Visible Yet Unseen: An Exploration of the Moderation Effects of Religiosity on the Relationship Between Discrimination and Psychological Distress among Muslim Women

by

Betool B. Ridha

A dissertation submitted to the Graduate Faculty of
Auburn University
in partial fulfillment of the
requirements for the Degree of
Doctor of Philosophy

Auburn, Alabama
August 6, 2022

Keywords: Muslim women, psychological distress, religious discrimination, religiosity, depression, anxiety.

Approved by

Evelyn Hunter, Chair, Assistant Professor of Special Education, Rehabilitation, & Counseling
Jamie Carney, HGS Distinguished Professor of Special Education, Rehabilitation, & Counseling
Janice Clifford, Associate Professor of Sociology, Anthropology, & Social Work
Kamden Strunk, Associate Professor of Educational Foundations, Leadership, & Technology

Abstract

The purpose of this study was to gain understanding into the experiences of gendered discrimination among Muslim women by examining the relationship between religious discrimination and psychological distress. Specifically, the study assessed the potential moderating effect of religiosity on the relationship between religious discrimination and psychological distress among this population. The study found that while religiosity did not moderate the relationship between religious discrimination and psychological distress among Muslim women, there is an important relationship between experiences of discrimination and psychological distress.

Acknowledgments

This dissertation is the culmination of six years of graduate studies, yet in many ways it feels like I have been working toward this my whole life. This research is not merely a fulfillment of the requirements of a doctoral degree, but rather an ode to myself, to my Muslim sisters, and to my creator. As I did not walk this journey alone, I am grateful for the opportunity to acknowledge all who have contributed to this accomplishment.

First and foremost, I offer my humble thanks to my creator. Thank you for gifting me the blessing of knowledge—knowledge of You, knowledge of myself, and knowledge of humanity. I have spent my entire life in the pursuit of knowledge, in order to be closer to You. Thank you for giving me the strength to pursue this degree and blessing me with so many people who supported me along the way.

To my father, Bashir Alkhalisy— thank you for believing in me. Thank you for always pushing me to be the best version of myself. You fostered my intellectual curiosity from the moment I was able to form thoughts. You were my first educator, always answering my questions, big and small. Nothing was ever off limits with you—religion, philosophy, politics, history, psychology—and no matter how old I get and what new things I learn, I always come back to you. You are the greatest person I know, and I hope that I can one day achieve even a small fraction of what you have accomplished in life. Who I am is because of you.

To my mother, Lobna Alkahfi— thank you for seeing me and supporting me unconditionally. I would not be who I am without you, setting an example of what it means to be a strong Muslim woman. This work has been inspired by your strength and tenacity in the face of extreme hardship. It is with your unwavering faith and unconditional love that I have made it this far.

To my dear sister, Bidoor—words are simply not enough. Doing graduate school with you these past six years has been the biggest blessing of my life. Thank you for being my best friend and biggest supporter. Thank you for understanding me and challenging me to be better. Thank you for keeping me fed—I literally would not have survived without you. There is no one else on earth I would have chosen to do this with but you.

To my brothers, Hassan and Hussain— thank you for being a bright light in my life. I don't say this enough, but I love you both. Thank you for always keeping me humble and reminding me that there's more to life than school and that I am more than my degree.

To my advisor and chair, Dr. Evelyn Hunter—I cannot thank you enough for your support and guidance throughout this process. Thank you for getting me together when I was acting foolish and giving me grace when I needed it most. And thank you for mostly putting up

with all the #trashtwin shenanigans for the past few years—your endless patience is much appreciated.

To my committee, Dr. Kamden Strunk, Dr. Jamie Carney, Dr. Janice Clifford— thank you for helping me to make this work the best it can be. I deeply appreciate your time and effort in this process. To Dr. Lisa Kensler, thank you for taking the time to serve as the university reader for this work.

To my Auburn community—thank you for making my graduate school experience life-changing. Erika, your friendship has anchored me through all the ups and downs of the past six years. From procrastinating at Dunkin, ranting on our commute to CSU, to dying of laughter on the floor of the LRC—I cherish all the moments that have made this journey unforgettable. Taylor, I can always count on you to keep it real. Your honesty, love, and support have helped keep me sane through all the ups and downs and I so appreciate all the ways you've showed up for me. SweetnShady16—thanks for being the best cohort to learn and grow with. Dr. Annette Kluck, thank you for your never-ending support, for keeping in touch long after leaving Auburn, and your willingness to Zoom on Sundays. Dr. Randy Pipes, my friend, mentor, and kindred spirit. Thank you for everything. Knowing you has changed my life and I am forever grateful.

To all the educators I have encountered throughout my journey— from Oakman Elementary, to Haynes Academy, to XULA, to Auburn— thank you for helping to foster my intellect, in both big and small ways. I would not be here without you all.

To my Muslim sisters—thank you for trusting me with your experiences in taking my survey, thank you for supporting me in sharing my survey, and thank you for being a constant source of light in my life. In the many cities I've lived, I've never found more comfort than in the smile of another muslimah. I hope you see yourself in this work.

Finally, because everything begins and ends with Him, I end this note with another note of gratitude for Allah (swt). Words of simple thanks don't feel enough, but they are all I have.

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I: INTRODUCTION

Background

As one of the most prominent religions in the world, Islam represents a diverse, multifaceted group of individuals, who somehow straddle the contradiction of being both a highly visible group yet remaining unseen. In the Western world, Muslims embody a cultural deviation from the religious norm that is widely observed by the majority Judeo-Christian populations (Mirza, 2013). Coupled with the widespread stereotypes of Muslims as violent, extremist terrorists that dominate Euro-American narratives, Muslims remain a visibly distinct religious group in the West, including the United States (Hopkins, 2016; Jamal, 2017; Kunst et al., 2012). However, despite their visibility, Muslim narratives beyond the overgeneralization of terrorism remain unseen and unheard by the majority of non-Muslim Americans. Muslim women sit at the crux of this paradox, as they navigate the intersectionality of marginalized religious and gender identities. In general, women face many barriers due to the overwhelming sexism and misogyny that is present in almost all aspects of society (Hayes & Colin, 1994; SteelFisher et al., 2019). However, Muslim women's experiences of gender inequality are inextricably linked to their experiences as religious minorities, creating unique experiences that cannot be accounted for by all women.

With multiple marginalized identities, Muslim women exist in a unique context that is largely misunderstood by Western perspectives. Perceptions of Muslim women in the West are understood through the lens of violence and terrorism, as they are for Muslim men, but the narratives regarding women are also centered on their oppression, in which they are seen as passive products of a violent religion, an ideology that is consistently reinforced through mainstream American culture (Shirazi & Mishra, 2010; Westfall et al., 2016). While Islam is a

patriarchal religion and Muslim women often occupy heteronormative gender roles as dictated by Islam, what is often overlooked by Western discourses is the flexibility and diversity of those roles (Allen, 2015). In Islam, women have autonomy over their bodies, income, wealth, property, employment, as well as their choice to marry, divorce, have children, and engage in religious practices (Ali, 2004). Despite this, the paternalistic perceptions of Muslim women rooted in Christian-American colonialism persist, in which Muslim women are simultaneously perceived as symbols of terrorism while also being submissive victims of a violent religion.

At the center of this conversation are Muslim women who observe the hijab. Hijab is a spiritual concept of modesty that is imposed on both men and women in Islam and encompasses spiritual, behavioral, and physical manifestations (Droogsma, 2007; Gurbuz & Gurbuz-Kucuksari, 2009; Wadud, 2006). The physical component for women involves the covering of their bodies in modest clothing, including a physical hijab (or scarf) covering their hair in public spaces. While wearing hijab is an obligation in Islam, the religion also prohibits compulsion in faith, meaning that even though a woman who does not observe the physical aspect of Hijab is engaging in sinful behavior, forcing said woman into observing hijab is prohibited (Ali, 2004). This is often overlooked due to many cultural practices around the world in which Muslim and non-Muslim women living in Muslim-majority cultures are forced to wear hijab, creating a misperception that Islam does not grant women autonomy over their bodies (Rehman & Dziegielewski, 2003). This ideology is propagated heavily in non-Muslim Western discourses across mass media, entertainment, politics, education and academia (Afshar & Franks, 2005; Ahmed, 1992; Hopkins, 2016). This biased, one-dimensional approach to understanding Muslim women becomes especially dangerous since this ideology provides the foundation for discrimination against Muslim women.

Discrimination against Muslims in the West has been prevalent for decades and has been increasing consistently since the terrorist attacks of 9/11 (Abu-Ras et al., 2018; Abu-Raiya et al., 2011; Allen, 2015; Chakraborti & Zempi, 2012; Ernst, 2013; Kulwicki et al., 2008; Nadal et al., 1999). Since the perpetrators of these attacks identified as Muslim, non-Muslim Americans have come to associate the population with violence and extremism, resulting in a combination of fear and hatred of Islam and its followers, which has been characterized by scholars as Islamophobia (Kunst, Tajamal, Sam, & Ulleberg, 2012). Often, discrimination that Muslims face due to their religious identity is rooted in Islamophobia, which can be understood as a form of cultural racism towards people from this particular social group (Haque et al., 2019; Kunst et al., 2012). Many non-Muslims do not have accurate information about the religion or its followers; yet vehemently oppose it and hold strong negative perceptions about its followers, partly due to misconceptions of violence and partly due to the religion's distinct otherness, which poses a threat to cultural norms (Awad, 2010). Islamophobia can be expressed in various forms, ranging from subtle microaggressions or verbal abuse to acts of violence against Muslim individuals. This also extends to non-Muslims that can be misidentified as Muslim due to their appearance or dress (e.g. Sikh men who wear turbans; Ahluwalia & Pellettiere, 2010).

Muslim women are especially vulnerable to discrimination, as they inhabit multiple marginalized identities and are subject to discrimination rooted in misogyny and Islamophobia. In general, women in the U.S. are more susceptible to gender-based discrimination, which ranges from verbal harassment and differential treatment to physical assault (Abu-Raiya et al., 2011; Awad, 2010; Moradi & Hasan, 2004; Derous & Ryan, 2009; Widner & Chicoine, 2011). Gender-based discrimination is present in almost all areas of society including the workplace, economy, education, health and politics. Muslim women's experiences of gender-

based discrimination are further complicated by the presence of Islamophobia. In particular, women that wear the hijab are often targets of discrimination due to the visibility of their religious identity (Chakraborti & Zempi, 2012; Terman, 2017). Muslim women have reported experiencing discrimination in their lives on a daily basis, which most commonly involves unpleasant looks, disapproval, being made to feel unwelcome in a place, and negative remarks (Kloek, Peters, & Sijtsma, 2013). Muslim women that wear the hijab also report having been harassed, fired from jobs, denied access to public spaces, and otherwise discriminated against because they wear hijab (ACLU, 2008). Discrimination can have many damaging effects on victims, including economic, physical, and mental impacts (Cassidy et al., 2004; Clark et al., 1999; Derous & Ryan, 2009; Gee et al., 2007; Noh et al., 2007). Of particular interest is the impact of religious discrimination on Muslim mental health. Discrimination among minority groups in general is associated with various mental health concerns, including increased depression and anxiety, with victims of Islamophobia being more likely to experience decreases in their self-worth, confidence, and feelings of security compared to victims of non-discriminatory related crimes (Benner et al., 2018; Chakraborti & Zempi, 2012; Isaksson et al., 2018; Smith-Bynum et al., 2014).

The relationship between experiences of discrimination and psychological distress has been well documented for a plethora of marginalized groups in the United States (Bierman, 2006; Cassidy et al., 2004; Fischer & Holz, 2007; Noh et al., 1999; Noh et al., 2007). Psychological distress is often primarily characterized by symptoms of depression and anxiety, which are two of the most common mental health disorders in the United States (American Psychiatric Association, 2013). Disparities exist among minority groups in their experiences of psychological distress (Williams et al., 2007; Woodward et al., 2013). For example, racial-ethnic

minorities are at higher risk for developing chronic depression and anxiety, while also being less likely to seek treatment and less likely to complete treatment, compared to White populations (Bailey et al., 2019; Hines, 2017; Shim et al., 2012; Stockdale et al., 2008). Additionally, many minority individuals are often misdiagnosed, increasing the prevalence of disparities (Stockdale et al., 2008). Discrimination has been shown to be a significant risk factor for causing distress and increasing the likelihood of developing symptoms of depression and anxiety among marginalized populations (Paradies, 2006; Rousseau et al., 2011; Thoits, 2010; Todorova et al., 2010). Emerging research in this area focusing on Muslim individuals has shown that Muslims are at a high risk for developing adverse psychological symptoms, compared to the national average, with discrimination being strongly correlated with poor psychological and physiological outcomes within this population (Gee, 2002; Lee & Ferraro, 2009; Moradi & Hasan, 2004; Nadal et al., 2012; Todorova et al., 2010; Williams, Neighbors, & Jackson, 2003). Muslim women experience a heightened vulnerability to experiencing such negative outcomes due to the inequities they face on multiple fronts. Compared to Muslim men, women face significantly higher levels of oppression (Abu-Ras et al., 2018). Muslim women who have experienced discrimination report lower quality of life, experience more anxiety in public places due to racial profiling, and are more negatively affected by discriminatory experiences compared to Muslim men (Abu-Ras et al., 2018; Hassouneh, 2017).

While religious identity is often the source of discrimination and inequity for many Muslim women, religiosity has been positively associated with psychological wellness (Moreira-Almeida, Neto, & Koenig, 2006; Wong, Rew, & Slaikeu, 2006). Research has shown that religiosity can serve a protective role to help buffer the impact of discrimination among minority groups (Ai et al., 2013; Bierman, 2006; Hayward & Krause, 2015). While research in this area

focusing on Muslims is scarce, existing studies have begun to establish an association between strong religiosity and better mental health outcomes among Muslim populations (Aflakseir, 2012; Bierman, 2006; Hashemi et al., 2019; Wink, Dillon, & Larsen, 2005). A strong sense of religiosity can provide individuals with a sense of significance, positive emotions, increased self-esteem, sense of meaning, purpose in life, and a sense of belongingness among fellow members of the religious community (Aflakseir, 2012; Chan et al., 2015; Davis et al., 2016; Hashemi et al., 2019). However, new research has emerged that contradicts this explanation of the role of religiosity as it relates to Muslim people's experiences of psychological distress (Ikizler & Szymanski, 2018). Essentially, this perspective suggests that having a strong religious identity is more likely to intensify the distressing impact of discrimination among Muslims, since the inequity is based upon their religious identity (Ikizler & Szymanski, 2018). Other marginalized populations, such as racial-ethnic minorities, who have an increased sense of religiosity often find refuge from chronic discrimination in their beliefs, however it's important to note that many of these individuals identify as Christians or Catholics, the majority religion in the United States. Therefore, it's possible that Muslims may not experience a similar refuge in their beliefs, since their religiosity is the primary target of prejudice and harassment.

Purpose

The existing literature illustrates the complexity of Muslim women's experiences in the U.S. that is often overlooked by mainstream narratives. In particular, research has illuminated the damaging effects of religious discrimination, which may be a significant risk factor for psychological distress among this population. However the role of religiosity among this population has yet to receive sufficient attention since the scarce research in the area illustrates contradictory viewpoints. On one hand, some scholars suggest that religiosity among Muslims

works as a protective factor against the damaging effects of discrimination, as it does for many minority groups. On the other hand, some emerging research suggests that high religiosity among Muslims may increase their vulnerability to the negative impacts of discrimination, due to their religion being the main focus of acts of discrimination.

The purpose of this study was to clarify the relationship between discrimination and psychological distress, specifically among Muslim women and explore what role religiosity plays in this relationship, if any. This study first examined whether there was a significant association between experiences of religious discrimination and psychological distress among Muslim women and attempted to clarify the direction of the relationship. This research also examined the role of religiosity in the relationship between religious discrimination and psychological distress among Muslim women. While existing research demonstrates contradictory standpoints on how religiosity impacts this relationship, there is agreement that religiosity has an effect. In other words, the level to which an individual adheres to religious values and practices may determine the way in which experiences of discrimination contribute to the development of psychological distress.

Significance of Research

This research has expanded the literature on Muslim women that takes into account their intersectional identities and examines their experiences through a decolonized lens. In particular, this research has increased the understanding of Muslim women's experiences with discrimination, psychological distress, and their religiosity, and the ways in which these constructs are related to each other. Exploration of these relationships helps to create a more accurate and nuanced understanding of narratives regarding Muslim women and sheds light on inconsistencies found in previous research relating to religiosity. Results of this study help to

inform theory on how religiosity operates within this population and present important implications for mental health practitioners that work with Muslim women. In particular, clarifying the role of religiosity in the relationship between discrimination and distress assists counselors in having a better understanding of Muslim women's experiences and how to best provide culturally-competent treatment. This is especially important given the research outlining the cultural mistrust of Western mental health providers among Muslim populations, resulting in a hesitancy to seek mental health treatment (Amri & Bemak, 2012).

Another noteworthy element of this study is the clear usage and measurement of religious identity, especially given the tendency for research on Muslim populations to confound religious identity with ethnic identity. An especially salient example of this is the Perceived Religious Discrimination Scale (PRDS), which was designed to assess discriminatory experiences specifically in Muslim populations (Rippy & Newman, 2007). The measure includes various items that use religious and ethnic identities interchangeably, such as: ''Has a wounded Iraqi or Afghani woman or child reminded you of a relative or friend?'' and ''Do you have a stronger association with other Muslims/Arabs?'' Research that fails to clarify the differences between religious and ethnic identities contributes to the erasure of the diverse ethnic groups that comprise the global Muslim population.

Research Questions

This study examined the following questions:

1. Is the experience of religious discrimination for Muslim women in the United States related to psychological distress?
2. Does religiosity moderate the impact of religious discrimination on psychological distress?

Research Hypotheses

This study examined the following hypotheses:

a. Experiences of religious discrimination will be positively related to psychological distress among Muslim women in the United States.

2. Religiosity will moderate the impact of religious discrimination on psychological distress among Muslim women.

2a. As religiosity increases, the strength of the relationship between religious discrimination and psychological distress will decrease.

2b. As religiosity decreases, the strength of the relationship between religious discrimination and psychological distress will increase.

Operational Definitions and Terms

Definitions of key terms used throughout this dissertation are provided below:

Anxiety: The experience of at least one or more anxious symptoms such as excessive worrying, feelings of panic, avoidance of social situations, and/or difficulties with concentration that have an impact on an individual's daily activities. Measured by higher scores on the Anxiety scale of the DASS-21.

Depression: The experience of at least one or more depressive symptoms such as hopelessness, feelings of sadness, loss of interest in activities once enjoyed, and/or lack of motivation that have an impact on an individual's daily activities. Measured by higher scores on the Depression scale of the DASS-21.

Discrimination: The experience of being treated unjustly due to an individual's membership to a particular minority group, as measured by higher scores on the RDS (Kawika Allen et al., 2018).

Hijab: The responsibility of modesty imposed on Muslim men and women that manifests spiritually, behaviorally, and physically.

hijab: The physical manifestation of Hijab among Muslim women that involves modest clothing and the covering of their hair. 'hijab' may refer only to the physical headscarf women wear or collectively to both the headscarf and general modest clothing.

Islam: One of the major Abrahamic monotheistic religions in the world. Islam is the religion established by the Prophet Mohammed (pbuh), who delivered the final message of Allah (swt).

Islamophobia: The unfounded fear and hatred of Islam and Muslims as a social group (Kunst et al., 2012).

Muslim: An individual that adheres to the teachings of Islam.

Psychological distress: The simultaneous experience of both depressive and anxious symptoms, as measured by higher scores on the DASS-21.

Religiosity: The extent to which a member of a religious group commits to religious values, beliefs, and practices and applies them in their daily living, as measured by higher scores on the RCI-10.

CHAPTER II: LITERATURE REVIEW

There is a growing body of research on Islam and its followers, in large part due to the increasing visibility of Muslims in the West after the events of September 11, 2001. Many published works include a focus on the discrimination Muslim individuals face known as Islamophobia (e.g. see Allen, 2015; Hopkins, 2016; Jamal, 2017; Kunst et al., 2012; McGinty, 2018; Sadek, 2017; Terman, 2017). Muslim women in particular, have recently become a focus of these studies due to their religious identity being overt through the use of the hijab. While these previous studies offer valuable insight into Islamophobia and its impact on Muslims, including social and psychological effects, they only provide partial insight into the specific role religious identity plays in the daily lives of such individuals. A limited body of research exists regarding how Muslim women's religious identity relates to their psychological outcomes in the face of discrimination.

The goal of this literature review is to provide background on Islam, the role of women in Islam and how they are perceived in the West. A summary regarding Muslim women's experiences with discrimination will also be provided, along with an overview of literature regarding psychological distress and mental health outcomes, specifically pertaining to Muslim Americans. Finally, as this study seeks to develop an understanding of religiosity as it pertains to Muslim women's mental health, a discussion on religious identity is included.

Islam

Islam is the fastest growing religion in the world with about 1.9 billion followers worldwide, approximately 24% of the world's population (Pew Research Center, 2017a). Given the large presence of Muslims around the world, there is a need for researchers and practitioners alike to incorporate a broader and more comprehensive understanding of the

Islamic faith and its followers. However, a lack of understanding and exploration of issues pertaining to this population continues, creating greater obstacles for Muslims in general, especially those facing mental health issues. The scarcity of research on Muslim Americans works to further stigmatize, oppress, and overlook the needs of this population, which is especially damaging given cultural mistrust of Western mental health treatments and providers, which increases the already existing barriers to mental health care among Muslim populations (Amri & Bemak, 2012). This is especially relevant for Muslim women, who are more likely to need mental health services but less likely to seek them due to perceptions of lack of quality and culturally competent care (Amri & Bemak, 2012). Muslim women are positioned at the center of multiple identities that interact with each other in various ways, creating a unique experience that cannot be understood through a Euro-centric perspective (Mirza, 2013). An understanding of the Muslim faith is necessary in order to begin exploring the experiences of Muslim American women, especially given the lack of knowledge regarding Islam in majority non-Muslim American populations.

Women in Islam

Islam plays a significant role in the daily lives and decision-making of Muslim women (Ali et al., 2008). A woman's role is delineated by Islam through the Qur'ān, which has had significant implications on women's involvement in society (Wadud, 2006). However, in order to understand the implications of the Qur'ān as it applies today, one must understand its implications during the time it was implemented. When the Qur'ān was first revealed, it ended many widespread practices in seventh-century Arabia that disproportionately harmed women and girls (Ahmed, 1992). It was the first religion in the world to legally mandate that women be granted rights as independent individuals (Ali, 2004). The Qur'ān also outlawed

female infanticide (a practice that had been common at the time) and allowed women to refuse marriage proposals, manage their dowries, and seek divorce (Ali, 2004). Additionally, men and women were entitled to identical property ownership rights, women were permitted to inherit property, and women could deny men's attempts to control their finances (Wadud, 2006). As a result of their enhanced rights, women ascended to significant and powerful positions in early Muslim society. During Prophet Mohammed's life, women held noteworthy positions in a variety of influential arenas, including religion, politics, education, law, economics, and the military (Ali, 2004). For context, Prophet Mohammed (pbuh) is understood to be the messenger of Allah (swt; denotes Arabic word for God) who delivered His final message to the people through the Qur'ān (the Holy book that is considered the word of Allah) and established the religion of Islam. The Prophet's wife, daughter, and other women in his household actively helped him establish the religion and he reportedly sought his wife's counsel on various issues (Nadwi, 2013).

Gender Roles in Islam

Gender roles are a significant concept in Islam as dictated by the Qur'ān, which indicates that both men and women are spiritual equals under God and should receive equal punishment for wrongdoings and equal rewards for their faith (Ahmed, 1992). However, their social roles are not viewed in the same manner. Islam's basic view of men and women proposes a complementarity of functions: like everything else in the universe, humanity was created in a pair and neither can be complete without the other (Qur'ān, 51:49). The emphasis that Islam places upon the dichotomy of femininity and masculinity results in a separation of social functions that is evident across almost all Muslim societies worldwide. The separation of gender in Islam follows the patriarchal view of gender roles, in which a Muslim woman's sphere of

operation is in the home, while a man's corresponding sphere is in the outside world (Ahmed, 1992). The Qur'ān states that men are the guardians of women, and therefore responsible for providing for the family and female relatives (Qur'ān). Women, however, are also given autonomy over their own income and property, given that their autonomy is exercised in accordance with Islamic principles (e.g. giving obligatory charity each year, not spending money in a wasteful manner, as well as refraining from using their income to engage in sinful behavior). Additionally, the distinction in gender roles between home/family and the outside world is not as rigid as it may appear (Ali, 2014). Many Muslim women, both in the early history of Islam and in the modern world, have inhabited prominent roles in the public sphere, including being queens, elected heads of state, wealthy businesswomen, and working professionals (Nadwi, 2013). Muslim women's perceptions of gender roles in Islam are also often congruent with the notion of different but equal, supporting a complementary view in which men and women occupy different roles but are still regarded equally (Ali et al., 2008). One important aspect of a woman's role in Islam is to observe the Hijab, a construct that is inextricably linked with the gender roles that have been ascribed to Muslim women, through both their religious and cultural practices.

Hijab

Hijab is a multi-faceted expression of personal identity, including religious identity, gender identity, and moral/cultural identities (Droogsma, 2007; Gurbuz & Gurbuz-Kucuksari, 2009). Muslim women are often easily identifiable due to their overt display of religious identity with the use of the physical hijab. The hijab is a tangible symbol of Islam that includes the veil that Muslim women wear to cover their hair as well as the modest clothing that covers all other body parts outside of the hands and feet. In order to fully understand the meaning and

significance of the hijab, one must examine the construct in both religious and cultural contexts. In the Muslim religion, both men and women are compelled to observed Hijab (Wadud, 2006). In this context, Hijab refers to the expression of modesty, through one's dress as well as one's behaviors. For example, in the Qur'ān, men and women are required to "lower their gaze" when interacting with the other gender in society, as a show of modesty and respect—behavior that constitutes one's Hijab (Baffoun, 1994). Additionally, both men and women are also required to dress modestly. For women, this includes concealing all parts of the body modestly, except for one's face, hands, and feet. In most modern societies however, the concept of Hijab is seen solely as the physical headscarf that a Muslim woman wears, without consideration for the behavioral or spiritual aspects (Westfall et al., 2016). While Hijab is a much more complex and nuanced concept beyond the physical headscarf women wear around their head, for the purpose of clarity and continuity in relation to existing literature, the word "hijab" in this dissertation will be used to specifically denote the headdress and overall modest clothing that Muslim women wear, as outlined by Islamic principles.

Muslim women who wear the hijab report that it offers them a sense of respect, dignity, and control over who has access to their physical body, which relates to feelings of security, self-confidence, and empowerment (Al Wazni, 2015; Alghafli et al., 2017; Ali, 2005). The hijab also serves as an important identifier especially for members of the Muslim community that may be perceived as outsiders, such as Euro-American women (Droogsma, 2007). Muslim women's choice to wear the hijab often stems from a desire to express and actively appreciate their religious identity (Ali, 2005; Droogsma, 2007; Haddad, 2007; van Es, 2019; Williams & Vashi, 2007). In doing so, this requires some women to explain the hijab to others who encounter them, leading the women to educate others about the hijab and combat stigma and stereotypes. Muslim

women have reported that this process has allowed them to learn more about Islam, transforming their religious identity from an ascribed to an achieved membership (Droogsma, 2007; Gurbuz & Gurbuz-Kucuksari, 2009).

Muslim women also view the hijab as a symbol of protection and freedom in patriarchal societies (Alghafli et al., 2017). Research has consistently documented that a majority of Muslim women who choose to wear the hijab often believe that it protects them from sexual objectification, with some identifying this protection as one of the primary reasons for wearing it (Al Wazni, 2015; Alghafli et al., 2017; Ali et al., 2008; Chapman, 2016; Droogsma, 2007; Tolaymat & Moradi, 2011; Williams & Vashi, 2007). Muslim women believe that this protection affords them the freedom to engage in society freely, without fear of gender-based harassment (Alghafli, 2017). However, it's important to note that many Muslim women do not observe the physical aspect of Hijab, which includes not covering their hair and/or forgoing modesty in their public dress. Much like for women that choose to wear the hijab, there are many reasons as to why Muslim women choose not to wear the hijab. For some Muslim women, wearing the hijab can be burdensome and even dangerous, with many women citing experiences of marginalization, harassment, and violence due to their physical appearance when they wear the hijab (Ghumman & Ryan, 2013). Muslim women have also reported that they do not wear the hijab to avoid becoming tokenized by peers and colleagues and to better acculturate into Western society (Al-Kazi & González, 2018). Additionally, some Muslim women report that they decide to not wear the hijab because they do not internalize it as a necessary part of their religious identity (Legate et al., 2020).

In the U.S. the amount of women that do not wear the hijab is relatively close to those that do not, with 38% of Muslim women reporting wearing the hijab all the time, 42% reporting

never wearing it, and the remaining 20% indicating that they sometimes wear it (Pew Research Center, 2017a). Compared to women that do not wear the hijab, Muslim women that wear the hijab report significantly lower levels of sexual objectification experiences (Tolaymat & Moradi, 2011). Additionally, wearing the hijab has been linked to lower rates of self-objectification, body surveillance, body shame, and eating disorder symptoms (Durovic et al., 2016; Tolaymat & Moradi, 2011). However, while Muslim women who wear the hijab are likely to report low levels of sexual objectification, they often experience high levels of stigma as a result of wearing hijab (Chapman, 2016; Hassouneh & Kulwicki, 2007). Such stigma often stems from the Western notion that Muslim women who wear the hijab are oppressed.

Muslim Women in the West

The perception that Muslim women, especially those that wear the hijab, are oppressed is a widespread ideology seen throughout the West (Shirazi & Mishra, 2010; Westfall et al., 2016). Most commonly, this ideology is reinforced through mainstream pop culture; Muslim women are portrayed as being completely subjugated by men, and the hijab is seen as a symbol of such oppression (Afshar & Franks, 2005). This image is often perpetuated through the mass media, politics, and the entertainment industry, which all work to reproduce images of Muslim women based on such negative stereotypes. This view of Muslim women is also frequently perpetuated by some Western feminists who argue that Islam, as a patriarchal religion works to subordinate women (Ahmed, 1992; Hopkins, 2016). This understanding of Muslim women is rooted in the perception that women who cover are oppressed and need liberation. Further, there is a widely held belief among Westerners that Muslim women cover because men force them to do so (Rehman & Dziegielewski, 2003). Collectively, Westerners tend to value individual freedoms, with feminists specifically focusing on a woman's ability to take control of her own

life without being subject to a man's authority. Thus, there is an inherent tension between Western feminism/Western perceptions of hijab and Muslim women who wear hijab. However, there has been an increase in criticism of such homogenous perspectives that discursively colonize non-Western women as the collective "Other" (Mahmood, 2005; Mernissi, 1993; Mohanty 2006; Mohanty et al., 1991). The universal categorization of a large group of women in or originating from non-Western countries and cultures is keen to label them as "poor, uneducated, tradition-bound, and victimized," while overlooking the complexity, diversity, and multiplicity of women in the non-Western world (Mohanty et al., 1991). This over-generalization of women damages the solidarity and unity among women, and also stratifies them into two opposite groups: Western women, who are universally liberated, enjoy equality, have control over their own bodies and sexuality, who are also superior, intelligent, and educated, versus the group categorized as "Third World women," who are universally uneducated, victimized, sexually battered, and therefore in need of some sort of salvation (Mahmood, 2001; Mernissi, 1975). This implicit categorization implies asymmetries of power that sets Western feminism as the gatekeeper of knowledge through texts and language concerning the Third World women, who are oppressed victims. In order to understand the complexity of women's identities in the non-Western world, Western perspectives of such populations must be de-constructed and examined from a lens that properly roots women's experiences within their culture. Therefore, Muslim women's identities must be properly contextualized within both the culture and religion in order to achieve a holistic and nuanced understanding of their experiences.

Contrary to the Western stereotype that the hijab is an oppressive mechanism that controls women's bodies, many Muslim women believe it is a tool that allows them to operate in

public spaces without the oppression of the male gaze (Gurbuz & Gurbuz-Kucuksari, 2009). American Muslim women have reported that wearing the hijab allows them liberation in expressing their gender identity (Ali, 2005). Additionally, compared to Christian women, Muslim women are more likely to identify themselves as feminists and report that their religion supports feminist principles, presenting a challenge to the mass-marketed images perpetuated by Western feminists (Al Wazni, 2015; Ali et al., 2008). However, despite the empowerment and freedom reportedly afforded by Islam and the hijab, Muslim women also report experiences of oppression within their communities, however they make the important distinction that culture often oppresses the rights of women under the guise of religion, despite its contradiction to religious teachings (Ali et al., 2008). For example, countries such as Saudi Arabia have passed some of the most restrictive laws in the world related to women, minimizing their rights in public and private sectors, with Islam used as justification for such regulations (Yee, 2020). In Saudi Arabia, women are required to have a male guardian's permission to acquire a passport, to travel, to marry, to work, and to receive healthcare. Women in Saudi Arabia could not legally vote until 2015 or drive cars until 2018. Additionally, all women are legally required to wear the hijab, regardless of their personal religious identity (Yee, 2020). These laws are often portrayed as following the teachings of Islam, however, it's important to note that such laws are more indicative of the culture, which is often contradictory to the laws and teachings of Islam, a distinction that is often lost in translation in the West (Abu-Lughod, 2002).

While it's impossible to fully explore the impact of Islam on women's rights independently of external cultural influence, not all Muslim women are categorically repressed, as Muslim women in various cultural contexts are empowered and active in society (e.g., see Al Wazni, 2015; Hertz- Lazarowitz). In the United States, Muslim women are among one of the

most highly educated female religious groups and are more likely to work in professional fields compared to women with other religious identities (Pew Research Center, 2016). Additionally, Muslim women have the highest degree of economic gender parity of any religious group in the United States (Younis, 2019). Since Muslim-majority countries are generally located in the Middle East, Western discourse often focuses on this area and Muslim women's successes in other places are generally overlooked. Anti-Islamic sentiment is especially strong in modern society after more than a decade of terrorist attacks planned and implemented by Islamic extremists (Budhwani & Herald, 2017). Westerners' fear of Islamic extremists has transformed and generalized into resentment and antagonism toward Muslims overall, as a general lack of knowledge regarding the basic tenants of Islam and sharia has created the commonly accepted stereotype that Muslims are terrorists or somehow related to terrorist activity (Westfall et al., 2016). Because women who wear hijab are easily identifiable as Muslims, they typically face increased discrimination including harassment, aggression, and violence (Alimahomed-Wilson, 2017; Perry, 2014)

Religious Discrimination

Discrimination is a long-studied construct that refers to beliefs, attitudes, institutional arrangements and acts that tend to denigrate or deny equal treatment to individuals or groups based on their group membership (Clark, Anderson, Clark, & Williams, 1999). Discrimination of minority groups presents a critical social justice and public health problem in light of the mounting evidence on the detrimental impact of discrimination on the mental and physical health of individuals from stigmatized groups, including ethnic/racial and religious minorities (Benner et al., 2018; Chang et al., 2019; Gilbert & Zemore, 2016; Pascoe & Smart Richman, 2009; Schmitt, Branscombe, Postmes, & Garcia, 2014). Individuals that identify as religious minorities

often face discrimination at levels comparable to racial/ethnic minorities, with similar outcomes (Haque et al., 2019). In particular, Muslims have experienced a significant increase in discrimination over the past two decades (Abu-Ras et al., 2018; Abu-Raiya et al., 2011; Allen, 2015; Chakraborti & Zempi, 2012; Ernst, 2013; Kulwicki et al., 2008; Nadal et al., 1999).

Islamophobia

Research and public discourse regarding religious discrimination toward Muslim individuals has increased significantly in the past two decades since the attacks against the United States on September 11, 2001 (9/11; Abu-Raiya, Pargament, & Mahoney, 2011; Ernst, 2013; Kulwicki, Khalifa, & Moore, 2008). The term 'Islamophobia' is used to denote the unfounded fear and hatred of Islam and its followers as a social group (Kunst, Tajamal, Sam, & Ulleberg, 2012). Islamophobia can be understood through the lens of cultural racism, in which the fear or hatred towards Muslims often translates into ideological and physical manifestations of cultural racism against perceived symbols of 'Muslimness', such as clothing. For example, individuals of the Sikh religion that wear turbans have reported experiences of hate crimes due to being misidentified as Muslim because of their dress (Ahluwalia & Pellettiere, 2010). Muslims face a multitude of negative stereotypes that illustrate them as being terrorists and un- or anti-American (Awad, 2010).

Various studies have documented the rise of Islamophobia, particularly in Western societies and media since the events of 9/11 (Kunst et al., 2012; Mason-Bish & Zempi, 2018). Muslims have reported experiencing discrimination and harassment in various forms including verbal abuse, special security checks, assumptions of being violent or dangerous, assumptions of being foreign born, hiring discrimination, and physical attacks (Abu-Raiya et al., 2011; Awad, 2010; Moradi & Hasan, 2004; Derous & Ryan, 2009; Widner & Chicoine,

2011). Recently, the Pew Research Center reported that assaults against Muslims in the United States have been on the rise, surpassing the number of assaults reported in 2001 after 9/11 (2017b). Some theoretical and empirical literature suggest that possible explanations for the increased levels of discrimination toward Muslims is a result of increased prejudiced attitudes in the United States toward Muslims (Haque et al., 2019; Keddie, 2018; Liepyte & McAloney-Kocaman, 2015). While anti-Muslim rhetoric has existed for decades since 9/11, this recent spike in anti-Muslim discrimination can be directly associated with the prejudicial statements and actions of the 45th president of the United States, who during his tenure, has made frequent use of anti-Muslim rhetoric, appointed members who have espoused anti-Muslim views to key cabinet positions, and signed an executive order banning people from Muslim-majority countries from entering the United States (Hopkins, 2016; Jamal, 2017).

An important factor to consider when understanding incidents of Islamophobia is the visible markers of Islam, such as the hijab. For example, studies have indicated that Muslims believe that their appearance increases their vulnerability to harassment and discrimination (Abu-Raiya et al., 2011). Additionally, research has also shown that non-Muslim individuals that appear Muslim (e.g. Sikh men who wear turbans) have experienced an increase in discrimination after 9/11, due to misidentification of their religious identity based on their appearance (Ahluwalia & Pellettiere, 2010). This poses a more serious threat for Muslim women, as they are more likely to be identified as Muslim based on their appearance, due to the practice of wearing hijab.

Gendered Islamophobia

In general, women in the United States experience widespread discrimination and harassment on systemic, institutional, and interpersonal levels that has existed for decades and continue to persist (Hayes & Colin, 1994; SteelFisher et al., 2019). These systems of sexism and misogyny are embedded in all social structures; so Muslim women's experiences of Islamophobia are uniquely distinct from those of men. Additionally, due to the overt nature of Muslim women's religious identity with the hijab, Muslim women face Islamophobia at disproportionately higher rates compared to Muslim men (Terman, 2017). The hijab is viewed as the most prominent symbol of Islam and its 'otherness', making Muslim women who wear it particularly vulnerable to discrimination, which is justified by perpetrators based on their visible religious identity (Chakraborti & Zempi, 2012). However, despite the highly visible role that Muslim women who wear the hijab play as overt representatives of Islam, the process of victimization Muslim women experience due to Islamophobia often goes unnoticed and unaddressed in society (Allen, 2015; Chakraborti & Zempi, 2012). In a span of 6 years (2000-2006), there was a reported 674% increase in the number of civil rights complaints filed by Muslim women who claimed they were harassed for their religious identity (ACLU, 2008).

Muslim women report experiencing discrimination in their lives almost daily, with the most common experiences typically including unpleasant looks, disapproval, being made to feel unwelcome in a public place, and negative remarks (Kloek, Peters, & Sijtsma, 2013). Muslim women also often face discrimination in the workplace, including being excluded from opportunities for advancement, facing negative stereotypes, and hearing negative comments based on their religion (Tariq & Syed, 2018). When applying for jobs, women who wear the hijab are less likely to receive permission to complete a job application or to receive job callbacks, and more likely to experience interpersonal discrimination, compared to women

without the hijab (Guhmman & Ryan, 2013). According to the American Civil Liberties Union (ACLU), Muslim women in the United States have been harassed, fired from jobs, denied access to public spaces, and otherwise discriminated against because they wear hijab (2008). Muslim women have been denied the right to wear the hijab in various occupations and have been fired for refusing to remove their hijab (ACLU, 2008; Ali et al., 2015). Additionally, Muslim women have been denied the right to wear hijab while in jail and courthouse detention, while visiting family members in correctional institutions, while working in correctional institutions, and while attending school and participating in extracurricular activities (ACLU, 2008). While some Muslim women directly identify their hijab as a source of empowerment, many others have also experienced oppression and discrimination as a result of negative stereotypes attached to the hijab (Al Wazni, 2015). As a result, Muslim women in the United States report experiencing less freedom to express their religious identity and taking steps to hide religious identity post-9/11 than Christian women in the United States (Ali et al., 2008).

Impact of Discrimination

Discrimination has wide spreading effects, most of which are detrimental to its victims. A majority of the existing literature that has explored the impact of discrimination details various effects ranging from financial to physiological as well as psychological (Cassidy et al., 2004; Clark et al., 1999; Derous & Ryan, 2009; Gee et al., 2007; Noh et al., 2007). Economic disadvantage is one of the most glaring indicators of the impact of discrimination. Racial-ethnic minorities are more likely to experience poverty compared to White populations in the United States, with the unemployment rate for African Americans consistently being much higher than the rate for White people in the past several decades (Marte, 2020). Additionally, racial ethnic minorities earn less than White workers for the same position, and such wage gaps have persisted

for decades (Sayler, 2016). These trends are evident amongst women in the United States, who also experience a significant wage gap compared to White men, with the gap significantly increasing for women holding multiple marginalized identities, such as women of color (Chapman & Benis, 2017).

Beyond the blatant financial injustices resulting from deep-rooted prejudice and discrimination, subtle discriminatory practices also have lasting economic impacts on marginalized populations. A prominent example of this is evident in discriminatory hiring practices that are rampant across the U.S. Research has shown that employers are more likely to be biased against racial-ethnic minorities in hiring decisions, including African Americans and Arab Americans (Derous et al., 2012; Stewart & Perlow, 2001). For example, employers were more likely to hire a Black applicant for a low status job versus a White applicant, even when both applicants demonstrated the same qualifications (Stewart & Perlow, 2001). The opposite effect was discovered when considering applicants for a high status job, in which a White applicant was more likely to be hired over a Black applicant with the same qualifications. The same effect was found when examining this relationship among Arab applicants versus White applicants (Derous et al., 2012). These findings demonstrate the subtle ways in which discrimination occurs in everyday practice, working to systematically oppress minority groups across the United States.

The relationship between discrimination and physical health issues has been long established, with discrimination being identified as a major public health issue by many scholars (DeLilly & Flaskerud, 2012; Pascoe & Smart Richman, 2009; Williams et al., 2019). Discrimination has been linked to various diseases such as heart disease, hypertension, breast cancer, and high blood pressure across numerous marginalized groups (Brondolo et al., 2008;

Steffen et al., 2003; Williams & Mohammed, 2009). Research also indicates that repeated exposure to discrimination may have long term effects on the body, in which individuals are in a continuous state of preparation for traumatic experiences of discrimination, which places a strain on their body's resources and makes them more susceptible to physical illness (Gee et al., 2007). Additionally, discriminatory experiences have also been shown to negatively impact health behaviors, in which individuals that are exposed to bigotry are often left with less energy or resources to engage in healthy behaviors (Inzlicht et al., 2006).

Perceptions of discrimination among minority groups in general are also strongly associated with various mental health concerns, including increased anxiety, depression, and withdrawal from social interactions (Benner et al., 2018; Isaksson et al., 2018; Smith-Bynum et al., 2014). There is a robust literature demonstrating the relationship between perceived discrimination and negative mental health outcomes in ethnic minority, immigrant, and refugee populations (Karlsen & Nazroo, 2002; Noh et al., 1999; Vedder et al., 2006). Recent literature has also started to document that some of these findings may generalize to Muslim communities (Every & Perry, 2014; Vang, Hou, & Elder, 2018). Muslims in America often report experiences of cognitive dissonance, in which they are constantly struggling to reconcile two contradicting identities (their religious identity with their national identity), often leading to experiences of distress (Suleiman, 2016). When faced with experiences of religious discrimination, Muslim people's national identification is negatively impacted, in which they are less likely to identify themselves as members of the nation (Kunst et al., 2012). Victims of Islamophobia are also more likely to experience decreases in their self-worth, confidence, and feelings of security compared to victims of non-discriminatory related crimes

(Chakraborti & Zempi, 2012). These findings demonstrate the significant relationship between experiences of discrimination and psychological distress.

Psychological Distress

One of the primary impacts of religious discrimination for Muslim women is psychological distress. Psychological distress in general can be defined as the subjective state of unpleasant feelings. Often, psychological distress involves psychosomatic responses that are very similar to symptoms of depression and anxiety. Symptoms associated with depression include feelings of dysphoria, hopelessness, self-deprecation, anhedonia, as well as difficulty concentrating and sleeping. Anxious symptoms commonly include feelings of worry, irritability and fearfulness, feelings of restlessness, trembling and autonomic arousal (Mirowsky & Ross, 1989). Researchers have thoroughly documented the relationship between discrimination and psychological distress (Clark et al., 1999; Miller & Kaiser, 2001; Sellers & Shelton, 2003). Poor mental health outcomes have been consistently linked to various forms of discrimination, including discrimination based on race, ethnicity, gender, and religion (Bierman, 2006; Cassidy et al., 2004; Fischer & Holz, 2007; Noh et al., 1999; Noh et al., 2007). Some of the documented outcomes include lower self-esteem, higher substance use, reduced positive affect, symptoms of trauma, symptoms of anxiety, and depressive symptoms (DuBois et al., 2002; Gee et al., 2007; Lam, 2007; Mossakowski, 2003; Noh & Kaspar, 2003; Stuber et al., 2003). When discussing psychological distress, research often focuses on depression and anxiety as strong indicators of general distress states.

Depression

Depression is a mental health construct that is characterized by feelings of sadness and/or loss of interest in activities once enjoyed, resulting in a decrease in an individual's ability to

function at work and at home (American Psychiatric Association, 2013). In the United States, depression is one of the most common mental disorders, with an estimated 17.3 million adults (7.1% of all adults in the U.S.) experiencing at least one major depressive episode (National Institute of Mental Health, 2017). When factoring in identity markers, such as race, ethnicity, and gender, disparities become clear across various minority groups. Research examining racial disparities in depression shows that while overall lifetime prevalence is higher for White individuals compared to African Americans, the chronicity of depression is significantly higher for African Americans (Williams et al., 2007; Woodward et al., 2013). Additionally, racial-ethnic minorities are less likely to seek treatment for their depression, are less likely to complete treatment, and are more likely to rate their condition as severe or disabling, when compared to White populations (Bailey et al., 2019; Shim et al., 2012). It's also important to note that minority-identifying individuals with depression often tend to be underdiagnosed or misdiagnosed (Hines, 2017; Stockdale et al., 2008). These findings suggest that the burden of depression is shouldered much more heavily on racial-ethnic minorities than Whites in the U.S., leading to an overall greater degree of functional impairment. These significant disparities can be linked to discrimination, which has been recognized as a major risk factor for depression among racial-ethnic minority groups. Racial discrimination has been strongly associated with worsening mental and physical health among African Americans, with women experiencing more significant distress compared to men (Williams et al., 2012).

Disparities also exist when examining rates of depression by gender. Women are twice as likely to be diagnosed with depression compared to men (Zender & Olshansky, 2009). There are various factors that place women at a higher risk for depression with a significant one being

women's marginalized status in society. Many women in the United States often face unequal power and status in society, as well as the burden of having to juggle multiple roles in their lives including work and family. Additionally, women frequently face discrimination in the form of misogyny and sexism, ranging from unequal representation and wages to sexual harassment (Albert, 2015). Furthermore, women of color face an even greater risk for experiencing depression due to their multiple marginalized identities.

Anxiety

Anxiety is defined as an emotion that is primarily characterized by worry and tension that typically results in physical arousal and possibly social avoidance (American Psychiatric Association, 2013). Anxiety disorders can interfere with daily activities such as job performance, school, work, and relationships. Much like depression, anxiety is also a very common mood disorder, with around 19.1% of adults in the U.S. being diagnosed with an anxiety disorder (NIMH, 2017). Evidence of disparities in anxiety is evident across numerous identity categories including race, ethnicity, and gender, with marginalized individuals in these categories experiencing higher rates of anxiety. Underrepresented groups are disproportionately exposed to both chronic and severe life stressors, such as victimization, trauma, and discrimination (Stuber et al., 2003). Discrimination has been shown to be a significant risk factor in causing distress and anxiety, increasing the vulnerability of marginalized individuals to develop clinically significant anxious symptoms (Rippy & Newman, 2006). Often, marginalized people experience discrimination by being identified as an "Other", and this "othering" often leads to a cyclical pattern in which marginalized individuals constantly feel threatened (Cokley et al., 2011).

Research shows that discrimination has differential impacts on psychological distress compared to other life stressors. For example, researchers suggest that religious individuals, including Muslims, demonstrate higher levels of anxiety when their beliefs are a cause of discrimination (Rippy & Newman, 2006; Uenal, 2016).

Psychological Distress among Muslims

Many studies have documented the impact of stress on individual health (Paradies, 2006; Rousseau et al., 2011; Todorova et al., 2010). Minority group members often face greater levels of stress, which adds an extra layer of burden and damage on their physical and mental health (Thoits, 2010). Discrimination has consistently been a major factor in explaining the health disparities observed among marginalized groups, with researchers agreeing that experiences of discrimination often lead to acute and chronic stress that may result in adverse physical and mental health outcomes (Gee, 2002; Lee & Ferraro, 2009; Moradi & Hasan, 2004; Nadal et al., 2012; Todorova et al., 2010; Williams, Neighbors, & Jackson, 2003).

While there is still a scarcity of research on Muslim American mental health, existing evidence suggests that this population is at a high risk for developing adverse psychological outcomes, compared to the national average (Amer & Hovey, 2012). Research focusing on Muslim Americans as a marginalized group shows that perceived ethnic and religious discrimination towards Muslims is strongly correlated with poor physical and psychological health outcomes (Hassouneh & Kulwicki, 2007; Kunst et al., 2012; Rousseau et al., 2011; Samari, 2016; Schmitt et al., 2014; Sheridan, 2006; Williams & Mohammed, 2007). These findings remain consistent in Muslim populations in the United States and across the world, with impacts ranging from increased feelings of anxiety to depression (Abu-Ras & Abu- Bader, 2018; Rousseau et al., 2011; Samari, 2016). Muslims who experience incidents of

discrimination also report feeling less safe living in the U.S. (Abu-Ras et al., 2018). Additionally, an increase in anxiety has been evident in this population, as a result of recent vilification of Muslims in the news and discriminatory policies introduced by the U.S. government, with Muslim women reporting significantly higher levels of stress compared to men (Abu-Ras et al., 2018).

Psychological Distress among Muslim Women

Muslim American women are subject to systematic discrimination and inequities based on their multiple marginalized identities, including gender, ethnicity, religious identity, and in some cases race, immigration, socioeconomic status, or disability status. Compared to men, Muslim women often face disproportionate levels of oppression, in part due to their high visibility as Muslims by wearing hijab. Muslim women who experience discrimination report lower quality of life, experience more anxiety in public places due to racial profiling, and are more negatively affected by discriminatory experiences compared to Muslim men (Abu-Ras et al., 2018; Hassouneh, 2017). Studies regarding Muslim women's help-seeking behaviors indicate that they are less likely to seek general healthcare treatment due to perceived discrimination in healthcare settings ranging from being excluded or ignored, offensive verbal remarks, issues related to Muslim practices, and physical assault (Martin, 2015). Additionally, a lack of same-gender providers presents a significant issue for many Muslim women, leading them to delay or completely avoid seeking treatment (Vu et al., 2016). For Muslim women with a strong religious identity, perceptions of discrimination are associated with more severe symptoms of depression and generalized anxiety (Lowe et al., 2019).

Impact of Religious Identity on Psychological Outcomes

Research indicates that religiosity is generally beneficial for mental health outcomes in that it is negatively associated with negative mental health outcomes and positively associated with indicators of wellbeing (Moreira-Almeida, Neto, & Koenig, 2006; Wong, Rew, & Slaikeu, 2006). Additionally, religious identity may serve a protective role to help deflect the impact of discrimination among minority groups (Ai et al., 2013; Bierman, 2006; Hayward & Krause, 2015). Religious identity has been illustrated to help minimize the presence of maladaptive behaviors among Muslim youth (Balkaya, Cheah, & Tahseen, 2019). There are various explanations that may be relevant in understanding this role. Specifically, the sense of membership to a religious group and belief in a god or higher power can provide individuals with a sense of significance, positive emotions, increased self-esteem, sense of meaning, and purpose in life, while also buffering the impact of discrimination and playing a protective role against depression (Aflakseir, 2012; Bierman, 2006; Hashemi et al., 2019; Wink, Dillon, & Larsen, 2005). Religious identity is also important for maintaining social connections with likeminded people and offers a support system through the participation and involvement in religious organizations, which has been shown to be related to better mental health outcomes (Hashemi et al., 2019).

However, despite accumulating evidence that having a strong religious identity is associated with better mental health outcomes and can function as a protective factor to counteract the stress of discrimination among Muslims (Bierman, 2006; Jarvis et al., 2005), recent findings have emerged that have challenged this view. These arguments have suggested that having a strong religious identity, such as a Muslim identity, is more likely to intensify the distressing impact of discrimination, due to the marginalized status of the Muslim identity (Ikizler & Szymanski, 2018). Having a strong religious identity in this

case emphasizes one's minority status in society and ultimately leads to disparaging one's identity, increasing the likelihood of experiencing psychological distress and thus having a harmful impact on the individual's mental health (Ikizler & Szymanski, 2018). Due to the contradicting views and scarcity of research in this area, specifically with Muslim Americans, more work is needed to truly understand the role of a marginalized religious identity in the relationship between discrimination and psychological distress. This study aimed to address this gap by exploring the role of religious identity in relation to psychological distress among Muslim women who experience religious discrimination.

CHAPTER III: METHOD

This study aimed to examine the impact of religiosity on the relationship between religious discrimination and psychological distress among Muslim women. Specifically, strength of religiosity was explored in order to understand whether it is a protective or risk factor for psychological distress in the face of religious discrimination. The following chapter outlines this study's research questions and hypotheses, population of interest, measurements used, study procedures, and statistical methods that were used to analyze the data.

Research Questions

This study examined the following questions:

1. Is the experience of religious discrimination for Muslim women in the United States related to psychological distress?
2. Does religiosity moderate the impact of religious discrimination on psychological distress?

Research Hypotheses

This study examined the following hypotheses:

1. Experiences of religious discrimination will be positively related to psychological distress among Muslim women in the United States.
2. Religiosity will moderate the impact of religious discrimination on psychological distress among Muslim women.

    2a. As religiosity increases, the strength of the relationship between religious discrimination and psychological distress will decrease.

    2b. As religiosity increases, the strength of the relationship between religious discrimination and psychological distress will increase.

Research Design

This study utilized a descriptive and correlational design to explore the relationship between experiences of discrimination and psychological distress among Muslim American women and whether religiosity moderates the relationship between discrimination and psychological distress.

Participants

Sampling Size & Statistical Power

Previous studies that have explored the relationship between discrimination and psychological distress as well as wellbeing among Muslim populations have obtained significant results with medium to large effect sizes ($r^2 = .11$ to $r^2 = .24$, $p < .05$; see Atari & Han, 2018; Balkaya et al., 2019; Every & Perry, 2017; Ikizler & Szymanski, 2018). Therefore, a medium effect size was used when conducting a priori statistical power analyses using G*Power statistical software (Faul et al., 2007). This analysis was conducted in order to determine the number of participants required to conduct regression analysis across three predictor variables. Given an estimated small effect size of 0.15, and power of 0.8 (Cohen, 1988), the projected sample size was 138 participants. Additionally, in order to properly conduct a regression model analysis with three predictor variables and an interaction term, there need to be a minimum of 30 participants per predictor. Based on the design of the study, the minimum adequate sample size needed in order to run a regression model was at least 120 participants. Therefore, participant recruitment continued until at a minimum of 120 to 138 participants were solicited.

Inclusion/Exclusion Criteria

Since the primary focus of this study was on Muslim American women's experiences with religious discrimination and psychological distress, participants were limited to women that

self-identify as Muslim and currently live in the United States. Participants were also required to be at least 18 years old.

Sampling Method

In order to ensure a diverse sample, participants for this study were recruited from various sources including Prolific and social media groups/internet forums. Prolific is an online research platform that recruits research participants worldwide. Researchers are able to post their surveys and decide who is able to access them based on inclusion criteria in order to reach their target population. Surveys are sent to potential participants at random, in order to ensure random sampling. When adding the inclusion criteria of this specific survey to filter potential respondents through Prolific, there were an estimated 159 Prolific users that met the criteria for participation. Given the limited data pool, social media platforms including Facebook, Instagram, WhatsApp, and Twitter were also used to advertise the study and recruit potential participants. A snowball sampling method was utilized for social media, with the study being posted to social media groups and users on the platforms being encouraged to share with other potential participants.

Sample Characteristics

Approximately 2,500 potential participants were solicited via the sampling methods described earlier. From these solicitations, 329 participants accessed the survey. 124 participants were excluded from the sample due to incomplete survey responses, leaving a total of 205 participant responses that were included in the final analyses. Approximately 85 participants (41.5%) accessed the survey through Prolific, while the remaining 120 participants (58.5%) accessed the study through social media platforms.

A summary of demographic data is shown in below in Tables 1 and 2. Of the sample used in the final analyses, 53.7% (n = 110) identified as Sunni Muslim, 38% (n = 78) identified is Shia Muslim, while the remaining 8.3% (n = 17) preferred not to disclose their religious affiliation. The majority of sample participants (76.1%, n = 156) reported that they began to identify as Muslim between birth and age 12 years old. The remaining participants reported identifying as Muslim around the ages of 13-17 years (5.4%, n = 11), 18-24 years (9.3%, n = 19), 25-34 years (5.4%, n = 11), and 35-44 years (4%, n = 8). When asked about hijab status, 146 participants (71.2%) reported wearing the hijab and 59 (28.8%) reported not wearing the hijab. With regard to racial-ethnic identity, 42.4% (n = 87) identified as Middle Eastern, North African or Arab American, 30.2% (n = 62) identified as East Asian, South Asian or Asian American, 11.7% (n = 24) of participants identified as Black, Afro-Caribbean, or African American, 7.8% (n = 16) identified as White, Caucasian or European American, 3.9% (n = 8) identified as bi/multiracial, and 2.4% (n = 5) identified as Hispanic/Latinx. Sample participants reported a mean age of 32.8 (SD = 11.07), with the youngest participant identifying as 18 years old and the oldest being 65 years old. Most participants reported either being single (30.7%, n = 63) or married (53.2%, n = 109), with the remaining participants indicating their relationship status as casual dating (2.4%, n = 5), in a relationship (5.4%, n = 11) engaged (1.5%, n = 3), divorced (5.9%, n = 12), and separated (1%, n = 2). With regard to educational status, 31.2% (n = 64) of participants reported having a Bachelor's degree, 21% (n = 43) had a Master's degree, 18% (n = 37) reported some college credit, but no degree, 17.6% (n = 36) reported having a professional/doctoral degree (e.g. M.D., J.D., Ph.D.), 8.3% (n = 17) reported having an Associate's degree, 2.9% (n = 6) had a high school diploma or GED, and 1% (n = 2) reported no formal degree.

Measures

Inclusion Criteria Questionnaire (Appendix F)

Individuals that were interested in participating in the study were asked to provide information regarding their age, gender identity, religious identity, and current country of residence. Those who were at least 18 years of age, identified as a woman, identified as Muslim, and were currently living in the United States at the time of data collection, were able to proceed to complete the study. Individuals that did not meet at least one of the inclusion criteria previously listed were redirected to the end of the survey.

Demographics Questionnaire (Appendix G)

The Demographics Questionnaire was created for use in this study. This measure was used to obtain relevant background information such as ethnicity, education level, religious identity, and hijab status. The demographics questionnaire was presented last in order of measures.

Religiosity (Appendix A)

The Religious Commitment Inventory (RCI-10) was used to assess level of religiosity. The RCI-10 is a 10-item self-report measure that assesses religiosity. This measure assesses religious commitment, which is defined as the "degree to which a person adheres to his or her religious value, beliefs, and practices and uses them in daily living" (Worthington et al., 2003). This measure is a shortened version of the original 17-item scale (RCI-17), which refined the measure and developed it for use in clinical and research settings. The RCI-10 was developed on a religiously diverse sample, including Christian, Jewish, Muslim, Hindu, and Buddhist individuals. The measure requires respondents to answer questions regarding their religious beliefs and behaviors on a 5-point Likert scale, which are then summed in order to provide a total

religiosity score. Higher scores on the RCI-10 indicate higher levels of religiosity. Exploratory and confirmatory factor analyses revealed two subscales: Intrapersonal Religious Commitment and Interpersonal Religious Commitment. The Intrapersonal Religious Commitment subscale includes items that refer to individual religious behaviors and beliefs while the Interpersonal Religious Commitment subscale includes items that refer to religious behaviors and beliefs that involve other members of the religion. Scores on items belonging to each subscale may be added in order to calculate subscale scores. Strong discriminant validity of the RCI-10 has also been established based on correlations between the measure (including both subscales) and the Visions of Everyday Mortality Scale (VEMS) as well as a single-item spirituality measure.

Religious Discrimination (Appendix B)

The Religious Discrimination Scale (RDS) was used in this study to assess experiences of religious discrimination. The RDS is a self-report measure that assesses respondents' experiences with religious discrimination. The RDS was developed on a sample consisting almost exclusively of Christian individuals using exploratory and confirmatory factor analyses to determine item content (Kawika Allen et al., 2018). This instrument is an 11-item measure on a 5-point Likert scale, in which respondents' answer questions about experiences of discrimination they have faced in their lifetime. Total religious discrimination scores are determined by adding scores for each item, with higher scores indicating more experiences of discrimination. Exploratory and confirmatory factor analyses revealed three different subscales: Perceived Prejudice, Closet Symptoms, and Negative Labels. The Perceived Prejudice subscale includes items that assess discrimination through overt hostility and subtle avoidance. The Closet Symptoms subscale focuses on respondents' hesitancy/fear around identifying publicly as a member of their religious faith. The third subscale, Negative Labels, focuses on the negative

stereotypes and assumptions that the respondent perceives others to have regarding their religious orientation. Scores for subscales may be determined by summing the individual items relating to each separate subscale.

The Everyday Discrimination Scale (Appendix C)

The Everyday Discrimination Scale (EDS) was used in this study to assess experiences of discrimination (Williams et al., 1997). The EDS is a self-report measure developed by David R. Williams in order to assess respondents' experiences with discrimination in their daily lives. This instrument is a 9-item measure on a 6-point Likert scale, in which respondents' answer questions about experiences of discrimination they have faced and how often they have faced them (ranging from "almost everyday" to "never"). Once the first 9 questions have been answered, respondents are then asked, *"What do you think is the main reason for these experiences?"* and are prompted to select one of ten possible identity categories that they would attribute their discriminatory experiences to, including ancestry/national origin, gender, race, and religion.

Psychological Distress (Appendix D)

The Depression Anxiety Stress Scales (DASS-21) was used to measure levels of psychological distress experienced by participants. The DASS is a self-report measure that assesses various aspects of psychological distress (Lovibond & Lovibond, 1995). The original measure consists of 42 items, which can be broken down into three scales (14 questions each), with each scale constituting scores for Depression, Anxiety, and Stress. A shorter version of the DASS, the DASS-21 was later developed in order to reduce administration time of the measure (Lovibond & Lovibond, 1995). The DASS-21 also includes the same three subscales of Depression, Anxiety, and Stress, except each scale contains seven questions. Questions refer to

the respondent's experiences in the past week, with each item answered on a 4-point Likert scale. Scores for depression, anxiety, and stress may be computed by adding item scores for each relevant subscale, while the sum of all subscale scores provides a score for overall psychological distress. Higher scores indicate increased levels of psychological distress.

Many studies have demonstrated strong reliability and validity of the DASS-21 with various populations worldwide, including American, British, Italian, Asian, and Vietnamese adults, including both clinical and non-clinical samples, and have demonstrated high internal consistencies for Depression (ranging from .91 to .97), Anxiety (ranging from .81 to .92), and Stress (ranging from .88 to .95) subscales (Antony et al., 1998; Henry & Crawford, 2005; Sinclair et al., 2012; Tran, Tran, & Fisher, 2013).

Sense of Community (Appendix E)

Sense of community was measured using an eight-item scale that included items such as 'I feel like part of family when I am with other Muslims' and 'I am proud to let other Muslims know that I am a Muslim', utilizing a 5-point Likert scale with 1 = strongly disagree and 5 = strongly agree. This measure was previously modified by researchers to measure sense of community among Muslims, based on the sense of community scale developed by Lambert and Hopkins (1995; Mumuni et al., 2018).

Procedures

Upon receiving approval from the Auburn University Institutional Review Board (IRB), the study materials (i.e. five measures and a demographics questionnaire) were posted to Prolific and social media platforms. When the study was published through Prolific, all potential participants that met inclusion criteria were sent an invitation to participate at random. Those who elected to participate and completed the survey in full were compensated $5. Participants

solicited via social media platforms were contacted through Facebook, Twitter, Instagram and WhatsApp and sent an invitation to participate in the study by completing the survey online. The study was posted to the researcher's social media pages as well as social media groups that were specific to Muslims and Muslim women. Those who interacted with the social media ads, regardless of participation, were asked to send the invitation for participation to other individuals within their social networks that meet inclusion criteria and may be interested.

Individuals that agreed to participate accessed the study by clicking on the survey link provided in the survey advertisement. The survey provided an information letter (Appendix D) including necessary information for informed consent to participate in the study. Participants provided their consent to participate in the study by clicking on the continue button.

After providing consent, participants were asked how they accessed the survey (Prolific or social media). For Prolific users, they were asked to enter their Prolific ID in order to properly approve their survey response, and receive compensation, once completed. All participants then completed the inclusion and demographics questionnaire, in which they provided information regarding their current age, gender identity, religious identity, and country of residence. Individuals that did not qualify for the study were removed prior to study analyses. Participants who met inclusion criteria then completed the study measures in randomized order to control for order effects.

After completing the study measures, participants then completed the demographics questionnaire, in which they provide information regarding their Muslim affiliation, hijab status, age they began to identify as Muslim, racial-ethnic identity, age, relationship status, and educational level. Prolific participants were given a completion code at the end of the survey, which they entered in order to receive compensation. Meanwhile, social media participants were

given the option of being redirected to another survey to enter a drawing for one of four $20 e-gift cards.

Ethical Considerations

Various precautions were taken in order to minimize risk associated with breach of confidentiality. First, all data was collected anonymously through online survey platform, Qualtrics, which has been vetted by the Auburn University IRB as a secure software program for data collection. The survey did not record any personal identifying information that would be able to link an individual to their responses, including the participant's name, email address, and IP address. The study presented limited risk to participants.

Analytic Strategy

Once data collection was complete, the raw data was downloaded from Qualtrics directly into the Statistical Package for the Social Science (SPSS) in order to complete the appropriate statistical analyses.

Sample characteristics

Descriptive statistics were computed in order to identify participant characteristics. Mean age, as well as percentages of participants' hijab status, race/ethnicity, education level, and citizenship status was computed. Additionally, a Multivariate Analysis of Variance (MANOVA) was used in order to determine if there were any differences in data based on sample origin (e.g. Prolific vs. social media).

Testing the relationship between religious discrimination and psychological distress

In order to test the relationship between religious discrimination and psychological distress, correlations between the measure of discrimination (RDS) and psychological distress (DASS-21) were conducted. Correlations between the RDS and different subscales of the DASS-

21 (anxiety, depression, and stress) were also computed in order to explore the relationship between religious discrimination and specific constructs of psychological distress to identify whether different relationships exist between these variables.

Testing the moderating effect of religiosity on psychological distress

A hierarchical linear regression analysis was conducted with hijab status as a predictor to examine the main effects of religious discrimination and religiosity on psychological distress, and to determine if religiosity moderates the relationship between religious discrimination and psychological distress for Muslim American women. Given the impact of hijab on many Muslim women's' experiences, Step 1 of the hierarchical linear regression analysis included hijab status as a potential demographic covariate. In Step 2, scores on the RDS and RCI-10 were entered simultaneously to assess potential main effects of perceived religious discrimination and religiosity. In the final step, the interaction effect (using a centered mean approach) of perceived religious discrimination and religiosity in the prediction of psychological distress was assessed.

Table 1. Demographic Data

Variable	*n*	*%*
Religious Affiliation		
Sunni	110	53.7
Shia	78	38.0
Other/prefer not to say	17	8.3
Age of Religious Identity		
Birth-12 years old	156	76.1
13-17 years old	11	5.4
18-24 years old	19	9.3
25-34 years old	11	5.4
35-44 years old	8	4
Hijab Status		
Wears hijab	146	71.2
Does not wear hijab	59	28.8
Race/Ethnicity		
Black, Afro-Caribbean, or African American	24	11.7
Bi/multiracial	8	3.9
East Asian, South Asian or Asian American	62	30.2
Hispanic/Latinx	5	2.4
Middle Eastern, North African or Arab American	87	42.4
White, Caucasian or European American	16	7.8
Relationship Status		
Single (never married)	63	30.7
Casual dating	5	2.4
In a relationship	11	5.4
Engaged	3	1.5
Married	109	53.2
Divorced	12	5.9
Separated	2	1
Educational Level		
Less than high school	2	1
High school graduate or GED	6	2.9
Some college credit, no degree	37	18
2 year degree (Associate's)	17	8.3
4 year degree (Bachelor's)	64	31.2
Master's degree	43	21
Professional/Doctoral degree (e.g. J.D., M.D., Ph.D.)	36	17.6

Table 2. Age

Variable	*n*	*Min.*	*Max.*	*Mean*	*Std. Deviation*
Age	205	18	65	32.8	11.07

CHAPTER IV: RESULTS

The aim of this study was to examine the potential moderating effect of religiosity on the relationship between religious discrimination and psychological distress among Muslim women. This chapter describes participant demographics, preliminary analyses used to prepare the data, analyses used to test the hypotheses, and a summary of the results.

Descriptive Statistics & Tests of Recruitment Method

Descriptive statistics including means, standard deviations, and intercorrelations among variables were examined for all measures used in this study (Table 3). Correlations between measures of psychological distress (DASS-21), religious discrimination, religiosity (RCI-10), sense of community, and everyday discrimination were computed (Table 4).

A one-way Multivariate Analysis of Variance (MANOVA) was used to test whether participants differed in scores based on hijab status. Results showed a significant difference between hijabi and non-hijabi participants on several variables, including Religious Commitment ($F_{(1, 203)} = 61.55$, $p < .001$), total DASS-21 scores ($F_{(1, 203)} = 9.97$, $p = .002$), DASS stress scores ($F_{(1, 203)} = 5.17$, $p = .024$), DASS anxiety scores ($F_{(1, 203)} = 7.86$, $p = .006$), DASS depression scores ($F_{(1, 203)} = 12.09$, $p < .001$), and sense of community scale ($F_{(1, 203)} = 20.65$, $p < .001$). These differences reveal that women who did not wear the hijab reported lower levels of religiosity, higher levels of psychological distress, and lower sense of community, compared to women who reported wearing the hijab.

Another MANOVA was used to test whether participants recruited through Prolific differed in their responses compared to participants recruited through social media platforms. There were significant differences between the two participant groups across several variables, including Religious Commitment ($F_{(1, 203)} = 21.88$, $p < .001$), total DASS-21 scores ($F_{(1, 203)} =$

6.35, $p = .013$), DASS anxiety scores ($F_{(1, 203)} = 5.59$, $p = .019$), DASS depression scores ($F_{(1, 203)} = 10.79$, $p = .001$), and sense of community scale ($F_{(1, 203)} = 8.62$, $p = .004$). In examining these differences, it appeared that participants recruited through Prolific expressed lower levels of religiosity, higher levels of overall distress, higher levels of anxiety, higher levels of depression, and a lower sense of community compared to participants recruited through social media. Due to these differences between groups, analyses related to primary hypotheses were examined with the entire sample as well as with specific recruitment groups to observe differences.

Tests of Research Questions & Hypotheses

Tests of the relationship between religious discrimination and psychological distress.

The first hypothesis proposed that experiences of religious discrimination would be strongly related to levels of psychological distress and that this relationship would be positive, such that greater experiences of discrimination would be related to higher levels of distress. Results showed that as scores on the religious discrimination scale increased, scores on the DASS-21 also increased ($r = .335$, $p < .001$). In other words, the more experiences of religious discrimination participants experienced, the more self-reported symptoms of psychological distress. Similar associations were revealed when examining the relationship between religious discrimination and each of the DASS-21 subscales. As scores on the religious discrimination scale increased, scores on the Stress ($r = .344$, $p < .001$), Anxiety ($r = .298$, $p < .001$), and Depression ($r = .275$, $p < .001$) subscales also increased.

Due to significant differences based on participation method noted above, the correlations were replicated for each participant subgroup. The results revealed a similar pattern for each subgroup, where religious discrimination was positively correlated with psychological distress

scores. For Prolific participants, as scores on the religious discrimination scale increased, scores on the DASS-21 also increased ($r = .438$, $p < .001$). This was also seen for each of the three DASS-21 subscale scores, which were all positively correlated with religious discrimination; Stress ($r = .475$, $p < .001$), Anxiety ($r = .324$, $p = .002$), and Depression ($r = .407$, $p < .001$). Social media participants also exhibited significant positive correlations between religious discrimination and overall psychological distress scores ($r = .241$, $p = .008$), religious discrimination and the Stress subscale scores ($r = .235$, $p = .010$), as well as religious discrimination and the Anxiety subscale scores ($r = .274$, $p < .002$). Religious discrimination and Depression subscale scores were not significantly correlated for this participant group.

The effect of religiosity on the relationship between religious discrimination and psychological distress. The second hypothesis proposed that religiosity would moderate the impact of religious discrimination on psychological distress, after controlling for the hijab. A hierarchical regression analysis was conducted to determine if experiences of discrimination would predict psychological distress as measured by the DASS-21 (Table 5). Hijab status was entered in the first step of the model, in order to control for variance accounted for by presence of the hijab. In predicting DASS-21 scores, participants' hijab status did explain a significant amount of the variance ($R^2 = .047$, $F_{(1, 203)} = 9.97$, $p = .002$). After entering hijab in the model, religious discrimination experiences and religiosity levels were entered into the model (i.e. RDI and RCI-10). The addition of religious discrimination and religiosity levels in the model significantly increased the variance accounted for in DASS-21 scores ($\Delta R^2 = .151$; $p = .000$). That is, experiences of religious discrimination and religiosity explained 15.1% of the variance in psychological distress, after accounting for hijab status.

Tests of moderation. To determine whether religiosity moderated the effects of religious discrimination on psychological distress, the RDI (religious discrimination) and the RCI-10 (religiosity) scores were centered and the interaction of the two variables was entered into the regression equation. The increase in variance accounted for in the prediction model by this interaction was not significant ($\Delta R^2 = .002$; *ns*).

Due to the significant differences noted earlier on some scales based on method of recruitment (Prolific vs. Social media), the regression model was replicated with the data from each recruitment group. For participants recruited through Prolific, overall results were in the same direction as previously reported. Participants' hijab status explained a significant amount of the variance in predicting DASS-21 scores ($R^2 = .113$, $F_{(1, 203)} = 10.54$, $p = .002$). The addition of religious discrimination and religiosity levels in the model significantly increased the variance accounted for in DASS-21 scores ($\Delta R^2 = .237$; $p = .000$). That is, experiences of religious discrimination explained 23.7% of the variance in psychological distress, after accounting for hijab status. The addition of the interaction term (religiosity and discrimination) was not significant ($\Delta R^2 = .007$; *ns*). For participants recruited through Social Media platforms, overall results were in the same direction as previously reported, with the exception of the control variable, in that participants' hijab status did not explain a significant amount of the variance in predicting DASS-21 scores ($R^2 = .001$, $F_{(1, 203)} = .123$, *ns*). The addition of religious discrimination and religiosity levels in the model significantly increased the variance accounted for in DASS-21 scores ($\Delta R^2 = .075$; $p = .011$), explaining 7.5% of the variance in psychological distress, after accounting for hijab status. The addition of the interaction term (religiosity and discrimination) in the model resulted in a slight increase in variance explained, which was not significant ($\Delta R^2 = .003$; *ns*).

Table 3. Means & Standard Deviations

Predictor	*Mean*	*Std. Deviation*
RCI-10	35.82	9.84
RDS	28.76	8.18
DASS-21	36.03	11.83
DASS-21 Depression	11.87	4.81
DASS-21 Anxiety	10.81	3.74
DASS-21 Stress	13.35	4.43
EDS	21.11	8.35
SOCS	34.76	5.54

Note: RCI-10 = Religious Commitment Inventory; RDS = Religious Discrimination Scale; DASS-21 = Depression Anxiety Stress Scales; EDS = Everyday Discrimination Scale; SOCS = Sense of Community Scale.

Table 4. Intercorrelations

	RCI-10	*RDS*	*DASS-21*	*EOD*
RDS	-.055			
DASS-21	-.303**	.335**		
EDS	-.020	.688**	.320**	
SOCS	.594**	.045	-.197**	.063

Note: RCI-10 = Religious Commitment Inventory; RDS = Religious Discrimination Scale; DASS-21 = Depression Anxiety Stress Scales; EDS = Everyday Discrimination Scale; SOCS = Sense of Community Scale.
**$p < .001$*

Table 5. Hierarchical Linear Regression Model

	Predictor	ΔR^2	*B*	*SE B*	*β*	(*sr*)
Step 1		.047*				
	Hijab		5.64	1.79	.216*	.216
Step 2		.198**				
	Discrimination		.457	.092	.316**	.332
	Religiosity		-.301	.087	-.251**	-.238
Step 3		.002				
	Discrimination*Religiosity		-.007	.009	-.050	-.056

*$p < .01$; **$p < .001$*

CHAPTER V: DISCUSSION

A plethora of research exists that explores the impact of discrimination on psychological distress among a wide range of marginalized populations, and religiosity has been identified as a protective factor that helps buffer the impact of discrimination among these populations (Aflakseir, 2012; Bierman, 2006; Hashemi et al., 2019; Wink, Dillon, & Larsen, 2005). However, research has overlooked how this relationship plays out among Muslims, specifically Muslim women, who hold multiple marginalized identities, and what role religiosity plays in buffering or exacerbating the impact of religious discrimination. The purpose of this study was to address this gap in the literature by (a) examining the relationship between religious discrimination and psychological distress specifically among Muslim women in the United States and (b) to explore the potential moderating effect of religiosity on the relationship between discrimination and distress. The following discussion aims to explain the findings outlined in the previous chapter within the context of relevant literature and explore the research, clinical, and faith-based implications of the findings. It also addresses the limitations of the study and suggests areas for future research.

Summary of Results

The relationship between religious discrimination and psychological distress.

This study first aimed to explore whether the experience of religious discrimination for Muslim women in the United States is related to higher levels of psychological distress. Based on previous literature, it was hypothesized that experiences of religious discrimination would be positively related to reported psychological distress among Muslim women. There is a long history of research that has demonstrated the relationship between discrimination and psychological distress generally (Bierman, 2006; Cassidy et al., 2004; Clark et al., 1999; Fischer

& Holz, 2007; Miller & Kaiser, 2001; Noh et al., 1999; Noh et al., 2007; Sellers & Shelton, 2003). Research has consistently shown that higher experiences of discrimination are associated with increased psychological distress, and this relationship is present among racial minorities and religious minorities (DuBois et al., 2002; Gee et al., 2007; Lam, 2007; Mossakowski, 2003; Noh & Kaspar, 2003; Stuber et al., 2003). While discrimination has been studied extensively, this research has only recently extended to include the experiences of Muslims. Muslims in the West have faced increasing rates of discrimination, known specifically as Islamophobia, largely due to the stereotyping of this group as violent and dangerous by many mainstream media sources (Hassouneh & Kulwicki, 2007; Kunst et al., 2012; Rousseau et al., 2011; Samari, 2016; Schmitt et al., 2014; Sheridan, 2006; Williams & Mohammed, 2007). Muslim women are positioned at the intersection of gender bias and Islamophobia, making them more vulnerable to discrimination, yet research has largely overlooked the specific experiences of this population. Research that has attempted to explore the experiences of Muslim women, or even Muslims in general has fallen into the trap of confounding religious and ethnic identity (Rippy & Newman, 2007).

The results from the current study supported the hypothesis, revealing that experiences of religious discrimination are related to symptoms of psychological distress among Muslim women. Specifically, as experiences of religious discrimination increased, reported psychological distress also increased. This relationship aligns with previous research that has illustrated this pattern among many marginalized racial groups (Karlsen & Nazroo, 2002; Noh et al., 1999; Vedder et al., 2006). More specifically, research has long established the negative impact of gendered racial discrimination on mental health outcomes among Black, Asian, and Hispanic American women (Jones et al., 2022; Thomas et al., 2008). These impacts extend to

symptoms of depression, anxiety, trauma and lower self-esteem (Lewis et al., 2017). Few studies, however, have examined the specific impact of gendered religious discrimination on psychological distress, which this study establishes. This study complements the literature on gendered racial discrimination, which has established that greater experiences of gendered racial microaggressions and other discriminatory experiences are significantly related to negative mental health outcomes among women of color (Bierman, 2006; Cassidy et al., 2004; Fischer & Holz, 2007; Jones et al., 2022; Noh et al., 2007; Thomas et al., 2008). In exploring the specific impact of gendered Islamophobia, results illustrated that Muslim women who face religious discrimination also experience increased psychological distress.

The results of this study are also important in establishing the specific impact of gendered Islamophobia, since previous research on the Muslim experience has treated Muslims as a monolithic group, without taking into consideration the distinct experiences of Muslim women or exploring differences in experiences of discrimination based on gender and the possible impact on mental health. Additionally, research on Islamophobia has been impacted by researchers' stereotyped understanding of the Muslim identity, resulting in the confounding of religious and ethnic identity (i.e., assuming that Muslims are Arabs and vice versa). Therefore, little research exists that accurately measures religious identity and religious experiences among Muslims. These results help to clarify the specific impact of religious discrimination on Muslim women's experiences and enhance the literature on Muslim women.

Moderating effect of religiosity on psychological distress.

The second aim of this study was to explore whether religiosity moderates the impact of religious discrimination on psychological distress among Muslim women. It was hypothesized that religiosity will have a moderating effect, however the exact impact of the moderation was

not clear due to conflicting research in the area (Bierman, 2006; Ikizler & Szymanski, 2018; Jarvis et al., 2005). Research on religiosity among marginalized populations reveals that religiosity acts as a protective factor, buffering against the negative impact of discrimination, however, this is mostly seen in Christian populations (Ai et al., 2013; Bierman, 2006; Hayward & Krause, 2015). Compared to research on Christian populations, which agrees that religiosity serves as a protective factor, attempting to understand how this relationship plays out among Muslim populations involves some important distinctions. While some studies focused on Islam show that religiosity has a positive impact on mental health outcomes, it's been posited that high religiosity among Muslims may exacerbate psychological distress in the face of discrimination, since the religious identity itself is marginalized and therefore the source of discrimination (Ikizler & Szymanski, 2018).

In the West, and specifically in the U.S., the socio-religious structure is centered on Christianity, in which Christianity is seen as the norm and one's faith is not questioned or othered. This extends to many aspects of society, including education, politics, the workplace, and the household (Duncan, 2002). On the other hand, Islam is not centered in the Western social structure as Christianity is. Furthermore, unlike other religions that exist as a different approach than Christianity, Islam specifically is seen as a threat to Christianity, and therefore villainized in Christian-normed societies (Considine, 2017). The current religious system in the United States does not just work to center and serve Christianity, but to simultaneously marginalize and oppress Islam and its people. Therefore, it's unclear whether religiosity among Muslim women will have the same protective impact for mental health as it does for marginalized Christian populations, not because the religion lacks protective elements, but because of the oppressive system in which Muslims in the U.S. have to operate within, which does not allow for the

positive aspects religiosity can provide to flourish or exist. So, it was hypothesized that religiosity may either serve a protective role, by decreasing the strength of the relationship between discrimination and distress, or a harmful role, by increasing the strength of the relationship between discrimination and distress.

Results of the hierarchical regression revealed several interesting findings. First, it showed that even after controlling for hijab, Muslim women's experiences of religious discrimination explained a significant amount of the variance in psychological distress scores. This means that for a Muslim woman who reported wearing hijab, the impact of religious discrimination on her psychological distress was impactful, just as it is for a Muslim woman who does not wear hijab. Despite the research that posits that Muslim women face discrimination largely due to hijab, this finding is not surprising given that Muslim women who do not wear hijab have also reported experiences of discrimination, alongside hijabi Muslim women (Al-Kazi & González, 2018). Research on Muslim women has often solely focused on women who wear hijab, which has created the assumption that it is only women who wear hijab that experience gendered Islamophobia (Chapman, 2016; Durovic et al., 2016; Tolaymat & Moradi, 2011; Utomo et al., 2018). This assumption leaves Muslim women who do not wear hijab largely unaccounted for in the discourse related to Muslim women's experiences. Therefore, this finding is important in that it establishes that Muslim women who do not wear hijab also experience religious discrimination, much like Muslim women who do wear hijab.

The second part of the analysis revealed that the interaction of religious discrimination and religiosity did not account for a significant amount of variance in psychological distress scores. This means that religiosity did not have a moderating effect on the relationship between religious discrimination and psychological distress, contrary to what was hypothesized. The lack

of a moderation effect means that religiosity had no significant impact on the relationship between experiences of discrimination and psychological distress. A possible interpretation of the lack of a moderation effect is that the that while Muslim women feel their religion is an important part of their identity, experiences of discrimination may be so routine that they have become accustomed to this being a part of their lived experience. Therefore, it may be that experiences of discrimination are so much a part of the daily lives of Muslim women that it is accepted as a routine part of their lives. While religiosity may not serve as a protective factor in buffering the impact of discrimination, it is also not a risk factor and does not exacerbate the negative impact of discrimination. Research has documented that in some cases, religion provides individuals with positive sources of coping when navigating traumatic experiences (Fallot & Heckman, 2005). So, while religion may be the source of discrimination for Muslim women, it may also help them to accept difficult life experiences, including discrimination, as part of their lived experience. This is likely a unique aspect of the experiences of Muslim women living in the United States, where Islamophobia is the norm.

The lack of a moderation effect also indicates that both Muslim women who are highly religious and those who have low religiosity by comparison experience negative psychological impacts due to religious discrimination. To best understand this outcome, it's important to consider distinctions in the experiences of discrimination among Muslim women. For Muslim women with high levels of religiosity, they likely experience discrimination from non-Muslims, including individuals, secular and other religious groups, and society at large. These experiences of Islamophobia have been documented by many researchers and discussed at length in this study (Abu-Raiya et al., 2011; Awad, 2010; Moradi & Hasan, 2004; Derous & Ryan, 2009; Widner & Chicoine, 2011). The experience of being othered for these women likely comes from

outside, non-Muslim sources (Abu-Raiya et al., 2011; Awad, 2010). However, for Muslim women with lower levels of religiosity, the source of discrimination may come from within the Muslim community itself. A recent study exploring Muslim women's experiences with discrimination revealed within-group discrimination as a common experience among Muslim women (Alsaidi et al., 2021). Muslim women reported discriminatory experiences from other Muslims including criticisms regarding their hijab status or hijab level, colorist remarks regarding skin tone, and microaggressions related to ethnic background and native language. An exploration of some of these experiences reveal that within Muslim communities, women experience greater privilege when they conform to traditional Islamic norms (wear hijab/greater level of covering) and have a closer proximity to Whiteness (lighter skin tone). While the relationship between discrimination and psychological distress may appear the same for both highly religious and less religious Muslim women, the experience is radically different. It appears that Muslim women's experience with gendered Islamophobia is paradoxical, in that they are simultaneously othered and rejected by both non-Muslim and Muslim communities if they do not fit into the expected norm of what a woman should be.

Limitations

There were a number of limitations that impacted this study. First, the method used for data collection involved two online platforms, which yielded two samples that differed from each other on several measures, including religiosity. The participants from social media platforms endorsed significantly higher levels of religiosity, compared to the participants from Prolific. This can be explained given the method of data collection used for social media. In order to best identify and target Muslim-identified women through social media, the study was posted to Muslim-based social media groups, and utilized a snowball sampling method to recruit as many

participants as possible. Given that Muslims with lower levels of religiosity are less likely to join or participate in religion-oriented social media groups, it makes sense that the sample gathered from social media expressed higher levels of religiosity. Additionally, the number of participants who reported wearing the hijab (N = 146) largely outnumbered the number of participants that did not wear the hijab (N = 59). Given the significant differences in experiences of psychological distress, sense of community, and religiosity between these groups, the study may have benefitted from having a greater number of non-hijabi participants.

Second, the scales used to measure religiosity and religious discrimination in this study were not validated on Muslims, nor were they specific to Islam. Given that existing measures that are Muslim-specific confound religious and ethnic identity, the scales used in this study were the most appropriate. Yet, it's possible that some of the nuance in religiosity and discrimination experienced specifically by Muslims is missed due to the use of these general scales. Additionally, since neither scale was validated using Muslims, it's impossible to say whether this sample of Muslim women responded as most Muslims would be expected to.

Third, while this study did not filter out participants based on racial-ethnic identity, a majority of respondents identified as Arab-American. This puts into question the generalizability of the results, since no racial or ethnic group makes up a majority of Muslim American adults (Pew Research Center, 2017). While the U.S. Census categorizes about 41% of Muslims as "White", this category includes European, Arab, Persian/Iranian, Middle Eastern, and North African individuals, making it impossible to understand the true diversity of this group.

It's possible that the lack of a moderation effect may be due to the fact that the study sample represented a group that is generally more religious than the overall Muslim population. There is a wide range of religiosity and religious expression within the Muslim population, yet

this sample yielded a similar range of responses on the religiosity measure showing low variability in religiosity scores. This likely had an impact on the moderation effect and it may be possible that a sample with more varied levels of religiosity may have yielded a significant moderation effect.

Finally, while the research design and use of regression models was an effective method in order to understand the relationships and impact between the variables of interest, it does not allow for explanation of causation. Therefore, it's impossible to say whether experiences of religious discrimination cause psychological distress, or if high levels of psychological distress cause higher levels of real or perceived discriminatory experiences.

Research Implications

The present study explored the relationship between religious discrimination and psychological distress and the potential effect of religiosity on that relationship. There are many possible areas for future research that extend from the results of this study. First, this study established that greater experiences of religious discrimination are related to higher levels of psychological distress among Muslim women in the United States. It may be worthwhile to explore what role racial-ethnic identity plays in this relationship, and whether there are any differences across racial groups. While religiosity did not moderate the relationship between discrimination and psychological distress, ethnic identity may have an impact on this relationship. It's possible that for members of a majority group (White, Arab), their ethnic identity may buffer the impacts of discrimination, compared to members of a minority ethnic group. Additionally, it may be interesting to explore the impact of both religious and ethnic discrimination on psychological distress outcomes.

Research on intersectionality shows that while individuals may be part of the same identity categories, their experiences can differ vastly based on their expression of their identities, as well as others' perception of their identities (Collins, 2000; Crenshaw, 1989; Lewis & Neville, 2015). This is especially relevant among Muslim women, as those who wear hijab are perceived differently than those who don't, as well as various racial-ethnic groups. Specifically, individuals with darker skin tones face greater experiences of discrimination, compared to lighter skinned individuals of the same racial-ethnic group, a concept known as colorism. Therefore, it may be worthwhile to explore experiences of colorism among Muslim women and to what extent they play a role in predicting psychological distress outcomes.

This study also revealed that regardless of hijab status, Muslim women experienced similar levels of discrimination. A future area of research could explore Muslim women's experiences with religious discrimination further, and whether those differ based on religious expression, including use of hijab. It may be worthwhile to explore how discriminatory experiences of hijab-wearing and non-hijab wearing Muslim women differ and relate to each other. This would provide an avenue for better understanding the nuances of Muslim women's experiences.

The findings related to differences in experiences of hijabi versus non-hijabi women also present opportunities for future research. Specifically, the differences in religiosity and sense of community between these groups is interesting, given that these two constructs are positively correlated to each other. The results showed that higher levels of religiosity are related to higher levels of sense of community among Muslim women. Additionally, data analysis of these variables based on hijab status showed that Muslim women who wore hijab experienced these at a higher level than women who did not wear hijab, such that women wearing the hijab reported

higher levels of religiosity and a higher sense of community. It may be worthwhile to explore the experiences of both hijab-wearing and non-hijab wearing Muslim women to better understand the factors that influence these outcomes.

Clinical Implications

The results of this study have various implications that are relevant for mental health clinicians practicing in the United States. Understanding these results may assist mental health practitioners in providing better care for Muslim women in their clinical practice. First, the results help to give clinicians a more nuanced understanding of the impacts of discrimination, specifically among Muslim women. Like many marginalized groups, Muslim women that experience significant discrimination have poor mental health outcomes. It's important for clinicians to not just be aware of this dynamic, but also to be mindful of their own perceptions of Muslim women and how they may influence the therapeutic relationship. Research on microaggressions has illustrated therapists who lack cultural humility when working with members of marginalized populations may re-traumatize or microaggress towards their clients, leading to exacerbated symptoms, ruptures in the therapeutic relationship, and discontinuation of therapeutic services (Owen et al., 2014).

Since research among this population is still growing, it may be particularly useful for clinicians to understand how discriminatory experiences play a role in the experience of psychological distress among Muslim women. Specifically, given the differences illustrated in this study between women wearing hijab and those not wearing hijab, counselors should allow clients to frame their own experiences. Researchers suggest that therapists should initiate conversations around the impact of microaggressions, while also allowing for the client to engage with or end the conversation as they see fit (Owen et al., 2011). This allows the client to

have autonomy over the subject and choose to engage with it to the extent they feel is relevant or comfortable. Additionally, in working with Muslim clients who face religious discrimination, therapists can encourage taking action to decrease feelings of helplessness and even work collaboratively with Muslim community leaders to navigate their client's concerns (Al-Krenawi & Graham, 2000). For Muslim clients that are isolated from their religious community or from the non-Muslim community, therapists can encourage clients to connect with Muslim community members for support (Amer, 2006) and even non-Muslim individuals or groups in their local proximity. Research has illustrated that doing so allows Muslim clients to forge connections that may help ease fears about potential hostility and marginalization, while allowing the client to remain autonomous and an agent of social change (Abu Raiya, & Pargament, 2010; Amer, 2006).

When working with Muslim women, it's important to assess their experiences with gendered Islamophobia as well as the role religiosity plays in their lives. Muslim women experience discrimination at similar levels, regardless of hijab status, which implies that when working with Muslim women, clinicians should attempt to avoid making assumptions based on their clients' religious expression. It's important for clinicians to make room for nuance and greater complexity in how Muslim women frame their faith and experiences. Muslim women are most likely to benefit from therapists who can understand the complexities of their identities and experiences (Abu Raiya, & Pargament, 2010). Clinicians should make space for clients to name their experiences with discrimination and explore sources of distress in relation to their experiences with gendered Islamophobia. Clinicians should also consider cultural affirming resources such as affinity groups or connection to religious communities, which research has shown is beneficial for Muslim women (Carter & Rashidi, 2004). Microinterventions can be

introduced to clients as a coping skill to help counteract the impact of microaggressions (Sue et al., 2019).

Faith-Based Implications

Given the direct focus on Islam and Muslim women's experiences in this study, it's important to understand how the results can be contextualized within an Islamic framework. An important finding showed that even after accounting for hijab status, Muslim women still experience religious discrimination and those who experience a greater frequency of discrimination also experience greater psychological distress. This challenges the assumption that wearing hijab is the main cause for discrimination that Muslim women experience. While this may be the case for Muslim women who wear the hijab, in which their visible religious identity warrants significant discrimination, it's also important to understand the discriminatory experiences of Muslim women who do not wear hijab. Islam is a faith that emphasizes the connection with the divine and focuses on the esoteric, inner dimensions of God-consciousness as much as it does external aspects of life, with the latter supporting the former. Therefore, the tangible, external practice of wearing hijab demonstrates just one layer of the multidimensional spiritual practice of modesty among Muslims. The implications of assuming that the physical manifestation of hijab is the only manner by which Muslim women express and experience their religious identity are dangerous. It creates a paradigm by which hijab-wearing Muslim women are perceived as more religious, and in Western contexts, extreme, while also erasing the very real experiences and discounting the existence of non-hijab wearing Muslim women.

Conclusions

The results of this study add to the literature on religious discrimination experiences among Muslim women in the United States. While data did not support the hypothesis that

religiosity moderates the relationship between religious discrimination and psychological distress among Muslim women, it did show that experiences of religious discrimination are related to symptoms of psychological distress. Specifically, it establishes that Muslim women's psychological distress is exacerbated when they experience higher incidents of religious discrimination, a trend seen across a wide range of marginalized populations. While religiosity had no moderation effect on the relationship between religious discrimination and psychological distress, an important yet unexpected finding from this study establishes that Muslim women experience religious discrimination regardless of hijab status. This illustrates that while hijab is an important aspect of religious expression and can often be a source of discrimination, it is not the only source of religious discrimination for Muslim women, and that Muslim women who do not wear hijab still experience significant levels of gendered Islamophobia. Together, these findings have a number of research, clinical, and faith-based implications related to better understanding Muslim women's lived experiences. Overall, this study provides a more nuanced understanding of Muslim women's experiences with discrimination and psychological distress as well as future research opportunities in order to continue better understanding the experiences of Muslim women related to discrimination and what factors may have an effect on the deleterious impacts of religious discrimination.

REFERENCES

Abdel-Khalek, A. M. (2011). Islam and mental health: A few speculations. *Mental Health, Religion & Culture, 14*(2), 87–92. https://doiorg.spot.lib.auburn.edu/10.1080/13674676.2010.544867

Abu-Lughod, L. (2002). Do Muslim Women Really Need Saving? Anthropological Reflections on Cultural Relativism and Its Others. *American Anthropologist*, *104*(3), 783. https://doi-org.spot.lib.auburn.edu/10.1525/aa.2002.104.3.783

Abu-Ras, W., Suárez, Z. E., & Abu-Bader, S. (2018). Muslim Americans' safety and well-being in the wake of Trump: A public health and social justice crisis. *American Journal of Orthopsychiatry*, *88*(5), 503–515. https://doi.org/10.1037/ort0000321

Abu Raiya, H., & Pargament, K. I. (2010). Religiously integrated psychotherapy with Muslim clients: From research to practice. *Professional Psychology: Research and Practice, 41*(2), 181–188. https://doi-org.spot.lib.auburn.edu/10.1037/a0017988

Abu-Raiya, H., Pargament, K. I., & Mahoney, A. (2011). Examining coping methods with stressful interpersonal events experienced by Muslims living in the United States following the 9/11 attacks. *Psychology of Religion and Spirituality*, *3*, 1–14. https://doi.org/10.1037/a0020034

Aflakseir, A. (2012). Religiosity, personal meaning, and psychological well-being: A study among Muslim students in England. *Pakistan Journal of Social and Clinical Psychology*, *9*(2), 27–31.

Afshar, H., Aitken, R., & Franks, M. (2005). Feminisms, Islamophobia and Identities. *Political Studies*, *53*(2), 262–283. https://doi.org/10.1111/j.1467-9248.2005.00528.x

Ahluwalia, M. K., & Pellettiere, L. (2010). Sikh men post-9/11: Misidentification, discrimination, and coping. *Asian American Journal of Psychology*, *1*, 303–314. https://doi.org/10.1037/a0022156

Ahmed, L. (1992). *Women and gender in Islam: Historical roots of a modern debate*. Yale University Press.

Ai, A. L., Huang, B., Bjorck, J., & Appel, H. B. (2013). Religious attendance and major depression among Asian Americans from a national database: The mediation of social support. *Psychology of Religion and Spirituality*, *5*(2), 78–89. https://doi-org.spot.lib.auburn.edu/10.1037/a0030625

Al Wazni, A. B. (2015). Muslim women in America and Hijab: A study of empowerment, feminist identity, and body image. *Social Work*, *60*(4), 325–333. https://doi.org/10.1093/sw/swv033

Al-Kazi, L. A., & González, A. L. (2018). The veil you know: Individual and societal-level explanations for wearing the hijab in comparative perspective. *Social Compass*, *65*(5), 566–590. https://doi.org/10.1177/0037768618800414

Al-Krenawi, A., & Graham, J. (2000). Culturally sensitive social work practice with Arab clients in mental health settings. *Health & Social Work, 25*(1), 9–22.

Albert P. R. (2015). Why is depression more prevalent in women?. *Journal of psychiatry & neuroscience : JPN*, *40*(4), 219–221. https://doi.org/10.1503/jpn.150205

Alghafli, Z., Marks, L. D., Hatch, T. G., & Rose, A. H. (2017). Veiling in fear or in faith? Meanings of the Hijab to practicing Muslim wives and husbands in USA. *Marriage & Family Review*, *53*(7), 696–716. https://doi.org/10.1080/01494929.2017.1297757

Ali, K. (2014). Feminist Thought in Islam. *Muhammad in History, Thought, and Culture: An Encyclopedia of the Prophet of God, Vol IS*, 195-197

Ali, S. (2005). Why Here, Why Now? Young Muslim Women Wearing Hijāb. *Muslim World*, *95*(4), 515–530. https://doi.org/10.1111/j.1478-1913.2005.00109.x

Ali, S. M. (2004). *The position of women in Islam: A progressive view*. SUNY Press.

Ali, S. R., Mahmood, A., Moel, J., Hudson, C., & Leathers, L. (2008). A qualitative investigation of Muslim and Christian women's views of religion and feminism in their lives. *Cultural Diversity and Ethnic Minority Psychology*, *14*(1), 38–46. https://doi.org/10.1037/1099-9809.14.1.38

Ali, S. R., Yamada, T., & Mahmood, A. (2015). Relationships of the practice of hijab, workplace discrimination, social class, job stress, and job satisfaction among Muslim American women. *Journal of Employment Counseling*, *52*(4), 146–157. https://doi.org/10.1002/joec.12020

Alimahomed-Wilson, S. (2017). Invisible Violence: Gender, Islamophobia, and the Hidden Assault on U.S. Muslim Women. *Women, Gender, and Families of Color*, *5*(1), 73–97. JSTOR. https://doi.org/10.5406/womgenfamcol.5.1.0073

Allen, C. (2015). 'People hate you because of the way you dress': Understanding the invisible experiences of veiled British Muslim women victims of Islamophobia. *International Review of Victimology*, *21*(3), 287–301. https://doi.org/10.1177/0269758015591677

Alsaidi, S., Velez, B. L., Smith, L., Jacob, A., & Salem, N. (2021). "Arab, brown, and other": Voices of Muslim Arab American women on identity, discrimination, and well-being. *Cultural Diversity and Ethnic Minority Psychology*. https://doi-org.spot.lib.auburn.edu/10.1037/cdp0000440

Amer, M. (2006). Confronting the top 10 challenges to effective mental health services for Muslims. In *Keynote presentation: Faith, culture & mental health conference (Manchester 30th November 2006)*.

Amer, M. M., & Hovey, J. D. (2012). Anxiety and depression in a post-September 11 sample of Arabs in the USA. *Social Psychiatry and Psychiatric Epidemiology, 47,* 409–418. https://doi-org.spot.lib.auburn.edu/10.1007/s00127-011-0341-4

American Civil Liberties Union. (2008). Discrimination against Muslim women [Fact sheet]. Retrieved from https://www.aclu.org/sites/default/files/pdfs/womensrights/discriminationagainstmuslimwomen.pdf

Amri, S., & Bemak, F. (2013). Mental Health Help-Seeking Behaviors of Muslim Immigrants in the United States: Overcoming Social Stigma and Cultural Mistrust. *Journal of Muslim Mental Health,7*(1). doi:10.3998/jmmh.10381607.0007.104

Antony, M. M., Bieling, P. J., Cox, B. J., Enns, M. W., & Swinson, R. P. (1998). Psycho- metric Properties of the 42-Item and 21-Item Versions of the Depression Anxiety and Stress Scales in Clinical Groups and Community Sample. *Psychological Assessment, 10*, 176-181. https://doi.org/10.1037/1040-3590.10.2.176

Atari, R., & Han, S. (2018). Perceived Discrimination, Ethnic Identity, and Psychological Well-Being Among Arab Americans. *The Counseling Psychologist*, *46*(7), 899–921. https://doi.org/10.1177/0011000018809889

Awad, G. H. (2010). The impact of acculturation and religious identification on perceived discrimination for Arab/Middle Eastern Americans. *Cultural Diversity & Ethnic Minority Psychology*, *16*, 59–67. https://doi.org/10.1037/a0016675

Baffoun, A. (1994). Feminism and Muslim fundamentalism: the Tunisian and Algerian cases. *Africa Development/Afrique et Développement*, 5-20.

Bailey, R. K., Mokonogho, J., & Kumar, A. (2019). Racial and ethnic differences in depression: current perspectives. *Neuropsychiatric disease and treatment*, *15*, 603–609. https://doi.org/10.2147/NDT.S128584

Balkaya, M., Cheah, C. S. L., & Tahseen, M. (2019). The mediating role of multiple group identities in the relations between religious discrimination and Muslim‐American adolescents' adjustment. *Journal of Social Issues*, *75*(2), 538–567. https://doi.org/10.1111/josi.12326

Benner, A. D., Wang, Y., Shen, Y., Boyle, A. E., Polk, R., & Cheng, Y.-P. (2018). Racial/ethnic discrimination and well-being during adolescence: A meta-analytic review. *American Psychologist, 73*(7), 855–883. https://doi-org.spot.lib.auburn.edu/10.1037/amp0000204

Bierman, A. (2006). Does Religion Buffer the Effects of Discrimination on Mental Health? Differing Effects by Race. *Journal for the Scientific Study of Religion, 45*(4), 551–565. https://doi.org/10.1111/j.1468-5906.2006.00327.x

Brondolo, E., Libby, D. J., Denton, E. G., Thompson, S., Beatty, D. L., Schwartz, J., Sweeney, M., Tobin, J. N., Cassells, A., Pickering, T. G., & Gerin, W. (2008). Racism and ambulatory blood pressure in a community sample. *Psychosomatic medicine, 70*(1), 49–56. https://doi.org/10.1097/PSY.0b013e31815ff3bd

Budhwani, H., & Hearld, K. R. (2017). Muslim women's experiences with stigma, abuse, and depression: Results of a sample study conducted in the United States. *Journal of Women's Health*, *26*(5), 435–441. https://doi.org/10.1089/jwh.2016.5886

Carter, D. J., & Rashidi, A. (2004). East meets West: Integrating psychotherapy approaches for Muslim women. *Holistic Nursing Practice, 18*(3), 152-159.

Cassidy, C., O'Connor, R. C., Howe, C., & Warden, D. (2004). Perceived discrimination and psychological distress: The role of personal and ethnic self-esteem. *Journal of Counseling Psychology, 51*(3), 329–339.

Chakraborti, N., & Zempi, I. (2012). The veil under attack: Gendered dimensions of Islamophobic victimization. *International Review of Victimology*, *18*(3), 269–284. https://doi.org/10.1177/0269758012446983

Chang, E. C., Chang, O. D., Lee, J., Lucas, A. G., Li, M., Castro, K. M., Pham, S., Cho, G. Y., Purmasir, Y. S., Yu, E. A., Wu, K., Lui, P. P., Rollock, D., Kwon, P., Chen, X., Hirsch, J. K., & Jeglic, E. L. (2019). Going beyond ethnoracial discrimination and social support in accounting for psychological adjustment: Evidence for the importance of hope as a positive psychological construct in multiethnoracial adults. *The Journal of Positive Psychology*, *14*(5), 681–693. https://doi.org/10.1080/17439760.2018.1510023

Chapman, M. (2016). Veil as Stigma: Exploring the Role of Representations in Muslim Women's Management of Threatened Social Identity. *Journal of Community & Applied Social Psychology*, *26*(4), 354–366. https://doi.org/10.1002/casp.2269

Chapman, S. J., & Benis, N. (2017). Ceteris non paribus: The intersectionality of gender, race, and region in the gender wage gap. *Women's Studies International Forum*, *65*, 78–86. https://doi-org.spot.lib.auburn.edu/10.1016/j.wsif.2017.10.001

Clark, R., Anderson, N. B., Clark, V. R., & Williams, D. R. (1999). Racism as a stressor for African Americans: A biopsychosocial model. *American Psychologist, 54*(10), 805–816. https://doi-org.spot.lib.auburn.edu/10.1037/0003-066X.54.10.805

Cohen, J. (1988). *Statistical Power Analysis for the Behavioral Sciences* (2nd ed.). Hillsdale, NJ: Lawrence Erlbaum Associates, Publishers.

Cokley, K., Hall-Clark, B., & Hicks, D. (2011). Ethnic minority-majority status and mental health: The mediating role of perceived discrimination. *Journal of Mental Health Counseling, 33*(3), 243-263. doi:10.17744/mehc.33.3.u1n0 11t020783086

Considine, C. (2017). The racialization of Islam in the United States: Islamophobia, hate crimes, and "flying while brown". *Religions, 8*(9), 165.

Derous, E., & Ryan, A. M. (2009). Hiring discrimination against Arab minorities: Interactions between prejudice and job charac- teristics. *Human Performance*, *22*, 297–320. https://doi.org/10.1080/08959280903120261

Derous, E., Ryan, A. M., & Nguyen, H. D. (2012). Multiple categorization in resume screening: Examining effects on hiring discrimination against Arab applicants in field and lab settings. *Journal of Organizational Behavior, 33*(4), 544–570. https://doi-org.spot.lib.auburn.edu/10.1002/job.769

Droogsma, R. A. (2007). Redefining Hijab: American Muslim women's standpoints on veiling. *Journal of Applied Communication Research*, *35*(3), 294–319. https://doi.org/10.1080/00909880701434299

DuBois, D. L., Burk-Braxton, C., Swenson, L. P., Tevendale, H. D., & Hardesty, J. L. (2002). Race and gender influences on adjustment in early adolescence: Investigation of an integrative model. *Child Development, 73*(5), 1573–1592.

Duncan Jr, J. R. (2002). Privilege, Invisibility, and Religion: A Critique of the Privilege that Christianity Has Enjoyed in the United States. *Ala. L. Rev., 54*, 617.

Đurović, D., Tiosavljević, M., & Šabanović, H. (2016). Readiness to accept Western standard of beauty and body satisfaction among Muslim girls with and without hijab. *Scandinavian Journal of Psychology*, *57*(5), 413–418. https://doi.org/10.1111/sjop.12315

Ernst, C. W. (Ed.). (2013). *Islamophobia in America: The Anatomy of Intolerance*. New York, NY: Palgrave Macmillan.

Every, D., & Perry, R. (2014). The relationship between perceived religious discrimination and self-esteem for Muslim Australians. *Australian Journal of Psychology*, *66*(4), 241–248. https://doi.org/10.1111/ajpy.12067

Fallot, R. D., & Heckman, J. P. (2005). Religious/spiritual coping among women trauma survivors with mental health and substance use disorders. *The Journal of Behavioral Health Services & Research, 32*(2), 215-226.

Faul, F., Erdfelder, E., Lang, A. G., & Buchner, A. (2007). G* Power 3: A flexible statistical power analysis program for the social, behavioral, and biomedical sciences. *Behavior research methods, 39*(2), 175-191.

Fischer, A. R., & Holz, K. B. (2007). Perceived discrimination and women's psychological distress: The roles of collective and personal self-esteem. *Journal of Counseling Psychology*, *54*(2), 154–164. https://doi-org.spot.lib.auburn.edu/10.1037/0022-0167.54.2.154.supp (Supplemental)

Gee, G. C. (2002). A multilevel analysis of the relationship between institutional and individual racial discrimination and health status. *American Journal of Public Health, 92,* 615–623. http://dx.doi.org/10 .2105/AJPH.92.4.615

Gee, G. C., Spencer, M. S., Chen, J., & Takeuchi, D. (2007). A nationwide study of discrimination and chronic health conditions among Asian Americans. *American journal of public health, 97*(7), 1275–1282. https://doi.org/10.2105/AJPH.2006.091827

Ghumman, S., & Ryan, A. M. (2013). Not welcome here: Discrimination towards women who wear the Muslim headscarf. *Human Relations*, *66*(5), 671–698. https://doi.org/10.1177/0018726712469540

Gilbert, P. A., & Zemore, S. E. (2016). Discrimination and drinking: A systematic review of the evidence. *Social Science & Medicine, 161*, 178–194. https://doi-org.spot.lib.auburn.edu/10.1016/j.socscimed.2016.06.009

Gulamhussein, Q., & Eaton, N. R. (2015). Hijab, religiosity, and psychological wellbeing of Muslim women in the United States. *Journal of Muslim Mental Health*, *9*(2), 25–40. https://doi.org/10.3998/jmmh.10381607.0009.202

Gurbuz, MustafaE., & Gurbuz-Kucuksari, G. (2009). Between Sacred Codes and Secular Consumer Society: The Practice of Headscarf Adoption among American College Girls. *Journal of Muslim Minority Affairs*, *29*(3), 387–399. https://doi.org/10.1080/13602000903166648

Hackney, C. H., & Sanders, G. S. (2003). Religiosity and Mental Health: A Meta–Analysis of Recent Studies. *Journal for the Scientific Study of Religion, 42*(1), 43–55. https://doi-org.spot.lib.auburn.edu/10.1111/1468-5906.t01-1-00160

Haddad, Y. Y. (2007). The Post-9/11 Hijab as Icon. *Sociology of Religion*, *68*(3), 253–267. https://doi.org/10.1093/socrel/68.3.253

Haque, A., Tubbs, C. Y., Kahumoku‐Fessler, E. P., & Brown, M. D. (2019). Microaggressions and Islamophobia: Experiences of Muslims Across the United States and Clinical Implications. *Journal of Marital and Family Therapy*, *45*(1), 76–91. https://doi.org/10.1111/jmft.12339

Hashemi, N., Marzban, M., Sebar, B., & Harris, N. (2019). Religious identity and psychological well-being among middle-eastern migrants in Australia: The mediating role of perceived

social support, social connectedness, and perceived discrimination. *Psychology of Religion and Spirituality*. https://doi.org/10.1037/rel0000287

Hassouneh, D. (2017). Anti-Muslim Racism and Women's Health. *Journal of Women's Health (15409996)*, *26*(5), 401–402. https://doi.org/10.1089/jwh.2017.6430

Hassouneh, D. M., & Kulwicki, A. (2007). Mental health, discrimination, and trauma in Arab Muslim women living in the US: A pilot study. *Mental Health, Religion & Culture*, *10*(3), 257–262. https://doi.org/10.1080/13694670600630556

Hayes, E., & Colin III, S. A. J. (1994). Racism and sexism in the United States: Fundamental issues. *New Directions for Adult & Continuing Education, 1994*(61), 5. https://doi-org.spot.lib.auburn.edu/10.1002/ace.36719946103

Hayward, R. D., & Krause, N. (2015). Religion and strategies for coping with racial discrimination among African Americans and Caribbean Blacks. *International Journal of Stress Management*, *22*(1), 70–91. https://doi-org.spot.lib.auburn.edu/10.1037/a0038637

Henry, J. D., & Crawford, J. R. (2005). The Short-Form Version of the Depression Anxie- ty Stress Scales (DASS-21): Construct Validity and Normative Data in a Large Non-Clinical Sample. *British Journal of Clinical Psychology, 44,* 227-239. https://doi.org/10.1348/014466505X29657

Hertz-Lazarowitz, R., & Shapira, T. (2005). Muslim women's life stories: Building leadership. *Anthropology & Education Quarterly*, *36*(2), 165–181. https://doi-org.spot.lib.auburn.edu/10.1525/aeq.2005.36.2.165

Hines, A. L., Cooper, L. A., & Shi, L. (2017). Racial and ethnic differences in mental healthcare utilization consistent with potentially effective care: The role of patient

preferences. *General hospital psychiatry*, *46*, 14–19. https://doi.org/10.1016/j.genhosppsych.2017.02.002

Hopkins, P. (2016). Gendering Islamophobia, racism and White supremacy: Gendered violence against those who look Muslim. *Dialogues In Human Geography*, *6*(2), 186–189. https://doi.org/10.1177/2043820616655018

Ikizler, A. S., & Szymanski, D. M. (2018). Discrimination, religious and cultural factors, and Middle Eastern/Arab Americans' psychological distress. *Journal of Clinical Psychology*, *74*(7), 1219–1233. https://doi.org/10.1002/jclp.22584

Inzlicht, M., McKay, L., & Aronson, J. (2006). Stigma as ego depletion: how being the target of prejudice affects self-control. *Psychological science, 17*(3), 262–269. https://doi.org/10.1111/j.1467-9280.2006.01695.x

Isaksson, A., Corker, E., Cotney, J., Hamilton, S., Pinfold, V., Rose, D., Rüsch, N., Henderson, C., Thornicroft, G., & Evans-Lacko, S. (2018). Coping with stigma and discrimination: evidence from mental health service users in England. *Epidemiology and Psychiatric Sciences*, *27*(6), 577–588. https://doi.org/10.1017/S204579601700021X

Jamal, A. A. (2017). Trump(ing) on Muslim Women: The Gendered Side of Islamophobia. *Journal of Middle East Women's Studies (Duke University Press)*, *13*(3), 472–475. https://doi.org/10.1215/15525864-4179144

Jarvis, G. E., Kirmayer, L. J., Weinfeld, M., & Lasry, J.-C. (2005). Religious practice and psychological distress: The importance of gender, ethnicity and immigrant status. *Transcultural Psychiatry, 42*(4), 657–675.

Jasperse, M., Ward, C., & Jose, P. E. (2012). Identity, perceived religious discrimination, and psychological well‐being in Muslim immigrant women. *Applied Psychology: An*

International Review, *61*(2), 250–271. https://doi-org.spot.lib.auburn.edu/10.1111/j.1464-0597.2011.00467.x

Jones, M. K., Leath, S., Settles, I. H., Doty, D., & Conner, K. (2022). Gendered racism and depression among Black women: Examining the roles of social support and identity. *Cultural Diversity and Ethnic Minority Psychology, 28*(1), 39–48. https://doi-org.spot.lib.auburn.edu/10.1037/cdp0000486

Karlsen, S., & Nazroo, J.Y. (2002). Relation between racial discrimination, social class, and health among ethnic minority groups. *American Journal of Public Health*, *92*, 624–631.

Kawika Allen, G. E., Wang, K. T., Richards, P. S., Ming, M., & Suh, H. N. (2020). Religious Discrimination Scale: Development and initial psychometric evaluation. *Journal of Religion and Health, 59*(2), 700–713. https://doi-org.spot.lib.auburn.edu/10.1007/s10943-018-0617-z

Keddie, A. (2018). Disrupting (gendered) Islamophobia: The practice of feminist ijtihad to support the agency of young Muslim women. *Journal of Gender Studies*, *27*(5), 522–533. https://doi.org/10.1080/09589236.2016.1243047

Kloek, M. E., Peters, K., & Sijtsma, M. (2013). How Muslim Women in The Netherlands Negotiate Discrimination During Leisure Activities. *Leisure Sciences*, *35*(5), 405–421. https://doi.org/10.1080/01490400.2013.831285

Kulwicki, A., Khalifa, R., & Moore, G. (2008). The effects of September 11 on Arab American nurses in metropolitan Detroit. *Journal of Transcultural Nursing: Official Journal of the Transcultural Nursing Society*, *19*, 134–139. https://doi.org/ 10.1177/1043659607313071

Kunst, J. R., Tajamal, H., Sam, D. L., & Ulleberg, P. (2012). Coping with Islamophobia: The effects of religious stigma on Muslim minorities' identity formation. *International Journal of Intercultural Relations*, *36*(4), 518–532. https://doi.org/10.1016/j.ijintrel.2011.12.014

Lam, B. T. (2007). Impact of perceived racial discrimination and collective self-esteem on psychological distress among Vietnamese-American college students: Sense of coherence as mediator. *American Journal of Orthopsychiatry, 77*(3), 370–376.

Lee, M. A., & Ferraro, K. F. (2009). Perceived discrimination and health among Puerto Rican and Mexican Americans: Buffering effect of the Lazo matrimonial? *Social Science & Medicine, 68,* 1966–1974. http:// dx.doi.org/10.1016/j.socscimed.2009.02.052

Legate, N., Weinstein, N., Sendi, K., & Al-Khouja, M. (2020). Motives behind the veil: Women's affective experiences wearing a veil depend on their reasons for wearing one. *Journal of Research in Personality*, *87*, N.PAG. https://doi-org.spot.lib.auburn.edu/10.1016/j.jrp.2020.103969

Lewis, J. A., Williams, M. G., Peppers, E. J., & Gadson, C. A. (2017). Applying intersectionality to explore the relations between gendered racism and health among Black women. *Journal of Counseling Psychology, 64*(5), 475–486. https://doi-org.spot.lib.auburn.edu/10.1037/cou0000231

Liepyte, S., & McAloney-Kocaman, K. (2015). Discrimination and religiosity among Muslim women in the UK before and after the Charlie Hebdo attacks. *Mental Health, Religion & Culture*, *18*(9), 789–794. https://doi.org/10.1080/13674676.2015.1107890

Lovibond, S. H., & Lovibond, P. F. (1995a). *Manual for the Depression Anxiety Stress Scales*. Sydney: Psychology Foundation.

Lovibond, P. F., & Lovibond, S. H. (1995b). The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories. *Behaviour research and therapy, 33*(3), 335-343.

Lowe, S. R., Tineo, P., Bonumwezi, J. L., & Bailey, E. J. (2019). The trauma of discrimination: Posttraumatic stress in Muslim American college students. *Traumatology, 25*(2), 115–123. https://doi-org.spot.lib.auburn.edu/10.1037/trm0000197

Lowe, S. R., Tineo, P., & Young, M. N. (2019). Perceived Discrimination and Major Depression and Generalized Anxiety Symptoms: In Muslim American College Students. *Journal of Religion & Health*, *58*(4), 1136–1145. https://doi.org/10.1007/s10943-018-0684-1

Mahmood, S. (2005). *Politics of piety: The Islamic revival and the feminist subject*. Princeton University Press.

Marte, J. (2020). Gap in U.S. Black and white unemployment rates is widest in five years. Retrieved from https://www.reuters.com/article/us-usa-economy-unemployment-race/gap-in-us-black-and-white-unemployment-rates-is-widest-in-five-years-idUSKBN2431X7

Martin, M. B. (2015). Perceived discrimination of Muslims in health care. *Journal of Muslim Mental Health*, *9*(2), 41–69. https://doi.org/10.3998/jmmh.10381607.0009.203

Mason-Bish, H., & Zempi, I. (2018). Misogyny, Racism, and Islamophobia: Street Harassment at the Intersections. *Feminist Criminology*, 1557085118772088. https://doi.org/10.1177/1557085118772088

McGinty, A. M. (2018). Embodied Islamophobia: lived experiences of anti-Muslim discourses and assaults in Milwaukee, Wisconsin. *Social & Cultural Geography*, *0*(0), 1–19. https://doi.org/10.1080/14649365.2018.1497192

Mernissi, F. (1991). *Women and Islam: An historical and theological enquiry*. Basil Blackwell.

Memissi, F. (1993). *The forgotten queens of Islam.* Minneapolis: University of Minneapolis Press.

Miller, C. T., & Kaiser, C. R. (2001). A theoretical perspective on coping with stigma. *Journal of Social Issues, 57*(1), 73–92. https://doi.org/10.1111/0022-4537.00202

Mirowsky, J., & Ross, C. E. (1989). *Social institutions and social change. Social causes of psychological distress.* Aldine de Gruyter.

Mirza, H. S. (2013). "A second skin": Embodied intersectionality, transnationalism and narratives of identity and belonging among Muslim women in Britain. *Women's Studies International Forum*, *36*(1), 5–15. https://doi.org/10.1016/j.wsif.2012.10.012

Mohanty, C. T. (2006). Under western eyes: Feminist scholarship and colonial discourses. *Media and Cultural Studies*, 396.

Mohanty, C. T., Russo, A., & Torres, L. (Eds.). (1991). *Third world women and the politics of feminism* (Vol. 632). Indiana University Press.

Moreira-Almeida, A., Neto, F. L., & Koenig, H. G. (2006). Religiousness and mental health: a review. *Revista brasileira de psiquiatria (Sao Paulo, Brazil : 1999)*, *28*(3), 242–250. https://doi.org/10.1590/s1516-44462006000300018

Moradi, B., & Hasan, N. T. (2004). Arab American persons' reported experiences of discrimination and mental health: The mediating role of personal control. *Journal of Counseling Psychology*, *51*, 418–428. https://doi.org/10.1037/0022-0167.51.4.418

Mossakowski, K. N. (2003). Coping with Perceived Discrimination: Does Ethnic Identity Protect Mental Health? *Journal of Health and Social Behavior, 44*(3), 318–331. https://doi.org/10.2307/1519782

Nadal, K. L., Griffin, K. E., Hamit, S., Leon, J., Tobio, M., & Rivera, D. P. (2012). Subtle and overt forms of Islamophobia: Microaggressions toward Muslim Americans. *The Journal of Muslim Mental Health, 6,* 15–37. http://dx.doi.org/10.3998/jmmh.10381607.0006.203

Nadwī, M. A. (2007). *Al-Muḥaddthat: the women scholars in Islam*. Interface Publ..

Noh, S., Beiser, M., Kaspar, V., Hou, F., & Rummens, J. (1999). Perceived racial discrimination, depression and coping: A study of Southeast Asian refugees in Canada. *Journal of Health and Social Behavior*, *40*, 193–207.

Noh, S., & Kaspar, V. (2003). Perceived discrimination and depression: Moderating effects of coping, acculturation, and ethnic support. *American Journal of Public Health*, *93*, 232–238.

Noh, S., Kaspar, V., & Wickrama, K. A. S. (2007). Overt and subtle racial discrimination and mental health: Preliminary findings for Korean immigrants. *American Journal of Public Health, 97*(7), 1269–1274.

Owen, J., Tao, K. W., Imel, Z. E., Wampold, B. E., & Rodolfa, E. (2014). Addressing racial and ethnic microaggressions in therapy. *Professional Psychology: Research and Practice, 45*(4), 283.

Owen, J., Imel, Z., Tao, K. W., Wampold, B., Smith, A., & Rodolfa, E. (2011). Cultural ruptures in short-term therapy: Working alliance as a mediator between clients' perceptions of microaggressions and therapy outcomes. *Counselling and Psychotherapy Research, 11*(3), 204-212.

Paradies, Y. (2006). A systematic review of empirical research on self- reported racism and health. *International Journal of Epidemiology, 35,* 888–901. http://dx.doi.org/10.1093/ije/dyl056

Pascoe, E. A., & Smart Richman, L. (2009). Perceived discrimination and health: A meta-analytic review. *Psychological Bulletin, 135*(4), 531–554. https://doi-org.spot.lib.auburn.edu/10.1037/a0016059

Perry, B. (2014). Gendered Islamophobia: hate crime against Muslim women. *Social Identities*, *20*(1), 74–89. https://doi.org/10.1080/13504630.2013.864467

Pew Research Center. (2016). *The most and least educated U.S. religious groups*. Retrieved from https://www.pewresearch.org/fact-tank/2016/11/04/the-most-and-least-educated-u-s-religious-groups/

Pew Research Center. (2017a). *American Muslims' religious beliefs and practices*. Retrieved from https://www.pewforum.org/2017/07/26/religious-beliefs-and-practices/

Pew Research Center. (2017b). *Assaults against Muslims in U.S. surpass 2001 level*. Retrieved from https://www.pewresearch.org/fact-tank/2017/11/15/assaults-against-muslims-in-u-s-surpass-2001-level/

Rehman, T. S. F., & Dziegielewski, S. F. (2003). Women Who Choose Islam. *International Journal of Mental Health*, *32*(3), 31–49. https://doi.org/10.1080/00207411.2003.11449590

Rippy, A. E., & Newman, E. (2006). Perceived religious discrimination and its relationship to anxiety and paranoia among Muslim Americans. *Journal of Muslim Mental Health, 1*(1), 5–20.

Rousseau, C., Hassan, G., Moreau, N., & Thombs, B. D. (2011). Perceived discrimination and its association with psychological distress among newly arrived immigrants before and after September 11, 2001. *American Journal of Public Health, 101,* 909 –915. http://dx.doi.org/10.2105/ AJPH.2009.173062

Sadek, N. (2017). Islamophobia, shame, and the collapse of Muslim identities. *International Journal of Applied Psychoanalytic Studies*, *14*(3), 200–221. https://doi.org/10.1002/aps.1534

Samari, G. (2016). Islamophobia and public health in the United States. *American Journal of Public Health, 106,* 1920–1925. http://dx.doi.org/ 10.2105/AJPH.2016.303374

Salyer, K. (2016). The Racial Wage Gap Has Not Changed in 35 Years. *Time.Com*, 53.

Schmitt, M. T., Branscombe, N. R., Postmes, T., & Garcia, A. (2014). The consequences of perceived discrimination for psychological well-being: A meta-analytic review. *Psychological Bulletin, 140*(4), 921–948. https://doi-org.spot.lib.auburn.edu/10.1037/a0035754

Sellers, R. M., & Shelton, J. N. (2003). The role of racial identity in perceived racial discrimination. *Journal of Personality and Social Psychology, 84*(5), 1079–1092. https://doi.org/10.1037/0022-3514.84.5.1079

Sheridan, L. P. (2006). Islamophobia pre- and post-September 11th, 2001. *Journal of Interpersonal Violence, 21,* 317–336. http://dx.doi.org/10 .1177/0886260505282885

Shim, R. S., Ye, J., Baltrus, P., Fry-Johnson, Y., Daniels, E., & Rust, G. (2012). Racial/ethnic disparities, social support, and depression: examining a social determinant of mental health. *Ethnicity & disease*, *22*(1), 15–20.

Shirazi, F., & Mishra, S. (2010). Young Muslim women on the face veil (niqab): A tool of resistance in Europe but rejected in the United States. *International Journal of Cultural Studies*, *13*(1), 43–62. https://doi.org/10.1177/1367877909348538

Sinclair, S. J., Siefert, C. J., Slavin-Mulford, J. M., Stein, M. B., Renna, M., & Blais, M. A. (2012). Psychometric Evaluation and Normative Data for the Depression, Anxiety, and Stress Scales-21 (DASS-21) in a Nonclinical Sample of U.S. Adults. *Evaluation & the Health Professions, 35*, 259-279. https://doi.org/10.1177/0163278711424282

Smith-Bynum, M. A., Lambert, S. F., English, D., & Ialongo, N. S. (2014). Associations between trajectories of perceived racial discrimination and psychological symptoms among African American adolescents. *Development and psychopathology*, *26*(4 Pt 1), 1049–1065. https://doi.org/10.1017/S0954579414000571

SteelFisher, G. K., Findling, M. G., Bleich, S. N., Casey, L. S., Blendon, R. J., Benson, J. M., Sayde, J. M., & Miller, C. (2019). Gender discrimination in the United States: Experiences of women. *Health Services Research, 54*, 1442–1453. https://doi-org.spot.lib.auburn.edu/10.1111/1475-6773.13217

Steffen, P. R., McNeilly, M., Anderson, N., & Sherwood, A. (2003). Effects of perceived racism and anger inhibition on ambulatory blood pressure in African Americans. *Psychosomatic medicine, 65*(5), 746–750. https://doi.org/10.1097/01.psy.0000079380.95903.78

Stewart, L. D., & Perlow, R. (2001). Applicant race, job status, and racial attitude as predictors of employment discrimination. *Journal of Business and Psychology, 16*(2), 259–275. https://doi-org.spot.lib.auburn.edu/10.1023/A:1011113301301

Stockdale, S. E., Lagomasino, I. T., Siddique, J., McGuire, T., & Miranda, J. (2008). Racial and ethnic disparities in detection and treatment of depression and anxiety among psychiatric and primary health care visits, 1995-2005. *Medical care*, *46*(7), 668–677. https://doi.org/10.1097/MLR.0b013e3181789496

Stuber, J., Galea, S., Ahern, J., Blaney, S., & Fuller, C. (2003). The association between multiple domains of discrimination and self-assessed health: A multilevel analysis of Latinos and Black in four low-income New York City neighborhoods. *Health Services Research, 38*(6), 1735–1759.

Suleiman, I. O. (2016). *Internalized Islamophobia: Exploring the Faith and Identity Crisis of American Muslim youth*. 12.

Tariq, M., & Syed, J. (2018). An intersectional perspective on muslim women's issues and experiences in employment. *Gender, Work and Organization*. https://doi.org/10.1111/gwao.12256

Terman, R. (2017). Islamophobia and Media Portrayals of Muslim Women: A Computational Text Analysis of US News Coverage. *International Studies Quarterly*, *61*(3), 489–502. https://doi.org/10.1093/isq/sqx051

The holy Qur'an. Wordsworth Editions, 2000.

Thoits, P. A. (2010). Stress and health: Major findings and policy implications. *Journal of Health and Social Behavior, 51,* S41–S53. http://dx.doi.org/10.1177/0022146510383499

Thomas, A. J., Witherspoon, K. M., & Speight, S. L. (2008). Gendered racism, psychological distress, and coping styles of African American women. *Cultural Diversity and Ethnic Minority Psychology, 14*(4), 307–314. https://doi-org.spot.lib.auburn.edu/10.1037/1099-9809.14.4.307

Tineo, P., Lowe, S. R., Reyes-Portillo, J. A., & Fuentes, M. A. (2021). Impact of perceived discrimination on depression and anxiety among Muslim college students: The role of acculturative stress, religious support, and Muslim identity. *American Journal of Orthopsychiatry, 91*(4), 454–463. https://doi-org.spot.lib.auburn.edu/10.1037/ort0000545

Todorova, I. L., Falcón, L. M., Lincoln, A. K., & Price, L. L. (2010). Perceived discrimination, psychological distress and health. *Sociology of Health & Illness, 32,* 843–861. http://dx.doi.org/10.1111/j.1467-9566 .2010.01257.x

Tolaymat, L. D., & Moradi, B. (2011). US Muslim women and body image: Links among objectification theory constructs and the hijab. *Journal of Counseling Psychology*, *58*(3), 383–392. https://doi.org/10.1037/a0023461

Tran, T. D., Tran, T., & Fisher, J. (2013). Validation of the Depression Anxiety Stress scales (DASS) 21 as a Screening Instrument for Depression and Anxiety in a Rural Community-

Based Cohort of Northern Vietnamese Women. *BMC Psychiatry, 13,* 24. https://doi.org/10.1186/1471-244X-13-24

Uenal, F. (2016). Disentangling Islamophobia: The differential effects of symbolic, realistic, and terroristic threat perceptions as mediators between social dominance orientation and Islamophobia. *Journal of Social and Political Psychology, 4*(1), 66-90. doi:10.5964/jspp.v4i1.463

van Es, M. A. (2019). Muslim women as "ambassadors" of Islam: breaking stereotypes in everyday life. *Identities*, *26*(4), 375–392. https://doi.org/10.1080/1070289X.2017.1346985

Vang, Z. M., Hou, F., & Elder, K. (2018). Perceived religious discrimination, religiosity, and life satisfaction. *Journal of Happiness Studies: An Interdisciplinary Forum on Subjective Well-Being*. https://doi.org/10.1007/s10902-018-0032-x

Vu, M., Azmat, A., Radejko, T., & Padela, A. I. (2016). Predictors of Delayed Healthcare Seeking Among American Muslim Women. *Journal of Women's Health (15409996)*, *25*(6), 586–593. https://doi.org/10.1089/jwh.2015.5517

Wadud, A. (2006). Reading the Sacred Text from a Woman's Perspective.

Westfall, A., Welborne, B., Tobin, S., & Çelik Russell, Ö. (2016). The Complexity of Covering: The Religious, Social, and Political Dynamics of Islamic Practice in the United States. *Social Science Quarterly (Wiley-Blackwell)*, *97*(3), 771–790. https://doi.org/10.1111/ssqu.12278

Widner, D., & Chicoine, S. (2011). It's all in the name: Employment discrimination against Arab Americans. *Sociological Forum*, *26*, 806–823. https://doi.org/10.1111/j.1573-7861.2011.01285

Williams, D. R., González, H. M., Neighbors, H., Nesse, R., Abelson, J. M., Sweetman, J., & Jackson, J. S. (2007). Prevalence and distribution of major depressive disorder in African Americans, Caribbean blacks, and non-Hispanic whites: results from the National Survey of American Life. *Archives of general psychiatry*, *64*(3), 305–315. https://doi.org/10.1001/archpsyc.64.3.305

Williams, D. R., & Mohammed, S. A. (2007). Racial harassment/ discrimination. In G. Fink (Ed.), *Encyclopedia of stress* (2nd ed., Vol. 3, pp. 321–326). Oxford, UK: Academic Press. http://dx.doi.org/10.1016/ B978-012373947-6.00617-6

Williams, D. R., & Mohammed, S. A. (2009). Discrimination and racial disparities in health: evidence and needed research. *Journal of behavioral medicine, 32*(1), 20–47. https://doi.org/10.1007/s10865-008-9185-0

Williams, D. R., Neighbors, H. W., & Jackson, J. S. (2003). Racial/ethnic discrimination and health: Findings from community studies. *American Journal of Public Health, 93,* 200–208. http://dx.doi.org/10.2105/AJPH .93.2.200

Williams, M. T., Chapman, L. K., Wong, J., & Turkheimer, E. (2012). The role of ethnic identity in symptoms of anxiety and depression in African Americans. *Psychiatry research*, *199*(1), 31–36. https://doi.org/10.1016/j.psychres.2012.03.049

Williams, R. H., & Vashi, G. (2007). Hijab and American Muslim Women: Creating the Space for Autonomous Selves. *Sociology of Religion*, *68*(3), 269–287. https://doi.org/10.1093/socrel/68.3.269

Wink, P., Dillon, M., & Larsen, B. (2005). Religion as Moderator of the Depression-Health Connection: Findings From a Longitudinal Study. *Research on Aging*, *27*(2), 197–220. https://doi-org.spot.lib.auburn.edu/10.1177/0164027504270483

Wong, Y. J., Rew, L., & Slaikeu, K. D. (2006). A systematic review of recent research on adolescent religiosity/spirituality and mental health. *Issues in mental health nursing*, *27*(2), 161–183. https://doi.org/10.1080/01612840500436941

Woodward, A. T., Taylor, R. J., Abelson, J. M., & Matusko, N. (2013). Major depressive disorder among older African Americans, Caribbean blacks, and non-Hispanic whites: secondary analysis of the National Survey of American Life. *Depression and anxiety*, *30*(6), 589–597. https://doi.org/10.1002/da.22041

Worthington, E. L., Jr., Wade, N. G., Hight, T. L., Ripley, J. S., McCullough, M. E., Berry, J. W., Schmitt, M. M., Berry, J. T., Bursley, K. H., & O'Connor, L. (2003). The Religious Commitment Inventory--10: Development, refinement, and validation of a brief scale for research and counseling. *Journal of Counseling Psychology, 50*(1), 84–96. https://doi-org.spot.lib.auburn.edu/10.1037/0022-0167.50.1.84

Yee, V. (2020). Saudi Law Granted Women New Freedoms. Their Families Don't Always Agree. *The New York Times.* Retrieved from https://www.nytimes.com/2020/03/14/world/middleeast/saudi-women-rights.html

Younis, M. (2019). *Muslim Americans Exemplify Diversity,* Potential. Retrieved from https://news.gallup.com/poll/116260/muslim-americans-exemplify-diversity-potential.aspx

Zender, R., & Olshansky, E. (2009). Women's mental health: depression and anxiety. *The Nursing clinics of North America*, *44*(3), 355–364. https://doi.org/10.1016/j.cnur.2009.06.002

Appendix A

Religious Commitment Inventory-10 (RCI-10)

Instructions: Read each of the following statements. Using the scale provided, select the response that best describes how true each statement is for you.

1: Not at all true of me
2: Somewhat true of me
3: Moderately true of me
4: Mostly true of me
5: Totally true of me

1. I often read books and magazines about my faith.
2. I make financial contributions to my religious organization.
3. I spend time trying to grow in understanding of my faith.
4. Religion is especially important to me because it answers many questions about the meaning of life.
5. My religious beliefs lie behind my whole approach to life.
6. I enjoy spending time with others of my religious affiliation.
7. Religious beliefs influence all my dealings in life.
8. It is important to me to spend periods of time in private religious thought and reflection.
9. I enjoy working in the activities of my religious affiliation.
10. I keep well informed about my local religious group and have some influence in its decisions.

Appendix B

Religious Discrimination Scale (RDS)

Instructions: Please rate how often during your life you have had the following experiences using the scale provided.

1	**2**	**3**	**4**	**5**
Never	Rarely	Sometimes	Frequently	Always

Items	**Ratings**				
1. I felt disrespected because of my religious views	1	2	3	4	5
2. I was ignored because I am a religious person	1	2	3	4	5
3. People assumed things about me because of my religion	1	2	3	4	5
4. I felt inclined to keep my religious affiliation private	1	2	3	4	5
5. I was afraid of others finding out about my religious beliefs	1	2	3	4	5
6. Felt socially avoided by others due to my religion	1	2	3	4	5
7. I was passed over for opportunities due to my religion	1	2	3	4	5
8. I sense hostility from others because of my religious affiliation	1	2	3	4	5
9. I have heard people make unfriendly remarks about my religion	1	2	3	4	5
10.Others hold negative stereotypes of people with my religion	1	2	3	4	5
11.I do not feel free to express who I am religiously	1	2	3	4	5

Appendix C

Everyday Discrimination Scale (EDS)

Instructions: Please read each statement and select a number based on the scale provided below, which indicates how much the statement applied to you.

0: Never
1: Less than once a year
2: A few times a year
3: A few times a month
4: At least once a week
5: Almost everyday

1. You are treated with less courtesy than other people are.
2. You are treated with less respect than other people are.
3. You receive poorer service than other people are restaurants or stores.
4. People act as if they think you are not smart.
5. People act as if they are afraid of you.
6. People act as if they think you are dishonest.
7. People act as if they are better than you are.
8. You are called names or insulted.
9. You are threatened or harassed.

Follow-up: What do you think is the main reason for these experiences? (Choose one)

- Your Ancestry or National Origins
- Your Gender
- Your Race
- Your Age
- Your Religion
- Your Height
- Your Weight

- Your Sexual Orientation
- Your Education or Income Level
- Other (please specify)

Appendix D

Depression Anxiety Stress Scales-21 (DASS-21)

Instructions: Please read each statement and select a number 0, 1, 2 or 3 based on the scale provided below, which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

0: Did not apply to me at all – **NEVER**
1: Applied to me to some degree, or some of the time – **SOMETIMES**
2: Applied to me to a considerable degree, or a good part of time – **OFTEN**
3: Applied to me very much, or most of the time - **ALMOST ALWAYS**

1. I found it hard to wind down
2. I was aware of dryness of my mouth
3. I couldn't seem to experience any positive feeling at all
4. I experienced breathing difficulty (e.g. excessively rapid breathing, breathlessness in the absence of physical exertion)
5. I found it difficult to work up the initiative to do things
6. I tended to over-react to situations
7. I experienced trembling (e.g. in the hands)
8. I felt that I was using a lot of nervous energy
9. I was worried about situations in which I might panic and make a fool of myself
10. I felt that I had nothing to look forward to
11. I found myself getting agitated
12. I found it difficult to relax
13. I felt down-hearted and blue
14. I was intolerant of anything that kept me from getting on with what I was doing
15. I felt I was close to panic
16. I was unable to become enthusiastic about anything
17. I felt I wasn't worth much as a person

18. I felt that I was rather touchy
19. I was aware of the action of my heart in the absence of physical exertion (e.g. sense of heart rate increase, heart missing a beat)
20. I felt scared without any good reason
21. I felt that life was meaningless

Appendix E

Sense of Community Scale (SOCS)

Instructions: Read each of the following statements. Using the scale provided, select the response that best describes the degree to which you agree or disagree with each statement.

1: Strongly **disagree**
2: Somewhat **disagree**
3: Neither agree nor disagree
4: Somewhat **agree**
5: Strongly **agree**

1. I feel like part of a family when I am with other Muslims.
2. I am proud to let other Muslims know that I am a Muslim.
3. I feel emotionally attached to other Muslims in my community.
4. I feel that problems faced by Muslims in my community are also my problems.
5. I value belonging to a Muslim community that really cares about its members.
6. I value belonging to a Muslim community that is willing to help its members.
7. I value belonging to a Muslim community that takes pride in its members' accomplishments.
8. I support initiatives by my Islamic community that benefit the wider community

Appendix F

Inclusion Criteria Questionnaire

What is your age?

a. Under 18 years old
b. 18 years or older

Do you identify as Muslim?

a. Yes
b. No

Do you identify as a woman?

a. Yes
b. No

Are you currently living in the United States?

a. Yes
b. No

Appendix G

Demographics Questionnaire

1. Please indicate your age. (Text box)
2. Please indicate your sexual orientation.
    a. Asexual
    b. Bisexual
    c. Gay/Lesbian
    d. Pansexual
    e. Queer
    f. Straight/Heterosexual
    g. Other/Not listed (text box)
3. Please indicate your Muslim affiliation.
    a. Shia
    b. Sunni
    c. Other/Not listed (text box)
4. At what age did you begin to identify as Muslim? (Drop down starts at 'Birth')
5. Do you wear hijab?
    a. Yes
    b. No
6. Please indicate your racial/ethnic background.
    a. Black, Afro-Caribbean, or African American
    b. Biracial
    c. East Asian or Asian American
    d. Hispanic/Latinx
    e. Middle Easter, North African, or Arab American
    f. Multiracial
    g. Native American, American Indian, or Alaska Native
    h. Native Hawaiian or Pacific Islander
    i. White or European American
    j. Other/Not listed (text box)
7. Were you born in the United States?

a. Yes
b. No

8. Please indicate the number of years you have lived in the United States. (text box)
9. Please indicate your relationship status.
    a. Single (never married)
    b. Casual dating
    c. In a relationship
    d. Engaged
    e. Married
    f. Widowed
    g. Divorced
    h. Separated
10. Please indicate the highest degree or level of school you have completed.
    a. Less than high school
    b. High school graduate or GED
    c. Some college credit, no degree
    d. 2 year degree (Associate's)
    e. 4 year degree (Bachelor's)
    f. Master's degree
    g. Professional degree (e.g. J.D., M.D., etc.)
    h. Doctoral degree

Appendix H

Information Letter

For Research Study entitled “Understanding Muslim Women’s Experiences in the United States"

You are invited to participate in a research study that explores the experiences of Muslim women in the United States. This study is being conducted by Betool Ridha, M.A. under the direction of Professor Evelyn Hunter, Ph.D. at Auburn University’s Department of Special Education, Rehabilitation, and Counseling. You are eligible to participate in this study because you are at least 18 years old and identify as a Muslim woman that currently resides in the United States.

What will be involved if you participate? Your participation is completely voluntary. If you consent to participate in this study, you will be asked to answer questions about yourself including your religious experiences, discriminatory experiences, your feelings on a daily basis, as well as demographic information. The questionnaire will take approximately 15-20 minutes to complete. Your survey responses will be anonymous and information from this research will be reported only in the total.

Are there any risks or discomfort? Upon completion of the survey, you should close your web browser. You may decide to discontinue participation at any point by simply closing your web browser. There is no risk to participating in this study beyond the normal levels of discomfort in answering questions about your personal experiences. If you do feel discomfort, please remember that you can stop at any time. Although we have designed the study so that we cannot link your responses to you, there is some chance that others around you may view your responses if you do not complete the survey in a private place. Therefore, we encourage you to complete the study in a place where others cannot observe your responses.

Are there any benefits to yourself or others? There are no direct benefits to you from participating in this study. Information learned during the study will contribute to understanding Muslim women’s experiences in the United States.

Will you receive payment for participating in this study? To thank you for your time, you can choose to be in a drawing for one of three $20 Visa e-gift cards by opening the link provided at the end of the study to a separate survey and entering your email address.

Are there any costs? There are no costs to you for participating in this study.

If you change your mind about participating, you can withdraw at any time during the study. Your participation in this study is completely voluntary. Your decision about whether or not to withdraw or not to participate or to stop participating will not risk your further relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling, Betool Ridha, M.A., or Evelyn Hunter, Ph.D.

Your privacy will be protected. Any information obtained in connection with this study will remain anonymous and private. Information obtained through your participation may be published in a professional journal and presented at a professional conference. To best ensure anonymity and privacy, please be sure to close your browser when finished.

If you have questions or concerns about this study, please contact Betool Ridha at bzr0027@auburn.edu. As a result of this survey being completed electronically, we suggest that you print a copy of this consent form for your records.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or the Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu.

HAVING READ THE INFORMATION PROVIDED, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, THE DATA YOU PROVIDE WILL SERVE AS YOUR AGREEMENT TO DO SO.

IF YOU ARE TAKING THIS SURVEY ON A MOBILE DEVICE, PLEASE SCREENSHOT THIS LETTER FOR YOUR RECORDS.

IF YOU ARE TAKING THIS SURVEY ON A COMPUTER, PLEASE PRESS "CTRL+P" TO PRINT A COPY OF THIS LETTER FOR YOUR RECORDS.

The Auburn University Institutional Review Board has approved this document for use from _____ to _____. Protocol #_____