THE ROLE OF ACCULTURATION, ETHNIC IDENTITY, AND RELIGIOUS

FATALISM ON ATTITUDES TOWARDS SEEKING PSYCHOLOGICAL HELP

AMONG COPTIC AMERICANS

A Dissertation

by

SALLIE ANN BOULOS

Submitted to the Office of Graduate Studies of
Texas A&M University
in partial fulfillment of the requirements for the degree of

DOCTOR OF PHILOSOPHY

May 2011

Major Subject: Counseling Psychology

The Role of Acculturation, Ethnic Identity, and Religious Fatalism on Attitudes Towards

Seeking Psychological Help Among Coptic Americans

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Approved by:

Chair of Committee,   Daniel Brossart
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ABSTRACT

The Role of Acculturation, Ethnic Identity, and Religious Fatalism on Attitudes Towards

Seeking Psychological Help Among Coptic Americans.

(May 2011)

Sallie Ann Boulos, B.A., Concordia University Texas;

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The purpose of this current study was to determine the role of acculturation, ethnic identity, and religious fatalism regarding attitudes towards seeking psychological help among Coptic (Egyptian Christian) Americans. In addition, differences between groups of gender and generational status, first-generation adult immigrants versus U.S.-born second-generation Copts, were analyzed. The study had a total sample of 91 individuals that self-identified as Coptic by race and/or Coptic Orthodox by religion, who voluntarily completed an anonymous online questionnaire.

Results indicate that ethnic identity and acculturation are strong predictors of religious fatalistic beliefs, and those who identified as having more Arab ethnic identity and less assimilation to dominate culture have stronger religious fatalistic beliefs than those who identified with more western culture and an American ethnic identity. However, religious fatalism and ethnic identity were not significant predictors of attitudes towards seeking psychological help, and other variables such as stigma,

language barriers, and skepticism of western psychology may be better predictors of attitudes towards seeking psychological help.   Between groups comparisons identified subtle differences between males and females, and between first and second-generation Coptic Americans on acculturation, ethnic identity, and religious fatalism, but the groups were not statistically significant from one another. Clinical implications and directions for future research will also be discussed.

DEDICATION

I would like to dedicate this to the members of the Coptic Orthodox Church worldwide, who have fought discrimination and persecution for centuries and continue to hope. I am indebted to my parents who courageously immigrated to the U.S. from Egypt to give their daughters hope and a future. Without your bravery, I would not be a Ph.D. Candidate.

ACKNOWLEDGEMENTS

I would first like to thank my committee chair, Dr. Daniel Brossart, who offered guidance and support through this project. I would also like to thank my committee members, Dr. Timothy Elliott, whose expertise in public health issues in psychology was invaluable, Dr. Michael Duffy, your knowledge of religion and spirituality in psychology was inspirational in this study, and Dr. Arnold LeUnes, whose objectivity and perspective created a perfect blend of voices to help give guidance to this study that is very dear to me.

I also wish to thank the faculty and staff of the CPSY Program and in the Educational Psychology Department who provided timely advice and insight throughout my graduate course work and journey. A huge thank you to my colleagues and friends, Sylvia Chen, Kylin Haedge-Lee, and many others who were always so supportive, encouraging, gave wonderful feedback and advice; your care and support will never be forgotten. Thank you to Chi-Tsun Chiu, a friend and colleague from University of Texas at Austin, who was always kind and patient in his role as a statistical consultant.

I would also like to deeply thank the members of the Coptic Orthodox churches in America who spent their precious free time to complete the survey, and for the Coptic Priests and Bishop Yousef, who were supportive of this research and helped recruit volunteer participants- this dissertation would not exist without you! I also wish to thank the member of the Holy Cross Coptic Orthodox Church in Austin, Texas who also supported my research and encouraged me throughout my life, and throughout my degree.

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CHAPTER I

INTRODUCTION

Statement of the Problem

According to the Arab American Institute (2007) it is estimated that

approximately 3.5 million individuals in the United States claim Arab/Chaldean descent.

However, mental health care access is limited and underutilized due to cultural and

religious constraints and social stigma found in this population (Abbudabeh & Aseel,

1999; Hakim-Larson, Kamoo, Nassar-McMillan, & Porcerelli, 2007). Other reasons for

underutilization of mental health services include language barriers, social stigma,

unfamiliarity with services, mistrust of the profession, and incompatible treatment

expectations between the therapist and client (McDonald & Steel, 1997).   The literature

also points to a general mistrust and skepticism of western psychology and

psychotherapy among Arab Americans, which also leads to underutilization of mental

health care (Nassar-McMillan & Hakim-Larson, 2003). In addition, the lack of mental

health care providers of similar ethnic descent contributes to this population being

underserved because previous research indicates that Arab Americans would prefer to

see providers who speak their native language (Shah, Ayash, Pharaon, & Gany, 2008).

Coptic and Arab families of the person with mental illness are afraid of societal

attitudes, and how these attitudes may affect the family's reputation.

_____

This dissertation follows the style of *Journal of Cultural Diversity and Ethnic Minority Psychology.*

They are also afraid that people will discriminate against the relative with mental illness (Doornbos, 1996).   As a result, the stigma associated with mental illness prevents many families from seeking treatment.

Another factor that contributes to ambivalence in seeking mental health treatment is the perceived discrimination and negative stereotyping of Arabs in western society in the media, and making blanket assumptions that all Arabs are Muslim and fanatic (Awad, 2010; Moradi & Hasan, 2004). This is a reality for many Copts who have experienced a lifetime of discrimination and persecution in their homeland.   Two recent examples of this occurred in Alexandria, Egypt with the bombing of a Coptic Church on December 31, 2010 that killed 26 Copts, and in Naga Hammadi (Upper Egypt) in January 2010 when one Police Officer and six Coptic young adults were killed and ten others were injured in a drive-by shooting outside their Coptic Orthodox church after January 6 Christmas Eve services (Slackman, 2010, p. A4; USCIRF, 2010). The 2010 Annual Report from the United States Commission on International Religious Freedom (USCIRF) reported elevated amounts of discrimination and violent crimes against Coptic Christians by Muslims. The report states:

> The reporting period marked a significant upsurge in violence targeting Coptic Orthodox Christians. The Egyptian government has not taken sufficient steps to halt the repression of and discrimination against Christians and other religious believers, or, in many cases, to punish those responsible for violence or other severe violations of religious freedom. This increase in violence, and the failure to prosecute those responsible, fosters a growing climate of impunity. (p.227)

Other Arab Muslim immigrants may perceive discrimination and face stereotyping due to their clothing, such as wearing the hijab or appearance. The discrimination, persecution, and trauma experienced by some Arab immigrants may lead to significant

acculturative stress for individuals and families assimilating in the United States

(Youseff & Deane, 2006). Many move to the U.S. and experience isolation, loneliness,

and feelings of helplessness because of the stark difference in American lifestyle

compared to the collectivist culture and community they had in their native country

(Awad, 2010; Moradi & Hassan, 2004). It is important to understand the immigration

pattern of Arabs to America and the reasons behind the immigration patterns. In

addition, Arab immigrants have unique cultural values, and strong religious beliefs and

practices. It is vital to view the obstacles to seeking mental-health treatment through a

cultural framework.

Arab Immigration

      Individuals of Arab descent have steadily immigrated to the United States since

the beginning of the 20th Century. There were three main immigration waves into the

U.S. The first wave occurred in the 1800's and was comprised of Christians mainly

from Syria and Lebanon who settled in urban areas in the North Eastern United States:

Boston, New York City, and in the Midwest. The second wave happened in 1948 and

included mainly Muslim immigrants who fled their homeland in response to the creation

of Israel. The third wave of immigration occurred almost 20 years later in 1967 after the

Arab-Israeli war and consisted primarily of professionals who used the flexible U.S.

immigration policy as a means of escape (Abraham, 1995). The last group is the least

assimilated, holding steadily onto their host culture and religion (Erickson & Al-Timimi,

2001).

The importance of Middle-Eastern immigrants in American culture and living has been most noticeable post September 11, 2001. According to the 2000 U.S. Census, 850,000 Americans endorsed Arab as their full ancestry with another 200,000 marking at least one half Arab ancestry, meaning that as of 2000 there are over one million people in the U.S. who identify themselves as Arab, with close to 400,000 of the 850,000 marking Lebanese or Egyptian ancestry (Brittingham & De la Cruz, 2005). As stated earlier, this number is now estimated to be over three million.   Also, in her study on Arab women, family, religion, and work ethic, Read (2004), stated that U.S. Census Statistics indicated that Arab immigrants came from 17 different Arab countries, and that only 33% of Arab immigrants identified as Muslim and 66% identified as Christian. More recent statistics from the Arab American Institute estimate the percentage of Christian Arabs in the U.S. to be 77% of the total Arab immigrant population (Samhan, 2006).

 Due to the diversity and range in the makeup of Arab Americans in the U.S., several issues such as acculturation, equality of women, religion, and psychological well-being among groups remain an enigma. Abudabbeh (2006), states that most Arabs would define their ethnicity as those who speak the Arabic language and claim a historical ancestry to the nomadic tribes of Arabia that spread throughout the Middle-East in Mohammed's invaded territories, and claimed them in the name of Islam.

However, there is a small minority of 14 million Arabs that are Christian whose heritage in that same land goes further back before the Islamic conversion. The majority of this Christian population consists of Coptic Orthodox Christians from Egypt, whose

mother tongue closely resembles Greek, but now speaks Arabic as a result of the conversion of Egypt and many other countries such as Syria, Lebanon and Jordan from a predominantly Christian country to a predominantly Muslim country (Abudabbeh, 2006). Abudabbeh also makes the clear distinction that Arab Christians who are now American Citizens have advocated for education of the Arab culture among Americans as well as educating the general public about Arab culture both Muslim and Christian (Abudabbeh, 1996).

Public Health scholars have focused research efforts into understanding the health disparities among US minorities. They often caution against simplifying culture into "ethnic", "assimilated" or other "risk" categories and focusing on these pieces while ignoring cultural constraints like access to resources (Abraido-Lanza, Armbrister, Florez, & Aguirre, 2006). They state, "A public health perspective that incorporates the roles of structural and cultural forces in acculturation may help identify mechanisms underlying links between acculturation and health" (Abraido-Lanza et al., 2006).

A group of researchers developed a socio-ecological model that seeks to bridge the health disparities, particularly psychological among ethnic minorities in the United States. She believes there are five dimensions that influence health-seeking behavior. The *Individual level* includes one's beliefs, values, educational level, and life skills that influence behavior. The *Interpersonal level* concerns one's relationships with others and within the family. Next is the *organizational level* that deals with how relevant institutions are organized and managed. At a grander scale is the *community level* that involves all the professional networks, associations, neighborhoods, and community

attitudes interacting with individual and his or her family; as well as the relationship

between different institutions within communities. The last dimension relates to *Policy*

and the way policies and regulations affect intervention from participants and places

they represent (Tucker, Herman, Ferdinand, Bailey, Lopez, Beato, Adams, & Cooper,

2007)

Keeping these five influential levels in mind, there are four methods the socio-

ecological model should utilize. Tucker states that this model should be informal,

empowerment oriented, culturally sensitive, and should focus on illness preventions and

health promotion.

The informal approach seeks to alleviate physical and psychological issues

through diverse group involvement. These diverse groups include: traditional healers,

family members, measures other than medications (e.g. lifestyle modification). It also

includes treatment in informal settings such as schools, community centers, churches,

and homes/offices of unconventional health care providers. The treatment should be

empowerment oriented. Due to societal constraints and historical discrimination, low

SES ethnic minority families feel they have little control over and power to change the

quality, quantity, or source of health care delivery. The goal is to help families gain

active control over their health care (i.e. Self-Determination).

Furthermore, Tucker's model encourages a culturally sensitive approach that

communicates verbally and non-verbally cultural competence through knowledge, skills,

and awareness. Health Professionals should educate themselves on minority issues and

interventions that relate cultural sensitivity while maintaining awareness of one's

cultural bias and cultural values. In particular, cultural differences should be seen as differences not deficits (Tucker et al., 2007).   Tucker's model may be a useful model when working with Arab Americans to increase their health seeking behavior.

Low occurrence of health-seeking behavior among Arab Americans has been noted in recent empirical research with this population. Legge and Westbrook (1994) surveyed 371 health workers about their perceptions of health services provided for older adults within their communities. The survey revealed that when compared with all other ethno-specific services that the Arabic-speaking community was most in need of doctors who speak their ethnic language and interpreters to explain diagnosis and treatment in their native language. Another study conducted in Israel examined health seeking behavior of Arab Israelis in Colorectal Cancer (CRC) screenings. They found that only 17% of Israeli Arabs engaged in CRC screenings compared to 50% of individuals in the US (Ore, Hagoel, Lavi, & Rennert, 2001).

Much of the literature on Arab Americans health behavior has been researched in Michigan, the 2nd largest population of Arab immigrants after New York. In these various studies, findings indicated that in a 15 year period up to 2001 the number one cause of cancer mortality among Arab men was lung cancer, while for Arab women it was breast cancer compared to general U.S. population in which lung cancer was the leading cause of cancer death for both sexes (Shah et al., 2008).

Another study from the Detroit metropolitan area revealed that the top barriers to seeking cancer prevention and treatment services was language, lack of transportation, and lack of knowledge. Additionally, beliefs of self-efficacy and one's

personal risk were significantly positively correlated with health seeking behavior among Arab Americans (Al-Omran, 2005).

Purpose of Study

The Coptic American population has a rich culture and history. This population encompasses a significant portion of the U.S. population, yet it is a highly underserved population for mental health services. Cultural values such as religious fatalism, importance of family, and religious beliefs among Copts as well as other Arabs, impacts their views on mental illness and mental-health treatment. This is compounded by the acculturation process and ethnic identity formulations of Arab immigrants in the United States and their U.S. born children.

There is a solid literature base regarding Arab values and its interaction on attitudes towards mental illness and mental-health seeking behavior. However, there is very little empirical research on this population in the U.S. to measure how these factors impacts their attitudes towards seeking mental health care. This gap in the research is even more noticeable with regard to Christian Arabs because much of the literature makes the distinction between Christian and Muslim Arab acculturation to the U.S. but focuses on Muslims (Amer & Hovey, 2007; Awad, 2010; Jackson & Nassar-McMillan, 2006). This study sought to add to empirical knowledge of the Christian Middle-Eastern population, specifically the Coptic American population. This population makes up 23 % of Middle-Eastern Christian in the U.S., who as a whole comprise 77% of the Middle-Eastern American population (Samhan, 2006). Hopefully, by better understanding this

population's beliefs and values, the mental-health field can better attend to their mental-

health needs.

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CHAPTER II

REVIEW OF THE LITERATURE

Coptic Orthodox Church History

Coptic is derivative of the Greek word Aigypto. The modern use describes

Egyptian Christians, who are direct descendants of the Ancient Egyptian Pharaoh

lineage (Kamil, 1997). According to the early church fathers' historical writings,

Ancient Egypt was Christianized by Apostle Mark in 64 A.D., and was later infused with

the Arab culture in 7th century in 646 A.D. when Muslims captured Alexandria. The

Arab/Muslim race and religion are now the predominant culture and race in Egypt

(Meinardus, 1999). Abudabbeh (1996) reports that make up about 8% of the Egyptian

population, which translates to 9.57 million Copts in Egypt and 1.2 million outside

Egypt. More recently, the number of Copts in Egypt has been estimated to be 10-15% of

Egypt's 80 million inhabitants (USCIRF, 2010).

Religious Practices and Beliefs of the Coptic Church

The Coptic Church states that the rituals, dogma, and beliefs have remained

intact since Apostle Mark, a disciple of Christ, started the church in the 1st century in

Alexandria, Egypt (Malaty, 1993). The Church has a hierarchical configuration with a

patriarch of the church understood as divinely appointed, followed by arch-bishops,

bishops, priests, and deacons, as well as monks who live in the desert land of Egypt

(Meinardus, 1999). The Virgin Mary, who is often called the Theotokos-Mother of God,

holds a holy position within the church and is held in high esteem. Copts believe that

the Virgin Mary does not act of her own accord, but through the wishes of God, as such,

she is not hierarchically equal to Christ (Dunaway, 1995; Jackson & Nassar-McMillan, 2006; Youseff & Deane, 2006).

Coptic Orthodoxy follows the Nicene Creed of 325 CE; which states:

> We believe in one Lord, Jesus Christ, the only Son of God, eternally begotten of the Father, God from God, light from light, true God from true God, begotten, not made, of one Being with the Father; through him all things were made. For us and for our salvation he came down from heaven, was incarnate of the Holy Spirit and the Virgin Mary and became truly human. For our sake he was crucified under Pontius Pilate; he suffered death and was buried. On the third day he rose again in accordance with the Scriptures; he ascended into heaven and is seated at the right hand of the Father. He will come again in glory to judge the living and the dead, and his kingdom will have no end (Botros, 2006).

According to church dogma, Coptic parishioners must partake of the sacraments of the church in order to maintain their salvation. There are seven sacraments of the Coptic Church including Priesthood, Baptism, Confirmation, Matrimony, Confession/Repentance, Eucharist/Holy Communion, and Unction of the Sick-anointing the sick with holy oil (Mettaous, 2007). The church believes in the omnipotence of God, and His power to change circumstances, heal the sick, performs miracles, as well as exorcisms, which all fall under the sacrament of Unction of the Sick. This sacrament is believed to provide a cure for those who are physically and mentally ill, which some believe is caused by sin or demonic forces (Youssef & Deane, 2006).

The Coptic Church is steeped in a heavy mysticism that pervades the liturgy as well as everyday life, such as the sacrament of the Eucharist, by which the bread and wine for communion are understood to be transformed into the true body and blood of Jesus Christ (Mettaous, 2007). The sacrament provides spiritual nourishment; it gives the promise of eternal life: "Whoever eats My Flesh and drinks My Blood has eternal

life and I will raise him up at the last day. He who eats this Bread will live forever"
(John 6:54, 58).

Another tradition unique to the Coptic Church is the holy bread called "*Qurban*"
that is used in the Eucharist. This bread is prepared the night before a liturgy by a
deacon serving in the church. The deacon prays and sings hymns during the preparation.
"*Qurban*" bread is round, decorated with a cross in the middle that is surrounded by
twelve dots. The dots represent the twelve disciples of Jesus. "*Qurban*" is treated with
reverence, it is not thrown away, and believers make the sign of the cross before
partaking of the bread, which is typically distributed after liturgy (Awad, 1996; Iskander
& Dunn, 2010).

The Coptic Orthodox Church fasts two-thirds of each year. Out of the 365 days
of the year, Copts fast for over 210 days. These fasting periods are called the "Seyam",
and during this time no animal products or by products (meat, poultry, milk, eggs, butter,
etc.) are allowed (Angaelos, 1997). Fasting seasons of the Coptic Church include, the
Fast of the Nativity (Christmas) which is 45 days, the Fast of the Apostles, the Fast of
the Virgin Mary, the Fast of Nineveh and of course Lent, known as "the Great fast"
which lasts 55 days (Awad, 1996).

Typically, the priest of each church serves not only as the religious leader but
also as the community and spiritual leader. He is treated with deference and has
authority over individuals in his congregation. This sign of reverence can be seen by
individuals bowing and kissing his right hand, which is done because it is the hand that
allots the body and blood of Christ during communion.

Miracles and apparitions of the saints are commonly believed in the Coptic

Orthodox Church (Malaty, 1993). One of the most notable and heavily documented is

the miraculous apparition of Virgin Mary who appeared on the dome of the St. Mary's

Cathedral in Zeitun, a suburb of Cairo for 2 years. According to the Egyptian newspaper

Watani, the first apparition occurred on April 2nd, 1968 at 8:30pm (Zaki, 1977). The

first individuals to see her were a group of workmen across the street as well as a group

of women walking by the church, all of whom were Muslim. They first reported seeing

what appeared to be a woman kneeling on top of the big dome, and thought it was a

woman attempting suicide. They began to yell at her, asking her not to jump and alerting

others to her presence. They reported that when they moved closer to the church, she

appeared with white glowing robes, and they recognized her as Virgin Mary (Zaki,

1977).

There are thousands of eye witness reports, as well as scientifically and

technically analyzed and substantiated photographs taken of her continued appearance.

Worldwide newspapers and reporters documented reports of the apparition and visits.

All accounts state similar experiences: an intoxicating smell of sweet roses and incense,

white glowing doves that suddenly appear and fly in the form of a cross, bright white

light, and the clear apparition of Virgin Mary. Reports of her visitation came at a

historically significant time, as the Six-Day War with Israel had just ended, and renewed

the hope of peace for the region (Zaki, 1977).

Many Coptic people openly believe in the spirit world, especially the ability of

Saints, and past Popes/Patriarchs, especially Pope Kyrollos IV, to continue to appear and

perform miracles, as well as icons producing tears of oil or blood, or the phantom smell of incense as a sign of the paranormal (Hanna, 1999). Coptic oral history narrative tells of a monk at St. Paul's Monastery in Egypt, Abouna (Father) Fanous, who has bright green crosses that appear in each of his pupils, and wraps his hands because they glow, which attracts many devout worshippers to the monastery who desperately hope to meet him or receive a blessing from him. The oral history narrative passed from generations and written by the church fathers regarding miracles and supernatural occurrences means that Coptic individuals in the church may have strong beliefs in the supernatural. In turn, Copts may use intercessory prayer and thus often rely on external sources in coping with mental and physical illness (Botros, 2006).

Cultural Values

The family systems dynamic penetrates gender roles as well as gender stereotypes. Aswad (1994) observes that women coming from families strongly adhering to strict ethnic values are less likely to be educated and employed, and have little to no power in decision making for the family. Christian or Muslim women, in more religious households tend to have lower rates of unemployment and higher rates of pregnancy than women who are not as religiously strict. In addition, she further explains that Arab women who have a disempowered status are more likely to be new immigrants to America than those who have been here longer or those who were born in the U.S.

Middle-Eastern families tend to be collectivist rather than individualistic, and children are raised to show respect and loyalty to their family. Authoritarian parenting style is often found in Arab families, and autonomy and independence of children is

usually discouraged (Dwairy & Achoui, 2006). Parents often remain financially

supportive and responsible for children into adulthood, especially unmarried children,

but continue to provide emotional and financial support even after marriage. However,

these roles are reversed when parents begin to age, and then children are expected to

care for their parents (Dwairy, 2006; Endrawes, O'Brien, & Wilkes, 2007).

It is common practice to give boys preferential treatment within the family, and

the rights of males in families is higher than that of female siblings, in such a way that

sons are prized and women devalued. In addition, when parents are asked about children

for census purposes, only sons are counted as children with daughters not being counted

as offspring. It also great shame for a man in an Arab country to be without sons and is

often disparaged as "Abu Banat" "father of daughters" (Moracco, 1983). Patai (1973)

adds that males have the distinct role of protecting their *sharaf* (honor) by going to great

lengths to obstruct interactions between females in his family i.e. wives, daughters,

sisters, etc… with other males.

Education is a high priority (especially for Copts). Arab Americans tend to have

more education than other U.S. ethnic groups; in part because educational achievement

and economic advancement are encouraged within Arab cultures (Abraham, 1995).

Furthermore, current U.S. immigration patterns and policies favor educated

professionals (Jackson, 1997). Census data from 2000 and the Arab American Institute

claim that the majority of the 1.2 million Arab Americans tend to have higher incomes

than the average American, more education, and tend to be business owners than the

average American population. Recent data comparing Arab Americans to the general

population shows that 1 in 4 Americans has a college degree, compared with 40% of Arab Americans who are university degree holders. In addition, 43% of Arab Americans hold professional/managerial positions compared to 34% of the American population (Hendricks 2005; Samhan, 2006). When taking into account that 77% of Arab American identifies as Christian, the common argument that socio-economic status is the main constraint for mental-health seeking behavior, does not fit for this specific minority group.

Food is an important part of family and social events/gatherings. It shows respect to your guests and is a status symbol to have a vast spread of food in great quantities. In addition, it is common practice to put guests and others first. Coptic culture prides itself on being extremely hospitable and treasuring house guests, and it is a sign of good will and honor to bestow the guest with the best of everything the family can offer (Dwairy, 2006; Moradi & Hasan, 2004; Nobles & Sciarra, 2000).

A common cultural value among Copts is the belief in evil, Satan, demons, and demonic possession, and the spirit world. It is believed that evil can directly impact humans, but that the saints, angels, and Holy Spirit can intercede on one's behalf. While these beliefs have been typically associated with lower social classes and those less educated groups, people from all social classes may attribute mental illness to evil spirit possession. This belief is rooted in the religious tradition of Christians and Muslims since evil spirit possession is mentioned in both the Bible and the Koran (Younis 2001).

In addition, there are more benign superstitious beliefs such as the evil eye. Fadlalla (2005) states that many still believe in the evil eye as a source of their

psychological and/or physical problems, which Egyptians believe occurs when someone covets something you have or is jealous of you. This other person's covetous thoughts lead to negative ripples, and can be dangerous to the envied person, leaving him/her unable to function. This evil eye can be remedied by saying the Lord's Prayer and making the sign of the cross (Meinardus, 1999).

For many Coptic Americans, the church provides key social and emotional support. Communion and Confession are integral sacraments for salvation and also contribute and maintain physical and emotional well-being. Communion is held as a holy mystery that can heal the sick because the Coptic Church believes in the manifestation of the communal bread and wine into the body and blood of Jesus. In Egypt, every city has at least one big church if it is a small town, as found in southern Egypt, or several churches in one neighborhood, common in Cairo, where all the Coptic residents of the area congregate. There, each family chooses a priest of confession who becomes the family's advisor. Egyptian Copts are known to be very religious; one rarely walks into a house without finding an icon or other depictions of the Virgin Mary, the church saints, and/or Jesus Christ (Malaty, 1993).

It should be noted that these mystical, paranormal, superstitious beliefs are also a cultural issue that can affect assessment as well as lead to western psychologists not understanding the fatalistic/deterministic attitude of middle-eastern individuals (Erickson & Al-Timimi, 2001).

Attitudes about Mental Illness

Jacobsson and Merdasa (1991), state that the Coptic Orthodox church has been a strong influence regarding attitudes of mental illness. The church has traditionally viewed mental illness as demonic possession. This evil possession is treated by monks or special clergy through prayers, holy water, and exorcisms. One hundred and sixty Arab men (Christian and Muslim) in Yemen were surveyed about their opinions and attitudes concerning both mentally ill and physically disabled people's characteristics, and subsequent treatment options. The study found that over 60% of participants agreed that mentally ill people are afflicted with an ''evil soul'' (Alzubaidi, Baluch & Moafi, 1995).

 In addition, families with members who are mentally ill may go to great lengths to hide the illness, and would only seek treatment if absolutely necessary (Abbudabeh, 1996). The protection of the family's reputation is of utmost important, and because there is such great stigma regarding mental illness; many Arabs would rather seek help from religious leaders and within their family rather than going to strangers for help (Hakim-Larson et al., 2007). Moreover, because Fatalism pervades Arab culture and religion, the belief that only God can change one's destiny, many Arabs believe that mental illness or physical illness is something that must be endured because it is God's will (Nydell, 2006).

Acculturation

Acculturation theory has strong roots in the social sciences. This is most notably seen through social psychologist Robert Park, who in the early 1900's theorized that

acculturation was a linear process that was marked by the degree to which an immigrant dismissed native cultural identity and accepted the new American identity. Park thought of this acculturation process as irrevocable and refined this idea into a three stage model consisting of contact, accommodation, and assimilation. This model has become the basis for scholarly understanding of the acculturation process (Abraido-Lanza et al., 2006; Padilla & Perez, 2003). Likewise, in 1936, anthropologists' defined acculturation as a cultural change that occurs when two cultures come into contact and interact with one another (Redfield, Linton & Herskovits, 1936). Acculturation at this time was nomothetic and focused on group changes.

However, understanding of acculturation began to shift focus from the group to individual experience. In 1954, the Social Science Research Council developed a formalized definition of individual acculturation to include various psychological processes that can occur including; "*reactive* (triggering resistance to change in both groups), *creative* (stimulating new cultural forms, not found in either of the cultures in contact), and *delayed* (initiating changes that appear more fully years later)" (Berry, 1980).

This movement was consolidated by Graves (1967) who differentiated this process into psychological acculturation to acknowledge the intrapersonal process of assimilation versus the group process of assimilation into another culture. The distinction of psychological acculturation is significant because it provides a comparison between a group's cultural shift and acculturation pattern and the unique patterns of individuals within that culture. Likewise, Teske and Nelson (1974) emphasized the

importance of factors such as psychological changes, individual characteristics, societal changes, social norms, cultural practice, and value systems that may impact an individual's acculturation process.

The importance of personality and environmental factors and the ability of certain individuals within a culture to complete the acculturation process, and others in that same culture to stop the process, adds another piece of self-determination and choice that is unique and overlooked in group acculturative process. Berry and colleagues have been researching acculturation for over twenty years (Sam & Berry, 2010). Berry termed these individual variations "acculturative strategies" (Berry, 2007), and includes two parts; *acculturation attitudes*- how individuals feel about certain aspects of acculturation (Berry, 2006) and *behavioral shifts*- the meaning they make out of this process and any egodystonic issues resulting from this process (Berry, Kim, Minde, & Mok, 1987).

Acculturation has been broadly defined as the psychological process of internal change that new immigrants to the U.S. undergo when continually interacting with majority culture (Padilla & Perez, 2003). Paniagua (2005) defines acculturation as "the degree to which an individual integrates new cultural patterns into his or her original cultural patterns" (p.9). Berry defines acculturation as the social interaction and communication styles that individuals adopt when interacting with individuals and groups from another culture. He believes acculturation is the degree of aptitude and ease in communicating with ethnic peers and the majority group. (Berry, 2006).

Berry and Poortinga (2006) organizes the process of acculturation into 4 sets of schema. The first is *Assimilation* which refers to the socialization and communication interactions primarily occurring with individuals from the majority culture. Next is *Separation* which is the experience and encounter of socializing and communicating primarily with one's ethnic peers. *Integration* occurs when an individual is then able to comfortably and adeptly socialize and communicate with both the majority group and his or her ethnic peers. The fourth schema is *Marginalization,* which is the absence of socialization and communication with both groups. It is an isolating conditional period where the individual feels uncomfortable in both situations. This acculturation process can be observed cross-culturally, but it is incomplete. It is necessary to also include specific cultural factors that cause obstacles within the assimilation process, and especially for Arab Americans.

Arab American Acculturation

Arabs emigrating from the Middle-East may have a more complex assimilation process because of the outwardly perpetuated negative stereotype of Arabs as terrorists and criminals (Barry, Elliott, & Evans, 2000; Faragallah, Schumm, Farrell, & Webb, 1997). In addition, acculturative differences exist between Muslim and Christian Arabs, and it is suggested that Christians may experience less acculturative stress due to perceived cultural similarities between Arab Christians and western culture (Jackson, et al., 2006). Abu-Ali and Reisen (1999), report for Arabs in their study, life satisfaction was related to religion, age of immigration, and length of residency in the U.S. Also,

they found that Muslims reported lower levels of life satisfaction than their Christian counterparts.

Another consideration is the era and immigration waives Arabs moved to the U.S., and how this impacts their degree of acculturation to western culture. The more recent immigrants from the 1970's onward were more educated, more religiously diverse, and more likely to be refugees (Abudabbeh & Hays, 2006, Shabbas & Al-Qazzaz, 1989). As a result, these groups of immigrants are more likely to preserve Arab ethnic identity and sense of community by speaking Arabic, marrying within the same ethnic/religious group, having more children compared to the U.S. average, as well as adhering to the traditional cultural values rather than adopting majority culture values (Hakim-Larson et al., 2007; Zogby 2001).

Arab immigrants may not only face post-acculturative stress, but also experience pre-acculturative stress. This is primarily due to the strong family structure in the Middle-East and the emphasis on immediate and extended family emotional support and relationship bonds that can be lost through the immigration process. Middle-Eastern immigrants may find that they are isolated and without the social supports that previously acted as a buffer to life stressors and even traumas associated with war or religious persecution (Nassar-McMillan & Hakim-Larson, 2003; Nydell, 1987).

Rissel (1997) investigated the impact of acculturation on health amongst 851 Arabic-speaking adults aged 18–70 who visited 20 Arabic-speaking general practitioners in Sydney, Australia. Participants completed a self-report questionnaire consisting of 46 items assessing acculturation, demographics, health risk, promotion, screening, and

practices. Three options were given (diagnosis of cancer, fatal prognosis, and decision to use a life-support machine) to assess patient preferences for autonomy and/or a family-centered model involving medical decisions.

More than a third of participants (38%) preferred that only the patient's family, and not the patient, be told of a diagnosis of cancer. Almost half the participants (47%) thought the doctor should tell the family of a fatal prognosis, but not the patient. Only 27% thought both the patient and family should be told. Findings revealed that less acculturated people preferred disclosing information regarding cancer patients with the family-centered model. The study highlights the strong view of family taking precedence over an individual member's rights.

Erickson and Al Timimi (2001) highlight that when assessing for acculturation in Arab Americans, it is vital to take into account whether the client's family beliefs are traditional or include western values; as well as the intergenerational gaps of acculturation between parents and their children or between older adult immigrants and young adult immigrants. Others point out that second generation Arab Americans may identify more with a White ethnic identity whereas others may identify more with an Arab ethnic identity and desire stronger connections to an Arab community (Naff, 1983). First and second generation adults and adolescents may feel the need to have a public identity closer to their friends and peers in the majority culture, and a private identity similar to family and their ethnic community (Hakim-Larson, et al., 2007).

Jackson (1997) measured acculturation among adolescents by the degree of fluency in Arabic, whether they were born in the U.S. or abroad, identification with

ethnic values, and the strength of relationships along with frequency of contact with extended families and ethnic community. In summary, Arab American acculturation is confounded by religious affiliation, ethnic identity, amount of social and family support, age of immigration and birthplace. Therefore, it is important to select an acculturation model that includes the individual variance of acculturation as well as the acculturation of a cultural group. Berry's model of acculturation provides a holistic framework for Arab acculturation as schemas that are interdependent and fluid rather than independent and linear.

Fatalism

Locus of control (LoC) research is widely recognized as beginning with Julian Rotter in 1966 when he and his colleagues expanded Phares' 13 item Likert type scale measuring expectation outcomes and perceived control to include LoC. Rotter distinguished LoC as a personality characteristic, furthering the research to differentiate between Internal versus External LoC and was termed external vs. internal attribution. External attribution attaches luck, chance, and fate as positive reinforcement for individual experiences both positive and negative. Internal attribution is when an individual positively associates personal characteristics or behavior as having a direct effect on positive or negative experiences. The manner in which a person categorizes life events impacts their attribution of internal or external control (Rotter, 1966).

However as the literature on LoC has expanded, it has developed into a multidimensional construct. Levenson (1974) created a scale consisting of 24 Likert-type items that measured three dimensions of Locus of Control. The first dimension was

labeled *Internal* and was defined as an individual's belief that he or she can affect outcomes in life. Second was the *Powerful Others* dimension that takes account of the control of "powerful people", "strong pressure groups," and "people above me" have over one's sense of self-determination. The third dimension was named *Chance* referring to outside forces such as "accidental happenings, "luck," "fate," and "fortune" that can change the outcome of one's life (Levenson, 1974). Reid and Ware (1974) also expanded Rotter's (1966) work on External LoC to include *Fatalism* and *Social System Control* (SSC). *Fatalism* is described as the luck, fate, or fortune aspect of Locus of Control, whereas *Social System Control* is the external societal factors such as government regimes, bureaucracies, and societal systems that are out of individual control.

Some years later in 1984, a two dimensional LoC model was hypothesized that emphasized a balance between external and internal LoC as most positive for psychological health. Individuals who integrated both views were better able to adjust and cope because they were able to maintain realistic control, while accepting situations and events out of their personal control (Wong & Sproule, 1983). Similarly, Strickland (1989) confirmed the multidimensionality of LoC by conducting a factor analysis of Rotter's original scale, that Rotter contended was one-dimensional. Strickland found several sub components to fatalism that was unique and independent of each other.

More specificity was added to locus of control's multidimensional components. Fournier and Jeanrie (1999) developed different levels of both External and Internal LoC. External LoC is divided into three levels: *defeatist*-believing that outcomes are

controlled by others or one's environment, *dependent*- chance and fate are the sources of outcomes, and third is *prescriptive*- the idea that social norms and societal culture beliefs are responsible for outcomes. Internal LoC is distinguished between two levels, *namely responsible*- one's actions determine outcomes and *proactive*- believing that individual effort and changing environmental factors can affect outcome. In their factor analysis, they found that all 5 levels are independent, yet clearly grouped together on the internal-external dichotomy of LoC.

Religious Fatalism

Fatalism, a dimension of external LoC, becomes more salient when the root of fatalism is one's religious/spiritual beliefs, which may be culturally embedded. Religion may be viewed as a protective factor in psychological health, but can also be also be a hindrance of maintaining one's psychological health if an individual's attribution to God means complete external attribution to well-being (McFadden, 1995; Sutherland, Hale, & Harris, 1995). This shapes how an individual interprets life events and health, and the amount of personal freedom one perceives as holding in improving quality of life (Franklin, Schlundt, McClellan, Kinebrew, Sheats, Belue, Brown, Smikes, Patel, & Hargreaves, 2007; Powe & Finnie, 2003; Seybold & Hill, 2001).

In the literature, locus of control has evolved as a mediating factor of how religion is utilized in health seeking behavior, and how an individual's attribution to God can impact his or her beliefs about self-determination and fatalism (Fiori, Brown, Cortnina, & Antonucci, 2006; Ellison & Levin, 1998; Gall & Clark, 2005). In addition, other researchers include the link between an individual's fatalistic beliefs in how they

attribute the meaning of life events within the framework of that individual's quality of life (Powe, 2001; Powe & Johnson, 1995). A new definition of *religious fatalism* is "the belief that an individual's health outcome is predetermined or purposed by a higher power and not within the individual's control (Franklin et al. 2007, p.564). Previous research in the area of religious fatalism has found that individuals with fatalistic beliefs feel their health is outside their control and that it is determined by a higher power, luck, or fate (Powe & Finnie, 2003). Religious fatalism is important because Arab culture is collectivist and is focused on family and community rather than on individual beliefs. In addition, religion is seamlessly integrated into all areas and organizational structures of Arab culture and because fatalism is a strong part of Arab culture, it must be taken into account when understanding health seeking behavior.

It is important to understand cross-cultural components specifically how Arab cultural beliefs such as religious fatalism interface with western psychology. Individualistic cultures, mainly western cultures value greater autonomy, individual personal achievement, and stress separateness and individual uniqueness (Markus & Kitayama, 1998). In contrast, collectivist cultures value the goals of the in-group over individual's goals and stress the importance of attending to societal roles and obligations to the in group or individual's family as a source of life meaning and satisfaction (Markus & Kitayama, 1998).

Morling and Fiske (1999) connect collectivist cultures to Fatalism. They contend that collectivist cultures may tend to be more fatalistic because there is a tendency to attribute control to outside forces. In addition, some collectivist cultures utilize fatalism

as a coping mechanism and as a means of harmonizing spiritual, environmental, and societal forces into their world view. Fatalistic attribution becomes a natural part of life rather than something to fight against, and one must accept the luck/fortune or trouble that comes with these uncontrollable events (Morling & Fiske, 1999).

One common assumption of western psychology is that the therapist and the client have two independent responsibilities although they are working collaboratively. Specifically, that a client must determine his or her own future, take responsibility and make changes discussed in treatment. This assumption and value is self-deterministic and is in some opposition to the eastern value of collectivism, fatalism and destiny (Varma, 1988).

Several studies have found that individuals from certain countries (Eastern and Southern Asia) and certain cultures (Hispanic and Middle East) are more likely to endorse externalizing beliefs about control (Al-Khawaja, 1998; Kureshi, & Husain, 1981; Yeh, Arora, & Wu, 2006). Marks (1998) warns of interpreting high externality scores in cross-cultural research as meaning that an individual believes he or she has no personal control in outcomes. Rather, it is encouraged to understand the degree to which an individual is tied to his or her cultural norms and to interpret an individual's sense of control based on the cultural context.

Neff and Hoppe (1993) surveyed 1,784 Caucasian, African-American, and Mexican-American adults to assess how acculturation and ethnicity paired with cultural factors (fatalism and religiosity) leads to differences between these ethnicities on levels of depression. They found that less acculturated Hispanic males had higher levels of

depression, but more acculturated Hispanic males had equal levels of depression s their Caucasian and African American counterparts. The most salient findings suggest strong interactive effects between fatalism and religiosity and cultural factors such as acculturation. Hispanic males with the lowest levels of acculturation had the highest levels of fatalism and religiosity and higher levels of depression. More acculturated Hispanic males had lower levels of religiosity, fatalism, and depression. Their findings suggest that strong fatalistic attitudes are the result of environment and are adaptive. Fatalism is impacted by one's level of acculturation; meaning that the more an individual is acculturated into western society, the more he or she will perceive higher personal control.

Middle-Eastern Fatalism

The Egyptian culture has a fatalistic and deterministic schema which is highlighted through many Arabic sayings. Differentiation is made between the Muslim God, *Allah* and the Christian God*, Rubina.* While many Copts will use Allah, some choose not to say things like*: En-shah Allah (*in God's will*), or Ba Isn Allah=* with God's wisdom*,* because they are Muslim sayings. Rather they will choose sayings such as: *Ba isn el Rub- through the Lord's will; Rubina sahal* (If it's the Lord's will, He will make it easy to do*); Rubina mahak (*The Lord be with you*); Rubina havez alake (*The Lord watch over you and protect you*), Rubina ya wah-fahak (*God's help and divine hand will give you success*), Lau Rubina ahrad* (If God allows*)* (Hakim-Larson, et al., 2007; Nydell, 2006; Nobles & Sciarra, 2000).

The issue that makes fatalism difficult to separate between religion and culture is the pervasive integration of Islam in Arab culture. Religion and state are interdependent and religion dictates everyday behavior (Nobles & Sciarra, 2000). Nydell (1987) states that, "For Arabs, fatalism is based on the religious belief that God has direct and ultimate control of all that happens. If something goes wrong, a person can absolve himself of blame or justify doing nothing to make improvements or changes by assigning the cause to God's will". (p34). Patai, (1973) explains that Fatalism is an integral part in religious and cultural norms within the Arab world, he writes:

> Neither the individual himself nor external factors can change
> a man's God-given character, which remains with him throughout
> his life and which destines him to a certain way of life. *(p. 148) (In Nobles
> &Sciarra, 2000).*

Nydell *(1987)* outlines *Basic Arab Religious Attitudes* that prevail through the Arab world: *1)* everyone believes in God, acknowledges God's powers, and has a religious affiliation. *2)* Humans cannot control all events; some things depend on God (i.e., "fate"). *3)* Piety is one of the most admirable characteristics in a person. *4)* There should be no separation between church and state; religion should be taught in schools and promoted by governments.*5)* Religious tenets should not be subjected to "liberal" interpretations or modifications, which can threaten established beliefs and practices. (p17).

Al-Khawaja (1998) explains the three different schools of religious beliefs among middle-eastern Muslims. *Determinists* believe that God controls everything, that there is no personal control and that their fate is completely dependent on the will of God. The second group believes that God gave humans total control over their lives, and

that all responsibility lies on the individual for his or her life outcomes. The third group,

which comprises the majority belief, is that while God has the ability to control

everything on Earth, He chooses to give humans free will to make decisions and choices

for themselves. Although He does have control over the world; He chooses not to

enforce His will on humans (Al-Khawaja, 1998).

Likewise, Christian theology also has two factions, pre-destination and free will.

Pre-destination is rooted in the works of St. Augustine of Hippo and the contemporary

theology of John Calvin, who make the argument that there are people God pre-destined

to be saved referred to as "the elect", and are thus plagued with understanding how one

can be fated to Heaven or Hell and yet retain free will (Calvin, 1960).

However, the Coptic Orthodox Church is in opposition to this belief and strongly

adheres to the early church fathers writings and the Bible in supporting the idea of free

will (Shenouda, 2003). One of the early church fathers, Theodoret of Cyrus, writes:

> He called both believing and struggling with distinction gifts of God, not to
> eliminate freedom of their will, but to bring out that free will of itself, devoid
> of grace, can achieve no good work: there is need of both, our enthusiasm and
> divine assistance. In other words, the grace of the Spirit does not suffice for
> those lacking enthusiasm, nor in turn can enthusiasm bereft of it succeed in
> amassing the riches of virtue. (pg.69)

Free will is the belief of the Coptic Church, as seen in The Agepaya: Coptic

prayer Book of Hours that God "…does not wish the death of the sinner but rather that

he returns and lives, who calls all to salvation for the promise of the blessings to come."

Thus, the church believes absolutely in free will, that God wishes everyone to be saved

and to lead a life of holiness, but people are free to make their choices without being

fated to a predestined outcome.

However, the pervasive persecution, violence, and discrimination Copts face in Egypt, such as the drive-by shootings in Naga Hammadi on January 7, 2010 that killed 7 Copts, the bomb that exploded on New Year's Eve 2010 outside a church in Alexandria killing 26 Copts and injuring 89, or the off-duty police officer who shot 7 Coptic Christians on a train in southern Egypt on January 11, 2011, (El-Naggar, & Goodman, 2011, A5) and the fact that the Egyptian Government does not prosecute or hold guilty parties responsible (USCRIF, 2010) strongly influence Copts to accept a more external view of control. They cannot change their circumstances, but can only control their attitude and look to their faith and divine intervention for safety and protection in Egypt.

In their study of Egyptian Muslim girls' life stressors and coping strategies, El Sheikh and Klaczynski (1993) found that middle-class girls tended to attribute internal personal control with the outcome of a current life stressor, whereas Inner-city or rural Egyptian girls attributed outcomes of life stressors to God and supernatural forces as controlling their future. This indicates that socio-economic status and environment impact whether individuals attribute internal or external control in the outcome of life events, and supports research in the US such as that of Neff and Hoppe (1993), which found that minorities of lower socio-economic standing and who are less acculturated have stronger fatalistic beliefs than their more acculturated peers.

In New York City, which has the highest Arab immigrant population in the U.S., a study using focus groups on the topic of cancer causes and health seeking behavior with Muslim and Christian Arab Americans was conducted. The researchers found a strong fatalistic attitude among Arab men and women in the

cause, prevention, and treatment of cancer. Womens' replies related to cancer prevention included ''God only knows;'' ''... I think cancer is from God. It has no reasons. If there were causes, I would go [get screened];'' (p. 434). Similarly, when the Women's group discussed cancer treatment, the overwhelming theme was that God is the ultimate healer and that He is also the main source for comfort and consolation. In Addition, both men and women had fatalistic thoughts regarding prognosis once diagnosed, which revealed an overwhelmingly pessimistic and external sense of control with comments such as "For our community and especially in our culture, cancer is a death sentence.'' (Shah et al., 2008).

The religious and cultural influence among Arabs impacts how fatalism is defined. Due to these significant influences, this study uses the term, *religious fatalism*, as seen in Franklin's (2007) research because for Egyptian Copts the root of fatalistic beliefs is religious, which is also integrated into the culture and found in both Muslim and Christian beliefs.

Attitudes Towards Seeking Mental Health Services

Increasing mental health seeking behaviors means first understanding the attitudes towards psychotherapy that deter individuals from seeking help. Throughout the literature, it is clear that immigrants and minorities underutilize mental health resources (Abe-Kim, Takeuchi, Hong, Zane, Sue, Spencer, Appel, Nicdao, & Alegría, 2007; Fischer & Farina, 1995; Fisher & Turner, 1970). Various reasons are cited as the principle deterrents; most often these are cultural beliefs, religion, language, stigma, and mistrust of professionals in the field (Whitley, Kirmayer, & Groleau, 2006).

Many immigrants from collectivist cultures such as East Asian, South Asian, Latino (a), and Caribbean have similar acculturation patterns into western society as Arab Americans, and likewise underutilize health-care, especially mental-health care services (Kirmayer, Weinfeld, Burgos, Galbaud du Fort, Lasry, &Young, 2007; Snowden & Cheung, 1990; Sue, 1999; Ying & Miller, 1992).   For example, the U.S. Department of Health and Human Services estimates that only 17% of the Asian American population utilizes mental health services (U.S. Department of Health and Human Services, 2001).

Some authors believe that Asian values are in conflict with western psychological values (Snowden & Cheung, 1990; Sue & Sue, 1977). Various studies have found significant differences between male and female minorities in seeking mental health services, and that women have more positive mental health seeking attitudes than their counter-parts (Fischer & Farina, 1995; Fischer & Turner, 1970; Komiya, Good, & Sherrod, 2000).

A study of one thousand Asian female immigrants and refugees from China, Taiwan, Vietnam, and Korea, found that immigrants with more western perceptions of illness had more positive attitudes towards seeking help than those with supernatural perceptions of illness who had more negative attitudes towards seeking help (Fung & Wong, 2007). Other studies have found that length of time in the U.S. also impacts attitudes towards seeking psychological help. A study of close to five-hundred older Korean adults found that length of stay in the U.S. was positively correlated with positive psychological seeking attitudes (Jang, Kim, Hansen, & Chiriboga, 2007).

In addition, significant differences have been found between first-generation Asian and Mexican Americans, those who immigrated to the U.S., and second-generation Asian and Mexican Americans, those born in the U.S. to immigrant parents. Second-generation minorities utilize mental-health services at a significantly higher rate than their immigrant counterparts (Abe-Kim et al., 2007; Tata &Leong, 1994; Vega, Kolody, Aguilar-Gaxiola, 2001).

Attitudes Towards Seeking Mental Health Services Among Arab Americans

The current research base on Arab Americans contains various factors that are thought to create barriers towards seeking professional psychological help which leads to underutilization of mental health treatment for Arab Americans. The literature abounds with empirical data pointing to an underutilization of mental health services in Middle-Eastern/Far-East countries. For example, a study of Moroccan and Turkish immigrants in Netherlands revealed a direct predictive relationship between level of acculturation and positive health seeking behavior (Kamperman, Komproe, & M. de Jong, 2007). Turkish university students were found to have significant sex differences in attitudes towards seeking psychological help (Turkum, 2005). United Arab Emirates university students, regardless of gender, were found to have more reluctance towards seeking psychological help, and reported more stigma attached to seeking counseling than their European peers. The majority of the students reported more traditional options to seeking help such as family, friends, spiritual/religious leaders, and more likelihood of seeing a Physician before seeing a Psychologist (Al-Darmaki, 2003).

In the United Arab Emirates, 350 parents, both Muslim and Christian, under the age of 45 were interviewed to assess mental health seeking attitudes. Of these 350 parents, 120 (about 33%) reported they would seek help for a family member with mental health concerns, but the vast majority (67%) would go to a primary care physician. Furthermore, 205 of the 350 participants (59%) reported that they would not seek help from a mental health professional. When questioned for the reason, 38% stated disinclination to admit the mental disorder of a family member, 28% reported the stigma of seeking mental health services, and 21% of respondents doubted the usefulness of mental health services, especially medication as reasons why they would not seek professional mental health services (Eapen & Ghubash, 2004). In Australia, researchers found that only 114 (21.5%) of a psychiatric sample of 531 Egyptians whose diagnosis included schizophrenia, depression, anxiety, or alcohol/drug abuse utilized metropolitan community mental-health services (McDonald & Steel, 1997).

A similar study conducted with 208 Arabic-speaking people sought to identity the cultural beliefs about mental illness by asking participants to evaluate 12 commonly presented symptoms of Kuwaiti psychiatric outpatients. The authors generalized that Arabic-speaking people, despite level of education, are more apt to describe and explain symptoms somatically and that males especially equate psychosocial problems with weakness of the self or faith. Arabic-speaking individuals are also more likely to attribute symptoms to a supernatural theme (El-Islam & Abu-Dagga, 1992).

In the United States many researchers site economic difficulty as the main obstacle for immigrants and minorities to not seek mental health services (Kirmayer et al., 2007; Schoen, & Doty, 2004; Smedley, Stith, & Nelson, 2003). However, due to cultural expectations and immigration difficulty, the majority of Arab Americans have graduate and professional degrees, are more likely to own their own business, and are in a higher socio-economic class than other immigrant groups (El-Badry, 1994; Hendricks, 2005). Additionally, Arab American scholars cite psychosocial factors such as culture, religion, and history as the main contributors of mental health seeking attitudes (Abbudabeh, 1996; Erickson & Al-Timimi, 2001).

In addition, research of Arab Americans points to other factors that act as barriers to mental health seeking attitudes. Some of these factors include a general lack of awareness of mental health issues, little exposure to western psychology, and the fear of speaking to someone outside of one's family or religious community (Abbudabeh, 1996; Okasha, 2003; Youseff & Deane, 2006). In addition, many Arabs rely and believe in the power of religious leaders and traditional healers to treat illnesses (Aloud, 2004; Tobin, 2000), and many interpret mental illness through religious doctrine or within a supernatural context (Al-Krenawi, Graham, Dean, & Eltaiba, 2004).

Other Arab American scholars emphasize stigma as a powerful deterrent towards mental health seeking behavior and negative attribution formation (Erickson & Al-Timimi, 2001). Many Arabs are very skeptical of the expertise and authority of the mental health field and its ability to treat their illness (Abbudabeh, 1996, Meleis,

1981). In addition, there is the also a fear of being seen in their community as "crazy" (Erickson & Al-Timimi, 2001).

One explanation for reluctance in seeking treatment is that Egyptian families are more tolerant of abnormal emotional or behavioral disorders that a family member may develop or suffer from than western families. Mentally ill family members are more likely to feel accepted by their family, and be less apt to seek treatment as the perception of their problem is viewed through a collective lens of the family (El-Islam, 1982).

In the study previously mentioned from Detroit on cancer prevention and treatment among Arab Americans, attitudes about mental health seeking behavior was also assessed. It was revealed that both Arab men and women saw mental health treatment as still having a negative stigma. Male Arabs, in particular, equated receiving mental health treatment with being crazy, a label that leads to shame and dishonor for the family. Other barriers to mental health seeking behavior among both sexes included lack of Arab mental health care providers, language barriers, and that most medical providers only specialized in helping women who were/are separated or divorced from their husbands (Shah et al., 2008).

In addition, most men stated that if they had a problem or issue, they would speak to their religious leader (imam, sheikh, or priest) rather than a mental health professional and most Arab women stated that they only speak to religious leaders about marital relationship concerns and tend to confide in a close female friend for psychosocial support (Shah et al., 2008).

Meiser & Gurr (1995) explored the perceptions of mental illness among Arabic women in Australia. They conducted two focus groups with women between 25 -54 years of age. They found that the majority of these women were unknowledgeable about mental illness, despite the homogeneity of above average intelligence among both groups. In Arabic, mental illness is referred to as ''*al'amrad al'aqliaa*,'': ''illness of the brain,'' literally. However, the women surveyed preferred the term ''*al'amrad al'nefschiaa,*'' or ''illness of the self''. In addition, all of the women surveyed were evasive about disclosing any personal or family examples of mental illness, but would refer to these instances as a more benign mental-health problem such as adjustment or loneliness.

Some parents believe that children who are unhappy or suffer from psychological problems will be cured by getting married (Al-Subaie & Alhamad, 2000).   Marriage is considered an essential rite of passage for young adults, and raises an individual's status within their community and family. The pressure for Arab women to be married along with cultural norms and expectations for marriage often results in Arab women concealing any mental distress or mental illness until after the marriage. This practice may contribute to an elevated risk of developing psychiatric disorders, and increased stress due to the transition and adjustment of marriage and societal pressures, expectations, and responsibilities of being an Arab wife (Al-Krenawi & Graham, 2000; El-Saadawi, 1985).

Research Questions

1. How does acculturation, ethnic identity, and religious fatalism impact attitudes towards seeking psychological help among Coptic Americans?

2. Does religious fatalism play a mediating role between acculturation and ethnic identity, and attitudes towards seeking psychological help among Coptic Americans?

3. Are there significant differences between male and female Coptic Americans in predicting attitudes towards seeking psychological help from acculturation, ethnic identity, and religious fatalism?

4. Are there significant differences between first-generation and second-generation Coptic Americans in predicting attitudes towards seeking psychological help from acculturation, ethnic identity, and religious fatalism?

CHAPTER III

METHODOLOGY

Participants

One hundred and twenty-two participants voluntarily consented to fill out an anonymous survey. However, of the one-hundred and twenty-two participants that consented; ninety-one participants completed the survey with a total completion rate of seventy-four percent. Participants were asked demographic information on gender, age, education, occupation, language fluency, and religious practices.

Participant's ages ranged from 18 to 70 years with a median age of 33.29 years-old, with a modal age of 26 years-old with next highest modal age being 65 years-old. Categorically, eighteen of seventy-nine (22%) respondents were between the ages of 40-70 years-old. However, sixty-one respondents (77%) were between the ages of 17-39. In terms of marital status, 49% reported being single, 44% reported being engaged or married, while only 6% reported being divorced.

Just over half (63%, n=57) of the 91 participants self-identified as female and 37% (n=33) self-identified as male. Overwhelmingly, 96% of respondents had a bachelor's degree or higher education, with 54% bachelor's degrees, 24% reported completion of a master's degree. 3% had doctoral degrees, and 19% had a professional degree like an M.D. or J.D.

There was equal representation between first-generation Copts, defined as Copts who immigrated to the U.S. from Egypt, and second-generation Coptic Americans, those born and raised in the U.S. to immigrant parents. Forty-three of ninety-one participants

(47.2%) of respondents reported being born in Egypt, or in another Arabian or European country. Similarly, forty eight of ninety-one participants (52.8%) self-identified as U.S. born Coptic Americans. Of the forty-three participants that that self-identified as first-generation, 72% have been in the U.S. more than eleven years, and 12% reported being in the U.S. from 1.4 to 10 years.

When asked to identify their racial identity, 75.9 % identified as Coptic, 17.7% identified as Caucasian, 1.3% identified as Hispanic, and 5.1% identified as unspecified other, but did not specify which race they identify with. The issue of Copts identifying as a separate race has been argued within the Coptic Church since the U.S. Census Bureau identifies those from the Middle-East as Caucasian. This distinction becomes more complex because ethnically, Egyptian Copts are different from Caucasian Americans in believes and values as described earlier. In addition, Copts are quick to point out that they are the indigenous people of Egypt and are the descendants of the Pharos, and are thus racially different than the Arab Muslims who invaded Egypt in 639 AD (Kamil, 1997). Furthermore, in Egypt there is little racial diversity, as it is not socially acceptable for a Copt to marry a black individual such as those from the Sudan or Nubian province. Copts living in the Sudan are still racially and ethnically different than native Sudanese because they are considered white and not black. However, in the U.S., there is more diversity among Copts because inter-racial marriage is more common and socially acceptable.

This sample of Coptic Americans was completely fluent in English with 55.4% of participants report being native English speakers, and 45.6% percent report being

native Arabic speakers.   Of the total sample of 91particpants, 97% of respondents report being fluent in English, but only 67% of these 91 participants also report being fluent in Arabic and English.

As reported earlier, 75.9% of respondents self-identified their race as Copt, but overwhelming 97.5% reported being Coptic Orthodox Christians and with the other 2.5% reported being Non-Denominational or other Orthodox Christians. Regarding religious practice, participants were asked "*On a scale of 1-5, with 1 being never and 5 being at least weekly; How often you participate in the following activities*"; 92% indicated that they attend church services weekly, and about 8% attend monthly. Praying daily was endorsed by 64%, and an additional 27% reported praying weekly. Specific to the Coptic Orthodox faith, participants were asked about their religious practices, e.g. "How often do you engage in the following activities", and 48% percent of people surveyed take communion weekly and an additional 35% take communion twice per month. In addition, 65% fast for the Great Fast of Lent (55 days), and 55% percent fast for Minor Fasts (e.g. Nativity, Saints).

Procedure

Participants were recruited through e-mail to priests who then sent the survey through their list-serves, and the social networking site Facebook. Coptic churches within the South, Midwest, and Northeastern regions of the U.S. were targeted to participate in an anonymous survey. Priests of each church community were contacted via e-mail to ask for voluntary participation from their church members. The priests then sent an e-mail through the church's list-serve asking his church community to

participate in the research. They were provided a URL link to participate online through the survey website Survey Monkey. Moderators of Coptic Churches and Coptic community list-serves were also contacted to distribute the website URL link with a description of the survey from the principal investigator. It is difficult to know the exact numbers of parishioners per church who had access to the survey because it is impossible for the investigator to know who was on the church list. However, specific regions of the country were targeted due to a high number of Copts living in the area and the presence of a large church or multiple churches. It is estimated that about 300 people had access to the survey.

Of those that participated, they were required to read and agreed to an online informed consent page before being able to proceed to the survey (Appendix A). Participants were informed that their participation was entirely voluntary, and that no one in their church community would know if they completed the survey. They were also informed that their identity would be kept completely anonymous to allow them to answer without inhibition. This distinction is important due to the fact that the Coptic Community is a tight network, and it is common for Copts across cross-country to know each other or of each other. Additionally, the investigator belongs to this community, and has personal and professional contacts in this community throughout the U.S., and wanted participants to feel comfortable answering without concern that the investigator would know specific individual's responses. They were told that the survey would take approximately 15-30 minutes to complete.

The survey consisted of six Likert-type scales: Arab Acculturation Scale, Arab Ethnic Identity Scale, Fowler's Faith Development Scale, Psychological Mindedness Scale, Franklin's Religious Fatalism, and Attitudes Towards Seeking Psychological Help-shortened form. The survey also included a participants' self report demographic questionnaire that sought information about socio-economic status, immigration status, nationality, and religious practices.

Structural Equation Modeling as well as a Multi-Group Analysis was conducted to help examine how one's level of acculturation, degree of ethnic identity, and degree of religious fatalism predicts positive or negative attitudes towards seeing psychological help (see Appendix B). These factors were expected to be moderated by sex and generational status, which is whether an individual immigrated to the U.S. from Egypt (first-generation) or was born in the U.S. to immigrant parents (second-generation). It was predicted that females will have more positive attitudes towards mental health seeking behavior than male Copts. It was also predicted that second-generation Coptic Americans compared with first-generation Copts would have higher levels of acculturation, lower levels of Coptic ethnic identity, lower levels of religious fatalism, and more positive attitudes towards mental health seeking behavior.

Instruments

The *Male Arab Acculturation Scale* (MAAS; Barry, 2005) is an 8-item self-report inventory. The 8 items cluster into two factors: Factor 1- Separation/ Assimilation, which contains questions such as "Most of my friends are Arab" and Factor 2- Integration/Marginalization which contains questions such as number 8: I

have a lot of difficulty making friends (reverse scored)". Items measure participants' ease in social interaction and fluency when communicating in various settings. The author reported internal reliability coefficients of the separation/assimilation and integration/marginalization scales are .71and .73 respectively. The overall reliability coefficient for this study was .29. Items are scored on a 7-point Likert-type response format (1 = strongly disagree, disagree, disagree somewhat, neutral, agree somewhat, agree, 7 = strongly agree). Scale scores are obtained by adding reverse-scored and positive-scored items, with higher scores reflecting less acculturation into western culture and maintaining the cultural values and beliefs of Arab culture. While this measure's name implies a gender oriented instrument, it was initially constructed as a unisex measure. However, due to survey constraints, the initial investigators were unable to gain access to an Arab female population (Barry 2005). Barry reports that the internal reliability for separation/assimilation to be .71 and .73 for the integration/marginalization scale. Another study examined the relationship between Arab American acculturation and nicotine smoking patterns, and utilized the MAAS. The investigators reported that the overall internal consistency reliability for the two factors was 0.54., and the overall consistency reliability for the measure was .73 (Al-Omari & Scheibmeir, 2009).

The *Male Arabic Ethnic Identity Measure* (MAEIM; Barry, et al., 2000), was also constructed as a measure for all Arab-Americans, but they were unable to gain access to a female sample and thus just surveyed Arab males. However, the authors state that this instrument is valid for both males and females. It is a 33-item self-report

inventory, comprised of four subscales: Religious-Family Values (RFV; 14 items; e.g., "I would never shout at my father even if he was to insult me badly"), Sense of Belonging/Ethnic Pride (EP; 7 items; e.g., "When an important newspaper praises the Arabs, I feel that it is praising me"), Friendship (F; 7 items; e.g., "I would risk dying for my close friends"), and Ethnic Arab Practices (EAP; 5 items; e.g., "I eat Arabic food every week"). Internal consistency reliability for the overall MAEIM score was .89, and the reliability coefficient for the four subscales was RFV .89, EP .81, F .69, and EAP .69 respectively. Internal consistency reliability for the overall measure was .87 for this sample. Correlations between individual scales and the overall measure ranged from .46 to .87. In addition, length of stay in the U.S. was negatively correlated with the MAEIM ($r = .32$, $p < .05$), suggesting that the longer an Arab immigrant stays in the U.S., the less they indentify with Arab ethnicity. Total scores are derived by summing both positively scored and reversed score items, and high total scores indicate stronger Arab ethnic identity. The MAEIM was significantly correlated ($r = 54$, $p < .01$) with the Separation/Assimilation subscale on the MAAS. Subscales on the MAEIM and the MAAS were also significantly correlated (see Table 1) (Barry, 2001, 2005; Barry, et al., 2000).

Table 1. Pearson Correlations between Acculturation and Ethnic Identity Scales (Barry, 2005)

	Separation/Assimilation	Integration/Marginalization
Ethnic identity		
Overall MAEIM index	.54**	−.07
Religious-family values	.40**	−.07
Sense of belonging/Ethnic pride	.31**	.12
Friendship	.23	−.02*
Ethnic Arab practices	.59	−.23**

Note. n = 115 male Arab immigrants. *p* < .05, **p* < .001.

The Attitudes Scale Towards Seeking Professional Psychological Help Scale (ASTPPH) (Fischer & Farina 1995; Fischer & Turner, 1970) instrument consists of 29 items created to understand the general attitudes toward seeking professional help for psychological problems and issues. Items with a 4-point Likert type scale are used with answers ranging from (0) disagree to (3) agree. Examples of items are "The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts" and "There are times when I have felt completely lost and would have welcomed professional advice for a personal or emotional problem." (Kaminetzky & Stricker, 2000).

In their original factor analysis, Fischer and Turner (1970) found four factors in the scale. These factors are: 1. Recognition of Personal Need for Psychological Help (8 items); 2. Stigma Tolerance Associated with Psychological Help (5 items); 3. Interpersonal Openness Regarding One's Problems (7 items); and 4. Confidence in Mental-Health Professionals (9 items). The internal consistency of the measure and of each factored subscale was computed with a sample of n=406. The internal reliability of

the instrument was reported to be .83. The internal reliability estimates for each factor

were: Factor I (need) .67; Factor II (stigma), .70; Factor III (openness), .62; and Factor

IV (confidence), .74. However, each subscale was reported to lack internal consistency

based on the alphas for each scale so the investigators suggested using the whole

measure rather than one subscale to examine help-seeking attitudes (Fischer & Farina,

1995).

Eighteen of the items are reverse scored, with the other 11 items scaled positively

so that agree answers indicate positive attitudes toward seeking psychological help.

Individuals receive a total score ranging from 0 to 87 with higher scores indicated more

positive attitudes towards seeking psychological help (Al-Darmaki, 2003; Segal,

Coolidge, & Mincic, 2005). Fischer and Turner (1970) reported good test-retest

reliability for the measure with testing intervals of five days .86 *(n = 26)*, two weeks .89

(n = 47), four weeks .82 *(n = 31)*, six weeks .73 *(n = 19)*, and two months, .84 *(n= 20)*,

respectively.

Fischer and Farina (1995) reconstructed this scale into a shortened form. The

abbreviated scale consists of 10 items that were refined from the original 29 items. The

authors selected the 14 items that had the strongest correlations with the whole

instrument (*r* >.45). These items were randomly implanted into other items measuring

attitudes on other service issues, and were then factor analyzed. Ten of the fourteen

items loaded onto the Attitudes Factor and all items had factor loadings above .50. The

internal consistency reliability estimate of these ten items on this factor was reported .84,

comparable to the findings of two independent studies that yielded reliability estimates

of .83 and .86 of the original instrument (Fisher & Tuner, 1970).   The four remaining items loaded onto a Disclosure/ Interpersonal Openness Factor but had low internal consistency .64 and were discarded. In this study, the overall internal reliability was .25.

A second study was conducted to examine the stability of the shortened form over time. The investigators tested the answers received from the first study, and also examined differences between the new and old versions. The investigators tested a group of 60 university students twice in the span of 28-31days between each testing session. In the first session, students were administered the same assessment as constructed in the first study that randomly placed the 10 items in with other questions examining attitudes on various social issues. In the second session, the participants were given two different forms, one form placed the new ten items first and the old Fisher and Turner version items second in the assessment. In form two, the order was reversed with the old version first and the shortened form second. The test-retest reliability estimate after one month of the first session was .80, which is similar to the Fischer & Turner (1970) test-retest reliability estimate of .82. In addition, the correlation between scores of the old version and the new version was .87.

Elhai, Schweinle, and Anderson (2008), tested the validity and reliability of the ATSPPH shortened form with 296 college students and 389 primary care patients. In the college student sample, the internal consistency reliability estimate was reported to be .77; correlations between the items were found to be 0.3 or less. In addition, correlation between items and the whole scale were higher than .40 except for one item which was below.30. In the patient sample, the internal reliability estimate was 0.78. Correlations

between the items were the same as the college student sample, and the same between the items and whole measure.

The investigators also examined convergent validity between the ATSPPH-SF and other measures. THE ATSPPH-SF correlated with the Stigma Scale for Receiving Psychological Help (SSRPH), ($r = .41$, $p < 0.001$) indicating that more positive attitudes towards seeking help was associated with lower stigma for receiving help. In addition, the ATSPPH-SF was not significantly correlated with the Center for Epidemiological Studies-Depression Scale (CES-D), $r = 0.01$. It was also not significantly correlated with the Health Survey Short Form-12 (SF-12) MCS score which measures perceived physical or mental health impairment, $r = -0.01$. However, the ATSPPH-SF was significantly correlated with the Behavioral Intentions to Seek Mental Healthcare Scale, and that participants with more positive orientation were also more likely to seek help in the next month, ($r = 0.26$, $p < 0.001$).

The investigators also examined the criterion validity of the scale and found that there was a significant relationship between ATSPPH-SF and the use of mental-health services, and that those college students who had recently used services in the past six months had more positive attitudes towards seeking help, ($M = 20.50$, S.D. $= 5.21$) than non-users ($M = 16.63$, S.D. $= 5.09$), $F(1,294) = 19.00$, $p < 0.001$ (Cohen's $d = 0.74$). Also, ATSPPH-SF was also a significant predictor of number of visits of college students seeking help, and that as number of visits increased so did the positive attitude towards seeking help, LR $\chi^2(1, N = 296) = 12.50$, $p < 0.001$ (Nagelkerke's $R^2 = 0.06$). Furthermore, ATSPPH-SF accounted for a significant amount of variance when added as

another factor with sociodemographic variables such as SES, race, ethnicity, and marital status in predicting previous service use. The investigators found similar significance in the medical patient population, in predicting number of previous visits and a significant relationship between attitudes and willingness to use mental-health services. However, ATSPPH-SF was not a significant predictor of previous service use and did not add variance to the model using sociodemographic variables as the first predictor (Elhai et al., 2008).

Findings in studies of attitudes toward seeking psychological help have shown significant sex differences with women generally having more positive attitudes towards seeking psychological help, and men more hesitant attitudes in help-seeking (Fischer & Turner, 1970; Fischer & Farina 1995; Kelly & Achter, 1995; Tata & Leong, 1994;). Elhai et al. (2008) also found significant differences, and that women in the college student sample were more likely to endorse positive help-seeking attitudes than men, and that married vs. unmarried college students also endorsed more positive attitudes. However, there were no significant differences between sexes among the medical patient group. For groups, race and ethnicity was not a significant predictor of attitudes towards seeking psychological help.

Good and Wood (1995), stated that 1 out of 7 men and 1 out of 3 women in the U.S. were seeking psychological help. In addition, these studies have shown that women attempt to seek help more often than men. Therefore, in using this scale, it is recommended that one should evaluate males and females separately since significant differences have been found between groups on attitude seeking behavior. The updated

shortened version of the instrument was used in this study to decrease the total time spend completing the survey. This was in the hopes that the mortality effect would be minimized. Individual's responses are calculated the same way as the old version by summing the ten items with a Likert type scale of 0 = "Disagree" to 3 = "Agree". The range of total scores ranges from 0-30, with higher scores indicating more positive attitudes towards seeking psychological help.

In the original construction of the instrument, Fischer found a significant relationship between all the subscales and overall scale on the Attitudes Towards Seeking Psychological Help with Rotter's 1966 Internal-External Control Scale for both men and women suggesting an established relationship between attitudes towards seeking psychological help and locus of control and possibly religious fatalism which falls on the external side of LoC (Fischer & Turner, 1970).

Franklin et al., (2007) *Religious Health Fatalism Questionnaire* (RHFQ-HI) was created to better understand fatalistic beliefs and has been used with church communities to assess how an individual's Christian faith and religious beliefs may impact their beliefs about health seeking behavior and health prevention. The items on the scale were constructed to measure "the belief that God, not the individual, has control over health outcomes" (p. 566). Franklin, conducted several pilot studies, and refined the instrument from 87 overlapping items to twenty-five items. The investigators then factor analyzed the items for further refinement. They found that the 25 items loaded onto 5 factors. However, only three of the five factors had strong loadings with a cutoff score of .40, and therefore the two weak factors with seven items were eliminated.

Another factor analysis of the remaining items was conducted and found 3 strong factors of religious fatalism: 1. Divine Provision e.g. "4. *If God wants me to have better health; He will provide.";* 2. Destined Plan e.g. 15. "*Sometimes someone can be ill because of disobedience to God.;*" 3. Helpless Inevitability e.g. 17. "*I can control a small health issue, but only God can control a big health issue".* The internal consistency reliability for these subscales was reported to be .89, .64, and .52, and the overall internal reliability for the measure was reported to be .67. The overall internal reliability for this sample was .86. The RHFQ scale contains Likert-type items that are scored from 1 (strongly disagree) to 5 (strongly agree) with higher scores indicating a greater degree of endorsement of the scale item.

Next, the investigators examined the psychometric properties of the RHFQ using a sample of 292 adults from various religious denominations, and a broad range of sociodemographic backgrounds. Convergent validity results indicate that all three factors of the RHFQ were significantly positively correlated with the God Locus of Health Control (GLHC) scale that measures the degree to which individual's attribute their health to divine control; *Destined plan-* the belief that God has a plan for any illness or health condition that an individual suffers from, *(r=.54, p <.01) Divine Provision-* belief that an God protects his followers from illness, and illness can be prevented through prayer or given by God's mercy, *(r=.52, p <.01), Helpless inevitability-* the belief that an individual has little or no control over their health *(r=.40, p <.01).* Two factors of the RHFQ were also positively associated with the Multidimensional Health Locus of Control scale (MHLC), which examines individual

perceptions regarding who or what is in control of their health. *Destined plan* and *Helpless Inevitability* were positively correlated with the MHLC– *Chance Externality* factor ($r = .24$, $p < .01$) and ($r = .37$, $p < .01$). Furthermore, positive correlations were significant between the MHLC– *Powerful Others Externality* factor and the *Helpless Inevitability Factor* of the RHFQ ($r = .21$, $p < .01$). These results are reported by the investigators as evidence of good convergent validity of the RHFQ.

Predictive validity was also examined, and further analysis of each dimension indicated that the *Helpless Inevitability* subscale of the RHFQ was the most significant predictor of poor health behaviors, ($r^2 = -.21$, $p < .05$). This suggests that the more an individual externally attributes their health outcome; their more their health is predicted to be in a poorer state (Franklin et al., 2007; Franklin, Schlundt, & Wallston, 2008).

Demographic Questions

Participants were asked a series of demographic questions such as sex, age, generational status, education level, and highest degree completed, marital status, language fluency, religious denomination, and religious practices. In addition, participants were asked "*How likely you would be to see a therapist under the following circumstances?*" and given a list of scenarios such as *"It was recommended by your Father of Confession"* or *"The therapist was also Coptic"* and were given a Likert-type scale with the following options (Never, Unlikely, Possibly, Very Likely).

CHAPTER IV

RESULTS

Descriptive and Frequency Statistics

Random missing data occurred in about 10 cases, and there was inconsistency as to where each response was missing. In each measure there was an average of two missing data fields on separate items. These data fields were replaced through multiple imputation (ML) using NORM as recommended by Schafer and Graham (2002). Comparative descriptive statistics in PASW using the sample with missing data and the sample with imputed data revealed no significant differences between the two data sets. Descriptive frequency data of the two data sets were almost identical for all the variables to be used in the analysis. Because these data sets were similar, only descriptive statistics, frequencies, skewness, kurtosis, and means for the final dataset with imputed values are reported.

All continuous variables had an approximately symmetric distribution within the range of $-\frac{1}{2}$ to $+\frac{1}{2}$ for the skewness statistic, which according to Bulmer (1979), is a valid range indicating a symmetric distribution. Kurtosis statistics for all continuous variables were platykurtic and suggest higher peaks closer to the mean with thinning in the tails suggesting a less extreme distribution at the tails within the sample. This was expected given the small sample size, and homogenous population being studied. These results may be viewed in Table 2.

Table 2. *Descriptive Statistics for Kurtosis, Skewness, and Distribution Frequencies*

Scale	N	Min.	Max.	Mean	S.D.	Skewness	Kurtosis
1. Sex	91	1	2	--	.48	.012	-1.37
2. Generational Status	91	1	2	--	.50	-.632	-2.03
3. Acculturation	91	22	48	37.5	4.78	-.518	.796
4. Ethnic Identity	91	126	210	166.8	13.39	.078	-.261
5. Religious Fatalism	91	33	85	59.7	10.39	.211	.361
6. Attitudes towards MH	91	12	40	26.58	6.49	.075	-.312

Note: For Sex, 1 = *Male and* 2 = *Female.* For Generational Status, 1 = *First Generation* and 2 = *Second Generation.*

Pearson correlations between the all the variables revealed several significant correlations, which are displayed in Table 3. As predicted, the correlation between acculturation and ethnic identity was significant, $r = .328$, $p < .01$. Surprisingly, acculturation did not have significant relationships with any other scales. However, ethnic identity was significantly correlated with religious fatalism; $r = .456$, $p < .01$. In addition, moderate negative correlations were found between ethnic identity and generational status, $r = -.208$, $p < .05$, and Sex, $r = -.240$, $p < .01$. As predicted, religious fatalism was significantly negatively correlated with attitudes toward seeking psychological help, $r = -.240$, $p < .01$. These correlations suggest that for participants, higher scores on Arab ethnic identity was associated with stronger religious fatalistic beliefs, and that stronger religious fatalism scores are associated with more negative attitudes toward seeking psychological help.

Table 3. Pearson Correlations between Scales

Scale	1	2	3	4	5	6
1. Sex	--					
2. Generational Status	.098	--				
3. Acculturation	-.112	-.043	--			
4. Ethnic Identity	-.240*	-.208*	.328**	--		
5. Religious Fatalism	- -.202	-.060	-.070	.456**	--	
6. Attitudes towards Mental Health	-.192	-.120	-.084	-.171	.240*	--

Note: For Sex, 1= Male and 2 = Female. For Generational Status, 1= First Generation and 2 = Second Generation. *p<.05 and **p<.01.

ANOVA

In order to determine if differences exist between males and females in their attitudes towards seeking psychological help and generational status in their attitudes towards seeking psychological help, two one-way ANOVA's in PASW were completed. The first ANOVA examined sex as a fixed factor and attitudes orientation as the dependent variable.   Levene's test of homogeneity of variances was not statistically significant, indicating that the two group's variances were not markedly different. Males and females were not statistically different in their attitudes towards seeking psychological help, F (1, 3.40) =.068, $p < .05$.

In terms of their attitudes towards seeking psychological help, Levene's test was not statistically significant for generational status and no significant differences were found between first and second generation Coptic Americans in their attitudes towards seeking psychological help, F (1, 1.298) =.258, $p < .05$. Since the ANOVA analysis did not reveal any significant differences between the groups on their attitudes towards

seeking psychological help, the whole sample was used in subsequent analyses. Path analysis was used to examine how acculturation, ethnic identity, and religious fatalistic beliefs predict attitudes towards seeking psychological help. Multi-group analysis was used to determine if there were differences between groups using the same path model.

Structural Equation Modeling

Structural Equation Modeling using *AMOS Student Version 5* was conducted to test a model that includes the following variables: acculturation, ethnic identity, religious fatalism, and attitudes toward seeking psychological help. Sex and generational status were used as moderating variables to determine between group differences of the model.

Hypothesis I

Acculturation, ethnic identity, and religious fatalism will predict attitudes toward seeking psychological help among Coptic Americans, and that this model will be a good fit for the whole sample.

The initial model proposed that acculturation, ethnic identity, and religious fatalism would predict attitudes toward seeking psychological help, and that there would be model differences between males and females and between first and second-generation Coptic Americans. Maximum likelihood estimation was used. The direct path analysis in AMOS yielded a significant chi-square of X^2 (3) = 37.588, $p < .001$, indicating poor model fit. This model with standardized path coefficients is displayed in Figure 1.

In addition, this path model did not produce fit indices that meet Hu and Bentler (1999) criterion for good fit. The Comparative Fit Index, CFI, compares the covariance

matrix predicted by the model to the actual covariance matrix, and compares the lack of

fit as a percentage between the hypothesized model and null hypothesis model (Garson,

2009). Bollen (1989) argues that the CFI should be at least .90 as in indication of good

model fit. The Normed Fit Index: NFI, which is an alternative to the CFI, is not

dependent on chi-square assumptions (Garson, 2009), and an NFI of .95 or higher

indicates good fit (Schumacker & Lomax, 2010). Furthermore, the Root Mean Square

Error of Approximation (RMSEA) is a measure of lack of fit that does not use the null

hypothesis as a comparison point and thus is not reliant on independence of latent

variables to determine goodness of fit (Garson, 2009). Schumacker and Lomax (2010)

suggest that the RMSEA ≤.05 indicates good model fit. Likewise, Hu and Bentler

(1999) state that the RMSEA < .06 points to good model fit. In addition, the NFI =.146,

CFI =.000, and RMSEA =.356, all of which did not meet criteria for good model fit.

This is further corroborated by the non-significant standardized regression weight of ß =-

.04 for ethnic identity in predicting attitudes towards seeking psychological help, and ß

=-.09 for acculturation as a predictor of attitudes towards seeking psychological help.

These results indicate that Arab acculturation, ethnic identity, and Religious Fatalism did

not explain attitudes towards seeking psychological help, and that a more complex path

model involving mediation may better answer the research questions. Thus Hypothesis I
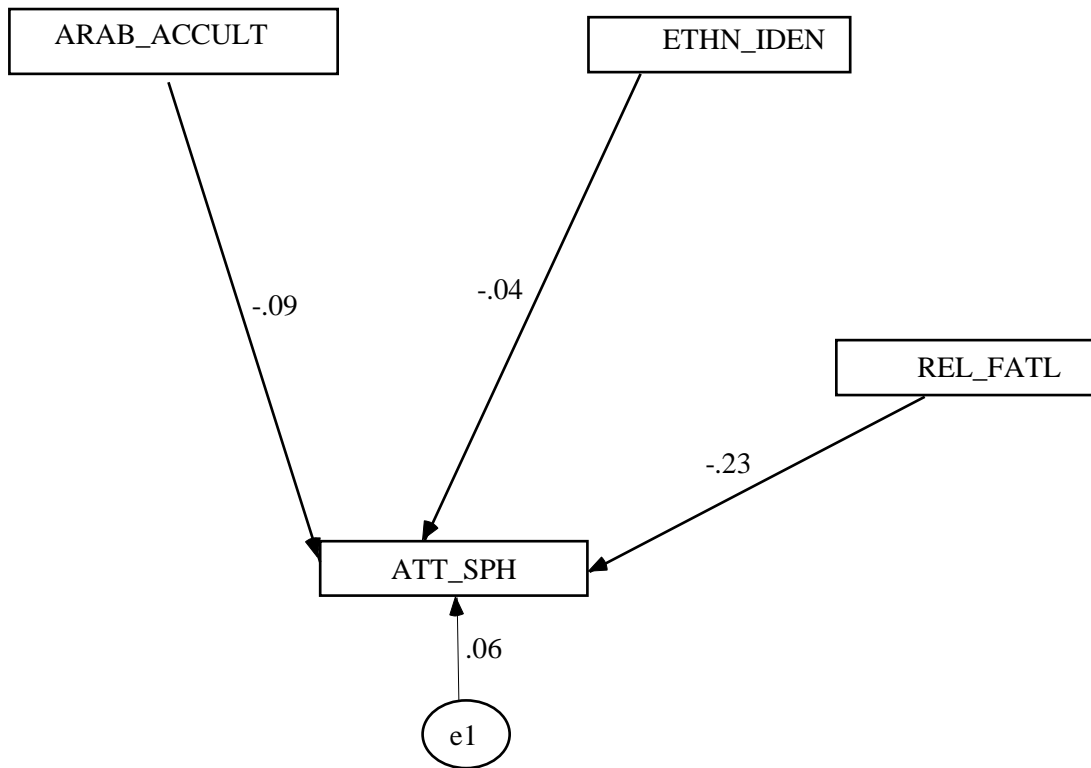
was not supported.

Figure 1. Hypothesis I Path Model.
Values reflect standardized coefficients. *p < .05

Hypothesis II

 Religious fatalism would act as a partial mediating variable in explaining the relationship between acculturation, ethnic identity*, and attitudes towards seeking psychological help among Coptic Americans.*

  One of the main factors that contribute to Arab Americans not seeking mental health services is religious fatalism (Hakim-Larson et al., 2007; Nobles & Sciarra, 2000; Nydell, 1987; Nydell, 2006; El-Sheikh & Klaczynski, 1993). Therefore, it is important to examine the extent to which religious fatalistic beliefs mediate the role of acculturation and ethnic identity with attitudes towards seeking psychological help. In this path model, paths to religious fatalism were added from acculturation and ethnic identity. In addition, the path from acculturation to attitudes towards seeking psychological help variable was deleted because it had a weak standardized coefficient, and a path from acculturation to ethnic identity was added since earlier analysis showed significant associations between the two constructs (Barry et al., 2000; Barry, 2005).

Summary of Results

  The direct path analysis in AMOS yielded a non-significant chi-square of X^2 (1) =.616, p =.432, CFI =1.00, NFI =.982, RMSEA = .000 indicated good model fit and a CMIN close to the ideal chi-square of zero for perfect model fit. This model with standardized path coefficients is displayed in Figure 2. This path model also produced stronger standardized regression weights which are displayed in Figure 2. The path from Arab acculturation to ethnic identity had a standard regression weight of, ß = .33, p < .05. The path from Arab acculturation to religious fatalism had a standardized

regression weight, ß = -.25, *p* < .05 and the path from ethnic identity to religious

fatalism, ß = .54, *p* < .05.   Ethnic identity was not a significant variable in predicting

attitudes towards seeking psychological help, ß = -.08. Religious fatalism was also not a

significant predictor of attitudes towards seeking psychological help, ß = -.20.

Therefore, once mediating paths from ethnic identity and Arab acculturation were added

to religious fatalism, a better model with good fit indices was obtained. This indicates

that religious fatalism does play an important role in this model but it was not a
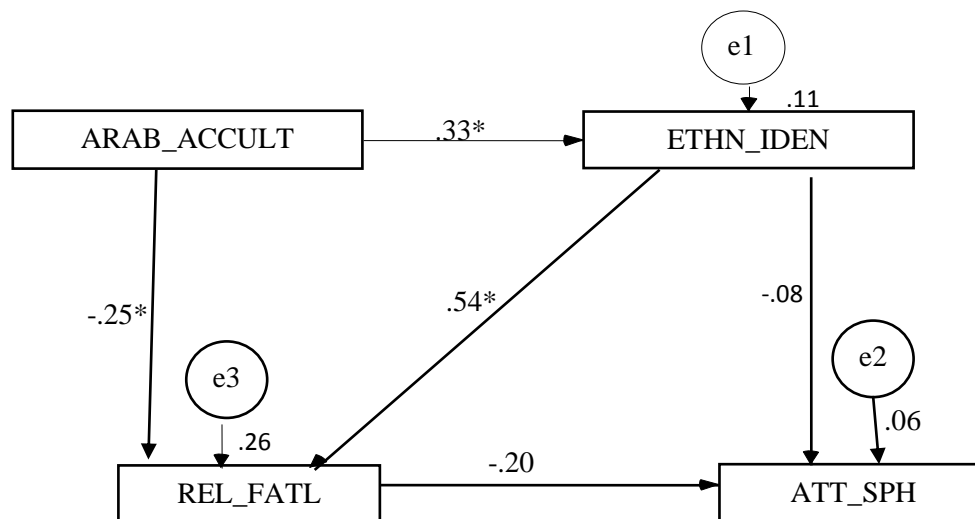
statistically significant predictor of ATTSPH.

Figure 2. Hypothesis II Amended Path Model.
Values reflect standardized coefficients. *p* < .05

Hypothesis III

In terms of the partial mediating model presented in Hypothesis II, we expected that

there would be significant differences between males and females regarding attitudes

towards seeking psychological help. Religious fatalism will act as a partial mediating

variable in predicting attitudes towards seeking psychological help from acculturation,

ethnic identity*, and religious fatalism. It was predicted that females will have more*

positive attitudes towards seeking psychological help as consistently found in other

cross-cultural research on attitudes towards seeking psychological help (Fischer &

Turner, 1970; Fischer & Farina, 1995; Turkem, 2005).

The model for Hypothesis II showed good fit for whole sample and was thus

used to examine fit for each sub group. The chi-square for the model for males was X^2

(1) =.216, *p* =.642, indicated good model fit. The fit indices for this model were NFI

=.990, CFI = 1.00, and RMSEA = .000, all of which support good fit of the model for

this group.   The path from Arab acculturation was a significant predictor for ethnic

identity, ß =.33, *p* < .05. Unlike the whole sample in the path model in Hypothesis II,

Arab acculturation was not a significant path to religious fatalism ß = -.06. However,

Ethnic Identity was a significant predictor towards religious fatalism ß =.61, *p* < .05.

Religious fatalism ß =.-37 and ethnic identity ß = -.04 were not significant paths in

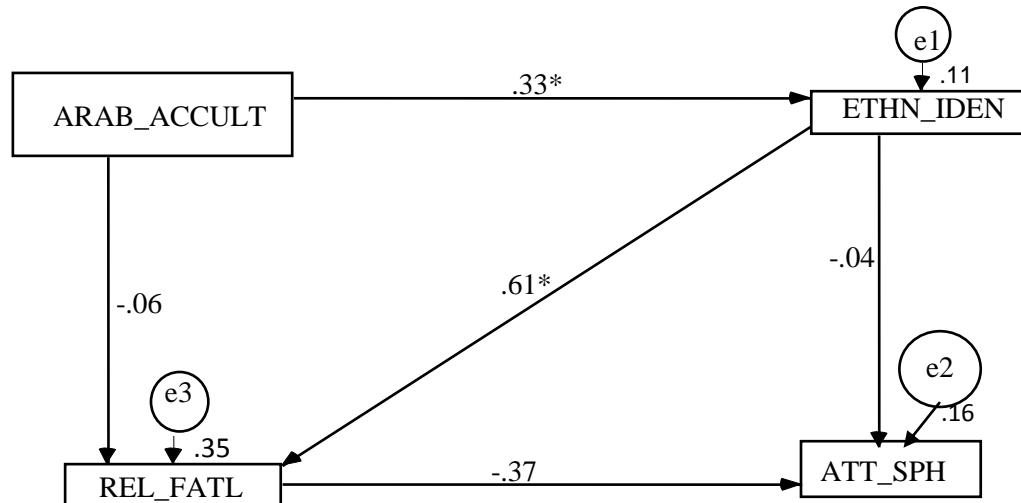predicting attitudes towards seeking psychological help (See Figure 3).

Figure 3. Hypothesis III Path Model for Males.
Values reflect standardized coefficients. *$p < .05$

The female model produced a chi-square of X^2 (1) =.787, p =.375, with the

following fit indices, NFI = .964, CFI = 1.00, and RMSEA = .000, which also indicated

a good model fit. In addition, standard regression weights showed Arab acculturation

was a significant path to ethnic identity ß= .30, $p < .05$, and to Religious Fatalism ß = -

.36, $p < .05$. Ethnic identity was a significant path to religious fatalism ß = .43, $p < .05$.

Similar to the male group, ethnic identity and religious fatalism were not significant

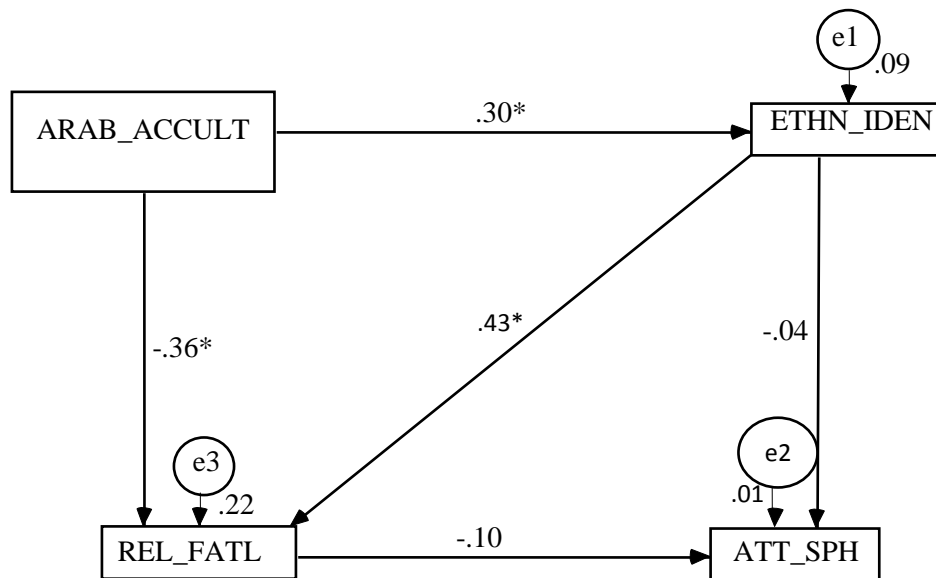paths attitudes towards seeking psychological help (See Figure 4).

Figure 4. Hypothesis III Path Model for Females.
Values reflect standardized coefficients. *p < .05

Hypothesis IV

Using the same partial mediating model, it was predicted that there would be significant differences between first-generation Copts and second-generation Copts (generational status) regarding attitudes towards seeking psychological help. Religious fatalism would act as a mediating variable in understanding the extent to which acculturation, ethnic identity*, and religious fatalism would predict attitudes towards seeking psychological help.*

First-generation Coptic Americans are those that were born in Egypt or another country and then immigrated to the U.S. and, second-generation Coptic Americans are U.S. citizens born to immigrant parents. The chi-square for first-generation participants was X^2 (1) =.140, p =.708. This chi-square statistic was supported by the fit indices, NFI = .994, CFI = 1.00, and RMSEA = .000, which were well above criteria for good model

fit. In addition standardized regression coefficients showed that the path from Arab

acculturation was significant to ethnic identity ß = .35, p < .05 and to religious fatalism ß

= -.22, p < .05. Ethnic identity was a significant path towards Religious Fatalism ß =

.55, p < .05, but not a significant path to attitudes towards seeking psychological help ß

= -.18. Religious fatalism was also not a significant path to attitudes towards seeking

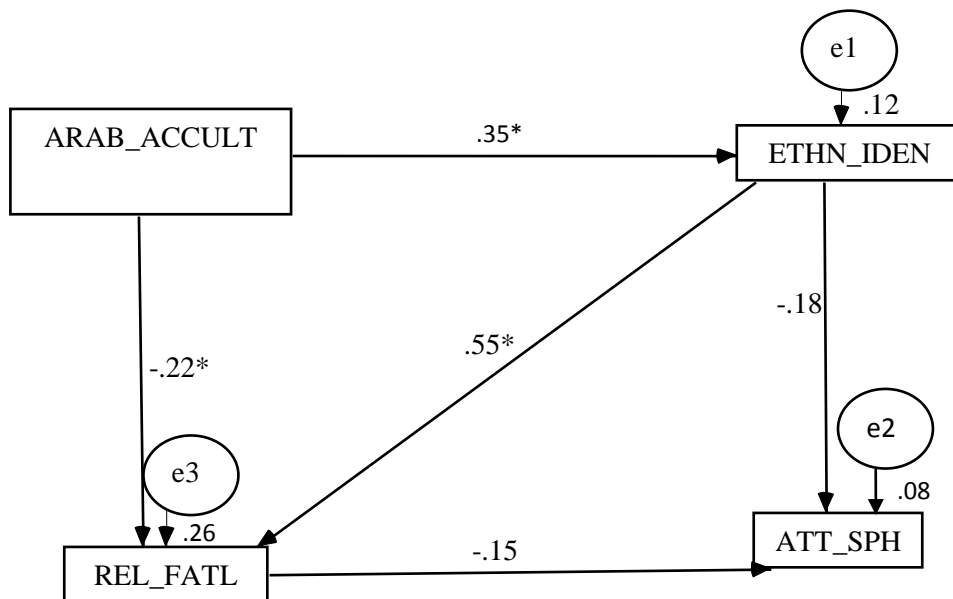psychological help ß = -.15 (See Figure 5).

Figure 5. Hypothesis IV Path Model for First-Generation Copts.
Values reflect standardized coefficients. *p < .05

The second-generation participant's model fit was acceptable (See Figure 6). The chi-square for this group was X^2 (1) =1.43, p = .231. The NFI = .94, was below the threshold of .95 or higher indicating less than acceptable fit. The CFI = .98 however was within the normal range for goodness of fit, but the RMSEA = .10 was higher than the cut-off point of .05 or .06 also indicating that this model's fit is not as good for this sub-group. The Standardized Regression Coefficients show Arab acculturation was a significant path to ethnic identity ß =.35, p < .05 and but not towards religious fatalism ß = -.28. Ethnic identity was a significant path to religious fatalism ß = .58, p < .05, but not a significant predictor of attitudes towards seeking psychological help ß = -.06. Similarly, religious fatalism was not a significant predictor attitudes towards seeking psychological help ß = -.21. These results indicated that while the model obtained acceptable fit, there may be other models that do a better job explaining attitudes towards seeking psychological help for second-generation Copts.
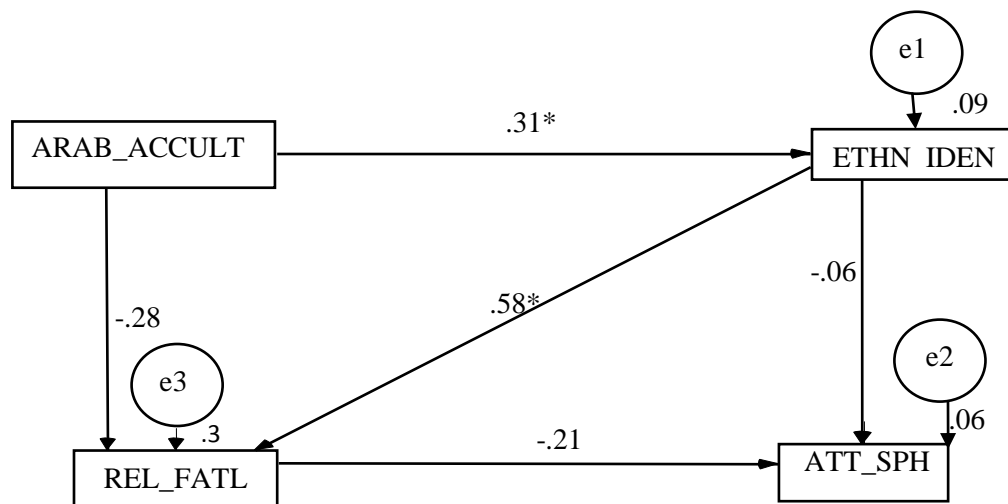

Figure 6. Hypothesis IV Path Model for Second-Generation Copts. Values reflect standardized coefficients. *p < .05

Multi-Group Analysis

A Multigroup analysis using AMOS 5.0 was performed to examine the invariance of the structural model to determine if there were differences between groups. Using the model presented earlier (in hypothesis two) as the "baseline" model, subsequent models were tested that included additional constraints. These models were then evaluated using the χ^2 difference test. This analysis allows one to determine if there was structural equivalence across groups – that the same model fits and functions equally well for both groups. It should be noted that these results are tentative because they're based on a small sample, which is then examined by two smaller groups (i.e., gender in the first analysis and generation immigrated in the second).

Males and females were compared first. There were three potential models that could have been analyzed (Unconstrained, Structural Covariances, and Structural Residuals, from least restricted to most restricted). These analyses consisted of comparing the "baseline" or unconstrained model to a model that constrained the path values to be equal across groups (Structural Covariances). The third model examined the equality of error components in the model, but was not analyzed because tests for equivalence of error variances-covariances are now widely considered excessively stringent. The maximum likelihood method was used as the fitting function for all multi-group analyses.

The results of the unconstrained model and the structural covariances model are presented in Table 4. The X^2 difference test was performed to determine if the more constrained model with equal path values could be retained over the unconstrained

model. Thus, the chi-square difference was X^2 (1) = .885, p =.347, which is below the critical value and was not statistically significant. Therefore, the more constrained model with equal path values was retained. This suggests that the model performed similarly for both genders.

Multi-group analysis was then conducted for first and second generation Copts. These results are reported in Table 5. The X^2 difference test was performed and indicated that the difference between the model one (unconstrained) and model two (structural covariances) resulted in X^2= .015 (1), p =.904, which is below the critical value. Therefore, the more constrained model with equal path values was retained. This suggests that the overall form or shape of the model performed similarly for both genders. In models with latent factors other tests of invariance are often of interested but could not be tested here (e.g., measurement invariance).

Table 4: Multigroup Analysis for Sex

Model	ModelX^2	df	P	GFI	CFI	NFI	RMSEA
Unconstrained	6.072	7	.531	.967	1.00	.863	.00
Structural Covariances	6.957	8	.541	.964	1.00	.843	.00

Note: *p<.05

Table 5: Multigroup Analysis for Generational Status

Model	ModelX^2	df	P	GFI	CFI	NFI	RMSEA
Unconstrained	2.419	7	.933	.987	1.00	.950	.00
Structural Covariances	2.433	8	.965	.964	1.00	.950	.00

Note: *p<.05

CHAPTER V

DISCUSSION AND CONCLUSIONS

The current study had four main hypotheses. The first hypothesis proposed that

three IVs (acculturation, ethnic identity, and religious fatalism) would predict attitudes

towards seeking psychological help (ATSPH). This hypothesis was based on previous

research indicating that these variables were most salient in understanding the barriers

towards seeking mental health treatment among Arab-Americans (Awad, 2010; Erikson

& El-Timini, 2001; Hakim-Larson et al., 2007; Moradi & Hasan, 2004). The second

hypothesis modified these relationships to include religious fatalism as a mediating

variable and removed the direct path from acculturation to ATTSPH. The third and

fourth hypothesis addressed gender differences and differences between first- generation

Coptic Americans, those who immigrated to the U.S. from Egypt and second-generation

American Copts, those born in the U.S. to Egyptian immigrants. This chapter will

interpret the results of each hypothesis, and explore the clinical implications of these

results. In addition, limitations of this study and future directions for this field will be

discussed.

Hypothesis I

Hypothesis I: acculturation, ethnic identity*, and religious fatalism will predict attitudes*

towards seeking psychological help among Coptic Americans.

The purpose of the first hypothesis was to determine if there is a simple direct

impact of acculturation, ethnic identity, and religious fatalism on attitudes towards

seeking psychological help. It was expected that this model would be a good fit for the

sample since previous research implied that these constructs all equally contributed to obstacles in Arab Americans seeking mental-health services. However, this model did not fit these data well. This model produced a significant large chi-square with parameter estimates that indicated poor model fit. The path model showed weak standardized regression weights as well. It was expected that level of acculturation would impact attitudes towards seeking psychological help, and that the more one is assimilated into western culture, the more positive their view of seeking psychological help would be. The results of the analyses did not support the hypothesis or the theory behind the hypothesis, and the simple model with direct paths was not a good fit for the data.

Hypothesis II

Hypothesis II: Religious fatalism will act as a partial mediating variable in explaining the relationship between acculturation, ethnic identity, and attitudes towards seeking psychological help among Coptic Americans.

The second goal of this study was to understand how religious fatalism, one of the most salient cultural values for Arab Americans, influenced attitudes of health seeking behavior. In this model, a path from acculturation to ethnic identity was added because these two scales were found to have significant correlation in this study, and in the original research of these measures (Barry, 2005). The researcher chose a directional path rather than a correlation because theoretically it seems sound to predict one's ethnic identity from their degree of acculturation into the west. It was expected that the less acculturated an individual is to western culture, the more likelihood that person would

identify with Arab ethnicity versus American ethnicity. In addition, there was an established correlation between these two constructs from the original research, and from this study, but both constructs are still conceptually independent of each other, and it was important to understand more about their predictive relationship to each other.

The path yielded a significant positive predictive relationship suggesting that level of acculturation could significantly predict degree of ethnic identity among Copts. Those who more strongly retain the Coptic culture will also identify more with Coptic ethnic culture than those identifying as more western in beliefs, practice, and lifestyle. The path from Arab acculturation to religious fatalism was not significant which implies that one's acculturation process is not predictive of their religious fatalistic beliefs. However, ethnic identity was a significant predictor of religious fatalism, but religious fatalism and ethnic identity were not significant predictors of ATTSPH.

This model suggests that the more an individual identifies with Coptic ethnic identity, the more likely they will be to endorse religious fatalistic beliefs, and that acculturation, ethnic identity, and religious fatalism alone are not sufficient in explaining attitudes towards seeking psychological help. This ran counter to our expectations regarding this model. In addition, religious fatalism may be the important determinant in one's attitudes towards seeking help given the small positive correlation found in this study (see Table 3), and that those with more fatalistic views regarding their health would be less likely to seek out help because of his or her perceived lack of control.

It is important to note that those identifying as having more Coptic ethnic identity have stronger religious fatalistic views regarding their health and are therefore less likely

to endorse positive attitudes towards seeking psychological help. However, religious

fatalism and ethnic identity were unable to predict ATTSPH. This suggests that other

variables such as stigma, language barriers, and mistrust of the psychology field found in

the literature on Arab American mental-health seeking behavior may be better predictors

of ATTSPH. This leads to other questions posed in the literature regarding attitudes

towards seeking mental-health services such as gender differences, and if there are

differences between first and second-generation Copts.

Hypothesis III

 Hypothesis III: There would be significant differences between males and females

regarding attitudes towards seeking psychological help. Religious fatalism will act as a

partial mediating variable in predicting attitudes towards seeking psychological help

from acculturation, ethnic identity, and religious fatalism. It was predicted that females

will have more positive attitudes towards seeking psychological help as consistently

found in other cross-cultural research on attitudes towards seeking psychological help

(Fischer & Turner, 1970; Fischer & Farina, 1995; Turkem, 2005).

The third goal of this study was to investigate sex differences among Coptic

Americans regarding their attitudes towards seeking psychological help and how

acculturation, ethnic identity, and religious fatalism impacted these attitudes. As

reported earlier, simple one way ANOVA did not reveal significant differences between

males and females regarding attitudes towards seeking psychological help. The same

path model used in Hypothesis II was analyzed for both males and females with similar

model fit outcomes but small differences were found in which paths were significant for each group.

It is important to note that these results were based on a small sample, which becomes smaller still when divided into gender or immigration status. Each group was analyzed separately to ensure that the "baseline" model fit each group well. When the results from each group were reviewed separately some differences were seen between these groups. Some of these differences may be due to the small sample size and low power and should be interpreted cautiously. For instance, ethnic identity was a significant predictor of religious fatalism for both females and males, but the standardized regression weight for men was stronger than for females. Arab acculturation was a significant predictor of ethnic identity for both males and females. For females, Arab acculturation also was significant in predicting religious fatalism whereas male's Arab acculturation was not a significant predictor of religious fatalism. For both sexes, religious fatalism and ethnic identity were not significant in predicting ATTSPH.

These results initially indicated that males and females have differences in how their acculturation and ethnic identity impact their degree of religious fatalism, but the multigroup analysis suggested that both groups fit the data well to the same model with equal path values. This suggests that some of the differences seen when the groups were analyzed separately may have been due to the problems mentioned earlier, small sample size and low power. Research has pointed out that women have more positive views towards seeking psychological help, and are three times more likely to seek out mental

health services than their male peers (Fischer & Farina, 1995; Fischer & Turner, 1970; Turkem, 2005), but the findings from this study were unable to support this.

Hypothesis IV

Hypothesis IV: There are significant differences between first-generation Copts and second-generation Copts (generational status) regarding attitudes towards seeking psychological help. Religious fatalism will act as a mediating variable in understanding the extent to which acculturation, ethnic identity, and religious fatalism will predict attitudes towards seeking psychological help.

The fourth purpose of this study was to determine the differences between first-generation Coptic Americans and American Copts who were born in the U.S. to Egyptian immigrant parents. The model from Hypothesis II was used for both groups, and the model was a good fit for the first-generation group and an acceptable fit for the second-generation group. For first-generation Copts, the model showed very good fit with these producing a χ^2 close to zero, which indicated perfect model fit compared to the second-generation group, which also had a non-significant χ^2 yet produced some fit indices which suggested only adequate fit.

In sum, the analyses for each group separately found that Arab acculturation was a significant, but negative predictor towards religious fatalism. This means that for both groups, those identifying with Arab culture had stronger religious fatalistic beliefs than those identifying with American culture. This same trend is also true for the path from ethnic identity to religious fatalism meaning that higher scores on Coptic ethnic identity indicated stronger religious fatalistic beliefs than those with less Coptic ethnic identity.

In addition, Arab acculturation was a significant predictor of ethnic identity. This suggests that less acculturated individuals or even American born Copts who feel more tied to Coptic culture also endorsed strong Coptic ethnic identity than those who were more acculturated and identified more as American than Copt or Egyptian. The multigroup analysis mirrored these findings in that the same model fit both groups will even when the path values were constrained to be equal across both groups.

Because this study did not find a significant predictor of ATTSPH, one salient conclusion is that it appears there may be other factors such as those offered by cross-cultural research that address barriers to health-care for minorities like economic issues, skepticism of psychology, access to more social resources, and possible better psychological adjustment (Abe-Kim et al., 2007; Vega et al., 2001), that could better explain Coptic Americans' attitudes towards seeking psychological help than the cultural factors addressed in the current study.

Clinical Implications

The results of this study corroborated previous studies regarding Arab American barriers to psychological treatment such as counseling. The previous research showed that Arab Americans, both Muslim and Christian, are skeptical of western psychology and would prefer to seek emotional support and help through their family, friends, and religious leaders (Hakim-Larson et al., 2007; Shah et al., 2008). In addition, it also appears that religious fatalism and religious beliefs and practices are vital in understanding Coptic Americans.

Another finding of this study was that there are differences between men and women in their religious fatalistic beliefs. The findings of this study suggested that female immigrants with more Arab cultural values and stronger ethnic identity also have stronger religious fatalistic beliefs. Due to the higher number of female responders in this study, and within the first generation group, it may be inferred that female immigrants may have more barriers in acculturating to the U.S. and integrating a bi-cultural identity. However, in order to fully understand these differences, further research comparing first-generation and second-generation female Arabs should be conducted.

It is important also to note that American Copts who are second-generation may more closely identify with American culture and ethnic identity, in which case other factors may influence their ideas and beliefs about seeking mental-health treatment. One possible strategy in better understanding this population, is to form a volunteer group within Arab religious organizations that may bridge the gap between underserved communities and access to mental health services. An example of this is the Family Ministry Program started by Bishop Yousef of the U.S. Coptic Orthodox Southern Diocese. This program trains volunteers from churches for 2 years by licensed mental-health professionals to provide emotional support, and act as a mediator between the church, the priest, and community professionals for parishioners with marital problems, family concerns, and individual issues that may require professional psychological help. This program is culturally-sensitive, and meets the needs of the community that may not otherwise seek treatment, without trying to change the cultural values or individual

beliefs into western values and beliefs. Currently, this training program is offered online

so that Coptic individuals from across North America can participate and become

liaisons. The goal is to have a Family Ministry contact in each state where there are

Coptic Communities.

Such a goal would appear to be congruent with the finds of this study. Questions

in the demographic section of the study suggested that 59% of respondents would

consider seeing a therapist who identifies as Coptic, and 52% would possibly or likely

go to a therapist who spoke Arabic. Most notable is that 80% of the sample reported that

they would likely or possibly go to a therapist who understood the Coptic culture, and

that 85% would seek therapy if it was recommended by their Father of Confession and

71% would consent to therapy if the priest was involved in the process. These responses

match previous studies with Arab Americans who preferred to seek help through their

religious and community leaders than with a professional who is a stranger to their

culture and way of life (Azaiza, & Cohen, 2008; Shah, et al., 2008). This suggests that

programs such as the Family Ministry Program in the Coptic Church may be a viable

strategy for decreasing the disparity in mental-health service seeking behavior among

Arab Americans.

Limitations of Study

There were several limitations of this study. The primary limitation and perhaps

the most important, was that the survey seems to have been too long, which led to

mortality effect. Originally this survey included instruments about religious faith

development and psychological well-being, which took about 30 minutes to complete

with the other instruments. A pattern was found that many participants skipped these instruments because they were towards the end, and moved to answering the demographic questions which were last. This is a possible explanation for why about thirty participants did not complete the survey, and left close to ninety-percent of the survey unanswered, which could not be used.

This leads into the second limitation, the small sample size of ninety-one participants. This small sample size made comparisons between groups more tentative, and less generalizable to the Coptic American population. In addition, it was hard to know if the small samples between groups affected the outcome. In addition, the small sample size may have impacted the results of this multi-group analysis since the sample is divided into smaller subgroups to conduct this analysis, which leaves more room for error in the results.

Some investigators, (Hoyle, 1995) have suggested that a small sample sizes (e.g. N<75) can affect the CFI. However, Fan, Thompson, and Wang (1999) argue that the CFI and RMSEA are strong alternatives to the NFI because they are not easily impacted by a small sample size. Therefore, it is unclear how much impact the small sample size of this study had on the results of this study. The results of the SEM and multigroup analysis should be interpreted with caution given the small sample size of n=91 for the whole sample, and imbalance between males and females with females accounting for about 64% of the sample. In addition, the initial path model analysis for the sub-groups indicated that this theoretical model was a better fit for first-generation Copts and did not

fit as well for second-generation Copts in examining their attitudes towards seeking psychological help.

The third limitation was that this survey was only available in English so older adults or new immigrants not fluent in English would have been unable to complete the survey. This is important because those new to the U.S. would be in the early stages of acculturation and ethnic identity formation with the new culture, and might yield more significant differences than immigrants who have been in the U.S. for several years. Another limitation was that the survey was only available online and no paper copies were distributed due to financial constraints, meaning those without internet access or inadequate computer skills would be unable to access the survey or receive information about the study.

The fifth limitation was that some of the instruments are new to the field and therefore did not have a breadth of psychometric research. The Multi-Group Ethnic Identity Measure created by Phinney (1992) may be a better alternative to Barry's (2000) Male Arab Ethnic Identity Measure because of the strong psychometric properties it displays. However, this measure may be too general to be used with an Arab Christian population, and may need further research to determine its validity in this group. In addition, Franklin's Religious Fatalism Health Questionnaire showed strong psychometric properties in the developer's research, but had not been examined on other populations other than African Americans, and therefore another religious fatalism instrument may be better suited for this population.

Directions for Future Research

As reported in the limitations, one suggestion would be to include a larger sample size of participants from different regions of the U.S. and perhaps Canada in order to establish more generalizability to this Coptic American Population. In addition, it would be important to try and produce an Arabic version of a survey in order to include new immigrants in the sample that may not be fluent in written English. Any such instruments would need to be investigated to determine their validity and reliability prior to substantive research.

As the results indicated, acculturation, ethnic identity, and religious fatalism were unable to significantly predict attitudes towards seeking psychological help. Other variables such as stigma, language barriers, and skepticism of western psychology may better explain attitudes towards seeking psychological help as reported in the literature on Arab Americans (Erickson & Al-Timimi, 2001; Shah, & et al., 2007).

Another possible direction would be to conduct a qualitative study asking participants about their views on psychology and their beliefs about the etiology of mental illness, and their perception of western psychology. This could lead to intervention studies on how to promote mental health and change attitudes towards mental-health illness and seeking help for mental-health issues. One such example could be a pre and post-test with a psycho-education workshop on psychotherapy offering information on different theories, expectation of what therapy can provide including confidentiality, and multi-cultural competence of therapists to test changes in attitudes towards seeking psychological help with an education component. The results of this

study as well as other cross-cultural research indicated that it is important to differentiate between immigrants and those of the same ethnic group who were born in the U.S. because they seem to have different perceptions of psychology and mental-health seeking behavior. Another essential research area is to conduct program evaluation studies for religious organizations that are forming bridge programs such as the Family Ministry Program through the U.S. Southern Coptic Diocese to understand the effectiveness of these programs, and establish an evidenced-based approach for cross-cultural therapy options.

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APPENDIX A

PARTICIPANT INFORMED CONSENT FORM

Page 1. Welcome to the survey

Hello,

My name is Sallie Boulos, and I am a Copt and second-generation American. I am a PhD student in the Counseling Psychology program at Texas A&M University.   Part of my program requirement is to conduct my own research, analyze and report the results. I have chosen to focus my research on the Coptic American community.

The purpose of this page is to provide you information that will help you make a decision as to whether or not to participate in this research study.

You have been asked to participate in a research project studying: "The impact of acculturation, religious identity development, and psychological mindedness on attitudes towards seeking psychological help in Coptic Americans". The purpose of this study is to understand how well our community has integrated into the US Culture, how much of our own Coptic culture we have kept, our Religious beliefs, and the attitudes towards psychotherapy. You were selected to be a possible participant because of my collaboration with Anba Yousef and Priests across the US who has shared this opportunity with you or your congregation.

Page 2. Information for consent of participation

What will I be asked to do?

If you agree to participate in this study, you will be asked to answer questions with regard to the extent that you agree or disagree with statement regarding your religious beliefs, your Coptic identity, and your life experiences. This survey will take about 20-30 minutes to complete.

What are the risks involved in this study?

There are no risks associated in this study, and the questions in the survey are not greater than questions encountered in daily life.

What are the possible benefits of this study?

The possible benefits of participation are to help increase the research knowledge of Middle Eastern Christians living in the US. There is currently no psychological research found on Copts in the US, and I would like to bridge this gap. In addition, I hope that in answering the questions to this survey, you will have a chance to review your life experiences as a Copt living in America and give the field of psychology insight into how psychologists can better serve our community, which is often ignored in the media and relatively unknown to many mental health professionals in the U.S.

Do I have to participate?

No. Your participation is voluntary. You may decide not to participate or to withdraw at any time without your current or future relations with Texas A&M University or the Coptic Church being affected.

Who will know about my participation in this research study?

This survey is completely anonymous, I will have no idea who has taken this survey and will not be able to connect completed surveys with specific individuals. I set the survey up this way so you can answer the questions as openly as possible without fear of identification. No possible identifiers linking you to this study can be included in any sort of report that might be published. Research records will be stored securely and only I and my research advisor will have access to the surveys.

Whom do I contact with questions about the research?

If you have questions regarding this study, you may contact me Sallie Boulos at (979)845-3127 or salsula@tamu.edu or my research advisor Dr. Daniel Brossart Ph.D. at Brossart@tamu.edu.
.
Whom do I contact about my rights as a research participant?

This research study has been reviewed by the Human Subjects' Protection Program and/or the Institutional Review Board at Texas A&M University. For research-related problems or questions regarding your rights as a research participant, you can contact these offices at (979)458-4067 or irb@tamu.edu. Please be sure you have read the above information, asked questions and received answers to your satisfaction.

I am grateful for your help in completing this survey and letting other Copts know about this study.

God Bless you

***By clicking "I agree" you consent to participate in this anonymous survey and will be directed to the next page where the survey begins. If you do not wish to participate, you may click "I do not agree" and may then close the website. If you do participate, you may choose to stop at any time without recourse.**

○ I agree   ○ I do not agree

APPENDIX B

INSTRUMENTS

Male Arab Acculturation Scale (Barry, 2005; Barry, Elliott, & Evans, 2000).

Scale 1: Separation/Assimilation

1. I would much prefer to live in an Arab country

2.   Most of my friends are Arabs

3. I behave like an American in many ways

4. Generally, I feel more comfortable around Americans than I do around Arabs

Scale 2: Integration/Marginalization

5. I mix equally well with Americans and Arabs

6. I am equally at ease socializing with Arabs and Americans

7. I have many Arab and American friends

8. I have a lot of difficulty making friends

Male Arabic Ethnic Identity Measure (MAEIM)(Barry, 2005; Barry, Elliott, & Evans, 2000).

Scale 1: Religious–Family Values (RFV)

1. I always obey my father's orders

2. Being an Arab is more important to me than my religion

3. A man is not a man if he hurts his mother's feelings

4. I believe that women should place their family before their career.

5. I would never allow my wife to have an abortion

6. Good things only happen to me when God wills them

7. I would never shout at my father even if he were to insult me badly

8. I shall always be faithful to the religion of my fathers

9. I have never doubted that God exists

10. When I meet a husband and wife who are living away from their extended families (e.g., parents, cousins), I feel sorry for them

11. It is important for me to know that I come from a family of ''clean descent'' (i.e., my mother, grandmother, etc., were all chaste)

12. I would be reluctant to get divorced as it would give my family a bad name

13. Older people deserve more respect than younger people

14. I have considerable respect for my father, grandfather(s), uncles, and older brothers

Scale 2: Sense of Belonging/Ethnic Pride (EP)

15. I am very proud of my Arabic background

16. Being an Arab plays an important part in my life

17. It is important for me to continue the reputation or ''good name'' of my family

18. When an important newspaper praises the Arabs, I feel that it is praising me

19. Arabs all over the world are my ''family''

20. Growing up, I learned a lot about my grandparents, and great-grandparents

21. I place little emphasis on my ''family name''

Scale 3: Friendship (F)

22. I would risk dying for my close friends

23. I have an obligation to my group of friends.

24. My parent taught me to be hospitable to foreigners

25. I find that many of my friendships only last a short time

26. I consider it an honor to help strangers.

27. I would immediately stop my work or study to help out a friend (e.g., if his car broke down)

28. If one of my friends had borrowed money from me but had not paid me back, I would not ask him to return the money

Scale 4: Ethnic Arabic Practices (EAP)

29. I express my feelings better in English than in Arabic

30. I listen to Arabic music at least once a week

31. I rarely write in Arabic

32. I eat Arabic food every week

33. I speak Arabic every day.

Attitude Toward Seeking Professional Psychological Help (ATSPPH) abbreviated scale

(Fisher & Turner, 1979), (Fisher & Farina, 1995).

1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention.

2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts.

3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy.

4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help.

5. I would want to get psychological help if I were worried or upset for a long period of time.

6. I might want to have psychological counseling in the future.

7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help.

8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me.

9. A person should work out his or her problems; getting psychological counseling would be a last resort.

10. Personal and emotional troubles, like many things, tend to work out by themselves.

Franklin Religious Health Faith Questionnaire (RHFQ)(Franklin, et al, 2007)

1. If I just pray to God about my health, he will work it out.

2. When I am sick I give my burdens to God and let Him handle it.

3. God will take care of my health because I have found favor in his sight.

4. If God wants me to have better health, He will provide.

5. I don't worry about my health because it is in God's hands.

6. If I am sick, I have to wait until it is God's time for me to be healed.

7. When I have a health problem, I pray for God's will to be done.

8. As long as I stay focused in prayer, I will be healed of any sickness.

9. Spiritual people should accept whatever God has meant for them.

10. I trust God, not man, to heal me.

11. If a person has enough faith, healing will occur without doctors having to do anything.

12. Sometimes, God allows people to be sick for a reason.

13. If I become ill, God intended that to happen.

14. Whatever illnesses I will have, God has already planned it.

15. Sometimes someone can be ill because of disobedience to God.

16. I don't need to try to improve my health because I know it is up to God.

17. I can control a small health issue, but only God can control a big health issue.

* The RHFQ scale items ranged from 1 (strongly disagree) to 5 (strongly agree) with higher scores indicating a greater degree of endorsement of the scale item.

Demographic questions

Sex: male or female

Age: _____

Race: Coptic, Caucasian, Hispanic, African American, or Other

Languages spoken:

 For each language spoken, how fluent are you:

    Reading, writing, speaking

Place of Birth: _____ If Egypt or outside the US, # of years in the US

Education: # of years

Highest Degree awarded or in progress:

Occupation:

Income range: <25k, 25-35k, 35-50k, 50-75k, 75-100k, >100K

Marital status: single, engaged, married, divorced, widowed

Number of children:

Religious denomination:

How often do you attend Religious services?

On a scale of 1-5, with 1 being never, 2 rarely, 3 sometimes, 4 often, 5 always, how often

you participate in (scale for each one):

- Church activities,

- Sunday school,

- Tesbeha,

- The great Fasts

- Confession,

- Communion,

- Retreats/Conventions

Any leadership position within the church E.G.: Deacon, Sunday School Teacher, Board

member, immediate family member of priest or bishop

In general, would you classify your religious beliefs as traditional or progressive?

On a scale of 1-5, would you say that your beliefs are conservative or liberal: 1-very

conservative 2-conservative 3-moderate, 4-liberal, 5-very liberal.

How often do you pray? Daily, weekly, monthly, rarely, never

How often do you read the Bible? Daily, weekly, monthly, rarely, never

VITA

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