (indicating no effect when there is one). As a result, the high power of 0.954 indicated the study was highly powered.

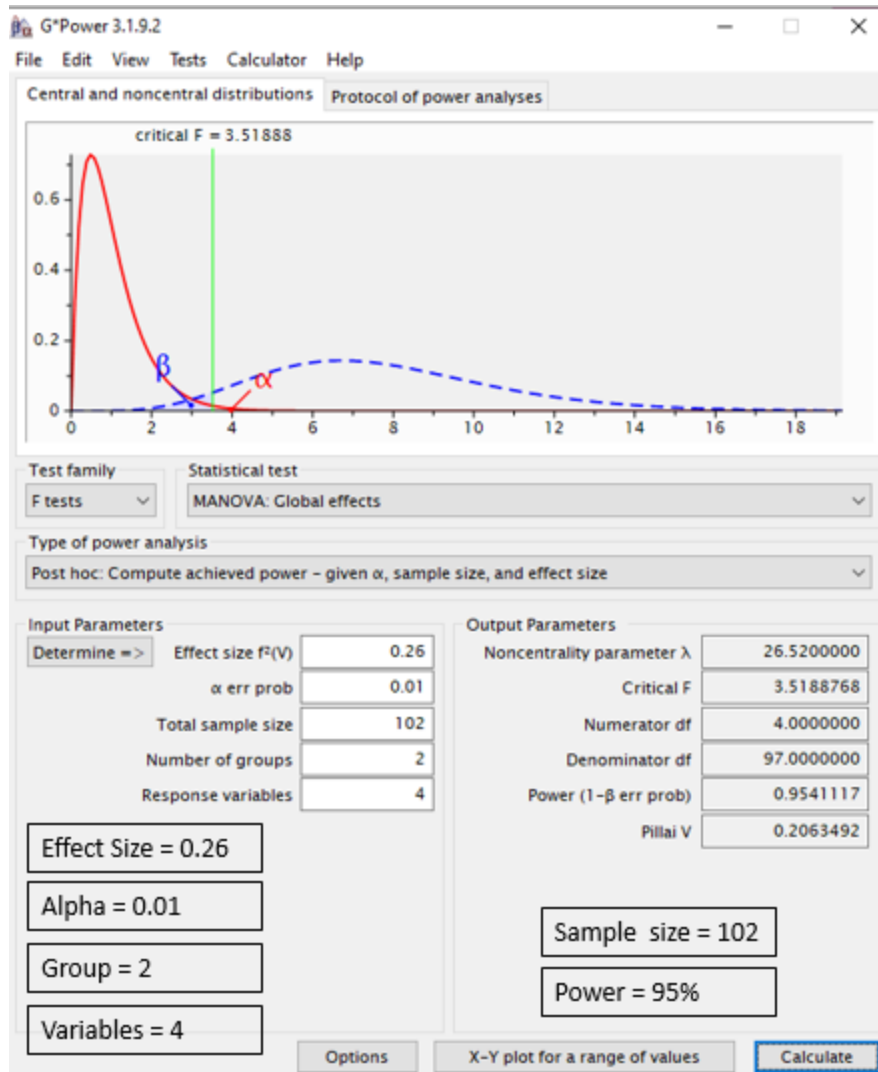


Figure 22. Post-hoc G*Power Analysis. With an effect size of 0.26, an alpha level set at .01, total sample size of 102 with 2 groups and 4 dependent variables, the power = 0.95

Review of Hypotheses (Accept or Reject)

Based on the previous summary of findings where the MANOVA values indicated a significance for all the variables and the reported ANOVA results and stratified/individual models, the null hypotheses were rejected. The alternative hypotheses will fail to be rejected, as seen in Figure 23.

RQ1. What are the factors (e.g., stigma, bias, acculturation, etc.) involved in the attitudes of Arab American population residing in the New York Metro area toward seeking professional mental health services?

Hypothesis RQ1:

Because this first question is descriptive/explanatory in nature, there is no corresponding hypothesis.

RQ2. Are there differences between the way first and second-generation Arab Americans seek professional mental health services?

Hypothesis RQ2: There are differences between the way first and second-generation Arab Americans seek professional mental health services.

RQ3. Are there differences between the way first and second-generation Arab Americans perceive professional mental health services?

Hypothesis RQ3: There are differences between the way first and second-generation Arab Americans perceive professional mental health.

Reject or Fail to Reject?



RQ 2: Are there differences between the way first and second generation Arab Americans seek professional mental health services?

H2A: There are differences between the way first and second generation Arab Americans seek professional mental health services.

FAIL TO REJECT THE ALTERNATE HYPOTHESIS



RQ 3: Are there differences, if any, between the way first and second generation Arab Americans perceive professional mental health services?

H3A: There are differences between the way first and second generation Arab Americans perceive professional mental health services.

FAIL TO REJECT THE ALTERNATE HYPOTHESIS

Figure 23. Reject or Accept? PI's hypotheses 2 & 3 – fail to reject the alternate hypothesis for each.

Chapter V

DISCUSSION, RECOMMENDATIONS AND CONCLUSIONS

Introduction

This chapter begins with a discussion of the study's findings, first by reflecting on the study's key findings, and, second, by comparing the study's findings to the findings of prior studies. Next will follow the consideration of the two theories that informed this study, Berry's Acculturation Theory (2017) and Horan's Multiculturalism Theory (1995). How well do these theories explain the study's findings? The chapter finishes with suggestions for practical implications of the study's findings, limitations of the study, and future research recommendations.

Overview of the Discussion

The survey results and statistical analysis results presented in chapter 4 aligned with some of the literature review studies/findings. New novel findings were present within this study that are not found in the literature, thus addressing the initial gap. There were significant differences between first and second-generation Arab Americans with respect to the way they seek and perceive mental health services. There was a small gender gap between participants since 55% (180) were females. According to the literature review, mental health services can be stigmatizing, particularly for women (Al-Krenawi & Graham, 2000; Carbonell et al., 2020; Dardas & Simmons, 2015; Fakhr Al-Islam, 2008). As Hamdan (2009) indicated, the depression level within Arabs varies according to gender. One in five women and one in ten men can expect to experience depression in their lifetime in the Arab world (Hamdan). Women are more likely to suffer from depressive illness due to the large cultural and religious differences between Arab and American women. The study findings aligned with the limited knowledge of both

generations concerning available mental health services and mental health professionals. The study findings also aligned with the relationship between acculturation choice and mental health well-being.

It was evident from the study findings that both generations have differences in how they perceive and seek mental health services. However, they shared a lack of knowledge about general mental health issues and mental health services within their communities. Although the survey findings showed that second-generation Arab Americans are more likely to utilize mental health services in the future, both generations lacked knowledge pertaining to psychologists, psychiatrists, and clinical social workers' role in the mental health field. The literature review showed that Arabs prefer to receive counseling from Arabs who share their culture and beliefs. Yet, both groups lacked knowledge pertaining to Arab mental health professionals within communities. The study findings showed no statistical difference between both groups related to stigma, where both groups believed using professional mental health services is difficult to societal stigma. The literature review stressed the relationship between acculturation and mental health issues and the differences between the two groups and their acculturation level. This was evident from the second-generation's choice in celebrating Thanksgiving compared to the first-generation. Although the study findings showed differences between the two groups with respect to the way they seek and perceive mental health services, a large number of participants from both groups have never been to mental health providers prior. A large percentage of the second-generation Arab Americans are planning on using mental health professional services compared to first-generation Arab Americans who are planning on using culturally accepted means, such as family and friend support, in the future if they require mental support.

Findings in Alignment with Literature Review

The study findings aligned with some prior studies. For example, the study results aligned with the limited mental health services scope in the U.S. that do not meet the Arab American community's needs (Amer & Hovey, 2005; Nadar, 2020; Shehadeh, 2011). The study findings also showed how various factors, such as age, family role, income level, and education, impacted the way first and second-generation Arab Americans seek and perceive mental health services. Those findings align with Al-Krenawi and Graham's study (2000). The study findings aligned with a study in Detroit that showed accounts of bad personal experiences and abuse among Arab Americans related to their ethnicity post 9/11 (Padela & Heisler, 2010). The study findings also aligned with a more recent study that examined the impact of discrimination and the mental health well-being of Arab Americans in Michigan, which revealed anxiety and depression symptoms (Kader et al., 2020). In addition to these considerations, there are a number of study findings that compare with prior literature and studies regarding factors that impact Arab Americans' attitudes concerning seeking professional mental health services (see Table 33).

Table 33

Factors Impacting Arab Americans' Attitudes Towards Seeking professional mental health services

Literature Review	Alignment
Mental health provisions for the Arab population in the U.S. are limited in scope compared to the community's needs (El-Khadiri, 2009; Kader et al., 2020; Nydell, 2012; Shehadeh, 2011).	Aligned
Factors such as gender relations, family role, common cultural beliefs among families and communities, and patterns of mental health services need to be accounted for (Al-Krenawi and Graham 2000; Carbonell et al., 2020; Dardas & Simmons, 2015; Fakhr Al-Islam, 2008; Padela & Heisler, 2010).	Aligned
As Arabs continue to migrate to the U.S, there is a need for special considerations and education to guide social work interventions (Al-Krenawi and Graham; Nadar, 2020).	Aligned

Also, the study findings were in alignment with other prior studies. The results aligned with the family role, associated shame, and few exceptions when seeking professional mental health counseling is culturally allowed. Several study findings compared with prior literature and studies regarding the differences between the way first and second-generation Arab Americans seek professional mental health services (see Table 34).

Table 34

Differences between the way first and second-generation Arab Americans seek professional mental health services

Literature Review	Alignment
Shame to the family (Nydell, 2012)	Aligned
Exceptions seeking mental health services allowed by the patient's family (Padela & Heisler, 2010; Howells et al. 2009)	Aligned

The study findings aligned with prior studies pertaining to the differences between the way first and second-generation Arab Americans perceive professional mental health services (see Table 35).

Table 35

Differences between the way first and second-generation Arab Americans Perceive professional mental health services

Literature Review	Alignment
Mental health services' viewed as taboo (Aloud & Rathur, 2009)	Aligned
Negative view of mental health (El-Khadiri, 2009; Nadar, 2020; Nydell, 2012)	Aligned
Second generation Arab Americans not sharing their parents' view (Shehadeh, 2011; Nadar)	Aligned

Unusual Findings

In addition to the many study findings that aligned with the findings from prior studies, other study findings are not aligned with prior study findings. For example, the study results were not aligned concerning the large number of second-generation Arab Americans who decided to use professional mental health services as the second and third option for mental health counseling. The literature review also showed that second-generation Arab Americans do not share their parents' views and are more prone to utilizing available mental health services. However, the study findings showed that many second-generation Arab Americans still think negatively about others who use mental health services. In addition to these two considerations, a large percentage of the second-generation indicated that they would utilize professional mental health services as the main second and third option for counseling, and a very high percentage, around 85% of first and second-generation Arab Americans have never been to a mental health provider prior (See Table 36).

Table 36

Differences between the way first and second-generation Arab Americans seek professional mental health services

Unusual Findings	Alignment
Large percentage second generation Arab American chose professional mental health services as the second and third option.	Not- aligned
Second generation unlike first generation are more prone to utilizing available mental health services, yet they still think negatively regarding others who use mental health.	Not - aligned
85% of first and second generation Arab Americans have never been to a mental health provider prior.	Not - aligned

Novel Findings

Concerning the study's novel findings, both first and second-generation Arab Americans had very little knowledge or familiarity with mental health services. There was no statistically significant difference between first and second-generation Arab Americans pertaining to stigma. As seen from the ANOVA results, education and income level impacted how first and second-generation Arab Americans seek and perceive mental health services. There was a significant difference between the first and second-generation Arab Americans and acculturation. There was a relationship between Thanksgiving celebration and acculturation. This was evident from the literature review, where many second-generation Arab Americans have been rejecting any ties to the Middle East. Their parents, however, focused solely on Middle Eastern cultural and religious events/holidays instead of American holidays (Aloud & Rathur, 2009; Fakhr Al-Islam; 2008; Nadar, 2020). Although Thanksgiving is not a religious holiday but merely an American cultural tradition, many first-generation Arab Americans chose not to celebrate it and instead celebrate

Arab holidays and cultural events. The study findings showed that most second-generation Arab Americans celebrate Thanksgiving, unlike the first-generation.

Berry's Acculturation Theory Revisited

In selecting Berry's (2017) Acculturation theory, the study design expected that the four alternative acculturation approaches, assimilation, separation, integration, and marginalization, would help explain how first and second-generations' of Arab Americans seek and perceive mental health services. Figure 24 shows the correlation between first and second-generation Arab Americans' survey results and Berry's acculturation theory. Concerning assimilation, the second-generation is more prone to use mental health services. They also chose mental health professional services as their second and third option for mental health counseling. The marginalization process did not apply to first or second-generation Arab Americans. Regarding the separation process, the first-generation had a negative view of mental health services. The survey findings showed that first-generation Arab Americans would seek mental assistance from a close friend or family member rather than a professional mental health provider. They feel embarrassed to utilize mental health services. Concerning the integration process, some first-generation Arab Americans will seek mental health services in the future. At the same time, some of the second-generation still think negatively about mental health services. Berry's acculturation theory explained the findings of this study. The marginalization process was the only exception that did not apply to generation Arab Americans

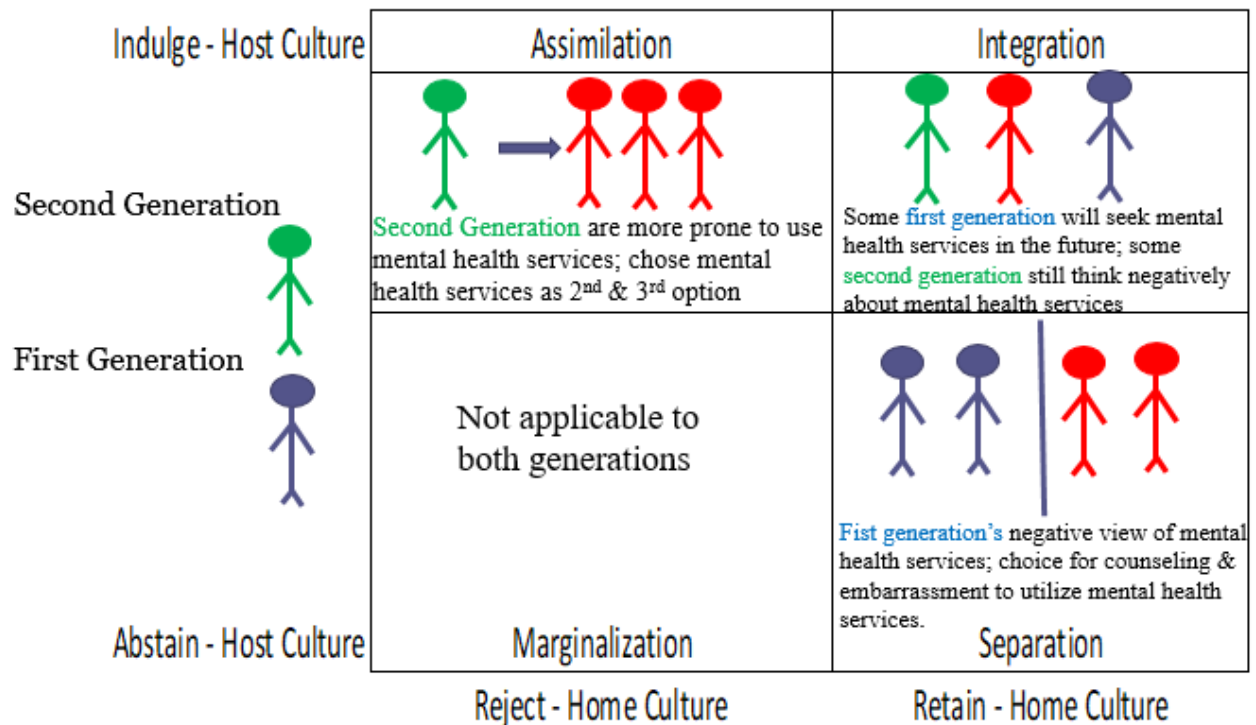


Figure 24. Berry's Acculturation Theory and Arab Americans (2017)

The Multiculturalism Theory

The multiculturalism theory (Figure 25) encourages appreciation between different cultures and languages in our society (Horan, 1995). This theory not only encourages individuals to welcome other cultures, but it also stimulates people to learn about different cultures and be more tolerant of others' beliefs when they contradict their own culture and beliefs. In proposing Horan's multiculturalism theory to inform the study, it was expected that this theory would explain Arab Americans' acculturation. Based on the study results, the Multiculturalism theory did not explain the findings from this study. According to the literature review, the Arab culture does not encourage learning about other cultures. It does not stimulate their members to tolerate others' beliefs if they contradict their own cultural beliefs. Arab culture is solely focused on its own culture. Findings from this study were not explained by the Multiculturalism theory.

Horan's theory does not fit the findings from this study.

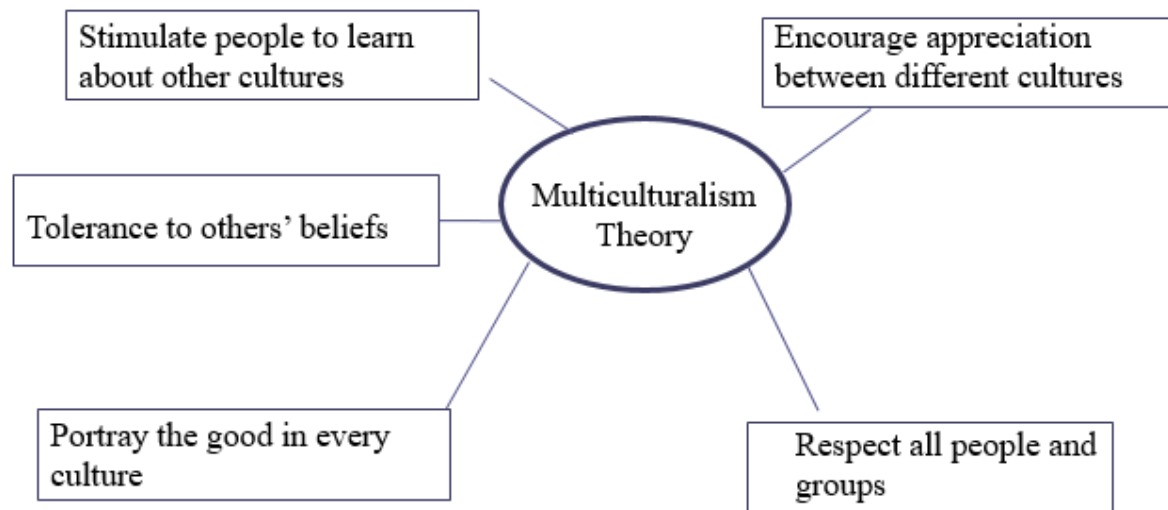


Figure 25. Multiculturalism Acculturation Theory Illustration

Practical Implications

Based on the study's findings, there are several practical implications:

- Education is needed for non-Arab professional mental health providers about the Arabic culture. This will enable professional mental health providers to learn about Arab Americans with respect to the way they seek and perceive professional mental health services, differences between first and second-generation, cultural taboos, and acceptable mental health services.
- Distribute available mental health services/providers' brochures at Arab religious institutions, Arab schools, Arab Sunday schools, Arab medical centers, and Arab youth centers. Based on how unfamiliar first and second-generation Arab Americans were with respect to questions concerning mental health services, those brochures will inform Arab Americans about the types of problems requiring mental health prevention, practicing mental health or psychological counseling, and the psychiatrist/psychologist's role.

- Provide mental health outreach near Islamic centers, medical centers, churches, and convention centers by Arab professional mental health providers.
- Provide mental health outreach at Arabic and Sunday schools for future generations. This will target both generations and ensure that the young generation will be informed at an earlier age about mental health issues and available services and professional mitigation methods.
- Arab professional mental health providers should utilize social media as an education and outreach tool. Social media is an integral part of Arab Americans' daily lives. Social media tools can educate Arab Americans about mental health issues and educate professional mental health professionals about Arab culture and their mental health services needs.
- Arab professional mental health providers should provide this study as a case-study for future mental health providers. This study summarizes the available literature review about Arab Americans and their mental health status and needs. The survey results, statistical analyses, and research questions could be used as case studies to guide future research and guide mental health providers.

Limitations

As with all research, this study has limitations. They are the following:

- As a convenience sample was used, there is a limited generalization of the findings to only the study participants.
- In utilizing a survey data collection method, the study assumed that participants provided honest answers to the questions.

- This study's results are only generalizable to the participants of this study. More research is necessary to see if the results of this study hold true to other Arab Americans.
- While Arab Americans may come from 22 different Arab countries, study participants were not equally distributed between those 22 countries of origin. Therefore, it was not possible to determine if the country of origin for the first-generation Arab Americans was related to the study findings.
- In utilizing an explorative, correctional research design, no causal relationships could be determined.

Future Research

Based on the study's limitations, opportunities for future research include the following studies:

- The type of problems that might require professional mental health or psychological intervention.
- The availability of mental health and psychological services in Arab communities.
- The psychiatrist's and psychologist's roles in mental health and psychological counseling settings.
- Role of the clinical social worker in mental health and psychological counseling settings.
- Classified medical/behavioral mental health or psychological disorders.
- The type of treatment models/clinical interventions used in professional mental health clinics.
- How to get professional mental health or psychological counseling services when needed.

- Common drug treatments prescribed to individuals with mental health or psychological problem.
- Arab professionals who practice mental health or Psychological counseling within the Arab community.
- Arab American mental health care services covered by health insurance plans.

Study Significance and Conclusion

This study added to the limited studies related to Arab Americans and mental health issues. This study was novel in analyzing the difference between the way first, and second-generation Arab Americans perceive and seek mental health services and the relationship between their acculturation choice and their mental health status. The study showed a significant difference between first and second-generation Arab Americans with respect to the way they perceive and seek professional mental health services. The study findings supported some prior study findings and found some differences and some novel findings. The study addressed the importance of educating mental health professionals about the Arab culture and how each generation perceive and seek mental health services. As Arabs continue to migrate to the U.S., it is essential to educate Arab Americans and professional mental health providers. More research is imperative in other geographical areas with a large Arab population.

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APPENDICES

Appendix A - IRB Certificate

Appendix B – Site Approval Letters

Appendix C – Data Collection Process

Appendix D – Script

Appendix E – Study Flyer

Appendix F – Written Confirmation to Utilize Instruments

Appendix G - Demographic Survey

Appendix H – Dissertation Proposal Hearing Approval

Appendix I - Solicitation Letter

Appendix A: IRB Certificate Pass



REQUEST FOR APPROVAL OF RESEARCH, DEMONSTRATION OR
RELATED ACTIVITIES INVOLVING HUMAN SUBJECTS

All material must be typed.

PROJECT TITLE: *Between Two Worlds: Acculturation Impact on the Mental Health Status of Arab Americans*

CERTIFICATION STATEMENT:

In making this application, I(we) certify that I(we) have read and understand the University's policies and procedures governing research, development, and related activities involving human subjects. I (we) shall comply with the letter and spirit of those policies. I(we) further acknowledge my(our) obligation to (1) obtain written approval of significant deviations from the originally-approved protocol BEFORE making those deviations, and (2) report immediately all adverse effects of the study on the subjects to the Director of the Institutional Review Board, Seton Hall University, South Orange, NJ 07079.

RESEARCHER(S) Sana DATE 6/17/18

**Please print or type out names of all researchers below signature.
Use separate sheet of paper, if necessary.**

My signature indicates that I have reviewed the attached materials of my student advisee and consider them to meet IRB standards.

RESEARCHER'S FACULTY ADVISOR (for student researchers only) Tamara F. Clark DATE 6/18/18

Please print or type out name below signature

The request for approval submitted by the above researcher(s) was considered by the IRB for Research Involving Human Subjects Research at the May 2018 meeting.

The application was approved ☒ not approved ☐ by the Committee. Special conditions were ☐ were not ☒ set by the IRB. (Any special conditions are described on the reverse side.)

DIRECTOR, SETON HALL UNIVERSITY INSTITUTIONAL REVIEW BOARD FOR HUMAN SUBJECTS RESEARCH Mary T. Reizella, Ph.D. DATE 7/14/18

Seton Hall University
3/2005

Seton Hall University
07/2018

Appendix B - Site Approval Letters



**ISLAMIC BROTHERHOOD, INC.
& MASJID ALFAROUQE ISLAMIC SERVICES, INC.**

552-54 Atlantic Avenue
Brooklyn, NY 11217

Date: December 21, 2017
To: Mrs. Sara Abubotain
From: Abdullah Alebdy
Re: Authorization to Conduct Research for Ph.D Dissertation

Dear Mrs. Abubotain:

As requested, I am writing to acknowledge that Masjid A-Farooq is aware of your study entitled "Acculturation Impact on the Mental Health Status of Arab Americans", which you will be completing in partial fulfillment of your Ph.D dissertation at Seton Hall University School of Health and Medical sciences under the oversight of your chair, Dr. Terrence F, Cahill.

I am writing to grant you permission to conduct your survey at Masjid Al- Farooq.

If either you or the University has any additional questions please contact me at my information listed below or by email at:

aalebdy@gmail.com

Tel: 917-295-7808

Sincerely,

Abdullah Alebdy

Board President



Mrs. Sara Abubotain,

Re: Authorization to Conduct Research for Ph.D Dissertation

Dear Mrs. Abubotain:

I am writing to acknowledge that Ben Sinai Clinic is aware of your study entitled "Acculturation Impact on the Mental Health Status of Arab Americans", which you will be completing in partial fulfillment of your Ph.D dissertation at Seton Hall University School of Health and Medical sciences under the oversight of your chair, Dr. Terrence F. Cahill.

I am writing to grant you permission to conduct your survey at the Ben Sinai Clinic.

If either you or the University has any additional questions please contact me at my information listed below or by email at: hossam_amin@hotmail.com

Sincerely,

A handwritten signature in blue ink, appearing to read 'Hossam Amin'.

✓ Hossam Amin, MD, FCCP
Professor of Medicine NYMC
Chief of Medical Intensive Care Unit MHC
Medical Director of Ben Sinai Medical Center
O: 212-423-6574
O: 718-238-6161
C: 917-825-0060
F: 718-238-6194

Subject: FW: Egyptian American Youth group Facebook Page - Permission to Post Survey

From: nora saber <nsaber021898@gmail.com>
Sent: Saturday, February 10, 2018 1:27:42 AM
To: Sara A Abubotain
Subject: Re: Egyptian American Youth group Facebook Page - Permission to Post Survey

Dear Sara,
The Egyptian American Youth Group organization grants you permission to conduct your survey by posting it to all members on our Facebook page.
We hope you all the best from the EAYG family.
Best regards,
Nourhaal Saber.
President of the Egyptian American Youth Group.

On Jan 17, 2018, at 10:58 PM, Sara A Abubotain <sara.abubotain@student.shu.edu> wrote:

Dear Nourhaal,

I hope all is well; as we discussed earlier during our phone conversation today, please let me know if you grant me permission to post the survey for my dissertation titled: "The Acculturation Process of Arab Americans Regarding Mental Health Issues" on your Egyptian American Youth group Facebook page, after I receive IRB approval.

The purpose of my research study is to:

- 1) Identify major factors impacting the attitudes of Arab American populations residing in New York Metro area toward seeking professional mental health services.
- 2) Understand how first and second generation Arab Americans seek professional mental health services.
- 3) Understand how first and second generation Arab Americans perceive professional mental health services.
- 4) Determine the impact, if any, of:
 - a) Cultural beliefs regarding mental health services.
 - b) Demographic factors pertaining to Arab Americans' attitudes towards seeking professional mental health.
 - c) Knowledge of available professional mental health services.
 - d) Acculturation method: fully acculturating or disassociating from the American culture.
 - e) Perceived societal stigma on Arab Americans' mental health.

I appreciate your assistance,

Please let me know if you have any questions.

Thanks,

Sara



June 5, 2018

Sara Abubotain
PhD Student
SHU-IHSA

Re.: Dissertation Study Recruitment

Dear Ms. Abubotain:

In response to your request to solicit participants for your study, *Between Two Worlds: Acculturation Impact on the Mental Health Status of Arab Americans*, from our PhD students, this is to confirm that following SHU IRB approval, if you provide me with your IRB approved study solicitation materials, I will be happy to have them forwarded to our PhD program students.

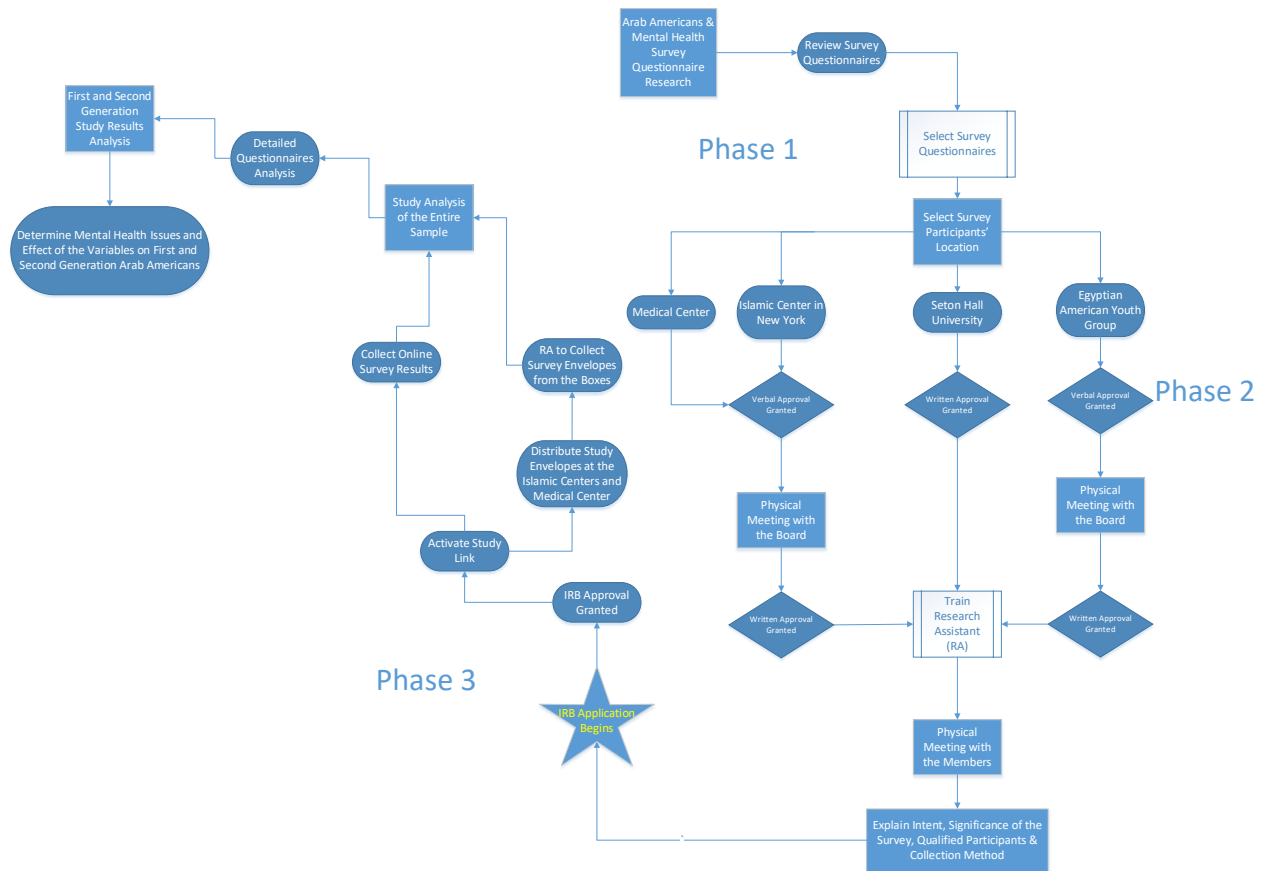
Sincerely,

A handwritten signature in black ink, appearing to read "Terrence Cahill".

Terrence F. Cahill, EdD, FACHE
Chair, IHSA

School of Health and Medical Sciences
Department of Interprofessional Health Sciences and Health Administration
(IHS) Campus I Building 123, 340 Kingsland Street, Nutley, NJ 07110
Tel 973 275 2076 Fax 973 275 2171 TDD 973 275 2169 shms.shu.edu

Appendix C: Data Collection Process



Appendix D: Script

Hello. Thanks for taking the time to meet me. Let me tell you about this study. The title is “Between Two Worlds: Acculturation Impact on the Mental Health Status of Arab Americans.” The goal is to learn how Arab Americans view and seek mental health services. This study will explore factors that may relate to Arab Americans’ views and practices about mental health:

- Cultural beliefs
- Demographic factors
- Knowledge of available mental health services
- Acculturation
- Stigma

This study is based on Arab Americans who live in the New York Metro area. This study is for first generation Arab American who migrated from Arabic countries in Africa and Asia. For this study, second generation Arab Americans are born in the U.S. to first generation Arab Americans.

To join this study, you must know how to speak and read English.

I will now explain:

- The survey steps and tools.
- The three surveys.
- The survey is optional. You can stop at any time.
- The survey is private; we will not ask for personal info.
- There are little to no risks.
- There are no direct personal.
- There is no financial reward.

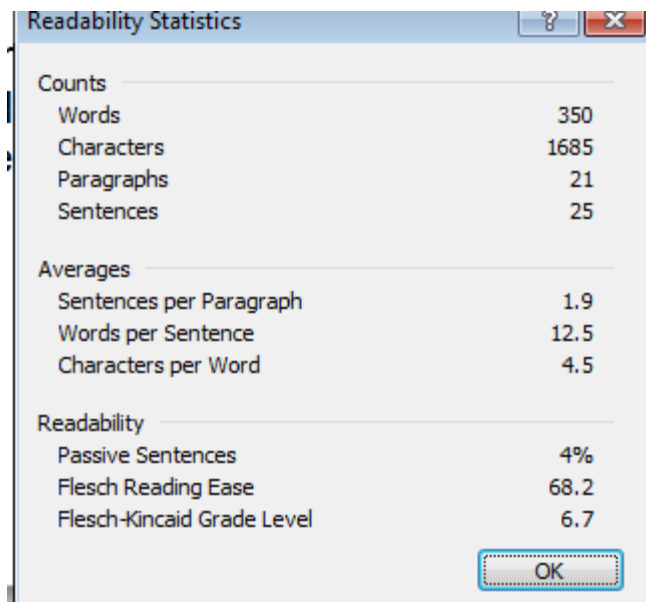
You all have an envelope with the study surveys in it, for those who want to complete the surveys, you can complete the surveys at your preferred location within the Islamic center and in 15 minutes, the collection box will be placed by the center’s entrance. For those who choose to take the survey, they should open their envelope, complete the surveys, put the surveys back in

the envelope and drop the envelope in the box. For those who do not wish to complete the survey and decide to stop, they should drop their blank or incomplete surveys in the envelope and drop the envelope in the collection box. There will be one collection box for males and female that will be located near the center's entrance.

The surveys will take about 20 minutes to complete. This study will help healthcare providers learn about Arab Americans and mental health conditions.

Please tell others about this study.

Thanks for taking the survey.



A screenshot of a software window titled "Readability Statistics". The window displays three sections of text analysis metrics. The first section, "Counts", lists Words (350), Characters (1685), Paragraphs (21), and Sentences (25). The second section, "Averages", lists Sentences per Paragraph (1.9), Words per Sentence (12.5), and Characters per Word (4.5). The third section, "Readability", lists Passive Sentences (4%), Flesch Reading Ease (68.2), and Flesch-Kincaid Grade Level (6.7). An "OK" button is located at the bottom right of the window.

Readability Statistics	
Counts	
Words	350
Characters	1685
Paragraphs	21
Sentences	25
Averages	
Sentences per Paragraph	1.9
Words per Sentence	12.5
Characters per Word	4.5
Readability	
Passive Sentences	4%
Flesch Reading Ease	68.2
Flesch-Kincaid Grade Level	6.7

Appendix E: Study Flyer

The Difference between the Way First and Second Generation Arab Americans View and Seek Professional Mental Health Service



This study is based on Arab Americans who live in the New York Metro area. To join this study, you must:

- Speak and read English.
- Immigrants from Arabic countries in Africa and Asia – first generation
- Born in the U.S. to first generation Arab Americans – second generation

Purpose of the Study:

The aim of this study is to learn how Arab Americans view and seek mental health services.

Expected Duration of Participation:

The surveys will take around 20 minutes to complete.

Voluntary Nature of the Study:

Participation is optional; you can stop at any time.

Anonymity and Confidentiality:

No personal data will be collected. Your answers are kept private.

For more details, please contact:

Sara Abubotain, Ph.D. student

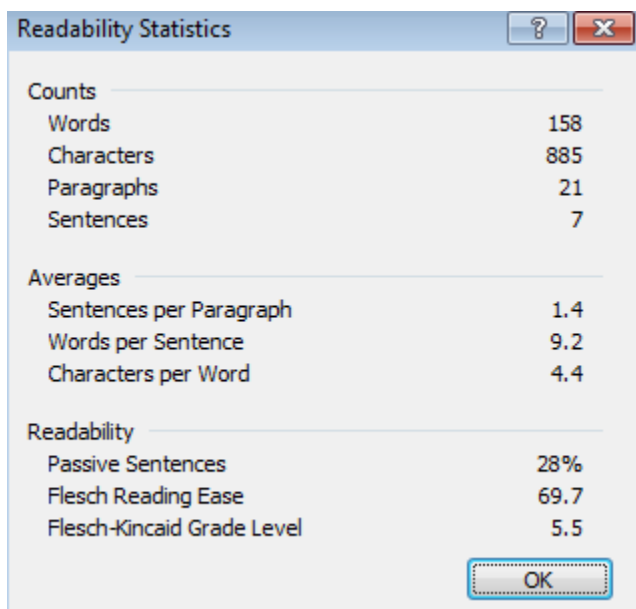
Interprofessional Health Sciences and Health Administration

School of Health Sciences and Health Administration

Seton Hall University

347-247-1789

sara.abubotain@student.shu.edu



Counts	
Words	158
Characters	885
Paragraphs	21
Sentences	7
Averages	
Sentences per Paragraph	1.4
Words per Sentence	9.2
Characters per Word	4.4
Readability	
Passive Sentences	28%
Flesch Reading Ease	69.7
Flesch-Kincaid Grade Level	5.5

Appendix F: Written Confirmation to Utilize Instruments

Permission to Use an Existing Questionnaire

01/28/2018

Dear Dr. Aloud,

My name is Sara Abubotain, I am a Ph.D. student at Seton Hall University, located in New Jersey. I am doing my Ph.D in Health Sciences at Seton Hall's School of Health and Medical Sciences. While I was working on my dissertation regarding the acculturation impact on the mental health status of first and second generation Arab Americans, I came across your study titled "Factors Affecting Attitudes Towards Seeking and Using Formal Mental Health and Psychological Services Among Arab – Muslims Population" and found that two of the instruments will be very beneficial for my dissertation.

I am requesting approval to utilize the following instruments:

- "Knowledge and Familiarity with Formal Mental Health (KFFMHS)".
- "Attitudes Toward Seeking Formal Mental Health Services (ATSFMHS)".

Please note that I will use this survey only for my dissertation study and will not sell or use it with any compensated or curriculum development activities. I will modify/ remove some statements that might not be applicable to my study and will show you the questionnaire after making any adjustment.

If these are acceptable terms and conditions, please indicate so by signing this letter and returning it to me through e-mail.

Sincerely,

Sara Abubotain, Ph.D. student
Interprofessional Health Sciences and Health Administration
School of Health Sciences and Health Administration
Seton Hall University
347-247-1789
sara.abubotain@student.shu.edu

Signature (sign here please)



with my permission

Good Luck

29/1/2018

Scanned by CamScanner

Appendix G: Demographic Survey

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

1. What is your Gender?

☐ Male ☐ Female

2. When were you born (year)?

3. Were you born in the U.S.A.?

☐ Yes ☐ No

4. How do you describe your original nationality (if you are a U.S. citizen, select your father's original nationality)?

☐ Algeria ☐ Bahrain ☐ Comoros Islands ☐ Djibouti ☐ Egypt ☐ Iraq

☐ Jordan ☐ Kuwait ☐ Lebanon ☐ Libya ☐ Mauritania ☐ Morocco ☐ Oman

☐ Palestine ☐ Qatar ☐ Saudi Arabia ☐ Sudan ☐ Syria ☐ Somalia ☐ Tunisia

☐ U.A.E. ☐ Yemen_____

Other_____

5. What is your marital status?

☐ Single ☐ Married ☐ Divorced ☐ Widowed

6. How many years have you lived in the U.S.?

Year/s _____

7. What is your highest (or current) level of education?

___ Less than high school ___ Associate degree ___ Master degree

___ High school ___ Bachelor's degree ___ PhD degree

8. Which category best matches your family's annual income?

___ Less than 10,000 ___ 20,000-29,999 ___ 40,000- 49,999 ___ 60,000-69,999

___ 10,000-19,999 ___ 30,000-39,999 ___ 50,000- 59,999 ___ 70,000 or more

9. In the past three years, approximately how many times have you visited a medical doctor for a *physical* health concern?

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

10. In the past three years, approximately how many times have you visited a mental health professional (psychiatrist, psychologist, or a clinical social workers) for a *mental health or psychological* concern?

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

11. Which of the following describes your occupation?

___ Student ___ Unemployed ___ Office employee ___ Manual worker ___ Professional / administrator

___ Personal business

___ Other(specify)_____

12. What type of health insurance do you have?

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

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

☐ Mental health professional ☐ Family doctor (M.D.) ☐ Close friend

☐ Religious leader ☐ Family member (e.g. father, etc.) ☐ No one

14. To whom would you go Second if you were to consider seeking outside help for mental health/psychological counseling (select only one different from question # 13)?

☐ Mental health professional ☐ Family doctor (M.D.) ☐ Close friend

☐ Religious leader ☐ Family member (e.g. father, etc.) ☐ No one

15. To whom would you go Third if you were to consider seeking outside help for mental health/psychological counseling (select only one different from question # 13 and 14)?

☐ Mental health professional ☐ Family doctor (M.D.) ☐ Close friend

☐ Religious leader ☐ Family member (e.g. father, etc.) ☐ No one

16. Do you celebrate American Holidays, such as Thanksgiving?

☐ Yes ☐ No

Appendix H: Dissertation Proposal Hearing Approval



PROPOSAL HEARING SIGN OFF SHEET


DOCTORAL CANDIDATES NAME: Sara Abubotain

PROJECT TITLE: Between Two Worlds: Acculturation Impact on the Mental Health Status of Arab Americans

PROPOSAL HEARING DATE: November 14, 2017

I HAVE PARTICIPATED IN THE ABOVE NOTED PROPOSAL HEARING AND MY SIGNATURE PROVIDES SUPPORT OF THE PROPOSED METHODOLOGY.

DISSERT. COMMITTEE CHAIR: Terrence F. Cahill

COMMITTEE MEMBER SIGNATURE: 

DISSERT. COMMITTEE MEMBER: Deborah A. DeLuca

COMMITTEE MEMBER SIGNATURE: 

DISSERT. COMMITTEE MEMBER: Fortunato Battaglia

COMMITTEE MEMBER SIGNATURE: 

School of Health and Medical Sciences
Department of Interprofessional Health Sciences & Health Administration
Tel: 973.275.2076 • Fax: 973.275.2171
400 South Orange Avenue • South Orange, New Jersey 07079 • gradmed@shu.edu

A H O M E F O R T H E M I N D , T H E H E A R T A N D T H E S P I R I T

Appendix I: Solicitation Letter



Dear Mr. /Ms.

My name is Sara Abubotain, I am a Ph.D. student at the School of Health and Medical Sciences at Seton Hall University. This research is part of my dissertation.

What is the purpose of the study?

The goal is to learn how Arab Americans view and seek mental health services.

What is the study procedure?

This study is for Arab Americans living in the New York Metro area who:

- Can speak and read English.
- Have migrated from Arabic countries in Africa and Asia (first generation)
- Are born in the United States to first generation Arab Americans (second generation)

You can join the study:

- In-person survey completion
- Online Survey Monkey @ site:
 - This is a safe site with a distant risk of hacking.
 - To submit the survey, please click the "Submit" button after you are done.
 - Please close the browser to end the survey.
- This study will use snow sampling.
- Feel free to share the survey or link with others. Please share the survey link with others.
- The survey will take around 20 minutes to complete.

Is participation voluntary?

- The survey is optional. Also, you can stop at any time:
 - In-person: you can place a blank or not complete survey in the box.
 - Online: you can close the browser at any time.

What will happen to the study data?

- We will not collect personal data
- We will only collect demographic data

School of Health and Medical Sciences
Department of Interprofessional Health Sciences & Health Administration
Tel: 973.275.2076 • Fax: 973.275.2171
400 South Orange Avenue • South Orange, New Jersey 07079 • gradsstud@shu.edu

A HOME FOR THE MIND, THE HEART AND THE SPIRIT

- Your answers are private.
- There is no way to reach you.
- There is no way to reach those you will send the survey to.
- The research data may be published at the end of the study. If it is, it will not identify anyone.

Risk and Benefit to participating.

There are no likely risks or direct benefits if you complete the survey. You will help future health care providers learn about mental health conditions of Arab Americans.

Can I request further information?

- If you have any questions, please contact me.
- If you have any questions about your rights as a participant, you may contact Dr. Mary Ruzicka. Dr. Ruzicka is the director of the Institutional Review Board. You can reach Dr. Ruzicka at 973-313-6314.
- For human subjects' rights questions, please email: irb@shu.edu. You may contact Dr. Terrence F. Cahill. He Dr. Cahill is the dissertation chair/advisor. You can reach Dr. Cahill at 973-275- 2449 or via terrence.cahill@shu.edu.

Ways to participate in this study?

- Face-to-face paper surveys
- Online: Survey Monkey ®.

The survey link to this study is:

- The survey link will be placed here after the IRB's approval.
- Once you click on the link, you will find three surveys:
 - Attitudes Toward Seeking Formal Mental Health Services
 - Knowledge and Familiarity with Formal Mental Health Services instrument
 - Demographic survey
- Please complete the surveys and kindly send the link to others.

Thank you for taking the time to read this and for taking the survey.

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Readability Statistics	
Counts	
Words	483
Characters	2375
Paragraphs	50
Sentences	41
Averages	
Sentences per Paragraph	1.3
Words per Sentence	8.8
Characters per Word	4.5
Readability	
Passive Sentences	4%
Flesch Reading Ease	68.0
Flesch-Kincaid Grade Level	5.9
OK	