Development and Validation of the Muslims' Perceptions and Attitudes to Mental Health (M-PAMH) Scale with a Sample of American Muslim Women

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Abstract

Proper study of the perceptions and attitudes of mental health in minority populations depends on valid and reliable measurements that are customized for each population. Currently, no existing measure is tailored to the unique needs of Muslim women residing in the U.S. The Muslims' Perceptions and Attitudes to Mental Health (M-PAMH) Scale was developed by adapting existing instruments in order to establish a psychometrically robust scale for the utilization in mental health care research when studying Muslim women. Scale validity was tested using data from 1,279 American Muslim women (mean age: 32.3) who anonymously completed a 40-item questionnaire hosted on a medical school website. The complete sample was randomly divided into roughly equivalent halves. The first half of the sample ($n=623$) was subjected to an exploratory factor analysis (EFA); a four-factor structure was indicated. The EFA pattern matrix was used to indicate the factor structure of a confirmatory factor analysis (CFA) with the remaining sample ($n=656$). Following this, 18 items indicated the proposed four-factor structure. The CFA demonstrated an excellent fit to the data, with small to moderate correlations between factors. The M-PAMH successfully assesses four important domains: rejection attitudes toward professional mental health care, cultural and religious beliefs about mental health, stigma associated with the usage of mental health services, and familiarity with formal mental health services.

Keywords: American Muslim Women, Perceptions and Attitudes, Psychometric Scales, Stigma, Islam, Muslim Mental Health, M-PAMH

Introduction

Recent scholarship recognizes that attitudes and perceptions toward mental health in minority populations require individualized attention in order to reduce stigma and increase service utilization (Gibbs & Huang, 1998; Herrick & Brown, 1998; Trinh, Rho, Lu & Sanders, 2009). The underutilization of mental health services by minorities is often attributed to beliefs about the origin and proper treatment of mental illness or beliefs that discourage the disclosure of problems to those outside of the family network (Gaw, 1993). Other theories of underutilization in minority groups include stigma (Corrigan & Kleinlein, 2005), lack of knowledge regarding available services (Aloud, 2004), and differences in values on the part of the clinician or counselor (Shafi, 1998; Ahmed & Reddy, 2007).

American Muslims are a growing minority group and a unique subset of the U.S. population with limited studies of their health and wellbeing (Sheridan & North, 2004; Maslim & Bjorck, 2009). This is regrettable considering the increased attention Muslims are receiving in the media and the steady growth of

the number of Muslims making it the projected second largest religious group in the United States by 2040 (Mohamed, 2016).

The limits of existing research on attitudes and perceptions of mental health in American Muslims creates a disadvantage for both providers and potential patients; a more thorough exploration of such can lead to better utilization and tailoring of services. Progress has been hampered in part due to the lack of appropriate measures specific to the Islamic faith (Abu Raiya, Pargament, Mahoney & Stein, 2008; Bjorck & Maslim, 2011). The lack of insight into a minority population that is increasingly suffering from poor mental health (Amer, 2005; El-Khadiri Derose, 2009), is growing at a rapid rate (Pew, 2007), and represents the largest population of refugees and asylum-seekers entering the United States (Leonard, 2003) runs the risk of forming a persistent barrier that alienates Muslims from acculturation and integration into the social fabric of this country (Khawaja, 2016).

Even more pressing is the need for research on American Muslim women (Sheridan & North, 2004). Muslim women living in the United States are of particular interest in this regard because of the prominent roles they play in making family and community decisions. Muslim women traditionally engage in a caretaking role. In this regard, they are influential decision-makers within their family and in their Muslim communities (Wang, 2006). Muslim women are also a source of guidance and consolation within their family and extended community (Turkes-Habibovic, 2011). To this end, their attitudes toward mental health may influence the decisions of others in their lives about whether to seek mental health care services.

To help remedy this research gap, our study specifically recruited Muslim women. The aim of the proposed study is to develop a valid psychological measure that examines attitudes and perceptions of Muslim women as it relates to their understanding of mental illness and use of mental health services. This article describes the process of adapting existing scales to develop the Muslim Perceptions and Attitudes to Mental Health (M-PAMH) scale and validating its psychometric properties in a sample of American Muslim women; the validation of the M-PAMH scale was part of a larger study that focused on the mental health of Muslim women.

Method

Instrument Development

To fully understand the ways in which American Muslims view mental health, the catalysts of mental illness and attitudes toward treatment and help-seeking preferences in this population must first be explored. In order to do this, we

conducted a literature review of scales that measure perceptions and attitudes toward mental health and help-seeking behaviors as it relates to minority communities. Our review indicated limited availability of such scales. In developing our study, the following scales by Fischer and Turner (1970) and Aloud (2004) were used and adapted:

The Attitude Toward Seeking Formal Mental Health Service (ATSFMHS; Aloud, 2004)

The most widely used scale to facilitate the exploration of help-seeking attitudes is the Attitudes toward Seeking Professional Psychological Help Scale (ATSPPH) by Fischer and Turner (1970). This scale was later adapted by Aloud (2004) who undertook a comprehensive revision to account for Islamic terms. An example of an Islamically sensitive modification by Aloud to the scale is adjusting the question, “A person with a strong character can get over mental conflicts by himself, and would have little need of a therapist” to instead read: “A person with strong Iman [faith] can get rid of a mental health or psychological problem without the need of professional help.” To capture the influence of religiosity and religio-cultural misconceptions on attitudes toward mental health, we developed five items as described in Table 1. These items were developed based on emerging concepts from the Muslim mental health literature (Ahmed & Amer, 2013; Ali, Milstein & Marzuk, 2005). The new scale was renamed the “Attitude Toward Seeking Formal Mental Health Service” (ATSFMH) and yielded high reliability (Cronbach’s Alphas of 0.74; Aloud, 2004).

Cultural Beliefs about Mental Health Problems, their Causes, and Treatments (Aloud, 2004)

This scale was created by Aloud to examine the influence of cultural, traditional, and religious beliefs on perceptions of the causes and treatment of mental health problems by Arab Muslims. The scale is comprised of eleven Likert-type items; we only used seven items in order to limit redundancy in our survey. For example, Aloud’s subscale had three questions that asked about beliefs in superstition as a cause of mental illness. We only included one question because including the three would have made the subscale longer without additional utility. The decision to keep or remove items was made based on the important concepts that emerged from the literature review, the primary researcher’s clinical experience with Muslim clients, and discussions with the research team. Because of the important correlation between Islamic belief and a Muslim’s wellbeing (Padela et al. 2012), we developed two items that asked about the Islamic concept of fate (*qadar*) as it has particular influence on Mus-

Table 1. The eight items developed by the authors

Familiarity with mental health services and conditions	How familiar are you with the type of conditions that can be treated by professional mental health or psychological treatment (e.g. mental instability, depression, etc.)?
Attitudes Toward Mental Health Services	<p>I would be comfortable contacting a mental health care professional or using psychological services in the future.</p> <p>The Islamic religion encourages Muslims to seek medical care for psychological and mental health difficulties.</p> <p>I would rather be advised by a religious figure (e.g., a Shaykh) than by a mental health professional, even for serious psychological problems.</p> <p>I admire an individual who is willing to cope with his/her conflicts without resorting to professional mental health care.</p> <p>Even if I sought professional mental health care, I would also still seek help from a religious figure (e.g. Shaykh) for a psychological difficulty I was facing.</p>
Cultural Beliefs About Mental Health Problems	<p>Mental health or psychological problems are the result of Qadar (fate).</p> <p>If it is in one's Qadar (fate) to have a mental health or psychological problem, it can still be treated using professional mental health or psychological counseling services.</p>

lim help-seeking behaviors (Ahmed & Amer, 2013). The two items developed are illustrated in table 1.

Knowledge and Familiarity with Formal Mental Health Services Instrument

This scale is used to explore the extent of familiarity with types of mental health problems treated by professional mental health workers, as well as familiarity with the mental health services offered in the community. Aloud's scale is comprised of eleven Likert-type questions which we found to be lengthy. We used only two of the items after modifying them because we wanted to keep the survey simple; we were interested in generally assessing the familiarity of participants with psychological problems, their treatments and mental health resources in their communities without going into specific details. Since our study did not focus on Arab Muslims or a certain geographical area in the US, but rather was a national study that aimed at including Muslim women from different ethnicities who are living in the US, the item "The Arab and Muslim professionals who practice mental health or psychological counseling within

your local community (Columbus, OH),” was modified to “The Muslim professionals who practice mental health or psychological counseling within your local community.” We developed a single item, “How familiar are you with the type of conditions that can be treated by professional mental health or psychological treatment (e.g., mental instability, depression, etc.)?” to replace the 5 items developed by Aloud that separately examined familiarity of the respondents with mental health problems, types of clinical interventions, and the role of clinical social workers, psychologists, and psychiatrists. We kept the item: “How familiar are you with the availability of mental health and psychological services in your community (e.g., location, phone #, type of services provided)?” The total eight items that we developed are illustrated in the Table 1.

The resulting survey was comprised of 40 questions divided into four sections: Section 1 included questions on attitudes toward professional mental health care, Section 2 evaluated cultural and religious beliefs as they relate to causes and treatments of disorders, Section 3 assessed the level of familiarity of mental health services, and Section 4 included demographic questions like age, education, and ethnicity. Questions in sections 1 and 2 were scored using a 4-item Likert-type scale that assesses the degree of agreement to each statement, for example, (1 = strongly disagree, 2 = disagree, 3 = agree, 4 = strongly agree). Questions in section 3 are scored using a 4-item Likert-type scale but with different wording (0 = not at all, 1 = very little, 2 = somewhat, 3 = very familiar). The survey questions are attached in the appendix.

Sample and Data Collection

After receiving IRB approval, the survey was posted on Stanford University’s School of Medicine website with a cover letter highlighting the primary author’s interest in determining how Muslim women felt about mental health care and its practitioners. Consent information was also provided. The researchers then sent a weblink to colleagues and friends to help spread the word about their survey and its purpose. Specific online interest groups and listservs known to cater to Muslim women living in the U.S. were targeted and their moderators were asked to forward the link to their constituents. In this way, participants were recruited using a snowball technique. By the end of the 3-month period, 1279 American Muslim women had completed the online survey.

Statistical Analysis

SPSS version 20 (Statistical Package for Social Sciences software) was used in examining the data, and conducting the exploratory factor analysis (EFA). Confirmatory factor analysis (CFA) was performed using LISREL program (version 8.80; Joreskog & Sorbom, 2006).

Table 2. Participants Characteristics: Frequencies and Percentages

Participants characteristics	Frequency	Percentage
Age		
<19	70	5.5%
20-39	934	73.5%
40-64	259	20.4%
>65	8	0.6%
Born in the U.S.		
Yes	531	41.8%
No	740	58.2%
Ethnicity		
Caucasian	201	15.8%
African American	92	7.2%
American Indian	6	0.5%
Arab	330	26%
African	30	2.4%
South East Asian	482	37.9%
Asian/ Pacific Islander	26	2%
Iranian	11	0.9%
Turkish	10	0.8%
European	34	2.7%
Latin American	36	2.8%
Other	10	0.8%
Education		
High school or less	151	11.9%
Undergraduate degree	689	54.2%
Graduate degree	431	33.9%
Occupation		
Not working	580	45.6%
Professional	668	52.6%
Blue collar	23	1.8%
Marital Status		
Single	335	26.4%
Married	840	66.1%
Divorced	83	6.5%
Widowed	13	1%

Results

Characteristics of the Sample

A total of 1279 Muslim women participated in the study. The mean age was 32.3 ± 10.5 (range: 11-94) and the average duration of their stay in the United States was 24.2 ± 12.2 years (range: 0-69). Few missing values were identified and treated by listwise deletion. Frequencies and percentages of the demographic variables are summarized in Table 2.

Approach to Exploratory and Confirmatory Factor Analyses

The complete sample was randomly divided into two roughly equivalents halves. The first half of the sample ($n=623$) was subjected to an exploratory factor analysis (EFA). For cross-validation, the EFA pattern matrix was then used to indicate the factor structure of a confirmatory factor analysis (CFA) with the remaining sample ($n=656$). We determined a priori that items must have a minimum factor loading of .40 to be retained in the analysis.

Goodness of fit was assessed via the chi-square statistic and the following alternative fit indices: the comparative fit index (CFI), the non-normed fit index (NNFI), and the standardized root mean square residual (SRMR). The chi-square statistic can reflect poor model fit due to sample size and large correlations within the data. The CFI, in contrast to the chi-square, benefits from large correlations within the data (which are assumed a priori to exist within the present data). In addition, the NNFI corrects for the number of parameters in the model. Both of these indices reflect good model fit at values of .95 or greater. Finally, the SRMR, as opposed to the chi-square, benefits from larger sample sizes and represents the difference between the observed and predicted covariance. A value of zero reflects a perfect fit, and values less than .08 reflect a good model fit.

Exploratory Factor Analysis

A principal components analysis was first applied to the 25 items. Given that we assumed some degree of correlation within the factor structure, an Oblimin rotation was employed. Visual inspection of the scree plot revealed a four-factor structure. The analysis was constrained to four factors and rerun. Five items exhibited factor loadings below the .40 cut off (items 7, 15, 17, 19, and 23) and were removed. A complete list of the survey items is provided in the appendix. The pattern matrix for the four-factor solution of the remaining 20 items was then used for CFA.

Confirmatory Factor Analysis

In addition to the decision rule to retain only items exhibiting a standardized loading of $\geq .40$, an additional decision rule was employed for CFA. Items cross-loaded at $\geq .40$ on more than one factor were also discarded in order to be maximally conservative about the information embedded within a given latent factor.

A CFA was performed on the 20 remaining items with items 4, 6, 9, 12, 14, and 15 indicating rejection; items 16, 20, 21, 22, 24, 25, and 26 indicating beliefs; items 2, 3, 10, and 11 indicating stigma; and items 27, 28, and 29 indi-

cating familiarity. This model exhibited an acceptable fit, $\chi^2(164) = 508.21$, $p < .001$, CFI = .94, NNFI = .93, SRMR = .056, however, one item (item 12, factor 1) exhibited a loading $< .40$ (loading = -.23), and inspection of the modifications indices revealed one item with a cross-loading of $> .40$ (item 3, factor 3). Thus, these two items were removed from the analysis and the remaining 18 items were rerun a final time. While this model maintained a non-significant chi-square statistic ($\chi^2(129) = 376.68$, $p < .001$), the alternative fit indices revealed a good (NNFI = .94) to excellent (CFI = .95, SRMR = .049) fit to the data. The final scale and factor loadings are shown in Table 3.

Discussion

Empirical findings indicate that religion has a driving role in the lives of Muslims affecting their attitudes toward mental illness, their help-seeking behaviors and hence their utilization of mental health services. In addition to the common religious values that Muslims share, they originate from different ethnic and cultural backgrounds that shape their worldviews and influence their behaviors. This interplay of religion and culture makes Muslim mental health a challenging phenomenon to study.

The aim of this study was to develop and validate a psychometric scale that evaluates the attitudes and perceptions toward mental health by Muslim women residing in the U.S. One of the strengths of this scale is its ability to examine the cultural and religious beliefs that can affect Muslims' utilization of mental health care services. The scale also took into consideration attitudes that some Muslims might have toward professional mental health care, that in turn, can negatively influence their help-seeking behaviors. As discussed in the introduction, stigma can influence the decision to seek help, thus, we included a subscale that focused on measuring stigma as it relates to help-seeking behaviors. Another important domain that the scale successfully captured was familiarity of clients with mental health resources that could facilitate or hinder clients seeking mental health services. The resultant M-PAMH scale is comprised of 18 brief items that can be used independently or be easily added to an existing survey with minimal additional response burden. The M-PAMH scale provides future researchers with an easy and feasible method to assess four important mental health domains: rejection attitudes toward professional mental health care, cultural and religious beliefs about mental health, stigma associated with mental health services and familiarity with formal mental health services offered in the community. Understanding these domains will help researchers investigate the reasons for the underutilization of mental health services by Muslim women and explore the underlying factors affecting their help-seeking behaviors.

In regards to the psychometric properties of the scale, we performed an

Table 3. Factor Structure and Factor Loading of the M-PAMH Scale

Items	Factor Loadings			
	Rejection	Beliefs	Stigma	Familiarity
1. Most mental health and psychological problems can be solved by oneself without the assistance of professionals.	.56			
2. I admire an individual who is willing to cope with his/her conflicts without resorting to professional mental health care.	.50			
3. Mental health and psychological difficulties, like many things, tend to go away on their own.	.49			
4. The idea of talking about my problems with a mental health professional is a poor way to solve mental health difficulties.	.54			
5. Seeking psychological and mental health services should be the last resort after trying all other options (e.g., self-help, Shaykh, or friend counseling).	.68			
6. Mental health or psychological problems can be caused by <i>Jinn</i> (spirits).		.77		
7. Mental health or psychological problems can be caused by <i>Ayn</i> (evil eye).		.72		
8. Mental health or psychological problems can be treated using <i>Ruqya</i> (Quranic Recitation).		.67		
9. Even if I sought professional mental health care, I would also still seek help from a religious figure (e.g., Shaykh) for a psychological difficulty I was facing.		.48		
10. There are certain mental health or psychological problems that CANNOT be treated using mental health or psychological treatment; rather they require <i>Ruqya</i> (Quranic Recitation).		.57		
11. Mental health or psychological problems can be treated using traditional medicine (e.g., black seed).		.53		
12. Mental health or psychological problems are the result of <i>Qadar</i> (fate).		.49		
13. I would feel embarrassed to seek mental health or psychological services because of others' negative opinions.			.74	
14. Using mental health or psychological services is more difficult than using other medical services because of the shame (societal stigma).			.51	
15. I would be comfortable contacting a mental health care professional or using psychological services in the future.			-.65	
16. Familiarity with the availability of mental health and psychological services in your community (e.g., location, phone #, type of services provided).				.94
17. Familiarity with the type of conditions that can be treated by professional mental health or psychological treatment (e.g., mental instability, depression, etc.).				.58
18. Familiarity with the Muslim professionals who practice mental health or psychological counseling within your local community.				.48

exploratory factor analysis on half of the sample which proposed a four-factor structure that was further validated by a confirmatory factor analysis that was performed on the second half of the sample. This statistical methodology afforded the M-PAMH scale stronger psychometric properties over other similar surveys found in mental health literature.

The M-PAMH scale also demonstrates methodological strengths. A limitation of many studies was their use of qualitative methodology and framework (Turkes-Habibovic, 2011). Such studies do not offer generalizable or quantifiable results about attitudes and perceptions of Muslims toward mental health. Similarly, when quantitative scales tailored to Muslims and demonstrated sound psychometric properties were available, they were focused on religious coping (Amer, Hovey, Fox, & Rezcallah, 2008; Khan & Watson, 2006), religious support (Bjorck & Maslim, 2011), or Muslim practice and belief (Almarri, Oei, & Al-Adawi, 2009) rather than on attitudes and perceptions as intended in the present work. The remaining studies, such as Aloud, were quantitative in nature but were limited by small sample sizes that do not permit rigorous validation of their scale (Bagasra, 2011). The present study had a sample size above the 1000-participant threshold needed to run factor analyses and produce a validated scale.

Another strength demonstrated by this study, is that the M-PAMH scale was created from an ethnically heterogeneous sample of Muslim women, unlike other studies that focused on one ethnically homogenous sample. Particular attention was also paid to ensuring that the M-PAMH scale was appropriate for the Muslim faith and culture.

There are some limitations to the M-PAMH scale. The online nature of the survey likely skewed the sample toward young, educated, tech-savvy, and English-speaking participants. This convenience sample is not representative of the entire population of Muslim women residing in the U.S. Volunteer bias is also plausible considering that those who were willing to volunteer their time were likely more interested in the subject matter. Thus, we cannot be sure to what extent the participants' motivation influenced their answers. Additionally, it is possible that participants may have broadened their definition of mental health and therefore responded with more positive perceptions or attitudes without shifting actual behavior. Therefore, when using the M-PAMH scale, it might be useful to include a separate question concerning the definition and actual behaviors employed by participants in relation to mental health to anchor their responses.

Despite these limitations, the M-PAMH scale significantly improves on previous scales by offering the research community a brief, feasible, psychometrically robust, and culturally congruent measure that has been proven successful in researching Muslim women.

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Appendix

The Original 40-Item Questionnaire

SECTION I ATMHS Attitudes Toward Mental Health Services (Name of Section 1)

4 = strongly agree 3 = agree 2 = disagree 1 = strongly disagree

Question #	Name	Question	Label
1	ATMHS1	A person with strong <i>Iman</i> (faith) can get rid of a mental health or psychological problem without the need of professional help.	strong faith can rid of psych prob
2	ATMHS2	I would feel embarrassed to seek mental health or psychological services because of others' negative opinions.	embarrassed to seek psych help
3	ATMHS3	If I believed I was having a psychological or mental health problem, my first step would be to seek professional mental health counseling.	first step seek psych help
4	ATMHS4	The idea of talking about my problems with a mental health professional is a poor way to solve mental health difficulties.	psych help poor way to solve prob
5	ATMHS5	I would rather live with certain mental health or psychological problems rather than going through the process of seeking professional help.	live with psych prob than get psych help
6	ATMHS6	Seeking psychological and mental health services should be the last resort after trying all other options (e.g., self-help, Shaykh, or friend counseling).	psych help is last resort after other options
7	ATMHS7	I would seek professional counseling services only if I was worried or upset for a long period of time.	psych help only if upset for long time
8	ATMHS8	If I were experiencing a serious psychological problem at this point in my life, I would be confident that I could find relief by going to a mental health professional.	If psych prob, confident in psych help
9	ATMHS9	Most mental health and psychological problems can be solved by oneself without the assistance of professionals.	psych problems solved by oneself
10	ATMHS10	Using mental health or psychological services is more difficult than using other medical services because of the shame (societal stigma).	social stigma for psych services
11	ATMHS11	I would be comfortable contacting a mental health care professional or using psychological services in the future.	comfortable to use psych service in future

12	ATMHS12	The Islamic religion encourages Muslims to seek medical care for psychological and mental health difficulties.	Islam encourages to get psych help
13	ATMHS13	I would rather be advised by a religious figure (e.g., a Shaykh) than by a mental health professional, even for serious psychological problems.	rather be advised by religious figure
14	ATMHS14	I admire an individual who is willing to cope with his/her conflicts without resorting to professional mental health care.	admire someone to cope w/o psych help
15	ATMHS15	Mental health and psychological difficulties, like many things, tend to go away on their own.	psych problems go away on their own
16	ATMHS16	Even if I sought professional mental health care, I would also still seek help from a religious figure (e.g., Shaykh) for a psychological difficulty I was facing.	psych help and religious figure help
17	ATMHS17	If I decide to seek mental health or psychological help, I would rather contact a Muslim professional than a professional from another background.	Muslim psych professional

Section II CBMHP Cultural Beliefs About Mental Health Problems (Name of Section II)

0 = False 1 = probably false 2 = probably true 3 = true

Question #	Name	Question	Label
18	CBMHP118	Mental health or psychological problems can be caused by biological factors (e.g., genetic illness inherited from parents or grandparents).	psych prob caused by biological factors
19	CBMHP219	Mental health or psychological problems can be caused by environmental factors (e.g., social stress, war experience, etc.).	psych prob caused by environ factors
20	CBMHP320	Mental health or psychological problems can be caused by <i>Ayn</i> (evil eye).	psych prob caused by <i>ayn</i> (evil eye)
21	CBMHP421	Mental health or psychological problems can be caused by <i>Jinn</i> (spirits).	psych prob caused by <i>Jinn</i> (spirits)
22	CBMHP522	Mental health or psychological problems are the result of <i>Qadar</i> (fate).	psych prob caused by <i>Qadar</i> (fate)
23	CBMHP623	If it is in one's <i>Qadar</i> (fate) to have a mental health or psychological problem, it can still be treated using professional mental health or psychological counseling services.	If it's in one's <i>Qadar</i> for psych prob, treated with psych help
24	CBMHP724	Mental health or psychological problems can be treated using traditional medicines (e.g., black seed)	psych prob helped with traditional prescribed meds (blackseed)

25	CBMHP825	Mental health or psychological problems can be treated using <i>Ruqya</i> (Quranic Recitation).	Psych problems can be treated with <i>Ruqya</i> (Quranic Recitation)
26	CBMHP926	There are certain mental health or psychological problems that CANNOT be treated using mental health or psychological treatment; rather they require <i>Ruqya</i> (Quranic Recitation).	Certain psych prob cannot be treated with psych help, need <i>Ruqya</i>

Section III KFMHS Knowledge about and Familiarity with Formal Mental Health Service

(Name of Section III)

0 = not at all 1 = very little 2 = somewhat 3 = very familiar

Question #	Name	Question	Label
27	KFMHS127	The type of conditions that can be treated by professional mental health or psychological treatment (e.g., mental instability, depression, etc.)?	Types of conditions treated by psych help
28	KFMHS228	The availability of mental health and psychological services in your community (e.g., location, phone #, type of services provided)?	Availability of psych help in community
29	KFMHS329	The Muslim professionals who practice mental health or psychological counseling within your local community?	Muslim Professionals doing psych help

Section IV DIS Demographic Information Sheet

Question #	Name	Question	Label
30	DIS130	How old are you?	age
31	DIS231	Were you born in the U.S.A.?	born in US?
32	DIS332	How many years/months have you lived in the U.S.? Year/s ____ Month/s ____	Number of years in US
33	DIS433	How do you describe your ethnic background (if you are from a mixed background, please select your father's ethnic origin)? ☐ American Indian ☐ Caucasian American ☐ African American ☐ African ☐ Hispanic American ☐ Arab ☐ Iranian ☐ Turkish ☐ South East Asian (Indian, Pakistani, Afghani) ☐ Asian/Pacific Islander (Chinese, Japanese, Korean, Filipino) ☐ Other	Ethnic Background
34	DIS534	What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widowed	Marital Status

35	DIS635	What is your highest (or current) level of education? ☐ Less than high school ☐ High school ☐ Associate degree ☐ Bachelor's degree ☐ Master degree ☐ PhD degree (or other Graduate degree)	Highest level of education
36	DIS736	In the past three years, approximately how many times have you visited a mental health professional (psychiatrist, psychologist, or a social worker) for a mental health or psychological concern? ☐ Never ☐ 1 or 2 times ☐ 3 to 5 times ☐ More than 5 times	How many times gone to psych professional
37	DIS837	Which of the following describes your occupation? Housewife Professional Student Business Owner Office Employee Store Employee Manual Worker Unemployed V45 Other (Please Specify)	Occupation Business Owner Office Employee Store Employee Manual Worker
38	DIS938	To whom would you go first if you were to consider seeking help for a mental health/psychological problem (select only one)?	Other (Please Specify) Who is the FIRST person you'd consider
39	DIS1039	To whom would you go second if you were to consider seeking help for a mental health/psychological problem (select only one different from question # 38)?	Who is the SECOND person you'd consider
40	DIS1140	To whom would you go third if you were to consider seeking help for a mental health/psychological problem (select only one different from question # 38 and 39)?	Who is the THIRD person you'd consider