ABSTRACT

SHAMSHAD, AHMED. Mental health of Muslims living in a southeastern city in the United States. (Under the direction of Edwin R. Gerler, Jr.)

This study sought to determine if differences exist in the level of anxiety and depression in Muslims from Arab and non-Arab countries living in America. Beck (1967) proposed that the essential component of a depressive disorder is a negative cognitive set; that is, the tendency to view the self, the future, and the world in a dysfunctional manner. In this study, depression was measured using Beck's Depression Inventory. The results show that Muslims from Arab countries scored higher in depression relative to Muslims from non-Arab countries. According to Spielberger (1966, p. 41,) trait anxiety refers to relatively stable individual differences in anxiety-proneness; that is, differences between people in the tendency to perceive a stressful situation as dangerous or threatening, and to respond to such situations with elevations in the intensity of their state anxiety (S-Anxiety) reactions. This study found that Muslims from Arab and non-Arab countries differed significantly from Muslims form Arab countries for depression, state and trait anxiety. National and international circumstances and events may help account for these differences. Probable origins and possible diagnosis for depression and anxiety in Muslims who immigrated to America are discussed here.

MENTAL HEALTH OF MUSLIMS LIVING IN A SOUTHEASTERN CITY IN THE
UNITED STATES

by

SHAMSHAD AHMED

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APPROVED BY:

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Chair of Advisory Committee

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DEDICATION

This work is dedicated to my beloved father, respected mother, and my loving family. They

have been my constant support during this incredible journey.

BIOGRAPHY

Shamshad Ahmed grew up in India and traveled to the United States in 2001 to complete her doctorate. Shamshad is currently living in Raleigh, NC with her husband Nasar Ahmed, and her daughter Nausheen Nazia. Her son Naveed Ahmed is a graduate student at the University of Tennessee-Knoxville. Shamshad Ahmed graduated from the University of Madras, India in 1981 with a Master's Degree in Psychology. She then completed her Master's Degree in Philosophy in 1982.

Shamshad worked as a Senior Lecturer at the Justice Basheer Ahmed Sayeed Women's College in India. She taught undergraduate and graduate psychology students for fourteen years. She was also the coordinator for the Inclusive Education Program at the institution where she worked. Shamshad was instrumental in starting a center for mentally challenged children. She later served as the Counselor at the Justice Basheer Ahmed Sayeed Women's College. Shamshad also served as a faculty member in the distance education program in India. During her tenure as a teacher, she attended several national and international conferences and workshops.

Shamshad's first love is teaching, especially at the graduate level. She served as a Teaching Assistant to two faculty members in the Department of Counselor Education at North Carolina State University, and she also served as an intern at the Counseling Center at North Carolina State University. Shamshad conducted several workshops such as 'Time Management', 'Study Skills', 'Assertiveness', and 'Overcoming Shyness' for the students at North Carolina State University.

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CHAPTER 1

INTRODUCTION

What is Islam, the Religion, and Who are the Muslims?

The tenants of Islam promote the principles of peace, harmony, respect, and love.

Muslims strive to cultivate these principles in their personal and professional lives. Two of

the most important tenants of Islam are valuing human life, and cherishing and promoting

peace. The term "Islam" means "peace", and the term "Muslim" means "one who practices

peace." In addition, "Islam" means "submission to the will of God." Islam teaches belief in

only one God, the Day of Judgment, and in the individual accountability for actions. Allah in

Arabic, the language of the Koran, means "God," "the Omnipotent," "the Compassionate,"

and "the Merciful." These titles can be found in numerous verses in the Koran (Abdalati,

1994, p. 3).

Abdalati (2003, p. 7) describes Islam as compounded in the classical books of

theology and law, and as a religion that does not bear a message of violence. In fact, salaam

(peace and tranquility) is a central tenet of Islamic belief, and amn and aman (safety,

security, or repose) are considered profound divine blessings to be cherished and vigilantly

pursued. The Koran persistently speaks of the condition or state of peace as an inherent

moral good. The absence of peace is identified in the Koran as a largely negative condition.

It is variously described as a trial and tribulation, as a curse or punishment, or sometimes as a

necessary evil. However, the absence of peace is never in and of itself a positive or desirable

condition.

Abdalati (2003, p. 9) states very clearly that the Koran teaches that the act of

destroying or spreading ruin on this earth is one of the gravest sins possible. *Fasad fi al-ard,*

which means to corrupt the earth by destroying the beauty of creation, is considered the ultimate act of blasphemy against God. Those who corrupt the Earth by destroying lives, property, and nature are designated *mufsidun* – evildoers who, in effect, wage war against God by dismantling the very fabric of existence. The Koran discourse on the corrupters of life inspired an extensive juristic debate on extremists groups in Islamic history, such as Khawarji, who were infamous for their terror-inducing tactics, and for waging indiscriminate attacks against non-combatants. Classical Muslim jurists reacted sharply to these groups by considering them to be corrupters on the Earth and the enemies of humankind.

Obviously, this juristic discourse is relevant to modern-day terrorism. According to this tradition, Bin Laden would be considered a *muharib* (literally, those who fight society) and, therefore, would be considered an enemy of humankind. However, even beyond the problem of Bin Laden and terrorism, this discourse indicates an aversion in the Islamic tradition to certain emotional states or conditions that might be forced on people. Forcing people to live in a state of fear or insecurity is considered reprehensible. Certain types of conduct are deemed unworthy of a Muslim and offensive to God. Therefore, for instance, Muslim jurists argue that treachery or betrayal, even in war, is unacceptable. Muslims must observe their treaty obligations and, in all circumstances, they cannot attack their enemies without issuing warnings and giving notice of their intentions.

Building on the proscriptions of the Prophet Muhammad, Muslim jurists insisted that there are moral prescriptions that must be observed in the conduct of warfare. In general, Muslim armies may not kill women, children, seniors, hermits, pacifists, peasants, or slaves unless they are combatants. Vegetation and property may not be destroyed, water holes may not be poisoned, flame throwers may not be used unless out of necessity, and the murder of

hostages is forbidden under all circumstances. Importantly, the classical jurists reached these discriminations not simply as a matter of textual interpretation, but as moral or ethical assertions [Abdalati, 2003, p. 9].

Haniff (2003) provided a brief profile of the Muslim community in America. According to him, the growth of the Muslim community in the United States is a recent phenomenon dating back to the period after the Second World War. It is one of the early consequences of globalization involving the movement of people from the developing to the more-developed parts of the world. Small batches of Muslim immigrants began to arrive on the shores of America, generally in the West, as soon as opportunities for travel became available. Many came for economic advantages, others to experience a new lifestyle, still others propelled by the desire to develop their knowledge and skills through education and training. Upon landing, most Muslims generally participated in communal life for the practice of their faith. As time passed, these immigrants' acquired families, friends, social contacts and assets, and full-fledged communities were underway. Once permanently settled, with institutions and collective life firmly established, Muslims took on the identity of a cultural and religious minority.

Historical Background

The early history of the Muslim population in America is virtually non-existent, although scholarly attention is gradually turning to that area of investigation. No doubt, tiny clusters of Muslims have been present in the United States for over a century. Isolated individuals of the Islamic faith likely appeared even earlier, although they left no identifiable progeny behind. The claim that Africans imported as slaves included Muslims, while quite plausible in view of the disparate evidence collected, has yet to be subjected to credible scholarly

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scrutiny. Unfortunately, slaves did not leave behind a community of any kind, nor did they develop institutional structures in the form of mosques or graveyards that could have constituted tangible proof of their existence. However, some descendants of African slaves did embrace Islam during the first half of the twentieth century, but their numbers never amounted to more than a handful of the population.

Historians have noted that Muslim immigrants originally arrived in the United States at the tail end of the nineteenth century. These early pioneers trickled in for the purpose of acquiring wealth, some to stay on permanently with their fortunes, though many eventually returned to their homelands to live in relative comfort. Large numbers of the early immigrants were Lebanese and Syrians, virtually all males of peasant stock, and illiterate. By the time the First World War ended, those who had remained behind formed isolated enclaves in a number of industrial cities in the Midwest. They constituted the nucleus of the Muslim presence, with at least one mosque founded in 1919 in Highland Park, Michigan that survived well into the 1970s. A larger more robust contingent of immigrants trickled in during the interwar period. The newcomers, while still basically Lebanese and Syrians, included a more diverse collection of ethnicities including Turks, Tartars, Yugoslavs and Albanians. They greatly supplemented the original population of Muslims, and much of the credit goes to them for founding three mosques in the Midwest before the Second World War. On the west coast, immigrants of Indo-Pakistani origin, having arrived in the earlier part of the century, eventually established a mosque in Sacramento, California, at the tail end of the 1930s.

The miniscule nature of the Muslim population in America could be ascertained from the fact that there were only four or five mosques in the entire nation at the end of the Second

World War. Only one of these was permanent enough, with a sufficiently robust congregation, to have survived to the present time. Anecdotal evidence indicates that there were individual Muslims, some with their families, living in scattered parts throughout the nation, most to be absorbed eventually into the great American melting pot.

The terrorist attacks that took place on September 11, 2001 not only had a profound impact on the American population, but a sobering effect on the entire world. In the United States, the attacks of September 11, 2001 have had significant negative consequences for a variety of ethnic and religious groups perceived by the general public to be associated with, or somehow to be blamed for these horrific events. Muslim families specifically experienced this post September 11, 2001 emotional consequences phenomenon. Muslims, who had lived peacefully in American society to this point, were widely perceived as being connected with various terrorist organizations. Therefore, they became perceived threats to the United States' national security. As a result, a significant number of hate crimes were committed. Bukhari (2002) states that 58% of American Muslims are reported to have experienced discrimination after 9/11. He further states that there a number of people who shared some stories about discrimination. For example, the principal of a Muslim school in New Jersey, who experienced stones crashing through the windows of the school only hours after the attacks on the World Trade Center, sent all of the children home fearing for their safety because they were Muslims. A young Muslim author, who had written books about American Muslims, and who always carried books on Islam in her bag, was interrogated at airports every time she tried to board a plane. Lastly, there was the story of the thirty-something modern woman, whose mother did not dare to leave the house for weeks for fear of attacks. These are some specific examples of incidents of discrimination.

According to Zaheerudin (2002), American Muslims were overcome with grief after the tragic events of September 11, 2001, and they mourned the deaths of their countrymen. However, they experienced something else, too; a lingering sadness for Islam, a faith they felt had been grossly abused. They condemned the attack in unequivocal terms, arranged blood drives, and donated generously as they deeply felt the pain of those who were touched by the tragedy. Unfortunately, some mosques and Islamic centers were targeted for arson, and many Muslims experienced personal hostility in their own neighborhoods. Over one thousand Muslims and Arab Christians were detained based on mere suspicion. Khan (2001, p. 4) says, "Muslims love to live in the US, but they also love to hate it." He calls this a "schizophrenic relationship with their new homeland" (p. 6). The situations in the Middle East and Afghanistan and, recently the talk about the war in Iraq make it difficult for American Muslims to reconcile their original loyalty towards their original countries and towards the United States of America. Muslims living in America have been going through stress. There are many cases reported where many Arab Muslims have been taken for interrogation. This has caused considerable stress and anxiety for their families, and has affected the entire Muslim community. Gilbert and Associates (2002) polled 521 Muslims who indicated that they experienced anti-Muslim acts and sentiments. These acts included discrimination, harassment, verbal abuse, and physical attacks. Some statements illustrating this abuse were: "You are demons," "Pig religion," and "You guys did it." Some experiences other respondents described included, "He spit in my face," and "He pulled off my daughter's hijab (head covering)." Research findings indicate that illegal discrimination is clearly a stressful event that affects both physical and mental health. Experiences like

these can place minorities at risk for mental disorders such as depression and anxiety

(Anderson & Clark & Williams, 1999)

Purpose of the Study

The purpose of this study is to explore the anxiety and depression experienced by Muslims in a southeastern city of United States. Anxiety and depression have been shown to relate to mental health. By studying the existence and level of these variables in Muslims, it is believed that substantial information about their effect on Muslims can be gained. This study will advance the knowledge about anxiety and depression in Muslims, and will suggest ways to improve the quality of counseling services for Muslims.

Importance of the Study

The area of investigation is relatively unprecedented. The intent of this study is to better understand depression and anxiety in Muslims. This study is important for three reasons: (1) it measures the level of anxiety and depression in Muslims living in southeastern city in the United States, (2) it attempts to provide implications for how mental health counselors can meet the needs of Muslims, and (3) it suggests ways to enhance the responsiveness of the society to the needs of Muslims in America. These three contributions to the literature will be discussed more fully later in the chapter.

Depression (Culture, Religion, Ethnicity, and Gender)

Depression in everyday life is a temporary experience that can range from mild dejection to profound despair. Depression becomes an illness when the individuals cannot rid themselves of a state of deep sadness that paralyzes them. Studies indicate that depression occurs more often in women than it does in men. While the symptoms of depression often include feelings of sadness, aches, pain, or the experience of anxiety (fear),

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all of these emotions can be qualified as a part of everyday experiences. Evidence that

women are more often depressed than men comes not only from statistics, but also from

hospitals and clinical practices (Howell & Bayes, 1981, p.19).

Men are less likely than women to show obvious symptoms of depression following a

traumatic loss experience. For most men, there may appear little correlation between the

experiences of trauma, loss, and the onset of depressive symptomology. Unlike men, women

are given permission culturally to express emotional pain overtly. Instead of overtly

expressing the emotional impact of loss, men are prone to outwardly diminish its significance

in order to maintain a balance in their lives (Cochran & Rabinowitz, 2000, p. 20-21).

Women are at higher risk for most types of depression than men. Specific life events

and other circumstances are correlated with depression in both genders, but are more likely to

be experienced by women. People who have less education, lower income, lower

socioeconomic status, and who are unemployed are at higher risk for depression than

individuals in other societal demographic categories (Golding, 1988). Knudson-Martin

(2000) writes, "Gender shapes how people experience themselves and others and influences

their psychological health and well-being. However, the relationship between gender, family

processes, and the presence of psychological symptoms is not clear. Men and women tend to

approach relationships differently." Other studies about gender differences indicate that

women's experiences are more emotional with higher levels of depression, while men

experience independence with lower levels of depression. One such study proposed that

women's ways of being emotional helps men to express the full range of their emotions,

thereby enriching their shared relationship (Feldman, 1982). This coping mechanism enables

men to share in socio-emotional tasks that have been traditionally borne by women, such as

the expression of grief and the comforting of others during times of loss and adversity (Walsh & McGoldrick, 1988, p. 13).

Cross-cultural studies offer a particularly important and unfulfilled opportunity to study gender differences in the experience of depressive symptoms. The fact that depression in most societies appears to be more prevalent among women, individuals occupying a specific social status such as the powerless, and the economically marginalized, provides support for an important hypothesis linking social and psychological theories. The differences between men and women regarding depression may be attributed to the social forces driving men to be powerful, strong, and capable, and women to be weak, emotional, and incapable. Psychosocial explanations include the social status hypothesis, which suggests that the disproportionate rate of exposure to stressors resulting from women's lower social status is responsible for their higher rates of depression (Weissman & Klerman, 1977, 1985).

Researchers are finding links between gender and acculturation to high levels of depression, and focusing more on cross-cultural and gender-related factors as the core social determinants of the distribution of depressive illness affecting the relatively powerless (Kleinman & Good, 1985, p. 42). "Discussing gender in the context of culture might help us to understand the problems of women more clearly, while highlighting some aspects of cultural differences that are otherwise hidden" (McGoldrick, Anderson & Walsh, 1991, p. 29).

Some men show high levels of anxiety and fear during crises or traumatic events. They have unusual emotional swings with disorganized and confused behavior, dramatic reduction of work and social functioning, and sleeping and eating disturbances which can be

associated with anxiety or depression (Witkin-Lanoil, 1986, p.37). Cavanaugh (1993, p. 47)

cites estimates of up to 10 % of women and 5 % of men who have symptoms of anxiety.

While men and women are "simply different", and there is a need to understand these

differences some researchers contend that men and women are socialized to behave

differently in personal and family situations (Chusmir, 2001). Knudson-Martin (2000)

examines gender differences and writes; "Even what constitutes well-being and defines

'appropriate' responses to distressing or problematic issues may be somewhat different for

women than for men." Others have attributed these differences to socialization, as well as

learning culturally different ways of behaving. Mead (2002) believes that men often deal

with conflict and stress by withdrawing, while women report higher levels of depression and

psychological distress. Women may experience more rigidity in their ability to express

negative emotions.

Depression in Early Adults

Negative or maladaptive belief systems play an important role in the onset and

maintenance of depression. Depressed early adults, especially girls, frequently exhibit low

self-esteem and negative body image, and depressed adolescents of both sexes show low

perceived control, competence, and excessive pessimism. These individuals also display

evidence of depressotypic attributional styles (e.g., they blame themselves for failures and

attribute positive experiences to external sources (Essau, 2004, p.189).

Life Events

The mechanisms that increase an individual's vulnerability to depression are unclear,

as not all adolescents who have been exposed to negative life events become depressed.

Individual differences in how adolescents cope with such events may be important. Given

the same level of stress, people who use more effective coping strategies will presumably experience less disruption of their behavior and, consequently, less distress. Consistent with this hypothesis, depressed adolescents have been found to use less effective coping styles (e.g., becoming intoxicated, isolating themselves, or running away from home), whereas, non-depressed adolescents tend to use more effective strategies (e.g., minimizing the importance of the events and engaging in problem-solving behavior), to deal with negative life events. Moreover, depression is consistently and positively correlated with emotion-focused strategies and cognitive avoidance, and is negatively associated with problem-focused coping (Lewinsohn & Essau, 2002, as cited in Dobson, 2004, p. 558).

Williams, Yu, Jackson, and Anderson (1997), identify an important relationship between race, class, education, and health. In addition, income has been found to influence educational levels, while race has been found to restrict education and employment. Overall, researchers have identified environmental and social factors that influence depression and fear, and several of these variables are interconnected. Race and education have been identified as demographics that influence health and well being. Researchers state that environmental factors, such as culture and economics, are correlated with levels of stress and instability.

Culture and religion cannot be separated. Culture may have as much or more to say about anxiety than does religion. The purpose of religion, on the other hand, is to provide peace of mind on a day-to-day basis (Koenig, 1998). Culture, gender, age and other social factors contribute to mental illness.

Depression and fear fall in the mental disorder category, and are considered the product of a complex interaction among biological, psychological, social, and cultural factors. The

psychological damage resulting from uncontrollable, terrifying life events has been the central focus of psychiatric interest for centuries (Kolk, 1987, p. 43). Human response to overwhelming and uncontrollable life events is remarkably consistent. Although the nature of the trauma, the personality of the victim, their predisposing personality, and community response all have an important effect on ultimate posttraumatic adaptation, the core features of posttraumatic syndrome are fairly constant across these variables (Kolk, 1987, p. 45).

Victims of trauma are often voiceless about their innermost fears, and become accustomed to having life happen to them. Victims of trauma are vulnerable to being used for a variety of political and social ends, both for good and for ill. They can be nurtured and idealized, or just as easily spurned, stigmatized, and rejected (Kolk & McFarlane, 1996, p. 15). Solomon (1995) reports how, between 1947 and 1982, Israeli society moved from the latter to the former position in its attitude to Holocaust survivors, without ever resting in the middle of the spectrum by treating them as fellow human beings who had been exposed to the unspeakable. The methods using the cross-cultural approach to the social significance of fear and rage require knowledge of the dynamics of personality within that specific culture. Solomon (1995) believed that to deal with cultural emotions is to understand their meaning of anxiety and fear.

Research studies suggest that the importance attached to certain "central issues" may increase the vulnerability of individuals to the point of distress and depression, and may explain the differential rates of depression across gender, racial, and ethnic groups (Cleary & Mechanic, 1983).

Definitions of Variables

Major Depressive Disorder is a type of mood disorder caused by either depressed mood or the loss of interest or pleasure in nearly all activities. Culture, age, and gender can influence the experience and communication of the symptoms of depression. Depression is a disorder that can be caused by many precipitating factors. Some of these are associated with the experience of a crisis, abuse, the loss or death of a loved one, and catastrophic events (DSM-IV-TR, 2000, p. 431).

Beck's (1967) cognitive theory of depression (as cited in Beckam & Leber, 1995, p.331) proposes that the essential component of a depressive disorder is a negative cognitive set-that is, the tendency to view the self, the future, and the world in a dysfunctional manner. This dysfunctional view of self, future, and world, which often reflects an underlying theme or loss, Beck (1967, p. 45) termed as a "negative triad". Beck further believed that depressed people regard themselves as unworthy, incapable, and undesirable. They expect failure, rejection, and dissatisfaction, and perceive most experiences as confirming those negative expectations. Their thoughts are automatic, repetitive, unintended, and not readily controllable; hence, they are termed "negative automatic thoughts".

A central feature of Beck's (1967, p. 46) theory is that the depressed individual's negative thinking is systematically biased in a negative direction. Beck (as cited in Dobson, 2004, p. 532) viewed "schemas" as cognitive structures through which events are processed, and which vary from person to person with respect to their content, valence, permeability, density, and flexibility. Once activated, these depressive schemas influence how external stimuli are interpreted, resulting in the cognitive distortions commonly observed in the thinking of depressed people.

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Beck (1967, p. 49) described several common systematic errors in the depressed individual's information processing which reflect the activity of dysfunctional cognitive schemas. These systematic errors in logic are: (a) Arbitrary inference—drawing a conclusion in the absence of evidence or when the evidence is contrary to the conclusion, (b) Selective abstraction—the tendency to focus on a negative detail in a situation and to conceptualize the entire experience on the basis of this negative fragment, (c) Overgeneralization—the tendency to draw a general rule or conclusion on the basis of one isolated incident, and to apply the concept indiscriminately to both related and unrelated situations, (d) Magnification and minimization—the tendency to overestimate the significance or magnitude of undesirable events, and to underestimate the significance or magnitude of desirable events, (e) personalization—the tendency to relate external events to oneself without evidence, and (f) All-or-none thinking—the tendency to think in absolute, black-or-white, all-or-none terms. The dysfunctional cognitive schemas are said to take the form of basic beliefs or "silent assumptions.

Beck (1967) noted that cognitions involving low self-esteem, deprivation, self-criticism, and suicidal wishes were common in depression. He believed that depressed patients distorted reality in a systematic manner that resulted in a bias against them. Many studies have ascertained that depression is more common in women in western society. Reed (as cited in Dobson, 2004, p. 533) studied depression in western society, and found that there were a large number of females whose cognitions prevented them from recovering from depression, while males were much better adjusted. Reed believed males run a fairly structured and consistent developmental course. Reed (1994, as cited in Dobson, 2004, p. 556) explained females are more likely to form dysfunctional beliefs due to mixed signals

from society. This coincides strongly with Beck's model of depression, and the large

problem of female depression in western society. Although this connection is probably true,

it is well documented that females have other underlying causes for their susceptibility to

depression. These include biological differences, age prevalence of depression differences,

sex/ gender-role identity differences, depression rate and recurrence differences, and co

morbidity differences in males and females.

<div align="center">*Negative Cognition*</div>

Cognitive factors must be included in any discussion of risk for depression. Not only

is the vast majority of contemporary psychological research on depression cognitive in

nature, but also cognitive factors have long been featured in models of vulnerability to

depression. Although the conceptual details of various cognitive models differ to various

degrees, they typically converge on several important concepts (Ingram et al, 1998, p. 52).

Several cognitive models suggest that dysfunctional cognitive self-structures, or schemas,

constitute central elements in the onset and maintenance of depression (Beck, 1967). In

addition, cognitive models of depression are typically of diathesis- stress in nature. Schemas

determine personal meaning and self-concept in various situations, thus setting the stage for

depression when stressful life circumstances are encountered. More specifically, diathesis-

stress perspectives argue that schemas are dormant or inactive until they become energized

by stressful events (Beck, 1967, p. 50).

Beck (1967, pp. 213-214) examined the two personality types that have been suggested

to constitute specific vulnerabilities for depression. These types are described as reflecting

either sociotropy or autonomy. Others, as a way of maintaining their own self-esteem, think

sociotropic individuals value interpersonal relationships, intimacy, and acceptance.

Correspondingly, they are considered to be vulnerable to depression when they experience a loss or rejection in social relationships. Autonomous individuals, in contrast, are invested in maintaining their independence and achieving their goals and standards. They are at risk if they experience failure in an achievement or in an individual accomplishment domain (e.g., a demotion at work). Although these specific personality types may be at risk, longitudinal studies have shown only somewhat mixed success in predicting self-reported distress or depression in sociotropic and autonomic individuals. Nevertheless, it seems clear that negative cognitive patterns can constitute a risk factor for depression and, because this category of risk can constitute vulnerability, may also be informative about the process to target in prevention programs.

On September 11, for the first time after World War II, the United States of America was attacked and the population felt threatened. The attackers were all Muslims, and their reasons were political and religious in nature. Consequently, the ire of the American population turned towards Muslims in the United States. This resulted in a great threat perception among Muslims, and contributed to a high level of anxiety and depression.

In a threatened situation, Muslims are expected to perceive themselves as unworthy, incapable, undesirable, and to develop negative automatic thoughts. These automatic thoughts may be repetitive, unintended, and not readily controllable. As Beck's theory addresses these issues, it was administered in the research.

Statement of the Problem

This study is based on research in the areas of anxiety and depression, and will investigate to what extent Muslims' experience of anxiety and depression affects their mental health. This study is designed to be exploratory. While Beck's theory is no longer a fledging

concept, its application to the counseling profession is still largely is undeveloped. This study will be a major breakthrough to research conducted on Muslims in the hope that the insights developed may lead to additional study. There is some evidence that the aftermath of 9/11 has had a negative effect (anxiety and depression) on the mental health of Muslims. The etiology and the extant of this effect have not been sufficiently investigated. There exists little, if any, research to inform how mental health professionals in America can help the Muslims who suffer from anxiety and depression.

The present study will assess anxiety and depression in Muslims. The general research questions will be as follows:

General Research Questions

1. Do Muslims suffer from depression and anxiety in the population?

2. What is the extent of the depression and anxiety in the population?

3. Are some Muslims more susceptible to anxiety and depression than others?

4. How are anxiety and depression manifested in the Muslim population?

Strengths of the Research

1. This study, being a pioneer study, will foster more such studies.

2. Participants were asked not to sign the Consent Form identifying them by name, and their confidentiality was maintained.

3. All sample data was collected using self-administered written response inventories maintaining anonymity to give confidence to the respondents in a vitiated atmosphere.

Limitations of the Research

1. There was no similar study immediately after 9/11. With the passage of time the targeted population learned to cope with the situation.

2. The study was limited to a southeastern city in the United States, and it was a pioneering effort.

3. Respondents were allowed to take the inventories home, which could have affected the outcome, as some external factors may have influenced their responses.

4. Data was collected from Indonesian participants simultaneously to the occurrence of Tsunami catastrophe. This only heightened their fear and anxiety.

Implications of the Research

1. Similar studies all over the United State of America in different situations would enhance our understanding of the mental health of Muslims.

2. Governmental and non-governmental organizations could use such studies to promote assimilation of the immigrant Muslim population.

3. Better understanding of the Muslim population by other communities would promote acculturation of the Muslim population in to the mainstream of the country.

Summary

Chapter 1 listed the problems and presented Beck's theoretical framework within which the problems would be studied. The rationale consisted of the prevalence of anxiety and depression in Muslims. The related research questions to be asked in this study were stated along with definitions of the research variables.

Ethnic minorities and trauma victims experience anxiety and depression. There is considerable literature and research, which supports the concept that ethnic minorities experience higher levels of anxiety and depression relative to the general population.

In Chapter 2 the literature relating to Beck's Theory of Depression and the studies of anxiety and depression experienced by ethnic minorities and war civilians present a justification for the research questions in Chapter 1, and are set forth again in Chapter 3. Chapter 3 describes the research design, subjects, instrumentation, and variables, sets forth the research questions, and describes the analysis procedure. Chapter 4 summarizes the results of the data analysis for each variable. Chapter 5 presents the conclusions, implications, and suggestions for further research.

CHAPTER 2

LITERATURE REVIEW

This study will investigate the mental health of Muslims in America with special regard to the level of anxiety, depression and posttraumatic stress. There is presently a dearth of psychological research conducted on Muslims throughout the world, and particularly on Muslims in America. In this section, the researcher will review studies conducted on Muslims from Arab and non-Arab countries that were designed to assess the level of anxiety, depression and posttraumatic stress in these populations. Many of these Muslims, especially from Bosnia, Iraq, and Afghanistan, had fled from the war zones and had arrived in America as refugees or as immigrants.

The researcher also looked into other groups such as Vietnamese, Cambodians, and Yugoslavians who had similar experiences to the Muslims. Therefore the researcher thought it appropriate to select these studies and to compare and contrast them. Kroll et al (1989) provides an historical overview of refugees from Vietnam and notes that these refugees have high levels of posttraumatic stress disorder in the United States. Carlson and Rosser-Hogan (1999) investigated Cambodian refugees who had lived in the United States for ten years, and found that even ten years after they had left their homes in Cambodia, these refugees are still suffering considerable mental distress yet have not sought mental health treatment. Blair (2000) reported that Cambodian refugees who experienced greater numbers of stressors around resettlement were at a higher risk for major depression. In Finland, Liebkind (1993) found that the levels of anxiety and depression increased with the length of stay not only in a group of Vietnamese refugees, but also in their children.

In Canada, Beiser, Kaspar, Hou, and Rummens (1999) found that South East Asians who experienced racial discrimination experienced higher levels of depression than did those who had not experienced discrimination. Whether relocating from one country to another is voluntary or not was found to be an important factor in a New Zealand study conducted by Pernice and Brook (1994) in which Indochinese refugees were found to exhibit higher levels of depression than two groups of voluntary immigrants.

Anxiety

The twentieth century has been called the Age of Anxiety, but concerns about fear and anxiety are as old as humanity itself. Although fear has been of interest since ancient times, anxiety was not fully recognized as a distinct and pervasive human condition until shortly before the beginning of the present century. It was Freud who first proposed the critical role of anxiety in personality theory and in the etiology of psychoneurotic and psychosomatic disorders. Anxiety was "the fundamental phenomenon and the central problem of neurosis" (Freud, 1836, p. 85). For Freud, anxiety was "something felt" – a specific unpleasant emotional state or condition of the human organism that included experiential, physiological, and behavioral components.

Spielberger (1966, p. 13) believed that anxiety was perhaps most used in an empirical sense to denote a complex reaction or response –a transitory state or condition of the organism that varied in intensity and fluctuated over time. However, the term anxiety was also used to refer to a personality trait of individual differences in the extent to which different people are characterized by anxiety states and by prominent defenses against such states.

Empirical evidence from different types of anxiety concepts had emerged from the factor analysis studies of Cattell and Scheier (1958; 1961, p. 15). These investigators identified two distinct anxiety factors, which they labeled as *trait anxiety* and *state anxiety* on the basis of the procedures by which these factors were isolated, and the variables, which loaded on them. The trait anxiety factor was interpreted as a personality characteristic. The state anxiety factor was based on a pattern of variables that covaried over occasions of measurement, defining a transitory state or condition of the organism, which fluctuated over time. Component characterological variables that loaded that trait anxiety factor included "ergic tension", "ego weakness", "guilt proneness", "suspiciousness", and a "tendency to embarrassment"(1961, pp. 57 & 182).

Anxiety as a Transitory State

Martin (as cited in Spielberger, 1966, p. 89.) proposed that anxiety should be defined as "a complex pattern of response and should be distinguished conceptually and operationally from the external or internal stimuli which elicit it. This approach dispenses with the traditional; stimulus- defined difference between fear as a response to a real external danger and anxiety as a reaction to some unknown threat, and emphasizes the importance of identifying and measuring the observable physiological and behavioral response patterns which distinguish anxiety (fear) and other emotional states".

Anxiety as a Personality Trait

Trait anxiety has been investigated in studies in which subjects who are presumed to differ in anxiety levels are selected from normal populations (Spence, 1958; Taylor, 1956), typically on the basis of extreme scores on a personality questionnaire such as the Taylor (1953) Manifest Anxiety Scale (MAS). Generally, at first it was assumed that subjects with

high scores on MAS were chronically more anxious or emotionally responsive than those with low MAS scores. Later findings suggested that subjects with high MAS scores react with higher anxiety levels in situations that contain some degree of stress, but not in the absence of stress (Spielberger, 1966).

A Trait-State Conception of Anxiety

Spielberger (1966, p. 39) suggested that it was meaningful to distinguish between a transitory state and a relatively stable personality trait, and to differentiate between anxiety states, the stimulus conditions that evoke them, and the defenses that serve to avoid them. Anxiety as a personality trait (A-trait) would seem to imply a motive or acquired behavioral disposition that predisposes an individual to perceive a wide range of objectively dangerous circumstances as threatening, and to respond to these with A-state reactions disproportionate in intensity to the magnitude of the objective danger.

According to Spielberger (1966, p. 41), Trait anxiety (T-Anxiety) refers to relatively stable individual differences in anxiety-proneness: that is, to differences between people in the tendency to perceive stressful situations as dangerous or threatening and to respond to such situations with elevations in the intensity of their state anxiety (S-Anxiety) reactions. T-Anxiety may also reflect individual differences in the frequency and intensity with which anxiety states have been manifested in the past, and in the probability that S-Anxiety will be experienced in the future.

Spielberger (1966, p. 42) believed that although personality states are often transitory, they can recur when evoked by appropriate stimuli, and they may endure over time when the evoking conditions persist. In contrast to the transitory nature of emotional states, personality traits can be conceptualized as relatively enduring differences among people in

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specifiable tendencies to perceive the world in a certain way, and in dispositions to react or behave in a specific manner with predictable regularity.

State and trait anxiety are analogous in certain respects to kinetic and potential energy. S-Anxiety, like kinetic energy, refers to a palpable reaction or process-taking place at a given time and at a given level of intensity. T-Anxiety, like potential energy, refers to individual differences in reactions. Potential energy refers to differences in the amount of kinetic energy associated with a particular physical object, which may be released if triggered by an appropriate force.

T-Anxiety implies differences between people in the dispositions to respond to stressful situations with varying amounts of S-Anxiety. However, whether or not people who differ in T-Anxiety will show corresponding differences in S-Anxiety depends on the extent to which each of them perceives a specific situation as psychologically dangerous or threatening, and this is greatly influenced by each individual's past experience.

People with high T-Anxiety exhibit S-Anxiety elevations more frequently than low T-Anxiety individuals, because they tend to interpret a wider range of situations as dangerous or threatening. High T-Anxiety people are also more likely to respond with relationships, which threaten self-esteem. In such situations, S-Anxiety may vary in intensity and fluctuate over time as a function of the amount of stress that impinges upon the individual, but the individual's perception of threat may have greater impact on the level of S-Anxiety than the real danger associated with the situation.

Eyesenck (1992, p. 37) believed that anxiety is a complex phenomenon, which can be studied in a number of different ways. Individual differences can be investigated in either clinical or normal populations. Since anxiety can be approached in a variety of different

ways, it is necessary to justify adopting the cognitive perspective. There are reasons for

claiming that at least some cognitive processing always precedes the experience of anxiety,

which means that the cognitive system is importantly involved in anxiety.

According to Eyesenck (1992, p. 38) anxiety, and other emotional reactions, often

occur in response to environmental stimuli or situations. An important theoretical issue is

whether it is essential for stimuli or situations to be processed cognitively before the

emotional reaction can occur. If it is the case that affective responses to all stimuli depend on

prior cognitive processing, then it would seem to follow that those theories of anxiety and

other emotions should have a distinctly cognitive flavor.

Turner (2003) discussed anxiety in terms of cognitive theory. It is considered that

some individuals readily catastrophize what is happening. Thus, they see a potentially

anxiety-inducing situation, feel themselves becoming tense, tend to focus on worst-outcome

scenarios, and reinforce their states of inner tension. A tendency to over-inclusive thinking,

and being unable to exclude troubling thoughts or symptoms is also common.

Blumfield (2002) stated that when people confront death and destruction beyond the

usual human experience, they may develop acute stress symptoms characterized by

flashbacks, distressing dreams, psychological numbness, and other symptoms. People in

close proximity to the event are more likely to have persistent problems. Most traumatic

events are brief, and the psychological impact recedes with time. However, terrorism or wars

are just the opposite. The ongoing reality hovers over the victims and they cannot prevent

posttraumatic symptoms from fading into the background.

Cognitive Theory of Depression

The researcher used Beck's Depression inventory to measure and assess the level of depression, and hence the researcher thought it appropriate to analyze Beck's Model of Depression. Easily the most influential theoretical account of anxiety disorders from a cognitive perspective is that of Beck. The central construct used by Beck and Emery (1985, p. 66) and Beck and Clark (1988, p. 56) in their cognitive theory of clinical anxiety is that of the schema. They believed that cognitive schemas guide the screening, encoding, organizing, storing and retrieving of information. Stimuli consistent with existing schemas were elaborated and encoded, while inconsistent or irrelevant information is ignored or forgotten.

Beck (1968, p. 31) believed that in addition to schema or schemata, there is a superordinate organizing principle he termed 'mode'. Each mode consists of various groups of rules and concepts, which are organized in terms of general themes. Beck's explanation of how schemas or schemata influence cognitive functioning was that these schemas serve to direct processing resources to those aspects of the external or internal environment, which are congruent with them. Beck's explanation was that anxious people will attend to stimuli, which present a physical or psychological threat, ambiguous stimuli will be interpreted in a threatening fashion, and threatening information will be readily retrieved from memory.

Beck (1967) proposed a rather similar schema theory of depression. He believed that depressed people have maladaptive schemata, which incorporate negative information about the self, the world, and the future, in addition to other schemata based on personal loss. As in case with the maladaptive schemas or schemata of anxious people, those of depressed people systematically affect information processing by favoring schema-congruent information.

According to Beck (1967), there are major similarities in information processing between anxious and depressed people. In both groups, maladaptive schemas systematically distort the processes involved in the perception, storage, and retrieval of information. In terms of the differences between the two groups, Beck and Clark (1988, p. 74) proposed the content-specificity hypothesis. According to this hypothesis, it is primarily the content of the faulty information processing system that distinguishes the anxiety and depression.

Beck et al (1987) compared the performance of anxious and depressed patients on the cognitions checklist, and found that the anxious group reported more anxiety-relevant thoughts and images than the depressed group, whereas the depressed group reported significantly more negative cognitions.

Information Processing Model

Weisharr (1996, as cited in Beckam and Leiber, 1995) believed that Beck's approach is based on an information-processing model 'which posits that during psychological distress a person's thinking becomes more rigid and distorted, judgments become over generalized and absolute, and the person's basic beliefs about the self and the world become fixed'. In other words, when people experience emotional stress, their emotional information-processing abilities tend to become faulty because they introduce a consistently negative bias into their thinking. Common information-processing errors or distortions in emotional disturbances include:

1. All-or-none thinking: situations are viewed in 'either/or' terms rather than in a more balanced and realistic way (for example, a student thinks 'Either I'm number one or I'm a flop' about his examination performance).

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2. Mind reading: thinking one can discern the thoughts of others without any accompanying evidence (for example, a lecturer who catches one of his students looking out of the window while he is leading a tutorial decides she must be thinking about him 'He is really boring').

3. Labelling: instead of labeling the behavior, one attaches the label to oneself (for example, 'Because I failed my driving test for the second time, this means I'm a failure').

4. 'Should' and 'Must' statements: demands and commands made on oneself, others and the world and the 'terrible' consequences when they are not met (for example, 'I must get a job because if I don't, my life will be awful without it')

5. Emotional reasoning: assuming that the disturbed thoughts and feeling are facts (for example, 'I feel that my friends are stabbing me in the back, so it must be true').

Structural organization of thinking

Neenan and Dryden (2000) in the structural organization of thinking describe the three cognitive levels distinguished by Beck. The first level is the *automatic thoughts.* These are thoughts that appear to come rapidly, automatically, and involuntarily when a person is in a negative frame of mind, and are linked to specific emotional reactions (such as depression or anxiety). Automatic thoughts usually lie outside of immediate awareness although they can be quickly brought to consciousness. The next level is the *underlying assumptions*. These are often unarticulated assumptions, which guide the behavior, set the standards to achieve, or provide rules to be followed. The authors describe this with an excellent example (for positive assumption): 'If I please others, they'll like me'; (negative assumption): 'If I don't please others, then they will reject me'.

Core beliefs are the fundamental beliefs people have about themselves; others and the world and which help them make sense of their experiences. People usually have positive core beliefs (such as, 'I'm successful') and negative core beliefs (such as, 'I'm a failure'). Core beliefs are usually formed through early learning experiences and become instrumental in shaping the outlook. Beck (1995, p.5) suggested that negative core beliefs fall into two categories: helplessness (e.g., 'I'm weak') and unlovability (e.g., 'I'm unattractive').

Beck (1967, p. 74) hypothesized that in depression, idiosyncratic schemas involving themes of personal deficiency, self-blame, and negative expectations dominate the thinking processes. A specific situation or stressor that would be expected to lower self-esteem might activate the depressive schemas in vulnerable individuals. Once activated, the depressotypic schemas lead to the negative automatic thoughts and cognitive errors.

Beck's Depression Inventory has grown out of the theory that Beck developed and this is used to measure the levels of depression in many studies. In one such study, Saisto et al (2001) attempted to show how different approaches to becoming a mother could stave off depression common with such a major life event. The results showed that women who adjusted their personal goals to match the particular stage-specific demands of the transition to motherhood showed a decrease in depressive symptoms, whereas those disengaged from the goals that focused on dealing with such demands showed an increase in depressive symptoms.

Posttraumatic Stress Disorder (PTSD)

Jackson (1991) stated that Posttraumatic Stress Disorder (PTSD) has become a more frequently recognized psychiatric condition in recent years. The media constantly focuses on personal disasters, and speculation on the psychiatric damage, such as Posttraumatic Stress Disorder (PTSD), that result is often included in the story. However, while the American Psychiatric Association first described the symptoms of Posttraumatic Stress Disorder (PTSD) in 1980 (and revised in 1987), these symptoms were not new. Historical records have described similar symptoms in individuals resulting from the experiences of war, natural disasters, train wrecks, and a host of other conditions. Some research suggests that there are biological features of Posttraumatic Stress Disorder (PTSD) that distinguish it from other conditions such as anxiety, grief, or depression. Such biological features seem to justify the establishment of Posttraumatic Stress Disorder (PTSD) as a separate clinical entity. However, it is also clear that the disorder is strongly influenced by cultural beliefs and social support. It is estimated that about 1 % of the general population suffers from Posttraumatic Stress Disorder (PTSD).

Different studies have found high rates of the disorder among people at high risk. The rate is estimated to be 3.5 % among victims of personal attacks and uninjured war veterans, and between 20 and 40% among war veterans who have received injuries. War and natural disasters are not new, so it is not clear why Posttraumatic Stress Disorder (PTSD) is only now receiving recognition and study.

Traumatic events can be experienced in various ways. Commonly, the person has recurrent and intrusive recollections of the event or recurrent distressing dreams during which the event can be replayed or otherwise represented. In rare circumstances, the person

experiences dissociative states that last from a few seconds to several hours, or even days, during which components of the event are relieved, and the person behaves as though the person is experiencing the event at that moment. These episodes, often referred to as "flashbacks," are typically brief, but can be associated with prolonged distress and heightened arousal. Intense psychological distress or physiological reactivity often occurs when the person is exposed to triggering events that resemble or symbolize an aspect of the traumatic event (e.g., anniversaries of the traumatic event; cold, snowy weather, or uniformed guards for survivors of death camps in cold climates (DSM 1V-TR, 2000, p. 234).

Individuals who may have recently emigrated from areas of considerable social unrest and civil conflict may have elevated levels of posttraumatic stress. Such individuals may be especially reluctant to divulge experiences of torture and trauma due to their vulnerable political immigration status (DSM 1V-TR, 2004, p. 235). Community-based studies reveal lifetime prevalence for posttraumatic stress of approximately 8% of the adult population in the United States. Studies of at-risk individuals (i.e., groups exposed to specific traumatic incidents) yield variable findings, with the highest rates (ranging between one-third and more than one-half of those exposed) found among survivors of rape, military combat and captivity, and ethnically or politically motivated internment and genocide.

A Cognitive Model of Posttraumatic Stress Disorder

Ehlers and Clark (2000, p. 52) believes that Posttraumatic Stress Disorder (PTSD) is a common reaction to traumatic events. Many people recover in the ensuing months. However, in a significant subgroup the symptoms persist, often for years. A cognitive model of the persistence of PTSD is proposes. It is suggests that PTSD becomes persistent when individuals process the trauma in a way that leads to a sense of serious, current threat. The

sense of threat arises as a consequence of (a) excessively negative appraisals of the trauma and/or its consequences, and (b) a disturbance of autobiographical memory characterized by poor elaboration and contextualization, strong associative memory, and strong perceptual priming. Changes in the negative appraisals and the trauma memory are prevented by a series of problematic behavioral and cognitive strategies.

The model proposes that two key processes lead to a sense of current threat: (a) individual differences in the appraisal of the trauma and/or its consequences, and (b) individual differences in the nature of the memory for the event and its link to other autobiographical memories. Once activated, the perception of current threat is accompanied by intrusions and other experiencing symptoms, symptoms of arousal, anxiety and other emotional responses. The perceived threat also motivates a series of behavioral and cognitive responses that are intended to reduce perceived threat and distress in the short-term, but which have the consequence of preventing cognitive change, and, therefore, maintaining the disorder.

It is assumed that, unlike individuals who recover naturally, individuals with persistent PTSD are unable to see the trauma as a time-limited event that does not have global negative implications for their future. The model proposes that these individuals are characterized by idiosyncratic negative appraisals of the traumatic event and/or its consequences that have the *common effect of creating a sense of serious current threat*. This threat can be either external (e.g. the world is a more dangerous place) or, very commonly, internal (e.g. a threat to one's view of oneself as a capable/acceptable person who will be able to achieve important life goals).

Appraisal of the traumatic event

Several types of appraisal of the traumatic event can produce a sense of current threat. First, individuals may over generalize from the event, and, as a consequence, perceive a range of normal activities as more dangerous than they really are. They may exaggerate the probability of further catastrophic events in general, or take the fact that the trauma happened to them, as opposed to other people, as evidence for appraisals such as, "I attract disaster" or, "Bad things always happen to me". Such appraisals generate not only situational fear but also avoidance, which maintains the over generalized reactions.

Appraisals of trauma consequences

A variety of idiosyncratic, negative appraisals of the consequences of the traumatic event can produce a sense of current threat and contribute to persistent PTSD. These include: interpretation of one's initial PTSD symptoms, interpretation of other people's reactions in the aftermath of the event, and appraisal of the consequences that the trauma has in other life domains (e.g. physical consequences such as pain, financial, or professional consequences).

Wegner (1989) noted that all of the symptoms such as intrusive recollections and flashbacks, irritability and mood swings, lack of concentration and numbing, are common reactions shortly after a traumatic event. If individuals do not see these symptoms as a normal part of the recovery process, they may interpret them as indications that they have permanently changed for the worse, or as indicators of a threat to their physical or mental well being. These are several examples of negative appraisals of initial PTSD symptoms. Such appraisals maintain PTSD by directly producing negative emotions (e.g. anxiety, depression or anger), and by encouraging individuals to engage in dysfunctional coping strategies that have the paradoxical effect of enhancing PTSD symptoms. For example,

individuals who believe that intrusive recollections mean they are losing control of their minds are likely to try hard to push such recollections out of their minds. Unfortunately, active thought suppression of this type often makes the thought more likely to surface.

Other people, including family and close friends, are often uncertain about how they should respond to a trauma victim, and may avoid talking about the event in order not to distress the victim. This 'consideration' can be interpreted as a sign that others do not care. Worse still, it can be interpreted that they think the event was partly the victim's fault. Such interpretations are likely to directly produce some of the symptoms of PTSD (estrangement from others and social withdrawal), and are also likely to prevent victims from discussing the trauma with others, hence, reducing the opportunity for therapeutic reliving (see below) and for feedback from others that might help correct excessively negative views about the meaning of the event. Of course, some people are also objectively uncaring, rejecting or critical of victims after a traumatic event. If traumatized individuals consider these people's views important, they may interpret such reactions as a sign that they are to blame for the event, that they are unworthy, that they are unlikable, or that they will not be able to have close relationships with others.

Traumatic events can have negative long-term effects on many areas of life. These include the individual's physical health, appearance, vocational, and financial situation. These traumatic events can be interpreted as a sign of a permanent negative change of one's life for the worst, or as a sign that the worst is still to come.

Appraisals and emotional responses

The nature of predominant emotional responses in persistent PTSD depends on the particular appraisals (Beck, 1967, p. 77). Appraisals concerning perceived danger lead to

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fear (e.g. "Nowhere is safe"), appraisals concerning others violating personal rules and unfairness lead to anger (e.g., "Others have not treated me fairly"), appraisals concerning one's responsibility for the traumatic event or its outcome lead to guilt (e.g., "It was my fault"), appraisals concerning one's violation of important internal standards lead to shame (e.g., "I did something despicable"), and appraisals concerning perceived loss lead to sadness (e.g., "My life will never be the same again"). Most patients with persistent PTSD experience a range of negative emotions. This is partly because different appraisals are activated at different times, and partly because the degree of conviction varies from time to time. For example, the possibility that a loss may occur tends to be associated with anxiety, whereas perceived certainty of a loss tends to be associated with depression.

Memory for the traumatic event

Foa et al (1989) believed that the nature of trauma memory and its relationship to unwanted recollections is another puzzle of persistent PTSD. On the one hand, patients often have difficulty in *intentionally* retrieving a complete memory of the traumatic event. Their intentional recall is fragmented and poorly organized, details may be missing, and they have difficulty recalling the exact temporal order of events. On the other hand, patients report a high frequency of *involuntarily-triggered* intrusive memories involving re-experiencing aspects of the event in a very vivid and emotional way. Models of PTSD need to explain this apparent discrepancy between difficulties in intentional recall and easily triggered re-experiencing of the event. In addition, the involuntary re-experiencing has a number of important characteristics that need to be explained. These characteristics will be described first. The researcher will then go on to outline a possible explanation for the memory disturbance.

Anniversary Event

Many people with persistent PTSD experience the aggravation of symptoms around the anniversary of the event. These may be explained by a combination of the presence of reminders and the appraisal of the PTSD symptoms. Around anniversaries, patients are confronted with many external reminders (such as weather, light conditions, or other people asking about it. They may generate internal retrieval cues by dwelling on what their lives were like before the traumatic event, and think about their feelings and experiences on that day, before the traumatic event happened. Furthermore, anniversaries often are taken as landmarks for negative appraisals of PTSD symptoms such as, "I am inadequate because I am still not over it". Such appraisals activate strategies (e.g. thought suppression) which prolong/intensify the symptoms.

Anxiety and Depression in Arab Muslims

For many years the Muslim community in America had been a small minority, but today it is one of the fastest-growing religions in the country. Muslims first came to America in the 1860's from Syria and Lebanon. Today it is estimated that there are 6 to 7 million Muslims in America, roughly 2% of the entire population. There are large communities of Muslims in almost every large city. Ethnically diverse, the largest community of Muslims comes from South Asia (33%) followed by African-Americans (30%). Arab Muslims make up 25% of the population.

To commemorate the events of September 11, 2001 and the attacks in New York City and in Washington, D.C., the Arab-American community of Brooklyn, New York, held a candlelight vigil near the World Trade Center site. Soon after, Muslim leaders attended a

formal gathering in the White House for the first time in history. Civil rights activists believe

that Muslims are now more vulnerable and suffer from religious prejudice.

The Livengood and Stodolska (2004) study was intended to give an account of the

treatment that American Muslims have been subjected to over a one-year period following

the events of September 11, 2001. The purpose of the study was also to establish how

discrimination has affected their leisure behavior, and to analyze Muslims responses to

discrimination and the strategies used to overcome obstacles to their leisure participation.

Qualitative, semi-structured interviews were conducted with 25 individuals from Palestine,

Jordan, Lebanon, Iraq, Egypt, Tunisia, Algeria, Turkey, Pakistan, India, Mexico and Korea.

Results indicate that discrimination has affected leisure of Muslim immigrants directly

through experiences in leisure-related settings. Most of the discrimination experienced by

Muslim Americans was of a non-violent nature. It included menacing looks, verbal abuse,

and social isolation. American Muslims have been found to employ certain negotiation

strategies to adapt to their new environment. These strategies include being vigilant, being

very aware of their surroundings, walking in groups, blending in, and restricting travel or

modifying travel patterns.

Amer (2003) studied how acculturation can cause stress in understudied ethnic groups.

Being an Egyptian-American, Amer quickly noted recent world events had thrust Arab

Americans onto the front page of newspapers, yet not on the pages of psychological research

journals. The author found that most multicultural funding sources for Arab Americans since

September 11, 2001 looked at geopolitical or economic issues. The author believed that

September11, 2001 put Arab Americans into the spotlight, and understanding this group

became important on a national level. He was amazed at how there could be so much

research and attention directed towards Arab politics and Americans' response to the attacks, while virtually no one looked at how the events affected Arab Americans' mental health. The researcher agrees with this viewpoint. The events of September 11, 2001 are sensational ones, and they have impacted everyone living in America and around the world. The impact will be felt most keenly among Arab Muslims, because all of the names connected with causing the trauma were Arab Muslims.

<center>*Anxiety and Depression in Refugees*</center>

The ongoing war in Iraq makes the Muslims in America become more susceptible to anxiety and depression, especially those who have escaped from war zones, and who have come to America as refugees. Every day the news seems to be a constant reminder of the trauma they experienced in their own countries. The trauma of leaving their homelands and the seeking of asylum and refuge in America is yet another traumatic experience for them.

Mghir and Raskin (2001) studied the psychological effects of the war in Afghanistan on two groups of young Afghan refugees currently residing in the United States. One group showed significantly less evidence of Posttraumatic Stress disorder (PTSD) and depression than the second group. These two groups of young refugees came from different socioeconomic and cultural backgrounds, and their wartime experiences were also different. One group, the Tajik, were wealthier, more likely to speak English at home, and were less religious than the Pashtun.   The Pashtun spent more time in Afghanistan during the war, and experienced or witnessed more traumatic events, such as torture or combat.

The study was conducted during the Afghan War, and it is interesting to note how the two groups reacted to the war. The Tajik group, the wealthier of the two, experienced a lower level of trauma than the Pashtun. Obviously, the Pashtun seemed to have suffered

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more as they were more affected by the war. Their houses were destroyed, and many members of their families joined the military because of financial constraints as they were economically deprived. Therefore, war or any reminder of war will have a greater impact on those who have already been traumatized by it.

Miller et al (2002) conducted a qualitative study on Bosnian refugees residing in Chicago. Semi-structured interviews were used to identify and explore the exile related stressors most salient within their community. The authors of the study realized that earlier studies of refugees had focused on understanding the psychological consequences of pre migration and war-related experiences. Miller et al also believed that there has been a recent shift toward examining the ways in which prior exposure to situations of violence may interact with ongoing migration. The researchers' application of the narrative approach facilitated a greater understanding of the ways in which war-related trauma, a hallmark of the refugee experience, may adversely influence peoples' capacity to effectively negotiate the many challenges of adapting to a new life. Recurrent war-related nightmares and chronic insomnia left many participants continually sleep-deprived.

War in Bosnia brought a lot of suffering to its people. Families were separated, severe loss of life was experienced, and many people were rendered homeless and sought refuge in another countries to preserve their lives. Thus, when the authors conducted a study on Bosnian refugees, the war in Iraq and Afghanistan brought back horrible memories, and terrifying experiences. The refugees tended to relive those traumatic images and memories, and the possibility of experiencing a high level of depression was very certain.

Jamil et al (2002) conducted a study to clarify the mental health needs of Iraqi immigrants who arrived in the United States in the 1990s after the Persian Gulf War. The

records of 375 clients were examined at a clinic that served Arab Americans. The data

showed more Post Traumatic Stress Disorder (PTSD) and health problems found in Iraqi

refugees than in other clients. The reason for Iraqis' experience of Post Traumatic Stress

Disorder (PTSD) and other health problems is due to the fact that war in Iraq makes it

difficult for them to forget their past. The Iraqis constantly tend to worry about their

relatives back home, and the everyday news of their people dying there makes it even more

difficult for them to maintain good mental health.

Becker et al (1999, p. 51) describe the psychiatric consequences of "ethnic cleansing"

in adolescent Bosnian refugees, via a one-year follow-up study. Ten Bosnian adolescent

refugees from the war in Bosnia-Herzegovina received a baseline assessment within the first

year after their resettlement, and a follow-up assessment one year later. Evaluations included

an assessment scale for posttraumatic stress disorder (PTSD) symptom severity. Overall,

rates of PTSD symptoms diminished during the one-year follow-up interval, suggesting that

they may be transient and not representative of enduring psychopathology. This finding may

reflect the relative resilience of adolescents, as well as a variety of factors that facilitated

adaptation in this particular group of adolescent refugees. The study seems to be a very

interesting one. There is clear evidence that the Bosnian refugees experienced severe trauma

while in Bosnia and during their migration to America. The study was conducted a year after

their settlement in America. As earlier research showed, PTSD symptoms tend to wax and

wane with time. Even for this sample, the PTSD symptoms diminished after a year. It would

be very useful to study the same sample and investigate to see the impact of war and any

revival of PTSD symptoms.

The researcher also looked at research on refugees from non-Muslim countries, the difficulties in adjusting to life in America, and the evidence of any psychological distress. Shapiro et al (1999, p. 51) reported that while first-wave immigrants adapted well to life in the United States, subsequent immigrants have had greater adjustment difficulties including more evidence of psychological distress. This study aimed to analyze psychosocial adaptation differences among three generations of recent Vietnamese immigrants. The immigrants were categorized as elderly, middle-aged, or young adults. They were assessed for levels of psychological distress, including depression, anxiety and PTSD, as well as family conflict, dissatisfaction with the life in the United States, acculturation and biculturalism, social support, coping, and premigratory stressors.

Young Vietnamese adults were more acculturated, most bicultural, and reported themselves as the healthiest and the least depressed. However, they also reported dissatisfaction with their current lives in the United States, and they experienced severe family conflict. Although young adults scored significantly higher than other generations on most of the risk factors for psychological distress, they appeared to be buffered against poor mental health outcomes by factors of generation and perceived positive overall well being.

Carlson and Hogan (1999) reported that people exposed to severe and lasting psychological trauma often suffer from Posttraumatic Stress Disorder (PTSD). Cambodian refugees constitute one group of people who have unquestionably been subjected to severe anxiety symptoms. These refugees had symptoms persisting even years after their settlement in the United States.

Strug et al (2003) studied the impact of 9/11 on older Hispanic immigrants in New York City. Six focus groups were conducted with a total of 31 elderly Hispanics attending a

community senior center day program. Most subjects had recovered from their acute distress reactions to 9/11, but many still experienced a wide range of psychological reactions related to the traumatic events, including anxiety, avoidance, and hypervigilance.

Gender Differences in Anxiety and Depression

Many studies have ascertained that depression is more common among women in western society. Reed (1994) studied depression in western society and found that a large number of females' cognitions prevented them from recovering from depression, while males adjusted much well. Reed believed males run a fairly structured and consistent developmental course. Reed (1994, as cited in Dobson) explained that females are more likely to form dysfunctional beliefs due to mixed signals from society. This coincides strongly with Beck's Model of Depression, and the large problem of female depression in western society. It is well documented that females have other underlying causes for the susceptibility to depression, including biological differences, age prevalence of depression differences, sex/ gender-role identity differences, depression rates, recurrence differences, and co-morbidity differences in males and females.

Baldwin and Chambliss (1997) evaluated the role of individual differences (gender and race) on the stress-illness relationship within the adolescent population. Participants were 119 adolescents (54 females and 65 males), recruited from two public high schools located in the southeast, who were administered four questionnaires designed to measure levels of stress, anxiety, and illness. Correlational analysis revealed that stress and anxiety were positively correlated with reported illness. However, racial and gender differences did emerge. Although no gender differences were found with regard to the experience of stress, African-American athletes reported a higher frequency of stressful life events than did their

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Euro-American counterparts. Further, African-American adolescents reported a lower frequency of illness than did the Euro-Americans. Females reported more illnesses than did males.

Foster et al (2004) examined gender differences in the levels of violence exposure, in levels of posttraumatic stress (PTSD), and in related symptomatology in a sample of inner-city predominantly African American youth. Because such youth are at risk for exposure to chronic community violence, they are likely to experience considerable distress and clinical or sub clinical levels of posttraumatic stress and related symptoms. Previous research has found that although boys are exposed to violence more frequently than are girls, girls are more likely to express posttraumatic stress and related symptoms as a result of violence exposure. It was also found that while girls do not appear to differ in their responses to witnessing violence versus being a victim of violence, boys appear to be more distressed by being a victim of violence than by witnessing violence.

Abdel-Khalek and Soliman (1999) studied a sample of 535 United States students, 11 to 18 years old. Seven factors were extracted by principal axis factor analysis (negative mood and self-depreciation, fatigue, loneliness, sleep problems, weak concentration, pessimism, and feeling unhappy), denoting clear factorial structure; however, the scale was intended to be one-dimensional. Sex and racial differences for this American sample were not statistically significant, but the correlation of depression scores with age was .22.

A year later the authors studied cross-cultural differences in childhood depression between samples from Egypt and Kuwait, and also used the same American sample from their earlier study. Results showed that female Kuwaitis had a lower mean depression score than either the Egyptian or American groups.

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Cuffe et al (2001) examined the prevalence and correlates of trauma and posttraumatic stress disorder (PTSD) symptoms and diagnosis in older adolescents aged 16 through 22 years. They found that approximately 3% of female subjects and 1% of male subjects satisfied the DSM-IV criteria for PTSD. Females reported more traumatic events than males, and black subjects reported more events than white subjects. The researchers concluded that while relatively few adolescents satisfy the criteria for PTSD, most subjects who experience it are females.

Nakazato and Shimonaka (1989) investigated scores on anxiety among adults of ages. The State-Trait Anxiety Inventory was administered to a representative community sample of 1,234 men and women whose ages ranged for 25 to 62 years. Anxiety declined linearly over the series of age groups. A sex difference was also observed on trait anxiety. Women showed higher anxiety than men. Possible development of anxiety and differential association of demographic variables with anxiety between sexes were discussed in relation to personality.

Kendler et al (2001) reported that women are at a greater risk for major depression than men. The authors sought to determine whether the gender difference in prevalence for major depression was due to more frequent exposure to stressful life events and /or greater sensitivity to their depressogenic effects. Results from the study showed that women consistently reported higher rates of housing problems, loss of confidence, crises and problems getting along with individuals in their proximal network.

Oliver and Toner (1990) investigated the influence of gender role typing on the expression of depressive symptoms. Based on previous findings that men and women differ in their expression of depressive symptoms, a proposed gender role expectation is a possible

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explanation. Undergraduates (99 men and 360 women) were divided into masculine and feminine groups according to the Bem Sex Role Inventory. Depressive symptoms were measured by the Beck Depression Inventory (BDI). The results are consistent with the hypothesis that depressive symptoms are influenced by societal expectations.

While men and women are 'simply different", and there is a need to understand these differences, some researchers contend that men and women are socialized to behave differently in personal and family situations (Chusmir, 2001). Knudson-Martin (2000, p. 451) examined the gender differences and wrote, "Even what constitutes well-being and defines 'appropriate' responses to distressing or problematic issues may be somewhat different for women than for men".

Mead (2002) attributed the gender differences to socialization as well as to learning culturally different ways of behaving. For example, men often deal with the conflict of stress by withdrawing, while women report higher levels of depression and psychological distress. Women may experience more rigidity in their ability to express negative emotions.

Looking for links between gender and acculturation to high levels of depression and focusing more on cross-cultural and gender related factors as core social determinants of the distribution of depressive illness affecting the relatively powerless, the researchers (Kleinman & Good, 1985) discussed gender in the context of culture to help us understand the problems of women more clearly, while highlighting some aspects of cultural differences that are otherwise hidden.

Golding (1988) believed that women are at higher risk for most types of depression than men. Specific events and other circumstances are correlated with depression in both genders, but are more likely to be experienced by women. People who have less education,

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lower income, lower socioeconomic status, and who are underemployed are at higher risk for depression than individuals in other societal demographic categories.

Other studies of gender differences indicate that women's experiences are more emotional with higher levels of depression, while men experience more independence with lower levels of depression Feldman (1982). Traditionally, the South Asian cultures are male dominated, with men usually in positions of authority both inside and outside of the home, while women are trained to yield to the demands of their environment. During war times both men and women experienced disintegration of their lives. However, while both were likely to have suffered a decline in the sense of coherence, men were likely to have experienced a relatively greater loss in their sense of manageability and meaningfulness given their previously higher status and power.

Some men show high levels of anxiety and fear during crises or traumatic events. They have unusual emotional swings with disorganized and confused behavior, dramatic reduction of work and social functioning, and sleeping and eating disturbances, which can be associated with anxiety or depression, reported (Witkin-Lanoil, 1986). Cavanaugh (1989) cites estimates of up to 10 % of women and 5 % of men have symptoms of anxiety.

The differences between men and women regarding depression may be attributed to the social forces driving men to be powerful, strong, and capable, and women to be weak, emotional, and incapable. Researchers are finding links between gender and acculturation to high levels of depression, and are focusing more on cross-cultural and gender-related factors as the core social determinants of the distribution of depressive illness affecting the relatively powerless (Kleinman & Good, 1986, p. 79). "Discussing gender in the context of culture might help us to understand the problems of women more clearly, while highlighting some

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aspects of cultural differences that are otherwise hidden". (McGoldrick, Anderson & Walsh, 1991, p. 211).

Anxiety and Depression in Early Adults

Krenawi and Graham (2001) investigated the well being of Arab adolescents who live under the threat of ongoing blood vengeance, and assessed the impact of socio-demographic characteristics, cultural context, and family functioning as mediating factors. The findings suggest that there are similarities among children and adolescents who live in war zones and those who live under a threat of blood vengeance. Family functioning appears as a major mediator of well being.

Foster et al (2004) examined gender differences in the levels of violence exposure and in the levels of posttraumatic stress (PTS) and related symptomatology in a sample of inner-city predominantly African American youth. Because such youth are at risk for exposure to chronic community violence, they are likely to experience considerable distress and clinical or sub-clinical levels of posttraumatic stress and related symptoms. As related before, previous research has found that although boys are exposed to violence more frequently than are girls, girls are more likely to express posttraumatic stress and related symptoms as a result of violence exposure. It was also found that while girls do not appear to differ in their responses to witnessing violence versus being a victim of violence, boys appear to be more distressed by being a victim of violence than by witnessing violence.

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than males, and black subjects reported more events than white subjects. The researchers concluded that while relatively few adolescents satisfy the criteria for PTSD, most subjects who experienced a specific type of traumatic event reported some PTSD symptoms.

Springer and Padgett (2000) examined the gender differences and levels of PTSD in young adolescents. The researchers believed that the extraordinarily high rates of PTSD symptomatology found in young adolescents reflect a deeply troubling aspect of life in contemporary United States society. Their findings show significant gender differences in severe PTSD symptomatology. Female adolescents were more likely to disclose symptoms than male adolescents. This shows that female adolescents are more likely to acknowledge mental distress, while male adolescents are reluctant to recognize or report mental problems.

Peterson et al (1991) examined the developmental pattern of depressed affect in early and middle adolescents. Longitudinal data on 335 adolescents randomly selected from two school districts was used to test the hypotheses. Results revealed that girls are at risk for developing depressed affect by 12th grade because they experience more challenges in early adolescence than do boys.

Anxiety and Depression in Adults

Research carried out by Powel et al (2003) with survivors of a variety of different traumas indicated that a large proportion of the survivors perceived changes in themselves after the trauma. The authors investigated whether posttraumatic growth also could be found among people who had been exposed to particularly severe trauma after several years, and results showed that younger people reported considerably more growth than older people.

Trautman et al (2002) surveyed forty-five Adult Asian and Middle Eastern immigrants living in Oklahoma City at the time of the 1995 bombing two years later as part

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of the disaster mental health outreach program. Demographic variables, physical and interpersonal exposure, initial physiologic and emotional responses to the bombing, and posttraumatic stress symptoms associated with the disaster and the earlier trauma were measured. Most participants had experienced prior trauma in their homelands. PTSD symptomatology from prior trauma was most predictive of initial physiologic and emotional responses and of later bomb-related PTSD symptoms. Bombing related PTSD symptoms increased with current age and was inversely related to age at the time of the trauma.

Anxiety and Depression in Americans

Pollard and Bates (2004) examined the relationship of religion and perceived stress, 97 undergraduate college students responded to the Perceived Stress Scale, the Spiritual Well-being Scale, and the Intrinsic/Extrinsic-Revised scale during a period of extreme national stressors during Fall 2001, namely, around the time of the September 11th terrorist attacks, Anthrax scare, and war in Afghanistan, in addition to the local stressor of pending final college examinations. Scores on the Perceived Stress Scale were negatively correlated to scores on Existential Well-being (-.66), Religious Well-being (-.43), and Intrinsic Religious Orientation (-.44). Age was unrelated to all variables. Both the quality (well-being) of the students' religious experiences, and the orientation of those experiences were related to their perception of stress. A sample of 440 undergraduate university students completed the Templer Death Anxiety Scale. Women comprised 66% of the sample, and 79% of the sample identified themselves as 18 to 21 years of age and either freshmen or sophomores. The authors found a significant relationship between religion and stress only for women. The scores showed that women scoring high on the religious scale also scored high on stress.

Whalen et al (2004) examined the perceived impact of the events of September 11, 2001, on adolescents distant from the disaster sites, and compared these perceptions with changes in everyday moods. 171 adolescents participating in a longitudinal study of stress and health completed a survey of reactions to September 11, 2001 two to five months after the events. Electronic diary ratings of contemporaneous moods before and after the attacks were also compared. Many adolescents distant from the disaster sites reported changes in everyday activities and signs of distress along with some positive outcomes. Elevated levels of negative affect emerged when adolescents were asked directly about the event (focused impact), but no changes were detected in their ongoing, momentary mood reports before and after September 11, 2001 (ambient impact). Trait and electronic diary measures of anxiety independently predicted posttraumatic distress. This clearly shows that reminder about disasters; either through television, newspaper, or interviews; forces people to focus on these incidents and make them more vulnerable to stress and depressed mood.

Piiparinne and Smith (2003) investigated stress symptoms before and after the September 11, 2001 terrorist attack on the World Trade Center. Responses to the Smith Stress Symptoms Inventory were compared for Chicago area college students assessed 1 to 5 weeks after 9/11 (n= 149), and a comparable sample tested up to 5 months prior to 9/11 (n=320). Post-9/11 participants scored higher on Attention Deficit. Contrary to prior research, post-9/11 participants did not score higher on distress, including Worry, Autonomic Arousal/ Anxiety, Striated Muscle Tension, Depression, and Anger. It is suggested that those indirectly exposed to a terrorist attack may display traditional symptoms of distress and arousal (as suggested by previous research). Later symptoms of attention deficit and distancing may emerge. This work was based on independent pre- and post-9/11 samples,

and must be replicated longitudinally as a test-retest to draw conclusions regarding change over time.

Blanchard et al (2005) studied the level of posttraumatic stress symptoms (PTSD), depressive symptoms, and frequency of diagnoses of probable posttraumatic stress disorder (PTSD) among college students. The researchers found proximity effects (Albany higher than Augusta which was higher than Fargo) for PTSS and depressive symptoms, but not for frequency of diagnoses of probable PTSD. Although depressive symptoms were significantly different in 2002 versus 2001, the arithmetic differences in PTSS or in frequency of diagnoses of probable PTSD were not significant. The September 11, 2001 attacks continued to exert a psychic toll on college students even a year later.

Pantin et al (2003) examined posttraumatic stress disorder (PTSD) symptom severity in Hispanic immigrants exposed to the September 11th attacks through television, ascertained the relationship between previous traumatic exposure and the September 11th-related symptoms, and investigated the effect of television exposure of the attacks on symptoms. A total of 110 Hispanic immigrant adults (22 males, 88 females) living more than 1,000 miles from the attacks completed measures of natural disaster exposure, war violence exposure, and September 11th-related PTSD symptoms. Of the sample, 14% self-reported September 11th-related PTSD symptoms were consistent with a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis. Previous exposure to natural disasters and war violence was significantly related to September 11th--related PTSD symptomatology. Individuals with symptoms consistent with a DSM-IV PTSD diagnosis reported twice as much war violence exposure and one-and-a-half times as much natural disaster exposure as those not meeting the criteria.

Bell and Marcum (2004) examined posttraumatic stress, religious coping, and non-religious coping in relation to positive religious outcomes following the tragedies of 9/11. In November 2001, a mailed survey of 814 active, ordained ministers in the Presbyterian Church (U.S.A.) measured posttraumatic stress, perceived threat, coping activities, positive and negative religious coping, positive religious outcomes, and perceived congregational responses. A majority of the respondents (75 %) experienced some posttraumatic stress symptoms, with 63 % feeling threatened for their personal safety. Non-religious coping behaviors included contributing money (60 %) and displaying the flag (56 %). Looking to God for strength, support, and guidance was the most frequently used strategy; increased prayer was second. High stress was associated with higher frequency of coping strategies, both religious and non-religious. More frequent positive religious coping was related to less severe stress symptoms of numbness and avoidance, and higher positive religious outcomes. Although religion failed to provide protection against stress in a population of religiously dedicated individuals, it provided a pathway for positive and effective coping strategies that resulted in positive religious outcomes.

Richman et al (2004) hypothesized that chronic stressors associated with an everyday social role (work) would interact with a traumatic macro social stressor (the terrorist attacks of September 11, 2001) in predicting mental health status (during the fall of 2001). Authors used mail surveys returned as part of wave 3 of a workplace cohort study, both before and after September 11, 2001, to assess decision latitude, sexual harassment, generalized workplace abuse, psychological distress, and alcohol use. They also used regression analyses to assess the main effect of September 11, 2001 and interactions between September 11, 2001 and stressors, after control for baseline mental health. The main effect of September

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11, 2001 on elevated alcohol use was significant for women, but not for men. For women, work stressors significantly interacted with experiencing the events of September 11, 2001 to affect alcohol use and anxiety outcomes.

Six months after September 11, 2001 (9/11), 124 New York City workers participated in a self-report study of symptoms of posttraumatic stress disorder (PTSD) Piotrkowski and Brannen (2001).   Although direct exposure to the terrorist attacks of 9/11 was limited, estimates of the prevalence of current PTSD in this mostly ethnic minority population ranged from 7.8% to 21.2%, as measured by the PTSD Checklist. Consistent with the study hypotheses, direct exposure to the attacks of 9/11, worries about future terrorist attacks (threat appraisal), and reduced confidence in self after 9/11 each predicted symptoms of PTSD, even after controlling for symptoms of anxiety and depression. These results support the idea that a traumatic event's meaning is associated with PTSD symptoms.

Summary

This chapter began by discussing the concepts of anxiety, depression and posttraumatic syndrome. Each concept was discussed as it related to the mental health of Muslims, refugees of different ethnicity and gender, as well as to different populations in America and the impacts of September 11, 2001 on these populations.

Previous research clearly shows that disasters, which may be natural or manmade, definitely have severe negative impacts on human beings, causing distress and anxiety. The victims of war develop symptoms, which may be either physiological or psychological in nature. The impacts of these events are very intense soon after the incidents and generally wax and wane, wearing away as times passes. In many cases, the symptoms may linger more than usual and impact the people for a considerable period of time. When these victims are

subjected to a new setback or reminded of their earlier experiences through pictures or news, some of them experience flashbacks, struggle to forget the past, and tend to relive the memories.

Previous research also found gender differences with regards to anxiety and depression. Women seem to be more vulnerable to anxiety and depression. Their mental health is definitely at stake in comparison to men. The trait factor seems to play an important role for them. Temperamentally women are more anxious and worry more than men. Therefore, when there is a setback, they tend to be more easily affected, and depression seems to last longer for them.

In studies conducted on Bosnian Muslims, Iraqis, and other Arab adolescents, there is much evidence of anxiety and depression and the impacts of September 11, 2001 may be greatest among the Muslims, since they are being viewed as perpetrators of violence. Therefore, many Muslims are living with constant fear of being attacked, picked up for interrogation or even deported to their homeland.

All previous research points out that any situation that threatens a population would create anxiety and depression to varying degrees. As the September 11, 2001 hijackers were Muslims, there were hate crimes all over United States of America were directed towards Muslims, which only created more fear and anxiety. In a vitiated atmosphere Muslims felt they were under threat post 9/11. As time progressed, the hate crimes were brought under control, and the Muslims were coping better with the situation. But the subsequent Iraq war would have once again heightened the fears and anxiety, although to a lesser degree.

The hate crimes against Muslims created apprehensions of their safety in United States. The Muslims of Arab origin would naturally perceive a bigger threat than the non-

Arab Muslims from other countries. Based on the results of previous research, it is reasonable to expect that Muslims in America are still experiencing anxiety and depression due to the events of 9/11 and the continuing war in the Middle East. It is also reasonable to postulate that refugees and immigrants from the Middle East will experience more distress than the American born Muslims.

There is a paucity of studies on these mental health issues, and there is an urgent need to address and to create better understanding and promote the assimilation of the Muslims to the mainstream. Since Muslims hail from several countries, it would be interesting to see to what extent they are affected in terms of their nationality.

Research Questions

Based on previous research this study will seek to answer the following specific research questions:

1. Is there a significant difference in depression between Muslims from Arab and non-Arab countries?

2. Is there a significant difference in State anxiety between Muslims from different Arab and non-Arab countries?

3. Is there a significant difference in Trait anxiety between Muslims from Arab and non-Arab countries?

4. Is there a significant difference in depression among Muslims from Arab countries?

5. Is there a significant difference is state anxiety among Muslims from Arab countries?

6. Is there a significant difference in trait anxiety among Muslims from Arab countries?

7. Is there a significant difference in depression among Muslims from non-Arab countries?

8. Is there a significant difference in state anxiety among Muslims from non-Arab countries?

9. Is there a significant difference in trait anxiety among Muslims from non-Arab countries?

CHAPTER 3

METHOD

Description of the Sample

Two groups of participants took part in this study. One group (hereafter referred to as Arab countries) consisted of Muslims from Egypt, Syria, Palestine, Iraq and Saudi Arabia. The second (hereafter referred to as non-Arab countries) consisted of Muslims from India, Pakistan, Bangladesh, Indonesia, and Malaysia. The participants were students, men, women, adolescents, adults, and older Muslims from a southeastern city in the United States (population: 10,000).

The list of Arab Muslims and the non-Arab Muslims was developed with the help of the registry at an Islamic Center. The researcher's decision to select Muslims from Iraq, Saudi Arabia, Palestine, Syria and Egypt as the Arab group was for the following reasons: (a) Iraq and Palestine, because of the ongoing turmoil in those countries (b) Syria, because it is experiencing the threat of being militarily attacked, and (c) Saudi Arabia and Egypt because these countries are involved in the Israel-Palestinian conflict, and they also share a common language.

The non-Arab countries such as India, Pakistan, Bangladesh, Indonesia and Malaysia were selected for these specific reasons: (a) All of these countries are from the Asian sub continent, (b) Indonesia, Pakistan and Malaysia because they are predominantly Muslim countries, (c) India, because it has the second largest Muslim population in the world, and (d) Bangladesh, because of its Muslim population majority, and because of its substantial presence in the United State of America.

The Muslims from the five Arab countries consisted of thirty-seven young adults,

seventeen females, and twenty males. They were also forty-six adults out of which twenty-two were females and twenty-four were males, and there were forty-three older adults, out of which twenty-two were females, and twenty-one were males.

The Muslims from the five non-Arab countries consisted of thirty-three young adults of these fifteen were females and eighteen were males. The adult category consisted of twenty-five females and twenty-eight males, and the older adults were fifteen females and twenty-one males.

Procedure

The researcher selected those Muslims who came from Saudi Arabia, Iraq, Syria, Egypt Palestine, India, Pakistan, Bangladesh, Malaysia, and Indonesia. This main sample consisted of two thousand and five hundred subjects. The researcher then prepared two separate lists, Muslims from Arab countries and Muslims from non-Arab countries. The Muslims from Arab countries were one thousand and three hundred and Muslims from non-ARAB countries were one thousand two hundred in number. Once the two main lists were prepared, the researcher selected every third person from each of the lists. This procedure was followed to make sure that every person on the list had an equal chance of participating. The final list consisted of three hundred participants. The researcher then sent out packets, which included a letter briefly explaining the purpose of the study, assuring participants' anonymity, and requesting their participation. The packet also contained the Beck's Depression Inventory and Spielberger's State Trait Anxiety Scale. Both the inventories were self- administered and carried clear instructions. The instructions were made very clear to the participants. They were instructed to do the T-Anxiety scale first, and then to move on to S-Anxiety scale. Instructions about the reverse scoring of some of the items on the scales

were included in the information. Those who completed and returned the packet of inventory materials were included in the sample.

<center>*Research Design and Methodology*</center>

The client sample was controlled for demographic characteristics. The participants were a heterogeneous group in terms of sex, age, and country of origin. The research was designed as an exploratory study using a random sample of the Muslims in a Southeastern city in United States. As a consequence of the design, generalizations are limited to the population included in the study, and causation is not assumed. For all objective measurement variables (age, gender and country of origin), the measures of anxiety and depression are the dependent variables.

<center>*Instruments*</center>

The client packet of materials contained two collection instruments. They were:

(1) State Trait Anxiety Inventory (Spielberger, 1972), (STAI)

(2) Beck's Depression Inventory (1987), (BDI)

Description and Applications of the STAI

The State- Trait Anxiety Inventory (STAI) has been used extensively in research and clinical practice. It comprises separate self-report scales for measuring state and trait anxiety. The S-Anxiety scale (STAI Form Y-1) consists of twenty statements that evaluate how respondents feel at the time they complete the instruments. The T-Anxiety scale (STAI Form Y-2) consists of twenty statements that assess how people feel in general.

The essential qualities evaluated by the STAI S-Anxiety scale are feelings of apprehension, tension, nervousness, and worry. In addition to assessing how people feel right now, the STAI S-Anxiety scale may also be used to evaluate how they felt at a

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particular time in the recent past and how they anticipate they will feel either in a specific situation that is likely to be encountered in the future or in a variety of hypothetical situations. Scores on the S-Anxiety scale increase in response to physical danger and psychological stress, and decrease as a result of relaxation training.

The S- Anxiety scale has been found to be a sensitive indicator of changes in transitory anxiety experienced by clients and patients in counseling, psychotherapy, and behavior modification programs. The scale has also been used extensively to assess the level of S-Anxiety induced by stressful experimental procedures and by unavoidable real-life stressors such as imminent surgery, dental treatment, job interviews, or important school tests.

The STAI T-Anxiety scale has been widely used in assessing clinical anxiety in medical, surgical, psychosomatic, and psychiatric patients. Psychoneurotic and depressed patients generally have high scores on this scale. The T-Anxiety scale is also used for screening high school and college students and military recruits for anxiety problems, and for evaluating the immediate and long-term outcome of psychotherapy, counseling, behavior-modification, and drug-treatment programs. In clinical and experimental research, the STAI T-Anxiety scale has proven useful for psychological experiments, which differ in motivation or drive level.

The STAI was developed for use with high school and college students and adults; it has also been useful with junior high school students (Spielberger, 1973). The STAI has been adapted in more than thirty languages for cross-cultural research and clinical practice (Spielberger & Diaz-Guerrero, 1976, 1983).

In Form Y, 30 percent of Form X items were replaced resulting in improved psychometric properties for both S-Anxiety and T-Anxiety scales. The number of anxiety-

present and anxiety-absent items for the Form Y is better balanced, and the factor structure is more consistent and replicable (see Appendix b). Further research will be required to demonstrate that replacing items that had obvious depressive content improved the power of the Form Y to discriminate between patients suffering from anxiety and depression.

Administration and Scoring

The STAI was designed to be self-administered and may be given either individually or to groups. The inventory has no time limits. College students generally require about six minutes to complete either the S-Anxiety or the T-Anxiety, and approximately ten minutes to complete both. Repeated administrations of the S-Anxiety scale typically require five minutes or less. The STAI and its subscales should be consistently referred to as the Self-Evaluation Questionnaire.

In research settings, subjects generally respond more objectively and accurately if they are informed that their responses will be kept confidential, especially if they are promised feedback about their test results. Clinical research findings suggest that distorting effects of adverse test-taking attitudes are not a serious problem if sufficient care is taken to obtain the cooperation and trust of the respondents at the time the STAI is administered.

Complete instructions for the S-Anxiety and the T-Anxiety scales are printed on the test form. Critical to the validity of the inventory is the examinees' clear understanding of the "State" instructions, which ask them to report how they feel right now at this moment, and the trait instruction, asked them to indicate how they generally feel. The examiner should emphasize that instructions are different for the two parts of the inventory and that examinees must read both sets of instructions carefully.

Although the T-Anxiety scale should always be given with the instructions printed on

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the test form, instructions for S-Anxiety may be modified to evaluate the intensity of S-Anxiety for any situation or time interval of interest to an experimenter or clinician. Most people have no difficulty responding to the S-Anxiety items according to how they felt in a specific situation or at a particular moment of time, provided that the feelings were recently experienced, and that the person is motivated to cooperate with the examiner.

The S-Anxiety Scale is always administered first, followed by the T-Anxiety scale. Since the S-Anxiety scale was designed to be sensitive to the conditions under which the test is administered, scores on this scale are given first. In contrast, it has been demonstrated that the T-Anxiety scale is relatively impervious to the conditions under which it is given (e.g., Auerbach, 1973; Lamb, 1969; Spielberger et al, 1973).

In responding to the STAI S-Anxiety scale, examinees blacken the number on the standard test form to the right of each item-statement that best describes the intensity of the feelings: (1) not at all; (2) somewhat;(3) moderately; (4) very much so. In responding to the T-Anxiety scale, examinees are instructed to indicate how they generally feel by rating the frequency of their feelings of anxiety on the following four point scale: (1) almost never; (2) sometimes; (3) often; (4) almost always.

Scoring

Each STAI item is given a weighted score of 1 to 4. A rating of 4 indicates the presence of a high level of anxiety for ten S-Anxiety items and eleven T-Anxiety items (e.g., "I feel frightened, "I feel upset"). A high rating indicates the absence of anxiety for the remaining ten S-Anxiety items and nine T-Anxiety items (e.g., "I feel calm", 'I feel relaxed). The scoring weights for the anxiety-present items are the same as the blackened numbers on the test form. The scoring weights for the anxiety-absent items are reversed, that is,

responses marked 1, 2, 3, or 4 are scored 4, 3, 2, or 1, respectively. The anxiety-absent items for which the scoring weights are reversed on the S-Anxiety and T-Anxiety scales are: S-Anxiety: 1,2,5,8,10,15,16,19,20 and T-Anxiety: 21,23,26,27,30,33, 34, 36,39.

To obtain scores for the S-Anxiety and T-Anxiety scales, simply add the weighted scores for the twenty items that make up each scale, taking into account the fact that the scores are reversed for the above items. Scores for both the S-Anxiety and the T-Anxiety scales vary from a minimum of 20 to a maximum of 80.The scoring key is used for scoring the scales by hand.

Norms for the STAI

In collecting the data for the normative samples, the S-Anxiety scale was always administered first, followed by the T-Anxiety scale. Normative data for form Y are available for the working adults, college students, high school students, and military recruits.

Reliability: Stability and Internal Consistency

The test-retest correlations for the T-Anxiety scale were reasonably high for college students, ranging from .73 to .86 for the six subgroups, but somewhat lower for the high school students, ranging from .65 to .75. The median reliability coefficient for the T-Anxiety scale for college and high school students were .765 and .695, respectively. For the S-Anxiety scale, the stability coefficients for college and high school students were relatively low, ranging from .16 to .62, with a median reliability coefficient of only .33. Relatively low stability coefficients were expected for the S-Anxiety scale because a valid measure of state anxiety should reflect the influence of unique situational factors that existed at the time of testing. Item remainder correlations computed for the normative samples provides evidence of the internal consistency of the STAI scales. The median S- anxiety item reminder

correlation was .63 for the working adults, .59 for the college students, .55 for the high school students, and .61 for the military recruits. The corresponding T-anxiety item remainder correlations were .56, .57, .54, and .62, respectively.

Given the transitory nature of anxiety states of internal consistency such as the alpha coefficient provides a meaningful index of the reliability of S-Anxiety scales than test-retest correlations. Alpha reliability coefficients are typically higher for the STAI-S Anxiety scale when the evaluation is given under conditions of psychological stress. For example, the alpha reliability of the Form X S-Anxiety scale was .92 when it was administered to a group of college males immediately after a difficult intelligence test and .94 when it was given immediately after a distressing film. For the same subjects, the alpha reliability was .89 when it was given following a brief period of relaxation training. In summary, stability, as measured by test-retest coefficients, is relatively high for the STAI T- Anxiety scale and low for the S-Anxiety scale. The internal consistency for form Y is slightly higher than for form X. The over all median alpha coefficients for the S-Anxiety and T-Anxiety scales for form Y in the normative samples are .92 and .90 respectively.

Validity

Validity for trait scores was estimated by correlating the scores with the IPAT Anxiety Scale, Manifest Anxiety Scale, and Affect Adjective Check List. For 126 college women, coefficients were .75, .80, and .52, respectively. For the state measure, both item and total score comparisons between presumably stressful states were given, with mean scores reflecting changes in the appropriate directions. Alpha coefficients reported for stressful and non-stressful conditions remain the same, again indicating internal consistency. Dreger (as cited in Buros, 1978, p. 684) stated that "the revised STAI is one of the best

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standardized anxiety measures, its reliabilities are nearly as high as one would expect for intelligence scales; it demonstrated expected differences among groups of persons; and its state form generates non-random factor structures when used over time".

Beck's Depression Inventory

The BDI is a 21 item self-report rating inventory measuring characteristic attitudes and symptoms of depression (Beck, 1967 as cited in Buros, 1978, p. 1101). The BDI has been developed in different forms including several computerized forms, and a card form (May, Urquhart & Tarran, 1969, cited in Groth-Marnat, 1990).

Description: The BDI is a self-administered 21 item self-report scale measuring supposed manifestations of depression. The BDI takes approximately10 minutes to complete, although clients require a fifth - sixth grade reading age to adequately understand the questions (Groth-Marnat, 1990).

Reliability

Internal consistency for the BDI ranges from .73 to .92 with a mean of .86 (Beck, Steer & Garbin, 1988). Similar reliabilities have been found for the 13-item short form (Groth-Marnat, 1990). The BDI demonstrates high internal consistency, with alpha coefficients of .86 and .81 for psychiatric and non-psychiatric populations, respectively (Beck 1988).

Split-half / Cronbach's Alpha divides the items on the scale into two halves. The scores on the two halves are then compared or correlated. One of the most common methods to slit the halves is to use all even numbered items for one half and all odd numbered items for the second half.

Criterion related validity, also referred to as instrumental validity, is used to demonstrate the

accuracy of a measure or procedure by comparing it with another measure or procedure, which has been demonstrated to be valid. The BDI has a split-half reliability co-efficient of .93.

Test-Retest Reliability Beck (1961) did not recommend conventional test-retest reliability for his original measures for the BDI. Beck suggested that if the BDI was re-administered within a short interval, then scores could be spuriously inflated due to memory factors. If the test were to be re-administered after a long interval, then consistency would be lower due to the intensity of depression. Alternate test-retest reliability methods by Beck et al, (1961) found that regardless of whether the 2 tests were reissued at 2 or 6 week intervals the scores on the inventory tended to reflect changes in the clinical depth of depression. However, Groth-Marnat (1990) reported that re-test reliabilities ranged from .48 to .86, depending on the interval between re-testing and type of population. Inter-rater Reliability. Inter-rater reliability is the extent to which two or more individuals (coders or raters) agree. Inter-rater reliability addresses the consistency of the implementation of a rating system. Beck (1961) reported that inter-rater reliability was not appropriate for the BDI.

Validity & Factor Analysis

A meta-analyses of studies on the revised BDI's psychometric properties by Richter, Werner, Heerlim, Kraus, & Sauer, 1998, as cited in Buros, 1968, p. 1108) reported advantages with the revised BDI's high content validity, and validity in differentiating between depressed and non-depressed people. Beck, Steer and Garbin (1988) reported that the revised BDI has been found to include three to seven factors, depending on the method of factor extraction. These include factors that reflect negative attitudes towards self, performance impairment and somatic disturbances, as well as a general factor of depression

(Brown, Schulberg & Madonia 1995).

Criterion (or Predictive) Validity Criterion related validity, also referred to as instrumental validity, is used to demonstrate the accuracy of a measure or procedure by comparing it with another measure or procedure, which has been demonstrated to be valid. The BDI has been able to discriminate the level of adjustment in seventh-graders (Albert & Beck, 1975 as cited in Groth-Marnat, 2003).

Content Validity Content Validity is based on the extent to which a measurement reflects the specific intended domain of content (Carmines & Zeller, 1991, p.20). The content of the BDI was obtained by consensus from clinicians regarding symptoms of depressed patients (Beck, 1961). The revised BDI items are consistent with six of the nine DSM-111 categories for the diagnosis of depression (Groth-Marnat, 2003).

Concurrent validity   utilizes correlations with clinician ratings of depression using the revised BDI range from .62 to .66 (Foa, Riggs, Dancu, & Rothbaum, 1993). Clinical ratings for Psychiatric patients are reported as high to moderate, ranging from .55 to .96 Man r=.72 (Beck et al., 1988 cited in Groth-Marnat 2003). Groth-Marnat (2003) reported moderate correlations between the revised BDI and other scales measuring depression such as the Hamilton Psychiatric Rating Scale for Depression (.73) and the Zung Self Reported Depression Scale (.76) and the MMPI Depression Scale (.76).

Construct Validity Groth-Marnat (2003) reported that controversy exists over whether the revised BDI is measuring state or trait variables. Furthermore, it has been suggested that the BDI is not specific to depression.

Convergent and Discriminant Validity   Groth-Marnat (2003) reports that the revised BDI discriminates Psychiatric patients from non-psychiatric patients as well as relatively higher

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scores for patients with major depressive disorder compared to patients with dysthymic

disorders. The revised BDI has also been used to discriminate loneliness, stress, and self

reported anxiety (Groth-Marnat, 2003).

Total Score Levels of Depression

05 - 09   scores in the range are considered normal

10 - 18   Mild to moderate depression

19 - 29   Moderate to severe depression

30 - 63   Severe depression

Below 4 = Possible denial of depression, faking well; this is below usual scores for

normals.

Data Analysis

The data analysis consisted of the following functional and statistical steps: data scoring;

elimination of incomplete data from the samples; compiling descriptive statistical summaries

(number of subjects, range, mean, standard deviation); performing t-tests, Analysis of

Variance (ANOVAs), and Multiple Regression.

Data Scoring

The State Trait Anxiety Scale (Spileberger, 1972) scoring directions were supplied by

its developer, and because of the objective nature of the scoring, no special training was

needed. The items were numbered, the direction of each item scale was noted, and the scores

related to each of the two forms were summed. Beck's Depression Inventory (1987), used for

measuring depression, was also hand scored. The scores were totaled and were compared

against the levels given in the scale.

Elimination of Incomplete Data

There were a number of subjects who only partially completed the inventory packet (e.g., completed Beck's but not STAI, or completed only form Y1 and not Y2 of STAI) and they were eliminated from the analysis for both of the inventories. The researcher mailed the packet to the respondents and maintained very minimal contact with them. This was done to ensure the anonymity of the respondent and the confidentiality of his or her data. On the other hand, some of the respondents did not feel obligated and either failed to return the questionnaires or returned partially completed ones.

The researcher met some of the participants who had completed the questionnaires and was able to obtain very interesting feedback from them. The researcher came to understand that some participants who had been directly affected by the ongoing turmoil in Iraq and Indonesia (the data was collected when the Tsunami had struck Indonesia), reading and answering the questionnaires made some participants very uncomfortable and emotional and therefore the participants were unable to complete them.

Descriptive Statistical Summaries

The statistical range is the difference between the lowest and highest valued numbers in a set of numbers. The statistical mean of a set of observations is the average of the measurements in a set of data. The sample mean is often used as an estimator of the mean of the population from whence the sample was taken. In fact, the sample mean is statistically proven to be a most effective estimator for the population mean.

Inferential Statistics

The t-test was used to determine if any significant differences between means existed for the variables being investigated. An indication of significance would then lead to an inspection of the statistics mentioned above for the groups involved in order to determine the direction and possible interpretations of the group differences. Where there were more than two factors considered, an analysis of variance was used.

An ANOVA (Analysis of Variance), sometimes called an F test, is closely related to the t- test. The major difference is that, where the t- test measures the difference between the means of two groups, an ANOVA tests the difference between the means of two or more groups.

The general purpose of multiple regression (the term was first used by Pearson, 1908) is to learn more about the relationship between several independent or predictor variables and a dependent or criterion variable.

Methodological Limitations

A major limitation of the study was the representation of a small proportion of the total client population. The time commitment involved in completing the inventories and returning them within a week further eliminated those who did not respond and thus satisfying the requirements of the research from those who did.

The test taking conditions were completely uncontrolled and left to the convenience of the respondents. Thus the validity of the data, which may have been confounded by dissimilar test-taking conditions, including timing, distraction, outside influences, would be suspect.

Based on the above restrictions, the results of this study may be generalizable only to a

sample of the same characteristics was attempted to strengthen this limitation through the use of an external consistency comparison. That is, if the trends found in this study are parallel to similar studies using other populations, then its reliability would be supported.

Chapter Summary

In this chapter, an overview of the study was presented, nine research questions were stated, and the subjects and their selection were described. The appropriateness of the instruments used in this study along with the review of the research related to test reliability and validity were discussed. To conclude, the major limitations to the generalizability of this study's findings were explicated.

CHAPTER 4

DATA ANALYSIS

Summary of Sample Composition and Size

Table 1

Descriptive Statistics for Arabs and Non-Arabs

Groups	Early Adults	Adults	Older Adults
Arabs-(126)			
Males-(65)	20	24	21
Females-(61)	17	22	22
Non-Arabs-(122)			
Males-(67)	18	28	21
Females-(55)	15	25	15

Note: Early Adults-17 to 24 years; Adults- 25 to 44years; Older Adults-45-55 years.
Number in parenthesis indicates the total sample size

Table 1 shows the number of participants in each group. The sample size for the Arabs was

126, which included 65 males and 61 females. The Arab males consisted of 20 early adults,

24 adults and 21 older adults. The Arab females consisted of 17 early adults, 22 adults and 22

older adults. For the non-Arab males, there were 18 early adults, 28 adults and 21 older

adults. The non-Arab group consisted of 15 early adults, 25 adults and 15 older adults.

There were two hundred and forty eight participants in this study who completed

Spielberger's State Trait Anxiety Scale and Beck's Depression Inventory. The list of Arab

Muslims -Arab Muslims was prepared with the help of the registry at the Islamic Center. A list of Muslims from Arab and non-Arab countries was also prepared. The Arab countries included Iraq, Palestine, Saudi Arabia, Egypt, and Syria. The non-Arab countries included India, Pakistan, Bangladesh, Indonesia and Malaysia. All of the participants received a packet that included a letter briefly explaining the purpose of the study, assuring participant anonymity, and requesting their participation. Those who completed and returned the packet of inventory materials were assigned to one of the two groups.

The participant sample was controlled for demographic characteristics. They were heterogeneous groups in terms of sex, age, and country of origin. Once the researcher had prepared the two main lists, the researcher then selected every third person from each of the list and sent out instruments to three hundred selected Muslims. This was done to ensure that every person on the list had an equal chance of participating. Two hundred forty-eight individuals returned completed forms. Forty-two were dropped from the original list as a result of inconsistent or missing data.

Table 2   *Elimination Data*

ARABS		Non-ARABS	
No of packets Sent	No of Packets Returned/Complete	No of Packets Sent	No of Packets Returned/Complete
Iraq- 34	29	Indonesia 25	19
Palestine 28	22	Pakistan 35	33
Syria 30	25	India 30	26
S.Arabia 31	26	Bangladesh 40	25
Egypt 27	24	Malaysia 20	19

The above table shows the elimination data. The researcher sent out packets to each of the Arab and non-Arab countries and some of the packets were incomplete or were never returned. A total of three hundred packets were sent out to participants belonging to Arab and non-Arab countries, two hundred and forty questionnaires were available for scoring. Some participants either failed to return or returned incomplete questionnaires.

Research Questions and Data Analysis

Research Question 1: Is there a significant difference in depression between Muslims from Arab and non-Arab countries?

The Muslims from Arab and non-Arab countries were compared for their mean scores on Beck's Depression Inventory. A key part of Beck's Theory is not only that the subject will feel negative underlying beliefs, but also that these beliefs fall into a certain field which

separates them from other disorders such as panic and anxiety disorder. Thus, the main

feelings of depression, according to Beck, are failure and loss. The researcher's aim was to

compare the Muslims from Arab and non-Arab countries, and to draw inference about their

depression based on their mean scores.

Table 3

Scores and Means for Muslims from Arab and Non-Arab Countries for Beck's Depression

Inventory

Arabs				Non-Arabs			
Country	Number	Total	Mean	Country	Number	Total	Mean
Palestine	22	958	43.54	Indonesia	19	931	49
Iraq	29	1088	37.51	Pakistan	33	1198	36.33
Egypt	24	770	32.08	Bangladesh	25	802	32.08
Syria	25	780	31.20	India	26	813	31.26
S.Arabia	26	729	28.03	Malaysia	19	548	28.89
Total	126	4325	172.36		122	4292	177.36
Overall Group Average			34.47				35.51

Table 3 shows the number of scores derived from each country, each country's total

scores, and each country's mean scores for Arabs and Non-Arabs for depression as

measured by Beck's Depression Inventory. The total score obtained for Palestine was 958

scored by 22 participants. Iraq had a total score of 1088 scored by 29 participants. Egypt

had a total score of 770 scored by 24 participants, and Saudi Arabia had a total score of 729

scored by 26 participants. The overall score obtained by the Muslims from Arab countries was 4325 and the mean score was 34.47. The mean range for depression for Muslims from Arab countries was 28.03 to 43.54. According to Beck (1976), a score of 43.54 indicates severe depression and a score of 28.03 indicates moderate depression. The range of depression for Muslims from Arab countries was moderate to severe. Palestine had the highest mean score followed by Iraq and Egypt, and the lowest value was secured by Saudi Arabia. It is interesting to note that although Palestine had the lowest representation of participants, they had the highest mean value, and this gives a clear indication of the level of depression among the Palestinians.

The score obtained by 19 Indonesians was 931 with an average of 49, the score obtained by 33 Pakistanis was 1198 with an average of 36.33, the score obtained by 25 Bangladeshis was 802 with an average of 32.08, the score obtained by 26 Indians was 813 with an average of 31.26, and the score obtained by 19 Malaysians was 548 with an average mean value of 28.89. Among the Muslims from non-Arab countries, the highest mean value was secured by Indonesia and the lowest was secured by Malaysia. The range of depression for Muslims from non-Arab countries was moderate to severe. The overall score obtained by the Muslims from non-Arab countries was 4292, and the overall mean score for Muslims from non-Arab countries was 35.51.   The results reveal that the Muslims from non-Arab countries scored higher than the Muslims from Arab countries on Beck's Depression Inventory. The first research question asked if there is a significant difference in depression among Arabs and non-Arabs. The researcher utilized PROC GLM in SAS (SAS Institute, 2001; version 8.02) to run an ANOVA to analyze the Beck's Depression Inventory as the dependent variable and the interaction of depression with the sex and age.

Table 4

ANOVA Comparing Muslims from Arab and Non-Arab Countries for Beck's Depression

Inventory

Source	DF	Type III SS	MeanSquare	F Value	Pr > F
Sex	1	0.147323	0.147323	0.00	0.9716
Age	2	43.419401	21.709701	0.198.28	0.8298
Country	9	8672.275016	963.586113	8.29	>. 0001
Sex*age	2	114.74833	57.374167	0.49	0.6112
ContrastArab vs non-Arab	DF	Contrast SS	MeanSquare	F value	Pr>value
	1	682.6158547	682.6158547	5.87	0.0162

Table 4 presents the results of ANOVA for the first research question. The Muslims from Arab and non-Arab countries differed significantly on Beck's Depression Inventory. The mean value for Muslims from non-Arab countries (M=177.56) was higher than that of the Muslims from Arab countries (M= 172.36). The F value was 5.87 and p=0.0162. There was a significant difference within the Muslims from Arab countries and Muslims from non-Arab countries where F=8.29 and p=>. 0001. Within the Arab and non-Arab countries, there seemed to be variation in the depression scores resulting in a significant difference. There is no evidence of a significant difference between the age groups, F=0.198.28 and p= 0.8298. The interactions between the age groups (adolescent, adult and middle age groups) and sex were not significant with F at 0.49 and p = 0.6112. Sex did not play a significant role with F at 0.00 and p=.9716.

Table 5

Scores and Means for Muslims from Arab Non-Arab Countries for Spielberger's State

Anxiety Inventory

Arabs				Non-Arabs			
Country	Number	Total	Mean	Country	Number	Total	Mean
Iraq	29	1323	45.62	Indonesia	19	883	46.47
Palestine	22	998	45.36	Pakistan	33	1256	38.06
Syria	25	846	33.84	India	26	829	31.92
Egypt	24	776	32.33	Bangladesh	25	715	28.60
S.Arabia	26	840	32.31	Malaysia	19	507	26.68
Total	126	4783	189.46	Total	122	4190	171.73
Overall Group Average			37.89				34.24

Table 5 shows the mean scores and total raw scores, as well as the overall group mean

scores for Muslims from Arab and non-Arab countries for Spielberger's State Anxiety.

Spielbergers' anxiety scales vary from a minimum of 20 to a maximum of 80. Iraq had

n=29, a total score of 1323, and a mean of 45.62. Palestine had n=22, a total score of 998,

and a mean of 45.36. Syria had n=25, a total score of 846, and a mean of 33.84. Egypt had

n= 24, a total score of 776, and a mean of 32.33. Finally, Saudi Arabia had n=26, a total

score of 840, and a mean of 32.31. Among the Muslims from Arab countries, the highest

mean value was secured by Iraq, and the lowest mean value was secured by Saudi Arabia.

The range of scores for Muslims from Arab countries was 32.31 to 45.62. The overall mean

for Muslims from Arab countries was 189.46, and the overall group average mean was 37.89.

For Muslims from non-Arab countries, the highest mean value was secured by

Indonesia and the lowest mean value was secured by Malaysia. Indonesia had n=19, a total

score of 883, and a mean of 46.47. Pakistan had n=33, a total score of 1256, and a mean of

38.06. India had n=26, a total score of 829, and a mean of 31.92. Bangladesh had n=25, a

total score of 715 and a mean of 28.60. Malaysia had n=19, a total score of 507, and a mean

of 26.68. The state anxiety ranged from mild to moderate. Indonesia secured the highest

score, and Malaysia secured the lowest score. The overall mean for Muslims from non-Arab

countries was 171.73, and the overall group average was 34.24. The results reveal that

Muslims from Arab countries demonstrated higher state anxiety score than their counterparts

from non-Arab countries.

Research Question 2: Is there a significant difference in state anxiety between Muslims from

different Arab countries and non-Arab countries?

The second research question asked if there is a significant difference in Spielberger's

State Anxiety between Muslims from Arab countries and non-Arab countries. Since the

purpose of the study was to see if Muslims from Arab and non-Arab countries differed

significantly, the researcher looked at interactions between the countries, sexes, and age.

Table 6

ANOVA Comparing Muslims from Arab and Non-Arab Countries for Spielberger's State

Anxiety Inventory

Source	DF	Type III SS	MeanSquare	F Value	Pr > F
Sex	1	41.19150	41.19150	0.28	0.5941
Age	2	528.11674	264.05837	1.83	0.1633
Country	9	10292.41010	1286.55126	8.90	>. 0001
Contrast	DF	Contrast SS	MeanSquare	F value	Pr>value
Arab vs non-Arab	1	679.00447	679.00447	4.70	0.0313

Table 6 shows the results for ANOVA for Spielberger's State Anxiety. There is

evidence of a significant difference between Muslims from Arab and non-Arab countries for

the state anxiety variable, F value=4.70 and p=0.0313. The overall means for the Muslims

from Arab countries was 189.46 and for non-Arab countries was 171.73. Muslims from

Arab countries scored higher on state anxiety than Muslims from non-Arab countries. There

was a significant difference within the Arab and non-Arab countries, F=8.90 and p=>.0001.

Within the Arab and non-Arab countries, there seemed to be a variation in state anxiety

scores resulting in a significant difference. Males and females did not differ significantly on

state anxiety, with F=0.28 and p=0.5941. The discrepancy between the means was

marginal, hence it was not significant. Also, there was no significant difference between the

Muslims of different ages, with F=1.83 and p= 0.1633.

Table 7

Scores and Means for Muslims from Arab and Non-Arab Countries for Spielberger's Trait

Anxiety Inventory

Arabs				Non-Arabs			
Country	Number	Total	Mean	Country	Number	Total	Mean
Iraq	29	1291	44.52	Indonesia	19	655	34.46
Palestine	22	949	43.14	Pakistan	33	1091	33.06
Syria	25	837	33.48	Bangladesh	25	798	31.92
S. Arabia	26	749	28.81	India	26	715	27.50
Egypt	24	498	20.75	Malaysia	19	393	20.68
Total	126	4324	170.70		122	3652	147.62
Overall Group Average			34.14				29.52

Table 7 shows the means and standard deviations for Muslims from Arab and non-Arab

countries for Spielberger's Trait Anxiety. Spielbergers' anxiety scales vary from a minimum

of 20 to a maximum of 80. Iraq had n=29 for total score of 1291 and mean value of 44.52,

Palestine had n=22 a total score of 949 and a mean value of 43.14. Syria had n=25, and

scored 837 with a mean value of 33.48. Saudi Arabia had n=26, a total score of 749, with a

mean value of 28.81. Egypt had n=24, a total score of 498, with a mean of 20.75. The over

all mean was 34.14. The range of mean for Muslims from Arab countries was 20.75-44.52,

which indicated that the range for trait anxiety was mild to moderate. The overall mean

score was 170.70.

The mean scores for Muslims from non-Arab countries are as follows. Indonesia had n=19, a total score of 655, and mean value of 34.46. Pakistan had n=33, a total score of 1091, and a mean value of 33.06. Bangladesh had n=25, a total score of 798, and a mean value of 31.92. India had n= 26,a total score of 715 and a mean score of 27.50. Finally, Malaysia had n=19, a total score of 393, and a mean value of 20.68. The overall mean was 29.52. The range of mean for Muslims from non-Arab countries was 20.68-34.46. The trait anxiety ranged from mild to moderate. The overall mean score was 147.62. Muslims from Arab countries demonstrated a higher mean score than their counterparts from non-Arab countries.

Research Question 3: Is there a significant difference in trait anxiety between Muslims from different Arab and non-Arab countries?

The third research question examined if there is a significant difference in the trait anxiety between Muslims from different Arab countries and Muslims from non-Arab countries. Since the purpose of the study was to see if Muslims from Arab countries differed significantly from Muslims of non-Arab countries on trait anxiety, the researcher also looked at interactions between the countries, sex, and age.

Table 8

ANOVA Comparing Muslims from Arab and Non-Arab Countries for Spielberger's Trait

Anxiety Inventory

Source	DF	Type 111 SS	Mean square	F Value	Pr>F
Sex	1	293.952389	293.952389	6.33	0.0125
Age	2	9.261631	4.630815	0.10	0.9051
Country	9	3281.868439	364.652049	7.86	<. 0001
Arab vs Non-Arab	1	327.1646377	327.164377	7.05	0.0085

Table 8 shows results for ANOVA for Spielberger's Trait Anxiety. There was

evidence of a significant difference between Muslims from Arab countries and Muslims from

non-Arab countries for the Trait Anxiety variable, F=7.05 and *p*=0.0085. The Muslims from

Arab countries scored higher than Muslims from non-Arab countries on trait anxiety. There

was evidence of a significant difference within the Muslims of Arab and non-Arab countries,

F=7.86 and *p*=<. 0001. Within the Arab and non-Arab countries, there seemed to be a

variation in trait anxiety scores resulting in a significant difference. Males and females

differed significantly, F=6.33 and *p*=0.0125. However, there was no significant difference

between the Muslims of different ages, F=0.10 and *p*=0.9051.

Table 9

Scores and Means for Muslims from Arab Countries for Beck's Depression Inventory

Arabs			
Country	Number	Total	Mean
Palestine	22	958	43.54
Iraq	29	1088	37.51
Egypt	24	770	32.08
Syria	25	780	31.20
S. Arabia	26	729	28.03
Total	126	4325	172.36
Average			34.47

Table 9 shows the total scores and means for Muslims from Arab countries. The total

number of participants was 126, Iraq being the most represented country. Palestine, although

having a smaller sample than Iraq, had the highest mean score value. It was followed by

Iraq. Egypt and Syria had very similar scores. Although Saudi Arabia had a good

representation of participants, it had the lowest score and mean value.

Research Question 4: Is there a significant difference in the level of depression within

Muslims from different Arab countries?

The fourth research question examined if there is a significant difference in the level of

depression within Muslims from Arab countries.

Table 10

ANOVA Comparing Muslims from Arab and Non-Arab Countries for Beck's Depression

Inventory

Source	DF	Type 111 SS	MeanSquare	F Value	Pr >F
Sex	1	26.448137	26.448137	0.23	0.6302
Age	2	57.893623	28.946812	0.26	0.7753
Country	4	3498.733001	874.683250	7.71	<. 0001
Sex*age	2	3. 286849	1. 642474	0.01	0.9856

Table 10 shows results for ANOVA for Beck's depression Inventory. There was evidence of a significant difference within Muslims from Arab countries, F=7.71 and $p=< 0.0001$. Within the Arab countries, there seemed to be a variation in the depression scores resulting in a significant difference. Males and females did not differ significantly, F=0.23 and $p=0.6302$. However, there was no significant difference between the Muslims of different ages, the F=0.26 and $p=0.7753$.

Table 11

Spielberger's State Anxiety Scores for Muslims from Arab Countries

	Arabs		
Country	Number	Total	Mean
Iraq	29	1323	45.62
Palestine	22	998	45.36
Syria	25	846	33.84
Egypt	24	776	32.33
S.Arabia	26	840	32.31
Total	126	4783	189.46
Average			37.89

Table 11 shows the state anxiety scores for Muslims from Arab countries. It is interesting to note that although Iraq had a larger number of participants than Palestine, the average mean for these two countries is almost same. Syria and Egypt seem to follow the same pattern. The two countries not only matched in their sample sizes, but also seem to be scoring closely in their averages. Among the Arab countries, participants from Saudi Arabia had the lowest mean score.

Research Question 5: Is there a significant difference in state anxiety among Muslims from different Arab countries?

The fifth research question examined if there is a significant difference in the state anxiety as measured by Spielberger's State Trait scale, and the researcher studied the differences in the level of state anxiety for Muslims from Arab countries.

Table 12

ANOVA Comparing Muslims from Arab Countries for Spielberger's State Anxiety Inventory

Source	DF	Type 111 SS	MeanSquare	F Value	Pr >F
Sex	1	1	1.210189	0.01	0.9308
Age	2	9.403532	4.701766	0.03	0.9710
Country	4	4839.106851	1209.776713	7.57	<. 0001

Table 12 shows results for ANOVA for Spielberger's State Anxiety.   There was evidence of a significant difference within Muslims of Arab countries, F =7.57 and *p*=<0.0001. Within the Arab countries, there seemed to be a variation in state anxiety scores resulting in a significant difference. Males and females did not differ significantly, F=0.01 and *p*=0.9308. Also, there was no significant difference between the Muslims of different ages, F=0.03 and *p*=0.9710.

Table 13

Scores for Spielberger's Trait Anxiety Inventory for Muslims from Arab Countries

| | Arabs | | |
Country	Number	Total	Mean
Iraq	29	1291	44.52
Palestine	22	949	43.14
Syria	25	837	33.48
S.Arabia	26	749	28.81
Egypt	24	498	20.75
	126	4324	170.70
Overall Group Mean			34.14

Table 13 shows the level of trait anxiety among Muslims from Arab countries. Iraq and Palestine have the highest scores very closely followed by Syria. It is interesting to note that participants from Saudi Arabia scored higher than participants from Egypt. Looking at the overall average of 34.14, Iraq and Palestine scored well above the average, where as Syria Egypt and Saudi Arabia were lying around it. The state anxiety was lower for participants from Saudi Arabia and Egypt.

Research Question 6: Is there a significant difference in trait anxiety among Muslims from different Arab countries?

The sixth research question examined if there is a significant difference in the trait anxiety within Muslims from Arab countries, and the researcher studied the differences in the level of trait anxiety within the Arab countries.

Table 14

ANOVA Comparing Muslims from Arab Countries for Spielberger's Trait Anxiety

Inventory

Source	DF	Type 111 SS	MeanSquare	F Value	Pr >F
Sex	1	169.3057983	169.3057983	4.43	0.0374
Age	2	103.3347330	51.6673665	1.35	0.2627
Country	4	533.1327565	133.2831891	3.49	0.0099

Table 14 shows results for ANOVA for Spielberger's Trait Anxiety. There was evidence of a significant difference among Muslims from Arab countries, F=3.49 and *p*= 0.0099. Within the Arab countries, there seemed to be a variation in the trait anxiety scores resulting in a significant difference. Males and females did differ significantly, F=4.43 and *p*=0.0374. Gender played a significant role for Muslims from Arab countries. However, there was no significant difference between the Muslims of different ages, F=1.35 and *p*=0.2627.

Table 15

Scores for Beck's Depression Inventory for Muslims from Non-Arab Countries

Non-Arabs			
Country	Number	Total	Mean
Indonesia	19	931	49
Pakistan	33	1198	36.33
Bangladesh	25	802	32.08
India	26	813	31.26
Malaysia	19	548	28.89
Total	122	4292	177.56
Overall Group Mean			35.51

Table 15 shows Beck's depression scores for Muslims from non-Arab countries.

There were only 19 Participants from Indonesia, yet they scored the highest average.

Bangladesh and India had nearly the same number of participants, and the means of these

two countries were very close. On the other hand Malaysia had 19 participants with a very

low total score and lowest average.

Research Question 7: Is there a significant difference in depression among Muslims from

different non-Arab countries?

The seventh research question examined if there is a significant difference in the

depression within Muslims from non-Arab countries, and the researcher studied the

differences in the level of depression within the non-Arab countries.

Table 16

ANOVA Comparing Scores for Muslims from Non-Arab Countries for Beck's Depression

Inventory

Source	DF	Type 111 SS	MeanSquare	F Value	Pr >F
Sex	1	28.046626	28.046626	0.23	0.6334
Age	2	115.706070	57.853035	0.47	0.6250
Country	4	5012.881534	1253.220384	10.22	<. 0001
Sex*age	2	207.311595	103.655798	0.85	0.4320

Table 16 shows results for ANOVA for Beck's Depression Inventory. There was evidence of a significant difference in mean scores between Muslims from non-Arab countries, F=10.22 and p=<. 0001. Within the non-Arab countries, there seemed to be a variation in the depression scores resulting in a significant difference. Males and females did not differ significantly, F=0.23 and p=0.6334. There was no evidence of a significant difference between the Muslims of different ages, F=0.47 and p= 0.6250.

Table 17

Totals and Means for Speilebergers's State Anxiety Inventory for Muslims from Non-Arab

Countries

Non-Arabs			
Country	Number	Total	Mean
Indonesia	19	883	46.47
Pakistan	33	1256	38.06
India	26	829	31.92
Bangladesh	25	715	28.60
Malaysia	19	507	26.68
Total	122	4190	171.63
Overall Group Mean			34.24

Table 17 shows the score range for state anxiety among Muslims from non-Arab countries. Indonesia scored the highest mean value, although the numbers of participants were less in comparison to countries like Pakistan, India and Bangladesh. Participants from Indonesia experienced greater state anxiety than other Asian countries. Pakistan had the highest representation of participants, and had the second highest mean value. Malaysia, whose numbers of participants was similar to that of Indonesia, had the lowest mean value.

Research Question 8: Is there a significant difference in state anxiety among Muslims from different non-Arab countries?

The eighth research question examined if there is a significant difference in Spielberger's State Anxiety within Muslims from non-Arab countries.

Table 18

ANOVA Comparing Muslims from Non-Arab Countries for Spielberger's State Anxiety

Inventory

Source	DF	Type 111 SS	MeanSquare	F Value	Pr >F
Sex	1	75.331514	75.331514	0.58	0.4471
Age	2	879.505243	439.752621	3.40	0.0369
Country	4	5265.072725	1316.268181	10.17	<. 0001

Table 18 shows results for ANOVA for Spielberger's State anxiety. The model was a good fit. It accounted for variance in depression within the Muslims from non-Arab countries. There was evidence of a significant difference between Muslims from non-Arab countries, F=10.17 and p=<. 0001. Males and females did not differ significantly with F=0.58 and p= 0.4471. There was evidence of a significant difference between the Muslims of different ages, F=3.40 and p=0.0369.

Table 19

Speilberger's Trait Anxiety Scores for Muslims from Non-Arab Countries

Non-Arabs			
Country	Number	Total	Mean
Indonesia	19	655	34.46
Pakistan	33	1091	33.06
Bangladesh	25	798	31.92
India	26	715	27.50
Malaysia	19	393	20.68
Total	122	3652	147.62
Overall Group Mean			29.52

Table 19 shows the trait anxiety scores for Muslims from non-Arab countries. The highest mean value was secured by Indonesia, closely followed by Pakistan and Bangladesh. There is a striking contrast in the trait anxiety level among the participants from Malaysia. Their mean score value was only 20.68.

Research Question 9: Is there a significant difference in trait anxiety within Muslims from different non-Arab countries?

The ninth research question examined if there is a significant difference in Spielberger's trait anxiety within Muslims from non-Arab countries. The researcher studied the differences in the trait anxiety within the non-Arab countries.

Table 20

ANOVA Comparing Muslims from Non-Arab Countries for Spielberger Trait Anxiety

Inventory

Source	DF	Type 111 SS	MeanSquare	F Value	Pr >F
Sex	1	135.488157	135.488157	2.54	0.1141
Age	2	210.676797	105.338398	1.97	0.1440
Country	4	2504.180236	626.045059	11.72	<. 0001

Table 20 shows results for ANOVA for Spielberger's trait anxiety. Within the non-Arab countries, there seemed to be a variation in the trait scores resulting in a significant difference. There was evidence of a significant difference between Muslims from non-Arab countries, F=11.72 and p= <. 0001. Males and females did not differ significantly, F=2.54 and p=0.1141. There was no evidence of a significant difference between the Muslims of different ages, F=1.97 and p=0.1440.

CHAPTER 5

DISCUSSION

Mujahid (2001) gave estimates of the Muslim population in the United States ranging from less than three million to nine million. The World Almanac (2001) states that there are about 5.8 million Muslims in the United States. About 79% of all Muslims fall between the ages of 16 and 65. The Muslims' average household size is 4.9 people. Most Muslims live the major cosmopolitan areas of America. 20% of all Muslims live in California, 16% in New York State, 8% in Illinois, 4 % in New Jersey and Indiana each, and about 3 % each in Michigan, Virginia, and Texas, and Ohio. About two-thirds of all Muslims in the United States are immigrants, 42% of all Muslims are African-Americans, 24% are of South Asian origin, and 12% are of Arab origin.

Given the large number of Muslims in the United States, it is important to conduct research related to the mental health of Muslims in America in reference to anxiety, depression and posttraumatic stress. There is a dearth of psychological research conducted on Muslims through out the world and particularly Muslims in America. For the purpose of this evaluation studies on Muslims from other Muslim and non-Muslim countries were analyzed to assess the level of anxiety, depression and posttraumatic stress. These Muslims, especially from Bosnia, Iraq, and Afghanistan, had fled from the war zones, and had come to America as refugees or as immigrants.

This research is unique and important because not only is there limited research on Muslims in America, but also this research investigates the extent of anxiety and depression in Muslims from Arab and non-Arab countries. The researcher also tested for a significant difference in age and gender on depression and anxiety.

Findings and Conclusions

The results of the data analysis using scores on Beck's Depression Inventory and Spielberger's State and Trait Anxiety Inventory derived from Muslims from Arab and non-Arab countries supports the research questions posed in this study. There were significant differences in the level of depression, state anxiety and trait anxiety between Muslims from Arab and non-Arab countries. The level of depression was significantly higher among the non Arab Muslims in comparison to the Muslims from Arab countries. However, for state and trait anxiety, the Muslims from Arab countries scored higher than did the Muslims from Arab countries. For the inter-group comparison among Muslims from Arab countries and Muslims from non-Arab countries, there was evidence of a significant difference among Muslims from Arab and non-Arab countries. Among the Arab countries, Iraq and Palestine had the highest scores on anxiety and depression. Among the non-Arab countries, participants from Indonesia scored the highest.

Overall, the means and standard deviation scores for Beck's Depression Inventory were greater for Muslims from non-Arab countries than for the Muslims from Arab countries. This indicates that Muslims from non-Arab countries are experiencing more depression than Muslims from Arab countries. Beck's main argument was that depression was instituted by one's view of oneself, instead of one having a negative view of oneself due to depression. Another way to look at these cognitive thoughts is through Beck's Negative Cognitive Triad, which explains that negative thoughts are about the self, the world, and the future. Boury et al (2001) studied Beck's theory by monitoring student's negative thoughts with the Beck Depression Inventory (BDI), and then he presented an overview of Beck's ideas stating, "Individuals who are depressed misinterpret facts and experiences in a negative

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fashion, limiting their focus to the negative aspects of situations, thus feeling hopeless about the future. A direct relationship is postulated between negative thoughts and severity of depressive symptoms."

The results of the present study suggest that the Muslims from non-Arab countries are having negative thoughts about their future, and negative thoughts about the world. The expectation that Muslims from Arab countries will experience more depression than Muslims from non-Arab countries was found to be supported by the data.

One possible explanation for the study findings relates to adverse psychological effects. For example, Norris (2001) believed that adverse psychological effects are greatest when two of the following are present: (a) high level of injury, threat to life, and loss of life; (b) human intent; (c) serious ongoing problems for the community; and (d) extreme damage to property. The non-Arab countries like Indonesia were experiencing a series of set backs such as Tsunami, damage to property, threat to personal safety, and serious ongoing problems for the community when the researcher administered the inventories to them, and measured their levels of anxiety and depression.

Beck (1967) hypothesized that in depression, idiosyncratic schemas involving themes of personal deficiency, self-blame, and negative expectations dominate the thinking processes. A specific situation or stressor that would be expected to lower self-esteem might activate the depressive schemas in vulnerable individuals. Once activated, the depressotypic schemas lead to the negative automatic thoughts and cognitive errors. This concept is very much applicable to Muslims from the Arab and non-Arab countries, although both groups scored high on depression. Muslims from non-Arab countries scored higher than Muslims from the Arab countries.

The results show that interactions between age and sex were not significant. The levels of anxiety and depression were the same for both sexes and all age groups. Reed (1994) explained that females are more likely to form dysfunctional beliefs due to mixed signals from society. This coincided strongly with Beck's model of depression and the large problem of female depression in western society, although it is well documented that females have other underlying causes for susceptibility to depression (including biological differences, age prevalence of depression differences, sex/ gender-role identity differences, depression rate and recurrence differences, and differences in males and females). The results of the present study show depression was prevalent in Muslims from Arab and non-Arab countries irrespective of sex and age.

The second research question examined if there is a significant difference in Spielberger's State Anxiety between Muslims from Arab countries and non-Arab countries. Muslims from Arab countries differ significantly from Muslims from non-Arab countries. The Muslims from Arab countries scored higher on Spielberger's state anxiety. According to Spielberger "state anxiety is a palpable reaction or process taken at a given time and level of intensity." It appears that currently the Muslims from Arab countries are experiencing more state anxiety. This is largely due to the state of affairs in countries like Iraq, Afghanistan and Syria. However, there was no evidence of significant sex differences or age difference in the groups. This is contradictory to the findings of Nakazato and Shimonaka (1989), who investigated scores on anxiety among adults of different ages. The state anxiety inventory was administered to a representative community sample and anxiety declined linearly over the series of age groups.

In the present study, the level of anxiety did not vary for participants of different age groups. Early adults, adults, and older adults seemed to be experiencing the same level of state anxiety. The ongoing events in Iraq probably have impacted them severely which has probably resulted in the physical and mental symptoms. It also appears that the participants are worried about their family members who are still living in their home countries. Earlier researchers have proved that females score higher on anxiety than males (Nakazato & Shimonaka, 1989). The current study shows that no such significant differences existed between them, which is an indication that the crisis in Iraq has disturbed the Muslims of Arab countries living in America.

The third research question examined if there is a significant difference in the trait anxiety between Muslims from Arab countries and Muslims from non-Arab countries. Since the purpose of the study was to see if Muslims from Arab countries differed significantly from Muslims of non-Arab countries, the researcher looked at interactions between the countries, sexes and age. The results show both the groups differed significantly on trait anxiety. In the present study, the majority of the Muslims from Arab countries came to the United States as refugees. They were consistently exposed to war and violence. That Muslims of all age groups appear to be predisposed to anxiety is definitely a trait factor. Besides that, the ongoing events and trends in Iraq seem to revive those horrifying memories.

Trait anxiety, according to Spielberger (1983), implies differences between people in the disposition to respond to stressful situations with amounts of anxiety. The results of this study clearly show that Muslims from Arab countries responded to stressful situations with higher levels of anxiety in comparison to Muslims from non-Arab countries. A qualitative study conducted by Miller et al (2002) on Bosnian refugees residing in Chicago, Illinois

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showed that recurrent war-related nightmares and chronic insomnia left many participants continually sleep deprived. Similarly, a majority of the Muslims from the Arab countries in the current study, especially those coming from Iraq, Palestine and Syria, arrived in the United States as refugees. Therefore, they are more susceptible to anxiety and may be predisposed to it.

The fourth research question examined if there is a significant difference in the level of depression among Muslims from Arab countries. There is a high significant difference level at .001. It may be attributed to the fact that Arabs from Iraq, Syria, and Palestine included in the study were from war affected zones, came to America seeking asylum and shelter, and have struggled to erase the traumatic memories. The political trends in Iraq, Syria, and Afghanistan, and the impacts of 9/11 may have revived the horrifying memories of war and destruction. They seem to live with fear of being deported, which makes them very depressed, and most Arabs experienced insomnia, irritability, and lack of concentration. Interestingly, Muslims from Saudi Arabia scored very low on depression in comparison to Muslims from the Arab countries. History reveals that Muslims living in Egypt and Saudi Arabia have been less exposed to war and trauma. Both of these countries are economically superior to countries such as Iraq, Palestine and Syria. Therefore, it is not surprising that the Muslims from these countries living in America have a lower level of depression. There is no evidence of a significant difference in depression among early adults, adults and older adults. Males and females experience same level of depression.

The results show that there is a significant difference in the state anxiety scores among Muslims from Arab countries. The high scorers on state anxiety are Iraq, Syria, and Palestine. Their responses on the anxiety scale are based mainly on their reactions to events

in their homelands. State anxiety, which is an emotional reaction characterized by subjective, conscious feelings of tension, apprehension, nervousness, and worry, is very clearly evident in the Muslims from Iraq, Palestine, and Syria. The majority of the Muslims who came from those countries were constantly exposed to trauma, and escaped from war-torn zones seeking asylum in the United States. On the other hand, Muslims from countries such as Egypt and Saudi Arabia have the lowest scores, and seem to be experiencing a lesser state of anxiety. Egypt and Saudi Arabia are rich countries. The needs of their citizens have always been addressed. These countries are well known for their infrastructure and wealth. Therefore, Muslims from these countries living in America are more prosperous and live more peacefully rather than worrying about their fortunes and families.

Another notable finding was the fact that there was no evidence of a significant difference among males and females. Three out of the five countries in the current study come from war-affected zones. Either their families or they themselves have been victims of trauma. Therefore, it is not surprising that females, early adults, and older adults all experience anxiety in the same manner as do the males and adults. Several of them lost their loved ones during the recent wars, and their escape to the United States may have temporarily provided security and solace. However, the crisis in Iraq has probably stirred some of those feelings up all over again.

The sixth research question examined if there is a significant difference in the trait anxiety within Muslims from Arab countries. The Muslims from non-Arab countries differed significantly on Spielberger's trait anxiety. The high scores obtained by Iraq, Palestine, and Syria may be attributed to a significant difference in trait anxiety. Trait anxiety, which deals with individual differences in the tendency to view the world as threatening or dangerous, is

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experienced. This tendency seems to be consistently lingering among these countries. As Spielberger (1983, p.5) says, "trait anxiety implies differences between people in the disposition to respond to stressful situations with varying amounts of state anxiety". Muslims from Iraq, Palestine, and Syria are predisposed to respond to stressful situations more acutely than do the Muslims from Egypt and Saudi Arabia. The researcher had expected the Muslims from Saudi Arabia and Egypt to score low on trait anxiety as these two countries have experienced the least trauma, devastation, poverty, violence, killings, and torture.

There is a significant difference in trait anxiety among the males and females. The females scored high on trait anxiety than the males, which proves that females are predisposed to respond to stressful situations. Besides predisposition being a major factor for anxiety, the current stressors have stimulated the female Muslims, and have caused them to be vulnerable to anxiety.

The seventh research question examined if there is a significant difference in the depression within Muslims from non-Arab countries. The higher scores on depression are from Indonesia and Pakistan. The majority of the Muslims from Indonesia living in America arrived here as refugees. There has been civil war going on there for years, and currently the ongoing internal turmoil and the Tsunami disaster seem to be the causes for depression. Trautman et al (2002) surveyed forty-five adult Asian and Middle Eastern immigrants. Demographic variables, physical and interpersonal exposure, initial physiologic and emotional responses to the bombing, and posttraumatic stress symptoms associated with this disaster and with earlier trauma were measured. Most participants from Indonesia had experienced prior trauma in their homeland. At the time the researcher approached them

with questionnaires, the Indonesians were going through the trauma of losing their property and loved ones because of the Tsunami catastrophe. PTSD symptoms from prior trauma were most predictive of initial physiologic and emotional response and of later bomb-related PTSD symptoms. Pakistan, on the other hand, is on the border of Afghanistan, and the constant influx of people of Afghanistan into Pakistan has disturbed the people in that country both physically and emotionally. Muslims from Bangladesh and India also scored high on depression. Bangladesh has been struggling with economical and political unrest, and Muslims from India are over-exposed to religious discrimination, which constantly makes these people depressed. On the other hand, Malaysia is a Muslim country that is very rich and flourishing compared to other Muslim countries in South East Asia. Malaysian Muslims living in America are self-satisfied and complacent. Therefore, they experience the least of depression. Age and sex played a insignificant role for Muslims from non-Arab countries. Depression seems to have uniformly affected the males and females and people of all age groups such as early adults, adults and older adults.

The eighth research question examined if there is a significant difference in Spielberger's state anxiety within Muslims from non-Arab countries. Muslims from Indonesia and Pakistan scored high on state anxiety, closely followed by India. The results suggest that there is a definite reaction to events taking place in their home country. Muslims from Indonesia are traumatized by the Tsunami event, and are aware many lives and property are lost in their country. Therefore, they are aware of their need to stay in America and hold on to their jobs. The constant fear of losing their jobs, visa expirations, and calamities in Indonesia are making them experience anxiety, while Muslims from Malaysia are well established both in the United States and in Malaysia.

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Although Muslims from India, Pakistan and Bangladesh are more qualified and arrived in America for employment, the outsourcing of jobs is causing the fear of being laid off, and they are aware that they may have to go back to their home countries to seek employment. Finally, it is noted that although gender did not play a significant role in state anxiety, age played a significant factor. The score for the adults is greater than that of early adults and adults.

The ninth research question examined if there is a significant difference in Spielberger's trait anxiety among Muslims from non- Arab countries. Muslims from Indonesia scored high on Spielberger's trait anxiety, which suggests that Indonesians have a predisposition to respond to stressful situations. This predisposition may be attributed to the continuous turmoil in their country, and they recently experienced a major natural calamity. That experience left most of them shattered and devastated. Muslims from Pakistan, Bangladesh, and India have been victims of partition, and have been exposed to civil wars, violence and stress. After 9/11, an event which altered the lives of many people, there is a revival of stress and anxiety in these Muslims. On the other hand, Muslims from Malaysia, who scored very low on anxiety, have experienced the least anxiety over the years, and this makes them less predisposed to anxiety.

Limitations of the Study

There are several important limitations to this study that must be taken into consideration. First, the sample was drawn from one Islamic center in a Southeastern city in the United States, and it may not be representative of other Islamic centers. The unique

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characteristics of both the Muslims and the center may limit the generalizability of the results.

Another potential limitation of this study was situational factors regarding when the study was conducted. The researcher notes that although the research was conducted during the ongoing events at Iraq, Indonesia was devastated by the Tsunami. Therefore, the researcher believes that the high scores of the Indonesians boosted the overall scores for anxiety and depression among the non-Arabs, and may have resulted in a marginal difference in the scores between the Muslims from the Arab and the non-Arab countries.

In addition, this study used extant data, which limited the questions the investigator was able to ask. The researcher would have liked to consider the mental health of Muslims by using a qualitative analysis as well. The sample was measured during the ongoing events in Iraq and the tragedy that struck the Asian countries, particularly in Indonesia. All sample data were collected using self-administered written response inventories.

Implications for Future Research and Practice

Overall, a gap continues in the literature in understanding the mental health of Muslims in America. Extensive research is needed comparing larger samples of Muslims from the Arab countries and non-Arab countries with more variables.

This study suggests that further research should be undertaken to examine the mental health of Muslims. The findings of this study present several implications for practice and further research. First, the Beck's Depression Inventory and Spielberger State and Trait Anxiety Scale are instruments that are easy to obtain, use, score, and interpret in this setting. Also, given the wide use of the BDI and STAI, it is possible not only to obtain data to study

mental health for clinical purposes, but the data can also be used for comparative purposes between other regions and states.

Further research is needed to ascertain not only the differences in refugees and immigrants, but also to develop a better understanding of how to assess and utilize their strengths. This study provides encouraging support for utilizing reliable and valid instruments to assess anxiety and depression within two major groups.

It is likely that social workers and other human services professionals will continue to work with not only existing refugee groups and immigrants, but also with new and emerging populations whose cultural backgrounds, problems, and strengths will differ in many ways. It is important that assessments are conducted for such problems as anxiety and depression and that the evaluations are culturally relevant (Kennedy et al, 1999). It is also essential that the strengths of the groups as well as the individuals within the groups are reflected and utilized in the development and provision of services that will be helpful to the needs of refugees and immigrants.

Kennedy et al (1999) noted numerous limitations in providing services to refugees and immigrants, and stressed the need for culturally competent providers, interdisciplinary collaboration, and comprehensive systems of referral and follow-up or needed services, including mental health. As reported earlier by Mujahid (2001), there are 5.8 million Muslims living in United States. There is a need to sensitize counselors about the needs of those Muslims who are currently experiencing anxiety and depression. Counseling is still perceived as a stigma in many Middle Eastern and Asian countries. Therefore, it is imperative that the Counselors encourage the Muslims to come out, and be open. There is a definite need for counselors to become culturally competent in order to help the Muslims

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from Arab countries who seem to currently experiencing anxiety and depression since the majority of them have arrived as refugees and immigrants.

The attacks on 9/11 not only caused the destruction of lives and property, they also resulted in a loss of a sense of security for many United States citizens. This loss of security manifested itself in many forms, including feelings of sadness, fear, victimization, anger, and sometimes blame. Hate crimes against Muslims have been on the rise since 9/11.

Unfortunately, Muslims in the United States were one of the primary groups who became targets of blame following the attacks. Disasters can differ greatly in the range of impact on 'victims' of various categories. Therefore, as one attempts to determine the impacts of the events of 9/11, one must examine the effects on various populations in the United States, specifically those who were targeted for the blame.

This research provides the findings from a limited survey on the reactions of the Muslims in America from Arab and non-Arab countries following the events of 9/11. Further research is necessary to understand the consequences of these attacks on a long time perspective for the entire Muslim population in the United States. Indeed, a longitudinal and more geographically and demographically representative study of Muslims is necessary. However, this research is the first step towards understanding the Muslim experience in the United States. In-depth research on the effects of 9/11 on the American-Muslim community could result in policy recommendations that would improve the safety and well being of all Muslims in America. Additionally, Americans of other faiths will have better appreciation of the difficulties encountered by the Muslims in the United States, which can result in lowering the hate crimes against them. The United States government can use the results of this study

to project the correct image of Muslims to the rest of the population thus enhancing the assimilation of diverse groups.

Nassar-McMillan (2003, p.12) stated that, "In the wake of the twin tower bombings, elected officials publicly discouraged the media and others from associating that deplorable act with Islam or any other specified group of individuals while simultaneously attempting to link the incident with the Arab-Israeli conflict. Even though no connection had been officially documented, in the American public's mind the association has been created and continues to be lodged there".

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APPENDICES

APPENDIX A

North Carolina State University
INFORMED CONSENT FORM for RESEARCH
_____
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INFORMATION
We are asking you to participate in a research study. This packet contains two sets of self-administered questionnaires for you to read and give your responses. It would be very much appreciated if you could fill out details such as your country of origin, gender, educational qualifications, and age. Please do not write your name or put your signature on any of the sheets provided to you. You will find enclosed in the packet two sets of questionnaires A & B. The directions are given clearly for both sets. You may first begin by reading and answering Set A, and when you are finished may then proceed to Set B. Set B has two forms (Y1 & Y2). Once again it is recommended that you complete Y1 first before you proceed to Y2. Some of the questions on the questionnaires may upset you or cause you to feel badly.

RISKS
It involves a potential of minimal psychological risks only. If you feel discomfort and need any counseling or psychological services, you are encouraged to contact the Counseling Center on campus. The phone number is 919-515-2423.

BENEFITS
The results of the study will be useful for sensitizing the counselors about Muslims in the United States.

CONFIDENTIALITY
The information in the study records will be kept strictly confidential. Data will be stored securely in a locked office, to which only the principal investigator and his research assistants have access. No reference will be made in oral or written reports that could link you to the study.

COMPENSATION
There is no compensation for you for participating in this study.

CONTACT
If you have questions at any time about the study or the procedures, you may contact the researcher, Dr. Edwin R. Gerler, Jr., at 919-515-5975. If you feel you have not been treated according to the descriptions in this form, or your rights as a participant in research have been violated during the course of this project, you may contact Dr. Matthew Zingraff, Chair of the NCSU IRB for the Use of Human Subjects in Research Committee, Box 7514, NCSU Campus (919) 513-1934,or Mr. Matthew Ronning, Assistant Vice Chancellor, Research Administration, Box 7514, NCSU Campus (919) 515-2148).

PARTICIPATION
Your participation in this study is voluntary; you may decline to participate without penalty. If you decide to participate, you may withdraw from the study at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

CONSENT
Once you have completed the questionnaires, you may return questionnaires to the researcher either in person or by mailing the packet. You will find enclosed a self-addressed envelope.

If you have any questions, feel free to contact the researcher by email shamshadusa@yahoo.com, or by phone at 919-512-3450.

Thank You. Your participation is very much appreciated!

Ms. Shamshad Ahmed
N-15, 3000 E. S. King Village
Raleigh, NC, 27607

Beck Depression Inventory
by Aaron T. Beck

_____

Read over the statements grouped with each letter, A through U. Pick out the statement within each group that best describes the way you feel today, that is, right at this moment. Circle the number next to the statement that you have chosen in each group. If two or more statements in a group describe the way you feel equally well, circle each one. Be sure to read over all of the statements in each group before you decide on one.

A. (Sadness)
- 0 I do not feel sad.
- 1 I feel blue or sad.
- 2a I am blue or sad all the time and I can't snap out of it.
- 2b I am so sad or unhappy that it is quite painful.
- 3   I am so sad or unhappy that I can't stand it.

B. (Pessimism)
- 0   I am not particularly pessimistic or discouraged about the future.
- 1   I feel discouraged about the future.
- 2a I feel I have nothing to look forward to.
- 2b I feel that I won't ever get over my troubles.
- 3   I feel that the future is hopeless and that things cannot improve.

C. (Sense of failure)
- 0   I do not feel like a failure.
- 1   I feel I have failed more than the average person.
- 2a I feel I have accomplished very little that is worthwhile or that means anything.
- 2b As I look back on my life all I can see is a lot of failures.
- 3   I feel I am a complete failure as a person (parent, husband, wife).

D. (Dissatisfaction)
- 0   I am not particularly dissatisfied.
- 1a I feel bored most of the time.
- 1b I don't enjoy things the way I used to.
- 2   I don't get satisfaction out of anything anymore.
- 3   I am dissatisfied with everything.

E. (Guilt)

    0 I don't feel particularly guilty.
    1 I feel bad or unworthy a good part of the time.
    2a I feel quite guilty.
    2b I feel bad or unworthy practically all the time now.
    3 I feel as though I am very bad or worthless.

F. (Expectation of punishment)

    0   I don't feel I am being punished.
    1   have a feeling that something bad may happen to me.
    2 I feel I am being punished or will be punished.
    3a I feel I deserve to be punished.
    3b I want to be punished.

G. (Self-dislike)

    0 I don't feel disappointed in myself.
    1a I am disappointed in myself.
    1b I don't like myself.
    2 I am disgusted with myself.
    3 I hate myself.

H. (Self-accusations)

    0   I don't feel I am any worse than anybody else.
    1 I am critical of myself for my weaknesses or mistakes.
    2 I blame myself for my faults.
    3 I blame myself for everything bad that happens.

I. (Suicidal ideas)

    0 I don't have any thought of harming myself.
    1 I have thoughts of harming myself but I would not carry them out.
    2a I feel I would be better off dead.
    2b I feel my family would be better off if I were dead.
    3a I have definite plans about committing suicide.
    3b I would kill myself if I could.

J. (Crying)

    0 I don't cry any more than usual.
    1 I cry more now than I used to.
    2 I cry all the time now. I can't stop it.
    3 I used to be able to cry but now I can't cry all even though I want to.

K. (Irritability)

    0 I am no more irritated now than I ever am.
    1 I get annoyed or irritated more easily than I used to.
    2 I feel irritated all the time.

3   I don't get irritated at all at the things that used to irritate me.

L. (Social withdrawal)
0   I have not lost interest in other people.
1   I am less interested in other people now than I used to be
2   I have lost most of my interest in other people.
3   I have lost all my interest in other people and don't care about them at all.

M. (Indecisiveness)
0   I make decisions about as well as ever.
1   I try to put off making decisions.
2   I have great difficulty in making decisions.
3   I can't make decision at all anymore.

N. (Body image change)
0 I don't feel I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance and they make me look unattractive.
3 I feel that I am ugly or repulsive-looking.

O. (Work retardation)
0   I can work about as well as before.
1a It takes extra effort to get started at doing.
1b I don't work as well as I used to.
2   I have to push myself very hard to do anything.
3   3 I can't do any work at all.

P. (Insomnia)
0 I can sleep as well as usual.
1 I wake up more tired in the morning than I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
4   I wake up early every day and can't get more than 5 hours sleep.

Q. (Fatigability)
0   I don't get any more tired than usual.
1   I get tired more easily than I used to.
2   I get tired from doing anything.
3   I get too tired to do anything.

R. (Anorexia)
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

S. (Weight loss)

        0 I haven't lost much weight, if any, lately.

        1 I have lost more than 5 pounds.

        2 I have lost more than 10 pounds.

        3 I have lost more than 15 pounds.

T. (Somatic preoccupation)

        0 I am no more concerned about my health than usual.

        1 I am concerned about aches and pains or upset stomach or constipation.

        2 I am so concerned with how I feel or what I feel that it's hard to think of much else.

        3 I am completely absorbed in what I feel.

U. (Loss of libido)

        0 I have no noticed any recent change in my interest in sex.

        1 I am less interested in sex than I used to be.

        2 I am much less interested in sex now.

        3 I have lost interest in sex completely.

INTERPRETING YOUR SCORE

Low scorers (0-5) -- If you scored this range, you probably took this test for fun. Your answers indicated that you are showing almost on signs of feeling depressed. Hopefully, your score also means that you're feeling quite good about yourself and the world around you. If, however things don't seem as right with your life as this low score suggests, depression may not be the best label for what you are experiencing. You may pick up on your problem area better by taking some of the tests in the other chapters of *The Mind Test*. Keep in mind also that this test asks for how you are feeling right this minute. If today just happens to be a great day, you may find it helpful to take this test again at another time.

Medium Scorers (6-14) – Scores in this range usually indicate a mild to moderate level of depression. You may feel "down" often enough to make life less enjoyable than it could be but no enough to have you generally feeling bad. This level of depression also suggests that there may be times when it's hard for you to find enough energy to make it through the day. This is a common problem for many of us, since almost everyone shows mild levels of depression at one time or another. That knowledge may not, however, make you feel any better. To help you understand your own level of depression, look over those items that produced your score with particular attention to any on which you scored 2 or 3. Think about how these symptoms relate to the way your life is going, and see if you can identify particular parts of you life that have you down. If you scored at the high end of this range, it's likely that there are important areas in your life causing you serious concern. Many of the professionally written self-help programs are designed to provide you with techniques for understanding and changing some of these problem areas. If you cannot identify the problems or if they seem overwhelming to you, you may gain the most benefit from professional help. It is likely that you are feeling bad enough to have to acknowledge your pain, but you probably also have enough energy to make treatment productive.

High Scorers (15 and above)—If you scored 15 or higher, you did not need this test to describe your current feelings as a possibly severe level of depression. You no doubt were well aware of how down you felt before you answered any other questions. In fact, it's a positive sign that you were interested enough in self-understanding and had enough energy to take this test. If you scored fairly high, You probably see most things in your life as a waste of time or just too much trouble. And the future doesn't look very bright. Since you've taken this one important step toward understanding your problems, continue that self- help direction by getting tin touch with you physician or a psychologist or other mental health professional; depression at this level does not often go away without help.

SELF-EVALUTATION QUESTIONNAIRE
STAI FORM Y-1

Please provide the following information:

Country_____ **Education**_____**S**_____
Age_____ *Gender (Circle)* **M   F** **T**_____

DIRECTIONS:
A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you feel *right* now, that is, at this moment. There are no right no wrong answers. Do not spend too much time on any one statement but give the number which seems to describe your present feelings best.

	NOT AT ALL	SOMEWHAT	MODERATELY SO	VERY MUCH SO
1. I feel calm	1	2	3	4
2. I feel secure	1	2	3	4
3. I am tense	1	2	3	4
4. I feel strained	1	2	3	4
5. I feel at ease	1	2	3	4
6. I feel upset	1	2	3	4
7. I am presently worrying over possible misfortunes	1	2	3	4
8. I feel satisfied	1	2	3	4
9. I feel frightened	1	2	3	4
10. I feel comfortable	1	2	3	4

11. I feel self-confident 1 2 3 4

12. I feel nervous 1 2 3 4

13. I am jittery 1 2 3 4

14. I feel indecisive 1 2 3 4

15. I am relaxed 1 2 3 4

16. I feel content 1 2 3 4

17. I am worried 1 2 3 4

18. I feel confused 1 2 3 4

19. I feel steady 1 2 3 4

20. I feel pleasant 1 2 3 4

SELF-EVALUTATION QUESTIONNAIRE
STAI Form Y-2

Please provide the following information:

Country_____ **Education**_____**S**_____
Age_____ *Gender (Circle)* **M   F**   **T**_____

DIRECTIONS:
A number of statements which people have used to describe themselves are given below. Read each statement and then circle the appropriate number to the right of the statement to indicate how you *generally feel*. There are no right no wrong answers. Do not spend too much time on any one statement but give the number which seems to describe your present feelings best.

NOT AT ALL *SOMEWHAT* *MODERATELY SO* *VERY MUCH SO*

21. I feel pleasant 1 2 3 4

22. I feel nervous and restless 1 2 3 4

23. I feel satisfied with myself 1 2 3 4

24. I wish I could be as happy as others seem to be 1 2 3 4

25. I feel like a failure 1 2 3 4

26. I feel rested 1 2 3 4

27. I am "calm, cool and collected" 1 2 3 4

28. I feel that difficulties are piling up so that I cannot overcome them . 1 2 3 4

29. I worry too much over something that really doesn't matter 1 2 3 4

30. I am happy 1 2 3 4

31. I have disturbing thoughts 1 2 3 4

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32. I lack self-confidence 1 2 3 4

33. I feel secure 1 2 3 4

34. I make decisions easily 1 2 3 4

35. I feel inadequate 1 2 3 4

36. I am content 1 2 3 4

37. Some unimportant thought runs through my mind and bothers me ... 1 2 3 4

38. I take disappointments so keenly that I can't put them out of my mind 1 2 3 4

39. I am a steady person 1 2 3 4

40. I get in a state of tension or turmoil as I think over my recent concerns

and interests 1 2 3 4