Second-Generation South Asian American Muslim Mothers: Constructing Knowledge, Perspectives, and Practices of Mental Health and Well-being

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A dissertation

submitted in partial fulfillment of the

requirements for the degree of

Doctor of Philosophy

University of Washington

2023

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Program Authorized to Offer Degree:

Education

University of Washington

Abstract

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Mental health and well-being have been studied through various lenses across time and cultures. However, cultural knowledge, perspectives, and practices are limited in the current western psychology field. The present study examined how second-generation South Asian American Muslim mothers (SAAMM-2) constructed knowledge, perspectives, and practices pertaining to mental health and well-being for themselves and their children. The role of various social and ecological processes was explored in the shaping of mental health knowledge. Ten individuals from the SAAMM-2 population participated in individual semi-structured interviews. A constructivist ground theory approach was used to explore how SAAMM-2 individuals constructed knowledge and which factors influenced meaning making. Findings indicated that SAAMM-2 individuals constructed knowledge from childhood experiences, adulthood

experiences, and contemporary resources. Knowledge, perspectives, and experiences were shaped by several phenomena, including immigration, the role of immigrant mothers, intergenerational trauma, cultural stigma, acculturation differences, and emotional expression. Participants integrated knowledge gained from South Asian culture, Islam, and the West. They tended to lean toward Islam to make sense of challenges impacting mental health and well-being. The findings indicated that meaning making in the South Asian American Muslim population is complex, involves multiple processes, and is a continuous process of reconstruction from knowledge and experiences passed down through generations.

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Acknowledgements

I would like to begin with my deepest gratitude for my advisor and Chair, Dr. Missall – you have been an unwavering source of support and encouragement from the start. Thank you for your guidance through this program, this dissertation, and for your dedication in pushing me to the finish line.

To my reading committee – Dr. Kara Jackson, Dr. Holly Schindler, and Dr. Deepa Rao – thank you for your support over the years. Each of you played a crucial role in my journey to this point. Dr. Jackson, thank you for sharing your knowledge, wisdom, and enthusiasm for qualitative research. I would never have discovered my own enthusiasm for it without you. Dr. Schindler, I am grateful for your mentorship and guidance over the years, as a member of this committee and on the BSK team. Working with you was one of the richest experiences of my PhD journey. Dr. Rao, your enthusiasm for this study and the resources you provided along the way encouraged me time and time again to keep going, for myself and for the community.

To the ten brave mothers that participated in this study – thank you for sharing your stories, knowledge, and experiences. This paper is as much yours as it is mine.

My love for Seattle is deeply and intricately wound up in the people I have met along the way – friends that have become family. Ghina and Hasan, you were my first family in the city. I am here because you were there through some of my toughest days. Elsha, my neighbor, thank you for every conversation we had walking down the hill and for always asking me if I wanted to grab Thai food with you. Meaghan, your kindness, encouragement, and thoughtfulness are unmatched. Thank you for always holding space for me.

Maha and Nausheen, I am deeply and forever indebted to you both. You hyped me up, encouraged me along, and taught me to celebrate the little things. The (after) party never stops when you two are around!

Farah, my deepest gratitude to you for providing me with a home, for trusting me to paint the counters, and for being the greatest pillar of wisdom over the years.

Someone once (wisely) asked, “for what?” and an incredible crew of people banded together. Sana, Sameen, Ambreen, Ayesha, and Azima – thank you for sustaining me with late night hangs, long talks, adventures, and constant encouragement. Samiah, thank you for always bringing the sparkle and sending me music recommendations. Tariq, thank you for your genuine kindness through the years (and the homemade desserts). Uzair, I will forever be grateful for our (circular) friendship, friend. Rafey and Waleed, thank you for being passengers in my car time and time again. Wally, a very special thank you for the pens and for reminding me to save my work. Wasay, I am especially grateful to you for your steady presence in the last year of this journey.

To the Dysfunx crew – Amena, Besan, Duaa, Fatima, Lyla, Sophia, Tasnia, and Uzma – near or far, each of you mean the world to me. Your friendship and sisterhood have been the greatest joys, blessings, and sources of support of the past 15 years.

To my siblings – I am deeply grateful for you both. Aqilah, you are my rock, inspiration, and the best built-in friend a little sister could ask for. Mustafa, I know I tell you stop but never stop walking into my room to bug me.

Ammi and Abu, I am here because you have never stopped believing in me. I owe you everything and more.

Chapter 1: Introduction

Statement of the Problem

Mental health and well-being have been studied and understood through various lenses across time, spaces, and cultures (Watters, 2010). Narratives of mental health and well-being include historical accounts of mental disorders, culturally influenced symptomology, and spiritual undertones in conceptualization and treatment (Watters, 2010). More recently, Western conceptualizations of mental health have permeated the field of psychology, pushing forth a medical understanding of mental health disorders and treatment. The Western model is rooted in treatment of illness and repairing damage from a psychopathological framework (Greenspoon & Saklofske, 2001; Seligman & Csikszentmihalyi, 2000). Evidence-based practices backed primarily by randomized-controlled trials normed in the West have quickly become the "worldwide standard" for conceptualizing psychology and treating mental health, leaving out opportunities for promoting and integrating cultural and spiritual knowledge and practices for mental health and well-being from other regions in the world (Bagasra & Mackenim, 2014; Padela et al., 2012; Watters, 2010). Contemporary research on non-Western models of mental health and well-being is limited, but the study of psychology spans centuries, cultures, and religions (Keshavarzi & Haque, 2014; Watters, 2010). South Asian cultures and Islam have vast knowledge about psychology and myriad practices to promote mental health and well-being. The present study focuses on the space in between – where second-generation South Asian American Muslim mothers (SAAMM-2) draw from and integrate South Asian, Islamic, and Western epistemologies to promote mental health and well-being in their own children being raised in the United States (U.S.).

South Asian Muslims hail from a deep history of colonization of the Orient, as referred to by Edward Said (1979). Said (1979) discusses the formation of the definition of the Orient – or regions in the East (i.e., the Middle East, Asia, and the Far East) – and how western colonialism constructs an image of the Orient as primitive, backward, exotic, and uncivilized (Said, 1979). Said argues that the Occident, or the West, defined itself in contrast to the uncivilized East. This contrasted construction of the West and East is reflective of the concept of orientalism – "a style of thought based upon an ontological and epistemological distinction between "the Orient" and "the Occident" (Said, 1979, p. 10). Essentially, orientalism highlights the relationship of power between the East and the West, with the colonizers of the West claiming superiority over the colonized East – in land, culture, and knowledge (Bhatia, 2002; Said, 1979). In India (and across the empire), the British Empire used science and technology to claim superiority and to "tame" and "civilize" Indians (Bhatia 2002). Western methodologies and knowledge in psychology permeated throughout Indian institutions, effectively de-valuing ancient traditional knowledge among India's own psychologists (Bhatia, 2002). This marginalization of indigenous knowledge and uplifting of western knowledge on colonized lands may be considered a colonization of epistemologies (Akena, 2012).

In post-colonial spaces, the multigenerational effects of colonization may be internalized among immigrant populations (e.g., Aujla, 2000; David, 2008; deSouza, 2017; Karimi & Bucerius, 2017). Internalized colonialism is the phenomenon where the colonized begin to believe in their own inferior identity as depicted by colonizers (Aujla, 2000), uncritically reject their own ethnic culture, and unequivocally prefer anything American (David & Okazaki, 2006a). This may include rejection or distancing from indigenous and cultural knowledge systems and practices, and acceptance of Western knowledge systems and practices, as a coping

mechanism for surviving and excelling as minorities in an ideologically Western country (Aujla, 2000; deSouza, 2017; Karimi & Bucerius, 2017). David and colleagues (2006a, 2006b, 2008, 2010) term this phenomenon as colonial mentality. Among Filipino Americans, colonial mentality has a negative relationship to self-esteem, ethnic identity, and enculturation, and a positive relationship with depression (David, 2008). Aujla (2000) examines how colonial mentality shows up among second-generation South Asian Canadian women by examining literature by South Asian women. In the poem "Banu" by Farzana Doctor (1995), the narrator responds to living in the West and enduring discrimination as a visible minority by going through various stages of acculturation, including assimilation in early childhood and young adulthood, and eventual resistance to Western cultural dominance in adulthood (Aujla, 2000). deSouza (2017) reflects on his own anger toward colonialism that disconnected him from the pluralistic and vibrant intellectual life of India. Colonial mentality is an understudied phenomenon among second-generation South Asian American mothers, but signifies the possible pendulum swing of accepting, rejecting, and integrating Western and non-Western mental health knowledge and practices as SAAMM-2 go through the stages of acculturation throughout their lifetime.

The purpose of the present study is to examine critically the field of psychology and mental health practices for binaries that marginalize non-Western epistemologies, specifically South Asian and Islamic epistemologies. The SAAMM-2 population is uniquely positioned to weave together American, South Asian, and Islamic conceptualization of mental health and expand the repertoire of treatments and practices to be more comprehensive and culturally representative. By exploring SAAMM-2 voices, stories and narratives, researchers and professionals in the psychology field can better understand how the multigenerational effects of

immigration, acculturation, and trauma influence second-generation South Asian American mothers in their construction of mental health knowledge and use of practices. Researchers and professionals may find the results of this study useful in expanding their thinking about psychology and mental health and in participating in the decolonization of the field. By creating space for the voices, stories and narratives of the SAAMM-2 populations, second-generation mothers may feel more empowered to seek support for their children's mental health – not just from Western-trained mental health professionals but from their ancestral knowledge, culture, religion, family, and community.

To this end, this study is grounded in the examination of *how* individuals in the SAAMM-2 population construct and recount their knowledge about mental health, particularly in relation to the mental health of their children and in exploring the patterns of colonial mentality that may emerge in their narratives. In order to attempt to accomplish the purposes of this study, the remainder of this chapter defines some important concepts, including "South Asian," "immigrants," and "generational status." Chapter 2 reviews the literature pertaining to the South Asian American Muslim population, including colonization, immigration, acculturation, mental health frameworks, and the theoretical concepts of Critical Race Theory (Delgado & Stefancic, 2011), and the decolonizing psychology movement (Akomolafe, 2012.; Bhatia, 2017; Coles & Mannion, 2017). Finally, chapter 2 includes the research questions that guide this study. Chapter 3 addresses the qualitative methodologies and procedures used to recruit participants, generate and analyze data, and report findings, as well as the researcher's positionality. Chapters 4 and 5 describe and discuss the findings generated through analysis of data.

South Asian Muslim Immigrants

South Asian American Muslims are a unique and underrepresented population in psychological research (Amer et al., 2013; Shah & Tewari, 2019). South Asia is a region in Asia comprising of several countries, including Bangladesh, Bhutan, India, Pakistan, Nepal, Sri Lanka, and the Maldives (Chang et al., 2018). The incredibly diverse region hosts more than 40 cultural groups with different religions, languages and norms, including those that ascribe to the religion of Islam (Chang et al., 2018; Rahman & Paik, 2017; Shah & Tewari, 2019). Nearly 31% of the world's Muslim population are from South Asia; 11.1% of the world's Muslim population are from Pakistan, 10.3% are from India, and 9.3% are from Bangladesh (Pew Research Center, 2009). Currently, over 5 million South Asians live in the U.S. (SAALT, 2019). Thirty-five percent of the U.S. Muslim population come from South Asia, with the majority being immigrants from Pakistan and Bangladesh (Pew Research Center, 2009; Rahman & Paik, 2017).

In simple terms, an immigrant is someone who has left their birth country to live in another country (Bolter, 2019). In North America, an individual is classified as an immigrant if they intend to stay in the new country permanently (Bolter, 2019). Individuals, such as international students, long- or short-term visitors, business workers, or anyone that is living temporarily in a country are not classified as immigrants. In the U.S., an immigrant is further sub-classified based on their legal status. An immigrant in the U.S. can be a naturalized citizen, a permanent resident, a refugee/asylee, or undocumented (Bolter, 2019). Although these legal statuses afford immigrants different privileges and rights in the U.S., describing those differences is beyond the scope of this study. South Asian immigrants in the U.S. are primarily voluntary immigrants that left their home countries in pursuit of economic opportunities and sought out permanent residency or citizenship in the U.S. (Leonard, 1997; Rahman & Paik, 2017).

Immigrants in the U.S. experience a number of challenges, including employment, housing, and language barriers, learning about the new country's culture, and creating a space for themselves in the new country and their new communities (Tummala-Narra et al., 2016). Among these challenges, immigrants in the U.S. have historically faced and continue to face anti-immigrant sentiment and discrimination for their race, ethnicities, and religion (Buchignani & Cooper, 2020; Leonard, 2010; Maira, 2008; Rahman & Paik, 2017; Tummala-Narra et al., 2016). Immigrants from South Asia (and other regions of Asia) have experienced anti-immigrant sentiment through various immigration policies since the early 19th century (Leonard, 1997) that have barred them from entering the U.S., from bringing their families, and that have put quotas on the number of individuals from South Asian (and other Asian) countries allowed to enter the U.S (Bhatia & Ram, 2018; Buchignani & Cooper, 2020). More subtly, U.S. immigration policies and sentiments have shown preference for a certain caliber of immigrants from South Asia – particularly those with higher education backgrounds and professional expertise (Bhatia & Ram, 2018). Still, the South Asian immigrant population in the U.S. is diverse and colorful, with individuals hailing from the many different regions of South Asia, speaking myriad languages, and ascribing to different religions.

The South Asian Muslim immigrant primarily came to the U.S. from Pakistan, India, and Bangladesh, but includes immigrants from other South Asian regions (Shah & Tewari, 2019). As Muslims in America, these individuals have experienced and continue to experience Islamophobia, in both major and microaggressions (SAALT, 2019; Sheridan, 2006). Muslims have existed in the U.S. since at least the 1800s when they were brought to America through the slave trade (GhaneaBassiri, 2010). Muslims of all backgrounds have established mosques across the country and built communities around them. South Asian Muslim immigrants have integrated

into these communities or created their own, making space for both their Islamic religion and their South Asian cultures in ways that may emulate the communities of their home countries. Children of these immigrants have grown up in these intersectional spaces and contributed to the evolution of the South Asian Muslim diaspora in the U.S.

Defining Generational Status

Immigrants in the U.S. are often designated by their generational status. Commonly in academia, first-generation immigrants are defined as individuals that left their home country and migrated to a new one. First-generation individuals' children that are born in the new country are considered second-generation individuals, their children are third-generation, and so forth (Shenoy, 2016; United States Census Bureau, 2021). Within immigrant communities, children of immigrants often refer to themselves as first-generation because they are the first generation to be born and/or raised in the U.S. (Shenoy, 2016). This study focuses on children of immigrants and will follow the academic precedent of designating them as second-generation. Specifically, this study focuses on second-generation South Asian American Muslim mothers who were raised in the intersection of Islam, South Asian, and American culture. For the purposes of this study, mothers that were born to at least one immigrant parent and or that immigrated to the U.S. at or before the age of five years will be included because these mothers will have been raised in the U.S. and exposed to American culture, as well as having exposure to at least one parent's immigrant background and culture during their formative years. Differences among individuals with two immigrant parents, individuals with one immigrant parent, and individuals who immigrated to the U.S. in early childhood may emerge. Providing clarity on terminology and designation is important for academics, participants, and readers to understand the population of focus in this study.

Chapter 2: Literature Review

History of the Subcontinent

The Indian subcontinent (current-day India, Pakistan, and Bangladesh) was under British colonial rule for almost two centuries before the events of Partition in 1947 split it into two countries: India and Pakistan (Khan, 2007). Under British colonial rule and driven by British colonial interests, Muslims and Hindus were pitted against each other such that religion became a primary axis of identification (Leonard, 2010). As animosity between Muslims and Hindus increased, the idea of a sovereign South Asian Muslim state (i.e., Pakistan which also included present-day Bangladesh) entered the forefront of politics. The months leading up to Partition and the months after the boundary line between Pakistan and India were drawn were fraught with confusion, animosity, and violence amongst Hindus, Sikhs, and Muslims that left almost one million men, women, and children dead. An additional 12 million Hindus, Sikhs, and Muslims on the subcontinent migrated between India and Pakistan, looking for a home that accepted them for their religious identities (Khan, 2007). Although Muslims had lived in what is present-day India for centuries, and continue to do so, Partition reified religious identity on the subcontinent. In contrast, post-1947 Pakistan's civil war of 1971 resulted in the liberation of Bengalis (a primarily Muslim ethnic group) and the formation of Bangladesh (Dowlah, 2016), which shed light on the saliency of ethnic heterogeneity of Muslims in South Asia. Although the events of Partition are much more complex and nuanced than summarized here, these events highlight several important features of the South Asian Muslim population. First, South Asian Muslims, among other South Asians, share a history of British colonization that contributed to the reification of religious identity and the permeation of western thinking on the subcontinent (Leonard, 2010). Second, the events of Partition heightened consciousness of religious identity

among South Asian Muslims on the subcontinent and in Western parts of the world (e.g., U.S., Canada; Leonard, 2010). Finally, the Liberation War of 1971 illuminated the strong ties to ethnic and cultural identity that separated South Asian Muslims (Dowlah, 2016). As British colonization, Partition, and the Liberation War shaped ways of identifying on the subcontinent, immigration to the U.S. and subsequent U.S. perceptions and laws of immigrants shaped South Asian acculturation and identities in the U.S.

South Asians in America

South Asians, including South Asian Muslims, have been migrating from South Asia to the Western part of the world for over a century (Bhatia & Ram, 2018). Over the course of their migration history, South Asians have faced barriers to immigration, less than favorable acceptance of their presence in the U.S., and ongoing prejudices and discrimination from their receiving country that have impacted the way they acculturated (Leonard, 2010). Historians have typically grouped South Asian immigration to the U.S. into three waves (Bhatia & Ram, 2018; Leonard, 2010; Rahman & Paik, 2017; Williams, 2019). The first wave of immigration from South Asia to the U.S. brought South Asian Muslim and Sikh male farmers from Punjab and Muslim Indian male sailors from Bengal to the U.S. (Williams, 2019). These early immigrants faced anti-immigrant sentiments and policies between 1907 and 1965 that led to disenfranchisement of South Asians (Buchignani & Cooper, 2020), exclusion from entry to the country, immigration quotas, or denial of citizenship (Bhatia & Ram, 2018; Buchignani & Cooper, 2020). It was not until the 1960s that the U.S. lifted restrictions and quotas to allow entry of a new wave of immigrants from South Asia (Bhatia & Ram, 2018; Buchignani & Cooper, 2020; Williams, 2019).

The post-1965 wave of South Asian immigrants in the U.S. were primarily well-educated professionals (e.g., doctors, engineers, scientists, academics, and students seeking higher education) from India, while some were immigrants from Pakistan and Bangladesh (Shah & Tewari, 2019). This population of South Asians were selected to increase the number of highly skilled workers in the U.S. and to combat beliefs that the U.S. was a racist nation (Bhatia & Ram, 2018). However, a later subset of immigrants, primarily South Asian Muslims from Pakistan and Bangladesh, during the early 1980s came to the U.S. under sponsorship from family members in the U.S. and consisted of blue-collar workers who took jobs in restaurants, convenience stores, and the cab-driving industry (Bhatia & Ram, 2018).

Although South Asians in the second wave of immigration were welcomed under the pretense of being well-educated individuals who integrated into American society through hard work (Rahman & Paik, 2017), third wave South Asians, and particularly South Asian Muslims, endured a renewed round of anti-immigration sentiment and racism. These sentiments were heightened after the 9/11 terrorist attacks which targeted South Asian Muslim, Sikh, and Arab American adults and young people (Maira, 2008; Rahman & Paik, 2017; Tummala-Narra et al., 2016). This complex history of shifting sentiments racialized South Asian Muslim immigrants, paradoxically categorizing South Asian Muslims in the U.S. as model minorities and terrorists (Kaduvettoor-Davidson & Weatherford, 2018).

The Racialization of South Asians in America

Racial classifications in the U.S. mark access to citizenship, both in terms of rights and in terms of cultural belonging. Cultural belonging in the U.S. is contingent on proximity to Whiteness and white cultural norms, such as language and accent, dress, and behavior (Abdul Khabeer, 2017). The further away from these norms, the less likely individuals and groups are

identified as “real citizens” and granted access to the rights and privileges of “full citizenship” (Abdul Khabeer, 2017; p. 105). The racialization of South Asians has been a shifting phenomenon marked with ambiguity (Harpalani, 2013).

Historically, South Asians in America have been included in different racial categories (e.g., Caucasian, White, Asian, Middle Eastern) based on the political contexts of the time (Harpalani, 2013). As detailed by a series of legislation, South Asian categorization has been ambiguous (Harpalani, 2013). A notable case exemplifying the ambiguity of South Asian racialization was the 1923 United States v. Bhagat Singh Thind (1923). Bhagat Singh Thind, a full-blooded Indian living in the United States was denied citizenship even though Asian Indians were categorized as Aryan or Caucasian based on racial categories of the time. Instead, the court ruled that Thind was not “white” according to common usage of the term, resulting in the de-naturalization of Bhagat Singh and 65 Asian Indians (Harpalani, 2013; United States v. Thind, 1923). Despite this ruling, the 1970s U.S. Census classified Asian Indians as “white” in an attempt to deny them legal minority status and accompanying protections (Harpalani, 2013; United States v. Thind, 1923). However, Asian Indians lobbied for minority status and overturned characterization as “white” in 1982 (Harpalani, 2013). Taken together, the changing litigation and policies around categorization of South Asians contributes to racial ambiguity. Over time, South Asians have been characterized as part of dominant society (i.e., white), have been denied the rights and privileges of dominant and minority societies, and have been relegated to minority status based on dominant society’s changing perceptions of South Asian Americans.

Model Minority Myth. The model minority myth is a concept that characterizes Asian Americans as model immigrants in the United States (Yi & Museus, 2016). The presumption of

this myth is that Asian Americans, including South Asians, are a hardworking, high achieving, and submissively obedient monolithic group (Poon et al., 2015; Yi & Museus, 2016). The model minority myth is rooted in U.S. immigration patterns and labor needs (Ng et al., 2007) that contribute to harmful racial categorization in the U.S. (Poon et al., 2015).

Dating back to the 19th century, the model minority myth was invoked by railroad barons in U.S. as a way to yield higher profits from cheap labor. The myth painted Chinese immigrant laborers as the kind of hard workers that other groups, such as the Irish, should aspire to be like (Ng et al., 2007). A pattern of comparing Asian groups to other racialized minority groups has continued throughout U.S. history. After the Chinese Exclusion Act of 1882, the model minority focus shifted to Japanese immigrants for their agricultural work. However, when Japanese immigrants started to show exceeding success in agriculture, the group was shunned. This change in model minority status was also reflected in the treatment and internment of Japanese immigrants and Japanese Americans during World War II (Ng et al., 2007). The most recent way the model minority myth has been used to categorize race and create hierarchies is as a tool to invalidate African American, Latinos, and other minority groups demanding equal rights during the Civil Rights Movement – a comparison that continues today (Ng et al., 2007; Yi & Museus, 2016). This history of the model minority myth highlights how Asian Americans have been accepted as a group that is closer in proximity to the white dominant group and how they have been marginalized in order to maintain white racial dominance.

The pendulum swing of valorization and ostracization of Asian Americans (Ng et al., 2007; Poon et al., 2015) negatively impacts the mental health of Asian Americans, including South Asian Americans (Bhatia & Ram, 2018). The model minority myth influences both external perceptions of Asian Americans' mental health (Cheng et al., 2017) and impacts

internalization of the model minority myth and subsequent help-seeking behavior for mental health challenges (Gupta et al., 2011; Kim & Lee, 2014). In a study involving 425 college students between the ages of 18-22 and of various racial backgrounds, individuals were randomly assigned to one of four groups: 1) Reading a clinical vignette describing a white college student with adjustment disorder, 2) Reading the same clinical vignette describing an Asian American with adjustment disorder, 3) Reading a newspaper article describing a white college student's success story plus the vignette from group 1, and 4) Reading the same newspaper article describing an Asian American student's success story plus the vignette from group 2 (Cheng et al., 2017). Cheng and colleagues (2017) found that after reading the newspaper article about the Asian American, college students were more primed to perceive that Asian Americans had higher mental health functioning than white American students. This study illustrates the way the model minority myth specifically endorses the perceptions that Asian Americans do not experience mental health challenges in the same way as white Americans (Cheng et al., 2017).

Internalization of the model minority myth also impacts mental health and help-seeking behavior in Asian Americans (Gupta et al., 2011; Kim & Lee, 2014). In a study with 291 Asian-American participants between the ages of 18-79 years old, endorsement of the model minority myth and other positive stereotypes about Asians (e.g., family-oriented culture) was significantly positively related with somatic symptoms and psychological distress. In other words, individuals who internalized the model minority myth were more likely to experience psychological distress and less likely to seek help (Gupta et al., 2011). Kim and Lee (2014) found a similar correlation between internalization of the model minority myth and help-seeking behavior for mental health in a sample of 106 Asian American college students, the majority of whom were second-

generation immigrants (Kim & Lee, 2014). These two studies (Gupta et al., 2011; Kim & Lee, 2014) indicate the detrimental impacts of the model minority myth on both external perceptions of Asian Americans and psychological distress and help-seeking behavior within multiple generations of the Asian American population.

Among South Asian Americans, the model minority myth is often internalized as true (Bhatia & Ram, 2018). South Asian immigrants are considered hardworking and may believe that their success can be attributed to merit (Bhatia, 2007). This contributes to South Asians highly endorsing their cultural values, such as productivity and independence (i.e., independence from government support, welfare; Bhatia & Ram, 2018). An important downfall of this internalization is that South Asians may perpetuate the idea that all South Asians are successful, effectively leaving out working class South Asian immigrants from the population narrative (Bhatia & Ram, 2018). Finally, internalizing the model minority myth is associated with South Asians remaining silent about issues of racism, discrimination, and mental health challenges within their communities (Bhatia & Ram, 2018). However, the events of 9/11 and post-9/11 have changed the South Asian narrative, as Muslims are racialized and individuals falling within the "racial" category of Muslims experience increasing Islamophobia (Abdul Khabeer, 2017).

The Racialization of Muslims in America

The racialization of Muslims in the U.S. is based on phenotypical characteristics such as having brown skin and looking "Middle Eastern," behavioral markers such as praying and speaking certain languages, and gendered markers such as wearing headscarves or sporting a beard has rendered Muslims as "others" or not belonging (Abdul Khabeer, 2017). Alongside black and brown Muslims being racialized, racialization of Muslims is experienced among white folks who convert to Islam and are re-racialized as "non-white" for ascribing to practices and

beliefs that no longer fit cleanly within White norms (Moosavi, 2015). The racialization of Muslims serves as an avenue for Islamophobia and discrimination against Muslims in the U.S (Abdul Khabeer, 2017).

Islamophobia. Islamophobia has been present for decades but more prominently in the U.S. since the late 1990s and early 2000s. It was first used politically to describe the phenomenon of harmful speech and actions against Islam and Muslims in the Western world (Bleich, 2011). The term "Islamophobia" is now used commonly in media (i.e., social media, news outlets, political campaigns) as a way to describe the rising discrimination against individuals and groups that identify as Muslims and/or look like adherents of Islam (e.g., women wearing headscarves, men with long beards, Arab-looking men, Sikh men wearing turbans; Sheridan, 2006). However, as Bleich (2011) reports, there is no widely accepted definition of Islamophobia in research. As a result, it is often functionally compared to xenophobia (Sheridan, 2006). Islamophobia can be defined as a negative attitude toward or dislike of Muslims and Islam; however, it often overlaps with discrimination toward ethnic and immigrant groups (Bleich, 2011; Sheridan, 2006).

Experiences of Islamophobia in the U.S. range from personal attacks to subtle discrimination disguised as political legislation and national security. The South Asian American Lead Together (SAALT) organization has recorded incidences of Islamophobic rhetoric and anti-immigrant hate incidents toward Asian Americans since 2015 (SAALT, 2019). Examples of incidents include media posts and comments from prominent politicians espousing ignorance and/or hate toward Muslims, South Asians, and immigrants of all backgrounds (SAALT, 2019). Legislation that has reflected the anti-Muslim and Islamophobic rhetoric in the U.S. includes President Trump's executive order to ban individuals from seven predominantly Muslim

countries from entering the U.S. (Kanno-Youngs, 2021). Passed in 2017, the contested "Muslim Ban" went through three iterations before it was repealed by President Biden (Proclamation No. 10141, 2021). This piece of legislation illustrates the ongoing pattern of legislation that targets immigrants, South Asians, and Muslims based on changing perceptions and acceptance of their presence in the U.S.

For South Asian Americans, a population that is considered a model minority, the security of the model perception is fleeting because of their closeness to racialized Muslims (Shams, 2020). In an ethnographic study with first- and second-generation South Asian Muslim immigrants, Shams (2020) observed South Asian Muslims navigating the perception of model minorities and perpetual foreigners. First-generation parents spoke about being proud of their college-aged children being accepted into prestigious universities and their reluctance in accepting their children pursuing non-STEM majors (e.g., fine arts, psychology, philosophy). The hesitancy to accept non-traditional majors stemmed from parents' own fears of being perpetual foreigners, no matter how successful (Shams, 2020). Second-generation South Asian Muslims of adult age expressed more concerns about being stereotyped for their religion. Participants within the second-generation group shared ostracization and discrimination based on activist beliefs that are often closely tied to Islam (e.g., involvement in Palestinian rights movements). While second-generation South Asian Muslims were more active and involved, they also shared that their first-generation parents warned them from getting too involved in religious and activist movements because of their fear of discrimination and ostracization (Shams, 2020). Shams's (2020) study demonstrates how South Asian Americans navigate their racial positions as South Asian model minorities and Muslim foreigners/threats. Notably,

racialized Muslims (including South Asians and non-Muslims mistaken for Muslims) uniquely experience Islamophobia.

Acculturation

Many definitions of *culture* exist that incorporate concepts of religion, socioeconomic status, social class, race, ethnicity, age, sex, family values, region of the country (Cohen, 2009; Eshun & Gurung, 2009). Culture includes systems of learning that facilitate interpretation and knowledge construction (Cohen, 2009) and systems of knowledge that can be learned (Cohen, 2009), such as values, beliefs, norms, symbols, and behaviors (Eshun & Gurung, 2009). These values and beliefs can be implicitly taught through observation and word of mouth or explicitly shared through written laws and rules (Eshun & Gurung, 2009). Acculturation is the complex process of change and adaptation within individuals and groups as result of long-term, continuous contact between different cultural groups (Juang & Syed, 2019; Redfield et al., 1936). Unidimensional, two-dimensional, and multidimensional models of acculturation have been proposed to understand the experiences of migrants settling in new countries (Berry, 1997; Gordon, 1964; Schwartz et al., 2010). Finally, a web of domains and contextual factors have been proposed to differentially explain acculturation among individuals and groups (Arends-Toth & van de Vijver, 2006; Bornstein, 2017; Suarez-Orozco et al., 2018; Ward & Geeraert, 2016).

The earliest proposed model of acculturation adopted a unidimensional stance in which cultural change was assumed to occur on a single continuum (Gordon, 1964). On this continuum, individuals and groups adopted aspects of the majority culture at the loss of aspects of their heritage culture (Arends-Toth & van de Vijver, 2006; Gordon 1964). However, Berry's (1997) two-dimensional model of acculturation is more widely accepted at a foundational level for understanding acculturation. This model attempts to measure the extent to which individuals

place importance in and strive to maintain their cultural identities (cultural maintenance), and the extent to which individuals interact with other cultural groups and participate in other cultural activities (contact and participation; Berry, 1997; Berry, 2001). Berry (1997) suggests four acculturation strategies based on this model: assimilation, integration, separation, and marginalization. Assimilation is the process by which individuals embrace their host country's culture and relinquish their heritage culture. Integrated individuals may strive to maintain their cultural identity *and* adopt aspects of their host country's culture. Conversely, separation is the process by which individuals hold onto their cultural identity and limit interactions with the dominant culture. Finally, marginalization, or the process by which individuals are minimally interested in their heritage culture and host culture, usually occurs because of forced cultural loss or exclusion and discrimination by the dominant society (Berry, 1997). Although Berry's (1997) two-dimensional model is the most widely referred to model in the literature, it is limited in addressing multidimensionality and a variety of factors that have been suggested to influence acculturation (Juang & Syed, 2019).

Schwartz and colleagues (2010) proposed a multidimensional model to acculturation whereby individuals might integrate, assimilate, or separate across three dimensions: cultural practices (e.g., language use, media preferences, cultural customs, and traditions), cultural values (e.g., belief systems, religious values), and cultural identifications (e.g., attachment to specific cultural groups). Additionally, the model posits that acculturation may not occur at the same pace or in the same direction across the three dimensions (Schwartz et al., 2010). The pace and direction of acculturation may be influenced by a variety of contextual factors, such as ecological contexts (e.g., family dynamics and expectations of ethnic and religious maintenance, neighborhoods of settlement, schools; Ward & Geeraert, 2016), broad contexts, such as the host

country's immigration policies and laws (Suarez-Orozco et al., 2018), sentiments and attitudes toward immigrants (Schwarts et al., 2010), experiences of discrimination (Ward & Geeraert, 2016), host country's expectations of how immigrants should acculturate (Kunst & Sam, 2013), and personal factors, such as reason for immigration, individual personalities and characteristics (Bornstein, 2017), whether individuals are visible minorities (as opposed to white-passing; Schwartz et al., 2010), and generational status (e.g., first-generation, second-generation; Suarez-Orozco et al., 2018). These factors come together to paint a complex and nuanced picture of how immigrant individuals and groups may adapt in new cultural settings (Juang & Syed, 2019).

Acculturation in South Asian American Muslims

Second-generation South Asian American Muslim adults uniquely experience acculturation as children of immigrants living in the intersection of their parents' cultures and faith (i.e., Islam) and U.S. culture and messages about their faith (i.e., Islam). As children of immigrants, the SAAMM-2 population grew up in a household where their own immigrant parents were acculturating to U.S. culture and adjusting to immigrant life in the U.S. (Aujla, 2000; Tummala-Narra et al., 2016). However, while immigrant parents had already formed a sense of identity before immigrating to the U.S. and going through the process of acculturation, second-generation children were experiencing acculturation in their formative years (Aujla, 2000). It is likely that SAAMM-2's knowledge of and experiences with their South Asian culture, Islam, and U.S. culture are filtered through their childhood and adolescence in an immigrant household and predicated on their parents' integration and transmission of South Asian culture, Islam, and U.S. culture to their children (Schwartz et al., 2016). Although literature on acculturation specifically in second-generation adults is limited, the research on children and youth acculturation from mixed-generation population samples is extensive.

Generally, immigrant youth are inclined to choose an integrationist strategy toward acculturation (Berry et al., 2006). In a study with 7,977 first- and second-generation immigrant youth between the ages of 13 and 18 and belonging to 26 different cultural groups living in predominantly white nations, four acculturation profiles emerged: ethnic, national, integration, and diffuse. The ethnic profile indicated high ethnic identity, proficiency and use of ethnic language, greater contact with ethnic peers, and larger endorsement of the separation attitude of acculturation. Alternatively, a national orientation indicated high national (i.e., host country) identity and endorsement of assimilation. While integration included high involvement in both ethnic and host county cultures, the diffuse category indicated a portion of youth with low ethnic and national identity, who paradoxically endorsed assimilation, marginalization, and separation (Berry et al., 2006). The study found that the majority of immigrant youth (36.4%) were inclined toward integration while 22.5% of youth exhibited high orientation toward ethnic identity. Endorsement of national identity was lowest (18.7 % of youth) and affiliation with the diffuse category (22.4% of youth) was almost equal to that of the ethnic category (Berry et al., 2006).

The Influence of Gender on Acculturation. Acculturation styles in South Asians have differed by gender, particularly as South Asian cultural gender roles are enacted within families (Farver et al., 2002; Singh Ghunam, 1997). In a study with East Indian second-generation adolescents of Hindu, Sikh, Muslim, and Zoroastrian backgrounds (mean age = 16.54; all parents were born in India and immigrated to the U.S. as adults), males were more likely to be integrated and females were more likely to be marginalized (Farver et al., 2002). This may be explained by South Asian culture which generally allows males greater cultural independence (Farver et al., 2002) while females are held to more traditional gender role expectations (e.g., stay at home, refrain from interacting with males; Tummala-Narra et al., 2016). Interestingly, Singh Ghunam

(1997) found differing associations between gender and acculturation style whereby South Asian Muslim adolescent boys indicated acculturation style scores closer to separation, while South Asian Muslim adolescent girls endorsed acculturation style scores that were between separation and assimilation (Singh Ghunam, 1997). It is posited that this association between gender and acculturation style was mediated by cultural expectations for males to pass down cultural and religious values to their children (Singh Ghunam, 1997). Although gender and acculturation styles demonstrate mixed results, cultural values and expectations of gender roles seem to play a role in how South Asian Muslim acculturate.

The Influence of Religiosity on Acculturation. Religiosity is also a factor in how Muslims acculturate (Goforth et al., 2014; Kunst et al., 2016). Goforth and colleagues (2014) measured religiosity in a sample of first- and second-generation Muslim Arab American adolescents (mean age = 15.50 years), including frequency of attendance in religious organizations, informal religious activities, and personal beliefs about their faith and spirituality. In the sample, high religiosity was positively correlated with higher orientation toward ethnic identity (Goforth et al., 2014). In a similar study of first- and second-generation Muslim immigrant youth between 16 and 21 years old (M = 18.3 years) of various Arab and South Asian origins living in Belgium, participants expressed significantly greater attachment to Belgian culture than their origin culture (Saroglou & Mathijsen, 2007). However, a higher intensity of religious practice was negatively correlated with acculturation to Belgian culture (Saroglou & Mathijsen, 2007). Moreover, greater questioning of religion and the possibility of loss of faith was positively correlated with an attachment to Belgian culture and negatively correlated with attachment to origin culture (Saroglou & Mathijsen, 2007). Although these studies sampled

Muslim youth from Asian and Arab origins, the findings indicate a relationship between religiosity and ethnic identity (Goforth et al., 2014).

The Influence of External Expectations on Acculturation. Although individual religiosity is associated with culturation orientation, external expectations from society also influence how Muslims may acculturate (Kunst & Sam, 2013). In sample of first- and second-generation Muslim immigrant adults (18-45 years old) of various ethnic backgrounds (i.e., German-Turks, French-Maghrebis, and British-Pakistanis), perceived acculturation expectations from the dominant society and ethnic community were associated with differential acculturation styles (Kunst & Sam, 2013). Although integration was the preferred acculturation orientation across all samples in the study, when Muslim individuals perceived a high expectation from their ethnic communities to separate, orientation toward assimilation was high, and orientation toward integration was low (Kunst & Sam, 2013). For the German-Turk sample, perceived high expectations from dominant society to assimilate was positively related to integration, indicating that external pressures within different contexts influenced how Muslim individuals acculturated (Kunst & Sam, 2013).

External expectations of how Pakistani Muslims immigrants should acculturate were also noted in Norway (Kunst et al., 2016). Kunst and colleagues (2016) examine how Norwegian natives viewed Pakistani Muslims in Norway and how they expected them to acculturate. Norwegian young adults (18-23 years old) primarily endorsed expecting Pakistani Muslims to integrate, followed by assimilate, and then segregate. Although their religious identity (presumed to be primarily Christian) was not associated with how they expected Pakistani Muslim immigrants to acculturate, religious identity was positively correlated with religious prejudices against Pakistani Muslims. Stronger religious identity was associated with higher levels of

anxiety and stereotyping toward Pakistani Muslims, which in turn was positively correlated with higher expectations for Pakistani Muslims to assimilate (Kunst et al., 2016). In the second half of the study, Pakistani Muslims in Norway (mean age: 25.15 years) indicated a large preference for integration, followed by assimilation and separation. However, high religious identity was positively associated with orientation toward their ethnic culture, particularly when individuals experienced religious prejudice from individuals within the dominant culture (Kunst et al., 2016). These results demonstrate that when prejudice and discrimination are salient factors, the dominant society prefers immigrants to assimilate and relinquish their ethnic and religious cultural identities, but those experiences of prejudice further drive immigrant Pakistani Muslims toward separation from dominant society (Kunst et al., 2016).

Acculturative Stress

Given South Asian Muslim immigrants' various identities, contexts and expectations, they often experience acculturative stress (APA, 2012). Acculturative stress stems from the challenges individuals face during the process of acculturation (Tummala-Narra et al., 2016). These challenges include adjusting to and navigating a new culture (Tummala-Narra & Sathasivam-Rueckert, 2016, Tummala-Narra et al., 2016), familial stress (Bhattacharya & Schoppelrey, 2004; Iqbal & Golombok, 2018; Islam et al., 2019; Tummala-Narra et al., 2016), and ethnic and religious discrimination (Stuart & Ward, 2018; Tummala-Narra & Claudius, 2013; Tummala-Narra & Sathasivam-Rueckert, 2016; Tummala-Narra et al., 2016). In turn, acculturative stress can impact immigrant-origin individuals' overall adaptation and mental health (APA, 2012).

Language and Communication on Acculturative Stress. For second-generation children of immigrants, a common cultural stressor is language and communication (Tummala-

Narra et al., 2016). In a study with South Asian Muslim, Sikh, Hindu and Buddhist adolescents in the U.S. (M_{age} = 16.50 years), second-generation youth often assumed the role of translator for their parents, who were less fluent in English. This pressure to serve as communication liaisons for parents contradicted pressure from peers to not speak in their heritage language in public (Tummala-Narra et al., 2016). Although the study by Tummala-Nara and colleagues (2016) included a small sample of South Asians (N = 16), a similar qualitative study with immigrant youth (mean age = 15.58) of various origins (i.e., Asian, Afro-Caribbean, Latinx, and South Asian; N = 64) had similar findings (Tummala-Narra & Sathisivam-Rueckert, 2016). It should also be noted that despite these stressors, immigrant youth from various backgrounds, including South Asian, expressed a pride and connection to their heritage and religious culture (e.g., food, religious holidays, traditions, etc.), language, and family (Tummala-Narra et al., 2016; Tummala-Narra & Sathisivam-Rueckert, 2016).

Immigration Expectations and Generational Gaps on Acculturative Stress.

Immigration expectations and generational gaps are another source of acculturative stress for immigrant-origin youth (Bhattacharya & Schoppelrey, 2004; Iqbal & Golombok, 2018; Tummala-Narra et al., 2016; Tummala-Narra & Sathisivam-Rueckert, 2016). South Asian parents of adolescents (11-17 years old) in the U.S. and Canada reported pre-immigration beliefs about living in the U.S. that contradicted with their post-immigration experience, further adding to the stress of acculturation for families (Bhattacharya & Schoppelrey, 2004). Specifically, parents believed immigrating to the U.S. or Canada would lead to better economic opportunities and a more comfortable life. However, post-immigration, most fathers experienced working in jobs well below their education level (e.g., cab driver, store manager) and working multiple jobs to make ends meet for their family (Bhattacharya & Schoppelrey, 2004; Islam et al., 2019).

Similarly, in a qualitative study with South Asian Muslim youth in the U.S., individuals reported assuming roles (e.g., working after school jobs) that countered role expectations in their origin communities which did not expect youth to work outside of school (Maira, 2008). Additionally, some parents tended to shift the responsibility of achieving higher economic and social status from themselves to their children post-immigration, possibly adding stress on children to meet parental expectations and to excel in their studies, and straining familial relationships (Bhattacharya & Schoppelrey, 2004; Tummala-Narra et al., 2016).

Generational differences also impacted acculturation with South Asian Muslim families. In a study with South Asian immigrant parents of young second-generation children (5-7 years old), many parents noticed their children rapidly acculturating to their new societies, which contrasted with their own slower acculturation pace (Iqbal & Golombok, 2018). Moreover, adolescents of various Asian origins, including samples of South Asian origin individuals, expressed conflict with parents, particularly when parents exhibited lack of understanding of certain societal norms, such as parental authority and children's rights at home (Kwak & Berry, 2001), moving away for college, or views about friendly and intimate relationships with the opposite gender (Tummala-Narra et al., 2016). The generational gap in adjusting to the new society may have also contributed to children hiding aspects of their lives from parents (Iqbal & Golombok, 2018), because of parental pressure to not get too "Americanized" (Tummala-Narra et al., 2016). Despite these challenges contributing to acculturative stress, South Asian adolescents also noted a strong emotional closeness to their family (Tummala-Narra et al., 2016).

Discrimination on Acculturative Stress. The most common acculturative stressor for first- and second-generation South Asian Muslims is ethnic and religious discrimination and prejudice (Tummala-Narra & Sathasivam-Rueckert, 2016). In study with first- and second-

generation immigrants of various origins, including South Asia (N = 95), more than three-quarters (75.8%) of the students reported discrimination from their peers, and more than half (63.2%) reported discrimination from adults in schools (Tummala-Narra & Claudius, 2013). In schools, many youth reported being teased about the types of lunches they brought to school or the possibility of arranged marriages based on their South Asian and Muslim backgrounds (Tummala-Narra & Sathasivam-Rueckert, 2016). Additionally, many Muslim youth of Asian, Middle Eastern, and African backgrounds reported Islamophobic discrimination because of their Muslim identities (Stuart & Ward, 2018). These experiences of discrimination may contribute to second-generation immigrant-origin children feeling pressure to distance themselves from their heritage and religion in public (Tummala-Narra et al., 2016).

Experiences with Islamophobia add distress to acculturating individuals and, in turn, are associated with weaker orientation toward dominant society culture (i.e., greater orientation toward a separationist attitude of acculturation; Kunst et al., 2016). Moreover, Islamophobia is associated with an increased expectation from dominant society that Muslims will assimilate rather than integrate, and move away from maintaining their Islamic identity and practices (Kunst et al., 2016). The drive toward separation for Muslim individuals and an expectation to assimilate are contradictory to a general preference by second-generation Muslims to integrate (e.g., Brown et al., 2013; Kunst et al., 2016; Kwak & Berry, 2001), further adding to acculturative stress (Tummala-Narra & Sathasivam-Rueckert, 2016).

Acculturation and acculturative stress are associated with mental health and well-being (e.g., Berry & Sabatier, 2010; Goforth et al., 2014; Stuart & Ward, 2018). In a study with 718 second-generation youth of various immigrant origins living in Paris and Montreal, Berry and Sabatier (2010), found varying relationships between acculturation and different forms of

adaptation. In particular, integration was the most widely endorsed acculturation attitude and was also positively correlated with self-esteem and school performance (Berry & Sabatier, 2010). Among individuals 15 years and older, a strong sense of belonging to ethnic, national, and religious identities was associated with greater life satisfaction and mental health scores, further indicating a positive association between the integration style of acculturation and psychological adaptation (Berry & Hou, 2019). However, relationships among orientations to cultures, religiosity, and stress with mental health and well-being are complex (Goforth et al., 2014). Although greater orientation to heritage culture in a sample of Arab Muslim youth was negatively associated with externalizing and internalizing problems, stronger orientation to American culture was associated with lower scores of social competence (e.g., making friends, participating in social organization, school performance; Goforth et al., 2014). Additionally, stress related to transitioning to a new culture was related to higher externalizing and internalizing problems. Moreover, discrimination among Muslim immigrants of various origin has been associated with lower social competence (Goforth et al., 2014) and well-being and depression (Stuart & Ward, 2018). However, the relationship between discrimination and well-being and depression has been shown to be moderated by religiosity (Stuart & Ward, 2018). More specifically, higher religious practice and cultural transition stress and higher religious practice and discrimination are both negatively associated with well-being. However, stronger religious identity can buffer the negative effects of discrimination on depression, while weaker religious identity can exacerbate the effects of discrimination on depression (Stuart & Ward, 2018).

Help-Seeking Barriers and Facilitators for Mental Health Support

The complexities of acculturation, acculturative stress, and mental health and well-being in second-generation South Asian Muslim youth warrants understanding how this population of children, adolescents, and their caregivers seek help for mental health concerns. Among adolescents experiencing acculturative stress, peer support was preferred over adult support (Tummala-Narra & Sathasivam-Rueckert, 2016). Peers of similar ethnic backgrounds were perceived to be particularly helpful for adolescents coping with stress (Tummala-Narra & Sathasivam-Rueckert, 2016). Conversely, adolescents reported a smaller likelihood of seeking out adult support at school when facing acculturative stress and discrimination (CAIR, 2017; Tummala-Narra & Sathasivam-Rueckert, 2016). From a study with Muslim students in California, only 12% of students who had experienced Islamophobic discrimination sought help from an adult, and of those, only 33% felt that the adult helped to resolve the problem (CAIR, 2017). Among South Asian adolescents specifically, half of a study sample of participants (N=16) were reluctant to seek support from a parent, particularly because they worried burdening their parents or ruining a sense of harmony within the family (Tummala-Narra et al., 2016).

Both parents and children expressed systemic and family- and community-level concerns about accessing professional mental health services (Islam et al., 2017). Systemic-level barriers included lack of South Asian representation in the mental health field (e.g., South Asian service providers, South Asian and/or Muslim faces in mental health promotional material; Islam et al., 2017), lack of consideration, understanding, and incorporation of culture and religion in psychological services (Hackett & Patel, 2006; Islam et al., 2017; Raghavan & Waseem, 2007), difficulty with language and communication (Raghavan & Waseem, 2007), general lack of

knowledge and awareness of mental health and mental health services (Bradby et al., 2007; Hackett & Patel, 2006; Islam et al., 2017), and a fear of discrimination (Bradby et al., 2007).

However, several facilitators to increase access to mental health support include increased knowledge and awareness of mental health services through advertising and psychoeducational sessions for adults (Hackett & Patel, 2006), mental health and resiliency education in schools (Islam et al., 2017), and increased representation, understanding, and incorporation of South Asian culture and Islamic faith among service providers and delivery (Islam et al., 2017).

Mental Health Stigma

One body of literature that necessarily informs help-seeking behaviors is mental health stigma. Ciftci and colleagues (2013) reviewed literature on mental health stigma and conceptualized it in terms of public stigma, self-stigma, and courtesy stigma (Corrigan & Watson, 2007). Public stigma is defined as stereotypes endorsed by and acted on by the general public (Corrigan & Watson, 2007). Self-stigma refers to the internalization of public prejudice and directing that prejudice to oneself (Ciftci et al., 2013). The concept of self-stigma is further broken down into awareness of the stigma, level of agreement of the stigma, and degree to which the stigma harms an individual's self-esteem and self-efficacy (Ciftci et al., 2013). Finally, courtesy stigma refers to the prejudice applied to individuals or a group of individuals associated with a stigmatized person, such as someone caring for someone with a mental health disorder (Corrigan & Watson, 2007). Corrigan and Watson (2007) further argue that stigma is situated within the intersection of various demographic and cultural factors that make up the Muslim community in America. Referred to as double stigma, the degree and kind of stigma can differ

because of intersectional identities, including caregiver stigma and burden, shame, cultural acceptance, hiding of family members, and abandonment (Ciftci et al., 2013).

Mental health stigma predicts help-seeking attitudes, stigma tolerance, and interpersonal openness to sharing mental health challenges (Masuda & Boone, 2011). Case studies of Muslim individuals that faced a variety of stressors (e.g., changes to employment status, discrimination) found that these individuals experienced subsequent symptoms of depression and anxiety. However, mental health stigma and cultural mistrust of American mental health providers hindered help-seeking behavior (Amri & Bemak, 2013). These studies on mental health stigma illustrate the conceptualization of stigma and how it impacts and influences minority populations perceptions of mental health and willingness to seek help. Various factors ranging from public perception, stereotypes, racial discrimination, and knowledge and education of mental health intersect to illustrate perceptions of mental health and stigma. Furthermore, intersectionality within minority communities leads to experiences of being twice-stigmatized based on race/ethnicity, religion/faith, mental health status, immigration, and so on.

On a family and community level, stigma was the most common barrier to seeking professional mental health support, among first- and second-generation South Asian Muslim parents and children (e.g., Bradby et al., 2007; Islam et al., 2019; Pilkington et al., 2012; Raghavan & Waseem, 2007). Stigma was particularly associated with feelings of shame of having children with poor mental health (Bradby et al., 2007; Pilkington et al., 2012) and the spread of “gossip” within communities that could impact future marriage opportunities for their children (Islam et al., 2019; Raghavan & Waseem, 2007). Stigma and beliefs about mental health may be shaped by mental health perceptions and conceptualizations.

Mental Health Frameworks and Perspectives

Several models of mental health and well-being exist. Dominant conceptualizations of mental health are predicated on a biomedical model in which mental health is defined by the absence or presence of psychopathology (Hatala, 2012). The biomedical model is a reductionist approach to understanding mental health in which illnesses are framed as physiological reactions and changes in the body and the brain (Hatala, 2012). A more comprehensive conceptualization of mental health has biopsychosocial underpinnings. The biopsychosocial model builds off of the biomedical model by conceptualizing mental health as the absence or presence of psychopathology that may have both biological and psychosocial components, such as the influence of family, community and wider society (Kinderman, 2005). Summarily, the biomedical and biopsychosocial models describe mental health as a construct of psychopathology in which mental health is defined by the presence or absence of a disorder (Suldo & Shaffer, 2008).

In contrast to the biomedical and biopsychosocial models of mental health, which focus almost exclusively on psychopathology, conceptualizations drawing from positive psychology view mental health and mental illness as a two continua model comprised of both psychopathology and subjective well-being (Seligman & Csikzentmihalyi, 2000; Westerhof & Keyes, 2016). The two continua model of mental health and illness view both as related but distinct continuums: one continuum indicates the absence or presence of mental health, and the other continuum measures the absence of presence of mental illness (Westerhof & Keyes, 2010). Together, these two continua comprise a complete state view of mental health that indicates both the absence of mental illness and the presence of subjective well-being (Keyes, 2016).

Critique of Dominant Conceptualizations of Mental Health

Criticisms of western conceptualizations of mental health and illness are that indigenous conceptualizations of mental health and illness are subsumed under universal definitions of mental health and illness (Mills, 2014; Watters, 2010). Mills (2014) argues that universalizing mental illness as conditions that are situated within the brain washes out local and indigenous understandings of distress. She further argues that the permeation of western models of mental health and illness in regions around the world reflect colonization of epistemologies – a phenomenon she calls "epistemicide (Mills, 2014, p. 125)," in which alternative health frameworks are rejected and replaced by biopsychosocial frameworks (Mills, 2014). Similarly, Watters (2010) argues that the spread of western conceptualizations of mental illness across cultures dismisses the notion that cultural and temporal understanding of symptoms, healing, and expectations of illness influence how individuals within a cultural space and time experience the illness itself. Conversely, exploring the beliefs and knowledge of other cultures can highlight western biases in psychology and open up new avenues for understanding and addressing mental health and illness (Watters, 2010).

Non-Western Conceptualizations of Mental Health

A major contrast between western and non-western conceptualizations of mental health and illness is how an individual is understood within the psychological paradigm. Western understanding of individuals is rooted in individualism, in which the psychological subject is decontextualized and alone responsible for its thoughts, emotions and behavior (Ingle, 2018). Within this model of the psychological subject, psychopathology is situated within the individual alone as is psychotherapeutic intervention (Ingle, 2018). In contrast, non-western conceptualizations, including Islamic and South Asian models, adhere to a collectivistic

understanding of the psychological subject (Keshavarzi & Haque, 2013; Shah & Tewari, 2019). Within collectivistic cultures, the psychological subject is situated within various ecological contexts, including family and community (Shah & Tewari, 2019). Within collectivistic models, emphasis is placed on interdependence, humility, authority, and community needs over individual needs and agency (Keshavarzi & Haque, 2013). Here, psychopathology and intervention are situated within the individual *and* within layers of ecological contexts (Ingle, 2018). While individualism within psychology is the dominant paradigm, critics argue that an individualistic view dismisses external factors and contexts that contribute to mental health and illness and that should also be addressed in intervention approaches (Ingle, 2018; Mills, 2014).

Islamic Framework of Mental Health

In contrast to dominant western conceptualizations that focus on the brain and body, non-western conceptualizations of mental health and illness incorporate a spiritual lens. Islamic conceptualizations of mental health and illness are based on the teachings of Imam Abu Hamid Muhammad al-Ghazali, a highly revered 11th century Muslim philosopher (Keshavarzi & Haque, 2013). Imam al-Ghazali defined mental health and illness based on an individual's spiritual distance from God, whereby mental illness is associated with more distance and mental health well-being is associated with proximity to God (Keshavarzi & Haque, 2013).

Other Islamic conceptualizations of mental health and illness may be multidimensional and include spiritual, social, and biological causes to mental illness (Bagasra & Mackinem, 2014). Several studies have been conducted to understand Islamic and cultural concepts that influence and shape perspectives of mental health (Bagasra & Mackinem, 2014; Tobah, 2018; Weatherhead & Daiches, 2010) and healing (Padela et al., 2012). Bagasra and Mackinem (2014) explored how Muslim Americans between the ages of 18 and 98 years understood and

interpreted the concept of mental illness and found that participants endorsed a multidimensional model of understanding that was comprised of spiritual, social, and biological causes. Spiritual causes included weakness in or lack of faith, false worship, sinful thoughts or actions, supernatural factors (i.e., *jinn* possession, evil eye, black magic), and tests from God. More than 41% of the 255 participants in Bagasra and Mackinem (2014) had a moderate score on spiritual conceptions. A significant percentage believed that mental illnesses originated from the Will of God and were tests from God. However, fewer endorsed supernatural factors and sinful thoughts and actions as causes of mental illnesses. Analysis of open-ended questions revealed an integrated and multidimensional understanding of causes of mental illness that included situational and biological conditions. Additional causes endorsed included environmental factors, such as abuse, trauma, stress, religious/social pressure, immigration, identity and belonging, interpersonal and community relationships, and environmental/natural causes (Bagasra & Mackinem, 2014).

Similarly, Weatherhead and Daiches (2010) found that a sample of 14 first-generation Muslims of varying nationalities (age = 28 - 77 years old) living in the United Kingdom endorsed causes of mental illness that could be grouped into two major themes: reaction to life events (e.g., stress, drugs, not having something to rely on, minor problems becoming bigger) and religious causes (e.g., punishment from God, test from God). At times, participants also endorsed multiple perspectives of causes of mental illness (e.g., *jinn* possession and drugs, bad things occur as a result of own actions and good things come from God, life is a test from God that should be accepted and managed with thanks). Weatherhead and Daiches (2010) also explored Muslim perceptions of how mental illness should be addressed and found that both

Islamic supports, such as prayer, seeking help from a religious leader and turning to family, and professional secular services for more extreme problems were accepted.

Haroun and colleagues (2011) found similar perspectives regarding mental health among a sample of Muslim American adolescents (N = 125) of primarily Pakistani and Bangladeshi origin between the ages of 14 and 21 years old. Individuals were surveyed on a variety of religious and secular beliefs about depression and their likelihood to accept a physician's diagnosis of depression (Haroun et al., 2011). The results of the study indicated that the sample adolescents held both religious and secular beliefs about depression. For example, over 80% of the adolescents agreed that reciting the Qur'an could relieve depression and nearly half of the sample believed diligence in prayer could relieve depression (Haroun et al., 2011). More than half the respondents also agreed that biological changes in the brain could cause depression (53.7% of the sample) and that changing one's behavior could alleviate depressive symptoms (58.7% of the sample). Notably, adolescents who endorsed secular beliefs about depression (e.g., biological basis of depression) were more likely to accept a physician's diagnosis of depression than adolescents who endorsed religious beliefs about depression and treatment (e.g., the belief that prayer can heal depression; Haroun et al., 2011).

Religiosity has been shown to be positively associated with subjective well-being among Kuwaiti Muslim adults, college students, and adolescents (Abdel-Khalek, 2012), with emotional health among Iranian Muslim adolescents living in Iran (Rafi et al., 2020), as well as with symptom reduction of depression and anxiety among Arab Muslim college students living in Israel (Agbaria, 2014). Several concepts within Islam have been suggested to shape positive cognitions about the self, distress, and control over life that reduce symptoms of depression and anxiety (Hamdan, 2008). Muslims believe in a temporal reality and the promise of a Hereafter

(i.e., life after death); this belief can counter hopelessness about distressing experiences in the present life (Hamdan, 2008). The promise of a Hereafter devoid of distress and affliction also serves as a goal that Muslims strive to attain and can help provide purpose for individuals experiencing difficulty with worry and focus (Hamdan, 2008). Additionally, Muslims are taught that for every affliction experienced in the present life, some of an individuals' sins are expiated or their good deeds are increased, thus providing positive reframing to negative and unhelpful thoughts such as "why is this happening to me" (Hamdan, 2008). Finally, focus on the remembrance of God, trust in the plan He has laid out for each individual, focus on the blessings He has provided, and recitation of the Qur'an have calming effects that may alleviate stress and anxiety (Hamdan, 2008).

South Asian Muslim Cultural Perspectives

South Asian culture, among most Asian cultures, is collectivistic in nature (Shah & Tewari, 2019). Within collectivistic cultures, the needs of a group, family, or community are placed above individual needs (Sue & Sue, 2013). Additionally, individual decision making is made with consideration of the impact of the decision on family/group/community (Shah & Tewari, 2019). Autonomy is often downplayed in favor of strengthening familial and community relationships and may be seen as a sign of defiance or disrespect (Datillio & Bahadur, 2005). Given the salient role of family and community within South Asian culture, an individual's family may be highly involved in attaching meaning to an individual's symptoms associated with physical and emotional health, and in the treatment of illnesses (Naeem et al., 2010). Additionally, limited cultural and familial acceptance of negative emotional expression may impact presentation of symptoms and the recovery process (Datillio & Bahadur, 2005). True to collectivism, South Asian culture tends to discourage negative emotional expression and

encourage individual sacrifice for the collective good of the family or community (Mahr et al., 2015). Associatively, somatic symptoms are more commonly expressed (Naeem et al., 2012) and accepted as explanations for mental illness (Datillio & Bahadur, 2005), and are preferred as the primary goal for treatment among South Asian Muslims (Naeem et al., 2010).

Theoretical Orientation

The present study is grounded in Critical Race Theory (CRT; Delgado & Stefancic, 2011) and Decolonizing Theory (Akomolafe, 2012; Bhatia, 2017; Coles & Mannion, 2017). CRT and its Asian and South Asian branches, AsianCrit and DesiCrit, respectively, provide a racial lens for examining the historical and contemporary experiences of South Asian Muslims in America that trickle down to influence and shape second-generation South Asian American Muslim mothers, their construction of knowledge, and their actions. Decolonizing Theory provides a critical purpose and need for this study – that contemporary Western psychological science pervades and overshadows other perspectives and practices backed by alternative evidentiary practices, such as the intergenerational exchange of information, storytelling, and the research of historical, non-Western scientists. Essentially, this study asserts that the psychology and mental health field is incomplete without the inclusion of non-Western science, perspectives, and knowledge (Bhatia, 2017; Iftikar & Museus, 2019). While bodies of literature on Western and non-Western psychology exist, this study places focus on a relatively young group in the U.S. – the second-generation South Asian American community – that exists in the intersection of Western and non-Western epistemologies. CRT and Decolonizing Theory provide the necessary tools for embarking on exploration within this group.

Critical Race Theory

Critical Race Theory (CRT) is a theoretical framework for examining dominant structures and systems through the lens of race and racism (Delgado & Stefancic, 2011). CRT originated in the 1970s when activists, scholars, and lawyers across the country noticed that changes from the civil rights era were slowing down or being reversed (Daftary, 2020). Drawing from several movements (e.g., critical legal studies, radical feminism, Black Power, the Civil Rights movement, Chicano movements) as well as several European and American philosophers and theorists (e.g., Michel Foucault, Frederick Douglass, W.E.B. Du Bois, Martin Luther King, Jr.), CRT proposed that multiple reasonable outcomes in legal cases exist, that favorable rulings tend to deteriorate over time, and that there is a relationship between power and the construction of social roles (Delgado & Stefancic, 2011). Ultimately, CRT sprung up as a movement to expose how the relationship among race, racism, power, and society impact the daily lives of people living the United States (Daftary, 2020). Furthermore, CRT seeks to transform society by dismantling racism within systems, policies, disciplines, and practices (Delgado & Stefancic, 2011). Although CRT originated as a framework to highlight racism within the law (Daftary, 2020), today CRT has branched out to specific groups, such as Asian Critical Theory (AsianCrit; Iftikar & Museus, 2018) and Desi Critical Theory (DesiCrit; Harpalani, 2013). Additionally, CRT is applied to research in a variety of disciplines beyond law, including psychology (McDowell & Jeris, 2004).

Although there is not a universally agreed upon set of CRT tenets, several basic tenets have been found to run across the majority of CRT disciplines (Daftary, 2020). The first basic CRT tenet is that racism is ordinary and pervades all political, legal, and social structures (Daftary, 2020; Stefancic & Delegado, 2010). Additionally, racism is commonly experienced by

most people of color in the United States (Delgado & Stefancic, 2011). Second, CRT asserts that racism advances the interests of the dominant group, and that interest convergence drives systemic change (Delgado & Stefancic, 2011). Interest convergence is the concept that racial equality will only happen when changes converge with white interests (Bell, 1980). Essentially, any progress toward racial equality within systems and disciplines will be driven by whether that progress is in the best interest of the dominant white group (Leonardo, 2013). The third CRT tenet arduously states that race is strictly a social construct and has no biological or genetic basis (Delgado & Stefancic, 2011). Minority groups are racialized by the dominant group in different ways and times in responses to shifting labor needs (e.g., the racialization of South Asians; Delgado & Stefancic, 2011). The fourth tenet of CRT is intersectionality which recognizes that oppression happens at the intersection of a variety of identities held by a single individual or group (Delgado & Stefancic, 2017). The final CRT tenet believes in the unique voice of color by uplifting minority perspectives and knowledge (Daftary, 2020; Delgado & Stefancic, 2011). Under this tenet, the unified voice of communities of color (e.g., Black, Latino, American Indian, and Asian communities) is more competent than the white voice to speak about race and racism and is stronger than the individual voice in fighting racial oppression (Daftary, 2020).

AsianCrit. CRT has been adapted several times. Asian Critical Theory (AsianCrit) was adapted from CRT to focus on experiences of immigration and discrimination within Asian American communities (Delgado & Stefancic, 2011). AsianCrit draws from Asian history and experiences to understand how race and racism impact Asian Americans (Iftikar & Museus, 2019). Following CRT, AsianCrit ascribes to at least seven tenets: Asianization, transnational contexts, (re)constructive history, strategic (anti)essentialism, intersectionality, story, theory, and praxis, and commitment to social justice (Iftikar & Museus, 2019). Asianization refers to the

process by which Asian Americans are racialized in the United States – as perpetual foreigners, yellow perils, and as both model and deviant minorities. This Asianization serves to exclude Asian Americans and their experiences and perspectives from systems, policies, and practices (Iftikar & Museus, 2019). The tenet of transnational contexts emphasizes the importance of past and present economic, political and social processes that have shaped the experiences of Asian Americans (Iftikar & Museus, 2019). (Re)constructive history addresses the reality that Asian Americans are invisible in U.S. history by uplifting Asian American narratives and incorporating the voices of Asian Americans in reanalysis of histories (Iftikar & Museus, 2019). Strategic (anti)essentialism argues that Asians are racialized based on economic, political, and social forces of the time *and* Asian Americans (re)define racial categories to leverage power and advocacy against white supremacy (Iftikar & Museus, 2019). Similar to the CRT tenet, intersectionality in AsianCrit addresses the how multiple systems of oppression (e.g., imperialism, colonialism, sexism) shape Asian American experiences and their racial and social identities (Iftikar & Museus, 2019). Story, theory, and praxis refers to Asian epistemologies dominating dominant white epistemologies. This notion draws from CRT's basic tenet of the unique voices of color, storytelling, and counternarratives (Bell, 1995). Finally, the commitment to social justice tenet of AsianCrit is a commitment to end all forms of oppression and exploitation (Iftikar & Museus, 2019).

DesiCrit. Although AsianCrit provides a framework for examining the impacts of various systems of oppression, most notably imperialism and colonialism, on Asian Americans and their experiences (Iftikar & Museus, 2019), Asian Americans are often racialized as one monolithic group or refer more commonly to Asians Americans with roots in East Asia (e.g., China, Japan, Korea; Inman et al., 2014). While South Asian Americans share many of the

experiences of other Asian groups in America, such as the model minority myth (Bhatia & Ram, 2017), South Asians also experience an element of racial ambiguity that is not fully addressed by CRT or AsianCrit (Harpalani, 2013). Desi Critical Theory, or DesiCrit, takes on this challenge by incorporating racial ambiguity into its framework. Racial ambiguity is the notion that racial characterizations change based on local and historical contexts (Harpalani, 2013). DesiCrit centers the racial ambiguity of South Asians shaped by dominant society in its framework.

Decolonizing Psychology

Within the realm of critical inquiries lies critical psychology. Critical psychology is explicit in examining the foundations of modern psychology and the power differentials inherent in psychology as a science and practice (Coles & Mannion, 2017). The key concepts of critical psychology are to address power relations in modern psychology and address how the discipline has marginalized communities in its advancement. Critical psychology emphasizes the interdependency of individuals within social contexts and highlights problems as arising from wider historical, environmental, and social contexts, rather than solely from within individuals. The goal of critical psychology is to promote equality and social justice within the discipline of psychology and beyond (Coles & Mannion, 2017).

The movement to decolonize psychology is closely aligned with the values of critical psychology (Bhatia, 2017). While critical psychology broadly examines power relations within psychology, the decolonizing psychology movement analyzes colonial and postcolonial influences on psychology (Bhatia, 2017). Both critical and decolonizing psychology movement acknowledge a western hold on knowledge and the de-valuation of non-western knowledge (Bhatia, 2002; Coles & Mannion, 2017). Critical psychology suggests that the field of psychology over-relies on randomized control trials to build evidence for knowledge and practice

(Coles & Mannion, 2017). Decolonizing psychology takes this a step further to suggest that the epistemological imbalance that privileges western knowledge over non-western or indigenous knowledge is an artifact of colonization (Akomolafe, 2012).

Decolonizing psychology, particularly among Asian communities, considers how orientalism, remnants of the British Empire, and the advancement of Western knowledge as universal in an allegedly postcolonial world continue to subjugate indigenous epistemologies, knowledge, and traditions (Bhatia, 2017). The decolonizing movement promotes counternarratives and storytelling, as well as the examination of how people on the ground make sense of their lives and experiences (Bhatia, 2017). Finally, it embraces a constructive approach to reimagining the field of psychology as one that is made up of the stories, theories, and knowledge of indigenous and marginalized people (Bhatia, 2017). Aligned with the decolonizing movement and critical psychology as a whole is Critical Race Psychology (CRP). While critical and decolonizing psychology highlight how western psychology is normalized and indigenous forms of psychology are denaturalized, CRP highlights the role of race and racism in the field of psychology (Salter & Adams, 2013). As an offshoot of CRT, CRP tenets draw heavily from the basic tenets of CRT. In CRP, racism is considered systemic and embedded within the fabric of society. CRP urges for the dismantling of systems that unevenly privilege Western epistemologies and ontologies over indigenous forms (Salter & Adams, 2013). The second tenet urges for increased consciousness of indigenous and marginalized perspectives. The third tenet highlights interest convergence in the field of psychology and how certain methodologies serve the interest of the dominant group. The fourth tenet argues that there is a possessive investment in whiteness that renders western psychological science as raceless and universal. The final tenet

of CRP emphasizes counter-storytelling as a way to reveal and resist racial bias in the field of psychology (Salter & Adams, 2013).

Summary and Purpose of Current Study

The second-generation South Asian American Muslim mother population is rich with complex intersecting identities and experiences. The SAAMM-2 population come from a multigenerational history of colonization and immigration. Colonization of the Indian subcontinent also resulted in the colonization of knowledge and culture (Akena, 2012; Bhatia, 2002; Said, 1979). Traditional knowledge about psychology and mental health were de-valued and replaced with Western methodologies and knowledge (Akena, 2012; Bhatia 2002). Colonization on the Indian subcontinent may have multigenerational impacts in the form of colonial mentality, in which individuals subconsciously believe in the inferiority of their own culture and knowledge and the superiority of the colonizer's culture and knowledge (David & Okazaki, 2006a). Researchers argue that colonial mentality persists among immigrants and children of immigrants living in the U.S. as a coping mechanism for surviving and excelling in an ideologically Western country (Aujla, 2000; deSouza, 2017; Karimi & Bucerius, 2017).

South Asian history of immigration to the U.S. is just as impactful on the lives of the SAAMM-2 population as colonization. Anti-immigration sentiment and discrimination in the U.S. toward South Asians and Muslims for over a century have contributed to the racialization of South Asians and Muslims (Abdul Khabeer, 2017; Bhatia & Ram, 2018), to first-generation South Asian immigrants expectations for their children in the U.S. (Shams, 2020), and how SAAMM-2 acculturated in the U.S. (e.g., Berry et al., 2006, Farver et la., 2002; Kunst et al., 2016).

SAAMM-2 were raised in immigrant homes where South Asian and American cultures and Islam intersected to form unique childhood experiences. The literature on acculturation indicates that children of immigrants' experience acculturation in their formative years (Aujla, 2000). Although, children of immigrants often prefer integrating their ethnic and host country cultures (Berry et al., 2006), the experience of acculturation is complex and influenced by myriad factors (Schwartz et al., 2006), including gender (Farver et al., 2002; Singh Ghunam, 1997), religiosity (Goforth et al., 2014; Saroglou & Mathijsen, 2007), as well as acculturative stress factors such as parental expectations (Bhattacharya & Schoppelrey, 2004; Tummala-Narra et al., 2016) and dominant society expectations (Kunst & Sam, 2013; Kunst et al., 2016).

Racialization, acculturative stress, and childhood acculturation may have impacted how SAAMM-2 view mental health and how they engage in mental health help-seeking behaviors. Racialization of the South Asian Muslim populations may have contributed to a sense of insecurity in belonging in the U.S. (Shams, 2020) and the minimization of mental health concerns within the population (Bhatia & Ram, 2018; Gupta et al., 2011; Kim & Lee, 2014). Acculturation and associated acculturative stress (e.g., expectations, discrimination) of both first-generation South Asian Muslims and the SAAMM-2 population may have contributed to mental health stigma and limited help-seeking behaviors for mental health support (Bradby et al., 2007; Islam et al., 2019; Tummala-Narra et al., 2016). The combination of these multigenerational experiences may influence how SAAMM-2 perceive mental health within their own children and the practices in which they engage to address mental health challenges and promote well-being.

Therefore, the purpose of this study is to critically examine the field of psychology and mental health practices for marginalized ways of knowing and uplift the voices, stories, and narratives of the South Asian American Muslim population. Adopting critical race theory (CRT;

Delgado & Stefancic, 2011) and decolonizing psychology (Akomolafe, 2012; Bhatia, 2017; Coles & Mannion, 2017) lenses will aid in exploring the role of immigration, acculturation, and intergenerational trauma in SAAMM-2's mental health perspectives and practices. Specific tenets of CRT, decolonizing psychology, and offshoots from these frameworks guide the purpose and design of this study. Specifically, the tenet of CRT that asserts the belief in amplifying the unique voices, perspectives, and knowledge of minority populations (Daftary, 2020; Delgado & Stefancic, 2011) sits at the foundation of this study's purpose. Tenets from AsianCrit (Iftikar & Museus, 2019) and DesiCrit (Harpalani, 2013) support the argument that South Asian American Muslim voices, perspectives, and experiences, shaped by the past and present, have been excluded from systems, policies, and practices (Iftikar & Museus, 2019). Key concepts from critical psychology, decolonizing psychology, and critical race psychology that further frame the purpose of this study include how the discipline of psychology has marginalized communities by pushing individualism in conceptualization and treatment of mental health challenges (Coles & Mannion, 2017) and by de-valuing non-Western knowledge and practices (Bhatia, 2017). The present study draws from these concepts to contribute to the reconstruction of the psychology field to include the stories, theories, and knowledge of indigenous and marginalized people (Bhatia, 2017; Salter & Adams, 2013).

Research Questions

The following research questions will guide data generation and analysis of this study.

1) How do individuals in the SAAMM-2 population construct and recount their knowledge about mental health, particularly in relation to the mental health of their children?

2) What role does being children of immigrants play in the shaping of SAAMM-2's knowledge, perceptions, and experiences pertaining to mental health?
3) How do SAAMM-2 negotiate their South Asian, Muslim, and American identities and cultural practices to make sense of mental health and well-being?

Chapter 3: Method

Study Design

The present study is a qualitative study aiming to elevate second-generation South Asian American Muslim mothers' (SAAMM-2) perspectives, experiences, and practices. Data were generated from individual semi-structured interviews, demographic surveys, and acculturation surveys. Ten SAAMM-2 participants were recruited. Each participant was asked to provide informed consent to participate, to complete one demographic survey and one acculturation survey, and to engage in one 90-minute individual semi-structured interview conducted by the researcher. A constructivist grounded theory approach was used to analyze the data, make claims, and report what was learned from the community.

Constructivist Grounded Theory

In this proposed study, a grounded theory approach to qualitative research was used to guide analysis. The approach was first proposed by Glaser and Strauss (1967) as an "attempt to discover theory grounded in the analysis of data collected during qualitative research" (Bhattacharya 2017, p. 104). Although, several strands of grounded theory exist (e.g., Glaserian, Straussian, constructive; Alammar et al., 2019; Charmaz, 2006; Glaser, 1992; Strauss & Corbin, 1990), this study used the constructivist approach to grounded theory (Charmaz, 2006) because of its close relationship to critical inquiry (Charmaz, 2017). While critical inquiry seeks to expose injustices in daily life (Denzin, 2017), constructivist grounded theory provides a method for doing so through the co-construction of meaning among researchers and participants (Tie et al., 2019). This includes constant interaction, analyses, and questioning of emergent data (Charmaz, 2017; Tie et al., 2019) and reflexivity (i.e., analysis of the researcher-self in relation to the research process; Green et al., 2011). Through this process, data are generated and

analyzed until saturation (i.e., no new concepts emerge; Atkin & Jackson, 2020) and concepts can be connected by a core category to inform theory (Merriam & Tisdell, 2015; Saldaña, 2014).

Rational for Using Constructivist Grounded Theory. Grounded theory has been used as a methodological approach in a variety of research studies with ethnic minority populations (Draucker et al., 2014), including South Asian Muslims (Hussain & Cochrane, 2002) and second-generation South-Asian Canadian youth (Sundar, 2008). Hussain and Cochrane (2002) asserted that the use of constructivist grounded theory challenges minority group stereotypes and provides a space for alternative experiences and meanings to emerge and be elevated (Hussain & Cochrane, 2002). These alternative experiences and meanings ultimately create new theories that center minority groups and diversity (Green et al., 2011). Following this assumption of the benefits of using grounded theory with critical inquiry (i.e., AsianCrit), the present study aimed to integrate the unique experiences and perspectives of SAAMM-2 with how they make sense of mental health, and discover concepts and theories that might shift the status quo on dominant/non-dominant mental health perspectives and practices in the U.S.

Researcher Bias & Positionality

Before beginning qualitative research, it is important to reflect on and recognize my values that define the meaning of the present study and state my positionality in relation to this study's design, participants, and analysis (Charmaz, 2017; Milner, 2007). This study's purpose and design sparked from the integration of multiple identities and experiences that shaped my knowledge construction of mental health. As a second-generation South Asian (Pakistani) American Muslim, I initially constructed a model of mental health based on my mother's knowledge of mental health situated in Pakistani culture and Islamic faith. Over the years, I studied psychology from the Western perspective and began rejecting the cultural and spiritual

representations of mental health I heard within my own family and community. However, recently, as I have become more immersed in providing professional mental health services, I have found myself critically examining how Western representations and forms of "treatment" share qualities, concepts, and practices similar to those my mom shared and taught me many years ago. In this period of examination, I have assumed a more critical lens that may influence how I analyze, interpret, and present findings (Dean et al., 2018).

In this study, I aimed to recruit SAAMM-2. Second-generation is defined as individuals born in the U.S. or individuals who moved to the U.S. by or before the age of 5 who have at least one parent who immigrated from South Asia. South Asian includes anyone from India, Pakistan, Bangladesh, Sri Lanka, Nepal, Bhutan, and the Maldives (Chang et al., 2018). Several sects of Muslims exist (e.g., Sunni, Shia, Ismaili, Ahmadi; Kaduvettoor-Davidson & Weatherford, 2018), and anyone who self-identifies as Muslim from any of the sects were considered for this study to increase inclusivity and to acknowledge the heterogeneity of the Muslim population.

As a second-generation SAAM, I am an insider in this community of participants based on my race, ethnicity, nationality, generational status, and religion (Dwyer & Buckle, 2009). My own strategy of acculturation, understanding of South Asian culture and the Islamic faith may have facilitated relationships with participants and supported access to their stories and experiences of mental health, and to the way they drew from multiple identities to construct knowledge and engage in practice regarding mental health. However, participants in this study were mothers and I am not; participants may have viewed me as an outsider and I may not have fully accessed their stories and knowledge of being mothers (Ryan et al., 2011). Finally, I was cognizant of how and in what context I brought academic and Western terms of psychology and mental health into conversations and how I encouraged and empowered participants to use

cultural and spiritual terms to share their knowledge about psychology and mental health (Paris, 2011).

Recruitment of Study Participants

Given the barriers that South Asian Muslims experience to participation in mental health research (e.g., Brown, Marshall et al., 2014; Brown, Woodham et al., 2014; Chen et al., 2005; Culley et al., 2007; Quay et al., 2017), strategies for recruitment included connecting via email with individuals within the community, including prominent community members in Muslim and South Asian spaces (Ahmed et al., 2019), advertising study information on common South Asian Muslim sites, online forums, and social media (Ahmed et al., 2019; Hussain-Gambles et al., 2006), and the use of snowball sampling (Mohammadi et al., 2008). These strategies have been found to be effective for other researchers engaging with South Asian and/or Muslim communities in research (e.g., Ahmed et al., 2019; Hussain-Gambles et al., 2006; Mohammadi et al., 2008; Quay et al., 2007).

An important consideration for researchers is remaining cognizant of the difficulty of gaining access to ethnic minority communities for insider and outsider members (Culley et al., 2007) and the extended time and resources needed to recruit ethnic minority participants (Quay et al., 2017). Recruitment of participants for the present study began in July 2022 and was completed in October 2022. Significant stigma surrounding mental health in South Asian Muslim communities may have impeded recruitment or influenced the type of participants willing to engage in the study (Ahmed et al., 2019; Brown et al., 2014; Quay et al., 2017). These considerations and other barriers in recruitment necessitated flexibility with recruitment strategies and time (Ahmed et al., 2019).

Prior to beginning recruitment for the present study, I obtained approval from the University of Washington Internal Review Board (IRB) to ensure the study design was consistent with ethical research protocol. After receiving IRB approval (exempt), recruitment began in July 2022. Initial recruitment for participants began in the Bay Area region of California. The Bay Area has one of the largest South Asian Muslim populations in the U.S. (Bazian & Senzai, 2013). In 2013, over 250,000 Muslims lived in the Bay Area; 30% of the Muslim population identified as South Asian (Bazian & Senzai, 2013). In 2011, a report on masjids (mosques) in the U.S. counted over 70 masjids in the Bay Area (Bagby, 2012). I am affiliated with three large masjids in the Bay Area which host a large South Asian Muslim population. It was anticipated that the large population of South Asian Muslims in the Bay Area would facilitate recruitment of SAAMM-2 participants for this study. Due to reported difficulties with recruiting participants from minority groups (Green et al., 2011), participants for this study were recruited by convenience (i.e., any self-identifying second-generation South Asian American Muslim mother interested in the study could participate). However, due to low response rates from within the Bay Area, I expanded my recruitment parameters to include participants from anywhere in the state of California or the state of Washington. I sought permission from my advisory committee and submitted an amendment to the university IRB prior to expanding recruitment parameters.

To recruit participants, I initially reached out to 3 masjid leaders and boards via email and requested to share information about the study through the masjid listservs. The email contained a digital flyer with information about the study and a link to a Google Form survey with the informed consent form (see Appendix A) and demographic survey (see Appendix B). However, I did not hear back from the 3 masjids. Consequently, I shared the digital flyer and link via social

media posts on Facebook and Instagram. Four community members within my social network in California and Washington reshared the digital flyer and link via their personal social media pages. Through these efforts, 22 individuals completed the demographic survey and provided contact information. Of the 22 individuals, 7 indicated that they moved to the U.S. after they turned 5 years old, thus disqualifying them from the study. I followed up with these 7 individuals via email, thanking them for their interest and explaining the reason they did not qualify for this particular study. I followed up with the remaining 15 participants that provided consent to schedule individual interviews up to 90 minutes in length. Five individuals did not respond to my emails requesting an interview. The remaining 10 participants responded positively and agreed to schedule a 90-minute interview with me. Each individual that participated in the individual semi-structured interview was offered one $15 gift card to Amazon® or Target®. Two individuals initially refused the gift card; however, one individual accepted the gift card and the other individual requested a $15 donation be made in her name, instead.

The recruitment strategies I used have both strengths and limitations that may have influenced the kinds of participants recruited for the study. By using my personal social media accounts, word-of-mouth, and snowball sampling, there was an increased likelihood of recruiting participants that were familiar with each other and with me. Of the 10 participants recruited, 2 indicated knowing another individual that had participated in the study. Furthermore, I was familiar with 4 of the participants. Familiarity with the participants supported comfort and rapport building between the participants and the researcher.

Data Generation

Three methods of data collection were used in this study: a demographic survey, virtual semi-structured individual interviews consisting of semi-structured interview questions and

vignette discussions, and an acculturation survey. Studies with American Muslims (Alhomaizi et al., 2018), British South Asians (Bradby et al., 2007), diverse ethnic minority mothers in the Netherlands (Flink et al., 2013), and Indian Muslims in South Africa (Laher et al., 2018) have used vignettes, semi-structured interviews, or a combination of the two to study perceptions of mental health and attitudes toward seeking help. These methods have facilitated exploration of group norms and cultural values (Bradby et al., 2007), open discussion and comfort with discussion topics (i.e., mental health; Bradby et al., 2007; Laher et al., 2018), and allowed for the inclusion of multiple perspectives (Alhomaizi et al., 2018).

Demographic Survey

The demographic survey was used to gather information about participant demographics (see Appendix B). The demographic survey asked participants to share their age, gender, age of children, relationship to children (e.g., mother, father, caregiver), parents' country of origin, marital status, and a question asking how they self-identify (e.g., South Asian, Muslim, South Asian American, Muslim American, American, other). Additionally, participants were asked whether they were born in the U.S. or how old they were when they first moved to the U.S. Questions about relationship to child, age of children, self-identity, and place of birth served to screen participants for the study.

Participant Demographics. Of the 10 participants in this study, 4 were from northern California, 5 were from southern California, and 1 was from central California. Participants' ages ranged from 29 years old to 47 years old. Their children's ages ranged from 1.5 years old to 19 years old. Eight participants were born and raised in the U.S. and two participants were born in Pakistan but moved to the U.S. before they turned 5 years old. Eight participants' parents were born and raised in Pakistan, one participant's parents were born and raised in India, and one

participant's parents were born in Pakistan but raised in Algeria, Saudi Arabia, and the U.S. All 10 participants indicated identifying with being South Asian, Muslim, and American, except for 1 participant who did not identify with the American identity despite being born and raised in the U.S. Nine participants identified with being Pakistani and 1 participant identified with being Indian. All participants identified as being mothers of their children. Eight participants were married, 1 participant was divorced, and 1 participant was divorced and remarried. (See Table 1).

Table 1

Participant Demographics

Pseudonym	Children's Age (Years)	Birth Country	Age Moved to U.S. (Years)	Years Lived in U.S.	Age (Years)	Parents' Birth Country
Zahra	9, 7, 5, 4	U.S.	NA	34	34	Pakistan
Nuriya	2	Pakistan	Before 5	30	33	Pakistan
Maheen	n.d.	U.S.	NA	37	37	Pakistan
Maira	12, 16, 19	U.S.	NA	47	47	India
Mehwish	5, 9	U.S.	NA	38	38	Pakistan
Ammara	4, 2	Pakistan	Before 5	37	38	Pakistan
Rasheeda	8, 10	U.S.	NA	36	36	Pakistan
Zainab	2, 5	U.S.	NA	31	31	Pakistan
Inaya	7	U.S.	NA	34	34	Pakistan
Maya	1.5	U.S.	NA	29	29	Pakistan

Note. N.d. indicates exact ages were not disclosed and participant preferred not to share.

Semi-Structured Interviews

Semi-structured interviews are individual conversations between the researcher and the participant (Bhattacharya, 2017) that utilize interview guides with flexible questions pertaining to the main topic(s) of interest (Merriam & Tisdell, 2015). Although a variety of sources are used in grounded theory (Merriam & Tisdell, 2015), interviews with individuals are the primary method for data collection (Creswell, 2013). The combination of systematic questioning, spontaneous analysis, inclusion of new questions that arise during the interview, and

opportunities for clarification and reflection support both constructivist grounded theory and critical inquiry (Charmaz, 2017). In the present study, 10 individuals participated in the interviews (Atkin & Jackson, 2020; Green & Thorogood, 2004).

Interview Protocol. The semi-structured interview guide included questions pertaining to experiences with mental health and mental healthcare systems in the U.S. or abroad, understanding of different cultural perspectives and models of mental health, knowledge shared across generations (e.g., mothers' parents' perspectives and experiences, similarities and differences between generations), mothers' propensity toward cultural (i.e., South Asian, Muslim, and American) beliefs, traditions and practices, experiences with discrimination, and exploration of acculturation attitudes and level of religiosity. Questions were drawn from existing literature and a prior unpublished pilot study on mental health with a similar population of Pakistani Muslim mothers. The interview was pilot tested with one individual similar to the target group (Alhomaizi et al., 2018; see Appendix C). After completing the interview with the individual, I gathered feedback from the individual to modify the semi-structured interview and use of the vignette questions. The pilot-tester noted that several questions felt redundant, particularly between the semi-structured interview questions and the vignette. I incorporated the individual's feedback to modify the semi-structured interview and vignette questions to reduce redundancy.

Vignettes. Vignettes are descriptions of events related to the topic of inquiry and can be used to facilitate discussion (Sampson & Johannessen, 2020), particularly when the topic is shrouded in stigma (Laher et al., 2018). Mental health is a particularly taboo topic in South Asian and Muslim communities (Amri & Bemak, 2013; Ciftci et al., 2013); as such, the vignettes were

included in hopes of mitigating discomfort in discussing the topic and encourage meaning making at a broader and hypothetical level (Bradby et al., 2007).

Vignettes were drawn from existing literature and modified accordingly for the SAAMM-2 population, with publishers' permission. Bradby and colleagues (2007) conducted a focus group study among British South Asian families, in which three vignettes were presented and discussed. These vignettes centered on three different scenarios of children experiencing mental illnesses: a 12-year-old with depression, a 9-year-old experiencing behavioral challenges at school, and a 16-year-old expressing psychotic symptoms (Bradby et al., 2007). Accompanying these vignettes were discussion questions to better understand how British South Asian families, primarily mothers, make sense of the challenges these children are facing and what kinds of supports they would recommend to these children's parents (Bradby et al., 2007). Modifications to these vignettes were made to represent common South Asian Muslim names, with original authors' permission. Similarly, modifications of the discussion questions were made to reflect the present study's research questions (see Appendix D).

Interview Process. All 10 individual interviews were held online via Zoom, as requested by each of the participants. Prior to beginning the interview, I reiterated that the session would be recorded for analysis purposes and addressed any questions or concerns. Then, I introduced myself, reshared the purpose of the study, stated my positionality, addressed any concerns, and shared how the interview would be structured. I began the interview with the semi-structured interview questions and ended the interview with the vignette questions. I engaged in some notetaking during the interview to aid with asking follow-up questions and processing discussion points, as needed. Following constructivist grounded theory practice, I engaged in asking additional questions as they arose throughout the interview, and periodically reflecting on the

conversation, asking for clarity, and summarizing what I had heard and learned from the participant (Charmaz, 2017). Questions from the vignette were included in the interviews; however, after the first 3 interviews, I noticed the vignette questions were redundant and decided to forgo inclusion of the vignette for future interviews. For example, the question "where or who do you generally turn to when it comes to advice about raising your children or addressing challenges as a parent" was yielding similar responses as the vignette question "a neighbor's 16-year-old daughter has become unhappy and withdrawn. What advice would you give the mother?" After completing the 90-minute interview, participants were requested to complete the acculturation survey sent to them via email. I asked participants for permission to contact them for follow-up to clarify data generated from interviews, if necessary, and/or to ensure participants' voices were accurately represented. Finally, I provided participants with gift cards sent via email. Recorded discussions were manually transcribed using a computer audio player (VLC Media Player) and Microsoft Word. All transcripts were de-identified by designating a pseudonym for each participant. All data generated from the study were stored on a secure hard drive.

Acculturation Survey

After the semi-structured interview, participants were asked to complete an acculturation survey to better understand how strongly participants identify with their South Asian, American, and Islamic backgrounds, and attitudes toward Islam. The acculturation survey was emailed to each participant with follow-up reminders. Questions from the Asian American Multidimensional Acculturation Scale (AAMAS; Chung et al., 2004) and the Sahin-Francis Scale of Attitudes toward Islam (SFSATI; Sahin & Francis, 2002) were included in this survey, with the permission of both scales' authors (See Appendix E). This additional survey served to

provide a general understanding of the sample's acculturation in the U.S. and their attitudes toward Islam.

Asian American Multidimensional Acculturation Scale. The AAMAS consists of three subscales that measure enculturation to culture of origin (AAMAS-CO), acculturation to European-American culture (AAMAS-EA), and enculturation to pan-ethnic Asian culture (AAMAS-AA; Chung et al., 2004). Following the example of Beri's (2012) study with Asian Indians in the U.S., this study used the AAMAS-CO and AAMAS-EA scales to measure acculturation in SAAMM-2 (Beri, 2012). The AAMAS consists of 15 six-point Likert-type scale questions; 10 items measure cultural behavior, 3 items measure cultural identity, and 2 items measure cultural knowledge (Chung et al., 2004). Each respondent obtains two overall scores (AAMAS-CO and AAMAS-EA); higher AAMAS-CO scores indicate greater enculturation to South Asian culture and higher AAMAS-EA scores indicate greater acculturation to European-American culture (Chung et al., 2004). Each subscale score is divided by two; scores above the midway point indicate greater adherence to either South Asian culture or European-American culture than scores below the midway point (Beri, 2012). Using this method, scores are mapped onto three acculturation attitudes: assimilation, separation, and integration (Beri, 2012; Berry, 1997).

Evidence of internal reliability was reported for the AAMAS-CO and AAMAS-EA subscales with a sample of Asian American undergraduate students between the ages of 17 and 31 years old (majority East- and Southeast-Asian; Cronbach alphas of .87 and .81, respectively; Chung et al., 2004). Criterion validity was measured with generational status of participants and was inversely related (-.36), as expected by Chung and colleagues (2004). Concurrent validity was measured against two measures of acculturation: the Suinn-Lew Asian Self-Identity Scale

(SL-ASIA; Suinn et al., 1992) and the Asian Values Scale (AVS; Kim et al., 1999). The AAMAS-CO was negatively correlated (-.75) with the SL-ASIA, a measure of acculturation to host cultures, and positively correlated (.37) with the AVS, a measure of enculturation to Asian culture (Chung et al., 2004). The AAMAS-EA was positively correlated (.32) with the SL-ASIA and negatively correlated with the AVS (-.25; Chung et al., 2004).

Sahin-Francis Scale of Attitudes toward Islam. The Sahin-Francis Scale of Attitudes toward Islam (SFSATI, Sahin & Francis, 2002) was used to measure religiosity in this study's sample. The SFSATI is an adaptation of the Francis Scale of Attitude toward Christianity (FSATC; Francis, 1978). The FSATC has been adapted to several languages and religions (Francis et al., 2016). Adaptation to the Islamic faith involved collaboration with Muslim scholars that ultimately led to a 23-item, five-point Likert-type scale for attitudes toward Islam (Francis et al., 2016; Sahin & Francis, 2002). Items on the SFSATI ask participants to rate agreement (strongly agree, disagree, not certain, agree, strongly agree) to various statements related to religiosity (e.g., 'I know that Allah/God helps me,' 'Allah/God means a lot to me,' 'I think praying/*du'a* is beneficial;' Francis et al., 2016). The maximum score is 115.

The SFSATI was administered to 381 16 to 20-year-old Muslim adolescents of Pakistani and Bangladeshi origin to evaluate psychometric properties (Sahin & Francis, 2002). Internal consistency reliability Cronbach alpha was .90. Construct validity was measured based on attitude score correlations with participants level of prayer and was found to be significantly positively correlated ($r = .24$, $p < .001$). Since then, the psychometric properties of the SFSATI have been examined with English speaking university students in Pakistan with an internal consistency reliability coefficient of .91 (Hamid et al., 2016). A similar study with Muslim participants in Malaysia tested construct validity of the SFSATI by examining correlations with

reciting the Qu'ran (r = .26), the belief that life is guided by Allah (r =.32), and religious experience (r = .36). Recently, the SFSATI was used in a small-scale study with Muslim American mothers of primarily Asian origin (Chowdhury et al., 2015) and in a larger dissertation study with Arab Muslim Americans (Elghoroury, 2017).

Participant Acculturation Scores. Seven out of 10 of the participants completed the AAMAS and SFSATI. The AAMAS scaled score ranges from 1-6. The SFSATI measured religiosity toward Islam; the highest possible score on the SFSATI is 115 and lowest score is 23. Descriptive comparisons of scores indicated that 3 participants reported a slightly bigger acculturation score to European-American culture, three participants indicated acculturation to South Asian culture, and one participant reported similar scores on both the AAMAS-CO and AAMAS-EA scales. Scores on the SFSATI ranged from 84 to 110, indicating a general closeness to the religion of Islam (see Table 2). Overall, information gathered from the AAMAS and SFSATI generally portray a sample that identifies with their South Asian culture, American culture, and Islam.

Table 2

Participant Acculturation and Religiosity Scores

Psyeudonym	AAMAS CO	AAMAS EA	SFSATI
Zahra	3.67	3.86	110
Nuriya	4.8	4.87	98
Maheen	N/A	N/A	N/A
Maira	3.87	4.4	100
Mehwish	N/A	N/A	N/A
Ammara	N/A	N/A	N/A
Rasheeda	4.33	3.73	92
Zainab	4.53	4.13	110
Inaya	5.53	4.87	84
Maya	4.8	5.27	104

Note. Maheen, Mehwish, and Ammara did not complete surveys.

Data Analysis

Data analysis using the constructivist grounded theory approach is an iterative process that occurs simultaneously with data collection (Eaves, 2001). Alongside data collection, analysis of interview data included constant comparative analysis, memoing, and theoretical sampling (Bhattacharya, 2017; Tie et al., 2019). Data analysis began with initial line-by-line coding of each individual interview. In initial coding, each line of data was assigned a word or phrase describing the data. Following Charmaz's (2014) guidance about coding, data in the initial coding phase were coded as actions, to the extent possible. For example, when a participant shared a conversation she had with her daughter about mental health, I looked for actions within that incident of data, such as "encouraging conversations about thoughts and feelings." Upon completion of the initial coding, a second round of focused coding was used to engage in comparison of initial codes and to collapse initial codes into categories (Charmaz, 2014). To engage in this process, initial codes were examined for frequency of certain codes over others and decisions were made about which codes were most salient and able to concisely categorize the data (Charmaz, 2014). For example, in initial coding, actions related to seeking independence, freedom to make decisions, and autonomy were collapsed into a single, focused code labeled "autonomy." As new data were generated, they were coded, compared to previous data and codes, and used to inform new collapsed codes. A third round of axial coding as described by Charmaz (2014) was used to develop subcategories of categories. This involved grouping together data that shared characteristics and identifying patterns in the data. For example, under the category "immigrants," a subcategory named "immigrant mothers" was included based on participants explicitly discussing their mothers' experiences as immigrants. Finally, categories and subcategories were analyzed for emerging themes based on their

relationships to one another. Through this process, increasingly more abstract concepts and themes were generated through induction (Merriam & Tisdell, 2015; Tie et al., 2019). Emerging categories and themes were used to gain insight into participants interpretations of their experiences with mental health and way in which they perceived mental health for themselves and their children.

The second component, memoing, allowed me to document ideas, thoughts, reflections, and intuitions throughout the research process (Tie et al., 2019). Following grounded theory methodology, I wrote memos as a way to engage with the data early on in the process and as a way to track decisions made throughout the process (Eaves, 2001; Tie et al., 2019; see Table 3 for example of memo). Bhattacharya (2017) described memoing as "notes to self" that include hunches, thoughts on literature, elaborations, interrogations of data, and connections among data. She recommended that researchers keep a journal to record notes throughout the research process (Bhattacharya, 2017). Memoing, in combination with comparative analysis and theoretical sampling essentially lead to the development of links among categories, and the emergence of a core category or central theme that subsumes all other categories (Eaves, 2001). I wrote memos in a personal journal, in a Microsoft Word document, and by using the comment feature on the mind-mapping computer application, Xmind.

Table 3

Example Memo

Acculturation: awareness of generational differences	Parents are aware of the differences between themselves and their children's acculturation and identity development; it seems that G1 parents lacked that awareness or were unwilling to be flexible with the way their children identified with being American, they seemed more keen on imposing the desi identity on their children, this led to some feeling like they were living a double life, were isolated from the broader, diverse community, or did not know how to connect with people outside of their immediate families, communities. For G2 growing up, this meant

	living a double life, not being able to share their authentic selves with their parents, and feeling like they weren't trusted as much by their parents. In contrast, G2 express awareness of their children's different cultures and identities and that they may not be as closely tied to the desi culture. Instead G2 is more concerned about their children maintaining their religion (Islam), some mentioned that there are values (e.g., respect) and cultural practices (e.g., language, arts, etc.) from the desi culture that they will continue to teach their children and pass down but recognize that their children will be more American than they were. G2's awareness of differences in acculturation across generations also expands to awareness of their own parents different acculturation patterns, for some this awareness is associated with interpersonal conflict they witnessed or experienced with their parents, for others this awareness helps them be more forgiving toward their parents and the choices they made in parenting.

After coding was complete, I continued to use memoing and mind-mapping to sort categories and themes into findings related to the research questions. In the Xmind program, I created labels for each of the categories that had emerged. Using the mapping feature, I was able to visually represent connections between categories and themes (see Figure 1). Memoing aided in documenting my thinking as I drew connections. Through this process, I was able to construct a visual representation of how different themes contributed to the three research questions (see Figure 2).

Figure 1

Mapping Categories using Xmind

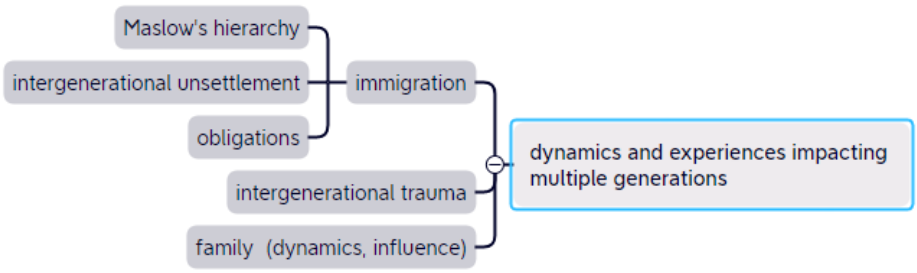
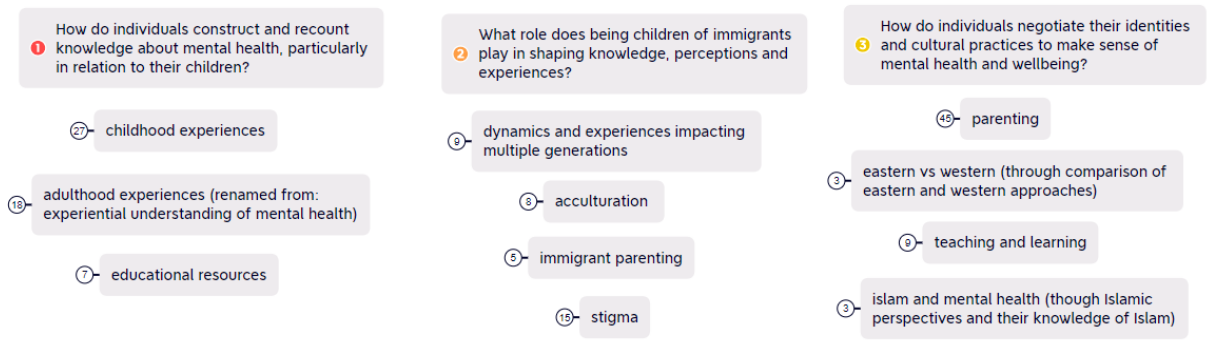


Figure 2

Sorted Themes by Research Question



In theoretical sampling, the researcher samples new participants to gather information and varied perspectives based on initial codes and emerging concepts (Tie et al., 2019). The researcher continues to sample based on emerging concepts and theories until saturation of themes is reached (Hussain & Cochrane, 2002). Although theoretical sampling is a defining feature of grounded theory, it can also be difficult to achieve (Eaves, 2001), possibly because of resource and time constraints (Alammar et al., 2019) and/or difficulties with recruiting diverse samples from among minority groups (Green et al., 2011). For this study, a fixed number of 10 participants were recruited, as deemed appropriate by my advisory committee. The demographic survey and acculturation survey served as the additional sources for understanding the participants involved in this study. As concepts emerged from the individual interviews, information about the participants helped build connections among possible theories and the sample of participants in the study.

Establishing Trustworthiness and Credibility

Although qualitative research rejects the idea of a single objective truth and embraces multiple realities (Merriam & Tisdell, 2015), establishing rigor and trustworthiness of the

research is essential to strengthening the study (Amankwaa, 2016; Lietz et al., 2006; Stahl & King, 2020). Credibility is one of the key criteria for establishing trustworthiness (Lincoln & Guba 1985; Shenton, 2004). Establishing trustworthiness is an exercise in ensuring that the study findings are congruent with reality (Shenton, 2004) and it includes the use of multiple methods and sources for triangulation, member checks, and reflexivity throughout the research process (Merriam & Tisdell, 2015; Stahl & King, 2020).

In order to establish rapport, I began each individual interview by stating my positionality. Lincoln and Guba (2000) asserted that stating positionality is part of reflexivity and includes critical reflection of the self as the researcher. For this researcher, this included stating the identities I held in relation to the study (i.e., Pakistani, Muslim, American), and the identities that differed in relation to the study (i.e., not a mother). I also stated her purpose for the study, from where interest in the study arose, and provided interviewees space to ask the researcher questions.

I engaged in triangulation as a method to establish credibility. Triangulation is the process of using multiple methods to gather data, multiple sources of data, multiple investigators, or multiple theories to confirm emerging findings (Denzin, 1978). I employed triangulation by using multiple methods to gather data. The study included semi-structured interviews to gather personal narratives and stories from participants, vignettes to supplement data gathered from narratives, and surveys.

Finally, members checks were used to establish trustworthiness. Members checks involve soliciting feedback from participants to establish credibility of emerging understanding and findings. A-priori members checks were integrated throughout the interview. I employed member checks by regularly reflecting back statements made by interviewees, asking follow-up

questions to clarify and establish understanding, and summarizing at the end of main topics to further confirm understanding. Finally, at the end of each interview, I asked participants for feedback on the interview and if there were any questions that I may have missed or information that the participant would like to share. This provided the participant space to follow-up on threads from the interview, clarify statements made previously, or provide additional information that participants deemed necessary for understanding the study topics.

Chapter 4: Findings

The purpose of the present study was to examine *how* individuals in the SAAMM-2 population constructed and recounted knowledge, perceptions, and practices related to mental health, for themselves and their children. The present study applied a critical lens to the field of psychology and mental health, in an effort to uplift the voices, stories, and narratives of the South Asian American Muslim population. In particular, key concepts from CRT, CRP, and decolonizing psychology framed the purpose of this study, including the demarginalization of minority communities in the field of psychology and a push to reconstruct the field of psychology to integrate marginalized epistemologies. Three research questions guided the analysis of data and the findings of this study: 1) How do individuals in the SAAMM-2 population construct and recount their knowledge about mental health, particularly in relation to the mental health of their children? 2) What role does being children of immigrants play in shaping SAMM-2's knowledge, perceptions, and experiences pertaining to mental health? and 3) How do SAAMM-2 negotiate their South Asian, Muslim, and American identities and cultural practices to make sense of mental health and well-being? Findings are organized by themes that contribute most prominently to understanding each of the three research questions.

Recounting and Constructing Knowledge of Mental Health

The first research question asked how individuals in the SAAMM-2 population construct and recount their knowledge about mental health, particularly in relation to the mental health of their children. Participants constructed knowledge from prominent experiences in their childhood and adulthood that they believed impacted their emotional well-being or their understanding of mental health. They recounted their knowledge of mental health through storytelling, with particular focus on the role their parents played in shaping their understanding of mental health.

Finally, participants gathered evidence from a variety of western and Islamic sources to expand upon and justify their understanding of mental health and well-being. Three main themes emerged as sources from where participants drew knowledge to construct concepts of mental health and well-being: 1) childhood experiences, 2) adulthood experiences, and 3) educational resources.

Childhood Experiences

Six of the 10 participants shared experiences in their childhood that shaped their initial perceptions of mental health and addressing challenges; however, participants' understanding was limited by their parents' knowledge of mental health and how challenges were addressed. Exposure to mental health challenges in their childhood laid the initial groundwork for participants to construct frameworks through which they viewed and understood mental health throughout their childhood and into adulthood. For example, Zahra's early exposure to her aunt's mental illness and the impact it had on relationships may have shaped Zahra's propensity to view mental health through a relationship-based framework. During the semi-structured interview, Zahra recounted her aunt's story with a particular focus on the negative impact of her aunt's mental illness on personal relationships with other members of the family.

> Zahra: "My *khala* (aunt) slowly mentally deteriorated. We believe – she will never get a diagnosis – but we believe she has some sort of bipolar disorder, or border personality disorder. She essentially cut out everybody from the family slowly, one by one. And I was a young person watching this happening, and not understanding. I thought it was just, like, adult conflict."

As a child, Zahra's initial understanding of her aunt's behaviors was confined by her limited knowledge and by her family's interpretations of what was occurring. In her narrative, Zahra

described how the first indication of her aunt suffering from a mental illness was when her aunt began to comment on her husband not "treating her right." She noted that the adults in her family were initially unaware of a possible mental illness and were primarily focused on resolving conflict between her aunt and her aunt's husband. However, over time, her family began to understand that there was an underlying illness associated with her aunt's behaviors and relational challenges.

> Zahra: "And so, the first time I heard that somebody could be mentally ill, like, just somebody I know and love and care about who needs help, was in the context of my khala…where slowly the family realized, like, 'I don't think she's just being *zidi*, I don't think she's just being obstinate. I think she's sick.'"

Zahra's narrative about her aunt highlighted how her family understood mental illness. Her family's understanding began with a focus on behaviors that negatively impacted personal relationships and efforts to resolve those conflicts. However, as her aunt's relationships with others continued to deteriorate over the years despite her family's efforts to help, Zahra's family looked to other explanations; as such, mental illness emerged as a possible explanation. In her retelling of this story, Zahra illustrated how her initial construction of the concept of mental health was through witnessing a close family member struggle with a mental illness. Zahra may have constructed a concept of mental health that centered relational health because her parents prioritized relationships and resolving relational issues when faced with challenges. Throughout the interview, Zahra shared several stories related to poor mental health, with a particular focus on how relationships were affected. Her way of recounting these stories demonstrated that she continues to view mental health and illness through a relational lens, based on her initial exposure to mental illness in her family.

Similarly, Maheen's construction of a framework to understand mental health was predicated on her childhood experiences in a domestically unstable home environment. In recounting her story, Maheen demonstrated adopting an environmental lens to viewing and understanding mental health. Her initial construction of this framework began with drawing connections between the environment she grew up in and the anxiety she (and her siblings) developed in her childhood.

> Maheen: "Growing up with a lot of conflict…definitely has taken a toll on all of us. We clearly all have a little of anxiety."

Here, Maheen directly related her anxiety to the conflict she was exposed to in her childhood, demonstrating how her concepts of mental health are grounded in the stability of environments. Maheen further noted that she developed feelings of resentment toward her parents for failing to recognize the impact of their conflicts on their children's mental health.

> Maheen: "I think that's why, that's something that is always top of mind for me, because in some ways, like, I kind of resent my parents for not doing something about it, you know. Like, not separating or taking medication, or doing what they had to do to stop the problems, you know. Because it definitely left an impact."

In her narrative, Maheen emphasized her belief that it was her parents' responsibility to address their interpersonal conflict or make changes to the environment to ensure their children's well-being. Throughout the interview, Maheen seemed to view mental health and treatment through an environmental lens. As she reflected on her own role as a parent promoting good mental health, Maheen seemed to prioritize building and maintaining nurturing environments for her children. Both Maheen and Zahra's narratives demonstrate how childhood experiences appeared

to lay initial groundwork for constructing frameworks through which to make sense of mental health and well-being.

Childhood experiences also influenced how participants viewed coping strategies for mental health challenges early on. For example, when asked about ways that her family coped with mental health challenges, Ammara recalled her father's emotionally expressive and extraverted personality. She reflected on how her father emphasized the importance of repairing ruptured relationships through open communication of thoughts and feelings.

> Ammara: "Growing up in an extroverted household where I could say my opinion…whenever we had a conflict in the house… for example, my dad would be big about calling a family meeting. He would give people the turn to talk, and then somebody else, because he was kind of like our therapist. We couldn't afford therapy, so we would do our own therapy."

Here, Ammara drew comparisons between her experience engaging in family meetings as a child and her understanding of therapy. Both served as spaces to "lay out grievances" and allow for conversation about feelings. As she reflected on this, Ammara said, "I like to be on good terms with people. I talk about my feelings a lot." Later in life, Ammara would draw from her childhood experiences with "family meetings" and her father's encouragement to express emotions to address interpersonal conflict and engage in formal therapy.

Several participants reflected on their parents' knowledge and awareness of mental health and how it shaped their perception of treatment. Four of the 10 participants described incidents where their parents demonstrated limited mental health knowledge leading to unaddressed mental health challenges in their children. Subsequently, participants emphasized the general

importance of parents understanding mental health to better address challenges in themselves and their children.

For example, Maya recalled an incident in her childhood when her parents misunderstood Maya's experience with an anxiety attack. When Maya told her mother that her "heart was beating so fast, and it hurt, and [she] couldn't breathe," her parents took her to the emergency room to treat the physical symptoms. Although the ER doctor pointed out the symptoms of anxiety, Maya believed the doctor did not accurately explain anxiety to her parents, especially when the doctor attributed her heart palpitations to "drinking too much coffee." Maya noted that relating her symptoms to "drinking too much coffee" was more comprehensible and palatable for her parents than seemingly abstract concepts, such as anxiety. Such an explanation provided her parents with concrete steps on how to prevent Maya from experiencing another attack: by limiting her coffee consumption.

For Maya, this incident was her first brush with a mental health challenge. Her understanding at the time was limited to her parents' understanding and what she learned from the doctor. However, Maya used this incident as the foundation for building her concepts of mental health, as she latched on to some "key words" the doctor used, such as "heart palpitations" and "anxiety" and began googling these terms to learn more as she got older. Maya noted that this incident was formative in how she developed her understanding of mental health.

> Maya: "If the doctor had not mentioned anything else and just said, 'oh, she just had too much coffee,' then I think it would have been a very different experience. But because they said those words, I was able to hold onto those and then learn about mental health and anxiety and depression for myself."

Maya's narrative highlighted how her parents' limited schema for mental health prevented them from fully understanding what their daughter was experiencing. As such, they focused on concrete causes of the symptoms with clear and simple resolutions. Although Maya was bound by her parents' understanding at the time, the incident served as an initial exposure to the concept of anxiety, helping her build up her mental health schema gradually through her own research.

Similarly, 2 participants commented on witnessing their siblings struggle with mental health in their childhood and the impact of their parents' limited mental health knowledge. During the interview, Zahra recalled her sister experiencing high levels of social anxiety and suspicion of others when they were children; however, her parents were unaware of how to treat their daughter's anxiety. Zahra noted, "nobody trained her [sister] to understand like, 'oh, you have this way of thinking, but it's not correct. You can let it go." As a parent, Zahra was able to draw from witnessing her sister's anxiety as a child to make sense of her own daughter's thoughts and behaviors. In spending time with her 5-year-old daughter, Zahra noticed similarities between her daughter's nervousness in public to the way her sister experienced anxiety in public during their childhood years. Zahra noted feeling grateful that she had the schema for anxiety already and that she could "parent with the attribute of awareness," unlike her own parents. Despite not understanding her sister's anxiety as a child, Zahra was able to make sense of mental health for her own daughter by drawing comparisons between observed behaviors and her family's experiences with mental health in her childhood.

Similarly, Mehwish recalled her sister dealing with severe social anxiety that impeded her ability to go to school. Mehwish noted that even after the school sent someone to their home to help Mehwish's sister get to school, her parents were unable to grasp the concept of anxiety

and how to support their daughter. Instead, Mehwish's sister was homeschooled and "there was no conversation [within the family] about what [her parents] should do for her." In contrast, Mehwish's stated that when her sister noticed a hint of anxiety in her own son, she was quick to take action and seek professional support, saying "she was going to do for [her son] what no one could do for her." Similar to Zahra, Mehwish noticed how her sister drew comparisons between her own experiences with mental health challenges growing up, what supports were offered, and what was missing with her own child's experience with anxiety, and strove to provide her son what was not an option for her. For both Zahra and Mehwish, the impetus to address mental health in children lies within the awareness of children's parents and their ability to understand the psychological aspects of various challenges.

Adulthood Experiences

Participants reflected on relatively recent experiences in their adulthood and as parents to build upon their foundational knowledge and perceptions of mental health from their childhood. Stories from their adulthood demonstrated a propensity toward exploring and understanding the utility of therapy for addressing mental health within themselves and their children. Experiences that prompted such exploration included divorce, the COVID-19 pandemic, loss of a parent in adulthood, and raising a child with a disability.

During the interview, Inaya recalled seeking out therapy for the first time during a difficult time in her marriage. Growing up in a tight-knit family, Inaya's parents and grandparents were highly involved in trying to resolve challenges in her marriage and in her eventual divorce. Although they understood the concept of therapy, Inaya's family frowned upon family members engaging in therapy to resolve personal challenges. However, for Inaya, therapy

provided her space to learn new skills in processing her childhood and coping with present day challenges.

> Inaya: "Therapy was, kind of, how I started to be like, 'wait, is this about me and what's going on with my situation or is this more than that? Is this like, you know, old stuff that's probably being brought to the surface because of the new stuff that's happening to me?'"

In her retelling of this narrative, Inaya shed light onto how therapy helped her learn to draw connections between her childhood experiences and challenges she was facing in adulthood. Although challenging, Inaya's divorce prompted her to seek out therapy as a tool for processing experiences and coping with distress, thus expanding her construct of coping mechanisms.

For Maira and Ammara, the COVID-19 pandemic prompted both participants to explore their understanding and acceptance of therapy as a tool for processing the stress of being physicians during the pandemic. Maira noted that her hospital encouraged physicians to seek mental health services, and while she chose not to see a therapist herself, she encouraged her husband to see a therapist. Maira compared her own beliefs about the utility of therapy with other outlets, such as being able to talk to friends and family about challenges and stress.

> Maira: "I feel like if you talk to a therapist, we can say all kinds of ridiculousness. I mean, they don't know. But like someone who actually knows you is going to get through all the layers in a second, because they know you. So, that's my only reason for not [seeing a therapist]."

COVID-19 and the push from her workplace prompted Maira to consider therapy, leading Maira to examine her concepts of mental health and what she needed to manage stress. For Maira, being able to have honest conversations with someone she trusted and receive straightforward

feedback was more effective than the longer-term processing that may occur in therapy. Despite her beliefs about her own needs, she accepted that therapy is a useful tool for addressing mental health, especially through times of extreme stress, and supported her husband's decision to see a therapist.

Ammara, also a physician, recounted her own experience with COVID-19 and seeking therapy as a result of the pandemic. For Ammara, the convergence of several events, including COVID-19, having a baby during the pandemic, and some conflict between her and her husband contributed to her developing symptoms of depression. The onset of those symptoms prompted her and her husband to explore their understanding of therapy. Ammara compared her acceptance of therapy to her husband's rejection of therapy.

> Ammara: "[My husband] views it as…his sentence to me was…why he didn't want to do it, 'Nobody knows me better than I know myself.' And I'm like, 'Okay, well, how are you going to change if you're just like going to do the same old, same old, you know?'"

As Ammara recounted this conversation during the interview, she explored her own understanding of the purpose of therapy. Ammara viewed therapy as a tool for introspection and change, noting that change in oneself may not be as easy without the support of someone else. However, as Ammara continued to talk about her experience with therapy, she pointed out several practices that she believed were enough for her to address stressors, namely journaling and accurately labeling problems. Ammara noted that after learning these skills in therapy and being able to effectively implement them on her own, she chose to end therapy. For her, effective therapy provides necessary skills and tools that empower individuals to eventually address their challenges independently.

Rasheeda and Nuriya also drew from their experiences as mothers of children with disabilities to make sense of mental health and neurodivergence in children. As they learned about their children's disabilities, both mothers learned to expand and change their view of mental health. Among those changes was the acceptance of therapy as an essential component for addressing the challenges their children were facing. For example, Rasheeda described her daughter being born without eyesight and the impact that had on her daughter, emotionally and behaviorally.

> Rasheeda: "It was more behavioral, because she was going through this phase, after two or three years, where she was more realizing her blindness, and having the questions of, 'why more?' or 'why would God do this?' And those were just, like heart-wrenching situations for me because I didn't have answers."

Rasheeda picked up on the impact of her daughter's blindness on her emotional well-being and cognitions, and quickly recognized her own limitations as a mother to support her daughter through processing her experience with blindness. Rasheeda said, "[My daughter had] all this negativity balled in, and I was like, 'you need to start talking. If it's not to me, then to a therapist.'" Here, Rasheeda drew connections between internalized thoughts and the need to process them through talk therapy. Rasheeda maintained that she was aware of her daughter's feelings and was available to her daughter in any capacity that she could be, but also opened herself up to the option of a professional helping her daughter. Through sessions with therapy, Rasheeda was exposed to a broader ecological framework for mental health that incorporated the influence of family (e.g., siblings) on an individual's overall well-being. Overall, Rasheeda used her story as the mother of a child with a physical disability to showcase how she integrated physical and mental health, her awareness of the connection between emotional states and

behavior (e.g., in her daughter), the ecological systems that influenced emotional well-being, and her acceptance of therapy as a space for her and her children to process their thoughts and feelings through talking.

During the interview, Nuriya shared that her first encounter with autism spectrum disorder (ASD) was when her daughter was diagnosed with ASD. Prior to her daughter's diagnosis, Nuriya had heard about ASD from her co-worker but did not understand the disorder in detail. However, after her daughter's diagnosis, Nuriya found herself engaging in multiple types of therapies to learn more about ASD and to support her daughter's development. Nuriya explained that the variety of therapies exposed her to a different way of viewing neurodivergence. In describing her daughter, Nuriya said,

> "She is normal, you know. She just thinks a little differently, you know. […] This is just more of, like, we just need to kind of cater to her in a different way until she's able to, you know, cope herself."

Nuriya further shared that the concept of therapy and engaging with it was familiar to her because her father had seen a therapist when Nuriya was younger. She explained that seeing her father engage in therapy had helped with breaking some of the taboo around therapy and made it easier for her and her family to accept the various therapies that her daughter needed. She said, "So, I think my whole family, even myself, we've really changed our thoughts on therapy and things like that, after, you know, things we've seen with my dad and daughter." Nuriya's exposure to ASD and associated therapies through her daughter's diagnosis helped her and her family expand her construct of neurodivergence and the utility of therapy for supporting development. For both Nuriya and Rasheeda, parenting children with disabilities encouraged

seeking out different avenues for knowledge about mental health and accepting therapy as an effective treatment option.

Seeking Other Resources

Finally, participants referenced myriad resources that supported them in expanding their knowledge and perceptions of mental health, in learning and incorporating practices to address mental health, and in fortifying their understanding with evidence from western and Islamic sources. All 10 participants indicated seeking out knowledge or doing their own form of research to better understand mental health, particularly in the context of parenting. These resources served to provide participants with both conceptual knowledge and practical strategies to promote mental health and well-being in themselves and their children.

For Mehwish and Ammara, their educational pursuits and professions provided academic insight into conceptual psychology. Mehwish recalled seeking out a psychology course in high school that initiated her journey into pursuing psychology as a profession. When asked about her experience, she says,

> "[High school] is where I was first introduced to all of it, and that's where I started to think more critically about mental health. But if I had not gotten it from school, I don't know where else I could have gotten it from."

Here, Mehwish pointed out how integral her high school education was to learning about mental health and that there were few other places that were offering teenagers and young adults an education about mental health. Similarly, Ammara gained exposure to mental health and psychology education in medical school. She noted that prior to medical school, she had not understood the role of mental health in an individual's overall well-being. It was in medical school that she began to consider mental health a "priority." For both Mehwish and Ammara,

school served as an entry to understanding mental health from an academic and scientific framework. Mehwish eventually pursued a doctorate in psychology and Ammara became a pediatrician, often teaching mental health skills and strategies to her patients and their parents. Their narratives highlighted that resources related to their professional fields of interest were easily accessible and integral in expanding their constructs of mental health.

For Rasheeda, Zahra, Maira, and Zainab, several different resources helped them draw connections among mental health, parenting practices, and Islamic conceptualizations of mental health and parenting. During interviews, Rasheeda, Zahra, and Maira noted turning to books and religious scholars that centered Islamic knowledge to help make sense of child mental health and addressing child emotional needs. For Rasheeda, religious books provided guidance when other resources failed to provide understanding. Rasheeda reflected that she "always tells others [that] we need to go back to our books and be, like, you know, these things were done before. It's not something new. They had the answers." Here, Rasheeda was referring to Islamic scripture and books that provide insight into how the Prophet (peace be upon him), and other prominent religious figures approached and addressed mental health, highlighting that mental health is indeed addressed by Islam. While Maira lauded several contemporary religious scholars for bringing mental health to the forefront of conversation in Muslim communities, Zahra noted gravitating toward religious scholars that had specifically pursued mental health degrees. For Zahra, these scholars were able to seamlessly integrate Islamic teachings and mental health knowledge, which helped her fortify her own mental health framework with an Islamic foundation. Zahra expressed that learning about mental health from these scholars "[got] the gears ticking in [her] head" to think more deeply and critically about how she promoted mental health and well-being for herself and her children with an Islamic backing.

Zainab and Zahra also turned to parenting classes taught by professionals with Islamic and psychodynamic backgrounds to make sense of their children's emotional development and how to address their emotions. Zainab recalled working with a parenting coach,

> "She was amazing. She was also Muslim, so she drew in a lot of Islamic things into her practice…in those sessions, you basically walk through your own childhood, and how the absence of things…basically, the conclusion was you weren't given a blueprint, like your parents weren't given a blueprint for how to raise kids, so learn to forgive yourself."

Zainab expressed that engaging in parenting classes like these helped her make sense of how her own childhood might influence her parenting today while also offering her an opportunity to reframe her own parenting in a positive light. Both Zainab and Zahra's narratives demonstrated how resources that centered Islamic knowledge appeared to resonate more strongly with the Muslim identities of some of the participants that felt close to their religion.

While some resources offered participants information that helped them make sense of mental health on a conceptual level, other resources provide practical knowledge that mothers then directly implemented in their own lives or with their children to promote mental health and well-being. For example, Maira and Maheen turned to podcasts geared toward parents that provide practical strategies on addressing negative cognitions and anxiety. Both Maira and Maheen indicated seeking out podcasts geared toward specific audiences: physicians parenting young children and mothers with anxiety. Maheen, Zainab, Maya, Nuriya, and Inaya often turned to more general internet resources, such as Google, YouTube, and TikTok to find answers to their questions about mental health, gathering different coping skills and strategies that they could apply into their own lives. The internet provided them a safe space to start looking for

information, connect with community members experiencing similar challenges, and receive validation for their own thoughts and feelings.

During interviews, both Mehwish and Maira separately admitted that many of the practical coping skills and strategies that they use with their children, such as mindfulness, journaling, and labeling emotions, came from their children's school's social emotional learning curriculums. Both took express interest in these curriculums and strove to implement strategies their children learned at school within their own homes. In describing her son's social emotional curriculum, Maira said,

> "You know, it's so interesting… in kindergarten, they were teaching them about talking about their emotions…and he was using it, which I loved, and I knew it wasn't coming from me. He would say things like, 'you know, mom, I'm feeling,' – he's 5 – and he'd be like, 'I'm feeling really angry here about something,' or, 'I feel really angry about whatever it was.' And I knew that did not come from me or from us, because I would have never said that, and I would never have taught him that, not that… it was good. And I was like, 'wow, I love that.' He, at that age, could actually express his emotions. And I really think that, like, if you think about it, that was what really, like, changed something. Like, I need to actually teach them that, because I'm not."

Here, Maira pointed out her own limitations in emotional learning and showed enthusiasm for her child's school curriculum. She admitted that she was lacking in teaching similar emotional labeling and language at home, but was inspired by her son's curriculum school and was eager to implement similar strategies at home. Similarly, Mehwish noted that her graduate school training in adult psychology provided her with foundational knowledge about mental health concepts, but that she learned various tools for "feeling included, feeling emotionally well, and learning the tools

you need to take care of yourself" from her children's school's social emotional learning curriculum.

Children of Immigrants

The second research question investigated how being children of immigrants played a role in shaping participants' mental health knowledge, perceptions, and experiences. Participants narratives about their parents seemed to highlight several aspects of the South Asian immigrant experience, including seeking economic security, assuming the role of caretakers in a new country, carrying intergenerational trauma, and cultural stigma toward mental health. In turn, these experiences appeared to influence how immigrant parents expressed, modeled, and addressed emotional well-being in their children.

The Most Painful Thing

Participants' narratives about their parents indicated that immigrating to the U.S. likely narrowed their parents' focus onto economic security and establishment in the U.S.; therefore, participants believed that their immigrant parents had limited capacity to understand and address mental health within their families. Mehwish reflected on the impact of immigration to the U.S. on parents' ability to address mental health and well-being within their families. She referenced Maslow's Hierarchy of Needs (Maslow, 1943)[1], stating that after immigrating to the U.S., her parents, like many other immigrant parents, were "just trying to survive" and so they were focused on the bottom tier of the hierarchy pyramid, such as food, shelter, and building community. Mehwish dubbed these the "pain points" of her parents' generation.

> "Mehwish: I think it's about the most painful thing you feel, it becomes the most important thing. And so, for our parents, the most painful things they may have been

[1] This author acknowledges that Maslow's theory of hierarchal needs is appropriated knowledge from the Blackfoot people of Alberta (see Feigenbaum & Smith, 2019).

> feeling were, like, poverty, lack of security. And for us, the most painful thing we felt was, like, not having inclusion, not feeling emotionally connected to others, right, and not feeling a sense of belonging, a sense of self-esteem, and so that became, like, our primary pain."

Mehwish noted that the "pain points" of each generation seemed to drive where they focus their attention to promote well-being in their families. However, she also noted that education, in addition to capacity, was a key factor in knowing to address other factors that contribute to mental health and well-being. Mehwish believed that even after her parents found financial security, they lacked the awareness and education of other components of well-being. She posited that they were unaware of the higher level of needs for mental health and well-being, such as developing a sense of self-esteem, belonging, mastery, etc. When asked how she thought growing up in a family and community where mental health and well-being were not understood, addressed, or discussed impacted her as a mother raising her own children, she said,

> "I think it just really pushes home, like, what happens when you don't talk about it, right. If you're not…it's like, you're in a dark house, and you're scared something is there with you…If you don't have a light to shine, you're not going to know what it is. And so, I think what our families were doing was they were just like, 'it's dark, we don't want to look, we're fine, we're fine, we're fine'…I think, getting back to, like, they were just trying to survive, getting to, like, Maslow's Hierarchy of Needs. But what they may not have understood was like, 'We are now safe enough that we could go a little higher.'"

Mehwish further reflected on how her parents and the immigrant generation tended to refrain from shining light on other problems, particularly challenges to mental health, which ultimately impacted future generations in their understanding of mental health. As Mehwish reflected on the

"pain points" of the second-generation (e.g., inclusion, belonging, self-esteem) that were unaddressed by their parents, she noted that she is focusing on making sure her children have the skills and tools to develop in those areas. She hopes that by providing those skills for her children in their childhood, they will be able to move up the hierarchy and "work on the top part with her kids," indicating a belief that every generation will go "higher and higher" in addressing needs for mental health and well-being.

For one participant, the focus on economic status and stability in her family contributed to experiences of classism and comparison to her cousins, which in turn impacted her own self-esteem. During the interview, Zainab described how her immediate family was looked down upon by extended family because of their "lower middle class" status. Zainab recalled extended family "pitting" her and her siblings against her cousins, whose parents were more financially secure and presumably of higher economic status.

> Zainab: "The thing that would happen a lot as kids is we would get compared. We weren't the favorite family of the *khandaan* (extended family) …I think because of our economic status, because my uncle, who studied [in the U.S.], his kids were the favorite ones, and we would get compared to them a lot.
>
> Interviewer: "What was that like for you?"
>
> Zainab: Obviously, it really diminished my self-esteem…I internalized a lot of things, and so, it really lowered my self-esteem…I felt like I wasn't good enough for the family, and, like, that manifests later throughout my life."

When asked if Zainab's parents noticed the impact of being compared on Zainab's well-being, Zainab could not recall having conversations about her feelings with her parents. Instead, she remembered learning to hide her feelings, noting that her diminished self-esteem from "family

stuff" continued to impact her through parts of grade school. Zainab shared that it was not until 7th grade when her older sister encouraged her to stand up to Islamophobic bullying at school that she felt her self-esteem boost because she finally felt that she "had a voice."

Both Mehwish and Zainab's discussion about their parents' focus on economic security showcased ways their parents may have lacked capacity or awareness of their children's emotional needs. For Mehwish, Maslow's Hierarchy helped her make sense of why her parents, among other South Asian immigrant parents, may not have addressed their children's emotional needs growing up or encouraged emotional expression. Similarly, Zainab's narrative highlighted how her family's focus on economic status fed into class comparison, which indirectly impacted her self-esteem. Her parents' lack of awareness of the emotional impact of what was occurring in their family network meant that Zainab learned to address her emotional needs as a child without her parents.

Always the Caretakers

Several participants specifically spoke about their mother's experiences parenting as immigrants in the U.S. Five participants discussed their immigrant mothers assuming the role of caretakers without the support of family and community that they would have received in their home countries. Their focus appeared to be almost solely on raising their children and caring for their family, which included in-laws; as such participants noted that their mothers did not appear to engage in emotional expression or self-care. This, in turn, influenced how participants perceived their own roles as mothers raising children and promoting mental health and well-being. During the interview, Zahra reflected on how her mother "hyper-focused" on taking care of her children with disabilities, her husband who was ill, and other family members with mental illness, even though that was not the life she wanted for herself. Zahra said,

> "After getting married and having kids and having this other relationship with my mom, as like, kind of two married women, that's when I heard some criticisms and complaints that it wasn't the way she would have wanted, or that it was too much."

Here, Zahra leaned into her own identity as a mother to understand her mother's experience raising children in the U.S. She empathized with her mother for suppressing her thoughts and feelings to assume the role of caretaker, as she navigated multiple illnesses within their large family with stoicism. Although Zahra understood and empathized with her mothers' responsibilities as a caretaker in their family, Zahra shared that she was more conscious of her own capacity to provide support to others, sought support from professionals as needed, and drew healthy boundaries to protect her own well-being.

Similarly, Nuriya, Ammara, and Rasheeda empathized with their mothers raising their children relatively alone in the U.S., without the family and community support they would have received had they been mothers living in their home countries. Nuriya reflected on the difficulties of her mother having to adapt to the U.S. culture while simultaneously raising children, noting that she only managed because she found support in a community of South Asian immigrant mothers. Ammara further reflected on the immigrant mother experience, recalling that her mother had symptoms of depression that she believed were likely associated with her mother "[raising] 4 children in a country that she was not familiar with." She noted that her mother was a sort of "victim" of immigration, in that she came to the U.S. without a support system, experienced conflict with her in-laws in the U.S., and that she "always just kind of bared the brunt of all the…any trauma they were dealing with." While Ammara did not delve into the types of trauma her mother may have experienced, Ammara empathized with her mother and seemed to understand why her mother "didn't have the emotional bandwidth at the end of the

day to talk about emotions with [her children].” Rasheeda also commented on her belief that immigrant mothers tended to for-go self-care to care for their families. She noted, “They’re always the caretakers. They’re never taking care of themselves. They never sit there and take that whole self-care that’s going on right now.” Rasheeda compared the emphasis on self-care in present-day rhetoric with the lack of emphasis on or knowledge of self-care in her mother’s time. She empathized with the challenges her mother faced raising children in the U.S. without the community support that was easily accessible in Pakistan and drew an important connection between parent self-care and parenting. Nuriya, Ammara, and Rasheeda’s reflections highlighted a tendency for immigrant mothers to relinquish expressing their own needs or engaging in self-care in order to fulfill their duties as caretakers in relative isolation from community. Maira believed that this tendency was reminiscent of immigrant mothers parenting the way they were raised by their own mothers. The impact of this was that immigrant mothers lacked the knowledge and bandwidth to teach, model and engage in conversations about emotional expression while raising their own children in the U.S., thus perpetuating a cycle of emotional suppression.

The Big Burdens

An important phenomenon discussed by 6 of the participants was the concept of intergenerational trauma and how it impacts mental health and well-being. Zahra, Ammara, Maya, and Zainab noted how intergenerational trauma has prevented previous and current generations from expressing their emotions, being vulnerable, and openly discussing mental health. Zahra reflected on a death by suicide in her parents’ generation that was never discussed or shared with family members of Zahra’s generation. She compared how her parents’ generation

preferred to keep it quiet while in her own generation of siblings and cousins' mental illness is discussed more openly. Zahra said,

> "I didn't know this growing up, but we actually had a great uncle who committed suicide. So, there was an awareness that mental illness is a thing in our family, but it was never addressed. It was never opened up and addressed. And it was never like, 'okay that happened to that generation, how do we…' And this year we had a suicide amongst my cousins. And I feel like it was just going to happen, you know, with the amount of generational trauma and pain…"

Zahra reflected on how the previous generation was aware of mental illness in their family and had experienced the detrimental impacts of untreated mental illness. However, they did not address it; Zahra alluded to how the previous generation accepting and addressing mental illness in their family, especially suicide, may have helped to prevent a more recent death by suicide. She reflected,

> "I would say, even when this recent occurrence that happened in my family, the recent death that I told you about, I don't know of any conversations that happened amongst my mom's generation. Probably because they're more hush, hush. Anyway, that's their culture. But my cousins had a big meeting. That's how we do things. To talk about and kind of address how we can support each other more."

Zahra's reflections demonstrated that her generation was aware of the trauma that occurred in the previous generation, the tendency for the previous generation to remain silent, and the impact silence had on future generations. Zahra noted that her generation is breaking the generational silence on mental illness by talking about it and addressing it openly with her siblings and cousins.

Ammara and Maya both spoke specifically about the burdens that have been passed down from generation to generation. Ammara says, “We do have a little bit of generational trauma in the sense that we’re being handed a lot of burden from previous generations of, like, living up to certain expectations.” She related these expectations to cultural pressures around marriage and staying affiliated with South Asian culture and Islam. Maya also spoke about the burdens of previous generations impacting future generations. She reflected on the trajectory of her own mother’s life and how it was shaped by the burden of poverty in her grandparents’ generation.

> “I remember her telling me how when she was in college, it was really expensive to go to college, because everything is tuition in Pakistan. And her parents were really, really poor. She was like, ‘the cheapest thing for me to do was get married, so that they wouldn’t have to worry about spending money on me, and my future was secured, you know.’ And that’s why mom got married.”

Maya associated generational burden and expectations to the ability to express emotions and be vulnerable with others about challenges. She pondered over how her mother sacrificed certain goals in order to decrease the burden on her parents; however, in doing so, her mother was not able to express how she felt about the choices she was asked to make. Maya noted that within her family and within South Asian culture, there is a tendency to dismiss feelings associated with decisions that were made for the collective good, such as foregoing attending college for a marriage to reduce economic burden on the family. She expressed, “that’s why depression is not talked about. That’s why anxiety is not talked about, mental health, in general, is not talked about…because of the responsibilities and big burdens of our grandparents and our parents.”

Mehwish also touched upon intergenerational trauma and the impact it had on mental health and addressing mental health in previous generations. She noted a significant level of

nervousness among women in South Asian communities. While reflecting on this, Mehwish shared a conversation she had with a friend about the impacts of generational trauma on women.

> "We were talking about Partition, and how this was the generational trauma that happened. It was not even that long ago, and so we are being raised by the grandchildren of these traumatized people. And I think that my grandmother was a child during partition. So, she's traumatized. She's raising her kids. They're not operating with all their batteries. And then they immigrate here, right. Which is another trauma, even though you want to move, right, it can still be traumatic to have to move. So, they were just surviving right…"

Mehwish's conversation with her friend and reflection on Partition demonstrated an association between multiple generations experiencing unsettlement and migration, whether by force or by choice, and nervousness within the women, or the caretakers, in South Asian communities. She noted that her generation, children of immigrants in the U.S., may be the first generation in some time to not be experiencing unsettlement, which allows them to "now feel safe enough to feel it and be like, 'my God, that what all that was." In other words, Mehwish highlighted how generational trauma associated with Partition did not leave space for those generations to address how it was impacting their mental health and well-being; however, now that Mehwish's generation is settled and safe, they have the space and the responsibility to address mental health and well-being for themselves and for future generations.

Log Kya Kahenge (What Will People Say)?

All 10 participants in this study mentioned culturally motivated mental health stigma showing up in their personal lives or within their communities, which directly and indirectly influenced levels of comfort in speaking about mental illness, seeking support, and expressing

feelings. Participants spoke about stigma in several ways: the types of stigma they have experienced, the impact stigma has had on them, from where they believed stigma originated, and the way stigma has already been reduced in their personal lives or in their communities.

Four participants discussed the ways stigma has shown up in their personal lives or in their communities. Rasheeda shared how "old school" thinking around mental health and therapy were present in her parents' generation and permeated her husband and older brother's beliefs around therapy. About her husband, an immigrant from Pakistan, Rasheeda said, "my husband will not sit down for therapy because of the whole taboo and 'I don't need it' mentality." She went on to note her brother held a similar mentality because he was "nurtured in a way where it's just…you don't talk about those things." Rasheeda shared feeling disappointed in the way her brother associated therapy with being "shameful." Rasheeda recognized the way stigma from older generations had been passed down through generations, but still found it hard to accept that someone raised in the U.S. with access to therapy could hold onto those stigmatizing beliefs so strongly. Still, she encouraged therapy to her family members when she felt it was important (e.g., after her father's death) and continued to engage in it herself and with her children.

Maira shared how stigma showed up in her family, particularly in the professional setting. Maira described a scenario in which her brother was prescribed antidepressants while he was studying in medical school.

> Maira: "My own brother, when he was in medical school, my parents went out there because he was having problems, and my mom wouldn't – what was it – oh, she did not want the antidepressants to be prescribed under his name, because she was afraid it would affect him professionally.

While Maira's mother understood the benefits of taking antidepressants and was not necessarily concerned about her son taking medication for depression, she worried about the way it might impact him professionally as a future doctor. In retelling of this story, Maira noted the specific way stigma around mental health, specifically associated with psychotropic medication, showed up in her mother's generation and impacted her mother's decisions regarding what was best for her son. Maira related this to the way her mom did not talk about mental health with her own sisters, despite being a doctor in the medical field. Maira said, "One of [my aunt's] is on antidepressants. They don't share any of that…and that's [my mom's] sister and she didn't know it. And it's because there is still so much of a taboo and a stigma…" Although this stigma showed up in her mother's generation, Maira noted that she does not believe that kind of professional stigma still exists and shared that she and her cousins discuss mental health, psychotropic medication, and mental illness in the family more openly than her mother and aunts.

While Maira shared feeling more comfortable speaking about mental health with her immediate family, she noted feeling the continued impact of mental health stigma as a mother addressing her son's mental health.

> "But there definitely was a lot of stigma, even for my own child. So, I took him to one of my friends who is a child psychiatrist. I took him for the first time to see a child psychiatrist, and I told my parents, but I haven't really told any of the other family. I don't know if it's because there is stigma, but even the fact that I would take him to a psychiatrist, I think was huge.

Here, Maira drew a connection between the way stigma influenced her mother's decisions and the way it influenced her own decisions as a mother. While Maira was comfortable with seeking

out a psychiatrist for her son, and was comfortable talking with her parents about her son seeing a psychiatrist, she still noted her own hesitancy in being open about it with others. Her narrative demonstrated how mental health stigma can be inadvertently passed down from one generation to another, despite awareness of it.

Inaya and Nuriya also noted how stigma impeded help-seeking behaviors, particularly because of the fear of what people will say about them or their children, or as Inaya expressed it in a common South Asian trope, "*log kya kahenge* (what will people say)." During the interview, Inaya noted that no one in her family was ever against therapy as a concept. However, in practice, her family was opposed to anyone in the family speaking about personal challenges with individuals outside of the family because "there was this fear that if our family problems are discussed, that's going to look bad…it might be embarrassing." Instead, Inaya learned to "mask" her feelings for the sake of her family and how they might be viewed in their community.

Nuriya reflected on how stigma within the South Asian community impacted her choices around sharing her daughter's ASD diagnosis and reaching out to others for support. She shared about a South Asian Muslim social media blogger who shared stories about her experience raising a child with ASD. Nuriya recalled feeling both compelled to connect with the blogger for support and hesitant because of prominent cultural stigma around child disabilities. When asked if she reached out to the blogger, Nuriya said,

> "I wasn't going to reach out to her because I was hesitant to, like, reach out to the desi community. Because, like you said, right, they're going to talk and say things, and they don't understand. So, I feel like I can't really be open about it…I haven't shared it with too many people, just because, like with the desi community, they're very like judge-y.

> And then, like, I feel like they just start rumors, or they'll say things like, 'Oh, *iski bachi ko problem hain* (oh, her daughter has a problem),' or this, that, whatever."

Nuriya described how cultural stigma made it difficult for her to share about her daughter's ASD diagnosis or talk about her experiences as a mother with others in the South Asian community, including her friends. Furthermore, stigma fed into her hesitancy around reaching out to members of the community experiencing similar situations as herself.

Several participants reflected on the roots of stigma and why it might be present in South Asian Muslim communities. Nuriya and Ammara pointed out the tendency to uphold a certain type of image as a South Asian Muslim in the U.S. When asked about how mental health is talked about in her community, Ammara responded,

> "I don't think it is. I think we have a little bit of a, like, we're very model citizens, so to speak, in the sense that our crime rate is low. We're not…very few are on drugs. It's not like we're bringing all this bad stuff to society. So, I think we're generally so good that mental health is just something we don't want to confess or admit to, that there's something that we need work on."

Ammara's conjecture on why mental health was not openly discussed in her community highlighted the impact of the model minority myth on mental health stigma. Ammara believed that South Asians may refrain from talking about mental health because they feel responsible for holding up the "model" citizen image, especially as immigrants coming from "poorer countries to a rich country like the United States" and the fear of "messing up." Similarly, Nuriya noted that South Asians may not talk about mental health because they are "taught not to burden anyone…and told to swallow our emotions." She went on to explain that the stigma may be associated with South Asians having defined "caricatures" for themselves and that they are "not

used to or accustomed to coming out of those characters or personas that they put on." Instead of speaking about mental health, Nuriya believed that South Asians are told to "put on a mask and just be normal." Both Ammara and Nuriya's reflections on where stigma might stem from reflected the model minority myth that is often associated with South Asians and other Asian groups in the U.S. As the myth is perpetually associated with South Asians and other Asian groups, it continues to remain difficult for them to accept and speak out about mental health or illness that may disrupt their image and place in society.

While Ammara and Nuriya focused on higher level reasons for where stigma around mental health may be stemming from, Inaya associated the stigma around mental health, and more specifically, therapy to cultural beliefs about autonomy, empowerment, and women. Beyond feelings of shame associated with problems being discussed with outsiders, Inaya noted that among the older generations in her family, there was a fear that therapy would give "youngsters ideas" or that therapy would "influence" her to make decisions that went against her family's values or beliefs. While Inaya's parents believed that therapy could potentially give "people ideas that might not fit with the plans of the elders or their family at large, especially when it came to girls," Inaya found therapy to be an empowering experience that gave her the language to describe her feelings and the confidence to make her own decisions.

While reflecting on stigma around mental health, participants noted the ways that stigma has been challenged or reduced in their families and communities. Zahra and Nuriya shared how stigma was reduced within their families as conversation about mental health and exposure to therapy became more common in mainstream culture. Zahra said that the vocabulary around mental health "rubbed off on [her] family and they understood it a little bit more." For Nuriya, seeing her father in therapy helped her understand how therapy "helps with seeing things in a

different way." Several participants noted shifts in language and acceptance in larger spaces, such as the masjid or within masjid group chats and forums. Rasheeda and Maya noted that conversations in larger spaces helped to normalize mental health challenges and validate their experiences. While Maya spoke about seeing mental health conversations in media spaces, Rasheeda mentioned a grief group led by a community member at her local masjid. She described the group as a space to hear about other community members' experiences with grief and loss.

> "She did a sit-down circle where it was talking about loss. The topic was loss. Every person came up with their story, and we went around saying, 'what did we lose?' And you don't realize until you sit down, and you don't know what's happening in someone's life until they talk about it.

For Rasheeda, the grief and loss group not only opened up conversation about loss and how it has impacted other members in the community but also normalized expressing emotions within the community. She reflected on how healing it was to be able to share her experiences with others and the way that the group brought the community together in a safe space to discuss mental health challenges. Mehwish and Zainab both commented on the importance of South Asian Muslim mental health professionals in the community to lead similar types of groups and sessions. Mehwish noted that as a psychologist herself, she has noticed how others in her community feel more comfortable with seeking out therapeutic services because Mehwish can serve as a sort of "bridge" to services.

> Mehwish: "And I'm so fortunate, because, like people trust me enough that when they need to find a therapist, they ask me, like, 'who do you know? Who do you trust?' and I'm sort of like a concierge, you know, how to find somebody and matchmake them a

> little bit. And everyone has been, like, so pleased with like, 'oh good, we know someone who can help us find someone.' I think it's very intimidating to be like, 'how do I even start,' like, 'how do I start to look for someone to help me, and understand me, and figure this out?' And so, I think I try to be a bridge."

Inaya related to increased visibility of South Asian Muslim therapists in the field, sharing that she felt more comfortable seeking out therapy because "seeing people make careers out of being mental health professionals…it feels like something that is there for you." As participants reflected on ways to reduce stigma in South Asian Muslim communities, several shared that they participated in the present study to share their own experiences, validate the experiences of others in the community, and encourage more open conversation and dialogue in the community.

Did My Parents Not Talk About Their Feelings?

Several participants noted an association between raising children as immigrants and parents' bandwidth to address, teach, and model emotional expression and regulation in their children. Participants shared that limited exposure to emotional expression in childhood led to seeking out different outlets, difficulty with self-regulation, and relearning emotional expression and regulation in adulthood.

In thinking about emotional expression, Mehwish found it interesting that her Urdu vocabulary for emotions was limited to "anxiety, anger, and sadness." She asked rhetorically, "did my parents not talk about their feelings?" demonstrating an awareness of how parents model emotional expression for their children through articulation of their own feelings. Mehwish noted that "her mom was a very anxious person, and she talked a lot about being stressed and nervous. And she was really aware of that, but she could not articulate what it was or why it felt that way." Maira also noted the importance of emotional expression as a parent, noting that because

she was not raised to express feelings by her mother as a child, she found herself raising her children similarly. However, after catching her son using emotion language to describe different situations, Maira realized that he was learning essential skills about emotional well-being from his school. She quickly recognized her role as a parent in reinforcing that learning by modeling emotion labeling and healthy expression at home. Although Maira reflected on the discomfort she felt in labeling and expressing feelings as a mother, her efforts to do so highlighted a change she made in cyclical parenting styles passed down through generations.

Maheen, Maya, and Zainab noted that in their families, their mothers either controlled emotions or discouraged emotional expression. During the interview, Maheen spoke about the level of conflict present in her childhood home and the emotional impact on her and her siblings. However, despite the level of conflict in her household, Maheen did not recall her mother addressing Maheen or her siblings' feelings. Instead, Maheen felt as though her mother encouraged an atmosphere in which emotions were "brushed under the rug" and that "feelings, thoughts, and personal decisions did not…matter." The impact of growing up in such an environment was that Maheen and her siblings grew accustomed to "hiding [their] thoughts and feelings." Maheen noted that when her school recognized that Maheen was struggling with an eating disorder, her mother did not address the emotional components of the disorder or encourage seeking professional help. Instead, Maheen learned to hide her disorder and associated thoughts and feelings from her parents. Maheen's narrative exemplified the way in which an atmosphere that discouraged expressing and addressing emotions was associated with unintentional dismissal of her eating disorder.

Zainab and Maya also spoke about their mothers' propensity toward dismissing emotions and the impact it had on learning self-regulation. Maya recalled the implicit messages she

received from her mother in her childhood about crying. Maya said, “if I [was] crying, it was a bad thing and I needed to hide my pain and I needed to hide my emotions because it was unwanted.” As a child, Maya internalized the belief that her emotions were unwanted; instead of learning to appropriately express her feelings, she learned to hide them from her mother. In her adulthood, Maya noticed that she and her siblings continued to struggle with expressing their emotions. Maya described her and her siblings “suffering for years to come because [they] have such a hard time expressing emotions because [they] were taught to suppress them [their] whole lives.” Maya also noted that there was a discomfort in her family toward emotional expression that sometimes led to invalidating comments and jokes about how she was feeling. As an adult, Maya learned that “[she] shouldn’t be laughing off something that was a very big, traumatic experience in her life,” implying that she had internalized dismissing feelings and was making a conscious effort to unlearn that as an adult. Maya’s narrative demonstrated a generational pathway for learning emotional expression in which the mother’s bandwidth to address and teach emotional expression influenced her daughter’s ability to express and address her own emotions well into adulthood.

Similarly, Zainab recalled that she never “had a healthy outlet for dealing with mental health stuff.” When asked if her mother talked about or addressed feelings with her growing up, Zainab said, “No. Maybe I would go into my room and cry and scream into a pillow, or like, scream really loud and punch the wall, but I was never taught how to regulate my emotions. And, I mean even to this day, I still struggle with self-regulating.” Zainab remembered trying to find ways to cope with her feelings but admitted she stumbled upon unhealthy strategies she learned from her friends in high school.

> Zainab: "[My friends] didn't do drugs or anything like that, but they would cut. And so, then I was like, 'What the hell is that?' I think I tried it once or twice, and I was like, 'This is really stupid. Why do people do this? But like again, I didn't know how to regulate. Like, I had all this stuff going on, like, seeing family stuff going on, and no one understanding me. And I had all this rage, you know, and I was like, 'How can I let it out?' But I didn't have a way to let it out. So, I was like, 'Okay, let me try this cutting thing.' I was like, 'this is so stupid.' And then, I think I just like, I don't know, I think, I just numbed it, numbed the pain. Yeah, like mentally, I was just like, 'Okay, I'm just going to block this one out.'"

Similar to other participants in this study, Zainab's narrative demonstrated the impact of growing up in a household in which emotion regulation was not modeled or taught by her mother. In her narrative, Zainab described the impact of various challenges on her mental health and her struggle to learn strategies for self-regulation by herself. Instead of being able to turn to her mother to learn healthy coping strategies, Zainab turned to her peers to learn how to self-regulate her emotions. However, she was unable to find effective strategies to cope, eventually resorting to numbing her pain.

Ammara and Inaya painted slightly different pictures of how emotions were expressed within their families. Ammara compares her parents comfort levels with expressing emotions, noting that while her father was emotive and created space for their children to express their emotions with him, her mother was the opposite in that she was not vocal about her feelings. And so, while Ammara was able to get her emotional needs met by her father as a child, she could not recall her mother expressing her feelings. Ammara reflected on a similar inclination to

suppress feelings associated with her parents' deaths as a teenager, which in turn may have impeded her ability to easily comprehend and access the concept of depression as an adult.

> Ammara: "As I learned about [depression], it was almost like I had to, like, question it, to be like, 'hmm, if somebody says they're depressed, how do we really know that they're depressed?' You know what I mean? So, I think that was that was probably my inner, like, my own conflict that I was trying to deal with, because I had just kind of bottled down all of my feelings, and I was not able to like, talk about them and address them and fix them because we didn't really talk about the fact that they weren't, you know, that our parents passed away. We didn't really discuss it."

Even though Ammara's father had created space for expressing emotions in her childhood, after her parents' deaths, Ammara suppressed her grief, ultimately making it harder for her to comprehend the concept of depression and associated symptoms. Her reflection on learning about depression in medical school highlighted possible internalized beliefs about emotion suppression and refraining from talking about feelings openly with others. As an adult, Ammara retrospectively understood the impact of bottling up her emotions and noted that she made conscious efforts to pursue healthier strategies for coping, including therapy during the COVID-19 pandemic. However, she noticed that she continued to hold some feelings of shame and failure associated pursuing therapy. When asked about her experience with pursuing therapy, Ammara said,

> "It was kind of scary, because, like, here I was having gone through all this other stuff, like, parents dying, financial problems, medical school stress, residency stress…never needed therapy, and here I am now, needing it. Like it was, kind of, you feel a little bit like a failure, you know. I mean, you're not. I completely don't think you are, but you feel

> like that. It's a completely irrational thought, but it is a thought. So, that's, kind of, what happened is that I felt ashamed, and all of that."

Similarly, Inaya described how she internalized feelings of guilt around expressing feelings as an adult, based on how she was raised by her parents. In Inaya's family, expressing feelings was accepted among the women in her family but there was a hierarchy of importance given to whose feelings and problems should be addressed, based on age and seniority. She noted an implicit expectation in her family that feelings should not be expressed until they became unbearable. Even in challenging situations, Inaya shared that there was a tendency in her family to mask feelings through different "coping" mechanisms, such as praying, focusing on being of service to elders, and the cultural and religious concept of *sabr* (patience) in which she was encouraged to have patience through challenging times. While *sabr* is a common concept in both Islam and South Asian culture and often viewed positively, Inaya recalled that it was sometimes used as a "stalling tactic until the [issue] passed or self-resolved and they did not have to deal with it anymore." When asked how *sabr* was taught to her by her parents, Inaya struggled with thinking of ways it was taught to her; Instead, she provided an example of why *sabr* was encouraged in her family:

> "I'm trying to think of examples. Like, for the sake of keeping, like, a relationship together, right, like, even if you're not one hundred percent happy, or whatever, you're still supposed to, kind of, for the happiness of the people around you, just kind of, like… So, just push things down and, kind of, make sure that you only really bring it up when it's, like, absolutely unbearable, right?"

Here, Inaya pointed out the way collectivistic beliefs shaped the way thoughts and feelings were expressed and accepted in her family. In an effort to maintain the happiness around her, Inaya

learned to mask her feelings about challenging situations she experienced, such as within her marriage. Although Inaya recognized that practicing *sabr* can be a helpful piece of advice for some people experiencing hardship, she believed that it was counterproductive for her ability to get her needs met.

> "So, there's some people who need to hear that [*sabr*], right, maybe, and that is the appropriate advice for them. And then there's some people who already internalize so much that, like, that makes it so that they feel guilty about expressing any – what's it called? Like, they basically feel unable to stand up for themselves, a little bit. I fell into that category, where I felt like, if I complain about anything, that was me being either ungrateful or not having *sabr*, and that meant that, like, I let a lot of things continue, but maybe I shouldn't have for as long as they did. So, that kind of backfired a little bit."

Although she saw some value in practicing *sabr*, Inaya learned to suppress her feelings until she reached a certain threshold of discomfort, noting retrospectively that she had internalized guilt associated with emotional expression. Inaya's reflection on *sabr* showcased the way a religious and cultural coping tool was used to shape her beliefs about and her family's practice of emotional expression in order to meet individualistic and collectivistic needs.

Caught Between Two Cultures

As participants reflected on experiences that shaped their understanding of mental health and well-being, acculturation differences between immigrant parents and their children appeared to play a role in participants' identity development, an important aspect of mental health and well-being. Narratives from the interviews seemed to highlight immigrant parents generally lacking awareness of their children's acculturation needs and identity development. For Mehwish

and Maya, their parents' lack of awareness led to them feeling as if they were unable to live authentically as South Asian *and* American *and* Muslim individuals.

For Maya, her parents' changing acculturation practices in her household left her somewhat confused about what was "right" and "wrong" growing up and impacted her sense of identity. Maya described her parents as initially being fairly integrated with U.S. culture and even incorporating some American holidays, such as Halloween, into their family lifestyle; however, as she and her siblings grew older her parents became increasingly more religious and separated from U.S. culture. Maya found her parents' drastic switch from integration to separation from U.S. culture confusing. She reflected on how her parents seemed to hold paradoxical beliefs about the U.S., in which they both sought opportunities to come to the U.S. but also seemed ashamed of American culture. Although she tried to understand it from her parents' perspective as immigrants to a new country in their adulthood, she expressed some frustration with her parents not fully accepting and understanding the implications of raising children in America who would take on both American and Pakistani identities.

> "I also had a lot of identity crises in my life, especially with understanding and learning that I'm American, even when told I wasn't American…I think that was a really hard thing for me growing up because I would come home from school and be like, 'yeah, you know, I found out that I'm American because I was born in America,' and my mom would be like, '*khabardaar*, no, you're not American, you're Pakistani,' and my dad would be like, 'no, no, no, you're Pakistani,' and I'm like, 'okay.'"

With her parents' refusal to accept her American identity, Maya found herself behaving differently at school with her "American" friends than when she was around her family at home in order to meet her parents cultural and religious expectations. Maya described it as her "double

life" in which she "would have [her] friends and it would be completely separate" from her life at home with her parents. When asked how that felt for her, Maya said: "It sucked because I felt like I was a different person completely. I wasn't true to myself. I wasn't true to my family. But I was terrified." Here, Maya touched upon feeling scared to show her parents, particularly her mother, parts of her life that did not align with her parents' cultural beliefs and values around dress (e.g., wearing *hijab*) and relationships at school.

Similar to Maya's experience, Mehwish recalled how her mother's separation from U.S. culture meant she dressed Mehwish in South Asian clothes growing up, which did not mesh well with Mehwish's own desire to integrate into U.S. culture. In turn, this contributed to her feelings of isolation and some difficulty making friends at school. Additionally, this led Mehwish to feel as if she was "caught between two cultures." When asked to elaborate, Mehwish described moving between her non-Muslim "American" friends and her Muslim, Pakistan friends:

> "So, like, the clothes would change, the way I would speak would change, the mentality would change. And then I would go back, and I was like 'I don't know which one I am, more one or the other.'"

Growing up in a household where South Asian culture and Islam were prioritized over her American identity seemed to force Mehwish into developing two different personas, based on who she was spending time with. In turn, she felt confusion about her own identity growing up. As Mehwish reflected on her parents' decisions about raising their children in America, she recalled a conversation she had with her parents as an adult about their expectations:

> Interviewer: "What did your parents expect for you in terms of what cultures you ascribe to, how you hold yourself in different arenas, and in different parts of your life?"

> Mehwish: “I actually asked [my parents] this question, and it appears they had not thought critically about the problem. So, they had told me that they expected raising kids here to be exactly like raising kids there [in Pakistan].”

Mehwish reflected on how her parents did not seem to make an effort to get to know their children’s school friends, to be involved in their school activities, or to really understand their children’s acculturation needs. As a result of her own experiences with her parents, Mehwish made a conscious decision to be more involved in her children’s lives, particularly at their school and in building community networks for her children.

As Mehwish reflected on the confusion she experienced around her cultural identities, she noted that she strives to help her children feel connected to their diasporic identity. She commented on how media representation (i.e., a Pakistani-American Muslim superhero in the Marvel Comics Universe) has helped her daughter develop a sense of pride in her diasporic identity as a Pakistani-American Muslim. About her daughter, Mehwish said,

> “[My daughter] is making her own comic books where there are Muslim characters in it, and so, she's taking pride in this identity. Whereas when I was a kid, I don't think I would…I was like trying to hide and blend in as much as I could everywhere I went. Where for her, it's about being authentic, and it's like, ‘let's just be proud of, like, who we are and where we come from,’ and it's really cool.”

This kind of representation in mainstream media seems to provide Mehwish’s daughter an avenue for connecting with her Pakistani roots while also celebrating being part of the diaspora. For Mehwish, this supports her in encouraging her daughter to live authentically, something that was difficult for Mehwish in her own childhood.

While most participants expressed a sense of confusion and uncertainty about identities, Inaya shared a slightly different experience with identity development in her childhood. Inaya remembered feeling very aware of being the only Muslim kid in her schools, until college, and having to explain herself and her Muslim identity to others. However, she also remembered having a strong sense of her own cultural and religious identity growing up and felt that was foundational for her. She noted,

> "Having that connection to Pakistan or Urdu or Islam was helpful. That solid foundation that I had growing up was helpful because I had a really solid sense of, like, who I was growing up."

In thinking about her son, Inaya expressed that she is trying to immerse her son in cultural learning, such as Urdu and Arabic classes, to develop a similar sense of connection and belonging within South Asian circles. However, she also realized that her son is growing up in a different space than she did and knows that she may have to "switch gears and kind of find something else that grounds him a little bit more," if cultivating a Pakistani cultural identity no longer makes sense for him. This awareness of her son's identity is greater than her parents' awareness of their children's diasporic identity. Furthermore, in contrast to her parents insulating her from Western culture and communities, Inaya demonstrated a desire to help her son find a sense of belonging as a Muslim growing up in the South Asian and American intersection.

Negotiating Identities

The third research question posed in this study was how participants negotiated their South Asian, American, and Muslim identities and cultural practices to make sense of mental health and well-being. Participants grappled with differences in eastern (i.e., South Asian), western (i.e., American), and Islamic conceptualizations of mental health. Several participants

engaged in critique of South Asian cultural perspectives of mental health, causes for mental illness, and treatment preferences. Participants drew primarily from their Islamic knowledge to reconcile controversial perceptions of mental health in their South Asian communities. Similarly, participants referenced Islam to qualify and reinforce western treatment modalities (i.e., therapy) as acceptable and effective treatment options for themselves and their children. Finally, participants critiqued the misalignment of western therapy with cultural and religious values that impacted access to therapy for themselves and their families.

Critiquing South Asian Perspectives. For several participants, South Asian perspectives on mental health seemed to fall short in providing meaning and satisfactory treatment options. A common critique was that South Asian conceptualizations of mental health appeared to focus primarily on religiosity, punishment (e.g., karma), and external blame. Participants expressed criticisms about these conceptualizations, noting their impact on individuals having access to effective treatment for mental health challenges. To reconcile with the shortfalls within South Asian perspectives of mental health, participants turned to Islam to justify other perspectives.

Several participants expressed that a common belief within South Asian culture is the idea that poor mental health is a punishment for not being spiritual enough, for being "far from God," or for not being a "good Muslim." When asked about the South Asian community in which she grew up, Nuriya said:

> "I think they always defaulted to like, 'oh, you're going through all these problems because you're not spiritual enough', you know, things like that. And it's like, yeah, spirituality can help. But that's one of the things, you know, like, you have to work on mind, body and soul, and they just think that working on your soul is enough."

Although Nuriya acknowledged that low spirituality could contribute to poor mental health and well-being, she emphasized other contributing factors, such as cognitive and physical health. Her commentary highlighted how a narrow focus on spirituality could serve to dismiss the need to address the "mind" and "body" when considering mental health and well-being.

Several participants commented further on the tendency for South Asians to narrowly focus on spiritually centered strategies for addressing mental health. One of the most common advices shared by participants for addressing mental health was to pray more or make more *dua'a* when faced with a mental health challenge. Participants acknowledged value in this advice while also critiquing it for falling short in providing solutions to challenges individuals may be facing. Zahra noted that offering specific *dua'as* prescribed by Islam for certain situations can be "comforting and really helpful" but "comfort is one thing; you need comfort to get through a problem but that isn't a solution to a problem." Similarly, Mehwish and Zainab noted how just relying on prayers and *dua'a* dismisses individuals from working through a problem or situation.

In a similar vein, Nuriya and Maheen addressed how South Asian perspectives tended to place blame on external factors for poor mental health. For example, Maheen recalled a story from her childhood of a young girl in her community who experienced a mental health breakdown. She remembered people in her community blaming the girl's parents for her poor mental health. According to Maheen, the community believed that the girl's parents had behaved poorly toward someone else in the community, and so, their daughter's poor mental health was a result of "bad karma." Maheen noted that this type of thinking did not make sense to her because it placed blame on an unrelated external factor rather than examining root psychological causes for the girl's mental health breakdown. Similarly, Nuriya reflected on how solely placing blame on parents for their children's poor mental health leads to parents "feeling guilty and then taking

it out on their children, like ‘oh, why aren’t you doing this’ or ‘why aren’t you doing that? Why are you not behaving?’” Her reflection highlighted shame associated with poor mental health that is often observed in South Asian communities. Maheen noted that the perpetuation of blame and shame further prevented parents from understanding the root causes of poor mental health and seeking out support for their children.

To make sense of their tension with South Asian perspectives on the causes of and strategies to address mental health, most participants turned to Islam. Zahra expressed that Islam taught her to look at mental health holistically:

> Zahra: “My understanding of the Islamic perspective is that mental health is a priority, and sometimes it has roots in having a bad opinion of God, or feeling hopeless or not understanding Him well enough that you don't have Him to lean on, really. And some of its roots are, you know, just the way you eat, like, you're not eating properly, you're not sleeping properly. Sometimes the roots are, you know, from your upbringing and, you know, things like that. But whatever the roots are, it needs to be addressed.”

Zahra’s discussion on a holistic approach to viewing mental health further emphasized an overarching belief within Islam to understand root causes for poor mental health and to address them appropriately.

Similarly, participants turned to Islam to reconcile with the South Asian cultural tendency to prescribe prayer and only prayer for addressing mental health. Mehwish noted that her faith taught her to pray to God when faced with challenges, but that God would also want individuals to “grow through [situations] and figure some things out for themselves.” Zainab held similar sentiments, saying that through Islam, she has learned “It’s not about ‘pray to Allah and you get what you want.’ You have to put in the work too.”

Finally, participants turned to Islam to combat cultural stigma around seeking therapy as a treatment option. Zahra and Mehwish both leaned into their knowledge of Islam to justify therapy, pointing out examples of how Islam encourages seeking professional help for mental health challenges. In reflecting on the multiple root causes for mental health, Zahra said, "whatever the roots are, it needs to be addressed. And it is recommended [by Islam] to seek expert advice." Similarly, Mehwish referred to Islamic *hadiths* encouraging individuals to "know themselves." She then reflected, "And what is therapy? Therapy is you just really getting to get deep into yourself. So, when you are doing therapy, we are getting closer to ourselves, which will allow us to be closer to God."

Making Meaning Through Islam. Finally, as participants contended with gaps in their understanding of mental health, they tended to lean toward Islamic concepts for understanding and meaning making. Maira, Ammara, and Nuriya commented on how their backgrounds in science and medical fields provided them with a scientific framework for understanding mental health and neurodivergence; however, Islam provided them with concepts to find comfort in what science could not explain for them. Nuriya acknowledged her STEM background before saying that terms about ASD drawn from spiritual frameworks were more comforting than some of the western, scientific terms.

> Nuriya: "I have a science background. I work in STEM and we always talk about science, science, science. But, you know, like, I think the one thing that brought me back a lot more to the spiritual aspect is…I loved the language that they used for, you know, neurodivergent kids. There was one place where I sent my daughter, where they called them little miracles, and they're like, 'Oh, they're little miracles,' because, like the way you see them think and grow, and like the way they absorb things is so amazing."

For Nuriya, western science significantly contributed to her understanding of ASD and neurodivergence. However, Islam provided her with an avenue to reframe the language from a "disorder" to "little miracles." This provided her with both comfort and a way to make sense of neurodivergence and her daughter's experiences with ASD.

Participants also reconciled with events that were out of their control but significantly impacted their emotional well-being by turning to Islamic concepts of faith in God, patience, and gratitude. Maira described an emotional time period in which she felt incredibly alone, noting that she was "probably depressed." She initially turned to her mother to process her feelings of loneliness but eventually found herself turning to God. Maira said,

> "That was the point, that was a changing point in my life when I realized, before I would always just go to my mom or I'd go to like my friends, or my cousins, or all these other people in my life, when I was having a hard time. But really, what you need to do is go to Allah and Allah is the only one that can help you, and I felt so much better after that. And it was so amazing, things totally turned around.

While Maira expressed gratitude for being able to turn to other individuals in her support network in times of need, she noted that when those options fell short, she found comfort and an avenue for change through her faith in God. She went on to share how her faith helped her find patience, or *sabr,* at a time when she was experiencing depression. Similarly, Nuriya, Rasheeda, and Ammara commented on how their belief in God having a "bigger plan" for them helps them make sense of situations that are out of their control, such as caring for children with disabilities and losing parents at a young age. Reflecting on her parents' early deaths, Ammara said,

> "My faith is what really got me through all of that stress. It was that – okay, my mom and dad were not, you know, they were young when they passed away – but that was God's

> decision, and we have to kind of come to terms with that. And there is a plan. And so, even though it's sad, and it's tragic, but in the end, it does kind of work out. I mean, thank Allah we have all these successes to be followed by all that tragedy, you know."

For Ammara, her faith in "God's decision" helped her find ways to make sense of her parents' deaths and to practice gratitude for the positive aspects of her life. Similarly, faith in God and His "greater plans" provided comfort and meaning making for Rasheeda and Nuriya as they navigated parenting children with disabilities. Nuriya reflected on how Islam helped her make sense of the challenges she faced parenting a child with ASD:

> I think having faith helps a lot. I think there is one really common phrase that people use, 'Allah (swt) doesn't give you more than you can handle,' and that's what I keep telling myself. It's that, you know, I was given this chapter to navigate, because, you know, He felt I could handle it. So, just kind of having that faith that, like everything, happens for a reason, and there's some good to come from this.

Nuriya's faith, similar to other participants, allowed her to practice acceptance for difficult circumstances and empowered her as a parent navigating unfamiliar and challenging territory. Overall, Islam appeared to provide a level of comfort, meaning making, and empowerment to participants facing various challenges that impacted their mental health and well-being.

Individualism in Western Therapy. Several participants shared their concerns about the misalignment of values between western modalities and South Asian culture and Islamic values. Notably, participants commented on the inherent individualism in western mental health modalities and its tension with collectivism in South Asian culture and Islam. Five participants discussed their hesitancy with engaging in western therapy due to misalignment of values and shared ideas on how it could be made more accessible for South Asian American Muslims.

The concept of individualism in western modalities and treatment for mental health appeared to create some tension for participants when considering therapy for themselves or their children. Although one participant noted that the second-generation was more individualistic than the immigrant generation, 5 participants discussed their concerns about western therapy seemingly pushing the concept of "setting boundaries" without considering South Asian and Islamic collectivistic values. During the interview Rasheeda noted:

> "It's different how they approach it here in the west. Here the mentality in the west is always more 'yourself'. It's about you and your personality and self-awareness of who you are and your identity. But in the east, we carry all of our family members. You're interconnected with your families…It's not just your eyes, you're thinking from other perspectives."

For Rasheeda, the concept of focusing solely on the self when addressing mental health felt dismissive of the collective family network that necessarily influences individuals and their perspectives when faced with challenges. Rasheeda's commentary highlights a need for western modalities to understand and incorporate collectivistic values when treating individuals from South Asian Muslim communities. Zahra and Zainab shared similar concerns with the individualistic approach to addressing challenges in western therapy. Both Zahra and Zainab noted that the concept of setting boundaries to protect the self seems to come at the expense of dismissing other people, and possibly hurting them along the way. Zainab noted specific concerns about being told to "cut" individuals from her life that may be toxic.

> Zainab: "I get nervous being with a non-Muslim therapist because their values might be different, especially if they are super western and individualistic. Like, I don't want people telling me, "Your parents are toxic. You need to cut them out of your life."

Zahra shared similar concerns about setting boundaries that serve to exclude thinking or "worrying about anyone else." To reconcile with and make sense of the differences between individualism in therapy and her collectivistic values, Zahra turned to Islam:

> "While Islam says, 'take care of yourself,' the purpose of taking care of yourself is so you can not be a burden to anyone else, and you can go…be a superhero to the world, essentially. It's not an individual centric 'taking care of yourself,' it's a God-given 'taking care of yourself.'"

For Zahra, Islam helps her make sense of individualism by providing her with a purpose for "taking care of the self." From an Islamic point of view, healing the self allows individuals to reduce burden on others, participate in society, and essentially be of services to others in the community.

Individualism in western modalities and an overall misunderstanding of South Asian collectivistic culture appeared to create some hesitancy in seeking out therapy for several participants. Although participants expressed value in therapy for themselves and their children, they expressed worry and fear about being misunderstood. Maira noted that she would encourage her child to seek out a therapist, if necessary, but would be "a little bit concerned about what that person would say to my child." She expressed feeling more comfortable with sending her child to therapy if the therapist is "in line with her own thought process." Specifically, Maira noted that if she had to choose between western therapy and Islam, she would turn to Islam for guidance on helping her child because it makes "more sense."

Zainab and Inaya shared similar concerns about western-trained therapists misunderstanding South Asian culture, Islam, and the dynamics of collectivism. Both participants expressed exhaustion around having to explain themselves, their culture, and the

dynamics of their family each time they see a western-trained therapist. Zainab described this as having to "teach the therapist" in the process of seeking out help. Inaya pointed out:

> "I feel like I've been doing this for a long time, just, like, explaining. There is so much explaining about how these circumstances came to be, or why we do the things that we do, the way we do them, or why so many people are involved in decision-making in everybody's lives."

Participants commentary on individualism in western therapy appeared to highlight a certain level of exhaustion with seeking western therapy. To mitigate this exhaustion, participants expressed hope for more South Asian and/or Muslim therapists that are able to understand the role of collectivism and can integrate South Asian and Islamic values in treatment.

Additionally, participants considered how misalignment between western therapy and South Asian and Islamic values may have influenced their parents' hesitancy to seek out therapy. Three participants commented on their attempts to recommend therapy to their parents. Inaya noted that after starting therapy herself and noticing the benefits of it, she recommended therapy to her parents as a way to process her divorce. Although her parents did not explicitly refute the suggestion, they did not take up Inaya's suggestion to seek therapy, saying they were "too busy and it was not the right time." Zahra and Rasheeda also reflected on how their parents refused to engage in therapy despite seeing others in their family use therapy to address their mental health. Both Zahra and Rasheeda wished for their mothers to seek out therapy but noted that they found other ways to teach their mothers adaptive coping skills for the challenges they were experiencing. Zahra said,

> "I actually wrote her this whole booklet, in handwriting, of how to deal with certain things, like, change your mindset, you know, how to help her with her anger, which she

> appreciated. She didn't take it as disrespectful or anything. Even when I suggested she go to a therapist, it didn't upset her or anything."

Here, Zahra shared how she was able to suggest coping skills to her mother in a way that was respectful and easier for her mother to access than therapy. Similarly, Rasheeda reflected on how her mother continually refused to see a therapist despite multiple family members suggesting therapy to help her process her husband's death. As a workaround, after every one of her own therapy sessions, Rasheeda recalled going to her mother to "tell her all of the things she learned for her to get that feedback." While Maya did not suggest therapy to her mother, she did often take what she learned about mental health and coping strategies from TikTok and other sources and tried to teach them to her mother. Maya noted that her mother is receptive but that it will take some time for her mother to fully understand the concept of mental health. Still, Maya said, "my mother is learning and understanding with me." In slight contrast to Zahra, Rasheeda, and Maya's mothers, Mehwish talked about when her dad had a panic attack and she sent him to therapy. He did not find therapy useful but did accept taking psychotropic medication (Lexapro) to help with the anxiety, though she did not know if her dad fully understood what he was taking. She noted that "psychotropics are really great for someone who is very concrete." Zahra, Rasheeda, Maya, and Mehwish's reflections on the ways they taught their parents about mental health highlighted that their parents are open to learning about and addressing mental health through avenues different than talk therapy.

Chapter 5: Discussion

The purpose of the present study was to explore *how* SAAMM-2 individuals construct their knowledge, perceptions, and practices related to mental health and well-being. Given the underrepresentation of South Asian American Muslims in mental health and psychology research (Shah & Tewari, 2019), the present study created space to amplify the voices, stories, and knowledge of the South Asian American Muslim diaspora. Tenets from CRT and critical psychology that guided the purpose of this study included the assertion that Asian American experiences and practices have been excluded from Western epistemologies and the field of psychology (asianization; Iftikar & Museus, 2019) and that Asian American experiences are necessarily shaped by past and present economic, political, and social processes (transnational context; Iftikar & Museus, 2019). Therefore, the present study centered the voices, narratives, and knowledge of 10 SAAMM-2 participants to explore three research questions:

4) How do individuals in the SAAMM-2 population construct and recount their knowledge about mental health, particularly in relation to the mental health of their children?
5) What role does being children of immigrants play in the shaping of SAAMM-2's knowledge, perceptions, and experiences pertaining to mental health?
6) How do SAAMM-2 negotiate their South Asian, Muslim, and American identities and cultural practices to make sense of mental health and well-being?

Summary of Findings

Three questions guided analysis of data generated from the present study. The first question asked how SAAMM-2 individuals constructed and recounted their knowledge about mental health, particularly in relation to the mental health of their children. The findings indicate

that participants constructed their knowledge of mental health from several sources across different time periods of their life. Participants tended to move across time, weaving together stories from their childhood and their adulthood to demonstrate their evolving understanding of mental health. The foundations of participants' knowledge about mental health were heavily influenced and shaped by their parents, particularly in their childhood. Experiences with mental health varied from witnessing interpersonal conflict, mental illness in the family, grief and loss, personal brushes with mental health disorders, and parenting children with disabilities. In each of these childhood instances, participants recounted how their parents shaped their understanding of mental health, either by defining the experience for them or by the impact of their minimal knowledge about mental health on effectively addressing and supporting their children. Participants in this study demonstrating endeavoring to construct – or rather reconstruct – their knowledge and understanding of mental health as adults and parents themselves, by drawing from their earlier experiences, their observations and interpretations of their parents' ways of addressing mental health, and the knowledge they continually seek out through contemporary means, such as books, podcasts, and professionals. Most significantly, participants in this study demonstrated that the initial groundwork for making sense of mental health is laid in early childhood and is heavily shaped by their parents' knowledge and awareness. Furthermore, participants demonstrated that knowledge of mental health is recounted and constructed through storytelling, which both exemplifies their knowledge and aids them in a constant process of reshaping, reconstructing, and refining their mental health frameworks for themselves and their children. Overall, these findings demonstrate that knowledge about mental health in the SAAMM-2 population is constructed over time, collectively through the experiences of parents and children, and is continually being reshaped and reconstructed by new information.

The second research question posed in the present study examined the impact of immigration on mental health. Specifically, the research question explored the role of being children of immigrants on shaping mental health knowledge, perspectives, and experiences. Findings from generated data highlighted several themes that appeared to shape participants' experiences with mental health and well-being. These themes included: immigrant parents establishing themselves in the U.S., immigrant mothers assuming the role of caretakers in the U.S., intergenerational trauma, and cultural stigma of mental health. Collectively, these phenomena appeared to shape how immigrant parents expressed emotions, which in turn shaped how participants understood emotional expression and well-being.

The findings demonstrated that the experience of immigration in the first-generation can have a significant impact on the mental health and well-being of subsequent generations. Notably, immigration to the U.S. appeared to limit immigrant parents' capacity to intentionally engage in addressing their own mental health and well-being; subsequently, they were also limited in capacity to understand and address their children's mental health and well-being. Maheen drew from Maslow's Hierarchy of Needs (Maslow, 1943) to situate immigrant parents at the lowest level of the pyramid and subsequent generations at higher levels of the pyramid. Essentially, Maslow theorizes that individuals move up a hierarchy of needs, starting with basic needs such as food, water, security, and safety. As they meet basic needs, they move up the pyramid to address psychological needs, such as belongingness and self-esteem. Individuals who meet these needs move to the top of the pyramid where they strive for self-actualization (Maslow, 1943). The findings suggested a shift in focus from establishment (e.g., basic needs) to psychological needs (e.g., self-esteem, belongingness, etc.) between the immigrant generation and the SAAMM-2 generation of parents. This shift may have been fueled by an increase in

capacity among the second-generation of parents to focus attention and energy on learning about, understanding, and addressing mental health. Additionally, the increased capacity and knowledge about mental health within the second-generation appeared to fuel their efforts to break intergenerational patterns perpetuating trauma and combat cultural stigma of mental health.

Notably, the findings demonstrated that most participants in the present study grew up in households where emotional expression was limited, discouraged, or dismissed. Participants retrospectively understood that this was in part a result of learned behavior passed down through generations. Participants recounted stories of their own mothers' experiences – as daughters growing up in post-colonial South Asia, as immigrants to the U.S., and as primary caretakers of their families – that ultimately taught their mothers to suppress their thoughts and feelings for the sake of their families. As such, participants were deprived of learning about emotional expression in their childhood homes; however, as parents raising the third-generation, participants demonstrated a keen awareness of emotional well-being and an eagerness to engage in, model, and teach healthy emotional expression and regulation to their children.

Another phenomenon of immigration that appeared to influence knowledge and perceptions of mental health was acculturation within the immigration and SAAMM-2 generations. The findings indicated that the immigrant generation may have lacked understanding of acculturation in the U.S. and had limited awareness of the differences between their own acculturation and their children's acculturation needs. In turn, this lack of knowledge and awareness impacted participants' ability to live authentically and finding a sense of belonging within the intersection of their South Asian-American-Muslim identities. Notably, the findings suggested that participants were unable to find the necessary support from their

immigrant parents to feel secure in their hyphenated identity, in part due to their parents' own lack of awareness and acceptance of their children's hyphenated identity. As parents, participants noted hope in being able to support their children in developing a strong sense of their identities and finding belonging in various communities, partly from their own learned experiences with acculturation and from increased acceptance and representation of multicultural characters in the media.

The final question of the present study asked how participants negotiated their South Asian, American, and Muslim identities and cultural practices to make sense of mental health and well-being. In general, participants tended to critique South Asian perspectives of mental health, noting that those perspectives fell short in understanding root causes of mental health challenges and taking appropriate action to address those challenges. To reconcile the tension they felt with South Asian perspectives of mental health, participants generally turned to Islam for justification of seeking professional help, such as therapy, to address mental health challenges. Similarly, when participants felt unease with western conceptualizations of mental health, they turned to Islam to find comfort. Notably, participants faith in God served as a protective factor when faced with challenges that western science our South Asian cultural perspective could not explain. Participants were able to draw from Islam to practice acceptance and gratitude, and to find a sense of purpose in the various challenges they faced.

Participants also grappled with inherent individualism within western conceptualizations and treatments of mental health. The findings indicated that participants felt a sense of nervous and exhaustion with western-trained therapist that were unaware of or dismissive of the collectivistic values within South Asian culture and Islam. This misalignment of values appeared to contribute to some hesitancy in participants seeking out therapy for themselves or for their

children. Participants expressed a desire for more South Asian and Muslim representation in the field of psychology to help integrate collectivistic values, awareness, and understanding into the mental health field.

The Marginalization of South Asian American Muslims

The present study aimed to examine SAAMM-2 participants narratives for indications of colonial mentality, racism, and other phenomena that marginalize minorities from the western field of mental health and psychology. Colonial mentality was described by David and Okazaki (2006a) as a form of internalized colonialism in a postcolonial world, in which individuals from colonized regions subconsciously reject or distance themselves from indigenous and cultural knowledge and accept western knowledge, as a way of surviving in an ideologically western country. However, the findings suggest that the immigrant generation seemed to outwardly reject western knowledge of mental health and hold steadfast to their cultural understandings of mental health and well-being. In contrast to their immigrant parents, participants seemed to engage in weaving together knowledge gained from South Asian culture, Islam, and the west, in order to support their efforts in effectively addressing mental health in themselves and their families.

However, indications of colonial mentality show up in both the immigrant generation and SAAMM-2 participants in the form of the model minority myth. The myth that caricaturizes South Asians (and other Asian groups) as hardworking, high achieving, and submissively obedient people (Poon et al., 2015; Yi & Museus, 2016) was (and continues to be) perpetuated to service the needs of the white majority in the U.S. (Ng et al., 2007). As such, the immigrant generations apparent lack of knowledge, awareness, and capacity for addressing mental health and well-being may be explained by internalization of the model minority caricature. In the interview, Mehwish described multiple generations of unsettlement due to British colonialism,

Partition, and immigration to the U.S. Therefore, the immigrant generation may have internalized the model citizen caricature imposed upon South Asians in order to achieve survival and settlement in the U.S. This showed up in the way participants described their parents' narrow focus on economic stability, their mothers tireless assuming the role of caretakers, and the immigrant generation refraining from discussing their problems with outsiders – all of which were efforts to secure space for subsequent generations of South Asian American Muslims. An unintended impact of the internalization of the model minority caricature was that the second-generation were essentially left on their own to learn about and make sense of the mental health challenges they faced in their early years, in adulthood, and as parents.

The findings also highlighted inherent marginalization of minority knowledge and culture within western psychology through the perpetuation of individualism and the lack awareness of collectivistic values in South Asian culture and Islam. Participants described a certain level of nervousness toward western-trained therapists due to misalignment of values and culturally insensitive interventions (e.g., cutting out "toxic" parents). Additionally, participants expressed exhaustion in having to explain their collectivistic values, culture, religion, and the dynamics of their intersecting identities when working with western-trained therapists. These experiences have been described by Kim and Hogge (2021) as microaggressions often experienced by Asian individuals in western therapeutic spaces. For the participants in this study, these microaggressions served as barriers to accessing therapy.

Implications for Professional Practice

Findings from this study demonstrate the need for increased representation of South Asian Muslims in the mental health field. Participants proposed increased representation of South Asian Muslim psychologists and therapists in the field as a solution to the marginalization

of the South Asian knowledge and culture in western psychology. Prior research cite representation in the mental health field as a common barrier to help-seeking behavior (Islam et al., 2017). Participants in this study found that representation in the field helped reduce the burden of having to explain religion, culture, and living in the diaspora, and increased feelings of comfort, familiarity, and empowerment within therapeutic spaces.

Participants emphasized the importance of Islam in their knowledge, perceptions, and practices related to mental health and wellbeing. As such, professionals may benefit from using biopsychosocial-spiritual framework (Engel, 1977) when working with South Asian American Muslims. The biopsychosocial-spiritual framework posits four domains that influence mental health: biological, psychological, social, and spiritual (Engel, 1977). Often overlooked in western therapeutic spaces, the spiritual domain highlights the way in which an individual's beliefs, values, and practices shape their sense of identity, purpose, and overall well-being (Engel, 1977). The findings of this study suggest that along with the biological, psychological, and social domains, the spiritual domain encapsulates the way in which Islam contributes to meaning making for the SAAMM-2 population.

Finally, the findings of this study illuminate the complexity of knowledge construction and myriad factors that contribute to meaning making. As such, professionals and researchers should consider multiple temporally located (i.e., contemporary and historical) sociocultural and ecological contexts, such as immigration, acculturation, generational status, intergenerational trauma, collectivism, and so forth, and their influence on shaping knowledge within South Asian Muslim populations. In particular, the findings of this study demonstrate how each generation builds upon knowledge and practices passed down from previous generations through the integration of their intersecting identities, cultures, and faith; as such, understanding each

individual in their own system and within a collectivistic system of both contemporary and historical influence is necessary.

Implications for Future Research

The present study examined the stories and narratives of 10 individuals from the SAAMM-2 population. While providing insight into multiple generations, the data generated are from the viewpoint of the second-generation. Researchers may wish to expand on this study by studying phenomena highlighted in this study by exploring the narratives of individuals of older and newer generations. For example, a phenomenological study involving immigrant mothers may provide greater insight into the experience of immigration and its impact on immigrant mothers' role as caretakers and their bandwidth for addressing mental health and well-being within their families. In the feedback portion of the interview, one participant wondered about generational differences in access to knowledge; she noted that her parents' generation did not have access to the internet and other resources as easily and she does to learn about mental health and strategies to support children's well-being. As such, future research on the role technology plays in knowledge construction and addressing mental health in South Asian Muslim groups may be of interest. Finally, future research specifically exploring SAAMM-2 individuals seeking therapy or their children seeking therapy may provide greater insight into the experience of marginalization and strategies to increase inclusivity in western therapeutic settings.

Limitations

There are several limitations to this study. First, establishing rapport and purpose with participants was necessary for meaningful conversation. I made every effort to clearly state my positionality and purpose for the study. Still, participants may have felt discomfort in discussing deeply personal experiences with mental health, due to inherent stigma and worry of oversharing

with an outsider. Another limitation to the study was the framing of questions from the semi-structured interview protocol. While questions were drafted to guide discussion, participants may have had their own expectations of the types of questions that would be asked and the direction of conversations. If and when there were discrepancies in participants' expectations and the interviewer's direction with questions, conversation may have steered from more meaningful discussion and shared meaning making. Another important limitation was representation of South Asian individuals in the study sample. Participants in the present study represented individuals of Pakistani and Indian origin; as such, the voices, knowledge, and experiences of individuals from other South Asian countries are not represented in these findings. Their experiences may yield different insights into how mental health and well-being is addressed in South Asian American populations. Finally, this study touched upon contemporary and historical narratives, often asking participants to reflect upon their parents' experiences as well as the experiences of generations prior. While the study and its findings are a reflection of participants' *perspectives* of previous generations' experiences, they may not be an accurate representation. Future research may benefit from recruiting members of each generation to explore their experiences with mental health and processes for meaning making.

Conclusion

The study was an effort to elevate the voices, narratives, and knowledge of second-generational South Asian American Muslim mothers. Participants in this study used storytelling to demonstrate the ways in which they construct knowledge and make sense of mental health, for themselves and their families. Through the stories and narratives shared in interviews, participants demonstrated making an effort to disrupt traditional western perspectives of mental health, to reduce stigma within their South Asian and Muslim communities and families, to

normalize discourse about mental health for previous and future generations, and to empower mothers in their efforts to address mental health and well-being in their families.

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Appendix A: Participant Consent Form

Study Title: Second-Generation South Asian Muslim Parent Perceptions of Mental Health and Well-being of their Children

Principal Researcher: Sana Hussain | sanah1@uw.edu | (408) 821-2061

Faculty Advisor: Dr. Kristen Missall | kmissall@uw.edu

RESEARCHER'S STATEMENT

I am inviting you to be in a research study that I am completing as part of my doctoral coursework at the University of Washington. The University of Washington Institutional Review Board (IRB) has reviewed the purpose, procedures, benefits, and risks of this study outlined below. The Institutional Review Board has approved this study.

If you have any questions about your rights as a research study participant, you can call the Institutional Review Board at (206) 543-0098 and/or review the IRB Frequently Asked Questions (FAQ) webpage.

Potential participants: This is a consent form. It provides a summary of the information you will need to help you decide whether or not to be in the study. If you decide that you would like to take part in this research study, you will sign this form to confirm your decision. I will provide you a copy of this form for your records.

- Please read the form carefully.
- You may ask questions about the purpose of the research, what I will ask you to do, the possible risks and benefits, your rights as a volunteer, and anything else about the research or this form that is not clear.
- When all your questions have been answered, you can decide if you want to be in the study or not.
- If you say 'Yes' now, you can still change your mind later.
- You can quit the study at anytime.
- You will not be penalized if you decide not to take part in the study or to quit the study later.

PURPOSE OF THE STUDY

The purpose of this study is to understand how second-generation (born and/or raised in the U.S.) South Asian American Muslim mothers view mental health and well-being. I am interested in understanding how the experience of growing up in the intersection of South Asian and American culture and Islam influences how mothers understand mental health and help support the well-being of their children. Through this study, I hope to develop ways we can integrate South Asian, American, and Islamic views and practices into mental healthcare for children, youth, and their families. If you choose to be in this study, I would like to interview you individually about your family's experiences with immigration and acculturation, and your understanding and experiences with mental health and well-being.

PROCEDURES

The interview is expected to last up to 1.5 hours. For your convenience, privacy, and safety, I will ask you to suggest meeting via Zoom or places that you are comfortable meeting in person (e.g., coffee shop, library meeting room, etc.).

With your permission, I would like to audio record your interview so that I can have an accurate record of our conversation. I will transcribe this recording without identifiable information and destroy the recording and transcripts after the study is complete. Only I will have access to the recording, which will be kept in a secure location. If you would like a copy of the transcript of the interview, I will gladly provide you with one.

Participants eligible for this study are:

- Mothers who were born and/or raised in the U.S. (second-generation) and who identify as South Asian, American, and Muslim.
- Mothers of children between the age of 0-21 years old.

Activities to be done:

- After receiving consent, I will ask you to complete a demographic form with some basic information about yourself in order to determine eligibility for this study.
- I will ask you to answer complete a few questions about your experiences growing up in the United States.
- I will reach out to schedule a virtual or in-person interview.
- During the interview, some of the questions I may ask you include:
    - I'd like to learn more about what mental health means to you. Tell me about a time when you first learned about "mental health."
    - Can you give me an example of a time when you saw or heard about a child in your community experiencing mental health challenges?
    - If your child was experiencing mental health challenges and therapy was recommended, would you pursue it? Why or why not?

RISKS, STRESS, OR DISCOMFORT

Some people feel that providing information for research is an invasion of privacy. I have addressed concerns for your privacy in the section below. Some people feel self-conscious when notes are taken or interviews are recorded. For some, mental health can be a difficult topic to discuss and might bring up concerns and/or feelings of distress. If concerns arise, I will provide support in finding appropriate resources to help you or any others that are impacted.

BENEFITS OF THE STUDY

You may not directly benefit from taking part in this research study. One benefit of this study is to understand how Islamic beliefs and practices and South Asian cultural values can be used to help support the mental health development of young people. Additionally, information from this

study may help support mental health professionals in working with South Asian American Muslim children, youth, and parents and understanding their cultural and religious backgrounds. All participants who complete the interview will be compensated for their participation with a $15 gift card to Amazon® or Target®.

OTHER INFORMATION

Taking part in this study is voluntary. You may refuse to participate, and you are free to withdraw from this study at any time without penalty or loss of benefits to which you are otherwise entitled. Information about you is confidential. I will assign you a pseudonym and code the study information. I will keep the link between your name and the pseudonym code in a separate, secured location until the study is complete. Then I will destroy the information linking your information to the pseudonym. In publications and presentations of this study, I will not use your name, or any other identifying information.

I may want to re-contact you for future related studies. Please indicate below whether you give me permission to re-contact you. Giving me permission to re-contact you does not obligate you in any way.

If you have any questions about this research study, please contact Sana Hussain at (408) 821-2061 or sanah1@uw.edu. If you have any questions about your rights as a research subject, please contact either of my course instructors overseeing this project: Dr. Kristen Missall | kmissall@uw.edu

_____

Signature of investigator Printed Name Date

PARTICIPANT'S STATEMENT

This study has been explained to me. I volunteer to take part in this research. I have had a chance to ask questions. If I have questions later on about the research, I can ask the investigator listed above. If I have questions about my rights as a research subject, I can contact the researcher, advisor, or the Institutional Review Board. I will receive a copy of this consent form.

____ I consent to participate in this research study.

____ I give permission for this researcher to audiotape my interview.
____ I do NOT give my permission for the researcher to audiotape my interview.

____ I give permission for the researcher to re-contact me to clarify information.
____ I do NOT give permission for the researcher to re-contact me to clarify information.

_____

Signature of participant Printed Name Date

Contact information:
Copies to: Investigators' file & Participant

Appendix B: Digital Demographic Survey

Contact information (*email, phone number, social media handle, or other way to contact*):

Name:

Age:

Gender:

Age of children:

Relationship to children:

Marital status:

Parents' country/countries of origin:

Your country of origin:

If you were not born in the U.S., at what age did you move to the U.S.:

How many years have you lived in the U.S.:

What other countries have you lived in?

How old were you when you lived outside of the U.S.?

For how many years did you live in a country outside of the U.S.?

Which of the following do you identify with:

South Asian
Which country/countries/regions of South Asia:
American
Muslim
Other:

Appendix C: Semi-Structured Interview Protocol

Preamble: *I am a doctoral student at the UW and have been studying school psychology and mental health for several years now. Much of my work as involved working closely with children and youth, and sometimes parents, with mental health challenges and helping children navigate those challenges. I, too, come from a South Asian (Pakistani) Muslim family and was born and raised in the U.S. I have wondered how growing in the U.S. as second-generation South Asian American Muslims, our culture and our religion help us understand mental health and well-being. It would be helpful if you could talk for 90 minutes about your understanding of this topic and how your cultural and religious views help you understand mental health and well-being. With your permission, I'd like to record this conversation so that I may go back to it and learn what worked well in the interview and what didn't. Is that okay with you? At any point, if you'd like me to stop recording, please let me know.*

1. Conversation to build rapport; opportunities to ask questions.
2. I'd like to start with learning a little bit about you and your experiences growing up in the U.S.
    a. What are the identities you hold for yourself? What communities do you feel that you belong to now? How about when you were growing up?
    b. How would you describe your experience growing up in the U.S. as a second-generation South Asian American Muslim?
    c. In what kind of community or communities were you raised? (Probes: Were you primarily raised in a South Asian (or use their ethnic origin/identifier) community? A Muslim one?)
    d. What does your South Asian (or use their ethnic origin/identifier) identity mean to you? What did it mean to you as a child and what does it mean to you now as an adult and a mother?
    e. What does your American identity mean to you? What did it mean to you as a child and what does it mean to you now as an adult and a mother?
3. Thinking about your identities/communities, I'd like to learn more about how you understood mental health growing up.
    a. In psychology, there several terms we use, including mental health, mental illness, and well-being. When you hear or read these words, what comes to mind for you? Are there other words that you use now, used, or heard being used while growing up?

b. I'm curious about your experiences with the concept of mental health while growing up. Did you hear mental health/illness discussed in the family and home when you were a child? *Sometimes, the terms mental health or illness aren't used. Did you hear about social, emotional, or behavioral challenges being discussed while growing up?*
c. Did your family talk about mental health or illness with each other when you were growing up?
d. Did you hear mental health/illness discussed in the community you grew up in?
e. Growing up, did members of your community talk to each other when someone, such as a child, was having a difficult time? How did they support each other?
f. If you attended the masjid growing up, did you hear mental health being discussed at the masjid from Islamic religious leaders (e.g., imams, sheikhs, maulanas)?
g. Growing up, did you hear about counseling or therapy as a way to address mental health challenges? What were some other ways people in your community addressed challenges?
h. How do you think growing up South Asian, American, and Muslim influenced your understanding of mental health as a kid? Did you notice differences in how mental health was talked about in the different community spaces?

4. I'm curious how your views about mental health may be the same or have changed now?
    a. How has your views or understanding or even comfort level with talking about mental health and illness changed or stayed the same since when you were a child?
    b. Where (e.g., in what spaces/communities) do you hear about mental health/illness the most? The least? Where do you go to learn more about it?
    c. What are ways people in your communities address mental health challenges, particularly in children, now?
    d. Where or who do you generally turn to when it comes to advice about raising your children or addressing challenges as a parent?
    e. How would you approach potential mental health challenges in your children? Where would you go/who would you talk to to better understand what is going on and/or how to help your child?

f. Do you hear about counseling and therapy as a way to address these challenges in your different community spaces? What are your thoughts on therapy for yourself or your children?
g. If your child was experiencing mental health challenges and therapy was recommended, would you pursue it? Why or why not? [Probes: What is helpful about therapy? What is unhelpful? Listen for: components that seem relevant, useful, and accessible; barriers].
h. In what ways do you think being part of the South Asian community might help with addressing mental health challenges in our children? In what ways do you think it hurts?
i. In what ways do you think Islam helps us understand mental health and ways to approach challenges for ourselves and our children?
j. How about our American culture? (In what ways does American culture/spaces help us understand mental health and our ways to approach challenges for ourselves and children)?

5. Vignettes: Introduction: I am interested in finding out where you think mothers should turn to for support in times of trouble. Different people go to different places when they need help; some people enjoy a good relationship with their mosque or community, others have supportive family or friends. What about you? I am interested in how you would react to the following scenarios.
    a. Vignette: Rukhsana and her daughter Amina
        i. A neighbor's 16-year-old daughter has become unhappy and withdrawn. What would your advice be to Rukhsana?
        ii. Your child confirms that Amina has felt sad and down-hearted at school. She tends to want to stay in her room, rather than go hang out with her family or friends.
            1. What would you suggest Rukhsana does next?
        iii. Rukhsana thinks that it would do no harm if her daughter spent more time at the mosque, pray more, and read more Qur'an.
            1. In your view, is this a good strategy? Will it help?
        iv. Who else could Rukhsana turn to for help?

v. What advice do you think your mother or father would give Rukhsana?

6. Generation Trauma:
    a. Something that tends to come up for us as adults are our experiences growing up. Sometimes this might be difficult and sometimes traumatic experiences we might have had as children (in our families and communities, including discrimination) that influence how we view parenting our own children.
    b. Are there any experiences that you are comfortable talking about that you think have influenced your parenting now or your experiences with mental health now?
    c. How has belonging to the South Asian, American, and Muslim communities shaped your understanding of those experiences – then and now? How has being part of these communities shaped how to address these challenges for yourself and for your children?
7. Final
    a. A part of what I am trying to understand here is if the communities that we belong to have nuggets (e.g., traditions, strategies, resources, etc.) that we can draw from to approach mental health. What are your thoughts about that?
    b. How was this conversation for you? Are there other thoughts that you have that you would like to share?
    c. Do you have any questions for me? Or concerns about this conversation?
8. Closing
    a. Thank you so much for your time! I think there is so much to learn from our generation about mental health and how to talk about it and address challenges within our families, especially for our children and being able to have this conversation with you has been so helpful! However, I know that these conversations can also be difficult and bring up difficult thoughts and feelings. If you experience distress and would like to talk to a professional, I am more than happy to provide resources.
    b. I would also like to thank you for your time by sending you a gift card. Do you prefer Amazon or Target and how can I send it to you (electronic, by mail)?

Appendix D: Vignette Protocol

Vignettes for use in individual interviews (adapted with author permission from Bradby et al., 2007)

Introduction: I am interested in finding out where you think mothers should turn to for support in times of trouble. Different people go to different places when they need help; some people enjoy a good relationship with their mosque or community, others have supportive family or friends. What about you? I am interested in how you would react to the following scenarios.

Vignette 1: Rukhsana and her daughter Amina

a. A neighbor's 16-year-old daughter has become unhappy and withdrawn. What would your advice be to Rukhsana?
b. Your child confirms that Amina has felt sad and down-hearted at school. She tends to want to stay in her room, rather than go hang out with her family or friends.
    i. What would you suggest Rukhsana does next?
c. Rukhsana thinks that it would do no harm if her daughter spent more time at the mosque, pray more, and read more Qur'an.
    ii. In your view, is this a good strategy? Will it help?
d. Who else could Rukhsana turn to for help?
e. What advice do you think your mother or father would give Rukhsana?

Appendix E: Acculturation Survey

Asian American Multidimensional Acculturation Scale (AAMAS; permission to use obtained by authors)

For the purposes of this study, the Culture of Origin (AAMAS-CO) and European Americans (AAMAS-EA) scales will be included; the Asian Americans cultural dimension scale (AAMAS-AA) will not be included. All option "b" responses will be eliminated from the survey. Please see "Description and scoring instructions" below.

Instructions: Use the scale below to answer the following questions. Please circle the number that best represents your view on each item. Please note that reference to "Asian" hereafter refers to Asians in America and not Asia.

			Not very well			**Somewhat**		**Very well**
			1	**2**	**3**	**4**	**5**	**6**
1.	**How well do you speak the language of --**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	English?	1	2	3	4	5	6
2.	**How well do you understand the language of --**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	English?	1	2	3	4	5	6
3.	**How well do you read and write in the language of --**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	English?	1	2	3	4	5	6
4.	**How often do you listen to music or look at movies and magazines from**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	the White mainstream groups?	1	2	3	4	5	6
5.	**How much do you like the food of -**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6

	c.	the White mainstream groups?	1	2	3	4	5	6
6.	**How often do you <u>eat</u> the food of -**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	the White mainstream groups?	1	2	3	4	5	6
7.	**How <u>knowledgeable</u> are you about the history of -**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	the White mainstream groups?	1	2	3	4	5	6
8.	**How <u>knowledgeable</u> are you about the culture and traditions of -**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	the White mainstream groups?	1	2	3	4	5	6
9.	**How much do you <u>practice</u> the traditions and keep the holidays of -**							
	a.	your own Asian ethnic culture?	1	2	3	4	5	6
	b.	other Asian cultures?	1	2	3	4	5	6
	c.	the White mainstream culture?	1	2	3	4	5	6
10.	**How much <u>do you identify with</u> -**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	the White mainstream groups?	1	2	3	4	5	6
11.	**How much do you feel <u>you have in common with</u> people from -**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	the White mainstream groups?	1	2	3	4	5	6
12.	**How much <u>do you interact and associate with</u> people from -**							
	a.	your own Asian ethnic group?	1	2	3	4	5	6
	b.	other Asian groups?	1	2	3	4	5	6
	c.	the White mainstream groups?	1	2	3	4	5	6
13.	**How much <u>would you like to</u> interact and associate with people from -**							

a.	your own Asian ethnic group?	1	2	3	4	5	6
b.	other Asian groups?	1	2	3	4	5	6
c.	the White mainstream groups?	1	2	3	4	5	6

		Not very well		**Somewhat**		**Very well**
		1	**2**	**3**	**4**	**5**	**6**

14. How <u>proud are you</u> to be part of -

a.	your own Asian ethnic group?	1	2	3	4	5	6
b.	other Asian groups?	1	2	3	4	5	6
c.	the White mainstream groups?	1	2	3	4	5	6

***15. How <u>negative</u> do you feel about people from -**

a.	your own Asian ethnic group?	1	2	3	4	5	6
b.	other Asian groups?	1	2	3	4	5	6
c.	the White mainstream groups?	1	2	3	4	5	6

*Reverse worded item.

AAMAS Description and Scoring Instructions

AAMAS is an orthogonal measure that assesses acculturation to three different cultural dimensions: Culture of Origin (AAMAS-CO), Asian American culture (AAMAS-AA), and European American culture (AAMAS-EA). The pan-ethnic Asian American (AAMAS-AA) acculturation dimension is unique to the AAMAS. If this dimension is not of interest to the researcher and there is a compelling need for a shorter measure, it can be left out by eliminating option "b" under each item. However, in order to maintain orthogonality, at least two cultural dimensions must be assessed at the same time.

Three *Cultural Dimension* Scales:

Name of Scale	What it measures
Culture of Origin (AAMAS-CO)	Acculturation to one's own culture of origin
Asian Americans (AAMAS-AA)	Pan-ethnic Asian American culture
European Americans (AAMAS-EA)	Host society's European American culture

Four *Acculturation Domain Subscales*

Within each of the cultural dimension scales above are 4 subscales assessing specific domains of acculturation:

Name of Scale	No. of Items	
Language	4	Items 1-4
Food Consumption	2	Items 5-6
Cultural Knowledge	3	Items 7-9
Cultural Identity	6	Items 10-15

Reliability Data for Cultural Dimension Scales

Internal Consistency	Range	Test-Retest: 2 week interval
AAMAS-CO	.87 to .91	.89
AAMAS-AA	.78 to .83	.75
AAMAS-EA.	.76 to .81	.78

Reliability Data for Acculturation Domain Subscales

Internal Consistency in 2 Studies

	AAMAS-CO		AAMAS-AA		AAMAS-EA	
Language	.84	.76	.85	.84	.82	.87
Food Consumption	.71	.65	.79	.68	.71	.68
Cultural Knowledge	.77	.89	.77	.66	.71	.67
Cultural Identity	.79	.79	.70	.72	.78	.74

Instructions for Scoring the AAMAS

1. Item #15 needs to be reverse scored:

To reverse the score:

1	should be changed to		6
2	"	"	5
3	"	"	4
4	"	"	3
5	"	"	2
6	"	"	1

2. Calculate the *total score* for each scale:

a) AAMAS-CO add together all of the responses to "a" (your own Asian ethnic group) for all 15 items

b) AAMAS-AA add together all of the responses to "b" (other Asian groups) for all 15 items

c) AAMAS-EA add together all of the responses to "c" (the White mainstream groups) for all 15 items

3. Divide the total score for each cultural dimension by 15 to obtain the *scale score*.

Sahin-Francis Scale of Attitude toward Islam (SFSATI; permission to use obtained by authors)

Please read each statement carefully and select the most appropriate response for you (from the Sahin-Francis Scale of Attitude toward Islam; SFSATI; Sahin & Francis, 2002).

1. I find it inspiring to listen to the Qur'an.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
2. I know that *Allah*/God helps me.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
3. Saying my prayers/*du'a'* helps me a lot.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
4. Attending the mosque is very important to me.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
5. I think going to the mosque is a waste of time.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
6. I want to obey *Allah*/Gods law/*shari'ah* in my life.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
7. I think mosque sermons/*khutbahs* are boring.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
8. *Allah*/God helps me to lead a better life.

a. Disagree strongly (1)
b. Disagree (2)
c. Not certain (3)
d. Agree (4)
e. Agree strongly (5)

9. I like to learn about *Allah*/God very much.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
10. Islam means a lot to me.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
11. I believe that *Allah*/God helps people.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
12. Prayer/*Salat* helps me a lot.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
13. I feel that I am very close to *Allah*/God.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
14. I think prayer/*salat* is a good thing.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
15. I think the Qur'an is out of date.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
16. I believe that *Allah*/God listens to my prayers/*du'a'*.
    a. Disagree strongly (1)

b. Disagree (2)
c. Not certain (3)
d. Agree (4)
e. Agree strongly (5)

17. *Allah*/God means everything to me.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
18. *Allah*/God is very real to me.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
19. I think praying/*du'a'* does no good.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
20. Belief in *Allah*/God means much to me.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
21. I do not find it hard to believe in *Allah*/God.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
22. I am happy to be a Muslim.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)
23. I love to follow the life/sunnah of the Prophet.
    a. Disagree strongly (1)
    b. Disagree (2)
    c. Not certain (3)
    d. Agree (4)
    e. Agree strongly (5)

Appendix F: Coding Scheme

Code	Theme	Code Description
Interpersonal conflict	Childhood experiences	Reference to conflicts impacting relationships between self and others or between others
Parent illness, disability, death	Childhood experiences	Reference to parent illness, disabilities, death that impacted emotional wellbeing
G2 awareness and recognition	Childhood experiences	Reference to understanding mental health as a child, when they first became learned about mental health
G1 MH awareness & recognition	Parents' experiences (G1)	Reference to G1 parents showing awareness or recognizing MH challenge in self and for their children; addressing MH for self and for children (adaptive or maladaptive)
G1 attitudes toward MH	Parents' experiences (G1)	Reference to G1 parents' attitudes, beliefs, sentiments, toward mental health, therapy, and other coping strategies for self, others, children
Comparison between G1 & G2	Parents' experiences (G1)	Reference to G1 mothers comparing their own awareness, attitudes, and ways of addressing MH in their children with their parents' ways
Events that prompted exploring MH and therapy	Adulthood experiences	Reference to events that prompted G2 parents to explore mental health and therapy for themselves or for their children (e.g., interpersonal conflict, divorce, COVID, grief & loss, postpartum, child diagnosis)
Educational resources	Educational resources	Reference to G2 mothers seeking out information from different resources (e.g., social media, podcasts, books, religious scholars, school curriculums, friends and family, profession and workplace, therapists, coaches, counselors)
Eastern vs Western comparisons	Mental health conceptualizations	Reference to eastern or western views of mental health, comparisons between the two approaches
Islam and mental health	Mental health conceptualizations	Reference to Islamic views and conceptualizations of mental health; ways that those views are accepted and/or integrated into G2 mothers' knowledge
Mind/body/soul	Mental health conceptualizations	Reference to holistic conceptualizations of mental health and wellbeing
G1 acculturation	Acculturation	Reference to G1 acculturation in the US, including impact of acculturation G2, awareness of generational differences in acculturation, and beliefs about cultural preservation
Belongingness	Acculturation	Reference to G2 feelings of belongingness, related to acculturation, impact on mental health, wellbeing, and parenting

Authenticity	Acculturation	Reference to G2 experiences with and beliefs about the ability to be authentic selves as bicultural children of immigrants, related to acculturation, impact on mental health, wellbeing, and parenting
Autonomy	Acculturation	Reference to G2 experience with and beliefs about having autonomy in life, related to cultural beliefs about autonomy, impact on mental health and wellbeing, and parenting
Diversity of community	Acculturation	Reference to beliefs about being part of diverse communities, related to acculturation, being bicultural children of immigrants, impact on mental health, wellbeing, and parenting
Beliefs about MH and therapy	Beliefs about MH and therapy	Reference to cultural beliefs about mental health and wellbeing (e.g., individualism vs. collectivism, integrating cultures and islam into western practices, cultural beliefs about seeking help, cultural barriers to seeking help, trust, representation, empowerment)
Stigma	Stigma	References to stigma and taboo related to mental health, therapy, etc. (e.g., placing blame, talking about problems, model minority myth, discussing and normalizing mental health, sharing experiences, log kya kahenge)
Immigration	Multigenerational dynamics	Reference to immigration, unsettlement, obligations related to immigration, including Maslow's hierarchy in relation to immigration, impact on multiple generations
Immigrant mother	Immigration	Reference to G1 mothers, their immigration experience, their experience of motherhood in the US, raising children, mental health in the US, etc.
Intergenerational trauma	Multigenerational dynamics	Reference to mental health challenges and trauma in older generations impacting G1 and G2 generations
Family dynamics	Multigenerational dynamics	Reference to family dynamics across generations and impact on mental health and wellbeing
Colonialism	Multigenerational dynamics	Reference to colonialism on mental health and wellbeing across generations
Emotional expression	Emotional expression	Reference to cultural beliefs and acceptance of emotional expression, receiving emotional validation from parents, learning coping and self-regulation strategies in childhood, and internalized beliefs about emotions as adults, impact on parenting

Parents' awareness	Parenting	G2 mothers' awareness, involvement, curiosity and knowledge about mental health, reference to childhood experiences
Parent-child relationships	Parenting	G2 mothers' beliefs about parent-child relationships, including trust, taking responsibility, reliance, restrictions, communication between parent and child, reference to childhood experiences
Parents' MH and wellbeing	Parenting	Reference to relationship between parent mental health and wellbeing and child mental health and wellbeing, including parents' emotions (e.g., expression, bandwidth, regulation), parent coping, child caring for parents' emotions)
Beliefs about parenting	Parenting	Reference to beliefs about the role of parents in promoting emotional wellbeing in children, including parents being guides, individualizing strategies to each child, and evolving parenting
Patterns and cycles	Patterns and cycles	Reference to G2 mothers making changes in their mental health and parenting practices that are breaking generational cycles, including references to what was missing in their own childhood
Children teaching parents	Teaching and learning	Reference to G2 mothers teaching their parents about mental health and wellbeing, including encouraging therapy and other practices
Generational change in MH	Teaching and learning	Reference to G1 parents showing changes in their beliefs and practices about mental health and wellbeing, as a result of their G2 mothers encouraging change, including G2 mothers empathizing with G1 parents way of parenting
Parents teaching children	Teaching and learning	Reference to parents teaching children about mental health, coping, etc. and comparisons between G1 and G2
Motherhood	Motherhood	Reference to motherhood as an identity and an experience, including pregnancy, postpartum, transitions, bandwidth as a mother, authenticity in portrayal of motherhood, and the impact of motherhood on mental health and wellbeing
Reasons for seeking support	Addressing MH	Reference to G2 mothers' reasons for seeking professional support (e.g., marriage counseling, parenting support, grief counseling)
Sources of support	Addressing MH	Reference to the sources of support G2 mothers seek out (e.g., social, school-based, parental, mosque, friends and family, spiritual, workplace, etc.)

Seeking professional help/therapy	Addressing MH	Reference to G2 mothers' seeking out professional support for self and/or child as a mother
MH strategies/coping	Addressing MH	Reference to G2 mothers' coping strategies for themselves and as mothers (for their children), including Islamic coping practices and cultural coping practices
Negotiating identities	Values	Choosing and repelling parts of culture, religion, etc.; integrating to create own biculture; related to values; Reference to G2 mothers talking about values, instilling values in their children, choosing cultural and religious values to continue within their own families