

THE LIVING IN AMERICA MUSLIM LIFE STRESS, COPING AND LIFE  
SATISFACTION STUDY: AN ONLINE MIXED METHODS STUDY  
OF ISLAMOPHOBIC DISCRIMINATION, MICROAGGRESSIONS,  
AND PREDICTORS OF LIFE SATISFACTION

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## ABSTRACT

### THE LIVING IN AMERICA MUSLIM LIFE STRESS, COPING AND LIFE SATISFACTION STUDY: AN ONLINE MIXED METHODS STUDY OF ISLAMOPHOBIC DISCRIMINATION, MICROAGGRESSIONS, AND PREDICTORS OF LIFE SATISFACTION

Susan Yasen Tirhi

The relationship between stress, trauma, microaggressions, overt violence and life satisfaction has long been established in the literature. This online study sought to identify significant predictors of life satisfaction in a Muslim American sample (N=247) that was 74.5% (N=184) female, 60.7% (N=150) Arab American/Middle Eastern, 21.9% (N=54) Asian American, and 10.5% (N=25) White. The sample had a mean age of 34.21 years with 70% married (N=173). Some 51.4% were born in the U.S. (51.4%, N=127); and, among those not U.S. born, 15.8% reported their country of origin was Egypt (N=39), followed by Palestinian Territories (6.5%, N=16) and Pakistan (5.7%, N=14). And 19.7% (N=49) have lived in the U.S. for 26-30 years. Also, 35.6% (N=88) completed a bachelor's degree, 64.8% were employed (N=160) and, 31.6% reported an annual household income in the \$50,000-\$99,000 bracket. This sample's mean

experience of microaggressions was 7.12 (SD=6.649, min=0, max=24) indicating low experience. While the mean exposure to overt acts of violence was 0.71 (SD= 1.457, min=0, max=9), indicating very low exposure. Regarding life satisfaction, 53.5% of the sample indicated a life satisfaction score of 8 or more (N=132). The mean perception to Islamophobia was 4.076, indicating a high ability to perceive Islamophobia.

Using backwards stepwise regression, *higher life satisfaction* was significantly predicted by: being less likely to be depressed in the past year (B=-0.59, p=0.012); older age (B=0.038, p=0.001); better overall health status (B=0.361, p=0.001); better rating of quality of provider (B=0.351, p=0.001); lower perceived stress (B=-0.07, p=0.0); lower stage for coping and responding to Islamophobia (B=-0.17, p=0.025); higher use of “stop unpleasant thoughts” coping style (B=0.129, p=0.007) with  $R^2 = 0.584$  (adjusted  $R^2 = 0.566$ ; 56.6% of variance explained).

Quantitative findings were augmented by emergent themes in the qualitative data. Case in point, living in a post-9/11 America and discrimination with subthemes including Islamophobia, acceptability of public discrimination, and destruction of personal property were found to be negatively associated with life satisfaction. Five overarching themes were found to be related to higher life satisfaction and ability to cope: feeling a sense of community, wearing hijab (headscarf for women), religiosity and Islamic identity, work, and financial stability.

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## Chapter I

### INTRODUCTION

In 2019, Muslims in two New Zealand mosques were targeted by gunmen resulting in the death of 50 worshippers during Friday prayers (Williams & Piccoli, 2019). Muslims in the United States and more globally have since been reeling and on alert. Nationally throughout the United States, Muslim Americans have received support from some political leaders and from law enforcement officials who have provided protection to Muslim Americans during Friday prayers (Williams & Piccoli, 2019).

Islamophobic discrimination in the United States is not new and has been documented in American history dating as far back as the dawn of World War II (Husain & Howard, 2017, p. 146). Sharp increases in documented Islamophobic discrimination and hate crimes, such as the New Zealand attacks, have sharply increased since the September 11<sup>th</sup> attacks on the United States (Council on American Islamic Relations, [CAIR], 2017).

The religion of Islam is growing globally and currently has the second largest number of believers worldwide (Samari, Alcalá, & Sharif, 2018). Regarding Muslim demographics in the United States, the Pew Research Center (2017) estimated that 1.1%, or 3.45 million Americans, of the total United States population identifies as Muslim (Pew Research Center, 2017). It is estimated that by 2050, this population of Americans will reach 2.1% of the total population, or 8.1 million, and will surpass Jewish Americans as the second largest religious group in the United States (Pew Research Center, 2017). Husain and Howard (2017) indicated this growth can be attributed to “natural births, ongoing immigration, and conversions to the faith” (p. 139).

The proportion of Muslim Americans who have experienced discrimination and Islamophobia is on the rise (Samari et al., 2018, p. e2). Islamophobia can be defined as a “social stigma towards Islam and Muslims, dislike of Muslims as a political force, and a distinct construct referring to xenophobia and racism towards Muslims or those perceived to be Muslim” (Samari et al., 2018, p. e2). Recent negative media focus and political opposition in the United States towards Muslims as well as a Muslim travel ban, public harassment of Muslims and Muslim places of worship, and increased racial profiling have ultimately led to “assaults against Muslims in the United States” surpassing the “modern peak reached after 9/11” (p. e2). While there has been little research on the effects of discrimination and its associations with Muslim health status, it is clear that “Islamophobia undermines health equity” (p. e1). Furthermore, a clear link between “discrimination at multiple levels” and “poor health” has been established with negative physical manifestation on regulatory systems in the body (p. e2). Stigma and bias against Muslim Americans can also impact their health by leading to “unequal access to health-enhancing resources or medical care” (Samari, 2016, p. 1921).

Discrimination also has a negative effect on an individual’s mental health (Abu-Ras, Suárez, & Abu-Bader, 2018; Aroian, 2012; Samari et al., 2018). Yet, the stigmatization surrounding mental health and the negative effects of non-treatment have long been documented in the literature; and, the question as to whether or not religiosity, and specifically Muslim religiosity, furthers such stigmatization is debatable (Amer & Hood, 2008; Kira et al., 2014). Further, Kira et al. (2014) noted that the negative effects of stigmatization on mental health tend to be more averse in minority populations such as Muslim Americans, as they “consistently view mental illness and mental health services

more negatively than European Americans” (p. 250). Kira et al. (2014), also suggested that the higher level of stigma surrounding mental health can be tied to Muslim Americans’ “minority status, extended family values and family prejudices, and collectivistic cultures and the masculine ideals in their traditionally patriarchal cultures” (p. 250). There is also evidence that in patriarchal cultures or religions, the Muslim faith was found to be “related to higher levels of self-stigma” (Kira et al., 2014, p. 251).

Rippy and Newman (2008) discussed how the experience of discrimination can lead to a “higher prevalence of psychological stress among minority group members, “while having a negative impact on health-related behaviors” (p. 53). Most importantly, stigmatization, public discrimination, and stereotypes due to mental illness in minorities are important challenges; and, such stigmatization acts as a barrier to seeking care and adhering to treatment (Kira et al., 2014). Also, the internalization of stigma contributes to “lowered self-esteem and self-efficacy” (Kira et al., p. 251).

Aroian (2012) reported that Muslim Americans “routinely encounter discrimination” and the spike in hate crimes since the September 11 attacks has made Muslim Americans “the most frequently targeted group, exceeding other minority groups that have historically been targets” (p. 206). Discrimination has been linked to increased stress and a “greater risk for mental health problems, including depression, anxiety, and PTSD” – and the trauma related to discrimination and hate crimes have additionally been associated with negative “physical, social, psychological, spiritual and economic” consequences (Aroian, 2012, p. 394). One potential consequence, psychological trauma, is an experience that is “outside the range of usual human experience, and that would be



markedly distressing to almost anyone, such as a serious threat, or harm, to one's life or physical integrity" (O'Driscoll, 2017, p. 14).

Abu-Ras and Abu-Bader (2009) emphasized how "racial discrimination against immigrants and minority groups has long been a part of the American experience;" and is linked "to the acceptance of race theory, which claims that some races are superior to others, and places non-Europeans, including Arabs and Muslims, in an "inferior" category," leading to the "general American perception of Arabs and Muslims as enemies of Christianity, to be feared and resented" (pp. 396-397). Such categorizations have "traumatized the Arab and Muslim community for years in this country, and the resulting discrimination, stereotypes, and prejudice has negatively affected the quality of life wherever Arabs and Muslims have settled" (p. 397).

Beydoun and Ayoub (2017) noted that a recent catalyst to the discrimination of Muslim Americans has been the 2016 United States presidential election of Donald Trump and the 2017 "Muslim Ban" that "restricted, effective immediately, the reentry into the United States of visa and green card holders" from seven Muslim majority countries (p. 215). Trump's tagline of "Make America Great Again" not only "excluded Islam but demonized it and its adherents" (p. 220). Unfortunately, this wasn't the only time that Trump's rhetoric shined a light on the "otherness" of Muslim Americans. In 2015, while on the campaign trail, Trump infamously said "I think Islam hates us" (p. 220). Trump's campaign trail became a place where "Islamophobia, xenophobia and racism openly thrived, dubbed by some as 'racism summits'" (p. 221). The campaign trail offered "a glimpse of the country" Trump "promised and hoped to deliver" (p. 221). The 'Muslim Ban' became a common chant at his rallies," while "Islamophobic images and

ideas were emblazoned on paraphernalia worn by his supporters” (p. 221). In addition, Muslims were ejected, supposedly “for other reason than being Muslim – at several of his campaign stops” (Beydoun & Ayoub, 2017, p. 221)

Todres (2018) noted that “even when courts strike down his attempts to marginalize certain groups, Trump’s rhetoric can still have an enduring impact” (p. 332). Trump has "repeatedly suggested that Islam is ‘radical Islamic terrorism,’ referred to Muslims as ‘sick people,’ and has even “hinted that he would consider requiring Muslims to carry special identification cards, as the Nazis required of Jews” (p. 332). With the President of the United States at the helm of a country that has been known to discriminate against the other, it comes as no surprise that violence has also increased against the marginalized population of Muslim American. Not surprisingly, Trump’s “embrace of violence and devaluation and marginalization of certain groups have spurred numerous attacks against people of color and religious minorities” (p. 333). Consider how those engaged in attacks have actually chanted “Trump’s name or his campaign slogans while beating or kicking innocent victims” (Todres, 2018, p. 333).

Disha, Cavendish, and King (2011) indicated that a rise in discrimination and violence occurs when “dominant groups in society” seek to “maintain their powerful positions” (p. 24). Members of the dominate group may then “resort to discrimination and perhaps even violence to obviate threats from minority groups” (p. 24). Also, “the number of anti-Arab/Muslim hate crimes” increases with “the proportion of Arabs or Muslims in a county” (p. 23). Also, “there are reasons to suspect that hate crimes against Arabs/Muslims may be higher in affluent areas” (p. 25). Of note, “September 11 was clearly a politically charged, transformative event for U.S. society in general, including

American Arabs and Muslims,” whereby Arabs and Muslims became characterized as a “unified, coherent, and threatening group consisting of ‘foreigners,’ ‘extremists,’ and ‘terrorists’” (p. 26).

In 2015, the Public Regional Research Institute reported that “three-quarters (75%) of Americans say that terrorism is a critical issue in the country” compared to just 53% in 2011; additionally, “nearly half (47%) of Americans say they are very or somewhat worried that they or someone in their family will be a victim of terrorism” (Jones & Cox, 2015, p.1). Also reported was the notion that “American Muslims have not done enough to oppose extremism in their own communities” with 53% of polled Americans agreeing (p. 3). With regards to how much responsibility the American public thought that Muslims had to stop or address the extremism in their religion, some two-thirds (67%) of Republicans “say that U.S. Muslims have not done enough to confront extremism, a view shared by less than half (45%) of Democrats” (p.3). Also, some 52% percent of independents “believe American Muslims have not done enough to address extremism in their communities” (p. 3). Some 47% of the public “believe the values of Islam are at odds with American values and way of life” (p. 3). It was noted that not only do few Americans “report knowing a lot about the religion,” but also “most Americans do not have regular contact with someone who is Muslim” (p. 4). There were only some “16% of the public” who reported “knowing a lot about the religious beliefs and practices of Muslims,” 57% reported knowing a little, and 26% reported knowing “nothing at all” (Jones & Cox, 2015, p. 4).

According to reports from the Council on American-Islamic Relations (CAIR), the nation’s largest Muslim civil rights and advocacy organization, a 2017 report found a

57% increase in Muslims incidents and a 44% increase in hate crimes against Muslim Americans in 2016 compared to reports in 2015 (Council on American Islamic Relations, [CAIR], 2017). CAIR also reported that the “number of Islamophobic incidents involving U.S. Customs and Borders Protection officials has increased by 1,000 since Donald Trump took office in January” (Buncombe, 2017).

The Pew Research Center (2017) found that not only did the negative prejudicial stereotypes and fear against Muslim Americans rise in the aftermath of the terror attacks in 2001, but also continue to prevail; for example, the number of Americans who believe that Islam as a religion promotes violence increased to 50% amongst respondents. Respondents also believed that Muslims should be “feared and distrusted as a group in America” (Pew Research Center, 2017).

Disha, Cavendish, and King (2011) sought to discern whether the events of September 11, 2001 had any “observable impact on patterns of hate crime incidents against various categories of people, particularly Arabs and Muslims” (p. 33). They noted how “hate crimes against Arab and Muslim Americans” has increased “dramatically in the months and years following September 11, 2001” (p. 21). There was a “1,600 percent increase in such hate crimes between 2000 and 2001—from 28 hate incidents in 2000 to 481 in 2001” (p. 21). Data collection is hampered by the lack of an “Arab” category in many surveys. Yet, the states of California, Colorado, and Illinois “along with a variety of Arab advocacy groups, report a dramatic rise in anti-Arab hate crimes over the same period” (p. 21). Further, “majority group members are emboldened to act on their prejudices when they anticipate little or no reprisal from local law enforcement and a low likelihood of retribution from the minority group” (p. 23).

Findings were consistent with reports from “the FBI and from Arab advocacy organizations suggesting that 9/11 created a climate in which many Americans felt united against a ‘new enemy’ and in which acts of hatred against Arabs and Muslims became ‘normalized’ behaviors” (p. 40). The “other” or “foreign alien” categorization of Muslim Americans has been directly linked to increased “levels of interethnic hostility and prejudice,” while fueling “intergroup violence through acts of vicarious retribution” (Disha et al., 2011, p. 40)

Kumar (2016) found when examining overt acts of violence against individuals of South Asian descent that the “victims attributed such incidents to visible characteristics such as skin color, ethnicity, and attire” (p. 12). The “evidence suggests that these incidents were not carried out at random” (p. 12). Instead, the victims “were targeted due to their racial, ethnic, or religious affiliation” (p.12).

Per reports gathered in 2016 by the Council on American Islamic Relations (CAIR, 2017), the top five types of anti-Muslim bias incidents were as follows: denial of religious accommodation (180 incidents reported); harassment (390 incidents reported); incidents involving the FBI (334 incidents reported); employment related incidents (281 reported incidents); and hate crimes (260 incidents reported).

The term microaggressions first came to light in the late 1970’s and was defined as “subtle, stunning, often automatic and nonverbal exchanges” meant to put down Black Americans (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978, p. 66). More recently, Sue (2010) has offered the definition of microaggressions as the “everyday verbal, nonverbal, and environmental slights, snubs or insults, where intentional or unintentional, that communicate a hostile, derogatory, or negative messages to target persons based solely

upon their group membership” (p. 3). Examples of such group membership can include race, ethnicity, sexual orientation, gender, and religious affiliation. Nadal (2008) further notes that “based on empirical support of the existence of racial microaggressions, it is likely that similar experiences can occur for different minority groups” (p. 23). Often the only indication that an individual has experienced a microaggression is that the experience is afterwards “accompanied by emotional arousal” (Husain & Howard, 2017, p. 140).

Shammas (2017) recently conducted a study with Muslim American college students and found that “Arab and Muslim students were two to four times more likely to feel discriminated against by other students, faculty, and administration because of their ethnicity or religion, as compared with their non-Arab and non-Muslim counterparts” (p. 116). Regarding microaggressions, in a focus group, one student, recalled how “during a club rush week, one student approached him and yelled out, “Your prophet is a molester”—referring to the Prophet Muhammad’s marriage to Aisha who was nine at the time (p. 113). Women who don the headscarf were “about a third of the focus group members,” and cited “Muslim names and dress as major sources of discrimination” (p. 113). Not surprisingly, some students initially denied that they had “personally experienced ethnic or religious discrimination;” however, as other students began to divulge the details of their negative experiences, those students also shared experiences of discrimination attributed to their ethnic and religious group (p.114). Still, “6 of the 15 participants” made statements “indicative of suppressing or denying feelings of discrimination” (p. 114). Underreporting microaggressions is not uncommon amongst those who experience it, and it is often “difficult to be persuaded that someone has

committed” a microaggression or act of discrimination (p. 115). Also, studies show that ethnic and religious minorities are “more likely to admit discrimination against their group than personal discrimination” (p. 113). Similar findings regarding teachers being significant perpetrators of microaggressions in school-aged children were reported by Dupper, Forrest-Bank, and Lowry-Carusillo (2015). Inman et al. (2015) indicated that “many discriminatory incidents go either unnoticed or unreported by participants, especially those who are unfamiliar with the U.S. racial context” (p. 217).

Over time, experiences of religious microaggressions can leave those affected with lower self-esteem and can increase their perception of paranoia of perpetrators (Husain & Howard, 2010). Other effects include “vigilance, mistrust and suspicion that may lead to functional impairment” as well as “loss of sleep and headaches” (Nadal et al., 2010; Husain & Howard, 2017; Rippy & Newman, 2008).

Aroian (2011) conducted a study on Muslim American adolescents and found that individual coping mechanisms differed based on gender, with males noting that they “routinely laugh off incidents of discrimination,” and females choosing to ignore acts of microaggressions (p. 210). However, it appears that how Muslim Americans are choosing to cope with microaggressions is shifting (p. 210). Per Aroian (2011), “on closer inspection it was apparent that both genders made calculated judgments, choosing strategies that fit the context surrounding specific discrimination incidents” (p. 210). Furthermore, “these calculated judgments included assessing perpetrators by considering whether educating them had a chance of being effective and/or whether directly confronting the perpetrator might incur further self-harm” (Aroian, 2012, p. 210).

## Statement of the Problem

The problem that this study addressed was the rise in Islamophobia and Islamophobic discrimination in the United States, including an increase in microaggressions and overt violence against Muslim Americans—both in the post-9/11 era, and era of President Donald Trump’s anti-Muslim rhetoric. There is a need for research that documents the prevalence of Muslim Americans’ experiences of stress, trauma, microaggressions, overt violence, as well as their coping strategies and resilience, in addition to their ratings of life satisfaction.

## Purpose of the Study

The purpose of the study was to identify significant predictors of the **study outcome variable/dependent variable of a high rating of life satisfaction for Muslim Americans**—when controlling for social desirability. In addition, a qualitative portion of the study allowed participants to fully express themselves, specifically, permitting the identification of emergent themes and categories when analyzing data on several topics: (a) factors impacting their life satisfaction as a Muslim American, (b) the most stressful parts of their life experience as a Muslim American, (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, (d) their experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression (e.g. being a Muslim American, and also a racial/ethnic minority, etc., or intersectionality), (e) examples of how they coped, bounced back, or healed, or were



resilient from stressful or traumatic discrimination/microaggressions/hate, and (f) recommendations to improve the overall life satisfaction of Muslim Americans.

### **Research Questions, Survey Parts, and Data Analysis Plan**

Given an online sample of diverse adult Muslim Americans (n=247) who have been living in the United States for at least two years and responded to a social media campaign (i.e. “GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card”) and completed the study survey, the research will answer the following questions:

#### **Quantitative Portion of the Study**

1-What are their demographic and other background characteristics (i.e. gender, age, race/ethnicity, skin color tone, born in the US or not, years living in the US, level of education, marital status, employment status, annual household income)?

*Part I: Basic Demographics (BD-10)*

2- How do they rate their overall health status, their Body Mass Index (BMI)/weight status, the overall quality of care that they receive for their health, the overall quality of care they receive from their provider, and the sensitivity and competence of their provider for treating someone who is Muslim? And, do they indicate having medical insurance, and if so, what type?

*Part II: Personal Health Background (PHB-9)*

3-Do they consider themselves to be practicing Muslims, what is their level of religiosity, and to what type of Muslim sect do they belong?

*Part III: Religious Affiliation and Religiosity Scale (RA-RS-3)*

4-What is the frequency of their wearing visibly Muslim clothing when out in public?

*Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1)*

5-To what extent do they tend to provide socially desirable responses?

***[Note: Regression will control for social desirability]***

*Part V: More About You (Social Desirability) (MAY-13)*

6-What is their rating for Life Satisfaction?

**[Note: The study outcome variable/dependent variable]**

*Part VI: Life Satisfaction Scale (LSS-1)*

7-What is their level of perceived stress in the past thirty days?

*Part VII: Perceived Stress Scale (MA-PSS-10)*

8-What is the prevalence of their experiences of trauma (e.g. in a war zone, natural disaster, terrorist attack, childhood abuse, etc.) including where they thought their life was in danger or they could be seriously injured—and whether they were actually seriously injured?

*Part VIII: Brief Trauma Questionnaire (BTQ-10)*

9-What is the prevalence of symptoms of posttraumatic stress disorder (PTSD)?

*Part IX: PTSD Checklist—Civilian Version (PCCV- 17)*

10-What is the prevalence of symptoms of depression and anxiety in the past year, and was counseling or advice sought out?

*Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3)*

11-Within their general life experience, what was the frequency of any experiences of microaggressions?

*Part XI: Ratings of Experiences of Microaggressions (REMI-6)*

12-What was their experience of any overt acts of violence?

*Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4)*

13-What was their level of ability for perceiving Islamophobia and/or Islamophobic discrimination—when it happening to themselves, as well as others?

*Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10)*

14-What was their stage of change (i.e. precontemplation, contemplation, preparation, action, maintenance) for coping and responding to any experiences of Islamophobia and/or Islamophobic discrimination?

*Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6)*

15-What was their coping self-efficacy—specifically, their level of ability and confidence for using (a) problem-focused coping, (b) stopping unpleasant emotions and thoughts, and (c) getting support from other family and friends?

*Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13)*

16-What are the significant relationships among selected independent variables (e.g. age, education level, etc.) and the study outcome variable/dependent variable of higher level of life satisfaction?

17-What are the significant predictors of the study outcome variable/dependent variable of higher level of life satisfaction—controlling for social desirable responses?

### **Qualitative Portion of Study**

18-What themes emerged when asked to provide open-ended responses to questions eliciting qualitative data on several topics—(a) factors impacting their life satisfaction as a Muslim American, (b) the most stressful parts of their life experience as a Muslim American, (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, (d) their experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression (e.g. being a Muslim American, and also a racial/ethnic minority, etc., or intersectionality), (e) examples of how they coped, bounced back, or healed, or were resilient from stressful or traumatic discrimination/microaggressions/hate, and (f) recommendations to improve the overall life satisfaction of Muslim Americans?

## **Rationale for the Study**

### **Rationale for the Theories Guiding the Study**

The study was rooted in multiple theories: Stress and Coping Theory (Lazarus & Folkman, 1986; Theory on the Biopsychosocial Effects of Perceived Racism (Clark et al., 1999); Stages of Change from the Transtheoretical Model (Prochaska & DiClemente, 1983); and, Self-Efficacy from Social Cognitive Theory (Bandura, 1977). More specifically, a rationale for the study rests in the Stress and Coping Theory of Lazarus and Folkman (1984). As per Folkman, Lazarus, Gruen and DeLongis (1986), it is a valid approach to “assess the way in which a person actually copes with one or more stressful events” (p. 571). In addition, the Theory on the Biopsychosocial Effects of Perceived

Racism advanced by Clark, Anderson, Clark and Williams (1999) was used. At the core, the theory asserts that exaggerated psychological and physiological stress responses may follow from the perception of racist stimuli in the environment, and these responses may negatively impact health over time; and, coping responses to stress may be adaptive or maladaptive (Clark et al., 1999).

There is also a rationale for using the stages of change of the Transtheoretical Model of Prochaska and DiClemente (1983). This includes a focus on the stages of precontemplation, contemplation, preparation, action and maintenance (Velasquez & DiClemente, 2002). In this case, the behavior of taking action to cope and respond to racism and/or oppression—specifically, Islamophobia and Islamophobic discrimination—may be “staged,” as per the work of Wallace (2005).

Also, Self-Efficacy from the Social-Cognitive Theory of Bandura (1977) also provides a framework for the present study. This includes a specific focus on coping self-efficacy, whether self-efficacy or confidence for using problem-focused coping, stopping unpleasant emotions and thoughts, and getting support from friends and family. (Chesney, Neilands, Chambers, Taylor & Folkman, 2006).

### **Rationale for Investigating Violence and Other Variables**

Muslim Americans’ experiences of discrimination and Islamophobia are on the rise (Samari, Alcalá, & Sharif, 2018). According to Aroian (2012), The September 11, 2001 attacks made Muslims living in the United States “the most frequently targeted group, exceeding other minority groups that have historically been targets” (p. 206). The term microaggressions was introduced to cover “subtle, stunning, often automatic and nonverbal exchanges” meant to put down Black Americans (Pierce, Carew, Pierce-Gonzalez, &

Willis, 1978, p. 66); and, extended to include the “everyday verbal, nonverbal, and environmental slights, snubs or insults, where intentional or unintentional, that communicate a hostile, derogatory, or negative messages to target persons based solely upon their group membership” (Sue, 2010, p. 3). It is important to focus on both experience of covert and overt violence, while physical attacks would constitute overt acts of violence (Wallace, 2003).

It is also clear that “Islamophobia undermines health equity” (Samari, Alcalá, & Sharif, 2018, p. e1). Islamophobia has extended past commonplace verbal and physical assaults and into the realm of healthcare—as research has shown links with negative mental health outcomes, negative physical health outcomes, and health disparities (Samari, 2016, p. 1921). The consistent exposure to microaggressions has “lead to a variety of emotional and psychological stressors and may have lasting impacts on the mental health of recipients” (Nadal, 2008, p. 23). Specifically, findings show a “relationship between racial discrimination and psychological stress, high blood pressure, depression, sleeping problems, substance abuse, eating disorders, and posttraumatic stress disorder” (Nadal, 2011, p. 470).

### **Rationale for Investigating Demographics and Other Background Factors**

Rippy and Newman (2008) write that despite common misconception that Muslim Americans immigrants into the United States are mostly Arab Americans, in fact, some 32% were found to be of South Asian background, while 26% were Arab Americans, and 20% were African American Muslim. Thus, “Muslim Americans, although ethnically and culturally diverse” (Rippy & Newman, 2008, 54).

While Middle Eastern Americans or Arab Americans are classified as “White” in terms of their demographics and census, they “do not benefit from White privilege and are still exposed to Islamophobia based on physical appearance” and “Arab Americans who identify as White experience more discrimination-associated psychological distress” (Samari, 2016, p. 1922). Prior research has demonstrated an association between darker skin color and a higher level of ability to perceive racism and/or oppression, as those with darker skin color had a very high ability for perceiving racism and/or oppression (Ellington-Murray, 2005).

Kaplan (2017) indicated that the “more minority groups a person belongs to, the more vulnerable they are to marginalization, invisibility, and intersectional microaggressions” (p. 16). The concept of intersectionality captures the experience of multiple disadvantages, such as having oppressive experiences based on race and gender, justifying a focus on those falling into race and ethnic categories, while there are also intersectional health inequities (Gkiouleka, Huijts, Beckfield & Bamba, 2018).

Others have noted how there may be double or triple jeopardy, such as from experiencing marginalization and discrimination from belonging to two or three categories (e.g. race and gender; age, gender, sexuality (Krekula, Nikander & Wilińska, 2018). There may also be multiple marginalization’s. This can also include an immigrant status, or age. There may similarly be multiple disadvantages for Muslim Americans who are also African American, for example, justifying a focus on race and gender demographics, as well as skin color tone.

There is also value in investigating frequency of wearing Muslim identifying clothing. According to Sue (2010), “the more it is visually clear that a person identifies

with Islam, the more likely this person would be attacked” (p. 293). Ethnic clothing, or religious clothing has been linked to experiences of ethnic profiling, hate crimes, and workplace discrimination (Wilkins-Laflamme, 2018). Religious microaggressions can include a focus on Muslim clothing (e.g. hijab, headscarf) or appearance (e.g. beard). Research has shown a direct correlation between how a Muslim individual looks and their likelihood of being discriminated against (Vang, Hou & Elder, 2018).

### **Rationale for Assessing and Controlling for Socially Desirable Responses**

According to Van de Mortel (2008), people tend to present a favorable image of themselves via self-report data. Engagement in socially desirable responding confounds research findings by either creating false relationships or obscuring relationships among study variable. It is, therefore, important to use a measure of social desirability, and to statistically control for socially desirable responding (Van de Mortel, 2008).

### **Rationale for Investigating Other Predictors of Life Satisfaction**

Vang, Hou and Elder (2018) provided justification for asking about being a practicing Muslim, since data shows “the frequency of attending religious services has been shown to be another important aspect of religion that affects well-being” (p. 5). Further, religious “attendance ensures regular interaction with other congregants, creating a sense of belonging reinforced by a common set of beliefs, values, and interests” (p. 5). Religiosity is a multidimensional, while including “the strength of an individual’s religious beliefs or spirituality, religious social ties, salience of religious identity, and intensity or frequency of religious practices, among other things (p. 5). Religiosity, or

religious belonging is hypothesized to enhance life satisfaction (Vang et al., 2018). On the other hand, Ikizler and Szymanski (2018) found for a sample of Middle Eastern/Arab Americans that high religiosity was a risk factor for experiencing discrimination and being vulnerable to related psychological distress. Hence, investigating religiosity using a single item scale is justified, especially as others have found very good reliability with adult Muslims (Abdel-Khalek, 2007).

Research has shown that a single item scale assessing life satisfaction, using a scale of 1 (very dissatisfied) to 10 (very satisfied), and asking about how the individual feels about their life as a whole right now, has great value (Vang, Hou & Elder, 2018). Such a scale of Life Satisfaction has been used widely in global research, while emerging as a reliable and valid measure of well-being. Life Satisfaction is similar to the construct of overall quality of life, and extent of exposure to discrimination is an important factor in determining quality of life (Vang et al., 2018).

Using both the Perceived Stress Scale and Life Satisfaction Scale, as well as a Resilience Scale, it was found that via multiple regression that perceived stress accounted for a significant amount of variance in life satisfaction (Abolghasemi & Varaniyab, 2010). Perceived stress has also been found to be a moderate predictor of life satisfaction (Hamarat, Thompson, Zabucky, Steele, Matheny & Aysan, 2001). Thus, there is justification for investigating perceived stress, as well as life satisfaction—including support for selecting life satisfaction as the study outcome variable/dependent variable.

### **Rationale for a Focus on Depression, Anxiety and Posttraumatic Stress Disorder**

Research has shown that the ways in which people cope with a stressful event may be related to their experience of depression (Folkman et al., 1986). There may also



be a link between experiencing situations as psychological threatening and anxiety (Folkman et al., 1986). It is speculated that having uncontrollable experiences and feelings of helplessness may be associated with “increasingly passive” coping efforts and feelings of demoralization and depression (p. 571). Others have investigated coping methods with stressful interpersonal events experienced by Muslims living in the United States following the 9/11 attacks, finding evidence of depression, anxiety, and symptoms of posttraumatic stress disorder, depending upon how they perceived the 9/11 events (Abu-Raiya, Pargament, & Mahoney, 2011). Thus, there is justification for investigating the prevalence of experiences of trauma across the lifespan, as well as past year depression and anxiety, and also symptoms of posttraumatic stress disorder.

### **Rationale for Investigating Ability to Perceive Islamophobia Coping**

Aroian (2012) asserted that the “cognitive ability to perceive discrimination based on group identity is well established by adolescence” (p. 206). However, as per the work of Clark et al., (1999), perceived racism involves one’s subjective experience of prejudice or discrimination, while racism is not always perceived. In addition, coping in response to perceived racism may be adaptive, or mitigate negative, enduring psychological and physiological stress responses, or be maladaptive—with persistent states of psychological and physiological arousal that may damage health over time. Following the work of Clark et al. (1999), the work of Wallace (2005) provided a rationale for assessing both the level of ability to perceive racism and/or oppression, as well as stage of change for the ability to actively cope and respond to racism and/or oppression.

Wallace (2005) broadened the focus beyond just perceived racism to oppression, in general, in order to accommodate the experiences of diverse marginalized and

oppressed groups—thereby encompassing groups such as Muslim Americans and exposure to Islamophobia and/or Islamophobic discrimination, as in the present study. Wallace (2005) also introduced the concept of there being stages of change for taking action to cope with racism and/or oppression (e.g. precontemplation, contemplation, preparation, action, maintenance, as per the theory of Prochaska & DiClemente, 1983). Thus, there is justification for focusing in the present study on the level of ability to perceive Islamophobia and/or Islamophobic discrimination, and the stage of change for taking action to cope and respond to it. Similarly, for taking action to engage in any behavior, level of self-efficacy for coping is also relevant. Thus, there is also a rationale for investigating coping self-efficacy spanning self-efficacy to engage in problem-focused coping, stopping unpleasant emotions and thoughts, and getting support from friends and family (Chesney, Neilands, Chambers, Taylor & Folkman, 2006).

### **Delimitations**

The study was limited to Muslim Americans, over the age of 18 who completed the study. Also, the study was delimited to those who completed the survey.

### **Limitations of the Study**

Study limitations included the following: use of an online sample of convenience, suggesting the sample may be biased toward those of higher socioeconomic status with convenient access to the internet; potential bias in self-reported data, a risk of providing socially desirable responses, as well a retrospective recall bias; and questions about stress, trauma, depression, anxiety, and experiences of Islamophobia and/or

Islamophobic, discrimination, as well as microaggressions, may evoke uncomfortable memories—and subjects may drop out or avoid the study—leading to a biased sample of those more able to manage these reactions, while excluding those unable or unwilling to share their experiences. These limitations must be kept in mind.

### **Definition of Terms**

This section will define the key terms that are associated with this dissertation.

**Covert violence** is violence that is not openly displayed to those not directly involved. Covert violence too can refer to physical harm and/or injury, however, it can also refer to violence that is verbally derogatory in nature (Brown, McLean, & McMillan, 2018).

**Health disparities** are defined as “systematic, potentially avoidable differences in health—or in the major socially determined influences on health—between groups of people who have different relative positions in social hierarchies according to wealth, power, or prestige (Braveman, 2006, p. 167). Further, health disparities are negatively associated with health outcomes.

**Health equity** is the “striving to eliminate health disparities strongly associated with social disadvantage” by “removing obstacles for groups of people—such as the poor, disadvantaged racial/ethnic groups, women, or persons who are not heterosexual—who historically have faced more obstacles to realizing their rights to health and other human rights” (Braveman, 2006, p. 181).

**Life satisfaction** is thought to be the extent to which an individual “positively evaluates the overall quality of his/her life as-a-whole” and is “believed to have antecedents

in the work domain, family domain and personality traits”; further, life satisfaction is an individual’s “conscious experience as to the dominance of their positive emotions over their negative emotions” (Prasoon & Chaturvedi, 2016, p. 26).

**Intersectionality** is the thought that “intersection of age and gender, race, socioeconomic level, sexual orientation” are the foundation of racism and discrimination (Ayalon, & Tesch-Römer, 2018, p. 8). It has been established that there is a significant link between social inequity and negative health, however, “attempts to explain this inequality that focus only on a single demographic factor, such as sex, race, or immigration status, often fall short of explaining health disparities” related to intersectionality (p. 2437).

**Intersectional inequality** or the idea that “multiple sources of inequality produce intersectional identities as embodied in the social identities constituted by the master statuses of sexuality, gender, class, race, ethnicity, and physical ableness” (Hurtado, 2018). Studying intersectional inequalities allow for one to “examine both intersections of disadvantage (e.g., being poor and of color) or intersections of both of disadvantage and privilege (e.g., being male and of color) as well as the “study of privilege when advantaged social identities are problematized” related to social and economic inequalities (Hurtado, 2018).

**Islamophobia** can be defined as a “social stigma towards Islam and Muslims, dislike of Muslims as a political force, and a distinct construct referring to xenophobia and racism towards Muslims or those perceived to be Muslim” (Samari, Alcalá, & Sharif, 2018, p. e2).

**Islamophobic discrimination** or the discrimination against Muslims based on their religion is typically acted upon by Islamophobics, or those that dread or fear Muslims.

Islamophobics tend to view Muslims as “the same and unchanging, with no real distinction between the plurality of communities and their histories” and may believe that Muslims should be considered as “other” (Wilkins-Laflamme, 2018, p. 89).

**Nativism** is a “form of ethnocentrism that considers previous residence in a country or region to constitute a claim to superiority in culture or a higher class of citizenship” (Bennet, 2013).

**Microaggressions** are defined as “subtle, stunning, often automatic and nonverbal exchanges” meant to put someone down (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978, p. 66). The was first coined in the 1970’s and has since been expanded to include “everyday verbal, nonverbal, and environmental slights, snubs or insults, where intentional or unintentional, that communicate a hostile, derogatory, or negative messages to target persons based solely upon their group membership” (Sue, 2010, p. 3). Examples of such group membership can include race, ethnicity, sexual orientation, gender, and religious affiliation.

**Macroaggressions** are defined as the “verbal or non-verbal communications that are not only purposeful and deliberate but are meant to create longitudinally debilitating and depressive results in the victim” (Osanloo, Boske, & Newcomb, 2016, p. 6). These types of communications move “past the subtle, unconscious aspects of microinsults and microinvalidations into a more literal and overt space” (Osanloo, Boske, & Newcomb, 2016, p. 6).

**Overt violence** “refers to an act of force exerted to impart physical harm or injury on another person” and unlike covert violence, is done openly and publicly (Brown, McLean, & McMillan, 2018). This type of violence refers exclusively to physical harm

or injury, neglecting psychological abuses or attacks” (Brown, McLean, & McMillan, 2018).

**Perceived racism** is the extent to which an individual subjectively identifies racist, prejudiced or discriminatory experiences (Clark et al., 1999, p. 808). Further, coping mechanisms to perceived racism can either be adaptive or maladaptive. Adaptive coping refers to the ability to mitigate negative stressors related to perceived racism and is thought to “reduce the potentially untoward effects of racism on health”, while maladaptive coping refers coping mechanisms that “do not attenuate stress responses and may negatively affect health” (Clark et al., 1999, p. 809).

**Perceived stress** or the “impact of ‘objectively’ stressfully events” is thought to be “determined by one’s perceptions of their stressfulness” (Cohen, Kamarck, Mermelstein, m 1983, p. 387). Perceived stress has been linked to “increased risk for disease associated with the occurrence of easily identifiable events” and are often temporal in nature (p. 386).

**Religiosity** is a multidimensional concept that is defined as “the strength of an individual’s religious beliefs or spirituality, religious social ties, salience of religious identity, and intensity or frequency of religious practices, among other things” (Vang, Hou, & Elder, 2018, p. 5).

**Self-efficacy** as defined by Bandura (1989), is the thought that “beliefs determine their level of motivation, as reflected in how much effort they will exert in an endeavor and how long they will persevere in the face of obstacles” (p. 1176). Self-efficacy can either be “self-aiding or self-hindering” (p. 1175). An individual’s self-efficacy functions as an “important set of proximal determinants of human motivation, affect, and action” and can affect “thinking patterns” as well as influencing action (p. 1175). As most human behavior

is regulated by goals, it has been found that the “higher the goals people set for themselves and the firmer the commitment”, the higher the self-efficacy of an individual (pp.1175-1176). Individuals with higher self-efficacy will tend to also see themselves more successfully and positively, with the opposite being true for individuals with low self-efficacy (Bandura, 1989, p. 1176).

**Trauma** is defined as the “state of disruption caused by stressors severe enough to threaten life or make one believe that one is about to die” (Elrod, 2013, p. 678). Trauma can also result in disruptions “to any or all levels of human functions, ranging from anatomical and physiological to existential and spiritual” and can “envelop individuals and range across groups and time including across generations” (p. 678). Oftentimes trauma does not fade, and leaves an “imprint, and even if covered by extra defenses, a degree of compromised functioning, sensitivity, and vulnerability remain” (Elrod, 2013, p. 678).

**Well-being** “refers to diverse and interconnected dimensions of physical, mental, and social well-being that extend beyond the traditional definition of health. It includes choices and activities aimed at achieving physical vitality, mental alacrity, social satisfaction, a sense of accomplishment, and personal fulfillment” (Naci & Ioannidis, 2015, p. 121).

**Xenophobia** is the “fear of foreigners or strangers, though the term is often used to refer to attitudes of hatred or contempt rather than pure fear” (Brown, McLean, & McMillan, 2018).

## **Conclusion**

This chapter introduced the topic of Islamophobic discrimination, stress, and quality of life of Muslim Americans living in the United States. It also served to provide an overview of the purpose and rationale of this study.

The following chapters will cover the following topics: Chapter II will provide a review of the literature relevant to this dissertation and study. Chapter III will include the methods utilized by this study. Chapter IV will include the results of data analysis. And Chapter V, will provide a discussion of the study results, including implications and recommendations for future research.



## Chapter II

### REVIEW OF THE LITERATURE

This chapter will provide a review of the existing literature that is relevant to this dissertation. More specifically, this chapter will detail literature related to the following topics: (1) Muslim American diversity (2) microaggressions; (3) macroaggressions; (4) exposure to overt acts of violence; (5) perceived stress and perceived racism; (6) Islamophobic discrimination; (7) intersectionality; (8) impacts on health; (9) protective factors; and (10) the theoretical framework guiding the study.

#### **I. Muslim American Diversity: Demographic Profile of American Muslims**

Estimates of Muslim migration have pointed to a large majority (72%) of Muslims being foreign born, migrating from countries such as Africa, Eastern and West Central Asia, and the Middle East (Wilkins-Laflamme, 2018, p. 88). More specifically, the majority of Muslims are of South Asian (32%), Arab American (26%) or African decent (20%) (Rippy & Newman, 2008, p. 54). And nearly “one fifth of American Muslims (19%) identify themselves as converts to Islam” (p. 88). Demographically, the Muslim population skews younger, is “better educated, has more members identifying as visible minorities” and commonly resides in more urban areas of the country (Wilkins-Laflamme, 2018, p. 88).

While Muslims have “for more than a century lived in the United States as citizens or legal residents, [they] have received very little scholarly attention from researchers” (Shammas, 2017, p. 100). Evidence points to the immigration of Muslims

into the United States as early as the late 1800's (Husain & Howard, 2017). However, there is little evidence that Muslims were discriminated against at that point in history. Documentation of Muslim discrimination came closer to the start of World War II where Muslims "suffered a similar fate in terms of discrimination as other Asian immigrants at the time, ranging from being victims of violence perpetrated by White workers to being referred to as 'slaves'" (Husain & Howard, 2017, p. 146). It wasn't until 1944 that the United States allowed for Muslims to gain citizenship (Abu-Ras, Suárez, & Abu-Bader, 2018, p. 2).

Political events such as the Iranian Revolution, the civil war in Lebanon, and the 1967 Arab-Israeli war resulted in a sharp increase of Muslim immigration (Husain & Howard, 2017, p. 146). This influx coupled with Muslim Americans who "selected quite actively to retain or at least promote their Islamic identity" began to turn the tides against Muslim Americans (p. 147). Media attention and the categorization of Muslims and Arabs as "other" lead to the dehumanization of Muslims and ensured "their second-class status upon arrival" (Husain & Howard, 2017, p. 147). Later, the September 11, 2001 attacks made Muslims living in the United States "the most frequently targeted group, exceeding other minority groups that have historically been targets" (Aroain, 2012, p. 206).

## **II. Microaggressions**

The term microaggressions first came to light in the late 1970's and is defined as "subtle, stunning, often automatic and nonverbal exchanges" meant to put down Black Americans (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978, p. 66). Sue (2010) later

expanded upon the definition of microaggressions by adding that they are “everyday verbal, nonverbal, and environmental slights, snubs or insults, whether intentional or unintentional, that communicate hostile, derogatory, or negative messages to target persons based solely upon their group membership” (p. 3). Examples of such group membership can include race, ethnicity, sexual orientation, gender, and religious affiliation.

Nadal (2008) adds that “based on empirical support of the existence of racial microaggressions, it is likely that similar experiences can occur for different minority groups” (p. 23). Consistent exposures to microaggressions have led “to a variety of emotional and psychological stressors” that “have lasting impacts on the mental health of recipients” (Nadal, 2008, p. 23). Additionally, “the relationship between racial discrimination and psychological stress, high blood pressure, depression, sleeping problems, substance abuse, eating disorders, and posttraumatic stress disorder” has also been established (Nadal, 2011, p. 470). As have negative impacts on self-esteem, self-efficacy, and performance (Nadal, 2011, p. 471). Individuals on the receiving end of microaggressions are “perceived negatively, given less status in society, and confined to existing in the margins of our social, cultural, political, and economic systems” (Sue, 2010, p. 5). Those guilty of microaggressions may not see themselves as such. As “most people experience themselves as good, moral, and decent human beings” and “discriminatory behaviors threaten their self-image”, these individuals “engage in defense maneuvers to deny their biases” (p. 5). Thus the “silence of the voices of the oppressed” continues and allows for “oppressors to maintain their innocence” (Sue, 2010, p. 6).

Per Sue (2010), “microaggressions reflect the active manifestation of oppressive worldviews that create, foster, and enforce marginalization” (p. 6). While it is common to consider the lasting effects of aggressive physical acts against an individual, “microaggressions can be many times more harmful to racial/ethnic minorities than hate crimes” adding that the “power of microaggressions lie in their invisibility to perpetrators and oftentimes the recipients” (p. 6). These lasting effects leave more than just a mental footprint and can cause “humiliation and pain, reduce self-determination, confine [the oppressed] to lesser job roles and status in society and deny equal access and opportunities in education, employment, and health care” (Sue, 2010, p. 6).

Sue et al. (2007) subcategorizes the types of microaggressions into three forms: microassaults, microinsults, and microinvalidations (p. 274). Microassaults or a purposeful “explicit racial derogation characterized primarily by a verbal or nonverbal attack meant to hurt the intended victim through name calling” (p. 274). These types of attacks are meant to harm the individual or and display minority inferiority. Microassaults are most often displayed publicly in two cases, either when an individual loses control or when they feel “relatively safe to engage in a microassault” (p. 274). Microinsults, rather, are “characterized by communications that convey rudeness and insensitivity and demean a person’s racial heritage or identity” (p. 274). Oftentimes, microinsults feel like a snub or can be hidden behind an insulting message and thus can often be “unknown to the perpetrator” (p. 274). Finally, microinvalidations are “communications that exclude, negate, or nullify the psychological thoughts, feelings, or experiential reality of a person of color (Sue et al., 2007, p. 274).

Examples of each type of microaggression in relation to this population are as follows: Microassaults are “acts that resemble the ‘old fashioned’ forms of racism, in which individuals speak and behave in blatantly racist ways” (Nadal, 2008, p. 22). Case in point, refusing to serve a Muslim American woman who wears the hijab (head covering) and demanding she remove her hijab. Microinsults are more subtle acts of discrimination in that the offender may not do so intentionally (p. 22). As with the example above, informing a hijab wearing Muslim American woman that her “English is very good”, when the offender has no idea if the woman grew up in the United States or what her personal history may be. Finally, an example of an microinvalidation against a hijab wearing woman would include telling her that you (the offender) have never discriminated against a person of another race or religion. In this case, such a statement would ignore the “person’s racial reality” and would “deny that he/she is capable of racism” (Nadal, 2008, p. 22).

In most cases, an individual will belong to some majority groups and some minority groups. Accordingly, “being part of a majority group comes with a series of privileges and power; whereas, being part of a minority group creates vulnerability and the potential to be targeted by members of the majority or other minorities” (Kaplin, 2017, p. 16). Concurrently, the “more minority groups a person belongs to, the more vulnerable they are to marginalization, invisibility, and intersectional microaggressions” (p. 16). Religious microaggressions too should be considered. Kaplan (2017) categorizes six types of religious microaggressions: “(a) endorsing religious stereotypes (b) exoticization of religious minority faiths (c) pathologizing marginalized religious groups

(d) assuming one's own religious identity is the norm (e) assuming religious homogeneity and (f) denying religious prejudice" (p. 17).

Let us define each of the above religious microaggressions. Religious stereotypes, or the promotion of an oversimplified ideal of an individual or group, can lead to discriminatory behavior against that group. Case in point, a religious stereotype about Muslims includes that they are "detached from American society, excessively religious, and that they pose a threat of violence and terrorism" (Kaplin, 2017, p. 18). Exoticization, or the act of making an individual or group "feel like their beliefs or actions are 'foreign' or 'bizarre'" can include the consistent asking of a Muslim woman why she chooses to wear the hijab (headscarf) in America or asking a Muslim man why he won't shave his beard (p. 18). Such questions can leave the Muslim individual feeling that that they are out of place and insecure and is also an example of a microinsult (p. 18). The implication that "a person's actions are sinful, immoral, or that a person's religious belief or practice is inherently wrong" can be patronizing to marginalized religious groups (p. 18). An example of this would include a statement to a Muslim individual stating that the "sharia" or the set of laws that Muslim adhere to, is too strict, too extreme, or outdated. The assumption of one's own religious identity as the norm is also a form of a microaggression. Here an individual may subconsciously interact with others as if they are part of the religious majority, in this case, as though they are Christians (p. 18). While not meant to cause harm, it can be considered a form of a microinsult to wish someone "Merry Christmas" or ask how they are celebrating Easter without knowing their religious background. Assumptions of religious homogeneity, or the assumption that all individuals of a religious group are the same, can include the belief that all Muslims

practice the same type of Islam in the same way (p. 19). This would include the denial of varying Muslim sects and of varying levels of an individual's Muslim religiosity (p. 19). Finally, the denial of religious prejudice is an individual's denial that individuals of other religions may experience forms of discrimination or microaggressions (Kaplan, 2017, p. 19). In this instance, an individual may deny that Muslims may be exposed to additional airport screenings for no reason other than their visibly Muslim appearance.

Post-offense, individuals may experience a sense of awkwardness and self-consciousness. The impact of a microaggression is thought to occur in five phases: "the incident, the perception, the reaction, the interpretation, and the consequence" (Sue, 2010). Following the experience, the victim may begin to feel the effects of the interaction. Per Husain and Howard (2017) the target's reaction to the incident may include "rumination over the incident, questioning his or her perception of the incident, emotionality, a desire to rescue the offender, and/or a sense of empowerment/self-validation" (p. 140). For example, a "Muslim Americans could be made to feel alone, despite being native born" after an experienced microaggression and may later experience "lower self-esteem" (p. 141). This could then lead to feelings of non-belonging, "powerlessness, invisibility, forced compliance/loss of integrity, or pressure to represent one's group" (Hussain & Howard, 2017, p. 140).

### **III. Macroaggressions**

Macroaggressions are "persistent and malicious" discriminatory acts that occur in the nebulous space between microaggressions and institutional/structural racism" (Osanloo, Boske, & Newcomb, 2016, p. 6). Macroaggressions are "verbal or non-verbal

communications that are meant to create longitudinally debilitating and depressive results in the victim” (p. 6). Macroaggressions “occur at a “structural level encompassing actions that are meant to exclude, either by action or omission” (p. 6). Accordingly, these behaviors should be examined from “purposeful, and conscious space” by researchers, as not doing so would run “the risk of continuing to examine and understand the concept from a White hegemonic space” and could result in an “even greater disservice to those that are impacted by the assaults” (p. 6). An example of a macroaggression towards Muslims Americans can include the non-compliance with laws or policies that would take care to protect Muslim Americans from exploitation in the workplace including “dangerous working conditions, long hours, and a multitude of health risks” (Osanloo, Boske, & Newcomb, 2016, p. 6).

Moreover, “daily structural macroaggressions communicate” to Muslim Americans that they are “less” than their counterparts (Osanloo, Boske, & Newcomb, 2016, p. 11). Further macroaggressions are considered to be “aggressive sociocultural intercultural interactions”, which have the ability to impact how Muslim Americans “not only interact with one another but understand how they are judged” by outsiders (p. 8). Macroaggressions “allow people to focus on examining perceived weaknesses or fixing the individual versus addressing the systemic conditions causing controversy” (p. 11). All the while “these beliefs become woven into the fabric of society and its socializing institutions such as schools, influencing hidden biases and perpetuating oppressive practices and policies (p. 11). Over time, these “deficit ideologies” continue to fester “because institutions house professionals who often accept the status quo ideology as the norm; and therefore, people do not tend to challenge deficit-laden norms” such as those



that are cultivated by macroaggressions (p. 11). Over time, macroaggressions have the power to become the “dominant cultural values and norms” of a society and can “perpetuate the marginalization of Othered populations and individuals” (Osanloo, Boske, & Newcomb, 2016, p. 12).

Further, microassaults are categorized as a type of macroaggression and are “similar to overt racism and comprise of conscious, mean-spirited acts against people of color” (Donovan, Galban, Grace, Bennet, & Felicie, 2012, p. 186). While microaggressions have readily been studied in their effects on perceived racial discrimination (PRD), “there is no empirical research that examines PRD in terms of racial macroaggressions” which can make it difficult to differentiate between a racially motivated macroaggression and/or a microaggression (p. 186). Additionally, it has been found that “because macroaggressions are blatant, egregious acts, they may be more difficult to cope with” (p. 193). Similar to microaggressions, macroaggressions too have been linked to poorer mental health outcomes and increased cases of “depressive and anxious symptoms” (p. 187). In their 2012 study, Donovan, Galban, Grace, Bennet, and Felicie (2012) found that in the past year, the top six most common sources of perceived microaggressive behavior came from arguments or fights, being accused or suspected, being called racist names, being made fun of or harmed, or from friends (p. 191).

#### **IV. Exposure to Overt Acts of Violence**

Overt acts of violence, such as hate crimes, have increased “17-fold since September 11, 2001” against Muslim Americans, Arab Americans, and individuals who appear to look Muslim or Arab (Abu-Ras & Abu-Bader, 2009, p. 397). By definition,

“anti-Muslim hate crime falls under the category of religious hate crime, which is where it is perceived, by the victim or any other person, to be motivated by hostility or prejudice based upon a person's religion or perceived religion” (Awan & Zempi, 2016, p. 3). These acts can include more than physical attacks. (p. 3). For example, “offensive graffiti, damage to property, abusive and threatening messages, harassment, intimidation, and verbal abuse” can all constitute as forms of hate crimes (p. 3). More specific to this population, there has been “a significant spike in anti-Muslim attacks, ranging from online threats, incitement, and harassment to actual physical attacks and arson in public” as well as “physical abuse and property damage in the public space (Awan & Zempi, 2016, pp. 1-2).

Spikes in attacks have been temporally linked to national and international terrorist attacks where Muslims have, unfortunately, been responsible for the attacks. As a result, these events “demonize Islam and Muslims” and “legitimize anti-Muslim attacks” (Awan & Zempi, 2016, p. 1). Links too have been established between online and later offline acts of violence. In fact, it has been found that “online communicative messages are used” to engage with anti-Muslim individuals to provoke “offline protests and demonstrations” and “promote anti-Muslim hatred and, in some cases, actual offline violence” (p. 2). Additionally, it has been found that “Muslim women are more vulnerable to intimidation, violence, and harassment” compared to their male counterparts (p. 2). This was found to be linked to the “visibility of a Muslim women’s Muslim identity”, particularly women who were “wearing the hijab or niqab” at the time of an attack (p. 3). Of note, in other, non-Muslim, cases of hate crimes, for example racially motivated hate crimes, “typically, males are overwhelmingly the victims” (p. 3).

It is believed that Muslim women are more targeted victims of hate crimes because attackers view “Muslim women as oppressed, dangerous, and segregated, and mark them a “uniquely” vulnerable” targets (Awan & Zempi, 2016, p. 4).

To further highlight how intensely violence against Muslim Americans has increased, it is imperative to note that, in the year 2000, only 28 hate crimes were reported; comparatively, a “1600 percent increase in such hate crimes” was noted from 2000 and 2001 (Disha, Cavendish, & King, 2011, pp. 21-22). And while in the decade following, hate crimes against Muslims decreased from the initial spike immediately following the September 11, 2001 terror attacks, the “numbers of anti-Muslim hate crimes remained five times what they were in 2000” (p. 22). Correlations between group size and the likelihood of an attacks has also been established. Case in point, it was noted that more densely populated geographic areas will see an increased likelihood of “intergroup crime simply because there are more targets available” (p. 23). Additionally, cases of violence against Muslim Americans, and more generally against minority groups, have been found to sharply increase when the majority group feels threatened by the minority group. And as the majority groups “seek to maintain their powerful positions” they may “resort to discrimination and perhaps even violence to obviate threats from minority groups” (p. 24). Further, hate crimes are perpetuated when members of the majority “are emboldened to act on their prejudices when they anticipate little or no reprisal from local law enforcement and a low likelihood of retribution from the minority group” (Disha, Cavendish, & King, 2011, p. 24).

Post 9/11, a shift in focus from other minority groups towards Muslim Americans occurred in the United States. Previous to this, “their plight was overshadowed by the

concerns of other minority groups (Disha, Cavendish, & King, 2011, p. 26). However, suddenly Muslim Americans were viewed as a “unified, coherent, and threatening group consisting of ‘foreigners,’ ‘extremists,’ and ‘terrorists’” (p. 26). Thus, the American environment became one that was “highly conducive to acts of aggressive retaliation against individuals who appeared to display characteristics of an Arab ancestry or Islamic faith” (Disha, Cavendish, & King, 2011, p. 26).

Aroian (2012) adds that adolescents are not immune to anti-Muslim violence, in fact, this age group can “encounter persistent problems in school, including physical assaults and death threats from peers and overt ethnic and religious bigotry and harassment from teachers, school administrators, and peers (p. 206). As the period of adolescence is “a time when youth explore self-identity, including racial and ethnic identity and the meaning of minority status” they inherently become aware that they are targets for discrimination and anti-Muslim violence (p. 206). Per a study by Aroian (2012), “seven of the nine reported incidents of interpersonal discrimination occurred in a school setting” were reported by adolescents (p. 209). The other two discriminatory events involved strangers in public, with female Muslims reporting being attacked more than male Muslims did, with Muslim dress and the hijab being a focal point for attackers (p. 2010).

## **V. Perceived Stress and Perceived Racism**

Perceived stress, or the “impact of ‘objectively’ stressfully events” is thought to be “determined by one’s perceptions of their stressfulness” (Cohen, Kamarck, Mermelstein, 1983, p. 387). Compared to measures of objective stress which seeks to

understand the “role of psychosocial and environmental stressors as risk factors in both physical and psychological illness” (p. 386). More plainly, measures of objective stress have been linked to “increased risk for disease associated with the occurrence of easily identifiable events” and are often temporal in nature (p. 386). However, given the “assumed centrality of the cognitive appraisal process” there is thought to be a “desirability [for] measuring perceived stress as opposed to or in addition to objective stress” (p. 386). Case in point, measures of perceived stress “could help to clarify the role of the appraisal process in the relationship between objective stressors and illness” (p. 386). Additionally, measures of perceived stress can help to shed light on whether factors such as “social support, hardiness, and the locus of control protect people from the pathogenic effects of stressful events by altering stressor appraisal or by altering the process or processes by which appraised stress results in physiological or behavioral disorder” (Cohen, Kamarck, & Mermelstein, 1983, p. 386).

Stress overall has been linked to poorer quality of life and more adverse physical and mental health outcomes (Aroian, 2012; Jasperse, Ward, & Jose, 2012; Nadal, 2008; Nielsen, Ørnboel, Vestergaard, Bech, Larsen, Lasgaard, & Christensen, 2016; Rippey & Newman, 2008). Examples of poor health outcomes include “increased risk of cardiovascular events, metabolic syndromes, and mortality” as well as the burden of mental illness which can cause “serious productivity loss with societal implications” (Nielsen, Ørnboel, Vestergaard, Bech, Larsen, Lasgaard, & Christensen, 2016, p. 22).

Further, “in many instances, visible minorities or “others” are believed to be at greater risk for mental health problems, particularly due to the stress of greater discrimination linked to visibility” of being a minority (Jasperse, Ward & Jose, 2012, p.

252). Stress can lead to “lower life satisfaction and greater symptoms of psychological distress” (p. 253). Two major hypotheses exist regarding perceived stress, ethnic identity, and discrimination. The first supports the notion that “ethnic identity acts as a coping resource and buffers the detrimental consequences of discrimination” and protects minorities from the adverse physical and mental health outcomes related to discrimination (p. 254). Conversely, the second states that “ethnic identity highlights minority status and exacerbates the stress of discrimination” and is directly linked to poorer health outcomes (p. 254). Further research has found that women are more prone to internalizing religious based discrimination and stress. This is due to women having a “strong psychological sense of Muslim identity” and thus they “experience a heightened reaction to threat, which elicits significantly more distress in response to religious discrimination (p. 265). Muslim women not only experience the “stress of prejudice and discrimination, but also the constraints of an appropriately ‘Muslim response’” which together, “negatively impact psychological well-being” (Jasperse, Ward & Jose, 2012, p. 265).

Additional research has found that “individuals who have already experienced trauma (survivors of war, immigrants, refugees, or those who have lived through periods of unemployment or discrimination) are more vulnerable to severe stress reactions following a traumatic event” (Abu-Ras, & Abu-Bader, 2009, p. 394). Many Muslims living in the United States are first generation immigrants. And as “migration is a difficult process” and “a very stress-inducing experience” it can “lead to various social and mental health issues ranging from social isolation and adjustment limitations, to depression and anxiety”; particularly if migrants are from politically unstable home-

countries (p. 396). Once Muslims find themselves in a new country without a support system, “isolation and loneliness set in, which can impede adjustment to a new society, and can increase vulnerability to stress reactions” (p. 399). Here, gender also matters. Muslim immigrant women have been found to be “especially vulnerable to depression and PTSD” as they are “more likely than men to be dependent on their support systems in dealing with trauma or crisis” (p. 410). These women find that “their social isolation may impede their adjustment to their new society and may also increase their vulnerability to stress reactions to trauma” (p. 410). Conversely, Muslim men, regardless of migration status, “are more likely to be perceived as threatening to others, and are therefore more likely to be arrested, interrogated, or otherwise discriminated against” and thus are more prone to higher levels of perceived stress (Abu-Ras, & Abu-Bader, 2009, pp. 410-411).

## **VI. Islamophobic Discrimination**

The religion of Islam is growing globally and currently has the second largest number of believers worldwide; concurrently the proportion of Muslim Americans who have experienced discrimination and Islamophobia is also on the rise (Samari, Alcalá, & Sharif, 2018, p. e2). Islamophobia can be defined as a “social stigma towards Islam and Muslims, dislike of Muslims as a political force, and a distinct construct referring to xenophobia and racism towards Muslims or those are perceived to be Muslim” (p. e2). Recent negative media focus and political opposition in the United States towards Muslims as well as a Muslim travel ban, public harassment of Muslims and Muslim places of worship, and increased racial profiling have ultimately led to “assaults against

Muslims in the United States surpass[ing] the modern peak reached after 9/11” (Samari, Alcalá, & Sharif, 2018, p. e2).

As a result of high-profile terrorism events in the past decade, the increasing spread of ISIS, the civil war in Syria and subsequent influx of Syrian refugees into Europe and the United States, Muslims living in the West have been subject to increasing discrimination and Islamophobia (Wilkins-Laflamme, 2018, p. 87). Islamophobics, or those that dread or fear Muslims, tend to view Muslims as “the same and unchanging, with no real distinction between the plurality of communities and their histories” and believe that Muslims should be considered as “other” (Wilkins-Laflamme, 2018, p. 89). In fact, per a study by Wilkins-Laflamme (2018) Islamophobics believe that Muslims have “no values in common with Westerners and [are] not influenced by Western culture in any way” and see Islam as an “inherently violent religion and political ideology” (p. 90). Islamophobics also see all Muslims as “religious radicals or fanatics; and seeing all of Islam and Muslims as inherently mistreating women and generally traditionalist” (Wilkins-Laflamme, 2018, p. 90).

Muslims may face different types of discrimination. For example: direct discrimination, indirect discrimination, and what is referred to as usual discrimination. In the case of direct discrimination, Muslims are “explicitly denied a right or a freedom, either in the labor market, workplace, at school, by government organizations, by ethnic profiling, or by hate crimes perpetrated against them” (Wilkins-Laflamme, 2018, p. 90). It is of importance to note that the “intentional exclusion of Muslims is the product of public laws and policies” otherwise known as institutional discrimination (p. 90). Rather, indirect discrimination occurs when there may be “an uneven effect for



Muslims by a measure put in place, even though this was not the explicit intention of whoever enacted the measure” (p. 90). For example, applying a dress code in a workplace that would exclude all forms of religious dress – this would force a Muslim, hijab (headscarf) wearing woman to remove her headscarf in order to comply with the policy, however, this policy would not only impact Muslims, it would impact any individual who wore religious clothing. Finally, there is what is referred to as usual discrimination, or the “negative attitudes and discriminatory practices toward Muslims among some individuals and private organizations, such as discriminatory media coverage or conflicts surrounding places of worship” (p. 90). While some acts of discrimination are more externally visible than others, all acts of discrimination can be felt by the individual who is discriminated against and can result in negative physical and mental consequences for those individuals (Wilkins-Laflamme, 2018, p. 91).

Sociodemographics play a role in the positive or negative perception of Muslims by non-Muslims. Negative attitudes towards Muslims have been attributed towards a lack of higher education amongst those who possess those negative attitudes (Wilkins-Laflamme, 2018, p. 92). In fact, a lack of higher education has actually outranked social class, gender, [and] religious minority status as a “mitigating factor in negative attitudes towards Muslims” (p. 92). In general, age is also a factor in the likelihood that an individual will perceive others negatively since “younger generations have also been found to be less likely to display negative attitudes toward Muslims and toward other minority groups” (p. 92). Religiosity has too been linked to Islamophobia, as “Christian fundamentalists have been associated with greater prejudice toward Muslims specifically

and towards other minority groups such as homosexuals, feminists, immigrants, racial and ethnic minorities as well as the nonreligious” (Wilkins-Laflamme, 2018, p. 92).

Regarding the direction of discrimination towards a specific religion, both Husain and Howard (2017) and Sue (2010) note that Muslim Americans are not the first religious group to face challenges. Case in point, in “pre-modern America, religious distinction was the basis for discrimination and persecution” (Husain & Howard, 2017, p. 144). Islamophobic discrimination is similar general microaggressions in that they are “subtle behavioral and verbal exchanges that send denigrating messages” to individuals or groups, but the catalyst of the behavior is triggered by an individual’s religion (p. 296). Sue (2010) further subcategorizes such religious microaggressions, such as Islamophobic discrimination, into six distinct categories; including, “endorsing religious stereotypes, exoticization, pathology of different religious groups, assumption of one’s own religious identity as the norm, assumption of religious homogeneity, and denial of religious prejudice” (p. 299).

While the U.S. is moving “towards becoming a progressively tolerant society, religious discrimination remains a blight that Americans have yet to overcome” (Sue, 2010, p. 287). And despite the statistical increase in religious discrimination, there has been “a paucity in the psychology literature regarding religious discrimination” (p. 288). Islamophobia and religious discrimination against Muslim Americans are certainly not new. While the September 11, 2001 attacks on the United States certainly pushed anti-Muslim sentiment to the forefront, Islamophobia “has been documented in many Western, European countries” well before 2001 and it has been reported to “exist throughout history” (p. 293). Discrimination towards Muslims takes on the same form

that it would for any other group or individual that has historically been discriminated against. Islamophobic discrimination can come in the form of “offensive jokes, being stared at, hearing insensitive remarks, and witnessing more offensive stereotypes in the media” (Sue, 2010, p. 293).

While the effects of Islamophobic discrimination may leave Muslim Americans feeling that they need to conform to the majority, it has been found that “forced conformity may have a deleterious impact on targets of microaggressions” adding that for Muslims “the loss of religious integrity may be more detrimental than conformity to racial standards, considering the centrality of religion in their lives” (Husain & Howard, 2017, p. 142).

Islamophobic discrimination can also come from groups. In fact, governments, law enforcement, other religious organizations, and the like can also direct discriminatory behavior towards Muslims as a group (Shammas, 2017, pp. 99-100). Specific examples include government surveillance programs, the 2011 King Congressional hearings, the New York Police Department and its religious profiling program and the “unconstitutional monitoring of Muslim American communities and Muslim student organizations” (Shammas, 2017, pp. 99-100).

Further examples of Islamophobic discrimination include “1) pathology of non-Christianity, 2) assumptions of Christianity, and 3) assumptions of religious stereotypes” (Nadal, 2008, p. 24). Examples include an individual who follows the Christian religion “assuming that non-Christians are ‘evil’ or ‘immoral’” or someone who perpetuates the notion that non-Christians are “going to hell” (p. 24). Religious assumptions are also classified as a form of Islamophobic discrimination; case in point, as assuming all

individuals celebrate the same holidays as Christians (Christmas, Easter, etc.) and wishing them merry holidays or having a fear of Muslim strangers on airplanes or in public (Nadal, 2008, p. 24).

According to Aroian (2012) “extensive population-based studies, and local studies of specific racial and ethnic groups” have concluded that “acute and sustained exposure to discrimination has cumulative effects that adversely impact mental and physical health and child development” (p. 206). Negative psychological and emotional effects related to discrimination in children are “poor self-concept, internalizing and externalizing behavior problems, poor academic performance, limited life aspirations, and estrangement from mainstream society” (p. 206). Furthermore, as the transition from childhood to adulthood occurs, as does the individual’s awareness of discrimination. The “cognitive ability to perceive discrimination based on group identity is well established by adolescence” (p. 206). Particularly since by adolescence “minority children understand discrimination and are sensitive to subtle expressions of prejudice and how others negatively characterize their racial or ethnic group” (Aroian, 2012, p. 206).

The perception of religious discrimination (PRD) and Islamophobia are “related but functionally and operationally different (Abu-Ras, Suárez, & Abu-Bader, 2018, p. 2). While both PRD and Islamophobia occur at the micro level, Islamophobia can also occur at the mezzo and macro levels and thus it becomes “important to assess individual, environmental, and institutional instances of perceived discrimination to have an expanded view of personal perception of the impact of Islamophobia as an environmental stressor” (p. 2). It is also suggested that Islamophobia “reflects not only hostility toward Muslims and Islam, but also a pattern of current and historical discriminatory policies and

practices” (p. 2). In the wake of the September 11, 2001 attacks in the United States, “not only are [Muslims] perceiving more discrimination, but the Federal Bureau of Investigation and Human Rights Watch have documented that Muslims are subjected to hate crimes and other micro and macro aggressions” (p. 3). Research has shown that “Islamophobia and PRD compromise Muslims’ safety and well-being and are linked to wholeness and health and people’s ability to conduct their daily lives without fear of systematic or large-scale discrimination and violence” (Abu-Ras, Suárez, & Abu-Bader, 2018, p. 3).

Another form of Islamophobic discrimination occurring at the institutional level involves the restriction of public Islamic practice. Such bans have increased across Europe and have constrained the lives of Muslims living in non-Muslim majority countries. Beginning in 2009, a series of European bans on various facets of Muslim practice and religiosity have negatively impacted Muslims (Awan, Zempi, 2016, p. 2). Examples of such include the 2009 banning of minarets on newly constructed Mosques in Switzerland; the 2011 banning of niqab (or a face veil worn by some Muslim women) in France in “in public places including public buildings, educational institutions, hospitals, and public transport”, similarly Belgium too followed with a similar ban shortly thereafter as did the city of Barcelona in Spain, and smaller towns in Italy (p. 2). Closer to the United States, Canada too has banned the niqab at certain public events, for example it is “illegal for Muslim women to wear a face veil at citizenship ceremonies” (p. 2). Similarly, Australia has a “law requiring Muslim women to remove their face veil in order to prove their identity to police” and there has been a call for “banning of the face

veil in public in New South Wales, Australia, on the basis that it could be used for the purposes of terrorism” (Awan, Zempi, 2016, p. 2).

## **VII. Intersectionality**

Intersectionality theory “suggests that it is not age per se, but the intersection of age and gender, race, socioeconomic level, sexual orientation, and/or other factors which results in discrimination” (Ayalon, & Tesch-Römer, 2018, p. 8). Adding to this, is another definition that notes that the “intersecting effects of race, class, gender, and other marginalizing characteristics that contribute to social identity and affect health” (Seng, Lopez, Sperlich, Hamama, & Meldrum, 2012, p. 2437). There has been significant literature that has proven that the link between social inequity and negative health exists, however, “attempts to explain this inequality that focus only on a single demographic factor, such as sex, race, or immigration status, often fall short of explaining health disparities” (p. 2437). The reality of the situation is that it is likely that multiple demographic factors are linked to negative health outcomes. For example, “suicide among African American men is positively associated with education and wealth” (p. 2437). From a social-ecological perspective, current “approaches have relied on demographic items (e.g., race, income, gender) and have emphasized structural inequalities” (Seng, Lopez, Sperlich, Hamama, & Meldrum, 2012, p. 2438). However, more realistically, “intersectionality may be playing out across several levels. Of note, the conceptual linkages and estimation of the contributions across several levels in modeling have not yet been delineated” (p. 2438). Thus, more research should be done in order to identify the multiple “conceptual linkages between common variables and

intersectionality” in order to help “proportion of variance in outcomes potentially attributable to intersectionality at each of these levels” (Seng, Lopez, Sperlich, Hamama, & Meldrum, 2012, p. 2438).

According to the concept of intersectionality, multiple identities can lead to can lead to “individual empowerment, health, and well-being” in one context and may uncover important and underscored factors in cross-cultural and cross-national contexts” in another (Gonzalez, Stefenel, & Dimitrova, 2016, p. 31). With its roots in U.S. law and feminist scholarship, the concept of intersectionality and multiple identities was the first to recognize the “double discrimination of African American women based on gender and racial identity, and that in extension recognizes important differences among individuals rather than simply between individuals in the axis of power differentials, oppression, access, opportunity, and individual agency” (p. 32). Intersectionality “compels us to examine the process by which individuals negotiate competing and harmonious social identities, as well as the fluidity, variability, and temporality of interactive processes that occur between and within multiple social groups, institutions, and social practices” (Gonzalez, Stefenel, & Dimitrova, 2016, p. 32).

To highlight an example of multiple identities and intersectionality, let us consider the complexity of female Muslims as an example. Firstly, at the most basic level, is “their gender status as women”; this sex “generally face more discrimination in access to educational, financial, health, and social resources” (Awan & Zempi, 2016, p. 4). Secondly, their cultural identity “is shaped by structural social and cultural constraints provided by gender socialization and patriarchal processes”; notably, this also subjects women to “certain types of discrimination” (p. 4). Thirdly, the status of Muslim women

as “immigrants and minorities in a Western country and the resulting social and economic marginalization” that they may face (p. 4). Fourthly, Muslim women may have language barriers which “often result in loss of power, influence, and control over their family members” (p. 4). Fifthly, because of their religious identity, there is a “separation from men and the wider society” (p. 4). And finally, their “Islamic dress code that symbolizes modesty and physical integrity, and identifies them from non-Muslims, marking them as targets for hate crimes, discrimination, and possible violations of their bodily integrity (Awan & Zempi, 2016, p. 4).

### **VIII. Impacts on Health**

It is “clear that understanding and preventing racial discrimination is important in order to promote the physical and mental health” of minority groups (Nadal, 2011, p. 470). Discrimination or the “unjust treatment or action toward a person belonging to a different category, specifically minority groups” (Allen, Wang, Richards, Ming, & Suh, 2018, p. 2). The effects of discrimination on minority groups has well been studied and the results have established that those who are discriminated against can experience increased levels of mental and physical health outcomes; these can include: “higher levels of psychological distress increased odds of major depressive disorder or depressive symptoms in decreased social competence, raised daily cortisol levels, increased risk of lifetime alcohol use disorders, and increased anxiety symptoms” (p. 2). As a whole, religious discrimination is not as extensively studied as well as other forms of discrimination, such as LGBTQ discrimination and gender discrimination (p. 2). This despite the fact that “over the last decade religious discrimination claims have risen more



rapidly than other categories protected under the Civil Rights Act” (p. 2). Furthermore, it has been shown that “religious affiliation may be a more meaningful predictor of prejudice than race or ethnicity”, and thus more attention towards this topic is well deserved (p. 2).

While there has been little research on the effects of discrimination and its associations specifically with Muslim health status, it is clear that “Islamophobia undermines health equity” (Samari, Alcalá, & Sharif, 2018, p. e1). The link between “discrimination at multiple levels [and] poor health” has been established and can go so far as to have a negative physical manifestation on regulatory systems in the body (p. e2). Discrimination too has a negative effect on an individual’s mental health (Abu-Ras, Suárez, & Abu-Bader, 2018; Aroian, 2012; Samari, Alcalá, & Sharif, 2018). For example, stigma and bias against Muslim Americans can affect also their health by leading to “unequal access to health-enhancing resources or medical care” (Samari, 2016, p. 1921).

Islamophobia and the fear of increasing Muslim conversion rates and immigration into the United States began long before the September 11, 2001 attacks. In fact, “Islam was an aspect of early US racism and was connected to the transatlantic slave trade—Americans were using the fear of Islam as a unifying concept to define what it means to be American” (Samari, 2016, p. 1920). In today’s America, Islamophobia has extended past commonplace verbal and physical assaults and into the realm of healthcare. Research has found links not only between negative mental health outcomes, as stated above, but also to negative physical health and health disparities (p. 1921). According to Samari (2016), the “everyday experiences of discrimination are also associated with a wide

variety of physical and mental health outcomes” (p. 1921). Specific negative physical health outcomes include “coronary artery calcification, high levels of C-reactive protein, high blood pressure, giving birth to low-birth-weight infants, cognitive impairment, poor sleep, visceral fat, depression, psychological distress, anxiety, and mortality, as well as risk factors for poor health such as substance abuse” (p. 1921). Additionally, the effects of discrimination on health can be felt through “reduced access to resources and increased exposure to risk factors, stress, physiological processes, allostatic load, reduced participation in health care-seeking and health promoting behaviors, and violence” (Samari, 2016, p. 1921).

Muslims who dress in accordance to Islamic principles, for example, men who wear kufis (Muslim skullcaps) or women who wear hijab (headscarves) are prime for religious discrimination, followed closely by individuals who appear to be non-white (Samari, 2016, p. 1921). It has also been found that non-Muslims who appear to be Muslim, for example, men who wear shalwar kameez (traditional Pakistani and Indian dress) or a turban or who appear to be non-white and have beards, have too been subjected to discrimination. These individuals, like Muslims who have been discriminated against, report “increased psychological distress, lower levels of happiness, and poorer perception of health status” (p. 1922). Interestingly enough, while Middle Eastern Americans or Arab Americans are classified as “White” in terms of their demographics and census, they “do not benefit from White privilege and are still exposed to Islamophobia based on physical appearance” and “Arab Americans who identify as White experience more discrimination-associated psychological distress” (Samari, 2016, p. 1922).

Discrimination can deter an individual from seeking healthcare when needed and from positively associated health behaviors. Unfortunately, “religious discrimination alienates individuals from the health system, directly interfering with health messaging in Islam that promotes disease prevention and care seeking” (Samari, 2016, p. 1922). Further adding to the negative associations with the health system are negative attitudes of providers towards Muslim patients. Case in point, when Muslim refugee patients were asked about their experiences with non-Muslim providers in the United States, they noted that the providers were “unhelpful, patronizing, and [had] stereotypical attitudes toward Muslim women—believing they [were] excessively pious, [had] too many children, and [were] oppressed by their husbands (p. 1922). Religious discrimination in a healthcare setting can result in “stress, social isolation, reductions in health promoting behaviors, discounting of health care providers’ information, and delays in seeking medical care” (Samari, 2016, p. 1922).

Religious discrimination can manifest itself through multiple health pathways. For example, at the individual level, Muslims can experience increased levels of stress and as a result can influence the “onset, progressions and severity of illness” (Samari, 2016, p. 1922). Additionally, stress and social marginalization can lead to high blood cortisol and heart rates which can further lead to chronic illness in a patient (p. 1922). Regarding mental health at the individual level, Muslim American discrimination has been linked to paranoia and psychological distress (p. 1922). Findings have also seen positive associations between exposure to discrimination at a younger age and lifelong cumulative health effects (p. 1922). Furthermore, stereotyping has been found to affect social and psychological functioning and has led to Muslim American men hiding their identities

from the public and also been found to “negatively affect physiological, psychological, and self-regulatory processes” (p. 1922). At the interpersonal level, “Islamophobia based stereotype threats can adversely affect the patient–provider relationship by producing impaired communication, discounted provider information, or failure to obtain medical care” (p. 1922). Muslims who lack comfort and trust in their healthcare providers have also reported fearing “obtaining services or [have felt] misunderstood by health care providers” and can impact the likelihood that an individual will seek preventative health services (Samari, 2016, p. 1922).

Community has shown positive impacts on health and can “buffer the adverse effects of discrimination on health” (Samari, 2016, p. 1923). However, the sociopolitical context in which Muslims are seeking community matters. Case in point, it was found that “identifying as Muslim in our current sociopolitical context is more of a stressor than an avenue for social support and so is more detrimental than protective for health” (p. 1923). Adding to this, from a “public health perspective, the social climate of Islamophobia in the United States is a risk factor for poor health” (p. 1921). Islamophobia too has been linked to “stigma and discrimination, which are known fundamental causes or determinants of adverse health” such as “suicide, greater violence and homicide, and cardiovascular disease” (p. 1921).

### **IX: Protective Factors? Muslim American Life Satisfaction and Religiosity**

Religiosity is known to have a protective effect on an individual’s well-being. Let us begin by defining religion as the “system of belief or worship” and religiosity as a multidimensional component that includes “the strength of an individual’s religious

beliefs or spirituality, religious social ties, salience of religious identity, and intensity or frequency of religious practices, among other things” (Vang, Hou, & Elder, 2018, p. 5). As further explained by the thesis of religious belonging, such as that to an Islamic community allows for “likeminded friendships and communities to form” and offers a network “of material and emotional support as well as co-religious solidarity for members” (p. 5). Religious communities offer its members a haven of comfort and social support and can allow for coping resources in times of need. The thesis of religious belonging adds that “that belief in a ‘divine other’ and perceived closeness to God may facilitate well-being by creating a sense of ontological security and personal import that enhances life satisfaction” of which tightknit Muslim communities can take advantage of during times of social and political distress (Vang, Hou, & Elder, 2018, p. 5).

Social identity, well-being, and the extent to which an individual has been discriminated against are important factors in determining the overall quality of life of an individual. Case in point, according to social identity theory, “social groups are an important source of individual and collective self-esteem for human beings” (Vang, Hou, & Elder, 2018, p. 3). Groups or communities, such as the Muslim community, help to provide its “members with a sense of identity, belonging, and self-worth” and are linked to protective and positive mental health outcomes (p. 4). Case in point, research has shown that “involvement in religious social activities have been found to positively enhance life satisfaction” (p. 5). Additionally, it has been shown that the more involved an individual is with their community, the more pronounced the positive effects are on that individual. In fact, the “frequency of attending religious services has been shown to be another important aspect of religion that affects well-being” (p. 5). Also, the

attendance of religious meetings/seminars/prayers “ensures regular interaction with other congregants, creating a sense of belonging reinforced by a common set of beliefs, values, and interests” (p. 5). Conversely, a disengaged individual will not experience the same sense of belonging as an engaged individual. Furthermore, a threat to the group’s social status can too have “dampening effects on members’ self-esteem” and can result in a loss of well-being (p. 4). Negative groups stereotypes, such as Muslims being viewed as terrorists and/or being openly discriminated against, can result in both direct and indirect behavioral and psychological consequences to a group’s social identity and thus their overall quality of life and well-being (p. 4). In terms of religious discrimination, being treated “unfairly or differently by outsiders because of one’s religion can signify to individuals that their group is less valued relative to others” and can devalue their social identity and can lead to increased levels psychological distress such as depression, anxiety, as well as psychosomatic symptoms (Vang, Hou, & Elder, 2018, p. 4).

There has been a direct correlation between how “Muslim” an individual appears and their likelihood of being discriminated against. According to Sue (2010), “the more it is visually clear that a person identifies with Islam, the more likely this person would be attacked” (p. 293). In fact, the “visible differentiation of these religious minorities along racial/ethnic lines may make them more prone to differential treatment, raising the question of how religious affiliation might affect experiences of discrimination and, related, subjective well-being” (Vang, Hou, & Elder, 2018, p. 1). Accordingly, the suspicion of minorities and Muslims in the United States has grown from an “undermined sense of citizenship, out-group distrust, and fear in Muslim communities” as well as the increase in international terror attacks by Muslims and has consequently led to religious

based hate crimes increasing and unequal treatment of minorities (p. 1). Furthermore, links between overall reported quality of life and religious discrimination have too been established by the literature minorities (Vang, Hou, & Elder, 2018, p. 1).

## **X. Theoretical Framework Guiding the Study**

Multiple theories provide a foundation for this research study. More specifically, the theories providing the theoretical framework guiding the study are, as follows: Stress and Coping theory (Folkman, Lazarus, Gruen, & DeLongis, 1986); The Theory on the Biopsychosocial Effects of Perceived Racism (Clark, Anderson, Clark, and Williams, 1999); the Stages of Change from the Transtheoretical Model (DiClemente & Velasquez, 2002); and Self-efficacy from Social Cognitive Theory (Bandura, 1989). The next section will highlight each of these and their contribution to this study.

### **Stress and Coping Theory**

Stress and Coping Theory examines the link between “stressful events and indicators of adaptational status such as somatic health and psychological symptoms” with a “belief that this relation is mediated by coping processes” (Folkman, Lazarus, Gruen, & DeLongis, 1986, p. 571). The theory posits that “these coping processes are at least moderately stable across diverse stressful situations, and so, over the long term, they affect adaptational outcomes” (p. 571). Stress and Coping Theory is also based on the framework that there is a “dynamic, mutually reciprocal, bidirectional relationship” between the person and the environment” (Folkman, Lazarus, Gruen, & DeLongis, 1986, p. 571). Both of which impact how well an individual can cope.

Coping is defined as a “person's cognitive and behavioral efforts to manage (reduce, minimize, master, or tolerate) the internal and external demands of the person-environment transaction that is appraised as taxing or exceeding the person's resources” (Folkman, Lazarus, Gruen, & DeLongis, 1986, p. 572). Accordingly, coping has two purposes. Firstly, coping allows an individual the capacity to deal “with the problem that is causing the distress” (Folkman, Lazarus, Gruen, & DeLongis, 1986, p. 572). This is known as problem-focused coping. Examples of problem-focused coping include “aggressive interpersonal efforts to alter the situation, as well as cool, rational, deliberate efforts to problem solve, and emotion-focused forms of coping include distancing, self-controlling, seeking social support, escape-avoidance, accepting responsibility, and positive reappraisal” (p. 572). Secondly, coping allows an individual to normalize their emotions; known as emotion-focused coping (p. 572). When coping, it has been found that “people use both forms of coping in virtually every type of stressful encounter” (Folkman, Lazarus, Gruen, & DeLongis, 1986, p. 572).

Stress and Coping Theory was applied to this study's survey to examine how Muslim Americans are coping with stressful events. In the study survey, the section titled Coping Self-Efficacy Scale—Reduced (CSES-RF-13) in Chapter III provides more details.

### **Theory on the Biopsychosocial Effects of Perceived Racism**

The Theory on the Biopsychosocial Effects of Perceived Racism as defined by Clark, Anderson, Clark, and Williams (1999) looks to examine the “effects of intergroup racism and intragroup racism” on health outcomes (p. 805).



The Theory on the Biopsychosocial Effects of Perceived Racism posits the following three principles: firstly, if an individual perceives that they've been exposed to racism and that the experience was "stressful, it may have a negative biopsychosocial sequela" and may also "help explain intergroup differences in health outcomes" (p. 806). Secondly, the theory asserts that "differential exposure to and coping responses following perceptions of racism may help account for the wide within-group variability in health outcomes" (p. 806). Thirdly, it is believed that if "exposure to racism is among the factors related to negative health outcomes" that "specific intervention and prevention strategies could be developed and implemented to lessen its deleterious impact" (p. 806). Ultimately, the researchers found that the combination of the aforementioned three principles was needed to "supplement the efforts aimed at reducing health disparities in American society" (Clark, Anderson, Clark, & Williams, 1999, p. 806).

Adding to the above, it was found that the "principal tenet of this proposed model" is the "perception of an environmental stimulus as racist results in exaggerated psychological and physiological stress responses that are influenced by constitutional factors, sociodemographic factors, psychological and behavioral factors, and coping responses" (Clark, Anderson, Clark, & Williams, 1999, p. 806). As time goes on, these negative environmental stimuli are thought to negatively impact health outcomes. Additionally, the theory asserts that coping mechanisms are a "complex interplay between an array of psychological, behavioral, constitutional and sociodemographic factors" (p. 806). The theory suggests that minorities, particularly the African American population that was studied for the purpose of the theory development, are "more disproportionately exposed to environmental stimuli" which may result in an increased

perception of “chronic and acute stress” (p. 807). The combination of which has the “potential to contribute to psychological and physiological sequelae that may be particularly toxic” for individuals (Clark, Anderson, Clark, & Williams, 1999, p. 807).

The Theory on the Biopsychosocial Effects of Perceived Racism was applied to this study survey to examine how perceived racism is affecting Muslim Americans. In the study survey, the section titled: Perceptions of Islamophobia and/or Islamophobic Discrimination in Chapter III can provide more details.

### **Stages of Change from the Transtheoretical Model**

DiClemente and Velasquez (2002) describe the importance of the stages of change by noting that they “represent a key component of the Transtheoretical Model and describe a series of stages through which people pass as they change a behavior” (p. 201). According to the theory, in the process to change a behavior, an individual moves through five different stages: precontemplation, contemplation, preparation, action, and maintenance (pp. 201-202). In the first described phase in the stages of change, the precontemplation stage, individuals are “not convinced that the negative aspects of the current or problem behavior outweigh the positive” (p. 204). And thus, are unlikely to take the necessary steps to change behavior at this point. The next step in this model is described as the contemplation stage; here individuals may be “willing to consider the problem and the possibility of change” but may, again, be unlikely to change behavior (p. 208). However, in the preparation stage, individuals may turn and be on the cusp of taking action towards behavior change. The authors note that in this stage, individuals “may have tried and failed to change in the past” and thus professionals need to be wary and help to put together an action plan to which individuals can commit (p. 210). The

action stage, appropriately named, is the “state of change people most overtly modify their behavior” in and begin to “implement the plan for which they have been preparing” (p. 211). Additionally, DiClemente and Velasquez (2002) note that “often change is not completely established even after 6 months of action” (p. 213). In the final stage, maintenance, individuals are working towards sustaining behavior change and can “last from as little as 6 months to as long as a lifetime” (Velasquez & DiClemente, 2002, p. 212).

The Stages of Change from the Transtheoretical Model was applied to this study survey to examine how perceived Muslim Americans are coping and responding to Islamophobia. In the study survey, the section titled: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale in Chapter III can provide more details.

### **Self-efficacy from Social Cognitive Theory**

As defined by Bandura (1989), self-efficacy “beliefs determine their level of motivation, as reflected in how much effort they will exert in an endeavor and how long they will persevere in the face of obstacles” (p. 1176). Self-efficacy can either be “self-aiding or self-hindering” (p. 1175). And a correlation has been found between the strength of beliefs in an individual’s capabilities, “the greater and more persistent their efforts” (p. 1176). The correlation is so strong that “among the mechanisms of personal agency, none is more central or pervasive than people’s beliefs about their capabilities to exercise control over events that affect their lives” than self-efficacy (p. 1175). An individual’s self-efficacy functions as an “important set of proximal determinants of human motivation, affect, and action” and can affect “thinking patterns” as well as

influencing action (p. 1175). As most human behavior is regulated by goals, it has been found that the “higher the goals people set for themselves and the firmer the commitment”, the higher the self-efficacy of an individual (pp.1175-1176). Individuals with higher self-efficacy will tend to also see themselves more successfully and positively, with the opposite being true for individuals with low self-efficacy (Bandura, 1989, p. 1176).

With regards to coping and self-efficacy, it was found that “perceived self-efficacy influences choice of behavioral settings” (Bandura, 1989, pp. 193-193). Additionally, not only does self-efficacy “have directive influence on choice of activities and settings, but, through expectations of eventual success, it can affect coping efforts once they are initiated (p. 194). And expectations of self-efficacy will ultimately “determine how much effort people will expend and how long they will persist in the face of obstacles and aversive experiences” (p. 194). Those individuals with a stronger sense of perceived self-efficacy will more actively attempt to persist in the face of adversity and the more likely they are to successfully cope with discrimination and negative experiences.

Self-efficacy from the Social Cognitive theory was applied to this study survey to examine the level of self-efficacy in Muslim Americans for coping with Islamophobia. In the study survey, the section titled: The Coping Self-Efficacy Scale-Reduced in Chapter III can provide more details.

## **Conclusion**

This chapter provided a review of literature on the following topics: (1) Muslim American diversity; (2) microaggressions; (3) macroaggressions; (4) exposure to overt acts of violence; (5) perceived stress and perceived racism; (6) Islamophobic discrimination; (7) intersectionality; (8) impacts on health; (9) protective factors; (10) theoretical frameworks guiding the study. The next chapter, III, will present the study methods.

## Chapter III

### METHODS

This chapter will outline the methods and procedures utilized in this study. This includes an overview of the study design and procedures, description of the study participants, description of research instrumentation, the data treatment plan, and the data analysis plan.

#### **Overview of the Study Design and Procedures**

The study conducted used a cross-sectional design via an online survey utilizing Qualtrics. The survey was administered to a convenience sample of Muslim Americans. This section provides an overview of all study procedures.

#### **IRB Approval**

On January 18, 2018, this study received approval under the category exempt from the Teachers College, Columbia University Institutional Review Board (IRB) as Protocol #19-108 (see Appendix A for IRB Approval Letter). Study data collection began after receiving IRB approval.

#### **Recruitment of Study Participants**

Recruitment for this study occurred primarily online via a social media campaign (i.e. Facebook, Twitter, LinkedIn, Craigslist ads) and through in-person recruitment methods (flyers in mosques, calls and announcements to national mosques).

The social media campaign for this study consisted of messages asking for participation in the study and describing the prize money associated with participation; for example, participants were sent messages that stated:

*“GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card”.*

There were two aspects to the recruitment campaign that assisted with the snowball sampling in this study. Firstly, the principal investigator met with local Muslim leaders in Tampa (ICT Masjid Al-Qassam and the Islamic Society of Tampa Bay Area) and Sarasota (the Islamic Society of Sarasota and Bradenton), FL, and the metropolitan Washington D.C. area (Adams Center, Islamic Center of Washington DC, McClean Islamic Center, and Dar Al Hijrah Islamic Center). The Islamic Society of Sarasota and Bradenton agreed to promote the study both during Friday prayers and via their website. Secondly, the principle investigator promoted the study through social media with distribution methods that included: emails, text/WhatsApp messages, Twitter posts, Facebook posts, Google group messages, and postings in Muslim social media pages (mosques, mommy groups) and local Muslim social media pages in various cities (Washington D.C., New York City, Philadelphia, Chicago, Sarasota/Bradenton, and Tampa).

### **Other Study Procedures**

Participants who were interested in participating in the study were able to click an electronic link to begin the survey on Qualtrics. Once directed to the study, participants were asked to read and electronically sign an informed consent (see Appendix E).

### Study Inclusion/Exclusion Criteria

After signing the informed consent, participants then completed a short screening questionnaire (see Appendix F) in order to determine if they met the inclusion criteria for the study, as follows:

1. Are you Muslim?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
2. Are you at least 18 years old?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have you been living in the United States for at least 2 years?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
4. Are you able to devote **about 10 minutes answering survey questions** about yourself and your experiences in the U.S.?  
 a. Yes \_\_\_\_\_ No \_\_\_\_\_
5. Are you willing to spend **another 10-15 minutes freely expressing yourself** by typing in your answers to open-ended questions about your experiences in the U.S.?  
 a. Yes \_\_\_\_\_ No \_\_\_\_\_

If they answered YES to all of the above questions → they access survey.

Participants who meet these criteria were then invited to continue onto the full study questionnaire (See Appendix H). Participants who did not meet these criteria were disqualified from the study and were thanked for their interest in the study and told they did not qualify for study participation; and, finally, they were asked to share the weblink with others who might qualify for study participation.

### Generating Prizes: The Study Incentive for Participation

Participants who completed the entire study survey were directed to a webpage informing them of their eligibility to win an Amazon gift card lottery. Participants who entered their email address into the lottery then had a one in three chance to win either a \$300, \$200, or \$100 Amazon.com gift card. Data collection for the study began on



January 28, 2019 and was completed on February 9, 2019. Upon closing the study, participants who entered the lottery and won were notified of their winnings and how to redeem the gift card. The entire prize process was administered by the Research Group on Disparities in Health (RGDH) webmaster, Dr. Rupananda Misra. The principal investigator was not able to view any identifying participant data (their email addresses) and associate them with the study results. This allowed for patient privacy to be maintained.

### **Description of the Study Participants**

Study participants (N=247) were a convenience sample of volunteers who completed the study. In total, 324 individuals gave Informed Consent, while 283 met the inclusion/exclusion survey and qualified to continue to the study survey. There was no issue involving duplicate IP addresses, so none were excluded for a duplicate IP; for example, it was known that in some situation's groups had taken the survey using the same computer. Of the 283 subjects who qualified for study inclusion, some 247 completed the entire study survey, including providing data for the study outcome variable/dependent variable of higher level of life satisfaction; thus, 59 were excluded from study participation as non-completers.

A total of 283 study participants completed the survey. The final number of completed surveys was 247, however, there were 59 respondents who were eligible but did not complete to the point of providing data for the study outcome variable/dependent variable of higher level of life satisfaction.

When comparing completers (N=247) of the survey who had the primary outcome variable to non-completers (N=59) who lacked that primary outcome data), it was found

that there were no significant differences. Of note, many subjects who did not complete the survey lacked data for some items (see Table 1).

Table 1. Comparing Survey Completers (N=247) to Non-Completers (N=59) Via Independent T-Tests

		<i>t</i> -test (significant at $p < 0.013$ )					
Has Primary Outcome Variable? Yes=Completer No=Non-Completer		N	M	SD	<i>t</i>	df	P
Age	Yes	247	34.21	9.379	1.068	55.141	0.29
	No	47	36.36	13.218			
Level of Education	Yes	247	7.48	1.388	0.345	52.778	0.732
	No	38	7.55	1.224			
Household Income	Yes	247	5.23	1.746	0.345	52.778	0.6
	No	36	5.42	2.005			
Skin Color	Yes	247	3.55	1.271	-0.509	64.377	0.612
	No	47	3.45	1.282			

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  Bonferroni Adjustment Significance ( $.05/7$ ,  $p = .013$ )

Note: All  $p$  values above .013 are considered non-significant, and only those below .013 are considered statistically significant

Study participants (N=247) were a convenience sample of volunteers who completed the study. The screening criteria for this study were, as follows, while embodying the study inclusion-exclusion criteria, as follows:

**Find out if you qualify for participation by answering the following questions:**

1. Are you Muslim?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
2. Are you at least 18 years old?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have you been living in the United States for at least 2 years?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
4. Are you able to devote **about 10 minutes answering survey questions** about yourself and your experiences in the U.S.?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_

5. Are you willing to spend **another 10-15 minutes freely expressing yourself** by typing in your answers to open-ended questions about your experiences in the U.S.?  
 a. Yes \_\_\_\_\_ No \_\_\_\_\_

If they answered YES to all of the above questions → they access survey.

If they answered NO to any of the above questions → they receive this message:  
 Thank you for your time, but unfortunately you are not qualified to participate in this study.

Feel free to invite other others who may qualify to participate in this study. Please send them the study link\* that you used to access this survey.  
 THANK YOU!

\* “GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card”

In total, 324 individuals gave Informed Consent, while 283 met the inclusion/exclusion survey and qualified to continue to the study survey. There was no issue involving duplicate IP addresses, so none were excluded for a duplicate IP; for example, it was known that in some situation’s groups had taken the survey using the same computer. Of the 283 subjects who qualified for study inclusion, some 247 completed the entire study survey, including providing data for the study outcome variable/dependent variable of higher level of life satisfaction; thus, 59 were excluded from study participation as non-completers.

## **Description of Research Instrumentation**

This study used a survey developed by the Principal Investigator, Susan Tirhi, in conjunction with her dissertation sponsor, Professor of Health Education, Dr. Barbara Wallace, Director of the Research Group on Disparities in Health (RGDH), Teachers College, Columbia University. Additionally, sections of the survey were adapted from surveys previously used by fellows of the RGDH. In addition, the survey includes many parts that are well-established and validated tools that have generated findings published in the literature, as will become clear upon description of those survey parts. This section will describe each of the part of the survey in detail (See Appendix G).

### **Part I: Basic Demographics (BD-10)**

The Basic Demographics (BD-10) scale was developed by Professor Barbara Wallace for use by the Research Group on Disparities in Health (RGDH) and was adapted for this study's Muslim American population. It has been used by previous fellows in the RGDH (e.g. Ingram, 2017; Lian, 2017) and contains 10 questions covering, as follows: gender, age, race/ethnicity, skin color, country of birth, years living in the United States, highest educational level, marital status, employment status, and annual household income.

### **Part II: Personal Health Background (PHB-9)**

The Personal Health Background (PHB-9) scale was also created by Professor Barbara Wallace for use by the RGHD and has been previously used by its fellows (e.g. Ingram, 2017). This scale asks participants to answer 9 questions on the following: rating

of their overall health status; reporting of their height and weight—for determining Body Mass Index (BMI); reporting their health insurance status; rating the quality of care received from their primary care provider; and, rating their primary care provider’s cultural sensitivity around their being Muslim. All rating questions used a Likert scale ranging from 1=very poor to 6=excellent, permitting obtaining mean, SD, minimum, maximum for those rating questions.

### **Part III: Religious Affiliation and Religiosity Scale (RA-RS-3)**

The Religious Affiliation and Religiosity Scale (RA-RS-3) was created by the Principal Investigator, Susan Tirhi and is meant to measure Muslim religiosity. This brief scale includes (question # 2) the single-item scale, the Self-Rating of Religiosity (SRR) scale developed by Abdel-Khalek (2007), which asks, as follows:

2 - “Do you consider yourself to be:  
 \_\_1 very religious \_\_2 religious \_\_3 somewhat religious \_\_4 not religious

Using the SRR scale with 531 Muslim men and women, the scale demonstrated high reliability (.89), good temporal stability, concurrent validity, and high loading (0.84), indicating good factorial validity (Abdel-Khalek, 2007). The RA-RS-3 also asks participants to self-report their religiosity (question # 1) and Muslim sect (question # 3), as shown in Appendix G.

### **Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1)**

The Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1) was created by the Principal Investigator, Susan Tirhi, and her

dissertation sponsor, Dr. Barbara Wallace, for first time use in this study. Questions were adapted for use from a larger study conducted by the Pew Research Center in which American Muslims were surveyed to understand their attitudes towards their place in American society (Pew Research Center, 2017). Also, additional female and male clothing items were added, given what is worn globally by Muslims, and may be worn by Muslim Americans. Male and female study participants indicated the frequency with which they wear Muslim-identifying clothing, using the following Likert Scale from 0 to 4:

\_\_4-All the time \_\_3-Most of the time \_\_2-Only some of the time \_\_1-Rarely  
 \_\_0-Never \_\_ I don't know/Not sure

Hence, this scale permits obtaining a mean, SD, minimum and maximum score.

#### **Part V: More About You (Social Desirability) (MAY-13)**

This study used a short form to measure social desirability that arose from the original scale developed by Crowne and Marlowe (1960) which has a total of 33 items. The short form, described herein as the MAY-13, has 13 items. The original scale showed good internal testing using the Kuder-Richardson formula (0.88) and good test-retest correlation (0.89).

In the MAY-13, participants are asked to read all 13 statements and answer if they are true (T) or false (F) as it pertains to them personally. The MAY-13 items are as listed in Appendix H. Of note, Tatman., Swogger, Love, and Cook, (2009) found a Cronbach's Alpha of 0.85, indicating good internal consistency for the scale. Regarding scoring the MAY-13, it is as follows:

- True is the socially desirable response for questions 5, 7, 9, 10, and 13
- False is the socially desirable response for questions 1, 2, 3, 4, 6, 8, 11, and 12

For each socially desirable response, participants “earn” a score of “1” with scoring ranging from 0-13. This permits obtaining a mean, SD, minimum and maximum score.

#### **Part VI: Life Satisfaction Scale (LSS-1)**

The Life Satisfaction Scale (LSS-1) was taken from the work of Vang, Hou, and Elder (2018). The LSS-1 is a single items scale that asks participants to rate how they feel about their life right now, using a rating scale of 0-10—with 0=very dissatisfied and 1=very satisfied, According to Vang, Hou, and Elder (2018), the LSS-1 “has been adopted extensively in national and international surveys and has been established as a reliable and valid indicator of individuals’ well-being” (p. 7). In their study validating the LSS-1, they found a mean score of life satisfaction of 7.97 with a standard deviation of 1.75, minimum=0, and maximum=10 (p. 7).

Across various fields of study, it has been found that single-item measures “do not always perform as well as multi-item scales of the same construct” and as “establishing predictive validity of measures is a major concern” for researchers, it is important to understand the limitations of single-item scales (Diamantopoulos, Sarstedt, Fuchs, Wilczynski, & Kaiser, 2012, p. 434) . In a study comparing factors such as predictive validity, average inter-item correlation, and correlation patterns, it was found that “multi-item scales clearly outperform single items in terms of predictive validity” (p. 434). Rather “only under very specific conditions do single items perform equally well as multi-item scales” and “therefore, the use of single -items measures in empirical research should be approached with caution” and “limited to special circumstances” (p. 434).

**Part VII: Perceived Stress Scale (PSS-10)**

The Perceived Stress Scale (PSS-10) was developed by Cohen (1994) to assess an individual's sources of situational stress in the past 30 days. The scale asks participants to rate on a 5-point scale of 0 to 4 (i.e. 0=never, 1=almost never, 2=sometimes, 3=fairly often, and 4=very often) how often they have been upset with a situation, how much control they felt they had, and how often they felt that they could not cope with all the things they had to do, among other situations. In the PSS-10, questions 4, 5, 7, 8 are reverse scored. Participants can score as high as 40 and as low as 0—with higher scores indicating higher perceived stress.

According to Cohen (1994), the PSS has “adequate internal and test-retest reliability and is correlated in the expected manner with a range of self-report and behavioral criteria” and is unaffected by an individual's age (pp. 392-393). Ingram (2017) reported for the PSS-10 a Cronbach's alpha of 0.868, indicating very good internal consistency. This study found a Cronbach's alpha for the PSS-10 of 0.896, indicating excellent internal consistency. For this study, the PSS-10 will permit determining mean, standard deviation, and minimum and maximum scores.

**Part VIII: Brief Trauma Questionnaire (BTQ-10)**

The Brief Trauma Questionnaire (BTQ-10) is a 10-item scale that investigates adult trauma exposure, such as to life threats and any serious injury. The BTQ-10 arose from the Brief Trauma Interview (BTI), as per the US Department of Veterans Affairs' National Center for PTSD (USDVA-NCFPTSD, 2015). The survey has also been used by previous RGHD fellows (e.g. Amnie, 2016; Ingram, 2017). Participants are asked questions about events that may be extraordinarily stressful or disturbing, such as



exposure to war zones, car accidents, or life-threatening illness. For all 10 items, participants are asked to answer “Yes” or “No” to the question, with all questions that participants answer positively (“Yes”) being followed by additional questions, as follows:

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please indicate “Yes” or “No” to report what has happened to you.

If you answer “Yes” for an event, please answer:

- (1) whether you thought your life was in danger or you might be seriously injured;
- (2) whether you were seriously injured.

If you answer “No” for an event, go on to the next event

An example of a question is as follows:

1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty)?

No  
 Yes

(YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  
 Yes

Were you seriously injured?

No  
 Yes

When scored, the Brief Trauma Questionnaire (BTQ-10) provides an overall mean, standard deviation, and minimum and maximum score related to exposure to traumatic events. This study determined a Cronbach’s Alpha of 0.896, indicating good internal consistency.

### Part IX: PTSD Checklist—Civilian Version (PCCV- 17)

The Posttraumatic Stress Disorder Checklist- Civilian Version (PCL-S-17) is a 17-item survey that is based on the diagnostic criteria for B, C, and D in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorder (Ruggiero, Del Ben, Scotti, & Rabalais, 2003). The survey has also been used by previous RGHD fellows (e.g. Amnie, 2016; Ingram, 2017). Participants are asked to rate their reactions to stressful events using a Likert scale (1=not at all, 2=a little bit, 3=moderately, 4=quite a bit, 5=extremely) over the past 30 days. According to Ruggiero, Del Ben, Scotti, and Rabalais (2003), the PCCV-17 provides strong internal consistence and good test-retest reliability and in validation was found that the scale had positive correlation with determining if a participant had PTSD. The PCCV-17 provides descriptive statistics, including means, standard deviations, frequencies and percentages when scored.

Examples of the PCCV-17 are below:

15. Having difficulty concentrating?

- (1) Not at all
- (2) A little bit
- (3) Moderately
- (4) Quite a bit
- (5) Extremely

16. Being “super alert” or watchful on guard?

- (1) Not at all
- (2) A little bit
- (3) Moderately
- (4) Quite a bit
- (5) Extremely

17. Feeling jumpy or easily startled?

- (1) Not at all
- (2) A little bit
- (3) Moderately
- (4) Quite a bit
- (5) Extremely

### **Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3)**

For the purposes of this study, we have used a shorter version of the scale that follows the work of Lian (2017)—as a common tool used by the Research Group on Disparities in Health (RGDH) (e.g. Lian, 2017; Rodrigues, 2016). For this study, subjects are only asked about the past year—and not past 3, 6 months. The counseling question appears just once and includes new options. The original Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3) was developed by Professor Barbara Wallace for use by the RGDH and was first developed in 2015. The R-DACS-3 asks participants if they have experienced any depression or anxiety in the past 12 months and if they have sought out any counseling. The R-DACS-3 also defines the terms “depression” and “anxiety” for participants before they answer any questions, helping to set a frame of reference for their experiences.

### **Part XI: Ratings of Experiences of Microaggressions (REMI-6)**

The Ratings of Experiences of Microaggressions (REMI-6) is an adaptation of a scale that was created for use by the Research Group on Disparities in Health and has previously (Liss, 2015). The scale asks participants questions about their general life experiences with microaggressions and the subcategories of microaggressions (microassaults, microinsults, and microinvalidations), specifically with regards to their being Muslim. Originally the scale was developed to assess the experiences of lesbian, bisexual, or queer-identified women “during maternal health care delivery services with their providers, or with others in their life in general” (Liss, 2015, p. 65). Participants are asked to score the experience (as a Muslim) using a Likert scale with scoring criteria as

follows: 0=never/not at all, 1= at least once, 2=more than once, 3=a few times, 4=many times. Internal consistency data was proven using Cronbach's Alpha (0.932 or excellent internal consistency).

## **Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4)**

The Ratings of Experiences of Overt Acts of Violence (REOAV-4) survey was created for first time use in this study by the Principal Investigator (Susan Tirhi) and her dissertation sponsor, Dr. Barbara Wallace—for use by the Research Group on Disparities in Health. It is based on the concept of overt violence advanced elsewhere (Wallace, 2003) – while also capturing some of what is discussed in the literature on macroaggressions (e.g. Osanloo, A. F., Boske, C., & Newcomb, W. S. (2016).

The REOAV-4 asks participants to identify to what extent either they personally or a family or friend experienced an overt act of aggression and are asked to score the experience (as a Muslim) using a Likert scale with scoring criteria as follows:

0=never/not at all, 1= at least once, 2=more than once, 3=a few times, 4=many times. An example question from the REOAV-4 is as follows:

To what extent did you personally or did a family member or friend experience any of the following—and it seemed related to being Muslim:

- 1-A physical attack, for example, being hit, slapped, kick or beaten up
- (0) Never/Not At All
  - (1) At Least Once
  - (2) More Than Once
  - (3) A Few Times
  - (4) Many Times

**Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10)**

The Perception of Racism and Oppression Scale (PROS-10) was created by Professor Barbara Wallace in consultation with Professor Robert Fullilove, as used in Ingram (2017) and many other studies conducted by the Research Group on Disparities in Health (e.g. Asamani-Asante, 2014; Daramola, 2008; Ellington-Murray, 2006; Phillips, 2010; Rodriguez, 2016; Santacruz, 2014). For this study, instead of defining and asking about experiences of racism and/or oppression, the focus is on Islamophobia and/or Islamophobic discrimination. The development of the original scale was based on the work of Clark et al. (1999) and was built to help understand an individual's perception of racism and oppression using a standard five-point Likert scale (1=strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly disagree). Data analysis of the PI-ID-10 will provide overall means, standard deviation, and minimum and maximum scores. Of the 10 items in this scale, it is of note that items 7-10 are reverse scored.

Previous studies by fellows of the RGDH have demonstrated that the PI-ID-10 has good internal consistency (e.g. Ellington-Murray, 2005, Cronbach's Alpha = .869; Asamani-Asante, 2014, Cronbach's Alpha = .838; Rodriguez, 2016, Cronbach's Alpha = .794; Ingram, 2017, Cronbach's Alpha = 0.848).

This present study determined a Cronbach's alpha of 0.797 indicating very good internal consistency.

**Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6)**

The Coping and Responding to Racism and Oppression Staging Scale (CRROSS-13) was developed by Professor Barbara Wallace for use by the Research Group on

Disparities in Health (RGDH) and was adapted for this study's Muslim American population. It has been used by previous fellows in the RGDH (e.g. Ingram, 2017; Rodriguez, 2016; Santacruz, 2014). Professor Barbara Wallace rooted this scale in the Stages of Change theory by Prochaska and DiClemente (1983) and is aimed at determining a participant's readiness for change when "coping and responding to racism and/or oppression" and was known as the CRROSS scale (Ingram, 2017). For this study, instead of defining and asking about participants' general experiences of racism and/or oppression, the focus is on Islamophobia and/or Islamophobic discrimination. This version of the scale was also shortened and questions number 1, 7-10, and 12-13 were deleted to shorten the scale.

The first six items of this scale are scored using a Likert scale (1= strongly agree, 2=agree, 3=undecided, 4=disagree, 5=strongly agree) and the final question (#7) is scored based on their self-determined timeline for actively working on their ability to cope.

Scoring for each question is as follows:

**Step # 1 in Scoring – Obtain the sum for answers to items # 1-6 as the Global CR-IID-SC-6 Score**

1-I *never thought about* how to cope with or respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree  
5. \_\_\_ Strongly Disagree

[score of 1 or 2 as 1=precontemplation stage]

3-I *have thought about* how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree  
5. \_\_\_ Strongly Disagree

[score of 1 or 2 as 2=contemplation stage]

4-I *never took steps* to learn more about how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree  
5. \_\_\_ Strongly Disagree

[score of 1 or 2 as 2=contemplation stage]

5-I am *planning to take steps* to learn more about how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree

5. \_\_\_ Strongly Disagree

[score of 1 or 2 as 3=preparation stage]

6-I *have been actively learning* how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree

5. \_\_\_ Strongly Disagree

[score of 1 or 2 as 4=action stage]

### **Item # 7 Contributes to a Global CR-IID-SC-6 Score**

7-Learning how to cope with and respond to it is something that *I have been actively working on:*

\_\_\_ never in my life \_\_\_ < 1 month \_\_\_ < 6 months \_\_\_ > 6 months \_\_\_ 1-3 years

\_\_\_ 4-6 years \_\_\_ 7-9 years \_\_\_ 10-20 years \_\_\_ 21-30 years \_\_\_ >31 years

\_\_\_ unsure

[score > 6 months as = 5 - maintenance stage]

According to a study done by Ellington-Murray (2005), the original CRROSS scale “reported a fairly good test-retest correlation for the highest (maintenance) stage of coping with racism ( $r = .508$ ,  $p = .031$ ), and an extremely good test-retest correlation for the self-rating of ability for coping with and responding to racism and/or oppression ( $r = .947$ ,  $p = .000$ )” (Ingram, 2017).

Data analysis of the CR-IID-SC-6 will provide means, standard deviations, and minimum and maximum scores. However, it is not deemed the type of scale where items are seen as related to each other; thus, no Cronbach’s Alpha was investigated.

### **Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13)**

The Coping Self-Efficacy Scale-Reduced (CSES-RF-13) was originally developed by Chesney, Neilands, Chambers, Taylor, and Folkman (2006). Within the Research Group on Disparities in Health, it was recently used by Ingram (2017). The original Coping Self-Efficacy Scale is a 26-item scale that seeks to determine an

individual's "perceived self-efficacy for coping with challenges and threats" (p. 424).

Rather, the CSES-RF-13 is was reduced by 50% to just 13 items. Participants are asked to rate their ability to cope with problems using an 11-point Likert scale as listed below:

<b>Cannot do at all</b>	<b>Moderately certain can do</b>	<b>Certainly can do</b>
<b>0 1 2 3</b>	<b>4 5 6 7</b>	<b>8 9 10</b>

An overall score for the CSES-RF-13 was determined by adding all of the scores given by the participant for each item. The CSES-RF-13 has three categories of adaptive behaviors that participants are asked to score based on: how well they use problem-focused coping, whether or not they could stop unpleasant emotions and thoughts from occurring, and how well they could seek support from friends and family. Chesney et al. (2006) found a mean of 137.4 with a standard deviation of 45.6 when validating the tool. Additionally, the original tool was found to have good reliability (using Cronbach's internal consistency coefficient alpha) with scores for each of the three categories, or scales, as follows:

- Part 1: use problem-focused coping (N = 346; mean = 5.6, SD = 2.1)
- Part 2: stop unpleasant emotions and thoughts (N = 348, mean = 4.5, SD = 2.2)
- Part 3: get support from friends and family (N = 348, mean = 5.1, SD = 2.3).

And this study found Cronbach's alphas of:

- Part 1: using problem focused coping exhibited excellent internal consistency (Cronbach's Alpha = 0.924).
- Part 2: stopping unpleasant emotions and thoughts excellent internal consistency (Cronbach's Alpha of 0.962).



- Part 3: getting support from friends and family had very good internal consistency (Cronbach's Alpha =0.810).

A mean, standard deviation, minimum and maximum score was produced for each of the 3 scales.

### **Part XVI: Life Satisfaction, Stress, Trauma, Intersectionality, Ways of Coping, and Resilience (LS-STI-WOC-R-5)**

The Life Satisfaction, Stress, Trauma, Intersectionality, Ways of Coping, and Resilience scale (LS-STI-WOC-R-5) was created by Professor Barbara Wallace for use by members of the Research Group on Disparities in Health (RGDH) and has previously been used by one of its fellows (Ingram, 2017)—as a qualitative research tool. The LS-STI-WOC-R-5 has been adapted to relate to Muslim Americans, per the study population. When analyzed, the LS-STI-WOC-R-5 will provide emergent themes. Two examples of questions on the LS-STI-WOC-R-5 scale, follow, while the entire set of questions is in the Appendix H:

T 2-What have been the most stressful parts of your life experience as a Muslim American? Please share how you coped, bounced back, or healed—or how you have been resilient.

3-Have you experienced any discrimination, microaggressions, or hate—such as for having a double or triple marginalized/oppressed identity (e.g. being a Muslim American AND ALSO a racial/ethnic minority, or being a woman, or disabled, or due to your physical appearance, or skin color)?

\_\_\_ Yes \_\_\_ No

Was it stressful? \_\_\_ Yes \_\_\_ No

Was it traumatic? \_\_\_ Yes \_\_\_ No

## The Data Treatment Plan

Given an online sample of diverse adult Muslim Americans (n=247) who have been living in the United States for at least two years and respond to a social media campaign (i.e. “GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card” and complete the study survey), the research will answer the following question—using the data analysis plan indicated:

1-What are their demographic and other background characteristics (i.e. gender, age, race/ethnicity, skin color tone, born in the US or not, years living in the US, level of education, marital status, employment status, annual household income)?

*Part I: Basic Demographics (BD-10)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

2- How do they rate their overall health status, their Body Mass Index (BMI)/weight status, the overall quality of care that they receive for their health, the overall quality of care they receive from their provider, and the sensitivity and competence of their provider for treating someone who is Muslim? And, do they indicate having medical insurance, and if so, what type?

*Part II: Personal Health Background (PHB-9)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

3-Do they consider themselves to be practicing Muslims, what is their level of religiosity, and to what type of Muslim sect do they belong?

*Part III: Religious Affiliation and Religiosity Scale (RA-RS-3)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

4-What is the frequency of their wearing visibly Muslim clothing when out in public?

*Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

5-To what extent do they tend to provide socially desirable responses?

**[Note: Regression will control for social desirability]**

*Part V: More About You (Social Desirability) (MAY-13)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

6-What is their rating for Life Satisfaction?

**[Note: The study outcome variable/dependent variable]**

*Part VI: Life Satisfaction Scale (LSS-1)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

7-What is their level of perceived stress in the past thirty days?

*Part VII: Perceived Stress Scale (MA-PSS-10)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

8-What is the prevalence of their experiences of trauma (e.g. in a war zone, natural disaster, terrorist attack, childhood abuse, etc.) including where they thought their life was in danger or they could be seriously injured—and whether they were actually seriously injured?

*Part VIII: Brief Trauma Questionnaire (BTQ-10)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

9-What is the prevalence of symptoms of posttraumatic stress disorder (PTSD)?

*Part IX: PTSD Checklist—Civilian Version (PCCV- 17)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

10-What is the prevalence of symptoms of depression and anxiety in the past year, and was counseling or advice sought out?

*Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

11-Within their general life experience, what was the frequency of any experiences of microaggressions?

*Part XI: Ratings of Experiences of Microaggressions (REMI-6)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

12-What was their experience of any overt acts of violence?

*Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

13-What was their level of ability for perceiving Islamophobia and/or Islamophobic discrimination—when it happening to themselves, as well as others?

*Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

14-What was their stage of change (i.e. precontemplation, contemplation, preparation, action, maintenance) for coping and responding to any experiences of Islamophobia and/or Islamophobic discrimination?

*Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-7)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

15-What was their coping self-efficacy—specifically, their level of ability and confidence for using (a) problem-focused coping, (b) stopping unpleasant emotions and thoughts, and (c) getting support from other family and friends?

*Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13)*

*Data Analysis Plan: Descriptive statistics, including means, standard deviations, frequencies, and percentages*

16-What are the significant relationships among selected independent variables (e.g. age, education level, etc.) and the study outcome variable/dependent variable of higher level of life satisfaction?

*Data Analysis Plan: Inferential statistics, including via Pearson's correlations and t-tests*

17-What are the significant predictors of the study outcome variable/dependent variable of higher level of life satisfaction—controlling for social desirable responses?

*Data Analysis Plan: Backward stepwise regression.*

### **Qualitative Portion of Study**

18-What themes emerged when asked to provide open-ended responses to questions eliciting qualitative data on several topics—(a) factors impacting their life satisfaction as a Muslim American, (b) the most stressful parts of their life experience as a Muslim American, (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, (d) their experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression (e.g. being a Muslim American, and also a racial/ethnic minority, etc., or intersectionality), (e) examples of how they coped, bounced back, or healed, or were resilient from stressful or traumatic discrimination/microaggressions/hate, and (f) recommendations to improve the overall life satisfaction of Muslim Americans?

*Data Analysis Plan: Identification of emergent themes and categories.*

### **Details of Qualitative Data Analysis Plan**

By way of an elaboration on the qualitative data analysis, this followed instruction of the Director of the RGDH, Professor Barbara Wallace, that are given to fellows of the Research Group on Disparities in Health (RGDH). Fellows were instructed to create a document with all participant responses, highlight quotes constituting emergent themes among the first 20 quotes, create action phrases to capture the emergent theme, and then list emergent themes. Fellows then were directed to do the following: repeat the process for the next 21-40 quotes to capture and expand upon emergent themes; create an expanded list of emergent themes; evaluate how well the expanded themes accommodate the remaining quotes in the entire data base, while determining the need to add any new emergent themes. The next step was to create a new expanded final list of emergent themes and use the list to evaluate the remaining data base of quotes.

Once the research fellows were confident that all emergent themes were on the list, they then were directed to classify all data by the list of emergent themes. Also, a vital step involved creating a table of the list of emergent themes, while organizing the list of emergent themes by categories that encompass a group of themes. such as 3-5 themes falling within a category. Fellows then were directed to also provide sample quotes from participants, to illustrate the emergent themes. Professor Wallace, Director of the RGDH, also then reviewed the data base of participant responses to evaluate the analysis of the qualitative data that was performed, following the recommended steps, including making any additions or modifications of the emergent themes, based on her analysis.

## **Data Management**

Data were downloaded from [www.Qualtrics.com](http://www.Qualtrics.com). The data were transferred to SPSS and analyzed using SPSS 25.0.

## **Conclusion**

This chapter described in detail the methods used in the present study. This included an overview of the study design, study procedures, recruitment of participants, and description of research instrumentation. The chapter concluded with how data was managed and analyzed. The following chapter, IV, will provide the study results of data analysis.

## Chapter IV

### RESULTS

This chapter provides a detailed presentation of the study results organized by research question. Additionally, findings are presented in table format.

#### **Data Analysis Results by Study Question**

##### **Results for Research Question #1**

*What are their demographic and other background characteristics (i.e. gender, age, race/ethnicity, skin color tone, born in the US or not, years living in the US, level of education, marital status, employment status, annual household income)? (BD-10)*

**Part I: Basic Demographics (BD-10).** The study sample was comprised of 247 Muslim Americans over the age of 18 (N=247). In total, 324 respondents gave consent to participate in the survey. However, when utilizing the criterion of participants having to have completed enough of the survey questions so that they had data for the primary outcome variable/dependent variable of a higher level of life satisfaction, then the N dropped to N=247 for “completers.” When comparing completers (N=247) of the survey who had the primary outcome variable/dependent variable (i.e., of a rating of their life satisfaction) to non-completers (N=59) (who lacked that primary outcome data), it was found that there were no significant differences—as discussed in Chapter III.

The sample was 74.5% female (n=184) and 25.5% male (n=63). Reported age ranged from 18 to 78 with a mean of 34.21 (min=18, max=78, SD=9.379) and are

categorized in detail below in Table 2. Reported ethnicity was: 60.7% Arab American/Middle Eastern (n=150), 21.9% Asian (n=54), 10.5% White (n=26), 6.5% Black/African American (n=16), 2.8% Hispanic/Latino (n=7), and 1.2% Native American/American Indian/Alaska Native (n=3).

Mean skin color was 4.45 (min=1, max=7, SD=1.271) or between medium to light and medium to dark. For example, 41.7% (N=103) reported medium to dark skin color. Some 51.4% reported that they were born in the United States (n=127). Results for country of origin were: Egypt (15.8%, n=39), Palestinian Territories (6.5%, n=16), Pakistan (5.7%, n=14). Mean number of years of living in the United States was 15.51 (min=2, max=64, SD=11.850). For example, 19.7% (N=49) reported living in the United States for 26-30 years.

Mean level of education was category 7.48 (min=3, max=10, SD=1.388), or between Bachelor's and Master's degrees. For example, 35.6% had Bachelor's degrees (n=88), and 29.6% had Master's degrees (n=73). Also, some 70% were married (n=173), 64.8% were employed for wages (n=160), and, the mean annual household income for survey participants was the category 5.23 (SD=1.746), equating to between \$50,000 – \$99,999; for example, 31.6% earned an annual income in this category (n=78) (see Table 2).

Table 2: Basic Demographics (BD-10) (N=247)

	N	%		N	%
<b>Gender Identity (N=247)</b>			<b>Years Living in U.S. (N=247)</b>		
Female	184	74.5	0-5	13	5.2
Male	63	25.5	6-10	19	7.6
			11-15	21	8.4
<b>Age (N=247)</b>			16-20	32	12.9
18-25	36	14.5	21-25	34	13.7
26-30	52	21.1	26-30	49	19.7



31-35	77	31.3	31-35	39	15.7
36-40	37	14.8	36-40	16	6.4
41-45	21	8.4	41-45	12	4.8
46-50	9	3.6	46-50	5	2
51-55	7	2.8	51-55	4	1.6
56-60	3	1.2	56-60	1	0.4
61-65	2	0.8	61-65	2	0.8
66-70	0	0	<i>Mean years (15.51), SD (11.850)</i>		
71-75	2	0.8	<i>min (2), max (64)</i>		
75-80	1	0.4			
<b>Mean age (34.21), SD (9.379)</b>			<b>Education Level (N=247)</b>		
<b>min (18), max (78)</b>			3- Some high school no diploma		
			4- High school graduate, diploma or the equivalent		
			5- Some college credit, no degree		
			6- Associate degree or technical degree		
			7- Bachelor's degree		
			8- Master's degree		
			9- Professional degree		
			10- Doctorate degree		
			<i>Mean education (7.48), SD (1.388)</i>		
			<i>min (3), max (10)</i>		
<b>Race/Ethnicity (N=247) *</b>			<b>Marital Status (N=247)</b>		
Arab American / Middle Eastern	150	60.7	Single, never married		
Asian	54	21.9	Married		
Black / African American	16	6.5	Widowed		
Cuban, other Spanish	2	0.8	Divorced		
Hispanic / Latino	7	2.8	Separated		
Native American/America	3	1.2	Other (please specify)		
Indian / Alaska Native					
Native Hawaiian / Pacific Islander	0	0			
White	26	10.5			
Other group(s) (specify)	13	5.3			
<b>Skin Color (N=247)</b>			<b>Employment Status (N=247) *</b>		
7- Very Dark	6	2.4	Employed for wages		
6- Dark	41	16.6	Self-employed		
5- Medium to Dark	103	41.7	Unemployed		
4- Medium to Light	57	23.1	A homemaker		
3- Light	7	2.8	A student		
2- Very Light	32	13	Military		
1- White			Retired		
<i>Mean skin color (4.45), SD (1.271)</i>					
<i>Min (1), max (7)</i>					
<b>Born in the U.S. (N=247)</b>					
Yes	127	51.4			
No	120	48.6			

<b>Country of Origin (N=105)</b>			Disabled/unable to work	3	1.2
Egypt	39	15.8	Other (please specify)	6	2.4
Palestinian Territories	16	6.5			
Pakistan	14	5.7	<b>Annual Household Income (N=247)</b>		
Iraq	5	2	1- Less than \$9,000	10	4
Morocco	5	2	2- \$10,000 to \$19,000	6	2.4
Syria	4	1.6	3- \$20,000 to \$39,000	24	9.7
Bangladesh	2	0.8	4- \$40,000 to \$49,000	18	7.3
Cuba	2	0.8	5- \$50,000 to \$99,999	78	31.6
El Salvador	2	0.8	6- \$100,000 to \$199,999	76	30.8
Guyana	2	0.8	7- \$200,000 to \$299,000	16	6.5
India	2	0.8	8- \$300,000 to \$399,000	8	3.2
Indonesia	2	0.8	9- \$400,000 to \$499,000	7	2.8
Iran	2	0.8	10- \$500,000 to \$799,000	3	1.2
Jordan	2	0.8	11- \$800,000 or More	1	0.4
Somalia	2	0.8	<b>Mean income (5.23), SD (1.746)</b>		
Sri Lanka	2	0.8	<b>min (1), max (11)</b>		
United Arab Emirates	2	0.8			

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Note: \* represents where respondents were able to select multiple answer options

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## Results for Research Question #2-

*How do they rate their overall health status, their Body Mass Index (BMI)/weight status, the overall quality of care that they receive for their health, the overall quality of care they receive from their provider, and the sensitivity and competence of their provider for treating someone who is Muslim? And, do they indicate having medical insurance, and if so, what type? (PHB-9)*

**Part II: Personal Health Background (PHB-9).** The mean rating for health status was 4.52 (min = 1, max =6, SD = 0.962), or between good and very good. For example, 37.2% (N=92) reported a very good overall health status. The category mean rating for self-reported weight was 2.52 (min = 1, max =4, SD=0.655), or between normal and overweight. Specifically, 40.1% (N=99) reported their weight as being overweight. The mean body mass index (BMI) was 26.780 (min=18.24, max=46.68,

SD=5.23), or overweight. Some 65.5% (N=162) indicated that they had private insurance.

The mean quality of care received for any medical condition(s) was reported as 4.33 (min=1, max=4, SD=1.0), or closest to good. For example, 32.4% (N=80) reported receiving good quality of care. The mean rating for quality of care received by their primary care provider was 4.37 (min = 1, max =6, SD=1.007), or closest to good. For example, 31.6% (N=78) reported receiving good quality of care from their primary provider. Finally, the mean rating for quality of care received as a Muslim was 4.44 (min = 1, max =6, SD=1.208), or closest to good. For example, 28.3% (N=70) reported receiving very good quality of care as a Muslim (see Table 3).

Table 3. Personal Health Background (PHB-9) (N=247)

	N	%		N	%
<b>Overall Health Status (N=247)</b>			<b>Quality of Care from Provider(N=247)</b>		
1-Very poor	1	0.4	1-Very poor	1	0.4
2-Poor	3	1.2	2-Poor	7	2.8
3-Fair	30	12.1	3-Fair	32	13
4-Good	83	33.6	4-Good	78	31.6
5-Very good	92	37.2	5-Very good	76	30.8
6-Excellent	38	15.4	6-Excellent	27	10.9
<b>Mean health status (4.52), SD (0.962)</b>			7- NA (I do not receive any health care)	26	10.5
<b>min (1), max (6)</b>			<b>Mean PCP care (4.37), SD (1.007)</b>		
<b>Self-reported weight (N=247)</b>			<b>min (1), max (6)</b>		
1 Underweight	5	2			
2 Normal weight	126	51	<b>Quality of Care as Muslim(N=247)</b>		
3 Overweight	99	40.1	1-Very poor	4	1.6
4 Obese	17	6.9	2-Poor	11	4.5
<b>Mean weight (2.52), SD (0.655)</b>			3-Fair	31	12.6
<b>min (1), max (4)</b>			4-Good	60	24.3
			5-Very good	70	28.3
<b>Type of Medical Insurance (N=247)</b>			6-Excellent	46	18.6
Private insurance plan	162	65.6	7- NA (I do not receive any health care)	25	10.1
HMO	35	14.2			

			<i>Mean care as a Muslim (4.44), SD</i>
Medicaid	17	6.9	<i>(1.208)</i>
Medicare	5	2	<i>min (1), max (6)</i>
NA/ No Insurance	23	9.3	
Other (please specify)	12	4.9	

**Quality of Care for Med Condition(N=247)**

1-Very poor	1	0.4
2-Poor	5	2
3-Fair	39	15.8
4-Good	80	32.4
5-Very good	73	29.6
6-Excellent	27	10.9
7- NA (I do not receive any health care)	22	8.9

*Mean quality of care (4.33), SD (1.000)*  
*min (1), max (6)*

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**Results for Research Question #3**

*Do they consider themselves to be practicing Muslims, what is their level of religiosity, and to what type of Muslim sect do they belong? (RA-RS-3)*

**Part III: Religious Affiliation and Religiosity Scale (RA-RS-3).** Some 79.8% (n=197) of respondents considered themselves to be a practicing Muslim. The sample's mean religiosity was 3.58 (min=1, max=5, SD=0.705), or between "somewhat religious" and "religious." For example, over 95% indicated that they were either "very religious" (6.9%, n=17), "religious" (49.4%, n=122), or "somewhat religious" (38.9%, n=96). Respondents mainly identified as being from the Sunni sect (93.5%, n=231) (see Table 4).

Table 4. Religious Affiliation and Religiosity Scale (RA-RS-3) (N=247)

Practicing Muslim (N=247)		Muslim Sect (N=247)	
N	%	N	%

Yes	197	79.8	Sunni	231	93.5
No	3	1.2	Shi'ite	6	2.4
Sometimes	47	19	Sufi	3	1.2
			Salafi	2	0.8
<b>Self-Reported Religiosity (n=247)</b>			Nation of Islam	3	1.2
5 Very religious	17	6.9	Baha'i or Ahmadiyya	0	0
4 Religious	122	49.4	Druze, Alevis, or 'Alawi	0	0
3 Somewhat Religious	96	38.9	Other	5	2
2 Not Religious	11	4.5			
1 Not Religious at All	1	0.4			
<b>Mean religiosity (3.58), SD (0.705)</b>					
<b>min (1), max (5)</b>					

#### Results for Research Question #4

*What is the frequency of their wearing visibly Muslim clothing when out in public? (FW-MIC-FFM-1)*

**Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1).** Some 53.9% (N=96) females reported their preference for wearing Islamic clothing *all of the time*, and 46.4% (N=32) of males reported that they *rarely* wear Islamic clothing (see Table 5).

Table 5. Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1) (N=247)

	N	%		N	%
<b>Female or Male Clothing (N=247)</b>			<b>Male Clothing Frequency (N=69)</b>		
Male Clothing	69	27.9	4 - All of the time	2	2.9
Female Clothing	178	72.1	3 - Most of the time	3	4.3
			2 - Only some of the time	8	11.6
			1 - Rarely	32	46.4
			0 - Never	24	34.8
<b>Female Clothing Frequency (n=178)</b>					
4 - All of the time	96	53.9			
3 - Most of the time	5	2.8	<b>Mean of Muslim Clothing (2.05)</b>		
2 - Only some of the time	8	4.5	<b>SD (1.717)</b>		
1 - Rarely	26	14.6	<b>min (0), max (4)</b>		
0 - Never	43	24.2	<b>(men + women)</b>		

### Results for Research Question #5

*To what extent do they tend to provide socially desirable responses? (MAY-13)*

**Part V: More About You (Social Desirability) (MAY-13).** The sample's **social desirability mean** was 8.76 (min 1, max 13, SD=2.822), suggesting a moderate level of social desirability. As a note, the results of research question #16 will control for social desirability.

### Results for Research Question #6

*What is their rating for Life Satisfaction? (LSS-1)*

**Part VI: Life Satisfaction Scale (LSS-1).** The mean rating for overall life satisfaction was 7.29 (min=0, max=10, SD=1.985), or moderately high. Of note, this was the study outcome variable or dependent variable. Further, 53.5% indicated a life satisfaction score of 8 or more (N=132) (see Table 6).

Table 6. Life Satisfaction Scale (LSS-1) (N=247)

	N	%
<b>Using a scale of 0–10 where 0 means ‘Very dissatisfied’ and 10 means ‘Very satisfied’, how do you feel about your life as a whole right now? (N=247)</b>		
0 - very dissatisfied	1	0.4
1	0	0
2	1	0.4
3	5	2
4	16	6.5
5	35	14.2
6	19	7.7
7	38	15.4
8	60	24.3
9	35	14.2

10 - very satisfied	37	15
<b>Mean life satisfaction (7.29), SD (1.985)</b>		
<b>min (0), max (10)</b>		

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### Results for Research Question #7

*What is their level of perceived stress in the past thirty days? (MA-PSS-10)*

**Part VII: Perceived Stress Scale (MA-PSS-10).** The Perceived Stress Scale had very good internal constancy (i.e. Cronbach's Alpha of 0.896). The mean perceived stress of was 18.025 (min=2, max=40, SD=7.179), indicating that respondents were perceiving a moderate amount of stress in their lives. For the question "*in the last month, how often have you been upset because of something that happened unexpectedly?*", 46.6% responded with *sometimes* (n=115) (see Table 7).

Table 7. Perceived Stress Scale (MA-PSS-10) (N=243)

	N	%
<b>1. In the last month, how often have you been upset because of something that happened unexpectedly? (N=243)</b>		
0 = Never	11	4.5
1 = Almost Never	57	23.1
2 = Sometimes	115	46.6
3 = Fairly Often	48	19.4
4 = Very Often	12	4.9
<b>2. In the last month, how often have you felt that you were unable to control the important things in your life (N=243)</b>		
0 = Never	18	7.3
1 = Almost Never	47	19
2 = Sometimes	109	44.1
3 = Fairly Often	41	16.6
4 = Very Often	28	11.3
<b>3. In the last month, how often have you felt nervous and "stressed"? (N=237)</b>		
0 = Never	4	1.6
1 = Almost Never	16	6.5
2 = Sometimes	93	37.7

3 = Fairly Often	70	28.3
4 = Very Often	54	21.9

**4. In the last month, how often have you felt confident about your ability to handle your personal problems? (N=237) \***

4 = Never	5	2
3 = Almost Never	18	7.3
2 = Sometimes	75	30.4
1 = Fairly Often	95	38.5
0 = Very Often	44	17.8

**5. In the last month, how often have you felt that things were going your way? (N=237) \***

4 = Never	2	0.8
3 = Almost Never	32	13
2 = Sometimes	103	41.7
1 = Fairly Often	86	34.8
0 = Very Often	14	5.7

**6. In the last month, how often have you found that you could not cope with all the things that you had to do? (N=234)**

0 = Never	19	7.7
1 = Almost Never	68	27.5
2 = Sometimes	87	35.2
3 = Fairly Often	42	17
4 = Very Often	18	7.3

**7. In the last month, how often have you been able to control irritations in your life? (N=234) \***

4 = Never	2	0.8
3 = Almost Never	27	10.9
2 = Sometimes	108	43.7
1 = Fairly Often	71	28.7
0 = Very Often	26	10.5

**8. In the last month, how often have you felt that you were on top of things? (N=234) \***

4 = Never	4	1.6
3 = Almost Never	36	14.6
2 = Sometimes	93	37.7
1 = Fairly Often	84	34
0 = Very Often	17	6.9

**9. In the last month, how often have you been angered because of things that were outside of your control? (N=228)**

0 = Never	10	4
1 = Almost Never	62	25.1
2 = Sometimes	97	39.3



3 = Fairly Often	41	16.6
4 = Very Often	18	7.3

**10. In the last month, how often have you felt difficulties were piling up so high that you could not overcome them? (N=228)**

0 = Never	26	10.5
1 = Almost Never	74	30
2 = Sometimes	76	30.8
3 = Fairly Often	37	15
4 = Very Often	15	6.1

*Mean Perceived Stress (18.0247), SD (7.17947)  
min (2), max (40)  
Cronbach's Alpha (0.896)*

Note: \* indicates a reverse scored item

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### Results for Research Question #8

*What is the prevalence of their experiences of trauma (e.g. in a war zone, natural disaster, terrorist attack, childhood abuse, etc.) including where they thought their life was in danger or they could be seriously injured—and whether they were actually seriously injured? (BTQ-10)*

**Part VIII: Brief Trauma Questionnaire (BTQ-10).** For the prevalence of experiences of **overall trauma**, the sample had a mean of 2.38 (SD=2.802, min=0, no exposure; max = 19, very high exposure), or very low exposure to traumatic events. This was calculated by summing all of the below sub-scales.

For each of the sub-scales, the results were as follows: the mean for being **exposed to trauma** was 1.25 (min=0, max=6, SD=1.247), or low exposure. For example, when asked if participants had ever “*served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties*”, 90.3% (N=223) responded *no*.

The mean for **felt like their life was threatened** was 0.61 (min=0, max=6, SD=0.998), or very low exposure. For example, when those who responded yes to the above question were asked: “*did you think your life was in danger or you might be seriously injured?*”, only 1.2% (N=3) responded with yes.

The mean for trauma resulting in being **seriously injured** was 0.15 (min=0, max=5, SD=0.527), or very low exposure. For example, when asked: “*were you seriously injured?*”, 0% (N=0) responded with yes.

Finally, the mean for **witness trauma to others** was 0.38 (min=0, max=2, SD=0.621), or low exposure. For example, 74.5% (N=184) responded *no* to this question: “*have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed?*” (see Table 8).

Table 8. Brief Trauma Questionnaire (BTQ-10) (N=228)

	N	%
<b>1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty)? (N=228)</b>		
Yes	5	2
No	223	90.3
<b><i>If yes: Did you think your life was in danger or you might be seriously injured? (N=5)</i></b>		
Yes	3	1.2
No	2	0.8
<b><i>If yes: Were you seriously injured? (N=5)</i></b>		
Yes	0	0
No	5	2
<b>2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else? (N=227)</b>		
Yes	52	21.1

No	175	70.9
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***If yes: Did you think your life was in danger or you might be seriously injured? (N=52)***

Yes	31	12.6
-----	----	------

No	21	8.5
----	----	-----

***If yes: Were you seriously injured? (N=52)***

Yes	11	4.5
-----	----	-----

No	41	16.6
----	----	------

**3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill? Or, have you been in a disaster related to a terrorist attack? (N=227)**

Yes	58	23.5
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No	169	68.4
----	-----	------

***If yes: Did you think your life was in danger or you might be seriously injured? (N=58)***

Yes	30	12.1
-----	----	------

No	28	11.3
----	----	------

***If yes: Were you seriously injured? (N=58)***

Yes	0	0
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No	58	23.5
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**4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.? (N=227)**

Yes	9	3.6
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No	218	88.3
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***If yes: Did you think your life was in danger or you might be seriously injured? (N=8)***

Yes	6	2.4
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No	2	0.8
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***If yes: Were you seriously injured? (N=8)***

Yes	3	1.2
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No	5	2
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**5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries? (N=226)**

Yes	55	22.3
-----	----	------

No	171	69.2
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***If yes: Did you think your life was in danger or you might be seriously injured? (N=55)***

Yes	17	6.9
-----	----	-----

No	38	15.4
----	----	------

***If yes: Were you seriously injured? (N=55)***

Yes	7	2.8
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No	48	19.4
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**6. Not including any punishments or beatings you already reported, have you ever been attacked, beaten, or mugged by anyone, including friends, family members, or strangers? (N=226)**

Yes	33	13.4
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No	193	78.1
----	-----	------

***If yes: Did you think your life was in danger or you might be seriously injured? (N=33)***

Yes	21	8.5
-----	----	-----

No	12	4.9
----	----	-----

***If yes: Were you seriously injured? (N=33)***

Yes	8	3.2
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No	25	10.1
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**7. Has anyone ever made or pressured you into having some type of unwanted sexual contact?**

**Note: By sexual contact we mean any contact between someone else and your private parts or between you and someone else's private parts. (N=226)**

Yes	52	21.1
-----	----	------

No	174	70.4
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***If yes: Did you think your life was in danger or you might be seriously injured? (N=52)***

Yes	15	6.1
-----	----	-----

No	37	15
----	----	----

***If yes: Were you seriously injured? (N=52)***

Yes	3	1.2
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No	49	19.8
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**8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed? (For example, during an arrest experience, an incarceration experience, a refugee crisis, or immigration/migration experience?) (N=226)**

Yes	20	8.1
No	206	83.4

***If yes: Did you think your life was in danger or you might be seriously injured? (N=20)***

Yes	16	6.5
No	4	1.6

***If yes: Were you seriously injured? (N=20)***

Yes	2	0.8
No	18	7.3

**9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack—including through school violence, gang violence, community violence, or some other type of serious violence or accident? (N=225)**

Yes	45	18.2
No	180	72.9

**10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed?**

**Note: Do not answer “yes” for any event you already reported.**

**(N=225)**

Yes	41	16.6
No	184	74.5

*Mean overall trauma (2.38), SD (2.802)*

*min (0), max (19)*

*Mean exposed to trauma (1.25), SD (1.247)*

*min (0), max (6)*

*Mean felt their life was threatened (0.61), SD (0.998)*

*min (0), max (6)*

*Mean were seriously injured (0.15), SD (0.527)*

*min (0), max (5)*

*Mean witness trauma to others (0.38), SD (0.621)*

*min (0), max (2)*

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## Results for Research Question #9

*What is the prevalence of symptoms of posttraumatic stress disorder (PTSD)?*

(PCCV- 17)

**Part IX: PTSD Checklist—Civilian Version (PCCV- 17).** Cronbach’s Alpha was 0.935, or excellent internal consistency. The mean prevalence of symptoms of posttraumatic stress disorder (PTSD) was 33.46 (min=6, max=75, SD=13.864), or a moderate amount of PTSD symptoms. For example, 30.8% (N=76) indicated that they have felt irritable or have had angry outbursts *a little bit* of the time (see Table 9).

Table 9. PTSD Checklist—Civilian Version (PCCV- 17) (N=225)

	N	%
<b>1. Repeated, disturbing memories, thoughts, or images of a stressful experience from the past? (N=225)</b>		
1 - Not at all	99	40.1
2 - A little bit	72	29.1
3 - Moderately	25	10.1
4 - Quite a bit	24	9.7
5 - Extremely	5	2
<b>2. Repeated, disturbing dreams of a stressful experience from the past? (N=225)</b>		
1 - Not at all	142	57.5
2 - A little bit	45	18.2
3 - Moderately	16	6.5
4 - Quite a bit	17	6.9
5 - Extremely	5	2
<b>3. Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)? (N=224)</b>		
1 - Not at all	129	52.2
2 - A little bit	57	23.1
3 - Moderately	25	10.1
4 - Quite a bit	12	4.9
5 - Extremely	1	0.4
<b>4. Feeling very upset when something reminded you of a stressful experience from the past? (N=224)</b>		
1 - Not at all	82	33.2
2 - A little bit	79	32
3 - Moderately	29	11.7
4 - Quite a bit	27	10.9
5 - Extremely	7	2.8

**5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past? (N=224)**

1 - Not at all	124	50.2
2 - A little bit	46	18.6
3 - Moderately	34	13.8
4 - Quite a bit	15	6.1
5 - Extremely	5	2

**6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it? (N=224)**

1 - Not at all	78	31.6
2 - A little bit	61	24.7
3 - Moderately	39	15.8
4 - Quite a bit	33	13.4
5 - Extremely	13	5.3

**7. Avoid activities or situations because they remind you of a stressful experience from the past? (N=224)**

1 - Not at all	107	43.3
2 - A little bit	48	19.4
3 - Moderately	25	10.1
4 - Quite a bit	34	13.8
5 - Extremely	10	4

**8. Trouble remembering important parts of a stressful experience from the past? (N=224)**

1 - Not at all	148	59.9
2 - A little bit	37	15
3 - Moderately	14	5.7
4 - Quite a bit	19	7.7
5 - Extremely	6	2.4

**9. Loss of interest in things that you used to enjoy? (N=223)**

1 - Not at all	92	37.2
2 - A little bit	60	24.3
3 - Moderately	35	14.2
4 - Quite a bit	29	11.7
5 - Extremely	7	2.8

**10. Feeling distant or cut off from other people? (N=223)**

1 - Not at all	74	30
2 - A little bit	75	30.4
3 - Moderately	38	15.4
4 - Quite a bit	23	9.3
5 - Extremely	13	5.3

**11. Feeling emotionally numb or being unable to have loving feelings for those close to you? (N=223)**

1 - Not at all	124	50.2
2 - A little bit	54	21.9
3 - Moderately	21	8.5
4 - Quite a bit	17	6.9
5 - Extremely	7	2.8

**12. Feeling as if your future will somehow be cut short? (N=223)**

1 - Not at all	111	44.9
2 - A little bit	49	19.8
3 - Moderately	26	10.5
4 - Quite a bit	25	10.1
5 - Extremely	12	4.9

**13. Trouble falling or staying asleep? (N=223)**

1 - Not at all	96	38.9
2 - A little bit	56	22.7
3 - Moderately	27	10.9
4 - Quite a bit	26	10.5
5 - Extremely	18	7.3

**14. Feeling irritable or having angry outbursts? (N=223)**

1 - Not at all	80	32.4
2 - A little bit	76	30.8
3 - Moderately	32	13
4 - Quite a bit	27	10.9
5 - Extremely	8	3.2

**15. Having difficulty concentrating? (N=221)**

1 - Not at all	76	30.8
2 - A little bit	72	29.1
3 - Moderately	30	12.1
4 - Quite a bit	28	11.3
5 - Extremely	15	6.1

**16. Being "super alert" or watchful/on guard? (N=221)**

1 - Not at all	98	39.7
2 - A little bit	51	20.6
3 - Moderately	37	15
4 - Quite a bit	27	10.9
5 - Extremely	8	3.2

**17. Feeling jumpy or easily startled? (N=221)**

1 - Not at all	124	50.2
2 - A little bit	47	19
3 - Moderately	24	9.7
4 - Quite a bit	19	7.7



5 - Extremely 7 2.8  
**Mean PTSD (33.46), SD (13.864)**  
**min (6), max (75)**  
**Cronbach's Alpha (0.935)**

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### Results for Research Question #10

*What is the prevalence of symptoms of depression and anxiety in the past year, and was counseling or advice sought out? (R-DACS-3)*

**Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3).** Mean depression amongst Muslim Americans in the past year was 0.52 (min=0, max=1, SD=0.501); and, 46.2% (N=114) indicated they had experienced depression in the past year. Some 54.7% (N=135) indicated they had experienced anxiety in the past year; and, mean anxiety was 0.61 (min=0, max=1, SD = 0.488). The mean survey respondents who sought out counseling for any depression and anxiety was 0.3 (min=0, max=1, SD=0.459). Also, 26.7% (n=66) indicated they had received counseling in the past year (see Table 10).

Table 10. Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3) (N=220)

	N	%
<b>1. Do you think you experienced any depression in the past year or 12 months? (N=220)</b>		
Yes	114	46.2
No	106	42.9
<b>Mean depressed (0.52), SD (0.501)</b> <b>min (0), max (1)</b>		
<b>2. Do you think you experienced any anxiety in the past year or 12 months? (N=220)</b>		
Yes	135	54.7
No	85	34.4

*Mean anxiety (0.61), SD (0.488)*  
*min (0), max (1)*

**3. In the past year, did you seek out any kind of counseling or advice for any depression and/or anxiety, or other stress—such as from a mental health professional, Iman, Mosque Elder, or family member? (N=220)**

Yes	66	26.7
No	154	62.3

*Mean sought counseling (0.3), SD (0.459)*  
*min (0), max (1)*

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### Results for Research Question #11

*Within their general life experience, what was the frequency of any experiences of microaggressions? (REMI-6)*

**Part XI: Ratings of Experiences of Microaggressions (REMI-6).** The Cronbach's Alpha for this scale was 0.932, indicating excellent internal consistency. The mean for experiencing microaggressions was 7.12 (min=0, max=24, SD=6.649), indicating low experience with microaggressions. Case in point, 44.9% (N=111) indicated that they had *never/not at all* had experienced a “*communication that excluded you, cancelled out your existence, made you invisible, or ignored the reality of your thoughts, feelings, and existence as a diverse person*” (see Table 11).

Table 11. Ratings of Experiences of Microaggressions (REMI-6) (N=220)

	N	%
<b>1. Brief exchanges or brief interactions where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative: (N=220)</b>		
0 - Never/Not at all	77	31.2
1 - At least once	48	19.4
2 - More than once	36	14.6

3 - A few times	42	17
4 - Many times	17	6.9

**2. A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose: (N=220)**

0 - Never/Not at all	101	40.9
1 - At least once	51	20.6
2 - More than once	31	12.6
3 - A few times	24	9.7
4 - Many times	13	5.3

**3. A nonverbal attack, or some behavior that was hurtful and caused mental or emotional pain, whether this involved someone avoiding contact and interaction, or avoiding communication, or some act of discrimination performed on purpose: (N=220)**

0 - Never/Not at all	104	42.1
1 - At least once	54	21.9
2 - More than once	30	12.1
3 - A few times	20	8.1
4 - Many times	12	4.9

**4. A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language: (N=220)**

0 - Never/Not at all	79	32
1 - At least once	68	27.5
2 - More than once	27	10.9
3 - A few times	31	12.6
4 - Many times	15	6.1

**5. A communication that excluded you, cancelled out your existence, made you invisible, or ignored the reality of your thoughts, feelings, and existence as a diverse person: (N=220)**

0 - Never/Not at all	111	44.9
1 - At least once	55	22.3
2 - More than once	22	8.9
3 - A few times	14	5.7
4 - Many times	18	7.3

**6. How often did you experience any of the above where you felt the treatment you received was related to BOTH your race/ethnicity, or skin color, or physical appearance, as well as your being Muslim? (N=219)**

0 - Never/Not at all	77	31.2
1 - At least once	56	22.7
2 - More than once	33	13.4
3 - A few times	29	11.7

4 - Many times	24	9.7
<i>Mean experienced microaggressions (7.12), SD (6.649)</i>		
<i>min (0), max (24)</i>		
<i>Cronbach's Alpha (0.932)</i>		

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## Results for Research Question #12

*What was their experience of any overt acts of violence? (REOAV-4)*

**Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4).** The mean for experiencing overt acts of violence was 0.71 (min=0, max=9, SD=1.457), or low exposure. For example, when asked to what extent respondents were “*physically attacked, for example, being hit, slapped, kicked or beaten up*”, 72.1% (n=178) responded *never/not at all*. Additionally, 83.4% of respondents indicated that they had *never/not at all* experienced “*sexual assault, for example, rape, attempted rape, made to perform some type of sexual act through force or threat of harm*” (see Table 12).

Table 12. Ratings of Experiences of Overt Acts of Violence (REOAV-4) (N=216)

	N	%
<b>1. A physical attack, for example, being hit, slapped, kick or beaten up: (N=216)</b>		
0 - Never/Not at all	178	72.1
1 - At least once	26	10.5
2 - More than once	6	2.4
3 - A few times	4	1.6
4 - Many times	2	0.8
<b>2. Assault with a weapon, for example, being shot, stabbed, threatened with a knife, gun, or bomb (N=216)</b>		
0 - Never/Not at all	199	80.6
1 - At least once	14	5.7
2 - More than once	2	0.8
3 - A few times	1	0.4
4 - Many times	0	0

**3. Sexual assault, for example, rape, attempted rape, made to perform some type of sexual act through force or threat of harm: (N=216)**

0 - Never/Not at all	206	83.4
1 - At least once	7	2.8
2 - More than once	2	0.8
3 - A few times	1	0.4
4 - Many times	0	0

**4. Violent destruction of property or damage to property or belongings (e.g., graffiti on a wall, broken window glass, smashed car windows, etc.) (N=216)**

0 - Never/Not at all	79	32
1 - At least once	68	27.5
2 - More than once	27	10.9
3 - A few times	31	12.6
4 - Many times	15	6.1

*Mean experienced overt acts of violence (0.71), SD (1.457)  
min (0), max (9)*

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**Results for Research Question #13**

*What was their level of ability for perceiving Islamophobia and/or Islamophobic discrimination—when it happening to themselves, as well as others? (PI-ID-10)*

**Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination**

**(PI-ID-10).** The Cronbach's Alpha for this scale was 0.797, indicating good internal consistency. The mean perception to Islamophobia was 4.076 (min=2, max=5, SD=0.571), or high level of ability. For example, 52.2% (N=129) agreed with the statement that they can see or sense when Islamophobia or Islamophobic discrimination is happening to themselves (see Table 13).

Table 13. Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10) (N=215)

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	N	%
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**I am not sure it is really exists or happens to people. (N=215)**

1 - Strongly agree	13	5.3
2 - Agree	19	7.7
3 - Undecided	14	5.7
4 - Disagree	54	21.9
5 - Strongly disagree	115	46.6

**When incidents are talked about, I am not sure what makes something racist or oppressive. (N=215)**

1 - Strongly agree	2	0.8
2 - Agree	20	8.1
3 - Undecided	20	8.1
4 - Disagree	82	33.2
5 - Strongly disagree	91	36.8

**I think it never happens to me. (N=215)**

1 - Strongly agree	21	8.5
2 - Agree	37	15
3 - Undecided	27	10.9
4 - Disagree	89	36
5 - Strongly disagree	41	16.6

**There are times when I “don’t get it,” or I can’t really tell when it is happening to me. (N=215)**

1 - Strongly agree	3	1.2
2 - Agree	37	15
3 - Undecided	41	16.6
4 - Disagree	87	35.2
5 - Strongly disagree	47	19

**I think it never happens to others. (N=214)**

1 - Strongly agree	3	1.2
2 - Agree	5	2
3 - Undecided	7	2.8
4 - Disagree	51	20.6
5 - Strongly disagree	148	59.9

**There are times when I “don’t get it,” or I can’t really tell when it is happening to others. (N=214)**

1 - Strongly agree	0	0
2 - Agree	24	9.7
3 - Undecided	20	8.1

4 – Disagree	73	29.6
5 - Strongly disagree	97	39.3

**I can usually see or sense when it is happening to me. (N=214)\***

1 - Strongly agree	49	19.8
2 – Agree	129	52.2
3 – Undecided	25	10.1
4 – Disagree	10	4
5 - Strongly disagree	1	0.4

**I can usually see or sense when it is happening to others. (N=214)\***

1 - Strongly agree	70	28.3
2 – Agree	121	49
3 – Undecided	20	8.1
4 – Disagree	3	1.2
5 - Strongly disagree	0	0

**When incidents are talked about, I think “That could happen to me or someone I love.” (N=214)\***

1 - Strongly agree	105	42.5
2 – Agree	96	38.9
3 – Undecided	11	4.5
4 – Disagree	1	0.4
5 - Strongly disagree	1	0.4

**When incidents are talked about, I can identify with and understand the experience. (N=214)\***

1 - Strongly agree	81	32.8
2 – Agree	101	40.9
3 – Undecided	24	9.7
4 – Disagree	8	3.2
5 - Strongly disagree	0	0

***Mean perception to Islamophobia (4.0758), SD (0.5706)***

***min (2), max (5)***

***Cronbach's Alpha (0.797)***

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\*Note: For scoring, items 7-10 are reverse scored, allowing a high score to mean a higher perception of Islamophobia. One then sums the scores for all 10 items to arrive at the total score, permitting arriving at a sample mean, minimum 1=very low ability, maximum 5=very high ability and SD. Also, for the interpretation of the mean score for level of ability to perceive racism/oppression: 1=very low ability, 2=low ability, 3=moderate ability, 4=high ability, 5=very high ability

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## Results for Research Question #14

*What was their stage of change (i.e. precontemplation, contemplation, preparation, action, maintenance) for coping and responding to any experiences of Islamophobia and/or Islamophobic discrimination? (CR-IID-SC-6)*

**Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6).** The sample's mean stage of change for coping and responding to Islamophobia and/or Islamophobic discrimination was 3.44 (min=1 or precontemplation stage; max=5, maintenance stage, SD=1.330), or closest to a preparation stage. Of note, when asked about how long survey respondents had been learning to cope with and respond to Islamophobia and Islamophobic discrimination, 30% (N=74) responded by stating *never in my life* (see Table 14).

Table 14. Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6) (N=214)

	N	%
<b>The Sample's Stages of Change for Coping and Responding to Islamophobia and/or Islamophobic Discrimination (N=214)</b>		
1- Precontemplation	9	3.6
2- Contemplation	66	26.7
3- Preparation	30	12.1
4- Action	40	16.2
5- Maintenance	69	27.9
<i>Mean stage of change (3.44), SD (1.330) min (1), max (5)</i>		

### The Sample's CR-IID-SC-6 Individual Item Responses (N=214)

#### 1. I never thought about how to cope with or respond to it. (N=214)



1 - Strongly agree	9	3.6
2 - Agree	37	15
3 - Undecided	31	12.6
4 - Disagree	106	42.9
5 - Strongly disagree	31	12.6
<b>2. I have thought about how to cope with or respond to it. (N=214)</b>		
1 - Strongly agree	48	19.4
2 - Agree	105	42.5
3 - Undecided	28	11.3
4 - Disagree	26	10.5
5 - Strongly disagree	7	2.8
<b>3. I never took steps to learn more about how to cope with and respond to it. (N=213)</b>		
1 - Strongly agree	20	8.1
2 - Agree	71	28.7
3 - Undecided	32	13
4 - Disagree	77	31.2
5 - Strongly disagree	13	5.3
<b>4. I am planning to take steps to learn more about how to cope with and respond to it. (N=213)</b>		
1 - Strongly agree	19	7.7
2 - Agree	77	31.2
3 - Undecided	76	30.8
4 - Disagree	36	14.6
5 - Strongly disagree	5	2
<b>5. I have been actively learning how to cope with and respond to it (N=213)</b>		
1 - Strongly agree	14	5.7
2 - Agree	57	23.1
3 - Undecided	45	18.2
4 - Disagree	79	32
5 - Strongly disagree	18	7.3
<b>6. Learning how to cope with and respond to it is something that I have been actively working on: (N=213)</b>		
never in my life	74	30
< 1 month	14	5.7
< 6 months	9	3.6
> 6 months	4	1.6
1-3 years	19	7.7
4-6 years	11	4.5
7-9 years	6	2.4
10-20 years	19	7.7
21-30 years	7	2.8

>31 years	3	1.2
Unsure	47	19

### Results for Research Question #15

*What was their coping self-efficacy—specifically, their level of ability and confidence for using (a) problem-focused coping, (b) stopping unpleasant emotions and thoughts, and (c) getting support from other family and friends? (CSES-RF-13)*

**Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13).** This scale has three sub-scales: 1) using problem-focused coping, 2) the ability to stop unpleasant emotions or thoughts, and 3) getting support from friends and family.

First, *problem focused coping* exhibited excellent internal consistency (Cronbach’s Alpha = 0.924) and returned a mean of 7.072 (min=0, max=10, SD=2.008). For example, 41.4% (N=102) responded with a score of 8 or higher when asked if they could “*break an upsetting problem down into smaller parts*”.

Second, *stopping unpleasant emotions* exhibited excellent internal consistency (Cronbach’s Alpha of 0.962) and returned a mean of 5.576 (min=0, max=10, SD=2.632). For example, 25.9% (N=64) responded with a score of 8 or higher when asked if they could stop themselves from “*being upset by unpleasant thoughts*”.

Third, *getting support from friends and family* exhibited very good internal consistency (Cronbach’s Alpha =0.810) and returned a mean of 5.916 (min=0, max=10, SD=2.527). For example, 32.4% (N=80), responded with a score of 8 or higher when asked if they “*had support from friends*” (see Table 15).

Table 15. Coping Self-Efficacy Scale—Reduced Form (CSES-RF-13) (N=212)

	N	%
<b>Subscale 1: Problem-Focused Coping</b>		
<i>Mean problem-focused coping (7.0715), SD (2.00762)</i>		
<i>min (0), max (10)</i>		
<i>Cronbach's Alpha (0.924)</i>		
<b>1. When things aren't going well for you, how confident are you that you can: Break an upsetting problem down into smaller parts. (N=212)</b>		
0	2	0.8
1	2	0.8
2	1	0.4
3	9	3.6
4	7	2.8
5	41	16.6
6	21	8.5
7	27	10.9
8	34	13.8
9	33	13.4
10	35	14.2
<b>2. When things aren't going well for you, how confident are you that you can: Sort out what can be changed, and what cannot be changed. (N=212)</b>		
0	2	0.8
1	2	0.8
2	1	0.4
3	5	2
4	7	2.8
5	34	13.8
6	12	4.9
7	31	12.6
8	45	18.2
9	35	14.2
10	38	15.4
<b>3. When things aren't going well for you, how confident are you that you can: Make a plan of action and follow it when confronted with a problem. (N=212)</b>		
0	3	1.2
1	2	0.8
2	4	1.6
3	10	4
4	13	5.3

5	22	8.9
6	17	6.9
7	17	6.9
8	47	19
9	37	15
10	40	16.2

**4. When things aren't going well for you, how confident are you that you can:**

**Leave options open when things get stressful. (N=212)**

0	2	0.8
1	5	2
2	3	1.2
3	9	3.6
4	13	5.3
5	29	11.7
6	19	7.7
7	29	11.7
8	45	18.2
9	28	11.3
10	30	12.1

**5. When things aren't going well for you, how confident are you that you can:**

**Think about one part of the problem at a time. (N=212)**

0	2	0.8
1	4	1.6
2	7	2.8
3	12	4.9
4	17	6.9
5	23	9.3
6	24	9.7
7	20	8.1
8	36	14.6
9	33	13.4
10	34	13.8

**6. When things aren't going well for you, how confident are you that you can:**

**Find solutions to your most difficult problems. (N=212)**

0	3	1.2
1	5	2
2	2	0.8
3	7	2.8
4	12	4.9
5	26	10.5

6	25	10.1
7	26	10.5
8	35	14.2
9	36	14.6
10	35	14.2

**Subscale 2: Stop Unpleasant Emotions and Thoughts**

*Mean stop unpleasant thoughts (5.5758), SD (2.63180)*

*min (0), max (10)*

*Cronbach's Alpha (0.962)*

**7. When things aren't going well for you, how confident are you that you can:**

**Make unpleasant thoughts go away. (N=211)**

0	8	3.2
1	6	2.4
2	18	7.3
3	15	6.1
4	21	8.5
5	37	15
6	22	8.9
7	20	8.1
8	28	11.3
9	15	6.1
10	21	8.5

**8. When things aren't going well for you, how confident are you that you can:**

**Take your mind off unpleasant thoughts. (N=211)**

0	9	3.6
1	8	3.2
2	15	6.1
3	17	6.9
4	20	8.1
5	25	10.1
6	25	10.1
7	29	11.7
8	31	12.6
9	12	4.9
10	20	8.1

**9. When things aren't going well for you, how confident are you that you can:**

**Stop yourself from being upset by unpleasant thoughts. (N=211)**

0	9	3.6
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1	9	3.6
2	18	7.3
3	18	7.3
4	25	10.1
5	26	10.5
6	19	7.7
7	23	9.3
8	26	10.5
9	19	7.7
10	19	7.7

**10. When things aren't going well for you, how confident are you that you can:  
Keep from feeling sad. (N=211)**

0	9	3.6
1	14	5.7
2	14	5.7
3	20	8.1
4	23	9.3
5	30	12.1
6	23	9.3
7	22	8.9
8	24	9.7
9	15	6.1
10	17	6.9

**Subscale 3: Get Support from Friends and Family**

*Mean get support from friends and family (5.9163), SD (2.52707)*

*min (0), max (10)*

*Cronbach's Alpha (0.810)*

**11. When things aren't going well for you, how confident are you that you can:  
Get friends to help you with the things you need. (N=211)**

0	11	4.5
1	8	3.2
2	14	5.7
3	12	4.9
4	16	6.5
5	34	13.8
6	13	5.3
7	23	9.3
8	31	12.6

9	23	9.3
10	26	10.5

**12. When things aren't going well for you, how confident are you that you can:  
Get emotional support from friends and family. (N=211)**

0	6	2.4
1	10	4
2	10	4
3	13	5.3
4	7	2.8
5	25	10.1
6	13	5.3
7	27	10.9
8	31	12.6
9	30	12.1
10	39	15.8

**13. When things aren't going well for you, how confident are you that you can:  
Make new friends. (N=211)**

0	17	6.9
1	15	6.1
2	13	5.3
3	24	9.7
4	21	8.5
5	32	13
6	15	6.1
7	14	5.7
8	21	8.5
9	15	6.1
10	24	9.7

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### **Results for Research Question #16**

*What are the significant relationships among selected independent variables (e.g. age, education level, etc.) and the study outcome variable/dependent variable of higher level of life satisfaction?*

These results were examined using both Pearson Correlations and independent t-test. Results for each are explained below.

**Independent t-tests Comparing Groups with The Outcome Variable – Higher Life Satisfaction.** In total, seven groups were compared to the outcome variable, thus the Bonferroni Adjustment Significance ( $0.05/7 = 0.007$ ) was  $p < 0.007$ . The following group comparisons were significant.

- When comparing survey respondents who were born in the United States (mean=6.95, SD=2.015) to those who were not born in the United States (mean=7.65, SD=1.895), there was a significant difference ( $t=2.709$ ,  $df=245$ ,  $p=0.006$ ), where those who were born in the United States had significantly higher life satisfaction ( $p<0.007$ , Bonferroni Adjustment Significance level).
- When comparing survey respondents' marital status, it was found that there was a significant difference ( $t=-4.4772$ ,  $df=245$ ,  $p=.00$ ) between those who were married (mean=7.66, SD=1.842) and those who were not (mean=6.46, SD=2.069). It was found that those who were married reported significantly higher life satisfaction ( $p<0.007$ , Bonferroni Adjustment Significance level).
- When comparing if survey respondents were depressed in the past year, it was found that there was a significant difference ( $t=8.864$ ,  $df=210.966$ ,  $p=0.00$ ) between those who reported being depressed in the past year (mean=6.33, SD=1.94) and those who did not (mean=8.4, SD=1.497). Respondents who indicated that they were less depressed in the past year had significantly higher life satisfaction ( $p<0.007$ , Bonferroni Adjustment Significance level).
- When comparing if survey respondents were anxious in the past year, it was found that there was a significant difference ( $t=6.971$ ,  $df=207.532$ ,  $p=.000$ ) between those who reported being anxious in the past year (mean=6.67, SD=2.003) and those who did not (mean=8.36, SD=1.572). Respondents who indicated that they were less anxious in the past year had significantly higher life satisfaction ( $p<0.007$ , Bonferroni Adjustment Significance level).



- When comparing if survey respondents sought counseling in the past year, it was found that there was a significant difference ( $t=4.036$ ,  $df=218$ ,  $p=.000$ ) between those who reported seeking counseling in the past year (mean=6.52,  $SD=2.01$ ) and those who did not (mean=7.68,  $SD=1.93$ ). Respondents who indicated that they had sought counseling in the past year had significantly higher life satisfaction ( $p<0.007$ , Bonferroni Adjustment Significance level) (see Table 16).

Table 16. Independent Group T-Test for Life Satisfaction

	Higher Life Satisfaction			<i>t</i> -test		
	N	M	SD	<i>t</i>	df	P
<b>Gender</b>				-		
Female	184	7.19	1.953	1.373	245	0.171
Male	63	7.59	2.061			
<b>If born in US</b>				2.798	245	0.006**
No	120	7.65	1.895			
Yes	127	6.95	2.015			
<b>If married</b>				-		
No	74	6.46	2.069	4.472	245	.000***
Yes	173	7.65	1.842			
<b>If full-time or part-time employed</b>				-		
No	54	6.85	2.277	1.851	245	0.065
Yes	193	7.41	1.883			
<b>If depressed in the past year</b>				8.864	210.966	.000***
No	106	8.4	1.497			
Yes	114	6.33	1.94			
<b>If anxious in the past year</b>				6.971	207.532	.000***
No	85	8.36	1.572			
Yes	135	6.67	2.003			
<b>If sought counseling in the past year</b>				4.036	218	.000***
No	154	7.68	1.93			
Yes	66	6.52	2.01			

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  Bonferroni Adjustment Significance ( $.05/7$ ,  $p = .007$ )

Note: All  $p$  values above  $.007$  are considered non-significant, and only those below

$.007$  are considered statistically significant

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**Pearson's Correlations:** Correlations between 26 independent variables were measured against the primary outcome variable (higher life satisfaction), thus the Bonferroni Adjustment Significance ( $0.05/26 = 0.002$ ) was  $0.002$ .

Significant correlations between the primary outcome variable of higher life satisfaction and the independent variables are below (see Table 17).

**A higher life satisfaction** was associated with:

- *Older age* ( $r = 0.0368$ ,  $p = .000$ )
- *Better overall health status* ( $r = 0.384$ ,  $p = .000$ )
- *Better quality of care for medical conditions* ( $r = 0.342$ ,  $p = .000$ )
- *Better quality of care from a primary care provider* ( $r = 0.380$ ,  $p = .000$ )
- *Better sensitivity from provider about Muslims/Islam* ( $r = 0.307$ ,  $p = .000$ )
- *Less perceived stress* ( $r = -0.57$ ,  $p = .000$ )
- *Less symptoms of post-traumatic stress disorder* ( $r = -0.513$ ,  $p = .000$ )
- *Less exposure to microaggressions* ( $r = -0.285$ ,  $p = .000$ )
- *More use of problem-solving coping* ( $r = 0.47$ ,  $p = .000$ )
- *Higher ability to stop unpleasant thoughts* ( $r = 0.532$ ,  $p = .000$ )
- *Greater use of social coping support* ( $r = 0.385$ ,  $p = .000$ )

Table 17. Correlations Between Selected Variables and Life Satisfaction

	Higher Life Satisfaction	
	Pearson's R	P
Age	0.367	.000***
Highest Education Level	0.17	0.789
Annual Household Income	0.139	0.029
Skin Color	0.11	0.867

BMI (Body Mass Index)	0.093	0.147
Overall Health Status	0.384	.000***
Weight	-0.085	0.181
Quality of Care for Medical Condition	0.342	.000***
Quality of Care from Primary Care Provider	0.38	.000***
Primary Care Provider's Muslim Competence	0.307	.000***
Religiosity	0.184	0.004**
Frequency of Wearing Muslim Identifying Clothing for Males and Females	-0.039	0.544
Perceived Stress Scale	-0.57	.000***
The Brief Trauma Questionnaire	-0.131	0.048
Being Exposed to Any Trauma	-0.137	0.039
Being Exposed to Any Life-Threatening Trauma	-0.086	0.194
Being Exposed to Any Trauma with a Serious Injury	0.018	0.782
Being Exposed to Trauma to Others	-0.186	0.005**
PTSD Checklist-Civilian Version	-0.513	.000***
Ratings of Experiences of Microaggressions	-0.285	.000***
Ratings of Experiences of Overt Acts of Violence	-0.085	0.215
Perceptions of Islamophobia and/or Islamophobic Discrimination	-0.153	0.024*
Coping and Responding to Islamophobia and/or Islamophobic Discrimination	-0.127	0.064
Using Problem-Solving Coping	0.47	.000***
Stopping Unpleasant Emotions and Thoughts	0.532	.000***
Getting Support from Friends and Family	0.385	.000***

\* $p < .05$ , \*\* $p < .01$ , \*\*\* $p < .001$  Bonferroni Adjustment Significance (.05/26,  $p = .002$ ). Note: All  $p$  values above .002 are considered non-significant; and, only those below .002 are considered statistically significant.

### Results for Research Question #17

*What are the significant predictors of the study outcome variable/dependent variable of higher level of life satisfaction—controlling for socially desirable responses?*

For the purposes of this study, the outcome variable of interest was **higher life satisfaction**, while controlling for socially desirable responses.

**Independent variables:** the following variables were selected for inclusion in the backwards stepwise regression model: gender; age; race/ethnicity; skin color tone; born in the US or not; years living in the US; level of education; marital status [partner—yes/no]; employment status (yes/no); annual household income; rating of overall health status; Body Mass Index (BMI); rating of their weight status; rating of overall quality of care they receive; rating of overall quality of care from their primary provider; ratings of sensitivity and competence of provider for treating someone Muslim; if practicing Muslim (yes/no); type of Muslim sect to which they belong; frequency of wearing visibly Muslim dress in public; past month level of perceived stress; prevalence of traumatic experiences across the lifespan; prevalence of symptoms of posttraumatic stress disorder (PTSD); prevalence of depression in the past year (yes/no); prevalence of anxiety in the past year (yes/no); receipt of counseling in the past year (yes/no); frequency of exposure to microaggressions in life in general; frequency of exposure to overt acts of violence in life in general; level of ability to perceive Islamophobia and/or Islamophobic discrimination when it is happening to one's self and others; stage of change for coping with and responding to Islamophobia and/or Islamophobic discrimination (i.e. precontemplation, contemplation, preparation, action, maintenance stage); level of coping self-efficacy/confidence for using (a) problem-focused coping, (b) stopping unpleasant emotions and thoughts, and (c) getting support from other family and friends.

**Backwards Stepwise Regression.** The model began with the full set of 29 independent variables of interested noted above and runs a regression to identify and remove the least significant variables at each step, while not controlling for the other

independent variables. The regression continues to run multiple times until all independent variables returned are statistically significant (i.e.  $p < 0.05$ ) in relation to the outcome variable.

The results of the backwards stepwise regression for this study yielded the following: **higher life satisfaction** was significantly predicted by:

- *Being less likely to be depressed in the past year* (B = - 0.588,  $p = 0.012$ )
- *Older age* (B = 0.038,  $p = 0.001$ )
- *Better overall health status* (B = 0.361,  $p = 0.001$ )
- *Better rating of quality of provider* (B = 0.352,  $p = 0.001$ )
- *Lower perceived stress in the past month* (B = - 0.066,  $p = 0.000$ )
- *Lower stage of change (preconception, contemplation) for coping and responding to Islamophobia* (B = - 0.168,  $p = 0.025$ )
- *Higher use of the “stop unpleasant thoughts” coping style* (B = 0.129,  $p = 0.007$ ).

It was found that according to this model, 56.6% of variance was predicted ( $R^2 = 0.584$ , adjusted  $R^2 = 0.566$ ) by the factors above (see Table 18).

Table 18. Backwards Stepwise Regression Predicting Higher Levels of Life Satisfaction

Variables	B	SE of B	P
More About You (Social Desirability)	0.096	0.04	0.017
More likely to be depressed in the past year	-0.588	0.232	0.012*
Older age	0.038	0.011	0.001**
Better overall health status	0.361	0.11	0.001**
Better rating of quality of provider	0.352	0.102	0.001**
Higher perceived stress	-0.066	0.018	0***

Higher stage of change for coping and responding to Islamophobia	-	0.168	0.074	0.025*
Higher "stop unpleasant thoughts" coping style		0.129	0.047	0.007**

*\*p<.05, \*\*p<.01, \*\*\*p<.001; R2 (0.584), Adjusted R2 (0.566)*

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### Qualitative Portion of Study

#### Results for Research Question #18

*What themes emerged when asked to provide open-ended responses to questions eliciting qualitative data on several topics—(a) factors impacting their life satisfaction as a Muslim American, (b) the most stressful parts of their life experience as a Muslim American, (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, (d) their experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression (e.g. being a Muslim American, and also a racial/ethnic minority, etc., or intersectionality), (e) examples of how they coped, bounced back, or healed, or were resilient from stressful or traumatic discrimination/microaggressions/hate, and (f) recommendations to improve the overall life satisfaction of Muslim Americans?*

**Part XVI: Life Satisfaction, Stress Trauma, Intersectionality, Ways of Coping, and Resilience (LS-STI-WOC-R-5).** Four open-ended questions were presented to participants (N=247). The emergent themes and direct quotes from each of the questions is presented below.

**For (a) *factors impacting their life satisfaction as a Muslim American, the emergent themes were:***

**Category I-Living in a Post-9/11 America**

- "...after 9/11 my house was spray painted. I was verbally abused on occasion as a teenager from non-Muslims. One student said I should be thrown into a camp like the "Japs."
- "...Islamophobia has become increasingly open, and ugly. It feels to me like racism is more allowed now, and hatred for people (specially Muslims) isn't really considered racist behavior."
- "Feeling that I'm part of a group that is vilified. At times I feel more comfortable that I look like a typical white person and that I'm not easily identified as a Muslim. I never thought I'd have that feeling. I'm proud to be a practicing Muslim, but sometimes it feels easier to not be singled out as 'the other'"
- "Increase of bigotry under Trump administration"
- "Islamophobia around the US has made it very difficult to feel safe and secure in the US"

**Category II-Feeling a Sense of Community**

- "Being active in the Muslim/Arab American community and involved in interfaith work."
- "Being around other Muslim friends"
- "[Being] where there is an active Muslim community and services. Especially during Ramadan."
- "Being part of a strong community, having tons of support from several people"
- "Community, service, family, civic engagement"
- "I live in an area with very active Muslim community and kids' activities at the mosques. We could make many friends, which later became our support system, through mosque meetups."
- "Living in a diverse environment..."
- "Strong faith-based community. Participation in Muslim organizations, local masjid and volunteering in community projects."

**Category III-Wearing Hijab (headscarf for women)**

- “My experiences as a hijabi (when I did cover)- how I was treated by my family, and by people I interacted with on a daily basis (from colleagues to strangers on public transportation).”
- “Daily discrimination, wearing hijab, being a woman in an elite Ivy League school space”
- “Fear for the safety of my family, specifically for my wife who wears a headscarf...”
- “The way people look at me when I’m walking with my hijab covered mother”

**Category IV-Religiosity**

- “Daily Prayer and Dhikr (daily remembrance of God)”
- “Faith gives you strength to deal with adversity”
- “Freedom of expression and worship...”
- “Going to the mosque regularly has helped me to keep a safe mental state
- Keeping my faith in God! Understanding that he does not give us what we cannot handle.”

**Category V-Work and financial stability**

- “The biggest factors have been quality of life related to work...”
- “Ability to provide for my family...”
- “... financial stability”
- “...career success...”
- “...be[ing] well off financially”
- “Job and work-life balance...”

See Table 19

Table 19. Factors Impacting Life Satisfaction of Muslim Americans (N=247)

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**(a) What factors have impacted your Life Satisfaction as a Muslim American?**

**Category I- Post 9/11 America**

Islamophobia  
 Acceptability of public discrimination  
 Discrimination  
 Destruction of personal property

**Category II- Feeling a Sense of Community**

Playing an active role in the Muslim community  
 Finding support amongst other Muslims  
 Diversity amongst Muslims in the community  
 Volunteering

**Category III-Wearing Hijab (headscarf for women)**



Negative perceptions of Muslim Women who cover  
 Discrimination against Muslim women  
 Fear of safety for Muslim women

**Category IV- Religiosity**

Daily Prayer  
 Keeping the Faith  
 Freedom to Worship

**Category V- Work and Financial Stability**

Financial stability  
 Working  
 Providing for family

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**For (b) *most stressful parts of their life experience as a Muslim American, the emergent themes were:***

**Category I-Islamic Identity**

- “I have a visible identity as a Muslim and have gone out of my way to make Islam visible in the community. While again this can be exhausting, I feel compelled to do it.”
- “Feeling pressure from the Muslim community to change my identity in exchange for their support- which, I needed, because I was desperate.”
- “Being both visibly Muslim but also feeling invisible out in public...”
- “Being in a high school as an only hijabi was very difficult for me. Teachers were extremely nice and the most students were nice as well, but I hated feeling different”
- “...it has been a struggle to me especially since I wear hijab many people in public tend to stare at me and give me bad looks without knowing me as a person...”

**Category II-Religious Discrimination**

- “Twice I have had to file a case of religious discrimination with EOAA.”
- “Activities of daily living can be quite stressful because one might face Islamophobic and bigoted remarks when it is least expected.”
- “Always being seen as different”
- “American xenophobia and ignorance. It’s an everyday struggle”
- “Being discriminated against and dismissed from professional school for being a male, Muslim American, in a (prominent) position of student leadership with a learning disability that was working through a depressive episode.”
- “Being screamed at in public, in front of my three young daughters, and the person telling them they had a bad mom.”

- “Discrimination or bullying due to being Muslim”
- “I fear for the well-being of my family members. Namely my mom, because she wears a hijab. I find myself overly protective and paranoid when I’m out with her. I’ve had times when I wished she didn’t wear the hijab because I never want to think of the possibility of someone attacking her verbally or physically when I’m not there to protect her.”
- “I went through several experiences involving microaggressions, name-calling, and prejudice as a Muslim, brown-skinned millennial growing up in the DC Metro area.”

### **Category III-Living in a Post-9/11 America**

- “9/11 I was young and was not fully aware of how drastically my life had shifted in a day.”
- “9/11 really affected my life. It changed how I reacted to things and kept me on high alert. I’m always looking for exits when I enter a building and I’m always looking at the people around me to gauge their reaction to me and to see if I’m welcome.”
- “After 9/11, we were afraid to leave the house. More afraid than in natural disasters.”
- “As a hijab wearing woman in the 70 and 80’s was tough, especially in public school. But once I got to college, I was very confident. Then 9/11 happened and I decided to stop wearing hijab a year later. I didn’t want to relieve my younger years.”
- “Being Muslim in the US comes with judgement. You sometimes feel very paranoid when other speak about or ask you about your religion. You can’t ever tell what their intentions are. To try and cope or bounce back, I try to keep these conversations quick so that I don’t have to deal with them too much.”
- “Growing up in a post 9/11 world, while wearing the hijab, I have insults hurled at me. Hurtful things have been said regularly but as I have grown, I have learned how to navigate these situations and make my voice heard.”
- “The day 9/11 happened, I was in my 11th grade English class and we were watching the news- shocked. This boy sitting in front of me asked me how I was linked to “jihad” and started screaming “jihad on you! Jihad on you!” While pointing his finger at me. No one said a word, not even the teacher. I was clueless and embarrassed.”
- “I got spit on, I got called “Osama bin Laden” numerous times, I had people throw their trash at me during lunch and tell me to “go back to your country”. I was asked a couple of times if I was “going to blow up the school”. I was even jumped by a group of African American students in front of my locker and they started punching me.”
- “After 9/11 I began hearing first hand from non-Muslims about how Muslims should be rounded up and imprisoned or shot to death.”

See Table 20

Table 20. Stressful Experiences for Muslim Americans (N=247)

**(b) What have been the most stressful parts of your life experience as a Muslim American?**

**Category I- Islamic Identity**

Being visibly Muslim (wearing Muslim dress)

**Category II- Religious Discrimination**

Workplace discrimination

Academic discrimination

Public discrimination

**Category III-Living in a Post-9/11 America**

Islamophobia

Wearing hijab

Public discrimination

**For (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, the emergent themes were:**

**Category I-Seeking out Community**

- “Worked with groups to promote racial and religious diversity in our communities. Actively sought positions of power by joining Boards and organizations focused on improving the lives of Muslims and POC in America.”
- “Participate in community and local charities. Make a fuss about Eid so kids may enjoy it as much as they want to during Christmas.”
- “Feeling accepted and finding a place to fit in.”
- “Good support system in family and friends.”

**Category II-Counseling with a Trusted Practitioner**

- “During 2016 elections, I felt unsafe in small town America. I moved to a more cosmopolitan area in order to feel safe as a visibly Muslim woman. I had to get counseling and family support to recover.”
- A prospect roommate did not allow me into a viewing of her apartment because of my hijab. I sought help from friends, I talked to a counselor”
- Surviving a hate crime. Only counseling helped.

**Category III-Prayer**

- “Pray 5 times a day and talk to God about what I felt and seek for his protection.”

- “I cope by remembering our beloved Prophet (s.a.a.w) and what he and the early Muslims endured and this feels like nothing! I engage, I smile, I listen attentively, and I try to leave them with useful information and encourage an open line of conversation.”
- “Praying on time and finding a place to pray at work”
- “Turning to faith, prayer”

#### **Category IV-Time**

- “Getting yelled at and harassed by a group of Zionists for being a Palestinian Muslim. I did not cope well, I just let time do its thing”
- “Time helps to heal these wounds. Living in the US around 2001 was incredibly stressful and worrying, even though I was still a child. I vividly recall feeling scared for my mother and father and if someone would hurt them or say negative things to them. Same for my siblings.”

See Table 21

Table 21. Coping and Bouncing Back Themes for Stressful Experiences (N=247)

**(c) Please share how you coped, bounced back, or healed—or how you have been resilient.**

#### **Category I –Community**

Joining groups

Feeling accepted

Support from family and friends

#### **Category II-Counseling**

Seeking out a mental health professional

#### **Category III-Praying**

Keeping the 5 daily prayers

Speaking to God

#### **Category IV-Time**

Allowing time to pass

**For (d) *experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression*, the emergent themes were:**

#### **Category I- Discrimination**

- “A former employer admitted at a later time that she was very close to not hiring me due to my name and the fact that I was Muslim.”
- “Almost got ran off the road, had a gun pulled beside me while filling up gas.”

- “As a child - right around 9/11-someone in my class suggested killing all Muslims. My teacher didn't stop them.”
- “Being a Muslim woman of color makes you stand out. When I was younger it seemed easier to cope with. But after 40, I was tired of it and would rather fit in or at least not stand out.”
- “My experiences of discrimination include incidents at work, by government agents, and individuals.”
- “People verbally insult me all time, and often I am scared, I carry MACE on my key chain.”

### **Category II-Microaggressions**

- “Being told not to oppress my kids like I have been oppressed by my elders”
- “I always get negative comments for not eating bacon or not drinking at happy hours. I'm always looked down upon.”
- “I was told by a coworker that another coworker associated all brown people to smell like curry and that I probably had ‘a bomb with my curry’.”
- “I've had people who know me as Muslim say that I'm very non-typical of being a Muslim, and when I delve deeper, I realize that their only perception of Muslims is from news and movies i.e. terrorists. I've had to explain often that 99% of Muslims are “normal” like me”
- “In a drug store, I was in line to check out when an older white woman came up behind me, sort of talking loudly to herself. Hearing the commotion, I turned around and she hit me on the head 3 times while saying, "Aren't you hot?". I was caught off guard and my reflexive instinct set in and I hit/pushed her shoulder while saying, "Aren't you cold?" (since she had on shorts)”
- “Micro-aggression in terms of being a woman more than anything. For example, not being considered for promotion by leadership. I believe most microaggression comes from the Muslim community - the constant lack of representation of Muslim women on boards/trusts/mosque leadership.”
- “Often in class when Islam is discussed or when I talk to people about being Muslim, they say little things like saying we don't believe in women's rights, we believe in child marriages, etc.”
- “One experience recently was walking through a Sam's club when I turned back to my shopping cart, I found a Bible in my cart. Had no idea who put it there.”
- “People asking me about my name and where I learned to speak English so well. I was born in the USA!!”

### **Category III-Hate**

- “At my college, there were a number of direct attacks on the Muslim community, including vandalizing our prayer space multiple times.”

- “Being told by random strangers at the mall, park, etc. to go back to where I came from and to leave their country.”
- “[Being] called a terrorist is the main one...”
- “I work in health care and have had patients request other staff to care for them solely because of my headscarf.”
- “Many years ago, experienced hate because of being young lady teenage Muslim who wore the hijab in public school. This caused many harassments from students and some tried to pull head scarf off.”
- “One time I was standing in my front yard with some friends and we were all in Islamic dress and someone came up to us and call us names and said he was going to go get his gun. They called the police. There have been many small incidents just like people calling us names. That is fairly common. I've had to involve the school with bullying of my children.”
- “A person at my high school claim up to me and whispered, "I swear to God I will f\*\*\*\*\* kill you, I swear to god". The entire time of lunch he would not stop looking at me.”

See Table 22

Table 22. Muslim American Experiences of Discrimination, Microaggressions or Hate N=247)

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**(d) Regarding any experiences of discrimination, microaggressions, or hate—  
if you have had any, please share some examples.**

**Category I- Discrimination**

Workplace discrimination

Public discrimination

**Category II- Microaggressions**

Assumptions of oppression

Rude comments (microinsults)

Microinvalidations

**Category III- Hate**

Vandalization

Harassment

Threats

---

*For (e) examples of how they coped, bounced back, or healed, or were resilient, the emergent themes were:*

**Category I. Set a good example**

- “I try to be a better example”
- “Show by example to be kind to humanity in general. It's the small gestures that add up.”
- “If you really want to know about a community look for the best example they have”
- “I learned to be positive, give back, led by example, purify my intentions and heart as much as possible, and find good company”

**Category II. Ignore the situation**

- “Did not take part in it, and ignored the situation”
- “I was a senior in High school when 9/11 happened. I felt other people be racist but I completely ignored it.”
- “I ignored them, and did not respond, in car I tried to explain how tawheed is the most important thing on this life and the next.”
- “...most of the time my reaction was to ignore or be quiet, or if I have opportunity to leave the place I did.”

**Category III. Stop wearing hijab**

- “Wearing hijab- and then years and years later, deciding to take it off.”
- “Then 9/11 happened and I decided to stop wearing hijab a year later. I didn't want to relieve my younger years.”

**Category IV. Try to speak to the person**

- “I try to educate when I hear ignorant comments”
- “I tend to speak my mind!”
- “It's up to you to speak up and educate...”

See Table 23

Table 23. Themes Related to Coping and Bouncing Back from Discrimination, Microaggressions or Hate (N=247)

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**(e) Please share how you coped, bounced back, or healed—or how you have been resilient.**

**Category I. Set a Good Example**

Being Kind  
Being positive  
Giving Back

**Category II. Ignore the Situation**

Ignore  
Walk Away from the Situation/Person

**Category III. Stop Wearing Hijab**

Remove the Hijab - *women only*

**Category IV. Try to Speak to the Person**

Speaking Up  
Educating Non-Muslims

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**For (f) recommendations to improve the overall life satisfaction of Muslim**

**Americans, the emergent themes were:**

**Category I-Cultural Competence**

- “There needs to be more understanding of the religious restrictions and better outreach within the Muslim Communities.”
- “Be always inclusive.”
- “Be informed on basics of that person's belief that are relevant to them (do they have a prayer schedule to maintain, can they shake hands, is maintaining eye contact a good idea, etc.)”
- “Be more educated and empathetic”
- “Be sensitive to the fact that we are all different, and not have preconceived notions for example about levels of modesty or diet, i.e. don't judge someone for wearing a hijab, but also don't question their faith if they wear miniskirts.”
- “Communication, education and respect.”
- “Culture sensitivity training, commuting to cultural humility”
- “Focus groups and training specific to our communities and identities; Place Muslim Americans at the center of the conversations about their experiences”
- “Learn about Muslims, what they believe, their daily obligations, their holidays, their dress, and the differences from other religions.”
- “Listen. Hear. Know appropriate places to refer them to. Follow up.”

**Category II-Acknowledgement**

- “Acknowledge hate crimes and use protected class status when we are discriminated against in workforce; get to know our concerns holidays and make space for us; invite Muslim Commentators to be on public channels on the news in shows - normalize us”
- “Ask how we are...no one ever asks...I sometimes think I am losing my mind waiting for the shoe to drop.... i.e. massive internments after a terror attack and I feel exhausted and can't remember what it felt like to be optimistic and hopeful like I did when I was younger”
- “Awareness and celebrate Muslim cultures”
- “Stand up for blatant injustice when you are witness to it.”
- “Be aware that Muslims are in a hypervigilant and stressful state.”
- “Becoming more aware of Islamic traditions and various cultures, being aware that people are different and that it doesn't make them strange or unidentifiable. Taking the responsibility of knowing”



- “Mental health professionals and primary care doctors should maintain an awareness about the stress being Muslim can cause on a person and take it into account when assessing overall health/risk factors.”

See Table 24.

Table 24. Advice for Americans on Muslim American Life Satisfaction (N=247)

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**(f) What could Americans (e.g. healthcare providers [physicians, nurses, psychiatrists, psychologists, counselors], employers, school personnel, policy makers, lawmakers, community members, etc.) do to improve the overall life satisfaction of Muslim Americans who are experiencing or have a history of experiencing stress and trauma—whether within the healthcare system, workforce, school system (i.e. needs of children), or the larger society?**

**Category I- Cultural Competence**

Understanding of Muslim practices

Inclusivity

Empathy

Cultural sensitivity/humility training

**Category II- Acknowledgement**

Awareness of Muslim stressors

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## Conclusion

In this chapter, the results of the data analysis were presented in order of the research questions presented earlier in the dissertation. The quantitative results of the study were first presented and summarized (including tables for each research question). Following, the qualitative results were presented with emergent themes (including tables for each research question that highlighted the emergent themes). The next chapter,

Chapter V, will present the conclusion of the study and will also include a discussion of relevant results and recommendations for future research related to this dissertation topic.

## Chapter V

SUMMARY, DISCUSSION, IMPLICATIONS, RECOMMENDATIONS,  
AND CONCLUSION

This chapter provides a summary of this dissertation as well as a discussion of all research findings and implications of this study. Also included are recommendations for future research, study limitations and a final conclusion.

**Summary of Research Study**

The sample (N=247) for this study was 74.5% (N=184) female and 25.5% (N=63) male with a mean age of 34.21 years (min = 18, max = 78, SD = 9.379). Regarding ethnicity, 60.7% of the sample identified as Arab American or Middle Eastern (N=150), followed by Asian American (21.9%, N=54) and White (10.5%, N=25). The sample skin color was between medium to light to medium to dark (mean=4.45, SD = 1.271, min = 1, max = 7). Slightly more respondents reported that they were born in the United States (51.4%, N=127) and the mean number of years that respondents reported living in the United States was 15.51 years (min=2, max=64, SD=11.850). The mean education level of respondents was 7.48 (min=3, max= 10, SD=1.388) which equated to between a Bachelor's degree and a Master's degree. And, 70% of respondents indicated that they were married (N=173), while 64.8% were employed for wages (N=160). The mean household income was reported as 5.23, or most closely aligned with the \$50,000-\$99,000 income bracket (min=1, max=11, SD=1.746).

Survey respondents reported that their overall health status was between good and very good (mean=4.52, SD =0.962, min=1, max=6) and that their weight was in the normal to overweight range (mean=2.52, SD= 0.655, min= 1, max= 4). The body mass index (BMI) calculation mean was 26.780 (min=18.24, max=46.68, SD=5.23). Additionally, 65.6% of respondents reported that they were subscribed to a private insurance plan. Participants felt that they received good care for their medical conditions (mean=4.33, SD= 1.0, min=1, max= 6), good care from their primary care provider (mean= 4.37, SD= 1.007, min= 1, max= 6), and good care as Muslim from their providers (mean=4.44, SD= 1.208, min=1, max=6).

The majority (79.8%, N=197) of survey respondents reported that they considered themselves to be a practicing Muslim. Regarding religiosity, it was found that overall participants felt that they fell somewhere between being somewhat religious and religious (mean= 3.58, SD=0.705, min= 1, max= 5). A full 93.5% (N=231) identified as being Sunni Muslims. Females reported being more likely to wear Muslim clothing all of the time (53.9%, N=96), compared to the majority of males who reported rarely wearing Muslim clothing (46.4%, N=32).

The sample's social desirability mean was 8.76 (min=1, max=13, SD=2.822), indicating a moderate level, and the mean life satisfaction reported was 7.29 (min=0, max=10, SD = 1.985), or moderately high. The Perceived Stress Scale was found to have very good internal constancy (i.e. Cronbach's Alpha of 0.896). The mean perceived stress of survey respondents in the past month was 18.025 (min = 2, max = 40, SD=7.17947), indicating a moderate amount of stress. The Brief Trauma Questionnaire returned a mean of 2.38 (min=0, no exposure; max=19, very high exposure, SD=2.802) or very low

exposure overall; the Cronbach's Alpha of this scale was 0.896, indicating very good internal consistency.

The returned mean prevalence of symptoms of PTSD amongst survey respondents was 33.46 (min=6, max=75, SD=13.864), or a moderate amount of PTSD symptoms; and, the scale's Cronbach's Alpha was 0.935 for excellent internal consistency. Mean depression amongst Muslim Americans in the past year was 0.52 (min=0, max=1, SD=0.501), indicating moderate prevalence of depression, while mean experience with anxiety was 0.61 (min = 0, max=1, SD = 0.488) in the past year, indicating moderate prevalence of anxiety. The mean for survey respondents who sought out counseling for any depression and anxiety was 0.3 (min=0, max=1, SD=0.459), or low.

The mean of experiencing microaggressions reported back by survey respondents was 7.12 (min=0, max=24, SD=6.649) or low exposure. The Cronbach's Alpha for this scale was 0.932, indicating excellent internal consistency. The mean that survey respondents had experienced overt acts of violence was 0.71 (min=0, max=9, SD=1.457) or very low exposure. The mean perception to Islamophobia was 4.076 (min=2, max=5, SD=0.571), or very high ability. The Cronbach's Alpha for this scale was 0.797, indicating good internal consistency. The mean stage of change for coping and responding to Islamophobia and/or Islamophobic discrimination reported by survey respondents was 3.44 (min=1 or precontemplation stage; max=5, maintenance stage, SD=1.330), or closest to a preparation stage.

Regarding coping self-efficacy, first, problem focused coping exhibited excellent internal consistency (Cronbach's Alpha = 0.924) had a mean of 7.072 (min=0, max=10, SD=2.008), for moderately high use of this type of coping. Second, stopping unpleasant

emotions exhibited excellent internal consistency (Cronbach's Alpha of 0.962) and had a mean of 5.576 (min=0, max=10, SD=2.632) for moderate use of this type of coping.

Third, getting support from friends and family exhibited very good internal consistency (Cronbach's Alpha =0.810) and had a mean of 5.916 (min=0, max=10, SD=2.527) for moderate use of this type of coping.

The independent t-tests with Bonferroni Adjustment Significance ( $p < 0.007$ ) found that for the study outcome variable of *higher life satisfaction*, that there was a significant difference ( $t=2.709$ ,  $df=245$ ,  $p=0.006$ ) between survey respondents who were born in the United States (mean=6.95, SD=2.015) to those who were not born in the United States (mean=7.65, SD=1.895). It was also found that there was a significant difference ( $t=-4.4772$ ,  $df=245$ ,  $p=.000$ ) between those who were married (mean=7.66, SD=1.842) and those who were not (mean=6.46, SD=2.069). It was found that those who were married reported significantly higher life satisfaction. There were also statistically significant differences in terms of higher life satisfaction for all measures of the Retrospective Depression, Anxiety Scale and Counseling Scale. More specifically, less depression in the past year (mean=8.4, SD=1.479), less anxiety in the past year (mean=8.36, SD=1.572), and "yes" to sought counseling in the past year (mean=6.52, SD=2.01) were associated with higher life satisfaction.

The Pearson Correlations, with Bonferroni Adjustment Significance ( $p < 0.002$ ), found that there were significant correlations between the primary outcome variable of *higher life satisfaction* and the following: *older age* ( $r= 0.03677$ ,  $p= .000$ ); *better overall health status* ( $r= 0.384$ ,  $p= .000$ ); *better quality of care for medical conditions* ( $r= 0.342$ ,  $p=.000$ ); *better quality of care from a primary care provider* ( $r= 0.380$ ,  $p= .000$ ); *better*

*sensitivity from provider about Muslims/Islam* ( $r= 0.307, p= .000$ ); *less perceived stress* ( $r= - 0.57, p= .000$ ); *less post-traumatic stress disorder* ( $r= - 0.513, r= .000$ ); *less exposure to microaggressions* ( $r=- 0.285, p= .000$ ); *more use of problem-solving coping* ( $r= 0.47, p= .000$ ); *more use of ability to stop unpleasant thoughts coping* ( $r= 0.532, p= .000$ ); and *more use of social coping support* ( $r= 0.385, p= .000$ ).

The backwards stepwise regression analysis for the outcome variable of interest of *higher life satisfaction*, while controlling for socially desirable responses, was predicted by the following: *being less likely to be depressed in the past year* ( $B= - 0.59, p=0.012$ ); *older age* ( $B=0.038, p=0.001$ ); *better overall health status* ( $B=0.361, p=0.001$ ); *better rating of quality of provider* ( $B=0.351, p=0.001$ ); *lower perceived stress* ( $B= - 0.07, p=.000$ ); *lower stage for coping and responding to Islamophobia* ( $B= - 0.17, p=0.025$ ); and, more use of “*stop unpleasant thoughts*” coping style ( $B=0.129, p=0.007$ ). And, per the model, 56.6% of variance was predicted ( $R^2= 0.584, \text{adjusted } R^2= 0.566$ ) by these factors.

Finally, the qualitative data found five overarching themes related to higher life satisfaction and ability to cope: Islamophobia and discrimination, feeling a sense of community, wearing hijab (headscarf for women), religiosity and Islamic identity, work and financial stability.

Islamophobia and discrimination were found to be negatively associated with life satisfaction of Muslim Americans with subthemes including Islamophobia, acceptability of public discrimination, and destruction of personal property. Feeling a sense of community and being involved in interfaith work and the overall Muslim community and volunteering were, however, linked to better quality of life for Muslim Americans.

Wearing hijab (headscarf for women) was found to be both a positive and negative factor

associated with life satisfaction for Muslim American women. While some women found the hijab to be empowering, other feared for their safety while wearing the hijab.

Religiosity and Islamic identity, specifically daily prayers, freedom to attend and worship at the mosque, and keeping faith in God were highlighted as impacting life satisfaction.

Work and financial stability, including subthemes of providing for family, career success, and work-life balance were noted by survey respondents as impacting life satisfaction.

### **Summary of the Statement of the Problem**

The purpose of the study is to identify significant predictors of the **study outcome variable/dependent variable of a high rating of life satisfaction for Muslim Americans**—when controlling for social desirability.

In addition, a qualitative portion of the study will allow participants to fully express themselves, specifically, permitting the identification of emergent themes and categories when analyzing data on several topics: (a) factors impacting their life satisfaction as a Muslim American, (b) the most stressful parts of their life experience as a Muslim American, (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, (d) their experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression (e.g. being a Muslim American, and also a racial/ethnic minority, etc., or intersectionality), (e) examples of how they coped, bounced back, or healed, or were resilient from stressful or traumatic discrimination/microaggressions/hate, and (f) recommendations to improve the overall life satisfaction of Muslim Americans



### **Summary of the Purpose of the Study**

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### **Summary of the Research Questions**

Given an online sample of diverse adult Muslim Americans (n=250) who have been living in the United States for at least two years and respond to a social media campaign (i.e. “GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a

chance to win a \$300, \$200 or \$100 Amazon gift card”) and complete the study survey, the research will answer the following questions:

### **Qualitative Portion of the Study**

1-What are their demographic and other background characteristics (i.e. gender, age, race/ethnicity, skin color tone, born in the US or not, years living in the US, level of education, marital status, employment status, annual household income)?

*Part I: Basic Demographics (BD-10)*

2- How do they rate their overall health status, their Body Mass Index (BMI)/weight status, the overall quality of care that they receive for their health, the overall quality of care they receive from their provider, and the sensitivity and competence of their provider for treating someone who is Muslim? And, do they indicate having medical insurance, and if so, what type?

*Part II: Personal Health Background (PHB-9)*

3-Do they consider themselves to be practicing Muslims, what is their level of religiosity, and to what type of Muslim sect do they belong?

*Part III: Religious Affiliation and Religiosity Scale (RA-RS-3)*

4-What is the frequency of their wearing visibly Muslim clothing when out in public?

*Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1)*

5-To what extent do they tend to provide socially desirable responses?

**[Note: Regression will control for social desirability]**

*Part V: More About You (Social Desirability) (MAY-13)*

6-What is their rating for Life Satisfaction?

**[Note: The study outcome variable/dependent variable]**

*Part VI: Life Satisfaction Scale (LSS-1)*

7-What is their level of perceived stress in the past thirty days?

*Part VII: Perceived Stress Scale (MA-PSS-10)*

8-What is the prevalence of their experiences of trauma (e.g. in a war zone, natural disaster, terrorist attack, childhood abuse, etc.) including where they thought their life was in danger or they could be seriously injured—and whether they were actually seriously injured?

*Part VIII: Brief Trauma Questionnaire (BTQ-10)*

9-What is the prevalence of symptoms of posttraumatic stress disorder (PTSD)?

*Part IX: PTSD Checklist—Civilian Version (PCCV- 17)*

10-What is the prevalence of symptoms of depression and anxiety in the past year, and was counseling or advice sought out?

*Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3)*

11-Within their general life experience, what was the frequency of any experiences of microaggressions?

*Part XI: Ratings of Experiences of Microaggressions (REMI-6)*

12-What was their experience of any overt acts of violence?

*Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4)*

13-What was their level of ability for perceiving Islamophobia and/or Islamophobic discrimination—when it happening to themselves, as well as others?

*Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10)*

14-What was their stage of change (i.e. precontemplation, contemplation, preparation, action, maintenance) for coping and responding to any experiences of Islamophobia and/or Islamophobic discrimination?

*Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6)*

15-What was their coping self-efficacy—specifically, their level of ability and confidence for using (a) problem-focused coping, (b) stopping unpleasant emotions and thoughts, and (c) getting support from other family and friends?

*Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13)*

16-What are the significant relationships among selected independent variables (e.g. age, education level, etc.) and the study outcome variable/dependent variable of higher level of life satisfaction?

17-What are the significant predictors of the study outcome variable/dependent variable of higher level of life satisfaction—controlling for social desirable responses?

### **Qualitative Portion of Study**

18-What themes emerged when asked to provide open-ended responses to questions eliciting qualitative data on several topics—(a) factors impacting their life satisfaction as a Muslim American, (b) the most stressful parts of their life experience as a Muslim

American, (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, (d) their experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression (e.g. being a Muslim American, and also a racial/ethnic minority, etc., or intersectionality), (e) examples of how they coped, bounced back, or healed, or were resilient from stressful or traumatic discrimination/microaggressions/hate, and (f) recommendations to improve the overall life satisfaction of Muslim Americans?

### **Summary of the Literature Review**

The religion of Islam is growing globally and currently has the second largest number of believers worldwide (Samari, Alcalá, & Sharif, 2018). Regarding Muslim demographics in the United States, the Pew Research Center (2017) estimated that 1.1%, or 3.45 million Americans, of the total United States population identifies as Muslim (Pew Research Center, 2017). It is estimated that by 2050, this population of Americans will reach 2.1% of the total population, or 8.1 million (Pew Research Center, 2017). Husain and Howard (2017) indicated this growth can be attributed to “natural births, ongoing immigration, and conversions to the faith” (p. 139).

Likewise, the proportion of Muslim Americans who have experienced discrimination and Islamophobia is on the rise (Samari et al., 2018, p. e2). Recent negative media focus and political opposition in the United States towards Muslims as well as a Muslim travel ban, public harassment of Muslims and Muslim places of worship, and increased racial profiling have ultimately led to “assaults against Muslims in the United States” surpassing the “modern peak reached after 9/11” (p. e2). While there has been little research on the effects of discrimination and its associations with Muslim health status, it is clear that “Islamophobia undermines health equity” (p. e1). Furthermore, a clear link between “discrimination at multiple levels” and “poor health” has been established with negative physical manifestation on regulatory systems in the

body (p. e2). Stigma and bias against Muslim Americans can also impact their health by leading to “unequal access to health-enhancing resources or medical care” (Samari, 2016, p. 1921).

Discrimination also has a negative effect on an individual’s mental health (Abu-Ras, Suárez, & Abu-Bader, 2018; Samari et al., 2018; Aroian, 2012.). Further, Kira et al. (2014) noted that the negative effects of stigmatization on mental health tend to be more averse in minority populations such as Muslim Americans, as they “consistently view mental illness and mental health services more negatively than European Americans” (p. 250). Kira et al. (2014), also suggested that the higher level of stigma surrounding mental health can be tied to Muslim Americans’ “minority status, extended family values and family prejudices, and collectivistic cultures and the masculine ideals in their traditionally patriarchal cultures” (p. 250).

According to a 2017 report from CAIR, a 57% increase in Muslims incidents and a 44% increase in hate crimes against Muslim Americans in 2016 was found compared to reports in 2015 (Council on American Islamic Relations, [CAIR], 2017). CAIR also reported that the “number of Islamophobic incidents involving U.S. Customs and Borders Protection officials has increased by 1,000 since Donald Trump took office in January” (Buncombe, 2017). CAIR also reported, the top five types of anti-Muslim bias incidents were as follows: denial of religious accommodation (180 incidents reported); harassment (390 incidents reported); incidents involving the FBI (334 incidents reported); employment related incidents (281 reported incidents); and hate crimes (260 incidents reported) (Council on American Islamic Relations, [CAIR], 2017).

Aroian (2012) asserted that the “cognitive ability to perceive discrimination based on group identity is well established by adolescence” (p. 206). However, as per the work of Clark et al., (1999), perceived racism involves one’s subjective experience of prejudice or discrimination, while racism is not always perceived. In addition, coping in response to perceived racism may be adaptive, or mitigate negative, enduring psychological and physiological stress responses, or be maladaptive—with persistent states of psychological and physiological arousal that may damage health over time. Following the work of Clark et al. (1999), the work of Wallace (2005) provided a rationale for assessing both the level of ability to perceive racism and/or oppression, as well as stage of change for the ability to actively cope and respond to racism and/or oppression.

Wallace (2005) broadened the focus beyond just perceived racism to oppression, in general, in order to accommodate the experiences of diverse marginalized and oppressed groups—thereby encompassing groups such as Muslim Americans and exposure to Islamophobia and/or Islamophobic discrimination, as in the present study. Wallace (2005) also introduced the concept of there being stages of change for taking action to cope with racism and/or oppression (e.g. precontemplation, contemplation, preparation, action, maintenance, as per the theory of Prochaska & DiClemente, 1983). Thus, there is justification for focusing in the present study on the level of ability to perceive Islamophobia and/or Islamophobic discrimination, and the stage of change for taking action to cope and respond to it. Similarly, for taking action to engage in any behavior, level of self-efficacy for coping is also relevant. Thus, there is also a rationale for investigating coping self-efficacy spanning self-efficacy to engage in problem-

focused coping, stopping unpleasant emotions and thoughts, and getting support from friends and family (Chesney, Neilands, Chambers, Taylor & Folkman, 2006)

### **Summary of the Research Sample and Procedures**

This study utilized a convenience sample of Muslim Americans over the age of 18 (N=247) who were willing to devote 30-40 minutes of their time to answering the survey. Participants for the study were recruited via an online social media campaign inviting them to complete the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card". There were two aspects to the recruitment campaign that assisted with the snowball sampling in this study. Firstly, the principal investigator met with local Muslim leaders in Florida, and the metropolitan Washington D.C. area. Secondly, the principal investigator promoted the study through social media with distribution methods for the that included: emails, text/WhatsApp messages, Twitter posts, Facebook posts, Google group messages, and postings in Muslim social media pages (mosques and mommy groups) and local Muslim social media pages in various cities (Washington D.C., New York City, Philadelphia, Chicago, Sarasota/Bradenton, and Tampa).

Data for this study was collected in January and February of 2019. Upon closing of the study opportunity, a computer program randomly chose and emailed three winners of the gift certificates. Data was downloaded from Qualtrics and analyzed using SPSS 25.0.

## Summary of the Research Instrumentation

The following measures were utilized in the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies:

- **Part I: Basic Demographics (BD-10)**
- **Part II: Personal Health Background (PHB-9)**
- **Part III: Religious Affiliation and Religiosity Scale (RA-RS-3)**
- **Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1)**
- **Part V: More About You (Social Desirability) (MAY-13)**
- **Part VI: Life Satisfaction Scale (LSS-1)**
- **Part VII: Perceived Stress Scale (PSS-10)**
- **Part VIII: Brief Trauma Questionnaire (BTQ-10)**
- **Part IX: PTSD Checklist—Civilian Version (PCCV- 17)**
- **Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3)**
- **Part XI: Ratings of Experiences of Microaggressions (REMI-6)**
- **Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4)**
- **Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10)**
- **Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6)**
- **Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13)**



- **Part XVI: Life Satisfaction, Stress, Trauma, Intersectionality, Ways of Coping, and Resilience (LS-STI-WOC-R-5)**

### **Summary and Discussion of Results by Research Question**

The following section will summarize the findings from this study organized by each research question. Additionally, below the summary of findings for each research question, there will also be a discussion section.

**Summary and Discussion for Research Question #1:** *What are their demographic and other background characteristics (i.e. gender, age, race/ethnicity, skin color tone, born in the US or not, years living in the US, level of education, marital status, employment status, annual household income)?*

**Summary for Question #1.** The sample (N=247) for this study was comprised of 74.5% (N=184) females with a mean age of 34.21 years (min = 18, max = 78, SD = 9.379). Some 70% of respondents indicated they were married (N=173). Regarding ethnicity, 60.7% of the sample identified as Arab American or Middle Eastern (N=150), followed by Asian American (21.9%, N=54) and White (10.5%, N=25). Slightly more respondents reported that they were born in the United States (51.4%, N=127) and the mean number of years that respondents reported living in the United States was 15.51 years (min=2, max=64, SD=11.850). The mean education level of respondents was 7.48 (min=3, max= 10, SD=1.388) which equated to between a bachelor's degree and a master's degree; and, 64.8% were employed for wages (N=160). The mean household income was category 5.23, or most closely aligned with the \$50,000-\$99,000 income bracket (min=1, max=11, SD=1.746).

**Discussion for Question #1.** The mean age for this study of 34.21 was lower than (min= 18, max=78, SD=9.379) a study with similar measures conducted by Vang, Hou, and Elder (2018) investigating perceived religious discrimination, religiosity and life satisfaction in Canadians (including sampling a Muslim population, N= 1074); Vang et al. (2018) reported a mean age of 37.78 years for a sample that was 50% female, 51% married, and 31% had completed a university degree. Similarly, this study comparatively reported 74.5% (N=184) female, 70% married, and a mean education level of 7.48 (min=3, max= 10, SD=1.388), or falling between a bachelor's degree and master's degree. This study also reported that 64.8% of survey respondents were employed for wages (N=160) compared to 56% in the Vang et al. (2018) study.

The mean household income in this study was reported as 5.23 or most closely aligned with the \$50,000-\$99,000 income bracket (SD = 1.746, min = 1, max = 11) while Vang, Hou, and Elder (2018) reported a middle-class household income (\$60,000-\$100,000) for 21% of their sample. This study found that 51.4% (N=127) of respondents reported that they were born in the United States--versus foreign born (48.6%, N=120). In a 2017 study conducted by the Pew Research Center on Muslim Americans, it was found that 58% of respondents were foreign born and 42% of respondents indicated that they had been born in the United States.

**Summary and Discussion for Research Question #2:** *How do they rate their overall health status, their Body Mass Index (BMI)/weight status, the overall quality of care that they receive for their health, the overall quality of care they receive from their provider, and the sensitivity and competence of their provider for treating someone who is Muslim? And, do they indicate having medical insurance, and if so, what type?*

**Summary for Question #2.** The mean reported overall health status was 4.52 for between good and very good (min=1, max=6, SD =0.962). The mean self-reported weight was 2.52, or in the normal to overweight range (min= 1, max= 4, SD= 0.655) and the body mass index calculation (BMI) mean was 26.780 (min=18.24, max=46.68, SD=5.23) for overweight. Some, 65.6% of respondents were subscribed to a private insurance plan. The mean quality of care received for any medical condition(s) was 4.33 (min=1, max=4, SD=1.0), or closest to good. The mean rating for quality of care received by their primary care provider was 4.37 (min = 1, max =6, SD=1.007), or closest to good. The mean rating for quality of care received as a Muslim was 4.44 (min = 1, max =6, SD=1.208), or closest to good.

**Discussion for Question #2.** Overall, this sample reported having good health status. The reported mean body mass index (BMI) for the sample was 26.780 (min=18.24, max=46.68, SD=5.231), which per the Centers for Disease Control and Prevention (CDC) is classified as being overweight. Ingram (2017) too found her sample of minority college students reported a good health status, but was overweight (mean BMI=26.119, SD=6.235). Vang et al. (2018) reported 39% of respondents being in good health in their study on perceived religious discrimination, religiosity and life satisfaction in Canadians.

**Summary and Discussion for Research Question #3:** *Do they consider themselves to be practicing Muslims, what is their level of religiosity, and to what type of Muslim sect do they belong?*

**Summary for Question #3.** The majority (79.8%, N=197) of survey respondents reported that they considered themselves to be a practicing Muslim. The sample's mean

religiosity was 3.58 (min=1, max=5, SD=0.705), or between somewhat religious and religious. Respondents mainly identified as being from the Sunni sect (93.5%, n=231).

**Discussion for Question #3.** In a study with similar measures by Abdel-Khalek (2007) that investigated religiosity, happiness, health and psychopathology in Kuwaiti Muslim adolescents, mean religiosity was 6.82 (min=0, max=10, SD=2.86,) for boys, closest to somewhat religious, and 7.14 (min=0, max=10, SD = 2.55), or somewhat religious for girls. Using a 1 to 5 scale in this study—versus the 0 to 10 scale used by Abdel-Khalek (2007), this study produced a mean of 3.58 (min=1, max=5, SD=0.705,) or between somewhat religious and religious. Abu-Ras and Abu-Bader's (2009) study on Arab and Muslim Americans reported 35.8% (N = 125) of their sample being somewhat religious and 42.7% of their sample (N=149) being religious. A 2017 study on Muslim Americans conducted by the Pew Research Center found that 55% of their respondents reported being Sunni compared to the 93.5% of Sunni Muslims in this study.

**Summary and Discussion for Research Question #4:** *What is the frequency of their wearing visibly Muslim clothing when out in public?*

**Summary for Question #4.** Regarding the frequency of wearing Muslim identifying clothing, 53.9% females were preferred to wear Muslim clothing *all of the time*, compared 46.4% of males who *rarely* wore Muslim clothing.

**Discussion for Question #4.** In a study conducted by the Pew Research Center in 2017, it was found that the proportion of Muslim women who thought dressing modestly was important was 52% compared to 36% of Muslim men. Comparatively, this study found that 53.9% of Muslim women reported dressing in Muslim clothing *all of the time* while 46.4% of males *rarely* wore Muslim clothing.

**Summary and Discussion for Research Question #5:** *To what extent do they tend to provide socially desirable responses*

**Summary for Question #5.** The sample's social desirability mean was 8.76 (min=1, max=13, SD=2.822) for moderately high level.

**Discussion for Question #5.** This research study found that the sample had a moderately high level of social desirability (mean=8.76, SD=2.822, min=1, max=13). While the original study done by Crowne and Marlowe (1960) done to validate the social desirability scale found a mean social desirability of 13.72 (SD= 5.78, min=1, max=33), indicating a low level of social desirability.

Gesinde's (2019) sample was all women (n= 64, 100%) with 74.2% (n= 51) Black, while having a social desirability mean of 6.77 (min 3, max 12, SD=2.543), suggesting a moderately average level of social desirability. This is a mean somewhat similar to what was found in the present study for social desirability (i.e., mean=8.76, SD=2.822, min=1, max=13).

**Summary and Discussion for Research Question #6:** *What is their rating for Life Satisfaction?*

**Summary for Question #6.** The mean life satisfaction reported was 7.29 (min=0, max=10, SD = 1.985), or moderately high.

**Discussion for Question #6.** A 2017 study by Vang et al. (2018) on Muslim American life satisfaction and religiosity produced a mean score for life satisfaction of 7.97 (min=0, max=10, SD=1.75), or moderately high. Similarly, this study produced a mean life satisfaction was a 7.29 (min=0, max=10, SD=1.985), or moderately high.

**Summary and Discussion for Research Question #7:** *What is their level of perceived stress in the past thirty days?*

**Summary for Question #7.** The Perceived Stress Scale was found to have very good internal constancy (i.e. Cronbach's Alpha of 0.896). The reported mean perceived stress in the past month was 18.025 (min = 2, max = 40, SD=7.17947).

**Discussion for Question #7.** Per Cohen (1994), the lower perceived stress scores, then the more normalized the individual's perception of stress. Comparatively, both this study and the study on experiences of stress, racism, and oppression on minority college students conducted by Ingram (2017) reported a moderate amount of perceived stress in the past 30 days, using the same scale. Specifically, this study found a mean perceived stress score (PSS-10) of 18.025 (SD=7.180) and Ingram (2017) found a mean PSS of 18.918 (SD=7.629).

**Summary and Discussion for Research Question #8:** *What is the prevalence of their experiences of trauma (e.g. in a war zone, natural disaster, terrorist attack, childhood abuse, etc.) including where they thought their life was in danger or they could be seriously injured—and whether they were actually seriously injured?*

**Summary for Question #8.** The Brief Trauma Questionnaire returned a mean of 2.38 (min=0, no exposure; max=19, very high exposure, SD=2.802), or very low exposure to traumatic events. The Cronbach's Alpha of this scale was 0.896, indicating very good internal consistency.

**Discussion for Question #8.** Compared to another study that used the same tool as this study, Amnie's (2016) reported a mean exposure to traumatic events of 2.09

(SD=2.719, min=0, max=16) or low exposure. This study had a similar mean score to Amnie, given this study's mean of 2.38 (min=0, max=19, SD=2.802).

**Summary and Discussion for Research Question #9:** *What is the prevalence of symptoms of posttraumatic stress disorder (PTSD)? (PCCV- 17)*

**Summary for Question #9.** Cronbach's Alpha was 0.935 for the PCCV-17 for excellent internal consistency. The mean prevalence of symptoms of posttraumatic stress disorder (PTSD) was 33.46 (min=6, max=75, SD=13.864), or a moderate amount of PTSD symptoms.

**Discussion for Question #9.** Ingram (2017), who used the same measure, reported for the PCCV-17 a mean of 38.206 (min= 17, max=74, SD= 14.082), indicating that her sample of minority college students was experiencing moderately number of symptoms of PTSD. In a study conducted on risk factors for depression and PTSD in Arab and Muslim Americans by Abu-Ras and Abu-Baser (2009), they found a mean score for symptoms of PTSD of 27.79 (min= 0, max= 76, SD=16.45,), indicating moderately low levels of symptoms of PTSD. This study's sample reported a moderate amount of PTSD symptoms (mean=33.46, SD= 13.864, min=6, max=75)--being more akin to the moderate level in Ingram's (2017) sample.

**Summary and Discussion for Research Question #10:** *What is the prevalence of symptoms of depression and anxiety in the past year, and was counseling or advice sought out?*

**Summary for Question #10.** Mean prevalence of depression amongst the sample of Muslim Americans in the past year was 0.52 (min=0, max=1, SD=0.501), while the mean prevalence of anxiety was 0.61 (min=0, max=1, SD = 0.488). The mean prevalence for seeking out counseling for any depression and anxiety was 0.3 (min=0, max=1, SD=0.459). Or, some 46.2% (N=114) indicated that they had experienced depression in the past year, and 54.7% (N=135) indicated that they had experienced anxiety in the past year. Also, 26.7% (n=66) indicated they had received counseling in the past year.

**Discussion for Question #10.** Regarding past year prevalence, the mean depression in this sample was 0.52 (SD=0.501). And the mean level of anxiety was 0.61 (SD = 0.488). This indicated a moderate prevalence of depression and anxiety, respectively, in the past year. Only 26.7% (N=66) of survey respondents sought out counseling.

Rodriguez (2016) used the same measure of depression, anxiety and counseling that was used in the present study — with the exception that in the present study the tool was shortened to just asking about the past 12 months; and, did not ask about the past 6 months, or past month experience of depression and anxiety. Rodriguez (2016) found with his sample of diverse college students a mean prevalence of depression in the past year as 1.93 (min= 0, max= 3, SD= 1.28), or moderate depression. Mean anxiety was 2.33 (min= 0, max= 3, SD=1.12), or moderately high anxiety — which is not surprising for a college sample facing exams and other college-related pressures. Some 21.6% (N = 87) of the Rodriguez (2016) sample reported seeking out mental health services, being somewhat similar to the 26.7% who sought out counseling in the present study.



**Summary and Discussion for Research Question #11:** *Within their general life experience, what was the frequency of any experiences of microaggressions?*

**Summary for Question #11.** The mean of experiencing microaggressions reported back by survey respondents was 7.12 (min=0, max=24, SD=6.649), indicating low exposure. The Cronbach's Alpha for this scale was 0.932, indicating excellent internal consistency.

**Discussion for Question #11.** As a study that used any of the same instruments used in this study, the work of Liss (2015) provides a good comparison, having found for lesbian and bisexual women who had sought to have children through the medical care system, a mean exposure to microaggressions of 3.222 (min=1, max=5, SD=1.2) for moderate exposure. In contrast, the present study found mean exposure to microaggressions of 7.12 (min=0, max=24, SD=6.649), indicating low exposure to microaggressions. Hence, Muslim Americans in this study had low exposure to microaggressions in comparison to the lesbian and bisexual women seeking to have children through the medical care system who suffered moderate exposure to microaggressions.

**Summary and Discussion for Research Question #12:** *What was their experience of any overt acts of violence?*

**Summary for Question #12.** The mean for experiencing overt acts of violence was 0.71 (min=0, max=9, SD=1.457), or low exposure.

**Discussion for Question #12.** The work of Disha, Cavendish, and King (2011) examining hate crimes against Arab and Muslim Americans found a mean exposure to hate crimes of 0.74 (SD=4.76, min= , max= ). This study comparatively found the mean exposure to overt acts of violence to be 0.71 (min = 0, max =9, SD=1.457), or very low exposure.

**Summary and Discussion for Research Question #13:** *What was their level of ability for perceiving Islamophobia and/or Islamophobic discrimination—when it happening to themselves, as well as others?*

**Summary for Question #13.** The mean level of ability for perceiving Islamophobia was 4.076 (min=2, max=5, SD= 0.571), or high level of ability. The Cronbach’s Alpha for this scale was 0.797, indicating good internal consistency.

**Discussion for Question #13.** As a study that used many of the same measures as the present study, Ingram (2017) reported a mean level of ability for perceiving racism and/or oppression of 4.336, or closest to high ability level (min= 2.3 max=5, SD=0.576). Similarly, respondents in this study reported a high level of ability to perceive Islamophobia (mean= 4.076, SD=0.571, min= 2, max= 5).

**Summary and Discussion for Research Question #14:** *What was their stage of change (i.e. precontemplation, contemplation, preparation, action, maintenance) for coping and responding to any experiences of Islamophobia and/or Islamophobic discrimination?*

**Summary for Question #14.** The mean stage of change for coping and responding to Islamophobia and/or Islamophobic discrimination reported by survey respondents was 3.44 (min=1 or precontemplation stage; max=5, maintenance stage, SD=1.330), or closet to the preparation stage.

**Discussion for Question #14.** This study found that for coping and responding to Islamophobia and/or Islamophobic discrimination survey respondents were closest to the preparation stage with a mean of 3.44 (min=1 or precontemplation stage; max=5, maintenance stage, SD=1.330). Using the same tool, but for measuring stage of change for coping and responding to racism and/or oppression, Ingram (2017) reported a mean of 4.33, or closest to the action stage (min=1, max=5, SD=1.021). In another study that also utilized the same tool, but for measuring stage of change for coping and responding to racism and/or oppression, Rodriguez (2016) reported a mean of 3.65 (min=1, max= 5, SD=1.334) or between the preparation and action stages. Wallace (2005) reported that scores that mean scores of approximately 4, or the action stage, denotes those actively engaged in coping with racism and/or oppression. Meanwhile, those in a preparation stage have not yet taken any action to cope and respond to Islamophobia and/or Islamophobic discrimination—but have made a determination that they will take action.

**Summary and Discussion for Research Question #15:** *What was their coping self-efficacy—specifically, their level of ability and confidence for using (a) problem-focused coping, (b) stopping unpleasant emotions and thoughts, and (c) getting support from other family and friends?*

**Summary for Question #15.** First, *problem focused coping* exhibited excellent internal consistency (Cronbach's Alpha = 0.924) and had a mean of 7.072 (min=0, max=10, SD=2.008) for moderately high use of this type of coping. Second, *stopping unpleasant emotions* exhibited excellent internal consistency (Cronbach's Alpha of 0.962) and had a mean of 5.576 (min=0, max=10, SD=2.632), or moderate use of this type of coping. Third, *getting support from friends and family* exhibited very good

internal consistency (Cronbach's Alpha =0.810) and had a mean of 5.916 (min=0, max=10, SD=2.527) for moderate use of this type of coping.

**Discussion for Question #15.** The study done by Chesney et al. (2006) to validate the Coping Self-Efficacy Scale—Reduced Form produced a mean of 137.4 (SD=45.6). Chesney et al. (2006) reported a mean ability to use problem-focused coping of 5.6 (SD=2.1), a mean ability to stop unpleasant emotions and thoughts of 4.5 (SD=2.2), and a mean ability to get support from friends and family of 5.1 (SD= 2:3).

In a similar vein, this study reported a mean ability to use problem focused coping of 7.072 (min=0, max= 10, SD= 2.008), a mean ability to stop unpleasant emotions and thoughts of 5.5758 (min= 0, max=10, SD= 2.63180), and a mean ability to get support from friends and family of 5.9163 (min= 0, max=10, SD=2.5270).

**Summary and Discussion for Research Question #16:** *What are the significant relationships among selected independent variables (e.g. age, education level, etc.) and the study outcome variable/dependent variable of higher level of life satisfaction?*

**Summary for Question #16.** The independent t-tests with Bonferroni Adjustment Significance ( $p < 0.007$ ) found, as follows. When comparing groups, a higher life satisfaction characterized: those born in the U.S. compared to those not born in the U.S. ( $t=2.709$ ,  $df=245$ ,  $p=0.006$ ); those who were married compared to those not married ( $t=-4.4772$ ,  $df=245$ ,  $p=.000$ ); those who reported being depressed in the past year compared to those not depressed ( $t=8.864$ ,  $df=210.966$ ,  $p=0.00$ ); those who reported being anxious in the past year compared to those not anxious ( $t=6.971$ ,  $df=207.532$ ,  $p=0.00$ ); those who reported seeking counseling in the past year compared to those who did not seek counseling ( $t=4.036$ ,  $df=218$ ,  $p=.000$ ).

The Pearson Correlations with Bonferroni Adjustment Significance ( $p < 0.002$ ) found as follows. A higher life satisfaction was associated with: *older age* ( $r = 0.0368$ ,  $p = .000$ ); *better overall health status* ( $r = 0.384$ ,  $p = .000$ ); *better quality of care for medical conditions* ( $r = 0.342$ ,  $p = .000$ ); *better quality of care from a primary care provider* ( $r = 0.380$ ,  $p = .000$ ); *better sensitivity from provider about Muslims/Islam* ( $r = 0.307$ ,  $p = .000$ ); *less perceived stress* ( $r = -0.57$ ,  $p = .000$ ); *Less symptoms of post-traumatic stress disorder* ( $r = -0.513$ ,  $p = .000$ ); *less exposure to microaggressions* ( $r = -0.285$ ,  $p = .000$ ); *more use of problem-solving coping* ( $r = 0.47$ ,  $p = .000$ ); *higher ability to stop unpleasant thoughts* ( $r = 0.532$ ,  $p = .000$ ); and, *greater use of social coping support* ( $r = 0.385$ ,  $p = .000$ ).

**Discussion for #16.** There is support in the literature for the results of this study's independent t-tests, which found a higher life satisfaction characterized: those being born in the U.S. compared to those not born in the U.S.; those who were married compared to those not married); those who reported being depressed in the past year compared to those not depressed; those who reported being anxious in the past year compared to those not anxious; and, those who reported seeking counseling in the past year compared to those who did not. These results were in line with the literature which found that increased levels of stress, anxiety, and depression led to "lower life satisfaction and greater symptoms of psychological distress" (Jasperse, Ward, & Jose, 2012). Also, other studies found that lower life satisfaction was associated with unemployment, and being widowed (Vang, Hou, & Elder, 2018).

Results of the Pearson Correlations found that there were significant correlations between higher life satisfaction and older age, better overall health, better quality of care

for medical conditions, better quality of care from a primary care, better sensitivity from provider about Muslims/Islam, less perceived stress, less symptoms of post-traumatic stress disorder, less exposure to microaggressions, more use of problem-solving coping, higher ability to stop unpleasant thoughts, and greater use of social coping. These results, too, were in line with similar studies which found that stress has been linked to poorer quality of life (Aroian, 2012; Jasperse, Ward, & Jose, 2012; Nadal, 2008; Nielsen, Ørnbøl, Vestergaard, Bech, Larsen, Lasgaard, & Christensen, 2016; Rippy & Newman, 2008). Studies have also found links between overall reported quality of life and religious discrimination (Vang, Hou, & Elder, 2012).

**Summary and Discussion for Research Question #17:** *What are the significant predictors of the study outcome variable/dependent variable of higher level of life satisfaction—controlling for social desirable responses?*

**Summary for Question #17.** Higher life satisfaction, while controlling for socially desirable responses, was significantly predicted by: *being less likely to be depressed in the past year* ( $B=-0.588$ ,  $p=0.012$ ); *older age* ( $B=0.038$ ,  $p=0.001$ ); *better overall health status* ( $B=0.361$ ,  $p=0.001$ ); *better rating of quality of provider* ( $B=0.352$ ,  $p=0.001$ ); *lower perceived stress in the past month* ( $B=-0.066$ ,  $p=.000$ ); *lower stage of change (precontemplation, contemplation) for coping and responding to Islamophobia* ( $B=-0.168$ ,  $p=0.025$ ); *higher use of the “stop unpleasant thoughts” coping style* ( $B=0.129$ ,  $p=0.007$ ). For this model, 56.6% of the variance was predicted ( $R^2= 0.584$ , adjusted  $R^2= 0.566$ ) by the factors above.

**Discussion for #17.** The results of the backwards stepwise regression results from this study were similar to other studies. Less depression, stress, and anxiety were

associated with higher life satisfaction and lower levels of adverse physical and mental health outcomes, particularly for minority populations, such as the Muslim American population surveyed in this study (Aroian, 2012; Jasperse, Ward, & Jose, 2012; Nadal, 2008; Nielsen, Ørnbøl, Vestergaard, Bech, Larsen, Lasgaard, & Christensen, 2016; Rippy & Newman, 2008). Additionally, Stress and Coping Theory research suggests how stressful events can be mediated by coping processes, which provides support for the finding in this study that better coping and responding to Islamophobia were associated with higher life satisfaction (Folkman, Lazarus, Gruen, & DeLongis, 1986). Additionally, the literature has shown positive associations between life satisfaction and better overall health status and “belonging for racial/ethnic minorities and religious groups” (Vang, Hou, & Elder, 2018).

**Summary and Discussion for Research Question #18:** *What themes emerged when asked to provide open-ended responses to questions eliciting qualitative data on several topics—(a) factors impacting their life satisfaction as a Muslim American, (b) the most stressful parts of their life experience as a Muslim American, (c) ways they coped, bounced back, or healed, or were resilient from those most stressful experiences, (d) their experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression (e.g. being a Muslim American, and also a racial/ethnic minority, etc., or intersectionality), (e) examples of how they coped, bounced back, or healed, or were resilient from stressful or traumatic discrimination/microaggressions/hate, and (f) recommendations to improve the overall life satisfaction of Muslim Americans?*

**Summary for Question #18.** For (a) *factors impacting their life satisfaction as a Muslim American*, the emergent themes were: within the Category **I-Post 9/11 America**—Islamophobia, acceptability of public discrimination, discrimination, destruction of property; within Category **II- Feeling a Sense of Community**—playing an active role in the Muslim community, finding support amongst other Muslims, diversity

amongst Muslims in the community, volunteering; within Category **III-Wearing Hijab (headscarf for women)**—negative perceptions of Muslim Women who cover, discrimination against Muslim women, fear of safety for Muslim women; and, within Category **IV- Work and Financial Stability**—financial stability, working, providing for family.

For (b) *most stressful parts of their life experience as a Muslim American*, the emergent themes were: within Category **I-Islamic Identity** – being visibly Muslim (wearing Muslim dress); within Category **II-Religious Discrimination** – workplace, academic, and public discrimination; and within Category **III-Living in a Post-9/11 America** – Islamophobia, wearing hijab, and public discrimination.

For (c) *ways they coped, bounced back, or healed, or were resilient from those most stressful experiences*, the emergent themes were: within Category **I-Community** – joining groups, feeling accepted, and support from family and friends; within Category **II-Counseling with a Trusted Practitioner** – seeking professional help; within Category **III-Praying** – keeping the five daily prayers and speaking to God; within Category **IV-Time** – allowing time to pass.

For (d) *experiences of any stressful or traumatic discrimination, microaggressions, or hate, or double or triple oppression*, the emergent themes were: within Category **I- Discrimination** – workplace and public discrimination; within Category **II-Microaggressions** – assumptions of oppression, rude comments (microinsults) and microinvalidations; and, within Category **III-Hate** – vandalization, harassment, threats.



For (e) *examples of how they coped, bounced back, or healed, or were resilient*, the emergent themes were: **I-Set a Good Example; II-Ignore the Situation; III-Stop wearing hijab; IV-Try to Speak to the Person; and V-Prayer**

For (f) *recommendations to improve the overall life satisfaction of Muslim Americans*, the emergent themes were: within Category **I-Cultural Competence** – understanding Muslim practices, inclusivity, empathy, cultural sensitivity/humility training; and within Category **II-Acknowledgement** – awareness of Muslim stressors.

**Discussion for #18.** The results of the qualitative questions produced five overarching themes, encompassing the entire body of data, including subthemes, specifically Islamophobia and discrimination, feeling a sense of community, wearing hijab (headscarf for women), religiosity and Islamic identity, work and financial stability.

**Islamophobia and discrimination** were found to be negatively associated with life satisfaction of Muslim Americans with subthemes including Islamophobia, acceptability of public discrimination, and destruction of personal property. Aroian (2012) too found that Muslim Americans “routinely encounter discrimination” and the spike in hate crimes since the September 11 attacks has made Muslim Americans “the most frequently targeted group, exceeding other minority groups that have historically been targets” (p. 206). Correspondingly, Abu-Ras and Abu-Bader (2009) found that the experience of Muslim Americans with “discrimination, stereotypes, and prejudice has negatively affected the quality of life wherever Arabs and Muslims have settled” (p. 397).

**Feeling a sense of community**, being involved in interfaith work and the overall Muslim community and volunteering was however linked to better quality of life for

Muslim Americans. Accordingly, Samari (2016) found that community has shown positive impacts on health and can “buffer the adverse effects of discrimination on health” (p. 1923).

**Wearing hijab (headscarf for women)** was found to be both a positive and negative factor associated with life satisfaction for Muslim American women. While some women found the hijab to be empowering, others feared for their safety while wearing the hijab. Per the literature, displays of religiosity, in this case wearing hijab, can have a protective effect on minority populations (Vang, Hou, & Elder, 2018). However, the literature has found that Muslim females having a “strong psychological sense of Muslim identity” also “experience a heightened reaction to threat, which elicits significantly more distress in response to religious discrimination” (Jasperse, Ward & Jose, 2012, p. 265).

**Religiosity and Islamic identity**, specifically daily prayers, freedom to attend and worship at the mosque, and keeping faith in God were highlighted as impacting life satisfaction. In this regard, it has been suggested in prior research that religious communities offer its members a haven of comfort and social support, and provide coping resources in times of need (Vang, Hou, & Elder, 2018).

**Work and financial stability**, including subthemes of providing for family, career success, and work-life balance were noted by survey respondents as impacting life satisfaction. As highlighted by Vang, Hou, & Elder (2018), employment was found to be linked to higher levels of life satisfaction and improved well-being.

## **Implications and Recommendations Arising from the Research**

This study found strong associations in the quantitative data between the study outcome variable of higher life satisfaction and lower levels of depression and stress, older age, better overall health status, better rating of quality of provider, lower perceived stress in the past month, and better coping via higher use of the “stop unpleasant thoughts” coping style. The qualitative data produced five overarching themes related to higher life satisfaction and ability to cope and bounce back from negative experiences, specifically: living in a post-9/11 America and discrimination, feeling a sense of community, wearing hijab (headscarf for women), religiosity and Islamic identity, work and financial stability.

The implications and recommendations for health professionals who serve Muslim Americans are as follows:

- Health professionals need to conduct assessments and make referrals for appropriate mental and physical health interventions, including on the basis of results from conducting brief assessments of life satisfactions, depression, and anxiety—*via one item surveys*, as done in the present study. This is supported by this study finding that higher life satisfaction amongst Muslim Americans was predicted by being less likely to be depressed in the past year ( $B=-0.59$ ,  $p=0.012$ ); older age ( $B=0.038$ ,  $p=0.001$ ); better overall health status ( $B=0.361$ ,  $p=0.001$ ); better rating of quality of provider ( $B=0.351$ ,  $p=0.001$ ); and lower perceived stress in the past month ( $B=-0.07$ ,  $p=0.000$ ). Per the literature, Islamophobic discrimination has extended past commonplace verbal and physical assaults and into the realm of healthcare with links between negative mental health outcomes

such as increased depression and anxiety, negative physical health outcomes such as increased daily cortisol levels, increased risk of alcohol abuse, and increased risk of cardiovascular disease, and health disparities evident (Allen, Wang, Richards, Ming, & Suh, 2018; Samari, 2016). Thus, contemporary health professionals who work with Muslim Americans will have a responsibility to engage in brief assessments and to make appropriate referrals.

- Contemporary health professionals also have a responsibility to engage in collaborative advocacy with other groups, as per the work of Wallace (2014), including using evidence in their work to monitor and improve the lives of Muslim Americans. Collaborative advocacy means working with other organizations, creating coalitions, and using data—such as that in this study—to advocate for Muslim Americans. The qualitative data is rich in examples of how Muslim Americans need organizations to advocate on their behalf so as to end their experiences of microaggressions and discrimination, as well as violence; this work is important. even as the quantitative data suggests low exposure to microaggressions and overt violence.
- An additional responsibility for all public health, community health, health education and healthcare infrastructure workers is to ensure receipt of training in cultural competence, as per the qualitative data (f) that identified Category I-Cultural Competence, with subthemes of Understanding Muslim practices, Inclusivity, Empathy, and Cultural sensitivity/humility training.
- Also, Muslim American communities and health professionals working with them need to stress the importance of life-long engagement in good health care,

including accessing quality medical providers. This follows from how higher life satisfaction was associated with *better overall health status* ( $B=0.361$ ,  $p=0.001$ ) and *better rating of quality of provider* ( $B=0.352$ ,  $p=0.001$ ).

- Partnerships between Muslim American communities or mosques and public health and academic organizations are strongly recommended. Per the work of Idler, Levin, VanderWeele and Khan (2019), as a determinant of population health, religious institutions must be so recognized—and may provide vital social capital to individuals and communities. Additionally, by acknowledging how faith-based leaders can be allies and change agents who can represent and guide their communities to pursue health-related changes, public health professionals can help foster progress and positive health outcomes in minority communities, potentially otherwise subject to health disparities.

### **Directions for Future Research**

The recommended directions for future research, based on the findings of this study, are as follows:

- The sample was a convenience sample ( $N=247$ ) that was recruited via a social media campaign and respondents were mainly concentrated in large metropolitan cities on the East coast (such as Tampa, New York City, Washington, D.C., Chicago). Future research should seek a more geographically distributed sample. Ideally, with receipt of major grant funding, the study is replicated with a nationally representative sample of Muslim Americans.

- The study was comprised of 74.5% females and only 25.5% males. Future research should seek a more gender balanced sample. Iman could be consulted regarding strategies to use to increase the recruitment of males. Also, non-religious venues could be used for recruitment.
- Longitudinal studies on discrimination and coping in Muslim Americans were missing from the literature. Thus, it is recommended that researchers seek to understand how discrimination, racism, and Islamophobia affect Muslim Americans over time and throughout the lifespan. Ideally, major grant funding would support such an endeavor.
- Given the importance of health professionals being trained in cultural competence, and the rich qualitative data on this theme, future research could specifically design a training for health professionals that aims to foster cultural competence with Muslim Americans—and, also evaluate the training. Also, existing cultural competence trainings could be evaluated for the extent to which these trainings cover that which is deemed relevant in achieving cultural humility and cultural competence with Muslim Americans.
- Health professionals are also obligated to be educated about the types of stressors impacting Muslim Americans, given what they experience as social determinants of their health status, or stress in the social context. As one study participant said, “Be more educated and empathetic.” And, another said, “Listen. Hear. Know appropriate places to refer them to. Follow up.” Research could design and evaluate brief interventions designed to provide this much-needed education to health professionals on stressors impacting Muslim Americans.

### **Limitations of the Study**

Study limitations included the use of an online sample of convenience, resulting in geographic bias, while suggesting potential bias toward those with convenient access to the internet and bias in self-reported data. A measure of social desirability was used to control for the risk of subjects providing socially desirable responses, while, there was still this risk, and the risk of retrospective recall bias. It is possible that some subjects dropped out or avoided the study because of uncomfortable questions (e.g. about stress, trauma, depression, anxiety, and experiences of Islamophobia and/or Islamophobic, discrimination), or painful memories evoked. Thus, the study may exclude those unable or unwilling to share their experiences. These limitations must be kept in mind.

### **Conclusion**

In a post-911 era of distressing rising Islamophobia, discrimination, and violence against Muslim Americans, a study examining predictors of the life satisfaction of Muslim Americans was deemed timely and appropriate. This study sought to understand significant predictors of life satisfaction in Muslim Americans. The sample (N=247) for this study was 74.5% (N=184) female, 70% married (N=173), with a mean age of 34.21 years (SD = 9.379, min = 18, max = 78). Some 60.7% identified as Arab American or Middle Eastern (N=150). Slightly more respondents reported that they were born in the United States (51.4%, N=127), versus not (48.6%, N=120)—with a majority indicating their country of origin as Egypt (15.8%, N=39) followed by Palestinian Territories (6.5%, N=16) and Pakistan (5.7%, N=14). The mean number of years that respondents reported

living in the United States was 15.51 years (SD = 11.850, min = 2, max = 64). The mean education level of respondents was 7.48 (SD= 1.388, min = 3, max = 10) for between a bachelor's degree and a master's degree, while 64.8% were employed for wages (N=160). The mean household income was reported as 5.23 or most closely aligned with the \$50,000-\$99,000 income bracket (SD = 1.746, min = 1, max = 11).

The results of the backwards stepwise regression found that *higher life satisfaction*, while controlling for socially desirable responses, was predicted by *being less likely to be depressed in the past year* (B=-0.59, p=0.012); *older age* (B=0.038, p=0.001); *better overall health status* (B=0.361, p=0.001); *better rating of quality of provider* (B=0.351, p=0.001); *lower perceived stress in the past month* (B= - 0.07, p=0.0); *lower stage of change for coping and responding to Islamophobia* (B= - 0.17, p=0.025); and *greater use of "stop unpleasant thoughts" coping style* (B=0.129, p=0.007). And, per the model, 56.6% of variance was predicted ( $R^2 = 0.584$ , adjusted  $R^2 = 0.566$ ) by these factors.

Finally, the qualitative data found five overarching themes related to higher life satisfaction and ability to cope: *Islamophobia and discrimination, feeling a sense of community, wearing hijab (headscarf for women), religiosity and Islamic identity, work and financial stability*. First, *Islamophobia and discrimination* were found to be negatively associated with life satisfaction of Muslim Americans with subthemes including Islamophobia, acceptability of public discrimination, and destruction of personal property. Second, *feeling a sense of community* and being involved in interfaith work and the overall Muslim community and volunteering was however linked to better quality of life for Muslim Americans. Third, *wearing hijab (headscarf for women)* was



found to be both a positive and negative factor associated with life satisfaction for Muslim American women. While some women found the hijab to be empowering, others feared for their safety while wearing the hijab. Fourth, *religiosity and Islamic identity*, specifically daily prayers, freedom to attend and worship at the mosque, and keeping faith in God were highlighted as impacting life satisfaction. Fifth, *work and financial stability*, including subthemes of providing for family, career success, and work-life balance were noted by survey respondents as impacting life satisfaction.

Despite study limitations, this study represents an important contribution to the literature with regard to the life satisfaction, stress, and coping that currently characterizes the lives of adult Muslim Americans in our post-911 society. The data has given rise to insight, as well as implications and recommendations that may begin to set a trajectory for the improved life satisfaction of Muslim Americans across this century.

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## Appendix A

## Letter of IRB Approval

*Teachers College IRB**Exempt Study Approval*

To: Susan Tirhi  
From: Myra Luna Lucero, Research Compliance Manager  
Subject: IRB Approval: 19-108 Protocol  
Date: 01/14/2019

Thank you for submitting your study entitled, "*THE LIVING IN AMERICA MUSLIM LIFE STRESS, COPING AND LIFE SATISFACTION STUDY: AN ONLINE MIXED METHODS STUDY OF ISLAMOPHOBIC DISCRIMINATION, MICROAGGRESIONS, AND PREDICTORS OF LIFE SATISFACTION*;" the IRB has determined that your study is **Exempt** from committee review (Category 2) on 01/14/2019.

Please keep in mind that the IRB Committee must be contacted if there are any changes to your research protocol. The number assigned to your protocol is **19-108**. Feel free to contact the IRB Office by using the "Messages" option in the electronic Mentor IRB system if you have any questions about this protocol.

Please note that your Consent form bears an official IRB authorization stamp and is attached to this email. Copies of this form with the IRB stamp must be used for your research work. Further, all research recruitment materials must include the study's IRB-approved protocol number. You can retrieve a PDF copy of this approval letter from the Mentor site.

Best wishes for your research work.

Sincerely,  
Dr. Myra Luna Lucero  
Research Compliance Manager  
irb@tc.edu

**Attachments:**

- 2-Susan Tirhi-REV-Consent Form\_FINAL.pdf

## Appendix B

## The Study Email

INVITING MUSLIM AMERICANS TO TAKE A  
 \*\*\*\*\*CONFIDENTIAL SURVEY\*\*\*\*\*  
 ON LIFE SATISFACTION AND EXPERIENCE LIVING IN THE U.S.  
 IRB Protocol Number19-108

The Research Group on Disparities in Health (RGDH) within the Department of Health and Behavior Studies at Teachers College, Columbia University, in New York, New York is conducting a study to learn more about the experiences of Muslims living in America. This includes how Muslim Americans rate their overall life satisfaction, any experiences of stress, trauma, anxiety, depression, discrimination, verbal abuse or violence—that seem related to being Muslim—and how people cope with such experiences.

- Participation in this survey is limited to the first 250 volunteers
- Completing the online survey takes about 20-30 minutes
- Those who complete the survey will have a 3 in 250 chance of winning 1 of 3 prizes: a \$300, \$200, or \$100 Amazon gift card.
- Please click on the link below to view the informed consent, learn about your rights as a participant and proceed to the survey.
- We also invite you to forward this email to other Muslim Americans you know, or to text message, or tweet the message, below:

GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American life satisfaction, stress and coping survey for chance to win a \$300, \$200, or \$100 Amazon gift card

NOTE: Participants have a 3 in 250 chance of winning 1 of 3 prizes: a \$300, \$200, or \$100 Amazon gift card

THANK YOU FOR YOUR PARTICIPATION!

*If you have any questions or would like to have additional information about the study, please contact:*

*Susan Tirhi, MPH, CPH, Doctoral Candidate, Department of Health and Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120<sup>th</sup> Street, New York, NY 10027; [syt2113@columbia.edu](mailto:syt2113@columbia.edu) - OR –*

*Barbara C. Wallace, Ph.D., Director, Research Group on Disparities in Health, Professor of Health Education, Clinical Psychologist, Department of Health and Behavior Studies,*

Teachers College, Columbia University, Box 114, 525 W. 120th Street, New York, NY  
10027; [bcw3@tc.columbia.edu](mailto:bcw3@tc.columbia.edu); Study Contact Number: 267-269-74

## Appendix C

## The Study Text/Tweet

*GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American life satisfaction, stress & coping survey for chance to win a \$300, \$200, or \$100 Amazon gift card*

OR

*Click <https://tinyurl.com/MuslimAmericanSurvey> to participate in the Muslim American life satisfaction, stress & coping survey for chance to win a \$300, \$200, or \$100 Amazon gift card*

OR

*GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American life satisfaction survey for chance to win a \$300, \$200, or \$100 Amazon gift card*

OR

*Click <https://tinyurl.com/MuslimAmericanSurvey> to participate in the Muslim American life satisfaction survey for chance to win a \$300, \$200, or \$100 Amazon gift card*

## Appendix D

## The Recruitment Flyer

**INVITING MUSLIM AMERICANS TO TAKE A  
\*\*\*\*\*CONFIDENTIAL SURVEY\*\*\*\*\*  
ON LIFE SATISFACTION AND EXPERIENCES LIVING IN THE U.S.  
IRB Protocol Number19-108**



The Research Group on Disparities in Health (RGDH) within the Department of Health and Behavior Studies at Teachers College, Columbia University, in New York, New York is conducting a study to learn more about the experiences of Muslims living in America. This includes how Muslim Americans rate their overall life satisfaction,

any experiences of stress, trauma, anxiety, depression, discrimination, verbal abuse, or violence—that seem related to being Muslim—and how people cope with such experiences.

- Participation is limited to the first 250 volunteers
- Completing the online survey takes 20-30 minutes
- Those who complete the survey will have a 3 in 250 chance of winning 1 of 3 prizes: a \$300, \$200, or \$100 Amazon gift card.

- Please click on the link below, or tear-off a tab below and use the link, so you can view the informed consent, learn about your rights as a participant and proceed to the survey.

- Also, please share this flyer or a tear-off tab with other Muslim Americans

**GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American life satisfaction, stress & coping survey for chance to win a \$300, \$200, or \$100 Amazon gift card**

**THANK YOU FOR YOUR PARTICIPATION! HAVE QUESTIONS?** *If you have any questions or would like to have additional information about the study, please contact:* **Susan Tirhi, MPH, CPH**, Doctoral Candidate, Department of Health & Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120<sup>th</sup> Street, NY, NY 10027, [syt2113@columbia.edu](mailto:syt2113@columbia.edu); or **Barbara Wallace, Ph.D.**, Director, Research Group on Disparities in Health, Professor of Health Education, Clinical Psychologist, Department of Health & Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120<sup>th</sup> Street, NY, NY 10027, [bcw3@columbia.edu](mailto:bcw3@columbia.edu). Study Contact Number: 267-269-7411

*If you have any questions or would like to have additional information about the study, please contact:* **Susan Tirhi, MPH, CPH**, Doctoral Candidate, Department of Health & Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120<sup>th</sup> Street, NY, NY 10027, [syt2113@columbia.edu](mailto:syt2113@columbia.edu); or **Barbara Wallace, Ph.D.**, Director, Research Group on Disparities in Health, Professor of Health Education, Clinical Psychologist, Department of Health & Behavior Studies, Teachers College, Columbia University, Box 114, 525 W. 120<sup>th</sup> Street, NY, NY 10027, [bcw3@columbia.edu](mailto:bcw3@columbia.edu). Study Contact Number: 267-269-7411

120<sup>th</sup> Street, NY, NY 10027, [bcw3@columbia.edu](mailto:bcw3@columbia.edu). Study Contact Number: 267-269-7411

**Tear-off a tab with the link to the survey and spread the word!**

**GO TO**  
<https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American life satisfaction, stress & coping survey for chance to win a \$300, \$200, or \$100 Amazon gift card

**GO TO**  
<https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American life satisfaction, stress & coping survey for chance to win a \$300, \$200, or \$100 Amazon gift card

**GO TO**  
<https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American life satisfaction, stress & coping survey for chance to win a \$300, \$200, or \$100 Amazon gift card

## Appendix E

## Informed Consent

**Teachers College, Columbia University**  
**525 West 120th Street**  
**New York NY 10027**  
**212 678 3000**

**INFORMED CONSENT****IRB Protocol Number 19-108**

**Protocol Title:** The Living in America Muslim Life Stress, Coping and Life Satisfaction Study: An Online Mixed Methods Study of Islamophobic Discrimination, Microaggressions, and Predictors of Life Satisfaction  
**Principal Researcher:** Susan Tirhi, MPH, CPH Teachers College  
 941-284-5319, syt2113@tc.columbia.edu

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**INTRODUCTION** You are invited to participate in this research study called “The Living in America Muslim Life Stress, Coping and Life Satisfaction Study: An Online Mixed Methods Study of Islamophobic Discrimination, Microaggressions, and Predictors of Life Satisfaction.” You may qualify to take part in this research study if you: 1- are a Muslim American; 2-at least age 18 or older; 3-have been living in the United States for at least 2 years; and 4-are able to devote about 20-30 minutes to answering questions in an online survey at this time. Approximately 250 people will participate in this study and it will take 20-30 minutes of your time to complete.

**WHY IS THIS STUDY BEING DONE?** This study is being done to learn about the experiences of Muslims living in America. This includes studying how Muslim Americans rate their overall life satisfaction, and to learn about any experiences of stress, trauma, anxiety, depression, discrimination, verbal abuse or violence—that seem related to being Muslim—and how people cope with such experiences.

**WHAT WILL I BE ASKED TO DO IF I AGREE TO TAKE PART IN THIS STUDY?** If you decide to participate in the study, you will answer a series of questions in an online survey. The questions will cover the following: your personal background and self-ratings of your health; the Muslim sect you belong to and the frequency of your wearing different types of Muslim identifying clothing; your experiences of any stress, trauma, depression, anxiety, and any discrimination, insults, or violence that seemed related to being Muslim; your ways of coping, or bouncing back from stress; and, about your life satisfaction and what should be done to improve the overall life satisfaction of Muslim Americans who have a history of experiencing stress and trauma.



**WHAT POSSIBLE RISKS OR DISCOMFORTS CAN I EXPECT FROM TAKING PART IN THIS STUDY?** The risks of study participation include the possibility that you may feel some discomfort from taking the survey or some stress due to some of the questions. However, your participation in this study is completely voluntary, and you can stop at any time.

**WHAT POSSIBLE BENEFITS CAN I EXPECT FROM TAKING PART IN THIS STUDY?** There is no direct benefit to you for participating in this study.

**WILL I BE PAID FOR BEING IN THIS STUDY?** You will not be paid to participate. However, when you complete the survey you will be invited to enter your email address and to hit a “submit” button—so that you are officially entered into a drawing for a chance to receive a prize (i.e., 1 of 3 bar coded Amazon gift certificates for \$300, \$200 or \$100). You do not have to enter the lottery drawing to complete the survey. Once you submit your email address, then it will automatically be entered into a private and secure data base that even the principal investigator cannot access. Once 250 people have completed the entire survey, you will have a 3 in 250 chance of winning a \$300, \$200 or \$100 bar coded Amazon gift certificate. The www.Amazon.com gift certificates will be sent to three randomly chosen e-mail accounts using a secure online program. This occurs without in any way linking your identity to the survey results. The principal investigator is not able to view any of the e-mail addresses to which the gift certificates are sent. Only the 3 winners will be contacted.

**WHEN IS THE STUDY OVER? CAN I LEAVE THE STUDY BEFORE IT ENDS?** The study is over when you have completed the online survey. However, you can leave the study at any time even if you have not finished.

**PROTECTION OF YOUR CONFIDENTIALITY** The study does not involve linking your survey responses to any personal information that might identify you, keeping your information confidential. Teachers College, Columbia University has determined that www.Qualtrics.com provides a secure platform for the online survey you will take. The survey data files will also be saved on the primary researcher’s password protected computer. Regulations require that research data be kept for at least three years.

For quality assurance, the study team, and/or members of the Teachers College Institutional Review Board (IRB) may review the data collected from you as part of this study. Otherwise, all information obtained from your participation in this study will be held strictly confidential and will be disclosed only with your permission or as required by U.S. or State law.

**HOW WILL THE RESULTS BE USED?** The results of this study will be published in journals and presented at academic conferences. This study is being conducted as part of the doctoral dissertation of the principal investigator.

**WHO CAN ANSWER MY QUESTIONS ABOUT THIS STUDY?**

If you have any questions about taking part in this research study, you should contact the primary researcher, Susan Tirhi, at 941-284-5319 or at [syt2113@columbia.edu](mailto:syt2113@columbia.edu). You can also contact the sponsor/ supervisor of this research study, Dr. Barbara Wallace, at [bcw3@tc.columbia.edu](mailto:bcw3@tc.columbia.edu) or 267-269-7411.

**If you have questions or concerns about your rights as a research subject, you should contact the Institutional Review Board (IRB) (the human research ethics committee) at 212-678-4105 or email [IRB@tc.edu](mailto:IRB@tc.edu). Or you can write to the IRB at Teachers College, Columbia University, 525 W. 120th Street, New York, NY 10027. Box 151. The IRB is the committee that oversees human research protection for Teachers College, Columbia University.**

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## Appendix F

## Participant's Rights

**PARTICIPANT'S RIGHTS**

- I have read the Informed Consent Form and have been offered the opportunity to discuss the form with the researcher.
- I have had ample opportunity to ask questions about the purposes, procedures, risks and benefits regarding this research study.
- I understand that my participation is voluntary. I may refuse to participate or withdraw participation at any time without penalty.
- The researcher may withdraw me from the research at his or her professional discretion. I understand that if I take the survey more than once I will be eliminated from the study.
- If, during the course of the study, significant new information that has been developed becomes available which may relate to my willingness to continue my participation, the researcher will provide this information to me.
- Any information derived from the research study that personally identifies me will not be voluntarily released or disclosed without my separate consent, except as specifically required by law.
- I should receive a copy of the Informed Consent Form document. (I understand that I can download it).

**By checking the box below, I agree to participate in the study, and I am confirming that I am a Muslim American, age 18 or older, and have been living in the United States for at least 2 years.**

**I agree to participate in this study.**

## Appendix G

## Screening Survey

**The Living in America Muslim Life Stress,  
Coping, and Life Satisfaction Study  
Screening Tool**

**Teachers College, Columbia University  
Institutional Review Board (IRB) Protocol #19-108**

We are looking for Muslim American adults over the age of 18 who are willing to spend 20-30 minutes taking the confidential Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a 3 in 250 chance to win a \$300, \$200 or \$100 Amazon gift card. NOTE: No identifying information will be collected from you, such as your name, address, etc.—allowing you to remain anonymous.

**Find out if you qualify for participation by answering the following questions:**

1. Are you Muslim?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
2. Are you at least 18 years old?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have you been living in the United States for at least 2 years?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
4. Are you able to devote **about 10 minutes answering survey questions** about yourself and your experiences in the U.S.?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
5. Are you willing to spend **another 10-15 minutes freely expressing yourself** by typing in your answers to open-ended questions about your experiences in the U.S.?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_

**Thus, some people may complete the survey in less than 20 minutes, while we are asking if you have about 20-30 to answer all the questions. Only those who answer all the questions (including brief open-ended answers), will be entered into the drawing for a 3 in 250 chance to win a \$300, \$200 or \$100 Amazon gift card.**

If they answered YES to all of the above questions → they access survey.

If they answered NO to any of the above questions → they receive this message:  
Thank you for your time, but, unfortunately you are not qualified to participate in this study.

Feel free to invite other Muslim Americans who may qualify to participate in this study. Please send them the study link\* that you used to access this survey.

THANK YOU!

\* “GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card”

## Appendix H

## The Study Survey

**The Living in America Muslim Life Stress,  
Coping, and Life Satisfaction  
Study Survey**

**Teachers College, Columbia University  
Institutional Review Board (IRB) Protocol #19-108**

Instructions: Please answer the following questions as honestly as possible by either selecting your desired answer or by providing an answer in the text box.

**Part I: Basic Demographics (BD-10)**

[A tool created for use by the Research Group on Disparities in Health (e.g. Ingram, 2017), and adapted for the present study population. See: Ingram, L. (2017). Toward improving the health and academic outcomes of minority college students: Predictors of experiences of racism and/or oppression, stress, trauma, health status and level of academic achievement. Doctoral Dissertation. Teachers College, Columbia University.]

**Please enter your zip code** \_\_\_\_\_

1-What gender do you identify with?

- a. Male
- b. Female
- c. Other (Please indicate \_\_\_\_\_)

2-What is your age? [DROP DOWN MENU from 15 to 100—Exit any 17 & below]

3-What is your race/ethnicity:

- a. Arab American / Middle Eastern
- b. Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- c. Black / African American
- d. Cuban, other Spanish
- e. Hispanic / Latino (including Puerto Rican, Mexican, Mexican American, Chicano,
- f. Native American/American Indian / Alaska Native
- g. Native Hawaiian / Pacific Islander
- h. White / Caucasian / European American
- i. Other group(s) (specify)

4-My skin color is

- a. \_\_\_ Very Dark
- b. \_\_\_ Dark
- c. \_\_\_ Medium to Dark
- d. \_\_\_ Medium to Light
- e. \_\_\_ Light
- f. \_\_\_ Very Light
- g. \_\_\_ White

- 5-Where you born in the United States?
- a. Yes
  - b. No [If no Skip next question]
- (If “No” to Q4)  
 What is your country of Origin?  
 [DROP DOWN MENU for countries]
- 6-How many years have you been living in the United States?  
 [DROP DOWN MENU from 1-100 years—Exit any 2 years or less]
- 7-What is the highest degree or level of school that you have completed?
- No schooling
  - Nursery school to 8th grade
  - Some high school, no diploma
  - High school graduate, diploma or the equivalent (for example: GED)
  - Some college credit, no degree
  - Associate degree or technical degree (for example: AA, AS)
  - Bachelor’s degree (for example: BA, BS)
  - Master’s degree (for example: MA, MS, MEd)
  - Professional degree (MD, DDS, DMD, PharmD)
  - Doctorate degree (PhD, EdD, DrPH)
- 8-What is your marital status?
- Single, never married
  - Married
  - Widowed
  - Divorced
  - Separated
- 9-Are your currently:
- Employed for wages
  - Self-employed
  - Unemployed
  - A homemaker
  - A student
  - Military
  - Retired
  - Disabled/Unable to work
- 10-My annual household income is:
- 1-Less than \$9,000
  - \$10,000 to \$19,000
  - \$20,000 to \$39,000
  - \$40,000 to \$49,000
  - \$50,000 to \$99,999
  - \$100,000 to \$199,999
  - \$200,000 to \$299,000
  - \$300,000 to \$399,000
  - \$400,000 to \$499,000
  - \$500,000 to \$799,000
  - 11-\$800,000 or More

**Part II: Personal Health Background (PHB-9)**

[This is a tool created for use by the Research Group on Disparities in Health (e.g. Ingram, 2017). See Ingram (2017) reference above under Part I.]

1-I rate my overall health status as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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2-What is your height in feet (Drop down, 4-9)

3-What is your height in inches (Drop down, 0-11)

4-My weight in pounds is (Drop down, 70-400)

5-I consider myself to be:

Underweight  Normal weight  Overweight  Obese

6-My type of medical insurance is:

- a. Private insurance plan (e.g. Blue Cross/Blue Shield, Aetna, Oxford, etc.)
- b. HMO
- c. Medicaid
- d. Medicare
- e. Not applicable, I have no medical insurance
- f. Other (please specify)

7-I rate the overall quality of care I receive for my health (and any medical condition I have) as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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**Not applicable (I do not receive any health care)**

8-I rate the overall quality of care I receive from my primary care physician/healthcare provider as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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**Not applicable (I do not have one)**

9-I rate my health care providers' sensitivity and competence for treating me as someone who is Muslim- as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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**Not applicable (I do not receive health care)**

**Part III: Religious Affiliation and Religiosity Scale (RA-RS-3)**

[Note: This is a new survey created by the Principal Investigator, Susan Tirhi. It includes (question # 2) the single-item scale, the Self-Rating of Religiosity scale (SRR; Abdel-Khalek, 2007): "Do you consider yourself to be: 1 very religious, 2 religious, 3 somewhat religious, 4 not religious, 5 not religious at all. Using the SRR scale with 531 Muslim men and women demonstrated high reliability (.89), good temporal stability, concurrent



validity, and high loading (0.84), thereby denoting good factorial validity (Abdel-Khalek, 2007).]

1-Do you consider yourself to be a practicing Muslim?

- a. Yes
- b. No
- c. Sometimes, but not always

2-“Do you consider yourself to be:

1 very religious  2 religious  3 somewhat religious  4 not religious  
 5 not religious at all.

3-What type of Muslim sect do you belong to?

- a. Sunni
- b. Shi’ite
- c. Sufi
- d. Salafi
- e. Nation of Islam
- f. Baha’i or Ahmadiyya
- g. Druze, Alevis, or ‘Alawi
- h. Other (Please indicate \_\_\_\_\_)

#### **Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1)**

[This is a new survey created by the Principal Investigator, Susan Tirhi, and her dissertation sponsor, Dr. Barbara Wallace for first time use in the study. Questions were adapted for use from a larger study conducted by the Pew Research Center in which American Muslims were surveyed to understand their attitudes towards their place in American society (Pew Research Center, 2017). [i.e., Pew Research Center, (2017). Pew Research Center 2017 Survey of American Muslims Final Questionnaire [PDF File]. Washington, D.C.. Retrieved from <http://assets.pewresearch.org/wp-content/uploads/sites/11/2017/07/25172454/Muslim-American-Final-Questionnaire.pdf>]. Also, additional female and male clothing items were added, given what is worn globally by Muslims, and may be worn by Muslim Americans.]

**Please remind us, for the question that follows, do you identify as**

**Male**  **Female**

#### **If female→**

Please think about what many Muslim wear when they are out in public and indicate what you wear and how often you wear it.

1-When out in public, how often do your wear

**visibly Muslim clothing**—such as a Niqab, or veil covering the head and face, but not the eyes; a Burka, or a veil covering the entire body and face, with a mesh window or

grille across the eyes; a Hijab (hee-jab) or a veil, or headscarf that covers the hair and neck; a Dupatta, or a long scarf that is loosely draped across the head and shoulders; a Chador, or full-length cloak that is held closed at the front by the woman's hand or under their arms; an Abaya, or Kaftan full length dress?

   4-All the time    3-Most of the time    2-Only some of the time    2-Rarely    0-Never  
   I don't know/Not sure

### **If male→**

Please think about what many Muslim wear when they are out in public and indicate what you wear and how often you wear it.

1-When out in public, how often do you wear

**visibly Muslim clothing**—such as a Kufi, Shalwar Kameez, or Salwar Kameez, or Thobe, or Kurta Shirt)?

   4-All the time    3-Most of the time    2-Only some of the time    2-Rarely    0-Never  
   I don't know/Not sure

### **Part V: More About You (Social Desirability) (MAY-13)**

[Using a short form, arising from the original work of: Crowne, D. and Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, 24(4):349-354. More details will be presented in dissertation]

*Read each item below and decide whether the statement is true or false as it pertains to you personally. Circle T for True or F for false.*

1. It is sometimes hard for me to go on with my work if I am not encouraged. T F
2. I sometimes feel resentful when I don't get my way. T F
3. On a few occasions, I have given up doing something because I thought too little of my ability. T F
4. There have been times when I felt like rebelling against people in authority even though I knew they were right. T F
5. No matter who I'm talking to, I'm always a good listener. T F
6. There have been occasions when I took advantage of someone. T F
7. I'm always willing to admit it when I make a mistake. T F
8. I sometimes try to get even rather than forgive and forget. T F
9. I am always courteous, even to people who are disagreeable T F
10. I have never been irked when people expressed ideas very different from my own. T F
11. There have been times when I was quite jealous of the good fortune of others. T F
12. I am sometimes irritated by people who ask favors of me. T F
13. I have never deliberately said something to hurt someone's feelings . T F

### **Part VI: Life Satisfaction Scale (LSS-1)**

[Taken from: Vang, Z. M., Hou, F., & Elder, K. (2018). Perceived Religious Discrimination, Religiosity, and Life Satisfaction. *Journal of Happiness Studies*, 1-20.]

Using a scale of 0–10 where 0 means ‘Very dissatisfied’ and 10 means ‘Very satisfied’,  
**how do you feel about your life as a whole right now?”.**

**0=Very Dissatisfied** \_\_\_\_\_ **10=Very Satisfied**  
 \_\_\_0 \_\_\_1 \_\_\_2 \_\_\_3 \_\_\_4 \_\_\_5 \_\_\_6 \_\_\_7 \_\_\_8 \_\_\_9 \_\_\_10

### **Part VII: Perceived Stress Scale (PSS-10)**

[Creator: Cohen, S., Kamarck, T., Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 385-396. Also see Cohen, S (1994).

Perceived Stress Scale. Retrieved from

<http://www.mindgarden.com/documents/PerceivedStressScale.pdf>]

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way, using the following options:

**0 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often**

1-In the last month, how often have you been upset because of something that happened unexpectedly?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

2-In the last month, how often have you felt that you were unable to control the important things in your life?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

3-In the last month, how often have you felt nervous and “stressed”?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

4-In the last month, how often have you felt confident about your ability to handle your personal problems?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

5-In the last month, how often have you felt that things were going your way?.

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

6-In the last month, how often have you found that you could not cope with all the things that you had to do?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

7-In the last month, how often have you been able to control irritations in your life?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

8-In the last month, how often have you felt that you were on top of things?

9-In the last month, how often have you been angered because of things that were outside of your control?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

10-In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

\_\_\_0 = Never \_\_\_1 = Almost Never \_\_\_2 = Sometimes \_\_\_3 = Fairly Often \_\_\_4 = Very Often

### **Part VIII: Brief Trauma Questionnaire (BTQ-10)**

[As a 10-item scale, The Brief Trauma Questionnaire (BTQ-10) investigates adult trauma exposure, such as to life threats and any serious injury. The BTQ-10 arose from the Brief

Trauma Interview (BTI), as per US Department of Veterans Affairs' National Center for PTSD (USDVA-NCFPTSD, 2015). This survey was used in Amnie (2016) and Ingram (2017). See: Amnie, A. (2016). An online investigation of trauma across the lifespan and predictors of coping self-efficacy: Post-traumatic stress disorder, attention deficit/hyperactivity disorder, substance use disorders, and engagement in risky sexual behavior. A doctoral dissertation. Teachers College, Columbia University. And, See: Ingram (2017) reference, above, under Part I.]

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please indicate "Yes" or "No" to report what has happened to you.

If you answer "Yes" for an event, please answer: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer "No" for an event, go on to the next event

1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty)?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill? Or, have you been in a disaster related to a terrorist attack?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members, or strangers?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes Were you seriously injured?  No  Yes

7. Has anyone ever made or pressured you into having some type of unwanted sexual contact?

Note: By sexual contact we mean any contact between someone else and your private parts or between you and someone else's private parts

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes Were you seriously injured?  No  Yes

8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed? (For example, during an arrest experience, an incarceration experience, a refugee crisis, or immigration/migration experience?)

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes Were you seriously injured?  No  Yes

9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack—including through school violence, gang violence, community violence, or some other type of serious violence or accident?

No  Yes

10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed?

Note: Do not answer "yes" for any event you already reported in Questions 1-9

No  Yes

### Part IX: PTSD Checklist—Civilian Version (PCCV- 17)

[As a 17-item survey, The Posttraumatic Stress Disorder Checklist- Civilian Version (PCL-S-17) is based on the diagnostic criteria for B, C, and D in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorder (Ruggiero, Del Ben, Scotti, & Rabalais, 2003). It was used by Amnie (2016) and Ingram (2017), for example. See Amnie (2016) and Ingram (2017) references, above.]

1- Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

2- Repeated, disturbing dreams of a stressful experience from the past?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

3-Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

4. Feeling very upset when something reminded you of a stressful experience from the

past?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
7. Avoid activities or situations because they remind you of a stressful experience from the past?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
8. Trouble remembering important parts of a stressful experience from the past?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
9. Loss of interest in things that you used to enjoy?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
10. Feeling distant or cut off from other people?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
12. Feeling as if your future will somehow be cut short?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
13. Trouble falling or staying asleep?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
14. Feeling irritable or having angry outbursts?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
15. Having difficulty concentrating?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
16. Being “super alert” or watchful on guard?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely  
17. Feeling jumpy or easily startled?

\_\_ (1) Not at all \_\_ (2) A little bit \_\_ (3) Moderately \_\_ (4) Quite a bit \_\_ (5) Extremely

### **Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3)**

[NOTE: This is shorter version of a scale that follows the work of Lian (2017)—as a common tool used by the Research Group on Disparities in Health (RGDH). For this study, subjects are only asked about the past year—and not past 3, 6 months. The counseling question appears just once and includes new options (e.g. Iman). See: Lian, Z. (2017). Predictors of depression/anxiety, mental health service utilization, and help-seeking for Chinese international students: Role of acculturation, microaggressions, social support, coping self-efficacy, stigma, and college staff’s cultural competence and cultural humility. Doctoral Dissertation, Teachers College, Columbia University.]

**Depression** is an overwhelming feeling of intense sadness. It can include feeling helpless, hopeless, and worthless. It can sometimes be expressed through angry outbursts, as well as bursting into tears. There can also be loss of appetite, or an increase in appetite.

There can also be difficulty sleeping or oversleeping. In addition, there can be a loss of interest in your activities. Such a depression can last for days or weeks. This goes beyond typical feelings of sadness, such as following some disappointment.

1-Do you think you experienced any **depression** in the past year or 12 months?  No  
 Yes

**Anxiety** is an overwhelming and intense feeling of nervousness, fear, tension, powerlessness, and apprehension. It can reach a peak so there are moments of panic where one's heart may be pounding/beating quickly, or there is rapid breathing/difficulty breathing. A person may also experience sweating and trembling. Sometimes it can be so intense that one has trouble concentrating/thinking, leaving the house, or trouble being around other people. The fear can be very intense, and one can feel like there is some impending danger. This goes beyond typical feelings of nervousness, such as when anticipating a new situation, or something unexpected, or unknown.

2-Do you think you experienced any **anxiety** in the past year or 12 months?  No  
 Yes

### **Receipt of Counseling**

3-In the past year, did you seek out any kind of counseling or advice for any depression and/or anxiety, or other stress—such as from a mental health professional, Iman, Mosque Elder, or family member?  
 Yes  No  Not Applicable/ No experience of depression or anxiety, or other related issues, etc.

**NOTE: Recall the online counseling resources recommended in the Informed Consent and Research Description—that will be repeated at the end of this survey for your convenience; and, recall the study contact number if you feel you need assistance seeking help.**

### **Part XI: Ratings of Experiences of Microaggressions (REMI-6)**

[This is an adaptation of a scale previously used in Liss (2015) and created for use by the Research Group on Disparities in Health. See Liss (2015) reference: Liss, A. R. (2015). Microaggression experiences, stress, and coping for lesbian, bisexual, or queer-identified women seeking the goals of childbirth and/or co-parenting: An online survey of experiences with maternal health care. A doctoral dissertation. Teachers College, Columbia University.]

Please think about your general life experiences, whether interacting with members of the general public, people in work settings, members of your family, or members of the larger community.

To what extent did you experience any of the following—that seemed related to your **being Muslim**:

1-Brief exchanges or brief interactions where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative

0-*Never/Not At All*  1-*At Least Once*  2-*More Than Once*  3-*A Few Times*  
 4-*Many Times*

2-A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose

0-*Never/Not At All*  1-*At Least Once*  2-*More Than Once*  3-*A Few Times*  
 4-*Many Times*

3-A nonverbal attack, or some behavior that was hurtful and caused mental or emotional pain, whether this involved someone avoiding contact and interaction, or avoiding communication, or some act of discrimination performed on purpose

0-*Never/Not At All*  1-*At Least Once*  2-*More Than Once*  3-*A Few Times*  
 4-*Many Times*

4-A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language

0-*Never/Not At All*  1-*At Least Once*  2-*More Than Once*  3-*A Few Times*  
 4-*Many Times*

5-A communication that excluded you, cancelled out your existence, made you invisible, or ignored the reality of your thoughts, feelings, and existence as a diverse person

0-*Never/Not At All*  1-*At Least Once*  2-*More Than Once*  3-*A Few Times*  
 4-*Many Times*

6-How often did you experience any of the above where you felt the treatment you received was related to BOTH your race/ethnicity, or skin color, or physical appearance, as well as your being Muslim?

0-*Never/Not At All*  1-*At Least Once*  2-*More Than Once*  3-*A Few Times*  
 4-*Many Times*

#### **Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4)**

[This survey was created for first time use in this study by the Principal Investigator (Susan Tirhi) and her dissertation sponsor, Dr. Barbara Wallace—for use by the Research Group on Disparities in Health. It is based on the concept of overt violence advanced elsewhere (Wallace, 2003) [i.e., Wallace, B.C. (2003). A multicultural approach to violence: Toward a psychology of oppression, liberation, and identity development. In B. C. Wallace, and R. T. Carter (Eds.). *Understanding and Dealing with Violence: A Multicultural Approach*, pp.3-39, Sage Publications: Thousand Oaks, California]—while also capturing some of what is discussed in the literature on macroaggressions (e.g. Osanloo, A. F., Boske, C., & Newcomb, W. S. (2016). Deconstructing Macroaggressions, Microaggressions, and Structural Racism in Education: Developing a Conceptual Model for the Intersection of Social Justice Practice and Intercultural Education. *International Journal of Organizational Theory and Development*,1, 1-19.)]



Please think about your general life experiences, or overall experiences in life, whether interacting with members of the general public, people in work settings, members of your family, or members of the larger community.

To what extent did you personally or did a family member or friend experience any of the following—**and it seemed related to being Muslim**:

1-A physical attack, for example, being hit, slapped, kick or beaten up  
Never/Not At All (0) \_At Least Once (1) \_More Than Once (2) \_A Few Times (3)  
\_Many Times (4)

2-Assault with a weapon, for example, being shot, stabbed, threatened with a knife, gun, or bomb  
Never/Not At All (0) \_At Least Once (1) \_More Than Once (2) \_A Few Times (3)  
\_Many Times (4)

3-Sexual assault, for example, rape, attempted rape, made to perform some type of sexual act through force or threat of harm  
Never/Not At All (0) \_At Least Once (1) \_More Than Once (2) \_A Few Times (3)  
\_Many Times (4)

4-Violent destruction of property or damage to property or belongings (e.g. graffiti on a wall, broken window glass, smashed car windows, etc.  
Never/Not At All (0) \_At Least Once (1) \_More Than Once (2) \_A Few Times (3)  
\_Many Times (4)

**Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10)**

[This is the Perception of Racism and Oppression Scale (PROS-10) created by Professor Barbara Wallace, as used in Ingram (2017) and many other studies conducted by the Research Group on Disparities in Health. For this study, instead of defining and asking about experiences of racism and/or oppression, the focus is on Islamophobia and/or Islamophobic discrimination. See Ingram (2017) reference above, under Part I.]

We are interested in learning about your perceptions of Islamophobia and/or Islamophobic discrimination—including Muslims' experience of any prejudice, harassment, violence, exclusion, disadvantage, or lack of access to opportunity—whether while driving, eating out, walking around, shopping, voting, hailing down a taxi, interacting with police, searching for employment, seeking health care, applying for a bank loan/mortgage, searching for housing, negotiating the criminal justice system, working, traveling, vacationing, or seeking out literally any opportunity etc.....

**NOTE: items # 7-10 are reverse scored.**

**Please answer the following questions.**

**In terms of experiences of Islamophobia and/or Islamophobic discrimination**

1-I am not sure it is really exists or happens to people.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

2-When incidents are talked about, I am not sure what makes something racist or oppressive.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

3-I think it never happens *to me*.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

4-There are times when I “don’t get it,” or I can’t really tell when it is happening *to me*.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

5-I think it never happens *to others*.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

6-There are times when I “don’t get it,” or I can’t really tell when it is happening *to others*.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

7-I can usually see or sense when it is happening *to me*.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

8-I can usually see or sense when it is happening *to others*.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

9-When incidents are talked about, I think “That could happen to me or someone I love.”

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

10-When incidents are talked about, I can identify with and understand the experience.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

#### **ITEMS # 7-10 ARE REVERSE SCORED**

#### **Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6)**

[This is the Coping and Responding to Racism and Oppression Staging Scale (CRROSS-13) created by Professor Barbara Wallace, as used in Ingram (2017) and many other studies conducted by the Research Group on Disparities in Health. For this study, instead of defining and asking about experiences of racism and/or oppression, the focus is on Islamophobia and/or Islamophobic discrimination. See Ingram (2017) reference above, under Part I]

**NOTE: deleted original CRROSS-13 items # 1; 7 -0; and, 12-13 - to shorten scale**

Please answer the following questions.

In terms of experiences of **Islamophobia and/or Islamophobic discrimination:**

1-I *never thought about* how to cope with or respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

3-I *have thought about* how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

4-I *never took steps* to learn more about how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

5-I am *planning to take steps* to learn more about how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

6-I *have been actively learning* how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

7-Learning how to cope with and respond to it is something that *I have been actively working on*:

\_\_\_ never in my life    \_\_\_ < 1 month    \_\_\_ < 6 months    \_\_\_ > 6 months    \_\_\_ 1-3 years  
 \_\_\_ 4-6 years            \_\_\_ 7-9 years    \_\_\_ 10-20 years    \_\_\_ 21-30 years    \_\_\_ >31 years  
 \_\_\_ unsure

### Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13)

[Developed by Chesney, Neilands, Chambers, Taylor, and Folkman (2006). See: Chesney, M. A., Neilands, T. B., Chambers, D. B., Taylor, J. M., & Folkman, S. (2006). A validity and reliability study of the coping self-efficacy scale. *British journal of health psychology*, 11(3), 421-437. Within the Research Group on Disparities in Health, it was recently used by Ingram (2017). See Ingram (2017) reference, above]

For each of the following items, write a number from 0 - 10, using the scale below. When things aren't going well for you, how confident are you that you can:

<b>Cannot do at all</b>		<b>Moderately certain can do</b>		<b>Certainly can do</b>
<b>0 1 2 3</b>		<b>4 5 6 7</b>		<b>8 9 10</b>

#### 1. Use Problem-Focused Coping

1. Break an upsetting problem down into smaller parts. \_\_\_\_\_
2. Sort out what can be changed, and what cannot be changed. \_\_\_\_\_
3. Make a plan of action and follow it when confronted with a problem \_\_\_\_\_
4. Leave options open when things get stressful. \_\_\_\_\_
5. Think about one part of the problem at a time. \_\_\_\_\_

6. Find solutions to your most difficult problems. \_\_\_\_\_
- 2. Stop Unpleasant Emotions and Thoughts**
7. Make unpleasant thoughts go away. \_\_\_\_\_
8. Take your mind off unpleasant thoughts. \_\_\_\_\_
9. Stop yourself from being upset by unpleasant thoughts. \_\_\_\_\_
10. Keep from feeling sad. \_\_\_\_\_
- 3. Get Support From Friends and Family**
11. Get friends to help you with the things you need. \_\_\_\_\_
12. Get emotional support from friends and family. \_\_\_\_\_
13. Make new friends. \_\_\_\_\_

**Part XVI: Life Satisfaction, Stress, Trauma, Intersectionality, Ways of Coping, and Resilience (LS-STI-WOC-R-5)**

[Adapted from Ingram (2017). See: Ingram, L. (2017). Toward improving the health and academic outcomes of minority college students: Predictors of experiences of racism and/or oppression, stress, trauma, health status and level of academic achievement. Doctoral Dissertation. Teachers College, Columbia University.]

This is an opportunity for you to freely share your experiences, views, and opinions.

- 1-What factors have impacted your Life Satisfaction as a Muslim American?
- 2-What have been the most stressful parts of your life experience as a Muslim American? Please share how you coped, bounced back, or healed—or how you have been resilient.
- 3-Have you experienced any discrimination, microaggressions, or hate—such as for having a double or triple marginalized/oppressed identity (e.g. being a Muslim American AND ALSO a racial/ethnic minority, or being a woman, or disabled, or due to your physical appearance, or skin color)?
- \_\_\_\_ Yes \_\_\_\_ No
- Was it stressful? \_\_\_\_ Yes \_\_\_\_ No
- Was it traumatic? \_\_\_\_ Yes \_\_\_\_ No
- 4-Please share some examples, including how you coped, bounced back, or healed—or how you have been resilient.
- 5.-What could Americans (e.g. healthcare providers [physicians, nurses, psychiatrists, psychologists, counselors], employers, school personnel, policy makers, lawmakers, community members, etc.) do to improve the overall life satisfaction of Muslim Americans who are experiencing or have a history of experiencing stress and trauma—whether within the healthcare system, workforce, school system (i.e. needs of children), or the larger society?

-----END OF SURVEY-----

**DID YOU JUST PARTICIPATE IN ONE OF  
OUR RESEARCH STUDIES? \*  
INTERESTED IN FREE OR LOW-COST ONLINE COUNSELING?**

**CLICK ON THIS LINK:**

<https://tinyurl.com/GET-FREE-LOW-COST-COUNSELING>

**OR READ BELOW**

It is possible that your answering questions as a participant in this research study brought up uncomfortable feelings, thought and memories. Brief emergency counseling, crisis intervention counseling, and a referral to longer-term support may be helpful to you at this time. If that is the case, you may use any of the following resources for immediate help:

**For Free Texting Crisis Help:** <https://www.crisistextline.org/>

You text 741741 when in crisis as a service available 24 hours a day, 7 days a week. You will reach a live trained Crisis Counselor who will respond quickly. The Crisis Counselor helps to move you from a hot moment to a cool calm and safe state, using effective active listening and suggested referrals—all using the Crisis Text Live’s secure platform. If you have a phone plan with AT&T, T-Mobile, Sprint, or Verizon, texting to 741741 is free of charge.

**Contact a Crisis Intervention Hotline for Immediate Help and Referrals: See a List of Hotline Phone Numbers:** [https://www.allaboutcounseling.com/crisis\\_hotlines.htm](https://www.allaboutcounseling.com/crisis_hotlines.htm)**Examples of Crisis Intervention Hotlines:**

- **If you are in immediate danger**, call 911
- **National Suicide Hotline:** 800-SUICIDE (800-784-2433)
- **National Suicide Prevention Lifeline:** 800-273-TALK (800-273-8255)
- **Grief Recovery Helpline:** 800-445-4808

**Seek Out Top Rated, Low-Cost Online Counseling Services:** <https://www.e-counseling.com/tp/therapy-1/?imt=1>

Please see a list of the top-rated online counseling services—with the average weekly cost as low as \$35.

**Seek Out Affordable Online Counseling:** <https://www.betterhelp.com/about/>

Access affordable and convenient online counseling with professionals.

**Seek Help from the Study Sponsor by E-Mail or Phone:** [bcw3@tc.columbia.edu](mailto:bcw3@tc.columbia.edu) or 267-269-7411.

You may contact the study sponsor, Dr. Barbara Wallace, receiving help with referrals.

\*NOTE: The Research Group on Disparities in Health (RGDH) is part of the Center for Health Equity and Urban Science Education, Teachers College, Columbia University. Numerous studies are conducted annually by the RGDH, with Dr. Barbara Wallace serving as the research sponsor.

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**SHARE WITH OTHERS!**

We invite you to text message, tweet, and e-mail others you know:

“GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card”

Thanks for completing the survey.

**The Living in America Muslim Life Stress,  
Coping, and Life Satisfaction Study  
Screening Tool**

**Teachers College, Columbia University  
Institutional Review Board (IRB) Protocol # \_\_\_\_\_**

We are looking for Muslim American adults over the age of 18 who are willing to spend 20-30 minutes taking the confidential Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a 3 in 250 chance to win a \$300, \$200 or \$100 Amazon gift card. NOTE: No identifying information will be collected from you, such as your name, address, etc.—allowing you to remain anonymous.

**Find out if you qualify for participation by answering the following questions:**

6. Are you Muslim?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
7. Are you at least 18 years old?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
8. Have you been living in the United States for at least 2 years?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
9. Are you able to devote **about 10 minutes answering survey questions** about yourself and your experiences in the U.S.?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_
10. Are you willing to spend **another 10-15 minutes freely expressing yourself** by typing in your answers to open-ended questions about your experiences in the U.S.?
  - a. Yes \_\_\_\_\_ No \_\_\_\_\_

**Thus, some people may complete the survey in less than 20 minutes, while we are asking if you have about 20-30 to answer all the questions. Only those who answer all the questions (including brief open-ended answers), will be entered into the drawing for a 3 in 250 chance to win a \$300, \$200 or \$100 Amazon gift card.**

If they answered YES to all of the above questions → they access survey.

If they answered NO to any of the above questions → they receive this message:

Thank you for your time, but, unfortunately you are not qualified to participate in this study.

Feel free to invite other Muslim Americans who may qualify to participate in this study.

Please send them the study link\* that you used to access this survey.

THANK YOU!

\* “GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card”

**The Living in America Muslim Life Stress,**

**Coping, and Life Satisfaction  
Study Survey**

**Teachers College, Columbia University  
Institutional Review Board (IRB) Protocol # \_\_\_\_\_**

Instructions: Please answer the following questions as honestly as possible by either selecting your desired answer or by providing an answer in the text box.

**Part I: Basic Demographics (BD-10)**

[A tool created for use by the Research Group on Disparities in Health (e.g. Ingram, 2017), and adapted for the present study population. See: Ingram, L. (2017). Toward improving the health and academic outcomes of minority college students: Predictors of experiences of racism and/or oppression, stress, trauma, health status and level of academic achievement. Doctoral Dissertation. Teachers College, Columbia University.]

**Please enter your zip code** \_\_\_\_\_

1-What gender do you identify with?

- d. Male
- e. Female
- f. Other (Please indicate \_\_\_\_\_)

2-What is your age? [DROP DOWN MENU from 15 to 100—Exit any 17 & below]

3-What is your race/ethnicity:

- j. Arab American / Middle Eastern
- k. Asian (Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese, or other Asian)
- l. Black / African American
- m. Cuban, other Spanish
- n. Hispanic / Latino (including Puerto Rican, Mexican, Mexican American, Chicano,
- o. Native American/American Indian / Alaska Native
- p. Native Hawaiian / Pacific Islander
- q. White / Caucasian / European American
- r. Other group(s) (specify)

4-My skin color is

- a. \_\_\_ Very Dark
- b. \_\_\_ Dark
- c. \_\_\_ Medium to Dark
- d. \_\_\_ Medium to Light
- e. \_\_\_ Light
- f. \_\_\_ Very Light
- g. \_\_\_ White

5-Where you born in the United States?

- c. Yes
- d. No [If no Skip next question]

(If “No” to Q4)

What is your country of Origin?

[DROP DOWN MENU for countries]

6-How many years have you been living in the United States?

[DROP DOWN MENU from 1-100 years—Exit any 2 years or less]



7-What is the highest degree or level of school that you have completed?

- No schooling
- Nursery school to 8th grade
- Some high school, no diploma
- High school graduate, diploma or the equivalent (for example: GED)
- Some college credit, no degree
- Associate degree or technical degree (for example: AA, AS)
- Bachelor's degree (for example: BA, BS)
- Master's degree (for example: MA, MS, MEd)
- Professional degree (MD, DDS, DMD, PharmD)
- Doctorate degree (PhD, EdD, DrPH)

8-What is your marital status?

- Single, never married
- Married
- Widowed
- Divorced
- Separated

9-Are you currently:

- Employed for wages
- Self-employed
- Unemployed
- A homemaker
- A student
- Military
- Retired
- Disabled/Unable to work

10-My annual household income is:

- 1-Less than \$9,000
- \$10,000 to \$19,000
- \$20,000 to \$39,000
- \$40,000 to \$49,000
- \$50,000 to \$99,999
- \$100,000 to \$199,999
- \$200,000 to \$299,000
- \$300,000 to \$399,000
- \$400,000 to \$499,000
- \$500,000 to \$799,000
- 11-\$800,000 or More

## Part II: Personal Health Background (PHB-9)

[This is a tool created for use by the Research Group on Disparities in Health (e.g. Ingram, 2017). See Ingram (2017) reference above under Part I.]

1-I rate my overall health status as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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2-What is your height in feet (Drop down, 4-9)

3-What is your height in inches (Drop down, 0-11)

4-My weight in pounds is (Drop down, 70-400)

5-I consider myself to be:

Underweight  Normal weight  Overweight  Obese

6-My type of medical insurance is:

g. Private insurance plan (e.g. Blue Cross/Blue Shield, Aetna, Oxford, etc.)

h. HMO

i. Medicaid

j. Medicare

k. Not applicable, I have no medical insurance

l. Other (please specify)

7-I rate the overall quality of care I receive for my health (and any medical condition I have) as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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**Not applicable (I do not receive any health care)**

8-I rate the overall quality of care I receive from my primary care physician/healthcare provider as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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**Not applicable (I do not have one)**

9-I rate my health care providers' sensitivity and competence for treating me as someone who is Muslim- as:

<b>1-Very Poor</b>	<b>2-Poor</b>	<b>3-Fair</b>	<b>4-Good</b>	<b>5-Very Good</b>	<b>6-Excellent</b>
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**Not applicable (I do not receive health care)**

### **Part III: Religious Affiliation and Religiosity Scale (RA-RS-3)**

[Note: This is a new survey created by the Principal Investigator, Susan Tirhi. It includes (question # 2) the single-item scale, the Self-Rating of Religiosity scale (SRR; Abdel-Khalek, 2007): “Do you consider yourself to be: 1 very religious, 2 religious, 3 somewhat religious, 4 not religious, 5 not religious at all. Using the SRR scale with 531 Muslim men and women demonstrated high reliability (.89), good temporal stability, concurrent validity, and high loading (0.84), thereby denoting good factorial validity (Abdel-Khalek, 2007).]

1-Do you consider yourself to be a practicing Muslim?

d. Yes

e. No

f. Sometimes, but not always

2-“Do you consider yourself to be:  
 \_\_\_1 very religious \_\_\_2 religious \_\_\_3 somewhat religious \_\_\_4 not religious  
 \_\_\_5 not religious at all.

3-What type of Muslim sect do you belong to?

- i. Sunni
- j. Shi’ite
- k. Sufi
- l. Salafi
- m. Nation of Islam
- n. Baha’i or Ahmadiyya
- o. Druze, Alevis, or ‘Alawi
- p. Other (Please indicate \_\_\_\_\_)

#### **Part IV: Frequency of Wearing Muslim Identifying Clothing for Females and Males (FW-MIC-FFM-1)**

[This is a new survey created by the Principal Investigator, Susan Tirhi, and her dissertation sponsor, Dr. Barbara Wallace for first time use in the study. Questions were adapted for use from a larger study conducted by the Pew Research Center in which American Muslims were surveyed to understand their attitudes towards their place in American society (Pew Research Center, 2017). [i.e., Pew Research Center, (2017). Pew Research Center 2017 Survey of American Muslims Final Questionnaire [PDF File]. Washington, D.C.. Retrieved from <http://assets.pewresearch.org/wp-content/uploads/sites/11/2017/07/25172454/Muslim-American-Final-Questionnaire.pdf>]. Also, additional female and male clothing items were added, given what is worn globally by Muslims, and may be worn by Muslim Americans.]

**Please remind us, for the question that follows, do you identify as**

**\_\_\_Male \_\_\_Female**

#### **If female→**

Please think about what many Muslim wear when they are out in public and indicate what you wear and how often you wear it.

1-When out in public, how often do your wear

**visibly Muslim clothing**—such as a Niqab, or veil covering the head and face, but not the eyes; a Burka, or a veil covering the entire body and face, with a mesh window or grille across the eyes; a Hijab (hee-jab) or a veil, or headscarf that covers the hair and neck; a Dupatta, or a long scarf that is loosely draped across the head and shoulders; a Chador, or full-length cloak that is held closed at the front by the woman’s hand or under their arms; an Abaya, or Kaftan full length dress?

*\_\_\_4-All the time \_\_\_3-Most of the time \_\_\_2-Only some of the time \_\_\_2-Rarely \_\_\_0-Never  
 \_\_\_ I don’t know/Not sure*

#### **If male→**

Please think about what many Muslim wear when they are out in public and indicate what you wear and how often you wear it.

1-When out in public, how often do you wear

**visibly Muslim clothing**—such as a Kufi, Shalwar Kameez, or Salwar Kameez, or Thobe, or Kurta Shirt)?

   4-All the time    3-Most of the time    2-Only some of the time    2-Rarely    0-Never  
   I don't know/Not sure

### **Part V: More About You (Social Desirability) (MAY-13)**

[Using a short form, arising from the original work of: Crowne, D. and Marlowe, D. (1960). A new scale of social desirability independent of psychopathology. *Journal of Consulting Psychology*, 24(4):349-354. More details will be presented in dissertation]

*Read each item below and decide whether the statement is true or false as it pertains to you personally. Circle T for True or F for false.*

1. It is sometimes hard for me to go on with my work if I am not encouraged. T F
2. I sometimes feel resentful when I don't get my way. T F
3. On a few occasions, I have given up doing something because I thought too little of my ability. T F
4. There have been times when I felt like rebelling against people in authority even though I knew they were right. T F
5. No matter who I'm talking to, I'm always a good listener. T F
6. There have been occasions when I took advantage of someone. T F
7. I'm always willing to admit it when I make a mistake. T F
8. I sometimes try to get even rather than forgive and forget. T F
9. I am always courteous, even to people who are disagreeable T F
10. I have never been irked when people expressed ideas very different from my own. T F
11. There have been times when I was quite jealous of the good fortune of others. T F
12. I am sometimes irritated by people who ask favors of me. T F
13. I have never deliberately said something to hurt someone's feelings . T F

### **Part VI: Life Satisfaction Scale (LSS-1)**

[Taken from: Vang, Z. M., Hou, F., & Elder, K. (2018). Perceived Religious Discrimination, Religiosity, and Life Satisfaction. *Journal of Happiness Studies*, 1-20.]

Using a scale of 0–10 where 0 means 'Very dissatisfied' and 10 means 'Very satisfied', **how do you feel about your life as a whole right now?**

**0=Very Dissatisfied** **10=Very Satisfied**  
   0    1    2    3    4    5    6    7    8    9    10

### **Part VII: Perceived Stress Scale (PSS-10)**

[Creator: Cohen, S., Kamarck, T., Mermelstein, R. (1983). A global measure of perceived stress. *Journal of Health and Social Behavior*, 385-396. Also see Cohen, S (1994). Perceived Stress Scale. Retrieved from <http://www.mindgarden.com/documents/PerceivedStressScale.pdf>]

The questions in this scale ask you about your feelings and thoughts during the last month. In each case, you will be asked to indicate how often you felt or thought a certain way, using the following options:

**1 = Never 1 = Almost Never 2 = Sometimes 3 = Fairly Often 4 = Very Often**

1-In the last month, how often have you been upset because of something that happened unexpectedly?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

2-In the last month, how often have you felt that you were unable to control the important things in your life?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

3-In the last month, how often have you felt nervous and “stressed”?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

4-In the last month, how often have you felt confident about your ability to handle your personal problems?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

5-In the last month, how often have you felt that things were going your way?.

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

6-In the last month, how often have you found that you could not cope with all the things that you had to do?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

7-In the last month, how often have you been able to control irritations in your life?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

8-In the last month, how often have you felt that you were on top of things?

9-In the last month, how often have you been angered because of things that were outside of your control?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

10-In the last month, how often have you felt difficulties were piling up so high that you could not overcome them?

*\_\_0 = Never \_\_1 = Almost Never \_\_2 = Sometimes \_\_3 = Fairly Often \_\_4 = Very Often*

### **Part VIII: Brief Trauma Questionnaire (BTQ-10)**

[As a 10-item scale, The Brief Trauma Questionnaire (BTQ-10) investigates adult trauma exposure, such as to life threats and any serious injury. The BTQ-10 arose from the Brief Trauma Interview (BTI), as per US Department of Veterans Affairs’ National Center for PTSD (USDVA-NCFPTSD, 2015). This survey was used in Amnie (2016) and Ingram (2017). See: Amnie, A. (2016). An online investigation of trauma across the lifespan and predictors of coping self-efficacy: Post-traumatic stress disorder, attention deficit/hyperactivity disorder, substance use disorders, and engagement in risky sexual behavior. A doctoral dissertation. Teachers College, Columbia University. And, See: Ingram (2017) reference, above, under Part I.]

The following questions ask about events that may be extraordinarily stressful or disturbing for almost everyone. Please indicate “Yes” or “No” to report what has happened to you.

If you answer “Yes” for an event, please answer: (1) whether you thought your life was in danger or you might be seriously injured; and (2) whether you were seriously injured.

If you answer “No” for an event, go on to the next event

1. Have you ever served in a war zone, or have you ever served in a noncombat job that exposed you to war-related casualties (for example, as a medic or on graves registration duty)?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

2. Have you ever been in a serious car accident, or a serious accident at work or somewhere else?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

3. Have you ever been in a major natural or technological disaster, such as a fire, tornado, hurricane, flood, earthquake, or chemical spill? Or, have you been in a disaster related to a terrorist attack?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

4. Have you ever had a life-threatening illness such as cancer, a heart attack, leukemia, AIDS, multiple sclerosis, etc.?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

5. Before age 18, were you ever physically punished or beaten by a parent, caretaker, or teacher so that: you were very frightened; or you thought you would be injured; or you received bruises, cuts, welts, lumps or other injuries?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

6. Not including any punishments or beatings you already reported in Question 5, have you ever been attacked, beaten, or mugged by anyone, including friends, family members, or strangers?

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes      Were you seriously injured?  No  Yes

7. Has anyone ever made or pressured you into having some type of unwanted sexual contact?

Note: By sexual contact we mean any contact between someone else and your private parts or between you and someone else's private parts

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes Were you seriously injured?  No  Yes

8. Have you ever been in any other situation in which you were seriously injured, or have you ever been in any other situation in which you feared you might be seriously injured or killed? (For example, during an arrest experience, an incarceration experience, a refugee crisis, or immigration/migration experience?)

No  Yes (YES → SKIP LOGIC TO)

Did you think your life was in danger or you might be seriously injured?

No  Yes Were you seriously injured?  No  Yes

9. Has a close family member or friend died violently, for example, in a serious car crash, mugging, or attack—including through school violence, gang violence, community violence, or some other type of serious violence or accident?

No  Yes

10. Have you ever witnessed a situation in which someone was seriously injured or killed, or have you ever witnessed a situation in which you feared someone would be seriously injured or killed?

Note: Do not answer “yes” for any event you already reported in Questions 1-9

No  Yes

### **Part IX: PTSD Checklist—Civilian Version (PCCV- 17)**

[As a 17-item survey, The Posttraumatic Stress Disorder Checklist- Civilian Version (PCL-S-17) is based on the diagnostic criteria for B, C, and D in the Fourth Edition of the Diagnostic and Statistical Manual of Mental Disorder (Ruggiero, Del Ben, Scotti, & Rabalais, 2003). It was used by Amnie (2016) and Ingram (2017), for example. See Amnie (2016) and Ingram (2017) references, above.]

1- Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

2- Repeated, disturbing dreams of a stressful experience from the past?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

3- Suddenly acting or feeling as if a stressful experience were happening again (as if you were reliving it)?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

4. Feeling very upset when something reminded you of a stressful experience from the past?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

5. Having physical reactions (e.g., heart pounding, trouble breathing, or sweating) when something reminded you of a stressful experience from the past?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

6. Avoid thinking about or talking about a stressful experience from the past or avoid having feelings related to it?

(1) Not at all  (2) A little bit  (3) Moderately  (4) Quite a bit  (5) Extremely

7. Avoid activities or situations because they remind you of a stressful experience from the past?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
8. Trouble remembering important parts of a stressful experience from the past?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
9. Loss of interest in things that you used to enjoy?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
10. Feeling distant or cut off from other people?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
11. Feeling emotionally numb or being unable to have loving feelings for those close to you?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
12. Feeling as if your future will somehow be cut short?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
13. Trouble falling or staying asleep?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
14. Feeling irritable or having angry outbursts?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
15. Having difficulty concentrating?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
16. Being “super alert” or watchful on guard?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely
17. Feeling jumpy or easily startled?  
 \_\_\_ (1) Not at all \_\_\_ (2) A little bit \_\_\_ (3) Moderately \_\_\_ (4) Quite a bit \_\_\_ (5) Extremely

**Part X: Retrospective Depression, Anxiety Scale and Counseling Scale (R-DACS-3)**

[NOTE: This is shorter version of a scale that follows the work of Lian (2017)—as a common tool used by the Research Group on Disparities in Health (RGDH. For this study, subjects are only asked about the past year—and not past 3, 6 months. The counseling question appears just once and includes new options (e.g. Iman). See: Lian, Z. (2017). Predictors of depression/anxiety, mental health service utilization, and help-seeking for Chinese international students: Role of acculturation, microaggressions, social support, coping self-efficacy, stigma, and college staff’s cultural competence and cultural humility. Doctoral Dissertation, Teachers College, Columbia University.]

**Depression** is an overwhelming feeling of intense sadness. It can include feeling helpless, hopeless, and worthless. It can sometimes be expressed through angry outbursts, as well as bursting into tears. There can also be loss of appetite, or an increase in appetite. There can also be difficulty sleeping or oversleeping. In addition, there can be a loss of interest in your activities. Such a depression can last for days or weeks. This goes beyond typical feelings of sadness, such as following some disappointment.

1-Do you think you experienced any **depression** in the past year or 12 months? \_\_\_ No  
 \_\_\_ Yes



**Anxiety** is an overwhelming and intense feeling of nervousness, fear, tension, powerlessness, and apprehension. It can reach a peak so there are moments of panic where one's heart may be pounding/beating quickly, or there is rapid breathing/difficulty breathing. A person may also experience sweating and trembling. Sometimes it can be so intense that one has trouble concentrating/thinking, leaving the house, or trouble being around other people. The fear can be very intense, and one can feel like there is some impending danger. This goes beyond typical feelings of nervousness, such as when anticipating a new situation, or something unexpected, or unknown.

2-Do you think you experienced any **anxiety** in the past year or 12 months? \_\_\_ No  
\_\_\_ Yes

### **Receipt of Counseling**

3-In the past year, did you seek out any kind of counseling or advice for any depression and/or anxiety, or other stress—such as from a mental health professional, Iman, Mosque Elder, or family member?

\_\_\_ Yes \_\_\_ No \_\_\_ Not Applicable/ No experience of depression or anxiety, or other related issues, etc.

**NOTE: Recall the online counseling resources recommended in the Informed Consent and Research Description—that will be repeated at the end of this survey for your convenience; and, recall the study contact number if you feel you need assistance seeking help.**

### **Part XI: Ratings of Experiences of Microaggressions (REMI-6)**

[This is an adaptation of a scale previously used in Liss (2015) and created for use by the Research Group on Disparities in Health. See Liss (2015) reference: Liss, A. R. (2015). Microaggression experiences, stress, and coping for lesbian, bisexual, or queer-identified women seeking the goals of childbirth and/or co-parenting: An online survey of experiences with maternal health care. A doctoral dissertation. Teachers College, Columbia University.]

Please think about your general life experiences, whether interacting with members of the general public, people in work settings, members of your family, or members of the larger community.

To what extent did you experience any of the following—**that seemed related to your being Muslim:**

1-Brief exchanges or brief interactions where you felt you were receiving messages that were a put down, denigrating, or conveyed something negative

\_\_\_ 0-Never/Not At All \_\_\_ 1-At Least Once \_\_\_ 2-More Than Once \_\_\_ 3-A Few Times  
\_\_\_ 4-Many Times

2-A verbal attack that was hurtful and caused mental or emotional pain, whether this involved name-calling, or some act of discrimination performed on purpose

\_\_\_ 0-Never/Not At All \_\_\_ 1-At Least Once \_\_\_ 2-More Than Once \_\_\_ 3-A Few Times

4-Many Times

3-A nonverbal attack, or some behavior that was hurtful and caused mental or emotional pain, whether this involved someone avoiding contact and interaction, or avoiding communication, or some act of discrimination performed on purpose

   0-Never/Not At All    1-At Least Once    2-More Than Once    3-A Few Times  
   4-Many Times

4-A communication that was insulting, or conveyed rudeness and insensitivity, put downs or demeaning language

   0-Never/Not At All    1-At Least Once    2-More Than Once    3-A Few Times  
   4-Many Times

5-A communication that excluded you, cancelled out your existence, made you invisible, or ignored the reality of your thoughts, feelings, and existence as a diverse person

   0-Never/Not At All    1-At Least Once    2-More Than Once    3-A Few Times  
   4-Many Times

6-How often did you experience any of the above where you felt the treatment you received was related to BOTH your race/ethnicity, or skin color, or physical appearance, as well as your being Muslim?

   0-Never/Not At All    1-At Least Once    2-More Than Once    3-A Few Times  
   4-Many Times

## **Part XII: Ratings of Experiences of Overt Acts of Violence (REOAV-4)**

[This survey was created for first time use in this study by the Principal Investigator (Susan Tirhi) and her dissertation sponsor, Dr. Barbara Wallace—for use by the Research Group on Disparities in Health. It is based on the concept of overt violence advanced elsewhere (Wallace, 2003) [i.e., Wallace, B.C. (2003). A multicultural approach to violence: Toward a psychology of oppression, liberation, and identity development. In B. C. Wallace, and R. T. Carter (Eds.). *Understanding and Dealing with Violence: A Multicultural Approach*, pp.3-39, Sage Publications: Thousand Oaks, California]—while also capturing some of what is discussed in the literature on macroaggressions (e.g. Osanloo, A. F., Boske, C., & Newcomb, W. S. (2016). *Deconstructing Macroaggressions, Microaggressions, and Structural Racism in Education: Developing a Conceptual Model for the Intersection of Social Justice Practice and Intercultural Education*. *International Journal of Organizational Theory and Development*,1, 1-19.)]

Please think about your general life experiences, or overall experiences in life, whether interacting with members of the general public, people in work settings, members of your family, or members of the larger community.

To what extent did you personally or did a family member or friend experience any of the following—and it seemed related to being Muslim:

1-A physical attack, for example, being hit, slapped, kick or beaten up

Never/Not At All (0) \_ At Least Once (1) \_ More Than Once (2) \_ A Few Times (3)  
\_ Many Times (4)

2-Assault with a weapon, for example, being shot, stabbed, threatened with a knife, gun, or bomb

Never/Not At All (0) \_ At Least Once (1) \_ More Than Once (2) \_ A Few Times (3)  
\_ Many Times (4)

3-Sexual assault, for example, rape, attempted rape, made to perform some type of sexual act through force or threat of harm

Never/Not At All (0) \_ At Least Once (1) \_ More Than Once (2) \_ A Few Times (3)  
\_ Many Times (4)

4-Violent destruction of property or damage to property or belongings (e.g. graffiti on a wall, broken window glass, smashed car windows, etc.

Never/Not At All (0) \_ At Least Once (1) \_ More Than Once (2) \_ A Few Times (3)  
\_ Many Times (4)

### **Part XIII: Perceptions of Islamophobia and/or Islamophobic Discrimination (PI-ID-10)**

[This is the Perception of Racism and Oppression Scale (PROS-10) created by Professor Barbara Wallace, as used in Ingram (2017) and many other studies conducted by the Research Group on Disparities in Health. For this study, instead of defining and asking about experiences of racism and/or oppression, the focus is on Islamophobia and/or Islamophobic discrimination. See Ingram (2017) reference above, under Part I.]

We are interested in learning about your perceptions of Islamophobia and/or Islamophobic discrimination—including Muslims' experience of any prejudice, harassment, violence, exclusion, disadvantage, or lack of access to opportunity—whether while driving, eating out, walking around, shopping, voting, hailing down a taxi, interacting with police, searching for employment, seeking health care, applying for a bank loan/mortgage, searching for housing, negotiating the criminal justice system, working, traveling, vacationing, or seeking out literally any opportunity etc.....

**NOTE: items # 7-10 are reverse scored.**

**Please answer the following questions.**

**In terms of experiences of Islamophobia and/or Islamophobic discrimination**

1-I am not sure it is really exists or happens to people.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

2-When incidents are talked about, I am not sure what makes something racist or oppressive.

1. \_\_\_ *Strongly Agree* 2. \_\_\_ *Agree* 3. \_\_\_ *Undecided* 4. \_\_\_ *Disagree* 5. \_\_\_ *Strongly Disagree*

3-I think it never happens *to me*.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

4-There are times when I “don’t get it,” or I can’t really tell when it is happening *to me*.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

5-I think it never happens *to others*.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

6-There are times when I “don’t get it,” or I can’t really tell when it is happening *to others*.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

7-I can usually see or sense when it is happening *to me*.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

8-I can usually see or sense when it is happening *to others*.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

9-When incidents are talked about, I think “That could happen to me or someone I love.”

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

10-When incidents are talked about, I can identify with and understand the experience.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

#### **ITEMS # 7-10 ARE REVERSE SCORED**

#### **Part XIV: Coping and Responding to Islamophobia and/or Islamophobic Discrimination Staging Scale (CR-IID-SC-6)**

[This is the Coping and Responding to Racism and Oppression Staging Scale (CRROSS-13) created by Professor Barbara Wallace, as used in Ingram (2017) and many other studies conducted by the Research Group on Disparities in Health. For this study, instead of defining and asking about experiences of racism and/or oppression, the focus is on Islamophobia and/or Islamophobic discrimination. See Ingram (2017) reference above, under Part I]

**NOTE: deleted original CRROSS-13 items # 1; 7 -0; and, 11-13 - to shorten scale**

Please answer the following questions.

In terms of experiences of **Islamophobia and/or Islamophobic discrimination**:

1-I *never thought about* how to cope with or respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

3-I *have thought about* how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

4-I *never took steps* to learn more about how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

5-I am *planning to take steps* to learn more about how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

6-I *have been actively learning* how to cope with and respond to it.

1. \_\_\_ Strongly Agree 2. \_\_\_ Agree 3. \_\_\_ Undecided 4. \_\_\_ Disagree 5. \_\_\_ Strongly Disagree

7-Learning how to cope with and respond to it is something that *I have been actively working on*:

\_\_\_ never in my life    \_\_\_ < 1 month    \_\_\_ < 6 months    \_\_\_ > 6 months    \_\_\_ 1-3 years  
 \_\_\_ 4-6 years    \_\_\_ 7-9 years    \_\_\_ 10-20 years    \_\_\_ 21-30 years    \_\_\_ >31 years  
 \_\_\_ unsure

#### **Part XV. Coping Self-Efficacy Scale—Reduced (CSES-RF-13)**

[Developed by Chesney, Neilands, Chambers, Taylor, and Folkman (2006). See: Chesney, M. A., Neilands, T. B., Chambers, D. B., Taylor, J. M., & Folkman, S. (2006). A validity and reliability study of the coping self-efficacy scale. *British journal of health psychology*, 11(3), 421-437. Within the Research Group on Disparities in Health, it was recently used by Ingram (2017). See Ingram (2017) reference, above]

For each of the following items, write a number from 0 - 10, using the scale below. When things aren't going well for you, how confident are you that you can:

<b>Cannot do at all</b>	<b>Moderately certain can do</b>	<b>Certainly can do</b>
0   1   2   3	4   5   6   7	8   9   10

#### **4. Use Problem-Focused Coping**

1. Break an upsetting problem down into smaller parts. \_\_\_\_\_
2. Sort out what can be changed, and what cannot be changed. \_\_\_\_\_
3. Make a plan of action and follow it when confronted with a problem \_\_\_\_\_
4. Leave options open when things get stressful. \_\_\_\_\_
5. Think about one part of the problem at a time. \_\_\_\_\_
6. Find solutions to your most difficult problems. \_\_\_\_\_

#### **5. Stop Unpleasant Emotions and Thoughts**

7. Make unpleasant thoughts go away. \_\_\_\_\_
8. Take your mind off unpleasant thoughts. \_\_\_\_\_
9. Stop yourself from being upset by unpleasant thoughts. \_\_\_\_\_
10. Keep from feeling sad. \_\_\_\_\_

#### **6. Get Support From Friends and Family**

11. Get friends to help you with the things you need. \_\_\_\_\_

12. Get emotional support from friends and family. \_\_\_\_\_
13. Make new friends. \_\_\_\_\_

**Part XVI: Life Satisfaction, Stress, Trauma, Intersectionality, Ways of Coping, and Resilience (LS-STI-WOC-R-5)**

[Adapted from Ingram (2017). See: Ingram, L. (2017). Toward improving the health and academic outcomes of minority college students: Predictors of experiences of racism and/or oppression, stress, trauma, health status and level of academic achievement. Doctoral Dissertation. Teachers College, Columbia University.]

This is an opportunity for you to freely share your experiences, views, and opinions.

- 1-What factors have impacted your Life Satisfaction as a Muslim American?
- 2-What have been the most stressful parts of your life experience as a Muslim American? Please share how you coped, bounced back, or healed—or how you have been resilient.
- 3-Have you experienced any discrimination, microaggressions, or hate—such as for having a double or triple marginalized/oppressed identity (e.g. being a Muslim American AND ALSO a racial/ethnic minority, or being a woman, or disabled, or due to your physical appearance, or skin color)?
- \_\_\_\_ Yes \_\_\_\_ No
- Was it stressful? \_\_\_\_ Yes \_\_\_\_ No
- Was it traumatic? \_\_\_\_ Yes \_\_\_\_ No
- 4-Please share some examples, including how you coped, bounced back, or healed—or how you have been resilient.
- 5.-What could Americans (e.g. healthcare providers [physicians, nurses, psychiatrists, psychologists, counselors], employers, school personnel, policy makers, lawmakers, community members, etc.) do to improve the overall life satisfaction of Muslim Americans who are experiencing or have a history of experiencing stress and trauma—whether within the healthcare system, workforce, school system (i.e. needs of children), or the larger society?

-----END OF SURVEY-----

**DID YOU JUST PARTICIPATE IN ONE OF  
OUR RESEARCH STUDIES? \*  
INTERESTED IN FREE OR LOW-COST ONLINE COUNSELING?**

**CLICK ON THIS LINK:**

<https://tinyurl.com/GET-FREE-LOW-COST-COUNSELING>

**OR READ BELOW**

It is possible that your answering questions as a participant in this research study brought up uncomfortable feelings, thought and memories. Brief emergency counseling, crisis intervention counseling, and a referral to longer-term support may be helpful to you at

this time. If that is the case, you may use any of the following resources for immediate help:

**For Free Texting Crisis Help:** <https://www.crisistextline.org/>

You text 741741 when in crisis as a service available 24 hours a day, 7 days a week. You will reach a live trained Crisis Counselor who will respond quickly. The Crisis Counselor helps to move you from a hot moment to a cool calm and safe state, using effective active listening and suggested referrals—all using the Crisis Text Live’s secure platform. If you have a phone plan with AT&T, T-Mobile, Sprint, or Verizon, texting to 741741 is free of charge.

**Contact a Crisis Intervention Hotline for Immediate Help and Referrals: See a List of Hotline Phone Numbers:** [https://www.allaboutcounseling.com/crisis\\_hotlines.htm](https://www.allaboutcounseling.com/crisis_hotlines.htm)

**Examples of Crisis Intervention Hotlines:**

- **If you are in immediate danger**, call 911
- **National Suicide Hotline:** 800-SUICIDE (800-784-2433)
- **National Suicide Prevention Lifeline:** 800-273-TALK (800-273-8255)
- **Grief Recovery Helpline:** 800-445-4808

**Seek Out Top Rated, Low-Cost Online Counseling Services:** <https://www.e-counseling.com/tlp/therapy-1/?imt=1>

Please see a list of the top rated online counseling services—with the average weekly cost as low as \$35.

**Seek Out Affordable Online Counseling:** <https://www.betterhelp.com/about/>

Access affordable and convenient online counseling with professionals.

**Seek Help from the Study Sponsor by E-Mail or Phone:** [bcw3@tc.columbia.edu](mailto:bcw3@tc.columbia.edu) or 267-269-7411.

You may contact the study sponsor, Dr. Barbara Wallace, receiving help with referrals.

\*NOTE: The Research Group on Disparities in Health (RGDH) is part of the Center for Health Equity and Urban Science Education, Teachers College, Columbia University. Numerous studies are conducted annually by the RGDH, with Dr. Barbara Wallace serving as the research sponsor.

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**SHARE WITH OTHERS!**

We invite you to text message, tweet, and e-mail others you know:

“GO TO <https://tinyurl.com/MuslimAmericanSurvey> to take the Muslim American Survey on life satisfaction, Islamophobia, stress and coping strategies for a chance to win a \$300, \$200 or \$100 Amazon gift card”

Thanks for completing the survey.