SOCIAL STIGMA, CULTURAL CONSTRAINTS, OR POOR POLICIES: EXAMINING THE PAKISTANI MUSLIM FEMALE POPULATION IN THE UNITED STATES AND UNEQUAL ACCESS TO PROFESSIONAL MENTAL HEALTH SERVICES[1]

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ABSTRACT:

This study involved the dissemination of a cross-sectional community survey to a convenience sample of 113 Pakistani Muslim women through either an online website or in-person at mosques and Pakistani American organizations. The purpose of this study was to determine whether there are any discrepancies between the rates of diagnosable mental health illnesses and the percentage of people who have sought professional help among Pakistani Muslim women ages 18 and older who are residing in the United States. Then, within this context, the study identified existing barriers that prevent these women from getting equal access to professional mental health services. Emphasis was placed on ascertaining what percentage of the sample population were victims of domestic violence, as intimate partner abuse is pervasive in the Pakistani Muslim community - it is both a stressor and a potential barrier to receiving mental health services. An ultimate assessment is taken of what policy changes can be implemented in order to reduce these barriers. This research project culminated in the first study to date that examined accessibility to mental health services within the Pakistani Muslim female population in the United States.

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This study will examine unequal access to mental health services and how women are disproportionately affected by existing disparities in the health care system.

RESEARCH QUESTION

The purpose of this study is to determine whether there are any discrepancies between the rates of diagnosable mental health illnesses and the percentage of people who have sought professional help among Pakistani Muslim women ages 18 and older who are residing in the United States. Then, within this context, the study aims to identify existing barriers that prevent these women from getting equal access to professional mental health services. Emphasis will be placed on ascertaining what percentage of the sample population is a victim of domestic violence as intimate partner abuse is pervasive in the Pakistani Muslim community - it is both a stressor and a potential barrier to receiving mental health services. An ultimate assessment will be taken of what policy changes can be implemented in order to reduce these barriers.

BACKGROUND INFORMATION

South Asians as a group - including Pakistanis, Indians, Bengalis, and Sri Lankans - are typically viewed by American society as the "model minority".[2] This stereotype upholds South Asians to unrealistically high standards of social success and personal morality. The subsequent homogenizing view of South Asians creates and sustains barriers to services, such as educational or health services. Although there is a possibility that South Asian Americans may internalize such an identity, the greater influence on the hurdles to services arises from the perceptions of the practitioners. Consequently, not enough attention is placed on addressing mental health and emotional problems among South Asian Americans.

Recent studies indicate that as South Asian female adolescents grow older, they are much more likely to engage in acts of self-harm, with the rate of self-harm for women between the ages of 16 and 24 being two-and-a-half times that of Caucasian women

[2] Ng, Jennifer S. et al. "Chapter 4 Contesting the Model Minority and Perpetual Foreigner Stereotypes: A Critical Review of Literature on Asian Americans in Education," Review of Research in Education 31 (2007): 95-130.

and seven times the rate for South Asian men.[3] [4] The act of self-harm in this paper will be defined as "Any deliberate act with a non-fatal outcome that attempts or causes self-harm or that consists of ingesting a substance in excess of its generally recognized or prescribed therapeutic dose".[5]Attempted suicide among young women of South Asian origin has become a major issue in the United Kingdom for instance, where the national mental health target to reduce the suicide rate by 20% by the year 2010 had placed an emphasis on South Asian women.[6] The prevalence of eating-related psychopathology among South Asian women in the UK has also become a major concern, with rates of clinical bulimia being, for example, much higher among South Asian females than Caucasian females.[7] [8] [9]

An increasing amount of research is demonstrating that a subset of the South Asian population, the Pakistani Muslim female population, is particularly vulnerable to psychological illnesses. For instance, one large-scale community led by researcher Francis Creed indicated that Pakistani Muslim women had the highest rates of anxiety and depression among a sample of British South Asian women and a sibling sample in India.[10] Researchers Edmund Sonuga-Barke and Mistry examined the mental health of three generations of Indian Hindu and Pakistani Muslim women using three versions (English, Gujarati and Urdu) of the Hospital Anxiety & Depression scale and found higher levels of depression and anxiety among the Pakistani Muslim women.[11] In another study, researchers Fazil and Cochrane found that British Pakistani women scored higher on severe depression, anxiety and insomnia in comparison to white

[3] Bhugra, Dinesh and Desai, Manisha. "Attempted suicide in South Asian women," Advances in Psychiatric Treatment. 8(6) (2002): 418-423.
[4] Cooper, J. et al. "Self-harm in the UK: differences between South Asians and Whites in rates, characteristics, provision of service and repetition," *Social Psychiatry and Psychiatric Epidemiology*. 41(10) (2006).
[5] Rutter, Michael and Taylor, Eric A. *Child and Adolescent Psychiatry* (Wiley-Blackwell, 2005), 1224.
[6] Jenkins, Rachel. "The Health of the Nation: Recent government policy and legislation," *The Psychiatrist*. 18 (1994): 324-327.
[7] Dolan, B. et al. "Eating behavior and attitudes to weight and shape in British women from three ethnic groups," *British Journal of Psychiatry*. 157 (1990): 523-528.
[8] McCourt, J. and Waller, G. "The influence of sociocultural factors on the eating psychopathology of Asian women in British society," *European Eating Disorders Review*. 4(2) (1996): 73-83.
[9] D. Bhugra and K. Bhui, "Eating disorders in teenagers in east London: a survey," *European Eating Disorders Review*. 11 (2003): 46-57.
[10] Creed, F. et al. "Preliminary study of non-psychotic disorders in people from the Indian subcontinent living in the UK and India," *Acta Psychiatrica Scandinavica*. 99 (1999): 257-260.
[11] Sonuga-Barke, Edmund J. S. and Mistry, M. "The effect of extended family living on the mental health of three generations within two Asian families," *British Journal of Clinical Psychology* 39 (2000): 129-141.

native women using the General Health Questionnaire.[12]

The rate of suicide within the Pakistani Muslim female population is particularly troubling. In Islam, suicide is considered "haraam" or forbidden, and an act that can never be forgiven.[13] Yet, Creed also found rates of suicidal ideas to be substantially more common among Muslim women relative to other Hindu and Sikh South Asian women.[14] These findings suggest that Pakistani Muslim women are subject to major stress factors that are causing them to mentally suffer and consequently, directly violate major religious principles with regard to taking one's own life.

The majority of the stress factors for Pakistani women appear to stem from their South Asian cultural background. One major source of stress is cultural conflict. For instance, one study conducted by researchers McCourt and Waller found that South Asian women from the most traditional homes - and thus the least integrated into British society - had greater prevalence of eating disturbances which was attributed to low levels of acculturation.[15] Culture conflict is particularly prominent for South Asian females versus South Asian males, due to the critical nature of South Asian society towards the behavior of women and whether or not it can be deemed as "good". While the nature of what constitutes as "good" is in fact arbitrary, it mainly rests upon adhering to socially mandated constraints on one's liberties such as practicing abstinence until formal marriage.[16] [17] Other similar stress factors include pressure for arranged marriage, rejection of marriage proposals, gender role expectations, living with an extended family, inter-generational conflicts, racism, social isolation, and marital problems.[18] [19] [20]

While no separate studies were found on the prevalence of

[12] Fazil, Q. and Cochrane, R. "The prevalence of depression in Pakistani women living in the West Midlands," Pakistani Journal of Women's Studies: Alam-e-Nizwan. 10. 1 (2003): 21-30.
[13] "Suicide: according to quran and sunnah," Muttaqun Online, accessed at http://muttaqun.com/suicide.html.
[14] Creed et al., "Preliminary study of non-psychotic disorders," 257-260.
[15] McCourt and Waller, "The influence of sociocultural factors," 73-83.
[16] Bhugra, B. and Jones, P. "Migration and mental illness," *Advances in Psychiatric Treatment*. 7 (2001): 216-223.
[17] Chew-Graham, C. et al. "South Asian women, psychological distress and self-harm: lessons for primary care trusts," *Health and Social Care in the Community*. 10(5) (2002): 339-347.
[18] Hussain, F. and Cochrane, R. "Depression in south asian women living in the UK: a review of the literature with implications for service provision," *Transcultural Psychiatry*. 41. 2 (2004): 253-270.
[19] Ineichen, B. "The influence of religion on the suicide rate: Islam and Hinduism compared," *Mental Health, Religion & Culture*. 1(1) (1998): 31-36.
[20] Thompson, N. and D. Bhugra, "Rates of deliberate self-harm in Asians: Findings and models," *International Review of Psychiatry*. 12(1) (2000): 37-43.

intimate partner abuse among the Pakistani Muslim female population in particular, numerous studies have indicated that another major source of stress for South Asian females in general is intimate partner abuse.[21] [22]Rates of domestic abuse among South Asian women residing in the United States are significantly high, with there apparently being no significant deviation between arranged and non-arranged marriages.[23] According to a recent cross-sectional survey disseminated among South Asian women living in Boston, nearly 35% of the participants claimed that they had experienced physical abuse with their husbands and 32.5% stated that the abuse was as recent as in the past year.[24] In comparison, 24.8% of all American women have reported to be victims of physical abuse or rape from their spouses.[25] It may be tempting to deduce that domestic violence can be designated as a "cultural" issue due to the speciously significant difference of approximately 10 percent for the rates of domestic violence between South Asian women and American women overall. However, upon considering that numerous incidences of domestic abuse go unreported and that the percentage for South Asians was ascertained from a small subsample that voluntarily admitted to being victims of intimate partner abuse, such a generalization would clearly be unsubstantiated.

Research has consistently shown that battered women are at a much higher risk than non-battered women of developing psychological illnesses later on in life. For instance, post-traumatic stress disorder, anxiety, and insomnia are much more prevalent among battered women than non-battered women, with studies indicating that victims of intimate partner abuse are more likely to suffer from post-traumatic disorder and depression even compared to victims of childhood sexual assault.[26] [27]

Unfortunately, there are numerous barriers that currently

[21] Hicks, M.H.R. and Bhugra, D. "Perceived causes of suicide attempts by UK South Asian women," *American Journal of Orthopsychiatry*. 27(4) (2003): 455–462.
[22] Silva, C. et al. "Symptoms of post-traumatic stress disorder in abused women in a primary care setting," *Journal of Womens Health*. 6 (1997): 543-52.
[23] Abraham, M. "Ethnicity, gender, and marital violence: south asian women's organizations in the united states," *Gender & Society*. 9(4) (1995): 450-468.
[24] Dasgupta, S.D. "Charting the course: an overview of domestic violence in the south asian community in the United States," *Journal of Social Distress and the Homeless*. 9. 3 (2000): 173-185.
[25] Tjaden, P. and Theonnes, N. "Full report of the prevalence, incidence, and consequences of violence against women." A special report prepared at the request of the Department of Justice. Washington, DC: Government Printing Office, 2000.
[26] Golding, J.M, "Intimate partner violence as a risk factor for mental disorders: a meta-analysis," *Journal of Family Violence*. 14 (1999): 99-132.
[27] Ratner, P.A. "The incidence of wife abuse and mental health status in abused wives in Edmonton, Alberta," *Canadian Journal of Public Health*. 84 (1993): 246-49.

prevent South Asian women in particular from accessing professional mental health services. For the purposes of this proposal, "professional" mental service providers would include psychiatrists, clinical psychologists, clinical social workers, marriage and family therapists, and psychiatric nurse specialists who meet the designation criteria set by the US Department of Health and Human Services. The barriers can be divided into two main categories: first, the ability and willingness to seek help, and second, receiving effective treatment. For instance, while domestic violence would clearly cause significant stress to South Asian women, the controlling husband can also act as a barrier to seeking help.

Another potential obstacle for South Asian women would be the lack of permission or approval from extended family members. It is a common practice among South Asians to live with multiple generations in the same household, and this often compels these women to take their family members' views and opinions into consideration before making decisions.[28] Furthermore, family members might be offended by even the mention of seeking outside formal help as talking about personal or intimate problems with someone outside the family is considered a cultural taboo.[29] [30] The need to protect one's "izzat," or honor, constructs another barrier for South Asian females; the burden of "izzat" is disproportionately placed on women who might fear that seeking professional mental health services would ruin both their individual and family's reputations.[31] [32]

Fear of being stereotyped by mental health professionals is another issue that prevents South Asian women from seeking help. Researcher Carolyn Chew-Graham found that South Asian women felt that they would be judged by the service providers who were usually white, and, in their eyes, had fixed views about the Asian

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[28] Ibrahim, F.A. and Ohnishi, H. "Asian American identity development: a culture specific model for South Asian Americans," *Journal of Multicultural Counseling and Development*. 25 (1997): 34–51.

[29] Randhawa, G. and Stein, S. "An exploratory study examining attitudes toward mental health and mental health services among young south asians in the United Kingdom," *Journal of Muslim Mental Health*. 2(1) (2007): 21-37.

[30] Tabassum, R. et al. "Attitudes towards mental health in an urban pakistani community in the united kingdom," *International Journal of Social Psychiatry*. 46. (2000): 170-181.

[31] Cinnirella, M. and Loewenthal, K.M. "Religious and ethnic group influences on beliefs about mental illness: A qualitative interview study," *British Journal of Medical Psychology*. 72 (1999): 505-524.

[32] Gilbert, P. et al. "A focus group exploration of the impact of izzat, shame, subordination and entrapment on mental health and service use in South Asian women living in Derby," *Mental Health, Religion and Culture*. 7. 2. (2004): 109–130

community.[33] Another major barrier that prevents South Asian women from seeking professional mental health services is the fact that their somatization of psychological distress hinders their primary physicians' recognition of any mental illnesses they may be suffering from.[34] [35] For instance, South Asians who claimed that they were suffering from a "sinking heart" were in fact exhibiting some of the main symptoms that are associated with the Western concept of "depression". [36] [37] Even though South Asian women have relatively high consultation rates with their primary physicians in comparison to other populations, they are not being adequately treated for their underlying mental conditions as only their physical symptoms end up being addressed.[38] [39] Subsequently, South Asians are less likely than their Caucasian counterparts to receive mental health referrals.

Some Pakistani Muslim women might claim to already be receiving help for their psychological distress through avenues other than professional mental health services, yet current statistics of self-harm and suicide among this population make it glaringly obvious that these alternative measures are not sufficient. Some of these methods might include speaking with a family member or friend, seeking the advice of a religious leader in the community, or making an appointment with a "hakeem," someone who practices herbal medicine.[40] [41] Researchers Shaheen Sheikh and Adrian Furnham found that among all South Asians, Muslims were the least likely to seek help from a mental health professional, which could have possibly been due to their preference of utilizing Islamic prayer to deal with mental distress.

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[33] Chew-Graham, C., "South Asian women, psychological distress and self-harm," *Health and Social Care in the Community*, 339-347.

[34] Department of Health. Ethnic differences in the context and experience of psychiatric illness: a qualitative analysis. United Kingdom: The Stationary Office, 2002.

[35] Wilson, M. and MacCarthy, B. "GP consultation as a factor in the low rate of mental health service use by Asians," *Psychological Medicine*. 24 (1994): 113–119.

[36] Fenton, S. and Sadiq-Sangster, A., "Culture, relativism and the expression of mental distress: South Asian women in Britain," *Sociology of Health and Illness*. 18 (1996): 66-85.

[37] Krause, I.B. "Sinking heart: A Punjabi communication of distress," *Social Science & Medicine*. 29(4) (1989): 563–575.

[38] Gillam, S.J. et al. "Ethnic differences in consultation rates in general practice," *British Medical Journal*. 299 (1989): 953-957.

[39] Husain, M.I. et al. "Self-harm in british south asian women: psychosocial correlates and strategies for prevention," *Annals of General Psychiatry*. 5(7) (2006).

[40] Ali, Osman M. et al. "The Imam's role in meeting the counseling needs of Muslim communities in the United States," *Psychiatric Services*. 56 (2005): 202-205.

[41] Sheikh, Shaheen and Furnham, Adrian. "A cross-cultural study of mental health beliefs and attitudes towards seeking professional help," *Social Psychiatry and Psychiatric Epidemiology*. 35 (2000): 326-334.

Even if South Asian women eventually decide to seek the help of a mental health professional, they are also less likely than their Caucasian peers to return for follow-up treatment. [42] There are several underlying reasons for this phenomenon that involves barriers to the actual receipt of effective mental health treatment. First, extended family members often insist in accompanying the individual with the mental illness to the psychiatric appointments. Not only does the presence of the family members obscure full disclosure of the individual's problems, but it also compromises patient confidentiality.[43] Another prominent barrier is language mismatch.[44] According to a recent US Census, English is not spoken in 16% of Pakistani households and 32% of Pakistanis have limited English proficiency.[45]Yet, studies have indicated that even when translators were present at appointments with mental health professionals, the problem of expressing and discussing subtle mental health issues persisted due to cultural variations in the interpretation of psychological distress symptoms.[46] [47]

A lack of comprehension of the patient's cultural values is another underlying factor that prevents South Asian women from receiving effective psychological treatment. Mental health professionals adhere to certain assumptions such as what constitutes proper parenting styles, gender roles, and normal family life that may not be shared with the patient.[48] A clash of cultural values becomes particularly evident when South Asian women feel uncomfortable going to a psychiatric appointment that employs Western practices such as psychotherapy, which places emphasis on the individual self, and consequently, goes against South Asian values of putting the family's wishes and needs before one's own.[49] [50]

Finally, another potential obstacle that might prevent South Asian women from receiving effective mental health treatment is resistance or reluctance to opening up with a mental health

[42] Cooper et al. "Self-harm in the UK," 782-788.
[43] Hussain and Cochrane, "Depression in south asian women," 253-270.
[44] Minnis, H. et al. "Cultural and language mismatch: clinical complications," *Clinical Child Psychology and Psychiatry*. 8(2) (2003): 179-186.
[45] Reeves, Terrance J. and Bennette, Claudette E. "We the People: Asians in the United States." *Census 2000 Special Reports*, CENSR-17 (Dec. 2004). Accessed at http://www.census.gov/prod/2004pubs/censr-17.pdf
[46] Green, G. et al. "Equity and culture: Is the NHS failing to meet the needs of mentally distressed Chinese origin women?" *Journal of Health Services Research and Policy*. (2002).
[47] Hussain and Cochrane, "Depression in South Asian women," 285-311.
[48] Minnis et al. "Cultural and language mismatch," 179-186.
[49] Green, G. "Equity and culture."
[50] Hussain and Cochrane, "Depression in South Asian women," 285-311.

professional of a different ethnic background.[51] For instance, researchers Fenton and Sadiq-Sangster found that South Asian women were more open to discussing their mental distress when talking to researchers whom they say as "one of us".[52] In the US, it has been shown that Asian American psychiatrists exhibit a different style of mental health assessment of their Asian American patients in comparison to non-Asian American psychiatrists.[53] A psychiatrist's style determines how he or she approaches the achievement of specific clinical tasks or goals, such as for instance, by offering direct advice to patients. The difference in styles between Asian American and non-Asian American psychiatrists might explain why Asians who attended ethnicity-specific mental health programs in the US had a higher return rate and stayed in treatment longer than those using mainstream services.[54]

South Asians mainly consist of Pakistanis, Indians, Bengalis, and Sri Lankans.[55] Although the aforementioned barriers to accessing professional mental health services are applicable to South Asian women as a whole, it is still important to focus on population subgroups in mental health studies - Pakistani Muslims in this case. For instance, through a large-scale community survey, researcher James Nazroo found that South Asian women as one group had lower rates of anxiety and depression than their Caucasian peers.[56] However, when analyses were conducted of the individual South Asian subgroups, Nazroo noticed subtle differences in the prevalence rates of the mental illnesses. Indian and Bengali women had in fact the lowest rates of anxiety and depression, while Pakistani women had similar rates as Caucasian women. These results highlighted the significance of distinguishing between subgroups of the South Asian population in mental health studies since there are indeed major differences of language, religion, and economic circumstances among the subgroups; yet mental health studies continue to clump all South Asians or even Asians together.

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[51] Conrad, M.M. and Pacquiao, D.F. "Manifestation, attribution, and coping with depression among asian indians from the perspectives of health care practitioners," *Journal of Transcultural Nursing*. 16(1) (2005): 32-40.

[52] Fenton and Sadiq-Sangster, "Culture, relativism and the expression of mental distress: South Asian women in Britain," *Sociology of Health and Illness*. 18 (1996): 66-85.

[53] Lu, Y.E. Underutilization of mental health services by Asian American clients: The impact of language and culture in clinical assessment and intervention. *Psychotherapy in Private Practice*. 15 (1996): 43-61.

[54] Takauchi, D.T. et al. "Return rates and outcomes from ethnicity-specific mental health programs in Los Angeles," *American Journal of Public Health*. 85. (1995): 638-643.

[55] Leonard, Karen I. *The South Asian Americans*. (Greenwood Press: 1997).

[56] Nazroo, James Y. Ethnicity and mental health: findings from a national community survey. (London: Policy Studies Institute, 1997).

This study ultimately explored different policy changes that can be implemented in order to ensure that Pakistani Muslim females in distress are getting professional mental health treatment by striking a balance between enabling Pakistani Muslims to become more aware about mental health services and incorporating unconventional but more culturally sensitive practices such as prayer into treatment. For instance, the UK has already initiated the use of "hakeems" in the clinical setting for Pakistani Muslims, but we do not know how applicable this would be for Pakistani Muslims residing in the United States.[57] Meanwhile, mounting evidence is denoting the significance of including a discussion of cultural and religious issues in the mental health professional's case notes.[58]

One alternative to psychotherapy for Pakistani women could be family therapy. Another alternative method of psychiatric treatment relies on allowing the counselor and patient to explore their values and beliefs together. Not only would this increase the patient's trust of the counselor, but it would also prevent the counselor from judging the patient based on stereotypes generated through book knowledge or personal experience with only a few Pakistani Muslims.[59]

Several mechanisms for enabling Pakistani women to view professional mental health services in a more positive light have been identified. In Carolyn Chew-Graham's study, the South Asian female participants themselves gave some advice on how to increase South Asian women's access to mental health services. These suggestions included availability of counselors of the same background as them, public presentations on what exactly is meant by the terms "psychology", "counseling", or "mental health" and the dissemination of translated informational brochures among the South Asian community.[60] Surprisingly though, only one published study to date has explored the effects of an educational pamphlet written in Urdu on depression and suicidal behavior on the willingness of South Asian women to seek help for mental distress. The results of this study demonstrated that the women who read the pamphlet were more likely to seek help, and subsequently, illustrated the significant

[57] "Ethnic differences in the context and experience of psychiatric illness: a qualitative analysis." Department of Health. (United Kingdom: The Stationary Office, 2002).
[58] Altareb, B.Y. "Islamic spirituality in America: A middle path to unity," *Counseling and Values*. 41 (1996): 29–38.
[59] Ibrahim and Ohnishi, "Asian American identity development," 34–51.
[60] Chew-Graham et al., "South Asian women, psychological distress and self-harm," 339-347.

benefits that simply raising awareness could have.[61]

Most studies on South Asian women and mental health have been conducted in the UK. In spite of the fact that a few studies conducted in the US are now indicating similar rates of psychological illnesses among South Asian women, the research conducted in the UK cannot be directly applied to Pakistani American women due to a couple of reasons. First, there are major differences in immigration patterns between South Asians immigrants in the UK and those residing in the US.[62] Second, as aforementioned, studies that group all South Asians or Asians together do an inadequate job of identifying specific barriers to accessing professional mental health services that are particularly relevant to Pakistani Americans.

Even though Pakistanis, Indians, Bengalis, and Sri Lankans are all considered South Asians, the differences in religion, for instance, result in substantial variations of values. Pakistani Americans represent the eighth largest group of Asian Americans in the United States.[63] This study will assess the mental health needs of this growing population to ensure that they are not being neglected from mainstream psychological services and will strive to identify various policy changes that can be pursued to eliminate any potential obstacles. This research project culminated in the first mental health study to date focusing on the Pakistani Muslim female population in the US.

EXPERIMENTAL PROCEDURE

This study involved collecting survey data from a convenience sampling of 113 women. The survey consisted of questions on demographics, identification of potential stress factors that especially pertain to the Pakistani Muslim female population, mental state, recent (if any) history of seeking professional mental health services, identification of potential barriers to seeking and receiving effective professional mental health treatment, and assessment of what steps can be taken to increase Pakistani Muslim women's access to mental health services. The questions assessing the participant's mental state and whether or not she is a victim of domestic violence were based on previous questionnaires circulated by the New York State Department of Health. The rest of the questions in the survey were developed after extensive research. An

[61] Bhugra and Hicks, "Effect of an educational pamphlet," 827-9.
[62] Patel, S.P. and Gaw, A.C. "Suicide among immigrants from the Indian subcontinent: a review," *Psychiatric Services*. 47 (1996): 517-521.
[63] "We the People: Asians in the United States." *Census 2000 Special Reports.*

Urdu-translated version of the survey was also made available to study participants.

Print survey copies were directly distributed at Masjid Noor, the Islamic Association of Long Island, the Muslim Center of New York and at the Domestic Harmony Foundation office, which is where they were completed. The online surveys were disseminated through the help of Counselors Helping (South) Asians, Inc.

When meeting a woman, the study coordinator initially asked her if she was Pakistani, Muslim, at least 18 years old, and whether she currently feels that she is in a safe position to complete the survey. The print surveys were only given out in all-female classes held at the different organizations. Subsequently, a woman's husband was not present while she was completing the survey. However, to ensure the safety of the study participants, the study coordinator informed the women that the survey contains sensitive questions about family relationships and that she should in no case attempt to participate in the study if doing so would increase the risk of discovery by an abusive partner. She was also asked if she felt safe with completing the survey even if another family member would happen to be nearby. The study coordinator then sat down and went through the verbal consent process with the women, assuring them that all information is confidential and that participation is completely voluntary. They should not hesitate to withdraw early from the study at any point if they feel uncomfortable. After that, the study participants were asked if they prefer an English or Urdu survey so they could provide information in the language that they felt most comfortable in.

Upon completion of the survey, the study coordinator provided the participant with a Mental Health Resources for South Asian Women document and advised the woman to keep it in a secure place. If it became apparent that possession of such a document would jeopardize the study participant, a hard copy was not provided and verbal descriptions of the services and respective locations were given instead. For the online survey, the Mental Health Resources for South Asian Women document was displayed on the last page and should have been viewed by the participant before she could click on the link to finish the survey.

DATA ANALYSIS

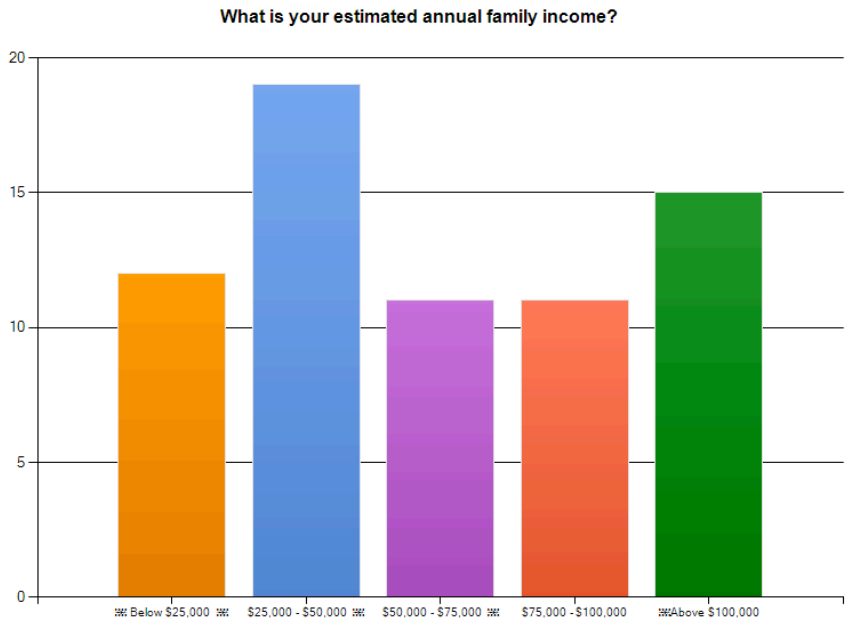
The scoring procedures for the survey questions on mental health and domestic violence were based on previously established guidelines. If the participant answered "yes" to any of the questions

pertaining to domestic violence, there is a high chance that she is a victim.[64] The survey questions assessing the mental state of the study participants emphasized depression and anxiety. One point was given for checking "None of the time", 2 points were given for checking "A little of the time", 3 points were given for checking "Some of the time", 4 points were given for checking "Most of the time' and 5 points were given for checking "All of the time". The sum of the points from all of these questions were used to gauge the level of psychological distress due to depression and anxiety. A score of less than 15 indicated minimal distress; a score of 16-30 indicated moderate distress, and a score of over 30 indicated a high level of distress.[65] This study relied on self-reported psychological distress since other available measures required the presence of clinical psychologists or psychiatrists.

For the rest of the survey questions, a score of 0 was given to the response "Not At All", 1 for the responses "Somewhat Relevant" or "Somewhat Important", 2 for the responses "Relevant" or "Important", and 3 for the responses "Very Relevant" or "Very Important".

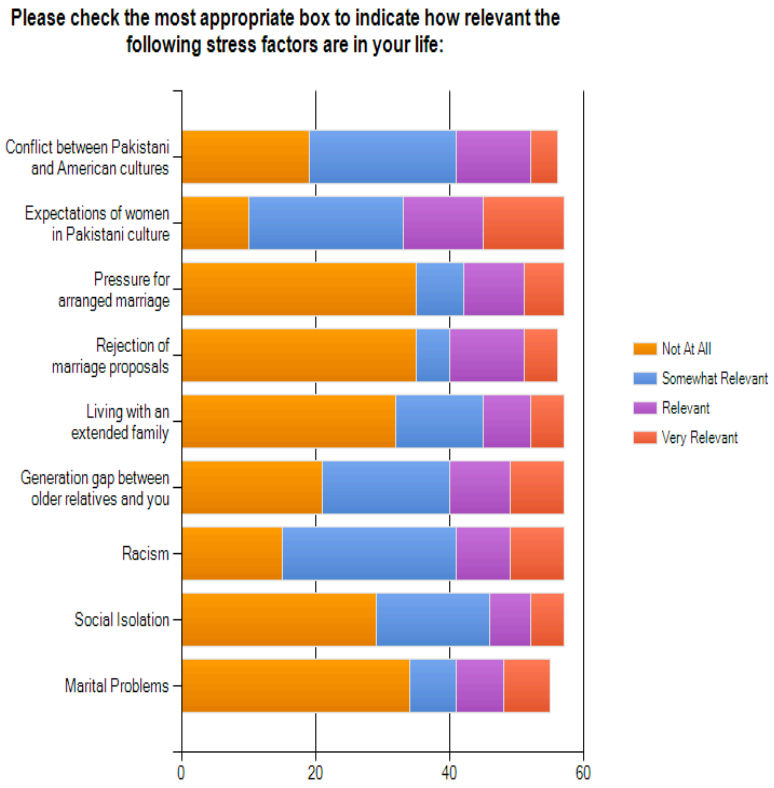
Ultimately 113 surveys were collected. Both married and unmarried women participated in this study, and consequently, certain stress factors might be disproportionately relevant for a given age group. All graphical depictions of the study results only represent participants that answered the particular question under consideration.

Figure 1



As seen in Figure 1, the study participants came from households with a wide range of annual incomes. This was an ideal outcome since socioeconomic class could have potentially acted as a confounding variable when ascertaining barriers to seeking or continuing professional mental health services. Most of the participants primarily spoke Urdu and were not born in the United States (see Charts 1 and 2 in the Appendix). Over 72% of the participants held at least a Bachelor's Degree (see Chart 3 in the Appendix).

Figure 2



Stress factors were self-identified by research participants on a scale of 0 to 3, with 3 being the highest value for relevance. According to Figure 2, gender role expectations were by far the greatest self-identified stress factor for the study participants, with an average rating of 1.46. Racism, a generation gap between older relatives and the participants, and conflict between Pakistani and American cultures fell closely behind, with average rates of 1.16, 1.07, and 1.00 respectively. However, factors such as marital problems or living with an extended family did not seem to be a major source of distress for married study participants as was originally expected for members of a collectivist culture, with average rates of only .62 and .60. Pressure for arranged marriage and rejection of marriage

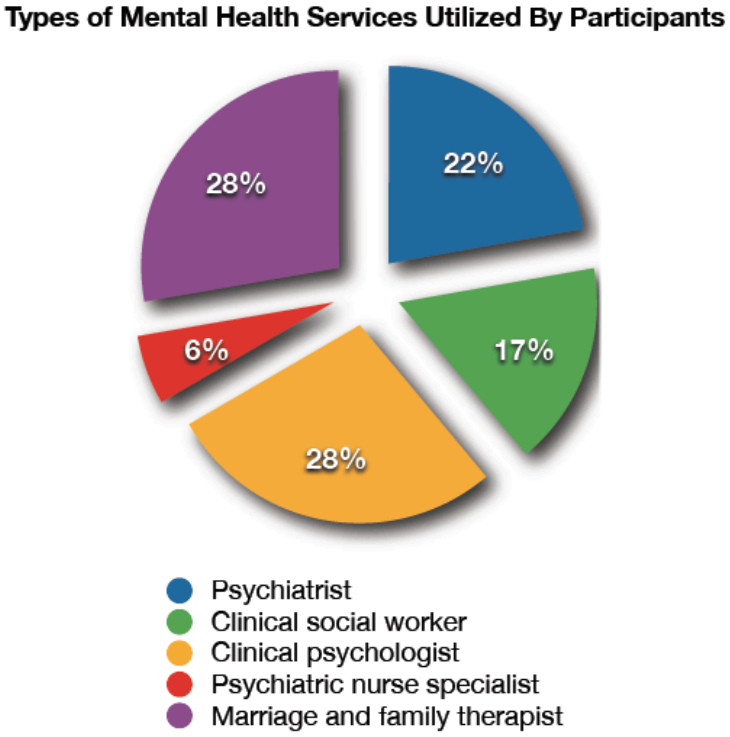
proposals might not appear to be significant stress factors when taking all study participants into consideration, with an average rating of .75 each. Yet, when focusing on participants between the ages of 18-25, who were predominantly single, the average rating greatly increased to 1.12 and 1.06, respectively.

48.44% of all participants were identified as suffering from moderate or high levels of depression/anxiety. From that group, only 35.48% of the women self-reported to having sought some sort of professional mental help. In addition, out of the participants who were suffering from moderate or high levels of depression/anxiety but had no history of utilizing professional mental health services, 80% of the women self-reported to have never even thought about getting professional mental health treatment.

The percentage of participants who self-identified as being victims of domestic violence was approximately 16.5%, which is actually below the US national average of 24.8%. However, 63.6% of the participants who were victims of domestic violence identified as suffering from moderate or high levels of depression/anxiety, in contrast to the prior determined percentage of 48.44% for all participants.

The majority of participants who did in fact utilize professional mental health services saw either a marriage and family therapist or a clinical psychologist, as shown below in Figure 3.

Figure 3



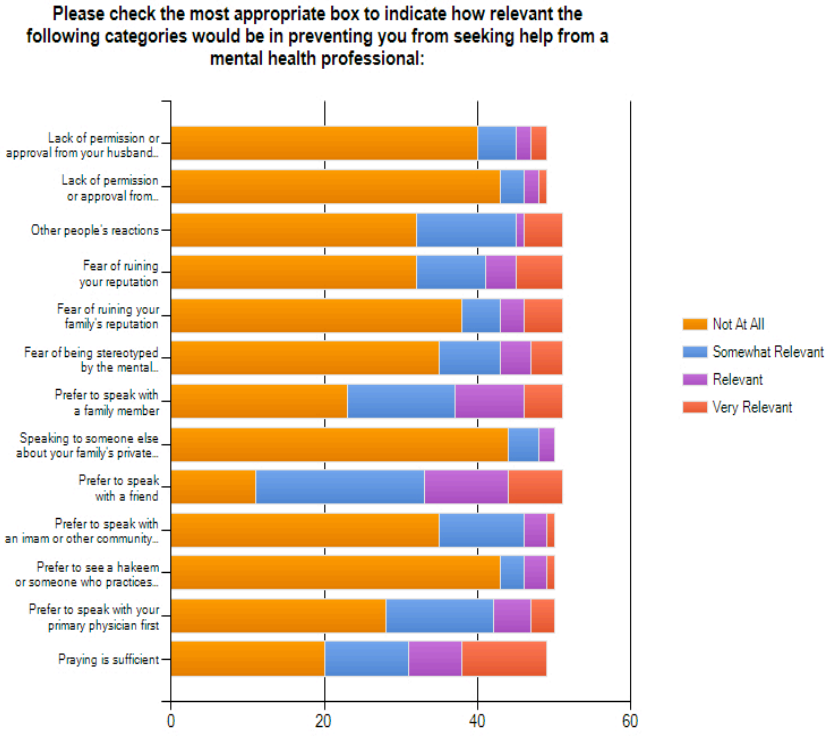


Figure 4

Barriers to seeking professional mental health services specifically pertaining to the Pakistani female population in the UK as identified by past studies did not seem to be as relevant for the Pakistani female population in the US, on a scale of 0 to 3. According to Figure 4, the vast majority of participants preferred to speak with a friend before deciding to go see a mental health professional, with an average rating of 1.27. The belief that praying is sufficient was a close second barrier to seeking mental health services, with an average rating of 1.18. Yet, factors such as preferring to see a "hakeem" or someone who practices herbal medicine, a lack of permission or approval from extended family members, and the belief that speaking to someone else about your family's private problems is "un-Islamic", had minimal relevance on the participants' lives, with average ratings of only .24, .20, and .16 respectively.

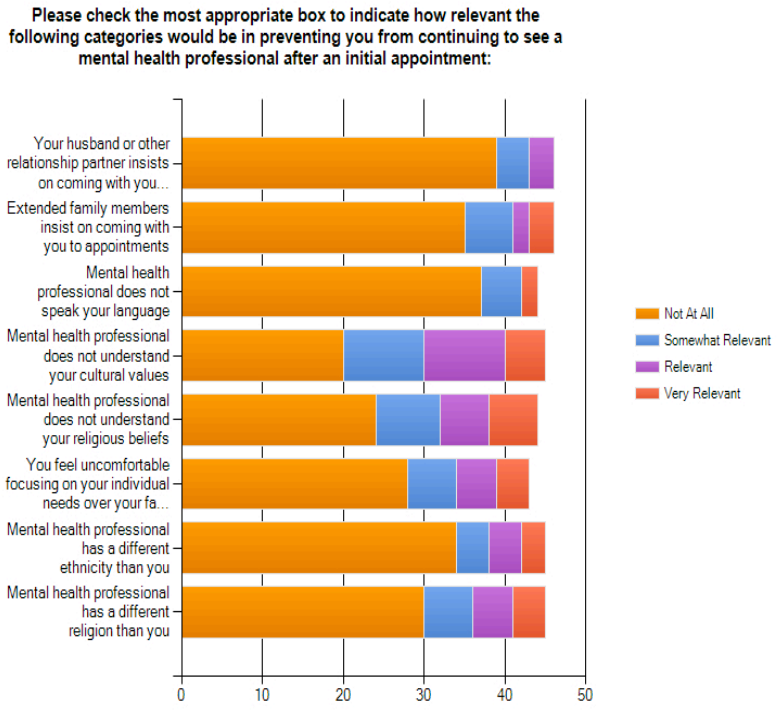


Figure 5

As seen in Figure 5, a mental heath professional's lack of understanding of Pakistani cultural values and religious beliefs contributed the most to the participants' resistance towards continuing professional mental health treatment, with average ratings of 1.00 and .86. One participant observed that "my little sister went through the 'system' a lot and my parents didn't understand her problems and depression. There was a language/culture barrier. They even gave us a Muslim psychiatrist but she was horrible." However,

barriers to continuing treatment that were prevalent among Pakistani women in studies conducted in the UK, such as a husband who insists on coming to appointments with the woman or a mental health professional that does not speak the same language as the woman had minimal relevance for these participants, with average ratings of only .22 and .25.

Subsequently, when asked to identify activities that would help make other Pakistani Muslim women more open to seeking professional mental health services on a scale of 0 to 3, with 3 being Very Important, choices such as an option of family therapy instead of individual therapy and free access to a translator during appointments did not receive the highest ratings. Rather, choices that were deemed to be most important by the participants were an availability of mental health professionals who are more sensitive to Pakistani cultural values, having an initial discussion with your mental health professional in which both of you explore your values together, and presentations in the Pakistani community on what exactly is meant by the terms "mental health", "psychology", "counseling" and "therapy", with average ratings of 2.11, 2.13, and 2.18 respectively.

Yet, simply finding a psychiatrist with the same ethnicity did not seem to solve the problem of a clash of cultural values for the participants. As one participant wrote, "I would personally not want to talk with a Pakistani psychiatrist for the fear of who she or he may know that I know. I hate to say this about my own people, but we gossip a lot and there's a def lack of ethics amongst our community." Another participant similarly commented, "I am a Pakistani Muslim Woman who happens to be a psychiatrist and I would like to emphasize that some patients avoid me because I'm too similar and they are afraid of mingling in social circles." Membership to tightly knit ethnic communities may in fact serve as a greater barrier to accessing health services that involve the discussion of sensitive and private matters, than the lack of culturally competent clinicians. Whereas psychiatrists can be mandated to attend cultural sensitivity trainings, it would not be as simple to guarantee confidentiality within a relatively small network of social relations.

CONCLUSION

Stress factors especially pertaining to the Pakistani American population became more or less apparent depending on what ages were being focused on. Barriers to seeking and continuing professional mental health services clearly cannot be directly applied from studies conducted in the UK Pakistani population on Pakistani women residing in the United States. One potential reason for this

discrepancy could be the difference in immigration patterns, with different provinces in Pakistan having greater representation in the UK than in the US, and consequently, differences in the educational background of the two populations. These findings highlight the need for more mental health studies specifically on the Pakistani American population.

As evident from the experimental results, Pakistani women suffering from moderate or high distress are not seeking the help they need. The fact that the vast majority of women, suffering from moderate or high levels of depression/anxiety and no history of utilizing professional mental heath services, did not even consider getting treatment is truly alarming. This is the most vulnerable population that should serve as the target of considerable outreach efforts. Merely hiring more Pakistani psychiatrists is not going to resolve the issue of Pakistani women being hesitant to seeing a mental health professional. Rather, providing cultural competency training to mental health professionals as well as allocating funding for community presentations and campaigns on discussing mental health issues might serve as better tools of increasing accessibility to mental health services within the Pakistani Muslim female population in the US.

The percentage of participants who self-identified as victims of domestic violence was in fact lower than the national average rate of domestic violence in the US. In addition to an inherent sampling error, the likelihood that study participants might not all have been equally honest in their responses due to the sensitive nature of the questions could have contributed to this discrepancy in the rates. Yet, as expected, victims of domestic violence were more likely to suffer from moderate or high distress. While some domestic violence agencies have already recognized the need for incorporating emotional support and other counseling services into their services, there is currently unfortunately not enough funding specifically allocated for this need.

This study helped elucidate distinctions between the Pakistani female populations in the United States and the United Kingdom in the types of barriers these women face when striving to access professional mental health services. The survey responses provided insight into the nature of the stigma against seeing a mental health professional among Pakistani Americans, and confirmed the notions that many Pakistani women are going untreated and become more susceptible to becoming inflicted by moderate or high levels of anxiety/depression if they are victims of domestic violence. However, in order to ascertain what specific guidelines the cultural competency training for mental health professionals should entail and better assess the types of campaigns and presentations that should be

conducted within the Pakistani female population in the US, more research still needs to be conducted.

APPENDIX

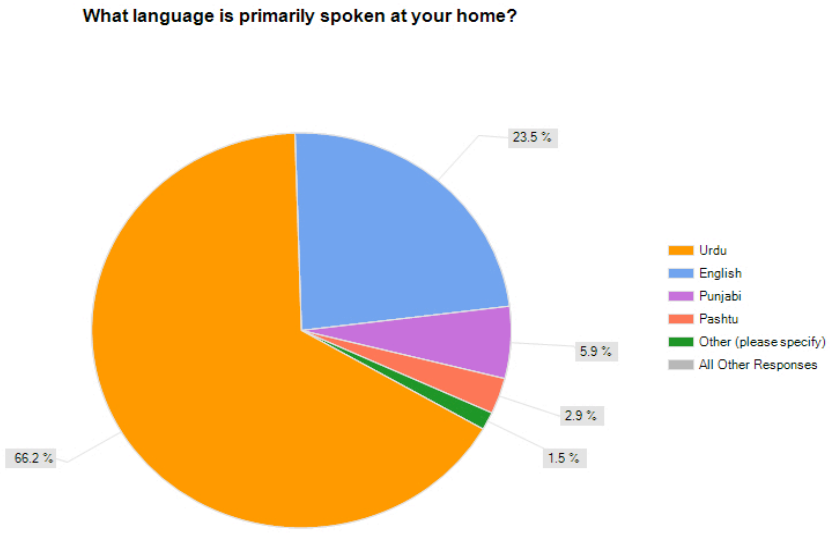


Chart 1

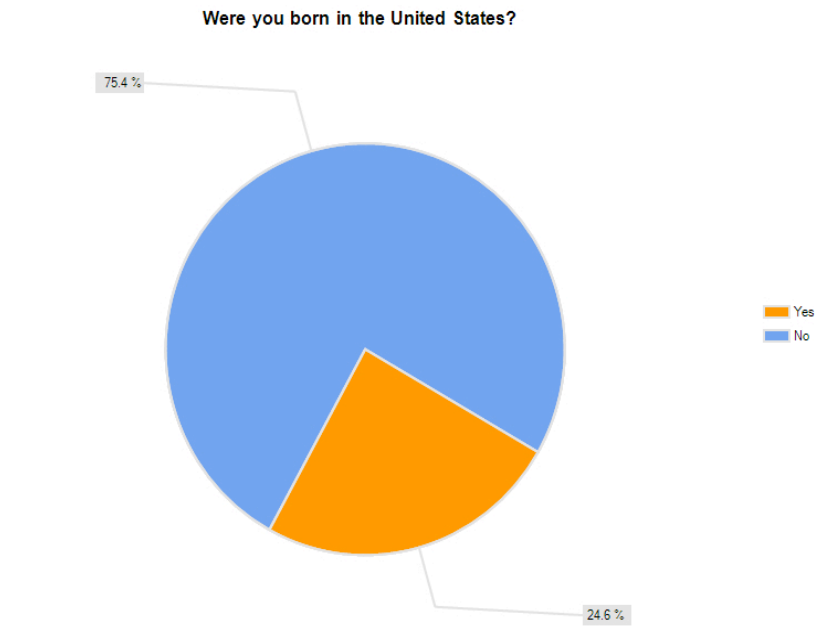


Chart 2

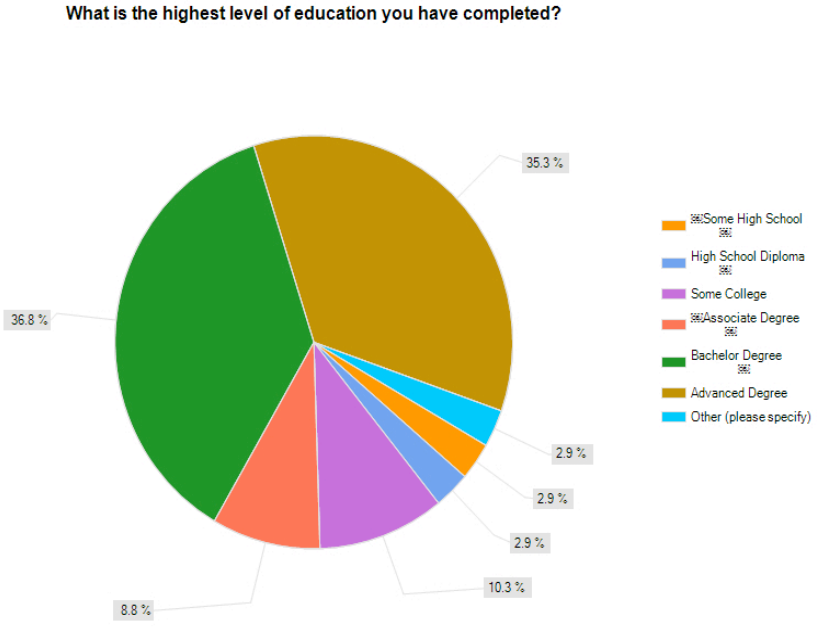


Chart 3